EXHIBIT A(1)(d)

FIFTH AMENDED MEDICAL PLAN DOCUMENT

MONTGOMERY COUNTY EMPLOYEE BENEFIT PLAN

FIFTH AMENDED MEDICAL PLAN DOCUMENT

Effective October 1, 2021

Montgomery County, Texas, (the "Employer"), hereby amends and restates the Montgomery County Employee Benefit Plan (the "Plan") effective as of October 1, 2021. The Plan, established under Chapter 172 of the Texas Local Government Code, provides medical and prescription drug coverage for the benefit of the eligible Employees, Elected Officials, Appointed Officials and Retirees of the Employer and their eligible Dependents.

Retirees and their eligible Dependents are eligible to participate in this Plan in accordance with the rules established and approved by Montgomery County Commissioners Court and Chapter 175 of the Texas Local Government Code.

The purpose of the Plan is to provide reimbursement for a Participant's Eligible Expenses incurred as a result of Medically Necessary treatment for an Illness or Injury. In consideration of any required Participant contributions, the Employer agrees to make payment as provided in the Plan document. Montgomery County, Texas reserves the right to amend this Plan. The Plan document constitutes the entire Plan.

The Employer has caused this instrument to be executed by its duly authorized officers with the effective date of the 1st day of October 2021.

Executed this 14 day of September, 2021

County Judge

Commissioner Precinct 1

Commissioner Precinct 2

Commissioner Precinct 3

Commissioner Precinct 4

MONTGOMERY COUNTY

EMPLOYEE BENEFIT PLAN DOCUMENT

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Plan Administrator's Discretionary Authority

The benefits provided under the Plan are for the exclusive benefit of the eligible Employees, Elected Officials, Appointed Officials, eligible Retirees (and their eligible Dependents) of the Employer. These benefits are intended to be continued indefinitely, however, the Employer 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 Employer 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. You should not, therefore, assume that the benefits that are provided under the Plan will continue to be available and remain unchanged, and you should disregard any information or communication (written or oral) that would seem to limit the Employer's absolute right and discretion to terminate, suspend, discontinue or amend such benefits. Furthermore, the Plan Administrator reserves the absolute right, authority and discretion to interpret, construe, construct and administer the terms and provision of the Plan, in its discretion, including correction of any error or defect, supplying any omission, reconciling any inconsistency, and making all findings of fact including, without limitation, any factual determination that may impact eligibility or a claim for benefits. All decision, interpretations and other determinations of the Plan Administrator will be final, binding and conclusive on all persons and entities subject only to the claims appeal provisions of the Plan. Benefits under the Plan will be paid only if the Plan Administrator determines in its discretion that the Participant is entitled to them.

The Plan is a "Grandfathered" Plan

This Plan believes it is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the "Affordable Care Act"). 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 501 North Thompson, Suite 202, Conroe, Texas, 77301, Phone 936-760-6935 and HIPAA Compliant Fax 936-538-8169. You may also contact the U.S. Department of Health and Human Services at https://www.healthcare.gov.

Life Insurance and Accidental Death and Dismemberment

$20,000.00 for each Plan Participant that is a full time Employee

Major Medical Benefits

Schedule of Benefits & Summary Plan Description

Low Medical Deductible Plan Option

Annual Deductibles:

Inside PPO Plan deductible can be used to satisfy Outside PPO Plan deductible:	Inside PPO	Outside PPO
Deductible per Participant per calendar year, with three (3) month carryover provision:	**$250.00**	**$500.00**
Family Deductible Maximum - per Participant deductible per family per calendar year:	**N/A**	**N/A**
Separate per Hospital confinement deductible:	**N/A**	**$450.00**

Low Medical Deductible Plan Option Coinsurance Provisions per Calendar Year:

Inside the PPO Coinsurance Provisions

If a Participant utilizes Preferred Providers, Inside the PPO, all Eligible Expenses will be paid by the Plan at 90% and the Participant will pay 10% up to the first $20,000.00, after the applicable deductibles have been satisfied unless otherwise stated in the Medical Schedule of Benefits. When Eligible Expenses reach $20,000.00, after the applicable deductibles and coinsurance provisions have been satisfied, the Plan will pay 100% of Eligible Expenses per Participant. The maximum Inside the PPO Coinsurance out-of-pocket of Eligible Expenses is $2,000.00 per Participant per calendar year subject to Plan provisions. No Family Coinsurance Maximum applies.

Outside the PPO Coinsurance Provisions

If a Participant utilizes providers outside the PPO, all Eligible Expenses will be paid by the Plan at 50% of the Maximum Eligible Charges and the Participant will pay 50% of the Maximum Eligible Charges up to the first $15,000.00, after the applicable deductibles have been satisfied unless otherwise stated in the Medical Schedule of Benefits. When Eligible Expenses reach $15,000.00, after the applicable deductibles and coinsurance have been satisfied, the Plan will pay 100% of Eligible Expenses per Participant. The maximum Outside the PPO coinsurance out-of-pocket of Eligible Expenses is $7,500.00 per Participant per calendar year. No Family Coinsurance Maximum applies.

Inside or Outside the PPO Coinsurance Provisions

Whether Inside or Outside the PPO, any Expenses other than qualified and Eligible Expenses will be disallowed and cannot be used to satisfy deductibles or the Participant's maximum medical coinsurance provisions. Any expense related to mental health care, substance abuse, alcoholism, or Prescription Drugs purchased with or without the Participant's Montgomery County Employee Benefit Plan ID/Prescription card will not be applied to the Participant's maximum medical coinsurance provision or any required deductibles. These provisions apply to each Participant.

Life Insurance and Accidental Death and Dismemberment

$20,000.00 for each Plan Participant that is a full time Employee

Major Medical Benefits

Schedule of Benefits & Summary Plan Description

High Medical Deductible Plan Option

Annual Deductibles:

Inside PPO Plan deductible can be used to satisfy Outside PPO Plan deductible:	Inside PPO	Outside PPO
Deductible per Participant per calendar year, with three (3) month carryover provision:	**$1,000.00**	**$2,000.00**
Family Deductible Maximum - per Participant deductible per family per calendar year:	**3 Individuals**	**3 Individuals**
Separate per Hospital Confinement deductible:	**N/A**	**$450.00**

High Medical Deductible Plan Option Coinsurance Provisions per Calendar Year:

Inside the PPO Coinsurance Provisions

If a Participant utilizes Preferred Providers, Inside the PPO, all Eligible Expenses will be paid by the Plan at 90% and the Participant will pay 10% up to the first $10,000.00 of Eligible Expenses, after the applicable deductibles have been satisfied unless otherwise stated in the Medical Schedule of Benefits. When Eligible Expenses reach $10,000.00, after the applicable deductible and coinsurance provisions have been satisfied, the Plan will pay 100% of Eligible Expenses per Participant. The maximum Inside PPO coinsurance out-of-pocket for Eligible Expenses is $1,000.00 per Participant per calendar year with a Family Coinsurance Maximum of three (3) covered individuals that must satisfy the calendar year coinsurance per family.

Outside the PPO Coinsurance Provisions

If a Participant utilizes Providers Outside the PPO, all Eligible Expenses will be paid by the Plan at 50% of the Maximum Eligible Charges and the Participant will pay 50% of the Maximum Eligible Charges up to the first $7,500.00 of Eligible Expenses, after the applicable deductibles have be satisfied unless otherwise stated in the Schedule of Benefits. When Eligible Expenses reach $7,500.00, after the applicable deductibles and coinsurance have been satisfied, the Plan will pay 100% of Eligible Expenses per Participant. The maximum Outside the PPO coinsurance out-of-pocket of Eligible Expenses is $3,750.00 per Participant per calendar year with a Family Coinsurance Maximum of three (3) covered individuals that must satisfy the calendar year coinsurance per family.

Inside or Outside the PPO Coinsurance Provisions

Whether Inside or Outside the PPO, any Expenses other than qualified and Eligible Expenses will be disallowed and cannot be used to satisfy the Participant's deductibles or maximum medical coinsurance provisions. Any expense related to mental health care, substance abuse, alcoholism, or Prescription Drugs purchased with or without the Participant's Montgomery County Employee Benefit Plan ID/Prescription card will not be applied to the Participant's maximum medical coinsurance provision or any required deductibles. These provisions apply to each covered Participant.

THE FOLLOWING BENEFITS WILL BE PAID BY THIS BENEFIT PLAN AT THE STATED PERCENTAGE LEVELS AFTER THE MEDICAL PLAN DEDUCTIBLE HAS BEEN SATISFIED, BASED ON THE HIGH OR LOW MEDICAL DEDUCTIBLE PLAN OPTION YOU PARTICIPATE IN. PRE-CERTIFICATION IS REQUIRED FOR HOSPITAL ADMISSIONS AND OUTPATIENT SURGERIES OR A 50% REDUCTION IN BENEFITS WILL OCCUR. (PLEASE REFER TO THE UTILIZATION REVIEW SECTION FOR APPLICABLE TIMELINES.)

	Coinsurance Percentage Plan Pays	
	Inside PPO	Outside PPO
***Inpatient Hospital Expenses** (Pre-Certification Required)		
1. **Average semi-private room** All Medically Necessary Hospital Services including blood, plasma, and intensive care	90%	50%
2. **Ancillary Expenses** Ancillary Provider expenses incurred while Inside a PPO facility, or in an Outside PPO facility in emergency situations, will receive the Inside PPO benefits (see page 6, #16)	90%	50%
3. **Newborn Well Care** Includes pediatric Expenses, room and board, Medically Necessary testing or testing required by the State of Texas for a newborn at time of birth until discharge.	90%	50%
4. **Mental Health Care, Alcohol & Substance Abuse** See Cost Containment Section for any additional limitations. **You must utilize and receive inpatient services from Preferred Providers Inside the PPO or benefits will be disallowed.**	80%	0%
Other Medical Expenses		
1. ***Medical Tourism Benefit** (Pre-Certification Required)		
a. ***Surgical Services at Approved Surgery Centers** (Deductible Waived) Covered Services include all medical costs incurred while receiving treatment or services at an Approved Surgery Center. Pre-certification is required. Limitations apply - refer to the Medical Tourism Benefit under Cost Containment Provisions for details and limitations.	100%	N/A
b. ***Travel Benefit ..... 100% up to $1,000/surgery** Pre-approval of all Travel Benefits is required. Includes transportation (from home to surgery center), lodging and incidental expenses. Limitations apply - refer to Medical Tourism Benefit section for details and limitations.		
IMPORTANT NOTE: *This benefit is ONLY available to members with this Plan as their primary coverage.*		
2. ***Surgery – Inpatient** (Pre-Certification Required)	90%	50%
3. ***Surgery – Outpatient** (Pre-Certification Required)	90%	80%
4. **Pre-Admission Testing, including X-Ray and Lab (Outpatient)** (see page 12)	100%	80%
5. **Second & Third Surgical Opinion** (see page 12) Notification to Prime Dx is highly recommended.	100%	100%
6. **Other Eligible Expenses** Except outpatient mental health care, alcohol and substance abuse	90%	50%
7. **Outpatient Mental Health Care**	80%	0%
Maximum Eligible Charge per Visit Including Alcohol and Substance Abuse conditions, Psychiatrist Expenses and Day Treatments.	**$80.00 Per Visit**	

	Coinsurance Percentage Plan Pays Inside PPO	Outside PPO
8. Chiropractic Expenses	**50%**	**50%**
Maximum visits per calendar year;	**18 Visits* / Annually**	
*Any additional visits require Pre-certification for medical necessity.		
9. Allergy Treatment	**90%**	**50%**
With a calendar year maximum	**$1,000.00 / Annually**	
10. Elective Sterilization	**90%**	**50%**
Vasectomy Tubal Ligation and Hysteroscopic Sterilization (see page 40, #52)		
11. Extended Care (Pre-Certification Required)		
The following benefits will be paid by the Plan at the stated percentage levels below, after the deductible has been satisfied for the High or Low Medical Deductible Plan Option that you participate in:		
a. Skilled nursing facility services	**90%**	**50%**
Maximum days per Calendar Year	**120 Days / Annually**	
b. Home health care	**90%**	**50%**
Maximum days per calendar year	**120 Days / Annually**	
c. Hospice	**90%**	**50%**
Maximum days per calendar year	**180 Days / Annually**	

12. Annual Health Screening Benefit / Well Care Per Calendar Year

Participants in the Plan are eligible to receive the following benefits without a medical diagnosis as indicated below. Any service listed below that is billed with a diagnosis will not be considered as an eligible benefit under the "Annual Health Screening Benefit / Well Care" benefit. The benefits listed below, with the exception of "h." Child Immunizations, will be subject to the $25.00 office copay and the balance will be paid by the Plan at 100% up to $750.00 per calendar year for any one benefit or a total of all benefits listed below:

These benefits may be used only once during the calendar year with the exception of "c." Colorectal cancer screening, "g." Well Baby checkups below, or "h." Child Immunizations. Eligible Expenses for any one benefit or a total of all benefits listed below that exceeds the applicable $750.00 benefit during the calendar year will be subject to the appropriate calendar year deductible and coinsurance provisions.

a. **Mammogram**, including interpretation by radiologist at a **Preferred Provider only**.

b. **Pap smear**, including office visit at a **Preferred Provider only**.

c. **Colorectal cancer screening**, including office visit at a **Preferred Provider only** for any one of the following tests or procedures per calendar year. Colorectal cancer screening is a digital rectal exam, barium enema, fecal occult blood test; or an outpatient colonoscopy screening with Pre-certification required. Colonoscopies are limited to one (1) every three (3) years.

d. **Proctoscopy, occult blood work and prostate specific antigen (PSA) test**, including office visit at a **Preferred Provider only**.

e. **Physical exam** including cholesterol testing and blood work at a **Preferred Provider only**.

f. **Bone density** testing at a **Preferred Provider only**.

g. **Well Baby checkups** outpatient office visits at a **Preferred Provider only**. Participants are required to pay the $25.00 office visit copay on a per visit basis when accessing the benefit and will be limited to no more than six (6) visits up to the first birthday; three (3) visits up to the second birthday; and one (1) visit per calendar year thereafter.

h. **Child Immunizations:**

   i. **birth to the sixth (6th) birthday**, paid at 100%;

   ii. **ages six (6) to the later of the eighteenth (18th) birthday or through twelfth (12th) grade**, paid at 100% at a **Preferred Provider only.**

Other Eligible well care expenses incurred at time of visit are subject to applicable Well Care Benefit provisions including copays, deductible, and coinsurance. (For Eligible **Child Immunizations** – see page 36, Article III Health Care Benefits, #24.)

13. Outpatient Dialysis — 100% of MEC

Important Note: The Plan does not use a preferred provider organization (PPO) for dialysis services. Please review the definition of "Maximum Eligible Charges" also referred to as "MEC", which is contained in the Section titled "Plan Definitions" for details. The definition of MEC is different for Outpatient Dialysis Services than other services.

The Maximum Eligible Charge, for Outpatient Dialysis Services provided in connection with the first 40-dialysis treatments while a Participant is covered by the Plan as determined in the discretion of the Plan Administrator or its delegate, is the lesser of:

1. The provider's normal charge for the same or a similar service or supply; or
2. A fee determined using a commercial healthcare database;

The Maximum Eligible Charge for Outpatient Dialysis Services thereafter, 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.

PRE-CERTIFICATION IS REQUIRED. A Participant must: (1) notify Prime Dx when Dialysis treatment begins; (2) notify Prime Dx diagnosed with End Stage Renal Disease ("ESRD"); and (3) enroll in Part A and B of Medicare when diagnosed with ESRD. While a Participant has ESRD and the Plan is primary, the Plan will pay or reimburse the Participant for Medicare Part B premiums.

14. Outpatient, Non-emergency Office Visits (Medical) at Preferred Providers Only

The Participant is required to pay $25.00 per visit toward the medical Physician's charge for an office visit, and if incurred prior to satisfying the calendar year deductible, the $25.00 will count toward satisfying the calendar year deductibles of the plan option that you participate in. The $25.00 office visit copayment will be assessed each time a Participant utilizes a Preferred Provider and will continue to be assessed after the calendar year deductible has been satisfied. Any office copayment that is paid after the deductible has been satisfied cannot be used to satisfy coinsurance provisions. The balance of the medical Physician's charge for an office visit due after the $25.00 office visit copay has been paid will be paid by the Plan at 100%. All Eligible Expenses incurred during an office visit, other than Physician's Expenses, shall be subject to the deductible and coinsurance provisions of the Plan Option that you participate in.

Example of an Outpatient Non-Emergency Preferred Provider Office Visit

PPO Medical Physician's Charge	**$100.00**
Minus PPO Discount/Reduction	**-$ 30.00**
Balance	**$ 70.00**
Minus Participant's Office Visit Co-pay	**-$ 25.00**
Plan pays 100% of balance of Physician's charge	**$ 45.00**

The Plan will pay other Eligible Expenses incurred during the office visit such as laboratory, X-Ray, injections, and any other Eligible Expenses, at 90% if billed by a Preferred Provider or at 50% of the Maximum Eligible Charges if billed Outside the PPO, after a Participant's deductible is satisfied.

15. Outpatient, Non-emergency Office Visits (Medical) Outside the PPO

The Participant will be required to satisfy the per Participant calendar year deductible of the Plan Option they participate in, before Expenses will be eligible for reimbursement. The Plan will pay for any eligible services performed Outside the PPO at the 50% coinsurance level subject to the Maximum Eligible Charge for the service the Participant received.

16. Emergency Room Services

All Eligible Expenses associated with an Accidental Injury or Emergency Illness when incurred at the Emergency Room will be paid at 90% after the PPO calendar year deductible and $150 Emergency room copay. All payments are based on the Plan's Maximum Eligible Charge guidelines. This includes all Ancillary services as defined within. If the Participant is admitted to the Hospital directly from the Emergency room, all additional Eligible Expenses incurred during that confinement will be paid as addressed above, except that the $150 Emergency Room copay will be waived. **Pre-certification is required for any Hospital admission or a 50% reduction in benefits will occur.**

17. Dependents and Retirees Office Visits/Non-Emergency or Scheduled Hospital Admissions (Outside the PPO Service Area)

If you reside Outside the PPO Service Area and there are no Preferred Providers within 100 miles, benefits will be paid at the 75% coinsurance level to $15,000.00 rather than the 50% coinsurance level, subject to all applicable deductibles of the Plan Option that you

participate in subject to the Maximum Eligible Charges for the location where the services were incurred. All other Plan provisions and limitations remain the same.

18. Outpatient Prescription Drug Expense Coverage With Drug Card

Participants that have been issued a prescription drug card must fill their prescriptions with the prescription drug card. Participants that are eligible for the drug card are Eligible for reimbursement of Compound Prescriptions under the Plan. Co-pays and any additional Prescription Drug Expenses cannot be used to satisfy deductibles or coinsurance maximums of the High or Low Medical Deductible Plan Options (see additional information and limitations - pages 2-3). A current list of Preferred and Non-Preferred Brand Name drugs is provided by MAXOR 1(800)687-0707 A current list of Specialty medications restricted to be filled at Maxor Specialty Pharmacy is 1(800)687-0707. The lists are subject to change.

Retail Pharmacy - 30 day supply or less only

Generic	**$15.00 minimum copay or a 10% copay*, whichever is greater, per Prescription.****
Preferred Brand Name	**$25.00 minimum copay or a 20% copay*, whichever is greater, per Prescription.****
Non-Preferred Brand Name	**$35.00 minimum copay or a 30% copay*, whichever is greater, per Prescription.****
Compound Prescriptions	**$35.00 minimum copay or a 30% copay*, whichever is greater, per Prescription.****

MXP Pharmacy - Mail Order – Greater than a 30 day supply

Generic	**$15.00 copay* per Prescription per Participant or the actual cost, if less.****
Preferred Brand Name	**$25.00 copay* per Prescription per Participant or the actual cost, if less.****
Non-Preferred Brand Name	**$35.00 copay* per Prescription per Participant or the actual cost, if less.****

Maxor Specialty Pharmacy – Up to 90 day supply

(Covered when purchased through Maxor's Specialty Pharmacy only)

Generic	**10% with a maximum patient pay of $15.00 per Prescription**
Preferred Brand Name	**20% with a maximum patient pay of $25.00 per Prescription**
Non-Preferred Brand Name	**30% with a maximum patient pay of $35.00 per Prescription**

*Co-pays are required for refills.

**If your Prescription cost is less than the minimum copay, you will pay the actual cost of the Prescription or if a patient requests a brand name drug when a generic equivalent exists, the patient will pay the difference between the brand and the generic medication in addition to the applicable brand copay.

Not all Expenses are an Eligible Expense (see Definition of Eligible Expenses - page 20). A person's protection under this coverage may be extended after the date that person ceases to be a Participant (See Continuation of Health Care COBRA- pages 28-30). The Plan is not liable for any prescription filled after the termination of coverage under this benefit. Any benefits paid after termination will be recovered from the former Participant.

The Montgomery County Employee Benefit Plan ID/Prescription card will be honored by most pharmacies. MAXOR will be responsible for contracting with all pharmacies that will accept the Montgomery County Employee Benefit Plan ID/Prescription card. They may be contacted at 1-800-687-0707. For Prescription Drugs ordered through MXP Pharmacy - Mail Order, you may receive up to a 90-day supply prescribed by your Physician for the $15.00, $25.00, or $35.00 copay. Participants are required to use the mail order service for maintenance drugs or any Prescription Drug that is written for greater than a 30-day supply. Contact the County Risk Management Department for additional information regarding the Mail Order Program. Any amounts spent on Prescription Drugs, whether actual costs or copays, do not apply toward deductibles or coinsurance provisions under this Plan. This Plan **will not** coordinate benefits with any other entity in regard to outpatient Prescription Drugs purchased with your Montgomery County Employee Benefit Plan ID/Prescription card or submitted for reimbursement to the Plan.

Prescription Drug Definitions - A Prescription Drug means:

1. A medicinal substance that, by law, can be dispensed only by prescription;
2. A compound medication that includes a substance described in (1); or
3. Injectable insulin.

*Note: A "generic drug" is a Prescription Drug identified by its official or chemical name rather than by a brand name.

Prescription Drug Eligible Expense Charge is an Eligible Expense charge for a Prescription Drug under the Plan if it meets all of the following conditions, unless it is specifically excluded under the Schedule of Benefits Limitations and Exclusions:

1. It is prescribed in writing by a licensed Physician in the United States;
2. It is bought while the person is a Participant;
3. It is dispensed by a pharmacy or any other person or organization licensed to dispense Prescription Drugs in the United States;
4. It is for prenatal vitamins prescribed by a Participant's Physician to be used during pregnancy or vitamins prescribed by a Participant's Physician if deemed Medically Necessary for an Injury or Illness not otherwise excluded;
5. It is approved by the Plan Administrator.

Prescription Drug Expenses Not Covered

Unless otherwise specifically included, benefits will not be paid for Expenses:

1. Expenses for a prescription or a refill of a prescription that are more than the Expenses for a 90-day supply;
2. Expenses for a refill of a Prescription that is:
   a. In excess of the number specified by the Physician; or
   b. Furnished more than one year after the date of the Physician's original order of the Prescription Drug;
3. Medicines or drugs for which reimbursement is provided under any workers compensation law, or by any municipal state, or federal program;
4. Medicines or drugs which are lawfully obtainable without a prescription written by a licensed Physician ("Over-the-counter" medications), except insulin, including vitamins (except prenatal vitamins prescribed by a Participant's Physician to be used during pregnancy or vitamins prescribed by a Participant's Physician if deemed Medically Necessary for an Injury or Illness not otherwise excluded), cosmetics and dietary supplements, or drugs that have any over-the-counter equivalent;
5. Any charge for the administration or injection of any drug including injectable insulin;
6. Medicines or drugs prescribed for the treatment of infertility, nicotine addiction, hair loss, or to change skin pigmentation;
7. Replacement of lost, stolen, or damaged Prescriptions;
8. Drugs or medications which are covered under the Major Medical Coverage section;
9. Any Generally Excluded Expenses shown in the Article IV Limitations and Exclusions (see pages 38-40);
10. For weight reduction beyond the limits in Article IV Limitations and Exclusions (see page 39, #25).

19. Observation Room Services:

In order for an observation stay (a period not to exceed 48 hours) to be considered medically necessary, the following conditions must be met:

1. The patient is clinically unstable for discharge; **and**
2. Clinical monitoring, and/or laboratory, radiologic, or other testing is necessary in order to assess the patient's need for hospitalization; **or** the treatment plan is not established or based upon the patient's conditions, is anticipated to be completed within a period not to exceed 48 hours; **or** change in status or conditions are anticipated and immediate medical intervention may be required.

Observation room services are not covered when the above criteria are not met. Observation services that extend beyond a 48 hour period are not covered. Providers must contact Boon Chapman and obtain approval for inpatient status for services beyond the initial 48 hour period.

The following is a list of services that are not considered appropriate for observation room services (this list is not all inclusive):

1. Services are not reasonable or necessary for the diagnosis and treatment of the patient
2. Outpatient blood or chemotherapy administration
3. Lack of/delay in patient transportation
4. When used as a substitute for inpatient admission or services would normally require inpatient stay
5. When it is provided only as a convenience for the physician, patient or patient's family
6. While waiting for transfer to another facility
7. When inpatient is discharged to observation status

20. Benefit Plan Annual Maximum Benefits

The following annual maximums apply to each Plan Participant:

Allergy Treatment	**$1,000.00 / Annually**
Morbid Obesity	
Surgical treatment	**One (1) procedure per covered participant under this medical plan**
Chiropractic Expenses	**18 Visits* / Annually**
*Any additional visits require Pre-certification for medical necessity.	
Temporomandibular Joint Dysfunction or TMJ syndrome	**$1,000.00 / Annually**
Skilled nursing facility services	**120 Days / Annually**
Home health care	**120 Days / Annually**
Hospice	**180 Days / Annually**
Transplants	**One (1) Solid Organ and/or Tissue Transplant Event per lifetime subject to the provisions of the Solid Organ and/or Tissue Transplant Event Benefit**

EXCEPTION TO OUTSIDE THE PPO BENEFITS:

In the event the services of a Forced Provider are used, the Plan will apply its Inside PPO benefits for the Forced Provider subject to the Plan's Maximum Eligible Charge (MEC) guidelines.

Cost Containment Provisions

Schedule of Benefits (Continued)

The Cost Containment Provisions of the Plan encourage all Participants to seek the best and most efficient medical care available. The following cost containment features are designed with that goal in mind. These include provisions for:

Preferred Provider Organization (PPO) (page 10)
A Preferred Provider Organization (PPO) is an organization of preferred Health care providers. This Plan participates with the following PPO:

Aetna Signature Administrators PPO provides a Preferred Provider listing of Hospitals, Physicians and Ancillary Providers and can be accessed by going online at www.aetna.com/asa.

Specialty Transplant Network / Centers of Excellence (pages 16-17)
Must be approved by **Prime Dx (1-800-477-4625), the Precertification/Utilization Review Organization.**

Pre-Certification (page 10)
Pre-Certification is required for Hospital admissions or Outpatient surgery

Utilization Review (pages10-12)

Overview

1. Definitions
2. Types of Review
3. Compliance Guidelines
4. Mental & Nervous, Alcohol & Substance Abuse Guidelines
5. Control of Medical Care

Employee Assistance Program (EAP)--Deer Oaks EAP Services at 1(866)327-2400 or TDD 1(800)735-2989
All Participants of the Montgomery County Employee Benefit Plan are offered assistance in a variety of areas such as debt management, budget planning, legal advice, supervisory consultations and referrals to Employee Assistance Program (EAP) counselors. This program will assist Participants in obtaining mental health and substance abuse counseling. The EAP counselor will assess your needs and determine what steps need to be taken in order to help resolve your situation. Participants are eligible to receive eight (8) free visits per calendar year at a provider referred through the EAP. These visits are not subject to any deductible regardless of the High or Low Medical Deductible Plan Options you have chosen to participate in. If a Participant exhausts the eight (8) free visits through the EAP, the EAP provider should coordinate your transition to a Preferred Provider Inside the PPO, where applicable. The EAP provider is Deer Oaks EAP Services at 1(866)327-2400 or TDD 1(800)735-2989 (24 hours-7 days a week) or accessed online @ www.deeroakseap.com.

Mental Health, Substance Abuse or Alcoholism Benefits (see page 4 Inpatient Hospital Expenses #4), (page 4 Other Medical Expenses #6), (page 4 Outpatient Mental Health Care #7), (pages 9,11,12,17 Cost Containment Provisions), (page 37 Article III Health Care Benefits #25), (pages 38-40 Limitations and Exclusions #11, #38, #43).

In the event of an inpatient Emergency Hospital admission or a scheduled inpatient Hospital admission, you must utilize and receive inpatient services from Preferred Providers Inside the PPO or benefits will be disallowed. Receiving evaluation and/or treatment for services Outside the PPO or the EAP will result in a 0% benefit pay out from the Plan.

Outpatient Diagnostic Testing (page 12)

Pre-Admission Testing (page 12)

Weekend Admissions (page 12)

Second Surgical Opinion (page 12)

Outpatient Surgery (page 13)

Medical Tourism (page 13)

Home Health Care Benefits (pages 14)

Hospice Benefits (pages 14)

Solid Organ and/or Tissue Transplant Event Benefit (pages 16)

Preferred Provider Organization (PPO)

Aetna Signature Administrators PPO is an organization called a PPO of preferred health care providers. Physicians are governed by a board or panel of their peers and have agreed to a credentialing process and ongoing peer and utilization review of their Hospital and office practices.

Aetna Signature Administrators PPO. This Plan participates with Aetna Signature Administrators PPO. Participants may access a Preferred Provider listing of Hospitals, Physicians and Ancillary Providers by going online at www.aetna.com/asa.

Read the front and back of the Montgomery County Employee Benefit 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 PPO. The Montgomery County Employee Benefit Plan ID card should be presented at the time of your appointment or utilization of services. During the year Aetna Signature Administrators PPO will update the directory. It is responsibility of the Participant to verify and ensure the provider is Inside the PPO prior to accessing services.

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

Pre-Certification Program
Prime Dx 1-800-477-4625

Overview

The Pre-certification Program is administered by Prime Dx. **A Participant must call Prime Dx to comply with the Pre-certification Program provisions below. See Utilization Review, Section C. Compliance Guidelines, below for the applicable timelines for notification. Pre-certification authorizes Medical Necessity only and does not guarantee payment of benefits by the Plan.**

Expenses incurred while confined to a Hospital as an inpatient, or any outpatient surgical procedure is subject to the Pre-certification provisions, consisting of Pre-Admission Evaluation and Concurrent Review. This Pre-certification program must be utilized on all Hospital admissions and outpatient surgeries to receive maximum medical benefits. Pre-certification is required before being admitted to the Hospital or incurring an outpatient surgery or surgical procedure. **Non-compliance will result in a 50% reduction of benefits**.

Length of stay is determined by the attending Physician and is evaluated by the Pre-certification program. Admission to a Hospital without prior determination of length of stay or an extended length of stay without a Continued Stay Review by the program will result in benefits being paid at a 50% reduction in benefits for all Expenses incurred for that Hospital stay.

Utilization Review
Prime Dx 1-800-477-4625

Overview

Utilization Review is the review of a Participant's Hospital confinement by the Plan through Prime Dx prior to the date of such confinement and/or during such confinement. The purpose is to avoid unnecessary Hospital confinement and/or reduce the length of some confinements without affecting the quality of treatment. Prime Dx will review the Hospital confinement with your Physician; however, in all cases the necessity of Hospital confinement and length of stay is determined by you and your Physician, not the Contract Claims Administrator or the Plan. In order for Prime Dx to review a Hospital confinement with your Physician, they must be advised of such confinement. Notification of confinement is considered "Compliance" and will vary based on different types of confinements as described later.

Benefits under the Plan (as to percentages payable) will be more favorable if a Participant goes through the Utilization Review. The Schedule of Benefits outlines the differences in payment between compliance with the Utilization Review System and non-compliance.

A. Definitions:

For purposes of Utilization Review, the following Definitions apply:

1. **Compliance** is notifying Prime Dx:
   a. Ten (10) Working Days prior to a Scheduled Admission;
   b. By the thirty-sixth (36th) week for pregnancy;
   c. Immediately prior to admission for an Urgent Admission; or
   d. Within forty-eight (48) hours of an Emergency Admission (seventy-two (72) hours on weekends or holidays).
2. **Emergency Admission** is a Hospital Admission that may not be scheduled at the convenience of the Physician and the patient without endangering the patient's bodily functions.
3. **Urgent Admission** is a Hospital Admission that is not an Emergency Admission, but is necessary within at least 72 hours from the time a Physician recommends such Hospital confinement.

4. **Scheduled Admission** is a Hospital Admission that a Physician has recommended that is neither an Emergency nor Urgent Admission.
5. **Working Day** means any day Monday through Friday, excluding national legal holidays.

B. Types of Review:

1. **Pre-admission Review** is a review performed on a Scheduled Admission.
2. **Concurrent Review** is a review performed on a Scheduled and a non-Scheduled Admission during confinement.
3. **Discharge Planning** is appropriate arrangements that are made to facilitate the earliest possible discharge.
4. **Medical Case Management** is alternate treatment plans, developed to meet the medical needs of the Participant that are more cost-effective than standard treatment forms.

C. Compliance Guidelines

A Participant's failure to comply with these steps will result in "non-compliance" with Plan provisions resulting in limited benefits being paid. Once the Participant has complied with these provisions, Prime Dx will proceed to work with the Physician's and Hospital in the Participant's behalf for necessary medical care in compliance with the Physician's recommendations:

1. **Scheduled Hospital Admission Including Pregnancy** - Prime Dx must be notified by the Participant or a personal representative by telephone before such Scheduled Admission so that the attending Physician can submit the pre-admission certification form to Prime Dx at least ten (10) Working Days prior to the Scheduled Admission. Pregnancies must have the Pre-Admission Certification Process completed by the thirty-sixth (36th) week of pregnancy.
2. **Urgent Admission** - Prime Dx must be notified by the Participant, Physician, or a Personal Representative by telephone immediately prior to actual admission.
3. **Emergency Admission** - Prime Dx must be notified by the Participant, Physician, or a personal representative within 48 hours of admission (72 hours on weekends or legal holidays).

D. Mental and Nervous, Alcohol and Substance Abuse Guidelines (see page 4 Inpatient Hospital Expenses #4), (page 4 Other Medical Expenses #6), (page 4 Outpatient Mental Health Care #7), (pages 9,11,12,17 Cost Containment Provisions), (page 37 Article III Health Care Benefits #25), (pages 38-40 Limitations and Exclusions #11, #38, #43).

Coverage for diagnosis or treatment relating to Mental and Nervous conditions, Alcoholism and Substance Abuse are subject to the following guidelines and the Schedule of Benefits:

1. **Acute Care Hospital Confinements (Pre-Certification Required)**
   a. Psychotic state or eminent danger – maximum of five (5) days inpatient care unless condition necessitates locked-door treatment in seclusion and/or under 24-hour watch.
   b. Detoxification – Maximum Eligible Charges for Medically Necessary inpatient care to provide the treatment to restore physiologic functions disturbed by overuse and withdrawal from alcohol or other addictive drugs through the use of medication, diet, fluids, and nursing care;
   c. Adolescent Substance Abuse, behavioral, or other diagnosis – maximum of five (5) days of inpatient care for all diagnoses not listed in paragraph 1 or 2 above;
   d. Eating disorders or chronic pain disorders – maximum of five (5) days inpatient care unless a condition of physical health that (regardless of psychiatric or substance abuse diagnosis) would necessitate inpatient care;
   e. Condition of physical health – Maximum Eligible Charges for Medically Necessary inpatient care to treat a condition of physical health that (regardless of a psychiatric or substance diagnosis) would necessitate inpatient care.
2. **Treatment or Therapies Requiring Pre-Authorization as Inpatient Care**
   a. Psychological testing;
   b. Aversion therapy;
   c. Multiple psychotherapy sessions per day. Without pre-authorization, a maximum of one (1) session per day and benefits would be limited to the Maximum Eligible Charge and Medical Necessity;
   d. Home therapy passes;
   e. Other inpatient approaches not listed may be Eligible Expenses pending review through pre-certification of the therapy types delivered and the hours per week of therapy delivered by the facility.
3. **Sub-acute (Residential) Inpatient Confinements (Pre-Certification Required) –** necessary when outpatient treatment is not effective or programmatic inpatient treatment is needed without the need for an acute-care confinement. Sub-acute care shall also apply to treatment modalities listed as residential inpatient; social model inpatient; social psychiatric residential; light psychiatric; group home; halfway inpatient treatment and psychiatric health facility.

4. **Treatment or Therapies Requiring Pre-Authorization as Outpatient Care**
   a. Psychological testing;
   b. Day treatment – necessary when outpatient treatment is not effective or programmatic treatment is necessary without the need for inpatient care;
   c. Multiple sessions per week;
   d. Necessary when used to prevent hospitalization or re-hospitalization;
   e. For a severe multiple problem family situation;
   f. To significantly shorten the length of standard (i.e. once per week) therapy to achieve the same therapeutic goals.
5. **Treatment or Therapies Excluded**
   a. Rest cures;
   b. Custodial care;
   c. Health and well-being enhancement programs (i.e. weight control programs; smoking cessation programs; stress reduction programs; marriage enrichment programs; any program significantly educational in nature and not giving special emphasis and treatment to a diagnosed illness).

E. The Attending Physician Retains Full Control Over the Medical Treatment Provided

If there is a potential conflict with the Contract Administrator or the Utilization Review, the Physician's instructions should be followed. The Contract Administrator should be contacted in all cases to ensure compliance under the Plan and the most favorable benefit schedule. Following your Physician's instructions is not a guarantee of payment by the Plan.

Outpatient Diagnostic Testing

The Plan will pay 90% coinsurance if a Preferred Provider performs the service for any eligible diagnostic testing that is performed on an outpatient basis. The Plan will pay 50% coinsurance insurance of the Maximum Eligible Charges if a non-Preferred Provider performs the service.

Pre-Admission Testing

The Plan will pay 100% of Eligible Expenses for outpatient X-rays and lab tests performed by a Preferred Provider prior to surgery or 80% of Maximum Eligible Charges for tests performed by a non-Preferred Provider. Eligible for pre-admission testing will be covered under the Major Medical Benefits. **The Calendar Year Deductible will not apply.** The Plan will pay 100% of Eligible Expenses for Pre-Admission Testing by a Preferred Provider or 80% of the Maximum Eligible Charges at a non-Preferred Provider.

"**Pre-Admission Testing**" means X-ray and laboratory exams made in contemplation of and within four (4) days of a scheduled surgery, which is performed within the forty-eight (48) hours following the Participant's admission to the Hospital. If for medical reasons, the scheduled Hospitalization is canceled or postponed for more than two (2) weeks; benefits will be payable for any similar diagnostic, X-ray and laboratory examinations again made in connection with and prior to the rescheduled Hospitalization. Benefits will not be paid for any duplication of the same tests after Hospital confinement.

Weekend Admissions

Non-Emergency Hospital admissions must be confined to weekdays. If a Participant is admitted to a Hospital between 12:00 noon on Friday and 12:00 noon on Sunday, no benefits will be paid for any Hospital Expenses incurred on these days. This provision will **not** apply if:

1. Surgery is performed within twenty-four (24) hours immediately following the Participant's admission to the Hospital; or
2. The Participant is admitted for an acute Illness not requiring surgery.
3. Pre-Certification Utilization Review is required within seventy-two (72) hours for an Emergency Hospital admission.

Second and Third Surgical Opinions

The Plan will cover 100% of Eligible Expenses for second and third surgical opinions if the second and third opinions are performed within forty-five (45) days of the first opinion. The Plan will only cover 100% of Eligible Expenses for third surgical opinions if the second surgical opinion does not confirm the recommendations of the Physician that gave the first opinion and will perform the surgery.

"**Second surgical opinion**" means an evaluation of the need for surgery by a second Physician (or a third Physician if the opinions of the Physician recommending surgery and the second Physician are in conflict), including the Physician's exam of the patient and diagnostic testing.

The surgical opinion must:

1. Be performed by a Physician that is certified or board eligible by the American Board of Surgery or other specialty board; and
2. Take place before the date the surgery is scheduled to be performed.

No payment for surgical opinions will be made if the Physician rendering the opinion:

1. Performs a surgical procedure as a result of the opinion; or
2. Is associated or in practice with the Physician that recommended and will perform the surgery.

Outpatient Surgery – Pre-Certification is Required
(Also see Medical Tourism Benefit below.)

When possible, Participants are encouraged to have necessary surgery performed on an outpatient basis. Eligible Expenses incurred in connection with outpatient surgery by a Surgery Center or Outpatient Department of a Hospital on the day surgery is performed on a Participant will be covered under Major Medical Benefits after the Deductible is satisfied, at a Coinsurance Percentage of 80% outside the PPO or 90% by a Preferred Provider:

"Outpatient Surgery" means Eligible Expenses for services and supplies furnished by the Surgery Center or by the Outpatient Department of a Hospital on the day the procedure is performed and includes the following:

1. All related Eligible Expenses for outpatient services including lab fees, biopsies, and supplies;
2. Anesthesiologist Expenses;
3. Fees by surgeons for surgery performed on an outpatient basis;
4. Any eligible outpatient surgeries or related Expenses including anesthesiologist Expenses will be paid by the plan at the eighty percent (80%) if performed outside the -PPO

"Surgery Center" means a freestanding surgical facility that:

1. Meets licensing standards;
2. Is equipped and operated for general surgery;
3. Expenses on its behalf;
4. Is directed by a staff of Physicians. A Physician must be present when surgery is performed and during the recovery period;
5. Has at least one certified anesthesiologist present when surgery which requires general or spinal anesthesia is performed and during the recovery period;
6. Extends surgical staff privileges to Physicians that practice surgery in an area Hospital and dentists that perform oral surgery;
7. Has at least two (2) operating rooms and one (1) recovery room;
8. Provides or arranges with a medical facility in the area for diagnostic x-ray and lab services necessary for surgery;
9. Is equipped and has a staff trained for medical emergencies, which requires:
    a. A Physician trained in cardiopulmonary resuscitation;
    b. A defibrillator;
    c. A tracheotomy set; and
    d. A blood volume expander;
10. Has a written agreement with a Hospital in the area for immediate emergency transfer of patients;
11. Provides an ongoing quality assurance program with review Physicians that do not own or direct the facility;
12. Keeps a medical record on each patient.

MEDICAL TOURISM BENEFIT Pre-Certification is Required

If covered services have been recommended, please contact your Boon Chapman Member Advocate at (888) 660-0467 or hightouch@boonchapman.com.

Domestic Approved Surgery Centers

Participants have access to certain Approved Surgery Centers that are Outside the PPO and are offering transparent, bundled pricing for 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 Medical Schedule 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. Travel benefits are only covered by the Plan if the travel and lodging is approved by the Plan in advance of travel. If these conditions are met, the Plan covers expenses for travel and lodging for the participant and one adult companion for the following expenses:

1. 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:
    a. Parking expenses at or transportation to and from the member's airport of origin
    b. Airfare at coach rate
    c. Taxi or ground transportation from airport to hotel, between hotel and doctor's office for consultation, between hotel and surgery center, and from hotel to airport.
    d. Mileage reimbursement at the IRS medical rate for the most direct route between the participant's home and the Approved Surgery Center facility (in lieu of airfare and other ground transportation)
2. Lodging: One-room accommodation at a Plan-approved hotel. Room and taxes only. Incidentals (Wi-Fi, etc.) not included.

3. Meals and Incidentals Expense Benefit
    a. 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:
Except in an urgent care situation, the participant must call the Nurse Advocate at (833) 864-4316, at least three (3) business days before any/all procedures scheduled in advance including, but not limited to the following:

1. Outpatient procedures/surgeries;
2. High Tech Radiology.

Home Health Care Benefits Pre-Certification is Required

Participants are encouraged to receive care at home, when possible, rather than in a Hospital. Home Health Care Benefits are a basic medical coverage benefit and are not part of the Major Medical Benefits. Benefits for Home Health Care will be payable for up to **120 visits** in a calendar year. Each visit by a person providing services under a Home Health Care Plan or evaluating the need for or developing a Home Health Care Plan will be viewed as one Home Health Care visit. Up to four (4) consecutive hours of home health aide service in a 24-hour period will be eligible for payment as one Home Health Care visit. The amount paid will be at 90% Inside PPO or 50% Outside PPO of the Medically Necessary, Maximum Eligible Charges for Home Health Care and is subject to the Plan deductible. Home Health Care must be provided in accordance with a Home Health Care Plan, once established.

Home Health Care means Eligible Expenses that are limited to those for services listed herein that are provided by a Home Health Care Agency to a Participant that is under the care of a Physician. Home Health Care services must be furnished in accordance with a Home Health Care plan that is established by the attending Physician, and the orders must be renewed at least every thirty (30) days. The attending Physician must also certify that the proper treatment of the Sickness or Accidental Injury would require confinement as a resident inpatient in a Hospital or skilled nursing facility in the absence of the services and supplies provided as part of the Home Health Care plan.

Eligible Expenses for Home Health Care visits are limited to those provided by:

1. a registered graduate nurse (RN), a licensed practical nurse (LPN), or a licensed vocational nurse (LVN);
2. home health aides under supervision of a RN;
3. physical, occupational, and speech therapists; or
4. a licensed midwife.

The Participant must be homebound, and a doctor must certify that the Participant is homebound. To be homebound means the following:

1. Leaving home is not recommended due to the Participant's condition;
2. The Participant's condition keeps them from leaving home without help (such as needing special transportation, using a wheelchair or walker, or getting help from another person); and
3. Leaving home takes a considerable and taxing effort by the Participant.

A Participant may leave home for medical treatment or short, infrequent absences for non-medical reasons, such as attending religious services. A Participant that attends Adult Day Care can receive Home Health Care services; however those services must be received in the Participant's home. Home Health Care Eligible Expenses will also include medical supplies, drugs, and medicines prescribed by a Physician, laboratory services, and special meals prescribed by a physician, nutritionist, or dietitian, but only to the extent that such charges would have been considered Eligible Expenses had the Participant remained in the Hospital.

Hospice Benefits Pre-Certification is Required

Terminally ill Participants are provided coverage for necessary care without Hospital confinement.

The Plan covers a Participant's Eligible Expenses for Hospice Benefits. A Participant is eligible for Hospice Benefits if the Participant is terminally ill, the attending Physician expects him or her to live no more than six (6) months after the date services are performed and the attending Physician has recommended a formal program of Hospice care. Benefits for hospice will be payable up to 180 visits in a calendar year. The amount paid will be 90% of Eligible Expenses for Hospice Benefits provided by Preferred Providers or 50% of the Maximum Eligible Charges for Hospice Benefits provided by Non-Preferred Providers. Some Expenses may be payable Eligible Expenses under other provisions of this Plan.

"Hospice" means a licensed or certified agency which:

1. Is primarily engaged in providing counseling, medical services or room and board to terminally ill persons and is licensed by the appropriate licensing authority;

2. Has professional service policies established by a group associated with it and the group includes one Physician, one registered nurse (RN) and one social service coordinator;
3. Has full-time supervision by a Physician;
4. Has a full-time administrator;
5. Provides services twenty-four (24) hours a day, seven (7) days a week; and
6. Maintains a complete medical record of each patient.

Eligible Hospice Expenses are:

1. Room and board;
2. Physician services and/or nursing care by a Registered Nurse, Licensed Practical Nurse or a Licensed Vocational Nurse;
3. Part-time or intermittent home health aid services by employees of the Hospice;
4. Social work performed by a licensed social worker; and
5. Nutrition services to include nutritional advice by a dietitian, and nutritional supplements such as diet substitutes administered intravenously or through hyper alimentation as determined to be medically necessary.

In-Eligible Hospice Expenses are:

1. Services provided by volunteers or others that do not usually charge for their services;
2. Services by a person that lives in your home or is a Close Relative;
3. Any period during which you are not under the care of a Physician; and
4. Bereavement counseling.

Outpatient Dialysis Pre-Certification is Required

This Plan does not use a preferred provider organization (PPO) for outpatient dialysis services. Please review the definition of "Maximum Eligible Charges" also referred to as "MEC", which is contained in the Section titled "Plan Definitions" for details. The definition of MEC is different for Outpatient Dialysis Services than other services.

The Maximum Eligible Charge, for Outpatient Dialysis Services provided in connection with the first 40-dialysis treatments while a Participant is covered by the Plan as determined in the discretion of the Plan Administrator or its delegate, is the lesser of:

1. The provider's normal charge for the same or a similar service or supply; or
2. A fee determined using a commercial healthcare database;

The Maximum Eligible Charge for Outpatient Dialysis Services thereafter, 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.

PRE-CERTIFICATION IS REQUIRED. A Participant must: (1) notify PRIME Dx when Dialysis treatment begins; (2) notify PRIME Dx diagnosed with End Stage Renal Disease ("ESRD"); and (3) enroll in Part A and B of Medicare when diagnosed with ESRD. While a Participant has ESRD and the Plan is primary, the Plan will pay or reimburse the Participant for Medicare Part B premiums.

Solid Organ and/or Tissue Transplant Event Benefit
Schedule of Benefits
Pre-Certification is Required

Precertification/Utilization Review Organization - 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.**

Lifetime Maximum Solid Organ and/or Tissue Transplant Event Benefit:
Limited to one (1) pre-certified, medically necessary Solid Organ and/or Tissue Transplant Event per Participant's lifetime with one (1) allowable pre-certified, medically necessary, re-transplant due to failure for the same organ within 180 days of the date of the initial Solid Organ and/or Tissue Transplant. Coverage for a medically necessary Solid Organ and/or Tissue Transplant would be considered as one (1) eligible Solid Organ and/or Tissue Transplant Event for: Heart, Kidney, Lung(s), Liver, Pancreas, Small Bowel or a simultaneous combination of these.

Solid Organ and/or Tissue Transplant Event Benefit Period:
Is the period beginning on the date of the Solid Organ and/or Tissue Transplant and ends on the date that is twelve (12) continuous months after date of the Solid Organ and/or Tissue Transplant.

Solid Organ and/or Transplant Event Eligible Expenses:
Means those Eligible Expenses for services, supplies, procedures and treatment incurred at a **Specialty Transplant Network / Centers of Excellence** that are specifically identified as covered only under this benefit and are medically necessary and appropriate to the Solid Organ and/or Tissue Transplant Event as approved by the Precertification/Utilization Review Organization - **Prime Dx 1-800-477-4625.**

1. **Pre-transplant Evaluation/Screening Eligible Expenses** incurred for a Solid Organ and/or Tissue Transplant Event professional and technical components required for the evaluation, screening and candidacy determination process.
2. **Pre-transplant/Candidacy Screening Eligible Expenses** incurred for a Solid Organ and/or Tissue Transplant Event includes HLA typing/compatibility testing of prospective organ donors that are immediate family members.
3. **Inpatient and Outpatient Eligible Expenses** for a Solid Organ and/or Tissue Transplant Event related health services and supplies provided to the Participant for:
   a. Solid Organ and/or Tissue Transplant surgical procedures;
   b. Solid Organ and/or Tissue Procurement Eligible Expenses:
      i. From a **non-living** donor for costs involved in removing, preserving and transporting the organ; or
      ii. From a **living donor** for the costs involved in screening the potential donor and for medical expenses associated with removal of the donated organ and the medical services provided to the donor in the interim and for follow up care as long as the donor is a covered Participant under this plan;
   c. Follow-up Care Expenses rendered within the 12 continuous months from the date of the Solid Organ and/or Tissue Transplant Event for transplant-related outpatient services including Home Health Care Services and Home Infusion Services;
   d. Prescription Drugs. For Outpatient prescription Drugs the Participant must use the Outpatient Prescription Drug Expense Coverage with Drug Card in this Plan (See page 7, Other Medical Benefits #18).

Extended Benefits in the Event of Termination of Solid Organ and/or Transplant Participant:
If an eligible Solid Organ and/or Tissue Transplant Event had commenced while coverage was in force and benefits had not been exhausted then coverage for eligible benefits will extend to the earliest of the following dates:
1. If the Participant fails to remit required contributions for his Health Care Benefits when due, his or her benefits will terminate at the end of the period for which contribution is made;
2. The last of the month in which you terminate your employment or lose your eligibility status as long as any required contributions have been paid;
3. Participation may be continued for an Employee on an Employer-approved leave of absence, but for no longer than six (6) continuous months. At the end of the six (6) continuous months of leave, employees will need to return to work or terminate employment. COBRA benefits will be offered to employees that terminate their employment. 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.); or
4. On the termination date of this Plan.

Notwithstanding the foregoing, a termination of coverage may only be effective retroactively if the Employee (1) performs an act, practice or omission that constitutes fraud, (2) makes an intentional misrepresentation of material fact, or (3) fails to make a required contribution when due.

Solid Organ and/or Tissue Transplant Event Benefit - Cost Containment Provisions
Schedule of Benefits (Continued)

	Coinsurance Percentage Plan Pays Inside SPECIALTY TRANSPLANT NETWORK Only
Solid Organ and/or Tissue Transplant Event Eligible Expenses:	**90%**

This Plan will pay at the stated percentage levels after the calendar year deductible has been satisfied for the either High or Low Medical Deductible Plan Option that you participate in including any Coinsurance out of pocket limits for that plan; however **NO BENEFITS WILL BE CONSIDERED AS ELIGIBLE EXPENSES OR PAYABLE BY THIS PLAN IF Prime Dx: 1-800-477-4625 the Precertification/Utilization Review Organization OR Specialty Transplant Network IS NOT UTILIZED.**

Solid Organ and/or Tissue Transplant Event Precertification: The one (1) Solid Organ and/or Tissue Transplant Event must be pre-certified and coordinated through **Prime Dx: 1-800-477-4625 the Precertification/Utilization Review Organization.** **All Solid Organ and/or Tissue Transplant Event care must be pre-certified or NO benefits will be considered eligible or payable by this plan.**

Solid Organ and/or Tissue Specialty Transplant Network / Centers of Excellence: The Participant must have a Solid Organ and/or Tissue Transplant Event performed at a **Specialty Transplant Network / Centers of Excellence** as directed by **Prime Dx: 1-800-477-4625 the Precertification/Utilization Review Organization** or **NO BENEFITS WILL BE CONSIDERED ELIGIBLE**. For Transplant Event purposes, the Aetna Signature Administrators PPO on your benefit plan ID card **IS NOT** the Specialty Transplant network. The purpose of the **Specialty Transplant Network / Centers of Excellence** is to perform necessary Solid Organ and/or Tissue Transplants in the most appropriate setting for the procedure, to improve the quality and probability of a successful outcome, and reduce the average cost of the procedures. The **Prime Dx: 1-800-477-4625 the Precertification/Utilization Review Organization** will advise you on the facilities which are considered in network for solid organ and/or tissue transplant services.

As soon as reasonably possible, but in no event more than ten (10) days after a Participant's attending physician has indicated that the Participant is a potential candidate for a transplant, the Participant or his physician should contact **Prime Dx: 1-800-477-4625 the Precertification/Utilization Review Organization** for evaluation and pre-authorization. A comprehensive treatment plan must be developed for this plan's medical review, and must include such information as diagnosis, the nature of the Solid Organ and/or Tissue Transplant Event, the setting of the procedure, (i.e. name and address of the hospital), any secondary medical complications, a five year prognosis, two (2) qualified opinions confirming the need for the procedure, as well as a description and the estimated cost of the proposed treatment (One or both confirming second opinions may be waived by the **Prime Dx.: 1-800-477-4625 the Precertification/Utilization Review Organization**). Additional attending physician's statements may also be required.

All potential Solid Organ and/or Tissue Transplant cases will be assessed for their appropriateness for Large Case Management.

Solid Organ and/or Tissue Transplant Event Benefit - Limitations and Exclusions

Solid Organ and/or Tissue Transplants Excluded Expenses:

1. A Solid Organ and/or Tissue Transplant that was not precertified;
2. A Solid Organ and/or Tissue Transplant not performed at a Specialty Transplant Network / Centers of Excellence;
3. Personal Services such as Transportation / Donor Transportation, Lodging / Donor Lodging, Meals / Donor Meals.
4. Harvesting or storage of organs, without the expectation of immediate transplantation for an existing Illness.
5. Medical care and service expenses that are not considered medically necessary or a standard of care as associated with respect to the Solid Organ and/or Tissue Transplant Event or donation.

Plan Information

EMPLOYER
Montgomery County, Texas
501 North Thompson, Suite 202
Conroe, Texas 77301 Telephone (936)760-6935

PLAN ADMINISTRATOR/PLAN SPONSOR AND AGENT FOR SERVICES OF LEGAL PROCESS
Plan Administrator/Plan Sponsor - Montgomery County, Texas
Agent for Legal Process - County Judge of Montgomery County
501 North Thompson; Suite 202
Conroe, Texas 77301 Telephone: (936)760-6935 HIPAA Fax: (936)538-8169

PLAN NAME
Montgomery County Employee Benefit Plan

PLAN NUMBER / IDENTIFICATION – Group #002248

BENEFIT YEAR – January 1 through December 31.

PLAN YEAR – October 1 through September 30.

CONTRACT CLAIMS ADMINISTRATOR
Boon-Chapman Benefit Administrators, Inc.
P.O. Box 9201
Austin, Texas 78766
General Customer Service: Telephone: (512)454-2681 or 1(800)252-9653 Fax: (512)459-1552
Member Advocate: Telephone: (888) 660-0467 or hightouch@boonchapman.com
Website @ www.boonchapman.com

PREFERRED PROVIDER ORGANIZATION (PPO)
Aetna Signature Administrators PPO: for Preferred Providers
Website @ www.aetna.com/asa

PRE-CERTIFICATION / UTILIZATION REVIEW / CASE MANAGEMENT
Prime Dx
PO Box 9201
Austin, Texas 78766 Telephone: 1(800) 477-4625

PRESCRIPTION DRUG CARD PROGRAM
MAXORPLUS
320 S. Polk St., Suite 200, Amarillo, Texas 79101 Telephone: 1(800)687-0707 or TTY 1(866)427-5573 Fax: 1(806)324-5493
MXP Pharmacy - Mail Order
P.O. Box 32050, Amarillo, Texas 79120-2050 Telephone: 1(800)687-8629 Physician RX Fax: 1(866)589-7656
MAXOR Specialty Pharmacy
216 S. Polk St., Amarillo, Texas 79101 Telephone: 1(866)629-6779 Physician RX Fax: 1(866)217-8034
Website @ www.maxorplus.com

EMPLOYEE ASSISTANCE PROGRAM (EAP)
Deer Oaks EAP Services
126 East Main Plaza, Suite 8
San Antonio, Texas 78205 Telephone: (24HR) 1(866)327-2400 or TDD 1(800)735-2989
Website @ www.deeroakseap.com

FINANCING OF THIS EMPLOYEE BENEFIT PLAN
You and your Employer contribute to this Plan if you chose to participate. The amount of the contribution is determined by the claims experience of those that participate in this Plan and the contribution level is determined by Montgomery County Commissioners Court. Montgomery County Commissioners Court reserves the right to adjust the contribution level of the Employer or the Plan Participants at any time.

Article I
Plan Definitions

Active Service means the Employee is performing in the customary manner all of the regular duties of his employment on a full-time basis either at his customary place of employment or at some location at which that employment requires him to travel on a scheduled work day, or if he is absent from work solely by reason of vacation and at the time his coverage would otherwise become effective and he has not been absent from work for a period of more than three (3) consecutive weeks. An Employee will be considered in Active Service on a day, which is not a scheduled workday only if he was performing in the customary manner all of the regular duties of his employment on the last preceding scheduled workday. An Employee will be deemed to be in Active Service if the Employee is absent from work due to a health factor. 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.

An Eligible Dependent will be considered in Active Service on any day if he or she is then engaging in all the normal activities of a person in good health of the same age and sex, and is not confined in a medical facility. (This paragraph will not apply to a well newborn child).

Allowable Expense means any Medically Necessary, Maximum Eligible Charge for an item of Expense for health care, when the item of Expense is covered at least in part by one or more Plans covering the person for whom the claim is made.

Amendment means a formal document that changes the provisions of the Plan Document, duly signed by the authorized person or persons as designated by the Plan Administrator.

Ancillary Provider means a provider of healthcare services in the following settings:

1. Inpatient;
2. Outpatient; and
3. Emergency Room.

Types of Ancillary Providers include, but are not limited to, pathologists, radiologists, anesthesiologists, assistant surgeons, emergency room physicians, on-call physicians and ambulances.

Appointed Official means a person that is elected to serve Montgomery County and that by virtue of their office is entitled to participate and meet the requirements under Article II Participation in Health Care Benefits, A.-2.-c. Appointed Official Participation.

Appropriate or Appropriateness refers to the classification of a medical service as Medically Necessary for the treatment of any given medical condition. The medical profession must commonly recognize such services as an accepted standard for that type and level of care.

Benefit Period means the period of time from January 1 through December 31.

Claimant is any Participant on whose behalf a claim is submitted for benefits under the plan.

Close Relative means the Spouse, parent, brother, sister, child, or Spouse's parent of the Participant.

Coinsurance means a cost sharing of what the Plan pays and what the Participant pays and is expressed in percentages or dollar amounts.

Commissioners' Court means the Commissioners' Court of Montgomery County, Texas.

Concurrent Review means a process that utilizes physician-developed criteria and standards for determining the appropriateness or reimbursement for continued hospital treatment or confinement.

Continued Stay Review refers to the process whereby Health Care Review implements a study to evaluate the appropriateness of and the necessity of medical services that are rendered to a Participant. Such reviews may occur at the time of admission to an acute-care hospital facility or during confinement at such facility.

Cosmetic Procedure means a procedure performed solely for the improvement of appearance rather than for the improvement or restoration of bodily functions.

Custodial Care means that type of care or service, wherever furnished and by whatever name called, which is designed primarily to assist a Participant, whether or not totally disabled, in the activities of daily living. Such activities include, but are not limited to: bathing, feeding, and preparation of special diets, assistance in walking or in getting in and out of bed, and supervision over medication that can normally be self-administered.

Deductible is the amount of Eligible Expenses a Participant must pay during the year before the plan begins to consider Eligible Expenses for reimbursement.

Dependent means any one or more of the following:

1. The lawful Spouse of the Employee not legally separated from the Employee, and
2. Natural children, legally adopted children, and step-children of the Employee, that have not attained age 26, and
3. Natural children, legally adopted children and step-children of the Employee, that reside with the Employee, and are incapable of self-sustaining employment due to mental or physical disability, provided such disability commenced prior to attainment of the Dependents 26th birthday, and the Dependent was covered prior to attainment of such age. Proof of dependency or mental or physical disability must be furnished by the Employee when required by the Plan Administrator.

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 Article II Participation in Health Care Benefits, A.-2.-b. Elected Official Participation.

Eligible Expense means a charge or expense that is eligible for coverage under the Plan.

Emergency Medical Care refers to those medically necessary health services which are provided for the repair of accidental injury, relief of acute pain, elimination of acute infection, or relief of illness, which if not immediately diagnosed and treated, could reasonably be expected to result in physical impairment or loss of life.

Employee means all full-time persons that meet the requirements under Article II Participation in Health Care Benefits, A.-2.-a. Employee Participation.

Employee Assistance Program (EAP) means an organization that assists Participants in managing a variety of problems they may encounter, both on the job and off the job.

Essential Health Benefits Includes (1) ambulatory services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services, including behavioral treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care, as determined by the Plan Administrator in accordance with the Affordable Care Act subject to exemptions claimed by the **Montgomery County Employee Benefit plan as permitted under the Health Insurance Portability & Accountability Act of 1996 (HIPAA) Election Under 45 CFR §146.180(f)** (see page 30, (HIPAA) Election H.). The above list of Essential Health Benefits is subject to further regulatory guidance and does not qualify that the benefit will or will not be covered under the Plan (see pages 4-8, Major Medical Benefits Schedule of Benefits & Summary Plan Description), (see pages 38-40, Article IV Limitations and Exclusions).

Family Deductible Maximum means that the maximum of three (3) covered family members must satisfy their individual deductibles and coinsurance on the High Medical Deductible Plan Option, and then the deductible will be considered satisfied for all covered family members for that Calendar Year. Satisfaction of the Family Deductible Maximum is based on the date Expenses are incurred. The Family Deductible Maximum also applies when both Spouses are Montgomery County, Texas Employees and covered by this Plan.

Family Coinsurance Maximum means that the maximum of three (3) covered family members must satisfy their individual coinsurance after meeting their annual deductible on the High Medical Deductible Plan Option and then the coinsurance will be considered satisfied for all covered family members for that Calendar Year. Satisfaction of the Family Coinsurance Maximum is based on the date Expenses are incurred. The Family Coinsurance Maximum also applies when both Spouses are Montgomery County, Texas Employees and covered by this Plan.

Family Status Change means an event that would include marriage, birth, death, divorce, changes in a Spouse or Dependent's employment status, or a change from full-time to part-time status by the Employee or the Spouse. Other status changes include termination of employment; lay off, unpaid leave of absence, or retirement.

Forced Provider means a physician, facility or other provider, outside of the PPO, in which the patient is not provided a choice in the selection of providers for the provision of health care services. Types of Forced Providers include, but are not limited to, labs, radiologists, diagnostic testing, anesthesiologists, assistant surgeons, hospitals, on-call specialists and ambulances.

Health Care Benefits means the medical and prescription drug benefits provided under the Plan.

Health Care Review/Medical Review Services means the organization established to study necessary and appropriate treatment of an injury or illness. Such studies are then used to evaluate whether or not treatment is rendered in the most cost-efficient manner possible in accordance with the norms of medical care common to that geographical.

Home Health Care means Eligible Expenses that are limited to those for services listed (See Pages 13-14, Cost Containment Provisions, Home Health Care Benefits) that are furnished by a Home Health Care Agency to a Participant that is under the care of a Physician. Home Health Care services must be furnished in accordance with a Home Health Care plan that is established by the attending Physician, and the orders must be renewed at least every thirty (30) days. The attending Physician must also certify that the proper treatment of the Sickness or Accidental Injury would require confinement as a resident inpatient in a Hospital or skilled nursing facility in the absence of the services and supplies provided as part of the Home Health Care plan.

Home Health Agency means a public or private agency that specializes in giving nursing and other therapeutic services in the Participant's home; provided that the agency is licensed as such Home Health Care will be provided or coordinated by a Home Health Care agency which is:

1. Is state licensed;
2. Is a Certified Rehabilitation Agency;
3. Qualifies under Medicare; or
4. Meets all of the following:
   a. Is mainly involved in home health care delivery, including skilled nursing care;
   b. Has a staff including at least one supervisor registered nurse (RN);
   c. Has an administrator; and
   d. Maintains daily health records for all patients.

Hospice means a licensed or certified agency which:

1. Is primarily engaged in providing counseling, medical services or room and board to terminally ill persons and is licensed by the appropriate licensing authority;
2. Has professional service policies established by a group associated with it and the group includes one Physician, one registered nurse (RN) and one social service coordinator;
3. Has full-time supervision by a Physician;
4. Has a full-time administrator;
5. Provides services 24 hours a day, 7 days a week; and
6. Maintains a complete medical record of each patient.

Hospital means a legally constituted institution which:

1. Is primarily engaged in providing diagnostic, medical and surgical facilities for the care and treatment of injured or sick persons and is compensated for such treatment;
2. Has a staff of one (1) or more Physicians available at all times;
3. Has 24-hour a day nursing services by Registered Nurses (RNs) or other nursing services when assumed under the complete responsibility of the Physician in charge;
4. Maintains inpatient facilities; and
5. Is licensed as a Hospital by the appropriate state agency.

"Hospital" does not include any institution, which is primarily a rest or convalescent facility, a facility for the aged or chemically dependent individuals.

Illness means a bodily disorder, disease, physical Sickness, mental infirmity, pregnancy or functional nervous disorder of a Participant. A recurrent Illness will be considered one Illness. Concurrent Illnesses will be considered one Illness unless the concurrent Illnesses are totally unrelated. All such disorders existing simultaneously, which are due to the same or related causes, shall be considered one Illness.

Injury means a condition caused by accidental means which results in damage to the Participant's body from an external force. Any loss which is caused by or contributed to by a hernia of any kind will be considered a loss under the definition of illness, and not as a loss resulting from accidental Injury.

Investigative, Experimental or for Research Purposes means:

1. Services or supplies not recognized or proven to be effective treatment of an Illness or Injury in accordance with generally accepted medical practice, based on consultation with an appropriate source; or
2. It involves the use of a drug or substance not formally approved by the United States Food & Drug Administration, even if
   a. Approval is not required, or
   b. It involves the use of a drug or substance that cannot be lawfully marketed without the approval of the Food and Drug Administration or other appropriate governmental agency, such approval not having been granted at the time of use or proposed use;
3. It is generally, commonly, and customarily regarded by experts that regularly practice in the area of treatment of the particular disease or condition in question as a drug, treatment, device, procedure, or other service whose usage should be substantially confined to research settings, as set forth in the published authoritative literature; or
4. It is being provided pursuant to a Food and Drug Administration Phase I or Phase II clinical trial or as the experimental or research arm of a Phase III clinical trial.

Inside PPO means receiving eligible services from Preferred Providers.

Late Entrant means an Employee, Elected Official, Appointed Official, or State Official that elects to waive participation and later decides to enroll in the Plan more than thirty (30) days after first becoming eligible to participate in the Plan. "Late Entrant" will also include the Employee, Elected Official, or Appointed Official and/ or Dependent of an Employee, Elected Official, Appointed Official, or State Official that was not enrolled in the Plan within the first thirty (30) days after such Dependent was eligible to be enrolled.
If you and/or your Dependent(s) are not enrolled in the Plan at the initial time you are eligible for benefits, and you are not eligible under the Special Enrollment provisions, then you and/or your Dependent(s) will be considered Late Entrants.

Maximum Eligible Charge (MEC) is an amount determined in the discretion of the Plan Administrator or its delegate using any one of the following:

1. A fee that was negotiated with the Provider;
2. A fee determined using a national relative value scale;
3. A fee determined using a percentage of what Medicare would allow for the service or supply;
4. A fee determined using an industry accepted fee database; or
5. A fee determined using a percentage off billed charges.

The Maximum Eligible Charge, for Outpatient Dialysis Services provided in connection with the first 40-dialysis treatments while a Participant is covered by the Plan as determined in the discretion of the Plan Administrator or its delegate, is the lesser of:

1. The provider's normal charge for the same or a similar service or supply; or
2. A fee determined using a commercial healthcare database;

The Maximum Eligible Charge for Outpatient Dialysis Services thereafter, 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.

With regard to charges made by a provider of service participating in the Plan's PPO program, "Maximum Eligible Charge" shall mean the rates negotiated between the preferred provider organization and the participating providers unless services have otherwise been specifically excluded from the PPO reimbursement arrangement in the Schedule of Benefits.

Medically Necessary or Medical Necessity means Expenses for a service, treatment, device, drug, or supply that is necessary and appropriate for the diagnosis or active treatment of an Illness or Injury based on generally accepted medical practice. To be Medically Necessary, Covered Expenses must be:

1. Rendered in connection with an Injury or Illness;
2. Consistent with the diagnosis and treatment of your condition;
3. In accordance with the standards of good medical practice; and
4. Provided at the most appropriate level of care or in the most appropriate type of health care facility. Only your medical condition (not the financial status or family situation, the distance from a facility of any other non-medical factor) is considered in determining which level of care or type of health care is appropriate.

Medically Necessary is the criteria by which the Plan Administrator determines the necessity of medical service and treatment under this plan.
A service, treatment device, drug, or supply will **not** be considered Medically Necessary if it:

1. Is provided only as a convenience to the Participant or Provider;
2. Is not appropriate treatment for the Participant's diagnosis or symptoms;
3. Exceeds (in scope, duration or intensity) that level of care that is needed to provide safe, adequate and appropriate diagnosis or treatment;
4. Is part of a plan of treatment that is considered to be Investigative, Experimental or for Research Purposes in the diagnosis or treatment of an Illness or Injury (See Page 21, Article I Plan Definitions - Investigative, Experimental or for Research Purposes).

The fact that any particular Physician may prescribe, order, recommend or approve a service, treatment, device, drug or supply does not, of itself, make it Medically Necessary. The sources of information to be relied upon are:

1. The Published authoritative medical or scientific literature regarding the drug, treatment, device, procedure, or other service at issue as it is applied to the particular Injury or Sickness at issue;
2. A Participant's medical records;
3. Protocol pursuant to which the treatments are to be delivered; or any regulations and publications set forth by any governmental agency.

Newborn refers to an infant from the date of his birth until the initial hospital discharge or until the infant is fourteen (14) days old, whichever occurs first.

Outpatient Surgery means Eligible Expenses for services and supplies furnished by the Surgery Center or by the Outpatient Department of a Hospital on the day the procedure is performed and includes the following:

1. All related Eligible Expenses for outpatient services including lab fees, biopsies, and supplies;
2. Anesthesiologist Expenses;
3. Fees by surgeons for surgery performed on an outpatient basis; and
4. Any eligible outpatient surgeries or related Expenses including anesthesiologist Expenses will be paid by the plan at the eighty percent (80%) if performed outside the PPO

Outside PPO means receiving eligible services from providers that are not Preferred Providers under this Plan.

Outside PPO Service Area means not within one-hundred (100) miles of a Preferred Provider.

Participant(s) means covered person(s), employee(s), elected official(s), appointed official(s) and their eligible dependent(s), eligible retiree(s) and their eligible dependent(s) that can meet the requirement under Article II Participation in Health Care Benefits A.-2.-a.,b.,c.,d. Retirees must

also qualify and enroll under the Retiree Continuation of Coverage Provisions under Article II Participation in Health Care Benefits L. and Surviving dependent(s) that qualify under Government Code 615.073 and that enrolled in the Plan in accordance with Plan provisions.

Physician means any professional practitioner that holds a lawful license authorizing the person to practice medicine or surgery in the locale in which the service is rendered, provided the service rendered is within the scope of that license, limited to the practitioners listed in the Texas Insurance Code, Article 3.70-2.

Physician Assistant means a health professional licensed to practice medicine in collaboration with physicians and must graduate from an accredited Physician Assistant educational program. Physician Assistant practice is centered on patient care, but may also include educational, research, and administration activities.

Pre-admission Evaluation means a process that utilizes physician-developed criteria and standards for determining the appropriateness of reimbursement for non-emergency inpatient hospital admissions and the length of hospital stay that will be considered Medically Necessary under the eligible medical benefits. To receive maximum medical benefits, all inpatient hospital admissions must be reviewed and documented in advance.

Pre-certification is a review and evaluation of medical necessity.

Preferred Provider is a health care provider that participates in the Preferred Provider Organization (PPO) adopted by this Plan.

Preferred Provider Organization (PPO) is a group of medical providers (Physicians and/or Hospitals) that, as a group or individually, agree to specified fee schedules and cost containment procedures in the delivery of health care and are named by the Plan as participating in the Plan.

Prescription Drug means:

1. A medicinal substance that, by law, can be dispensed only by prescription;
2. A compound medication that includes a substance described in (1);
3. Injectable insulin.

*Note: A "generic drug" is a Prescription Drug identified by its official or chemical name rather than by a brand name.

Qualified Beneficiary is an Employee that was covered by the Plan on the day before the Qualifying Event or an Employee's Dependent that was covered by the Plan on the day before the Qualifying Event, or a child that is born to, or placed for adoption with, a covered Employee during continuation coverage.

Qualifying Event shall mean any one of the following that would result in the loss of coverage under the Plan: the death of the covered Employee, the termination of the covered Employee (other than by the Employee's gross misconduct), reduction in a covered Employee's hours of employment to an ineligible status, the divorce or legal separation of the covered Employee from the Employee's spouse, the Employee's coverage termination due to Medicare entitlement, or the cessation of covered Dependent child coverage by operation of a plan provision.

Retiree is any person that meets the definition of Retiree as defined by Montgomery County Commissioners Court and Chapter 175 of the Local Government Code and meets the requirements under Article II Participation in Health Care Benefits, A.-2.-e.

Sickness is any physical or mental illness, including pregnancy.

Solid Organ and/or Tissue Transplant Event means the implantation of one or a combination of organs during one medical procedure.

Spouse is a person to whom an Employee is lawfully married, which marriage was solemnized, authenticated and recorded as required by the state in which the marriage took place, but shall not include an individual separated from the Employee under a legal separation or divorce decree. The term "Spouse" shall also include a common law Spouse if the Employee resides in a state which recognizes common law marriages and meets the requirements for common law marriage in that state. The Employee must provide proof of a common law marriage as reasonably requested by the Plan Administrator such as, for example, an affidavit or certificate of common law marriage issued by the applicable state.

State Elected Official is a District Judge and District Attorney that has a District Office in the County Seat of Montgomery County, Texas.

Surgery Center is a freestanding surgical facility that:

1. Meets licensing standards;
2. Is equipped and operated for general surgery;
3. Makes Expenses on its behalf;
4. Is directed by a staff of Physicians. A Physician must be present when surgery is performed and during the recovery period;
5. Has at least one certified anesthesiologist present when surgery which requires general or spinal anesthesia is performed and during the recovery period;
6. Extends surgical staff privileges to Physicians that practice surgery in an area Hospital and dentists that perform oral surgery;
7. Has at least two (2) operating rooms and one (1) recovery room;

8. Provides or arranges with a medical facility in the area for diagnostic x-ray and lab services necessary for surgery;
9. Is equipped and has a staff trained for medical emergencies, which requires:
    a. A Physician trained in cardiopulmonary resuscitation;
    b. A defibrillator;
    c. A tracheotomy set; and
    d. A blood volume expander;
10. Has a written agreement with a Hospital in the area for immediate emergency transfer of patients;
11. Provides an ongoing quality assurance program with review Physicians that do not own or direct the facility; and
12. Keeps a medical record on each patient.

Surgical Technician means a technician assisting surgeons and anesthesiologists before, during, and after surgery, while working under the supervision of a registered nurse, operating room technician supervisor or Physician and must complete a one-year surgical training program.

Survivor(s) means an eligible surviving Spouse and/or Dependent of an Employee as defined in Chapter 615 of the Local Government Code.

Total Disability or Totally Disabled means the complete inability of an Employee, because of Sickness or accidental Injury, to engage in or perform the duties of the Employee's regular occupation or employment, or in the case of a Dependent, unable to perform his normal, routine activities or confined to a Hospital.

Waiting Period means the period of time the applicant must wait before coverage becomes effective.

Well-Baby Care means medical treatment, services for supplies rendered to a child or newborn solely for the purpose of health maintenance and not for the treatment of an Illness or Injury.

Article II
Participation in Health Care Benefits

A. Employee Participation

1. Waiver of Participation in this Plan

An Employee, Elected Official, Appointed Official, have the right to waive their medical coverage under this Plan. If coverage is not elected, Dependent coverage will not be available.

2. Eligibility for Health Care Benefits

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 thirty (30) 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 for the Employer; and additionally,
   5. An Employee shall be deemed to be in full-time employment if he/she is absent from work due to a health factor. However, in order to be eligible to participate in the Plan, the Employee must begin work for the Employer. If he/she is unable to do so, then he/she will be considered eligible for participation on such later date when he/she actually begins work.

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 that:
   1. Complete the plan enrollment application within their first thirty (30) 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 that:
   1. Complete the plan enrollment application within their first thirty (30) 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. The State plan will be considered primary coverage. 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. 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 that:
   1. Complete the plan enrollment application within their first thirty (30) days of employment; and
   2. Satisfy the waiting period.

e. **Retirees:** All Retirees and their dependents that meet the qualifications for retiree continuation of coverage and make application prior to the last day before retirement (see page 33, L. Retiree Participation).

f. **All other persons are excluded.**

3. Waiting Period/Effective Date of Health Care Benefits Newly Hired Employees that Elect Coverage when First Eligible.

a. The Waiting Period is the first (1st) day of the month following fifty-eight (58) days of continuous active service from:
   1. Hire date for fulltime employees;
   2. The date you take office for Elected Officials, Appointed Officials and State Elected Officials.

b. The Effective date of coverage is the first (1st) day of the month following fifty-eight (58) days of continuous active service from:
   1. Hire date for fulltime employees;
   2. The date you take office for Elected Officials, Appointed Officials and State Elected Officials.

Employees with a change of status from part-time to full-time or from temporary to regular will be subject to the above waiting period in #3, a. and b. above beginning the date their status changes.

Payment of any contribution toward the cost of Health Care Benefits, if required by the Employer, must be made prior to coverage becoming effective.

4. Newly Hired Employees that Elect Coverage when First Eligible

If additional information on you or your dependent is received by the Plan after the effective Date of Health Care Benefits, that would have disqualified you and your Dependents from coverage originally, the plan will have the right to terminate coverage back to your original effective date and the Employer will refund any contributions that you have paid. The Employee will be responsible for paying for all claims paid by the plan on behalf of the ineligible Employee or ineligible Dependent.

Termination of coverage may only be effective retroactively if the Employee (1) performs an act, practice or omission that constitutes fraud, (2) makes an intentional misrepresentation of material fact, or (3) fails to make a required contribution when due (see page 28, Article IV E. Termination of Health Care Benefits).

B. Dependent Participation

1. Required Documentation for Proof of Dependent

a. **Spouse:** Certified Marriage License or Certified Informal Marriage Certificate, and Social Security 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.
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.
d. **Adopted Children:** Certified copy of a legal certificate of Adoption Decree (adopted parent must be an Employee) and Social Security Number.

2. Eligibility for Dependent's Health Care Benefits

A Dependent will be eligible to participate in the Health Care Benefits Plan on:

a. The date the Employee is eligible for benefits under the Plan, if on that date he has such Eligible Dependents and enrolls them in the plan; or,
b. The date the Employee gains an Eligible Dependent, if on that date he is covered by the Plan, and has made any necessary contributions; and has notified the plan within 30 days of gaining that Dependent. If notification is given after 30 days of gaining the Dependent, the Dependent will be considered a late entrant and will be subject to the late entrant provisions.
c. If a Dependent, other than a well newborn child, is hospitalized on the date participation would normally commence, participation of that Dependent will not be effective until the day after the Dependent is discharged from the hospital;
d. In no event will the Dependent's coverage begin before the Employee's.
e. 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, but not enroll as a new Participant at a later date.

****In the event both lawfully married spouses are eligible to participate in the Plan as Employees, only one Spouse will be eligible to cover any Eligible Dependent children they might have. If the Employee covering a Dependent terminates his or her employment, the currently covered Dependents may be added to the coverage of the remaining (Spouse) Employee, provided that there is no lapse in coverage** (see page 33, Article II Participation in Health Care Benefits, K.).

3. Change in Dependent Health Care Benefits

Changes in the Health Care Benefits will be effective for Dependents at the same time the benefit change is effective for the participating Employee, Elected Official, or Appointed Official.

4. Dependent Disability Extension

In the event of Total Disability, Benefits will continue for ninety (90) days following the date Health Care Benefits terminate, but only under the following conditions:

a. The Dependent was totally disabled when Health Care Benefits terminated;
b. The Dependent remains totally and continuously disabled through the date on which the medical Expenses are incurred;
c. Only Expenses incurred for the treatment of the condition causing the total disability will be eligible for consideration under this benefit.

A Dependent will be considered to be totally disabled if the Dependent is confined to a hospital.

If prior to, or within thirty (30) days after the attainment of the specified age whereby participation would otherwise terminate for a Dependent Child, the Contract Administrator has received due proof such child is mentally retarded or physically handicapped and thereby incapable of earning his own living and is dependent upon the Employee for his support, his or her participation will continue so long as the incapacity continues and the Plan remains in full force and effect. The plan has the right to require that the Employee show proof of the incapacity of the Dependent from time to time, as determined by the plan administrator.

All Plan provisions apply during this extension.

C. Special Enrollment Provision

1. Special Enrollment for Loss of Other Medical Coverage:

If an Eligible Employee, Elected Official, and Appointed Official does not enroll for coverage for themselves and for their Eligible Dependents within thirty (30) days of becoming eligible for coverage and the reason given on their enrollment form was the existence of alternative health coverage and later wants to elect such coverage may enroll for coverage provided the other medical coverage has

terminated. A completed enrollment form must be submitted to the County Risk Management Department within thirty (30) days after the date of Loss of Other Medical Coverage for the following:

a. COBRA continuation coverage has been exhausted; or
b. Loss of eligibility for the Other Medical Coverage (for reasons other than the individual's failure to pay premiums or for cause); or
c. Employer contributions toward the cost of the coverage terminated; or

A completed enrollment form must be submitted to the County Risk Management Department within sixty (60) days after the date of Loss of Other Medical Coverage for the following:

a. Termination of Medicaid or Children's Health Insurance Coverage (CHIP) due to loss of eligibility; or
b. Eligibility for a premium assistance subsidy under Medicaid or CHIP and the employee requests coverage.

Waiting Period/Effective Date of Health Care Benefits for Special Enrollment for Loss of Other Medical Coverage

a. The Waiting Period is the first (1st) day of the month following the date your completed application is received by the County Risk Management Department; and
b. The Effective date of coverage is the first (1st) day of the month following the date your completed application is received by the County Risk Management Department

Loss of Medical Coverage under Special Enrollment for Loss of Other Medical Coverage

If additional information is received by the Plan after the effective Date of Health Care Benefits, for you and your Dependents that would have disqualified you or your Dependents from coverage originally, the plan will have the right to terminate coverage back to your original effective date and the Employer will refund any contributions that you have paid. The Employee will be responsible for paying for all claims paid by the plan on behalf of the ineligible Employee or ineligible Dependent.

Termination of coverage may only be effective retroactively if the Employee (1) performs an act, practice or omission that constitutes fraud, (2) makes an intentional misrepresentation of material fact, or (3) fails to make a required contribution when due (see page 28, E. Termination of Health Care Benefits)

2. Special Enrollment for Family Status Change

In addition, an Eligible Employee, Elected Official, Appointed Official may enroll for coverage, provided that they are eligible for coverage under the Plan but not currently enrolled and declined coverage under the Plan when it was offered previously; and have newly acquired Eligible Dependent(s) through:

a. Marriage;
b. Birth; or
c. Adoption.

For the above listed Family Status Changes the Eligible Employee, Elected Official, and Appointed Official must submit a completed enrollment form for themselves and/or their newly eligible dependents within thirty (30) days of the marriage, birth, or adoption.

Waiting Period/Effective Date of Health Care Benefit for Family Status Change

For a Special Enrollment due to Family Status Change there is no Waiting Period. The Effective Date of Health Care Benefit is on the date of the Eligible Employee, Elected Official, Appointed Official's new marriage, new Dependent's birth, or new Dependent's adoption with proper documentation.

Loss of Medical Coverage under Special Enrollment for Family Status Change

If additional information is received by the Plan after the effective Date of Health Care Benefits, for you and your Dependents, that would have disqualified you or your Dependent from coverage originally, the plan will have the right to terminate coverage back to your original effective date and the Employer will refund any contributions that you have paid. The Employee will be responsible for paying for all claims paid by the plan on behalf of the ineligible Employee or ineligible Dependent.

Termination of coverage may only be effective retroactively if the Employee (1) performs an act, practice or omission that constitutes fraud, (2) makes an intentional misrepresentation of material fact, or (3) fails to make a required contribution when due (see page 28, E. Termination of Health Care Benefits).

D. Late Entrant

An Eligible Employee, Elected Official, Appointed Official and State Official must enroll on behalf of yourself and/or your eligible Dependents within thirty (30) days of the date you become eligible. If you or your eligible Dependents fail to enroll within thirty (30) days and subsequently do not qualify for the Special Enrollment provisions of the Plan, you and/or your Dependents will be considered late entrants and you must complete and submit a Late Entrant application. Late entrant forms are available at the County Risk Management Department and will not be submitted to the Claims Administrator until all information has been completed and received by the County Risk Management Department.

If additional information is received by the Plan after the effective Date of Health Care Benefits, for you and your Dependents that would have disqualified you or your Dependents from coverage originally, the plan will have the right to terminate coverage back to your original effective date and the Employer will refund any contributions that you have paid. The Employee will be responsible for paying for all claims paid by the plan on behalf of the ineligible Employee or ineligible Dependent.

Waiting Period/Effective Date of Health Care Benefits for Late Entrants

1. The Waiting Period is the first (1st) day of the month following fifty-eight (58) days from the date your completed application is received by the County Risk Management Department; and
2. The Effective date of coverage is the first (1st) day of the month following fifty-eight (58) days from the date your completed application is received by the County Risk Management Department.

Late Entrant

If additional information is received by the Plan after the effective Date of Health Care Benefits, for you and your Dependents that would have disqualified you or your Dependents from coverage originally, the plan will have the right to terminate coverage back to your original effective date and the Employer will refund any contributions that you have paid. The Employee will be responsible for paying for all claims paid by the plan on behalf of the ineligible Employee or ineligible Dependent.

Loss of Medical Coverage under Late Entrant

Termination of coverage may only be effective retroactively if the Employee (1) performs an act, practice or omission that constitutes fraud, (2) makes an intentional misrepresentation of material fact, or (3) fails to make a required contribution when due (see page 28, E. Termination of Health Care Benefits).

E. Termination of Health Care Benefits

Except as provided in the Continuation of Health Care Benefits (COBRA) provision and except as provided below, the Participant's coverage will terminate on the earliest of the following dates:

1. If the Participant fails to remit required contributions for his Health Care Benefits when due, his or her benefits will terminate at the end of the period for which contribution is made;
2. The last of the month in which you terminate your employment or lose your eligibility status as long as any required contributions have been paid;
3. Participation may be continued for an Employee on an Employer-approved leave of absence, but for no longer than six (6) continuous months. At the end of the six (6) continuous months of leave, employees will need to return to work or terminate employment. COBRA benefits will be offered to employees that terminate their employment. 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.); or
4. On the termination date of the Plan.

Notwithstanding the foregoing, a termination of coverage may only be effective retroactively if the Employee (1) performs an act, practice or omission that constitutes fraud, (2) makes an intentional misrepresentation of material fact, or (3) fails to make a required contribution when due.

Except as provided in the Continuation of Health Care Benefits (COBRA) provision and except as provided below, Dependent's coverage will terminate on the earliest of the following dates:

1. The day the Employee's coverage terminates;
2. If the Employee fails to remit required contributions for Dependent Health Care Benefits when due, dependent's benefits will terminate at the end of the period for which contribution is made;
3. The day you cease to be an eligible Dependent as defined by the Plan;
4. The day of the month in which the Employee ceases to be in a class eligible for coverage as long as contributions are paid for the month in which you are terminated; or
5. On the termination date of the Plan.

F. Age Discrimination in Employment Act

For Participants age seventy (70) and over, that are actively at work full-time, and covered Dependents age seventy (70) and over, that are Dependents of Covered Employees that are actively at work on a full-time basis, medical coverage benefits will be the same as those medical benefits for Covered Persons and Dependents that are less than age seventy (70) in the same coverage class. Benefits under this Plan will not be reduced by any benefits the Covered Person may receive from Medicare.

G. Continuation of Coverage in Compliance With COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985)

Continuation of Coverage

In order to comply with COBRA, the Plan includes a continuation of coverage option that is available to certain Participants whose health care coverage under the Plan would otherwise terminate. This provision is intended to comply with that law, and if it is found to be incomplete or in conflict in any way with the law and its amendments, the law will prevail.

Definitions

Qualified Beneficiary is an Employee that was covered by the Plan on the day before the Qualifying Event or an Employee's Dependent that was covered by the Plan on the day before the Qualifying Event, or a child that is born to, or placed for adoption with, a covered Employee during continuation coverage.

Qualifying Event shall mean any one of the following that would result in the loss of coverage under the Plan: the death of the covered Employee, the termination of the covered Employee (other than by the Employee's gross misconduct), reduction in a covered Employee's hours of employment to an ineligible status, the divorce or legal separation of the covered Employee from the Employee's spouse, the Employee's coverage termination due to Medicare entitlement, or the cessation of covered Dependent child coverage by operation of a plan provision.

While an individual may incur more than one Qualifying Event, the length of continued coverage will never exceed thirty-six (36) months (except for certain circumstances under COBRA's special bankruptcy rules for retirees and their Dependents).

Notification

Employees must notify the employer or contract administrator within sixty (60) days of a qualifying event in event of divorce, legal separation, or dependent child becoming ineligible. Qualified beneficiaries must notify the employer or contract administrator within sixty (60) days of a qualifying event or secondary qualifying event in event of:

1. Divorce;
2. Legal separation; or
3. Dependent child becoming ineligible.

The Plan Administrator must notify Qualified Beneficiaries of continuation of coverage rights in the event of the Employee's:

1. Death;
2. Termination;
3. Reduction of hours; or
4. Entitlement to Medicare.

Notice mailed to Qualified Beneficiary's last known address will be considered adequate. Notice to a spouse is treated as notification to all other Qualified Beneficiaries residing with spouse at the time notice is made. Notification must be made to Qualified Beneficiaries within forty-four (44) days of the Plan Administrator's notice of the occurrence of a Qualifying Event.

COBRA Election and COBRA Election Period

Continuation of coverage may be elected during the period beginning on the date coverage would otherwise terminate due to a Qualifying Event and ending on the later of the following:

1. Sixty (60) days after coverage ends due to a Qualifying Event; or
2. Sixty (60) days after the Qualified Beneficiary receives notice of the continuation of coverage option rights.

If continued coverage is elected by one Qualified Beneficiary, it will be deemed to be an election for all other beneficiaries that would otherwise lose coverage. However, each individual that would otherwise lose coverage is entitled to make an individual election that would allow one to elect continued coverage even if others in the same family have declined, or, if optional benefits were available, an Eligible Employee and his Dependents could elect different coverage.

Effective Date of Coverage

Continuation coverage, if elected within the period allowed for such election, is effective retroactively to the date coverage would otherwise have terminated due to the Qualifying Event, and Qualified Beneficiary will be retroactively charged for coverage accordingly.

Level of Benefits

Continuation coverage hereunder will be equivalent to coverage provided to a similarly situated Participant to whom a Qualifying Event has not occurred. If coverage of similarly situated Participants is modified, the same modification shall apply to Qualified Beneficiaries.

Cost of Continuation of Coverage

Except as provided below, the cost of coverage may be paid in monthly installments, and such cost will not exceed 102% of the cost of coverage, during the same period, for a similarly situated Participant to whom a Qualifying Event has not occurred. Retroactive premiums must be paid by the Qualified Beneficiary to the Plan within forty-five (45) days of election of continuation of coverage hereunder. Thereafter, payments are due on the first (1st) day of each month to continue coverage for that month. If a payment is not made within thirty (30) days of the due date, coverage will be cancelled and will not be reinstated. The American Recovery Reinvestment Act of 2009, (ARRA), temporarily provides federally subsidized COBRA premium assistance in the amount of 65%. This provision with regard to the ARRA only applies to those that were involuntary terminated, during the period beginning September 1, 2008 and ending December 31, 2009, unless otherwise extended by legislation.

Termination of Continuation of Coverage

Coverage under this provision will terminate on the occurrence of the earlier of:

1. The end of thirty-six (36) months, if the Qualifying Event is the death of the covered Employee, divorce or separation, Employee's entitlement to Medicare, or a Dependent child that no longer qualifies as a Dependent;
2. At the end of eighteen (18) months, if the Qualifying Event is termination of employment or reduction of hours to an ineligible status. However, in the case of a Qualified Beneficiary that is determined under the Social Security Act ("the Act") to have been totally disabled within sixty (60) days of such Qualifying Event, the Qualified Beneficiary may continue coverage (including coverage for Dependents that were covered under the continuation coverage) for a total of twenty-nine (29) months provided the Qualified Beneficiary notifies the Plan Administrator of the disability prior to the end of the eighteen (18) months of continuation coverage, and within sixty (60) days of the determination of total disability under the Act. The cost for continuation coverage for months nineteen (19) through twenty-nine (29) will not exceed 150% of the cost of coverage, during the same period, for a similarly situated Participant to whom a Qualifying Event has not occurred. Further, if during continuation coverage months nineteen (19) through twenty-nine (29), the Qualified Beneficiary is finally determined under the Act not to be Totally Disabled, then the Qualified Beneficiary shall within thirty (30) days notify the Plan Administrator, and continuation coverage shall terminate the last day of the month following thirty (30) days after the date of the determination;
3. The termination of all group health plans provided by the Plan Sponsor;
4. The failure to make timely premium payments to the Plan (coverage may be terminated if the beneficiary is more than thirty (30) days delinquent in paying his premium);
5. The date the Qualified Beneficiary is covered under any other group health plan, as a result of employment, re-employment, or remarriage; and
6. The date the Qualified Beneficiary becomes entitled to Medicare benefits.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, keep the employer or contract administrator informed of any changes in addresses of you or your family members.

Certificates of Coverage

The Plan will provide individuals with an automatic Certificate of Coverage in cases where they lose coverage under this Plan. Such certificates will be provided within the following time frames:

1. For an individual that is a Qualified Beneficiary entitled to elect continuation coverage, no later than when a notice is required to be provided for a Qualifying Event, as set forth above;
2. For an individual that is not a Qualified Beneficiary entitled to elect continuation coverage, within a reasonable time after coverage ceases; and
3. For an individual that is a Qualified Beneficiary and that has elected continuation coverage, within a reasonable time after cessation of continuation coverage or, if applicable, after the expiration of any grace period for the payment of premiums.

In addition, a Certificate of Coverage will be provided upon request, if the request is made within twenty-four (24) months after the individual loses coverage under this provision.

H. Health Insurance Portability & Accountability Act of 1996 (HIPAA) Election Under 45 CFR §146.180(f)

Group health plans sponsored by State and local governmental employers must generally comply with Federal law requirements in title XXVII of the Public Health Service Act on (1) standards relating to benefits for mothers and newborns, (2) parity in the application of certain limits to mental health benefits and (3) required coverage for reconstructive surgery following mastectomies.

Federal law permits a group health plan sponsored by State and local governmental employers (such as the Montgomery County Employee Benefit Plan for Employees of Montgomery County, Texas) to elect to exempt its Plan in whole or in part from these requirements: (1) standards relating to benefits for mothers and newborns, (2) parity in the application of certain limits to mental health benefits and (3) required coverage for reconstructive surgery following mastectomies. Montgomery County, Texas requests annually that the Montgomery County Employee Benefit Plan be exempt from the requirements listed above and eligible under 42 U.S.C. '300gg-21.

Montgomery County, Texas is required to provide certificates of coverage to those individuals covered by the Plan at the time they cease to be covered by the Plan and when they request a certificate within twenty-four (24) months following cessation of coverage.

I. Health Insurance Portability & Accountability Act / Privacy

This Plan complies with the requirements of § 164.504(f) of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations, 45 CFR parts 160 through 164 (the regulations are referred to herein as the "HIPAA Privacy RULE" and § 164.504(f) is referred to as "the "504" provisions") which establish the extent to which the Plan Sponsor will receive, use and/or disclose Protected Health Information.

The Plan's Designation of Person/Entity to Act on its Behalf

The Plan has determined that it is a group health plan within the meaning of the HIPAA Privacy Rule, and the Plan designates Director of Risk Management as Privacy Officer to take all actions required to be taken by the Plan in connection with the HIPAA Privacy Rule (e.g., entering into business associate contracts; accepting certification from the Plan Sponsor).

The Plan's disclosure of Protected Health Information to the Plan Sponsor – Required Certification of Compliance by Plan Sponsor

Except as provided below with respect to the Plan's disclosure of summary health information, the Plan will (a) disclose Protected Health Information to the Plan Sponsor or (b) provide for or permit the disclosure of protected Health Information to the Plan Sponsor by a health insurance issuer with respect to the Plan, only if the Plan has received a certification (signed on behalf of the Plan Sponsor) that:

1. The Plan Documents have been amended to establish the permitted and required uses and disclosures of such information by the Plan Sponsor, consistent with the "504" provisions;
2. The Plan Documents have been amended to incorporate the Plan provisions set forth in this section;
3. And the Plan Sponsor agrees to comply with the Plan provisions as described by this section.

Permitted disclosure of members' Protected Health Information to the Plan sponsor

The Plan (and any health insurance issuer) will disclose members' Protected Health Information to the Plan Sponsor only to permit the Plan sponsor to carry out plan administration functions. Such disclosure will be consistent with the provisions of this section.

All disclosures of the Protected Health Information of the Plan's members by a health insurance issuer to the Plan Sponsor will comply with the restrictions and requirements set forth in this section and in the "504" provisions.

The Plan may not permit a health insurance issuer, to disclose members' Protected Health Information to the Plan Sponsor for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

The Plan Sponsor will not use or further disclose members' Protected Health Information other than as described in the Plan Documents and permitted by the "504" provisions.

The Plan Sponsor will ensure that any agent(s), including a subcontractor, to whom it provides members' Protected Health Information received from the Plan (or from the Plan's health insurance issuer), agrees to the same restrictions and conditions that apply to the Plan Sponsor with respect to such Protected Health Information.

The Plan Sponsor will not use or disclose members' Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

The Plan Sponsor will report to the Plan any use or disclosure of Protected Health Information that is inconsistent with the uses or disclosures provided for in the Plan Documents (as amended) and in the "504" provisions, of which the Plan Sponsor becomes aware.

Disclosure of members' Protected Health Information – Disclosure by the Plan Sponsor

The Plan Sponsor will make the Protected Health Information of the member that is the subject of the Protected Health Information available to such member in accordance with 45 CFR § 164.524.

The Plan Sponsor will make members' Protected Health Information available for amendment and incorporate any amendments to members' Protected Health Information in accordance with 45 CFR § 164.526.

The Plan Sponsor will make and maintain an accounting so that it can make available those disclosures of members' Protected Health Information that it must account for in accordance with 45 CFR § 164.528.

The Plan Sponsor will make its internal practices, books, and records relating to the use and disclosure of member's Protected Health Information received from the Plan available to the U.S. Department of Health and Human Services for purposes of determining compliance by the Plan with the HIPAA Privacy Rule.

The Plan Sponsor will, if feasible, return or destroy all members' Protected Health Information received from the Plan (or a health insurance issuer with respect to the Plan) that the Plan Sponsor still maintains in any form after such information is no longer needed for the purpose in which the use or disclosure was made. Additionally, the Plan Sponsor will not retain copies of such Protected Health Information after such information is no longer needed for the purpose for which the use or disclosure was made. If, however, such return or destruction is not feasible, the Plan Sponsor will limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

The Plan Sponsor will ensure that the required adequate separation, described below, is established and maintained.

Disclosures of Summary Health Information and Enrollment and Disenrollment Information to the Plan Sponsor

The Plan, or a health insurance issuer with respect to the Plan, may disclose summary heath information to the Plan Sponsor, if the Plan Sponsor requests the summary health information for the purpose of:

1. Obtaining bids/proposals from health plans for providing health insurance coverage under the Plan; or
2. Modifying, amending, or terminating the Plan.

The Plan, or a health insurance issuer with respect to the Plan, may disclose enrollment and disenrollment information to the Plan Sponsor without the need to amend the Plan Documents as provided for in the "504" provisions.

Required separation between the Plan and the Plan Sponsor

In accordance with the "504" provisions, this section describes the Employees or classes of Employees or workforce members under the control of the Plan Sponsor that may be given access to members' Protected Health Information received from the Plan or from a health coverage issuer. (Classes may include, for example: Analyst/Administrators; Service Personnel; Information Technology Personnel; Clerical Personnel; Supervisors/Managers; Quality Assurance Unit)

1. Director and Assistant Director of Risk Management
2. Risk Management Analyst
3. Information Technology personnel
4. Financial Accountants
5. Legal advisors that represent the plan
6. Consultants that advise the plan

This list reflects the Employees, classes of Employees, or other workforce members of the Plan Sponsor that receive members' Protected Health Information relating to payment under, health care operations of, or other matters pertaining to plan administration functions that the Plan Sponsor provides for the Plan. These individuals will have access to members' Protected Health Information solely to perform these identified functions, and they will be subject to disciplinary action and/or sanctions (including termination of employment or affiliation with the Plan Sponsor) for any use or disclosure of members' Protected Health Information in violation of, or noncompliance with, the provisions of this section.

The Plan Sponsor will promptly report any such breach, violation, or noncompliance to the Plan and will cooperate with the Plan to correct the violation or noncompliance; to impose appropriate disciplinary action and/or sanctions, and to mitigate any deleterious effect of the violation or noncompliance.

Security Standards

Plan Sponsor Obligations

Where Electronic Protected Health Information will be created, received, maintained, or transmitted to or by the Plan Sponsor on behalf of the Plan, the Plan Sponsor shall reasonably safeguard the Electronic Protected Health Information as follows:

1. Plan Sponsor shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information that Plan sponsor creates received, maintains, or transmits on behalf of the Plan;
2. Plan Sponsor shall ensure that the adequate separation that is required by 45 CFR § 164.504(f)(2)(iii) of the HIPAA Privacy Rule is supported by reasonable and appropriate security measures;
3. Plan Sponsor shall ensure that any agent, including a subcontractor, to whom it provides Electronic Protected Health Information agrees to implement reasonable and appropriate security measures to protect such information; and
4. Plan Sponsor shall report to the Plan any Security Incidents of which it becomes aware as described below:

    a. Plan Sponsor shall report to the plan within a reasonable time after Plan Sponsor becomes aware, any Security Incident that results in unauthorized access, use, disclosure, modification, or destruction of the Plan's Electronic Protected Health Information; and
    b. Plan Sponsor shall report to the Plan any other Security Incident on an aggregate basis every month, or more frequently upon the Plan's request.

J. Continuation of Coverage under the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA").

The Plan offers benefits for continuation of coverage to Employees that participant on the Plan as mandated by the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA").

An Employee has the right to elect Continuation of Coverage under USERRA for a leave from active employment service due to a call to active military service in one of the uniformed services of the United States. "Service" means: active duty, active duty for training, initial active duty for training, inactive duty training, full-time National Guard duty and an Employee's leave from their employment position to determine the Employee's fitness for any of the designated types of duty.

Employees that are dishonorably discharged from the military are not eligible.

The Employee must give written or verbal advance notice of the active military service leave, if it is practical to do so, and failure to do so may result in the departing Employee's coverage being cancelled, unless the Employee is excused from giving advance notice of active military service under USERRA's provisions because it was impossible, unreasonable, or precluded by military necessity. A designated, authorized officer of the branch of the military in which the Employee will be serving may also provide such notice.

If a departing Employee leaves for a period of active military service that exceeds thirty (30) days and gives advance notice of an active military service leave, but fails to elect Continuation of Coverage under USERRA, the coverage will be cancelled the last day of the month rates were paid through. However, should the Employee pay all unpaid rates due within sixty (60) days from the date of the Employee's active military service leave, the coverage will be retroactively reinstated with uninterrupted coverage back to the cancellation date.

If the Employee elects Continuation of Coverage under USERRA, the coverage offered is identical to that provided under the Plan prior to the Employee's active military service leave. The rate for Continuation of Coverage under USERRA will continue at the Plan's established Employee rate for either the High or Low Deductible Plan Option the Employee and covered dependents participate in. Rates are due on the first (1st) day of each month and payments made payable to Montgomery County, Texas. Payments are remitted to: Risk Management Department, 501 N. Thompson, Suite 202, Conroe, Texas 77301. If payments are not received within thirty (30) days of the due date, coverage will cancel the last day of the month the rates were last paid through.

If the Employee does not return to active employment service from active military service, the Employee and covered dependents will be subject to the COBRA Continuation of Coverage Provisions within this Plan (see page 28, G. Continuation of Coverage in Compliance with COBRA). COBRA Continuation of Coverage will be offered at the Plan's established COBRA rate of the either the High or Low Deductible Plan Option the Employee and covered dependents participate in.

If an Employee cancels coverage due to an active military service leave in the uniformed services, that coverage must be reinstated upon re-employment. At the time of re-employment, no exclusion or waiting period of the Plan may be imposed where one would not have been imposed if the coverage of the Employee had not terminated as a result of active military service in the uniformed services. This provision also applies to the coverage of an Employee's dependent that is covered under the Plan. Injuries or illnesses determined by the Secretary of Veterans' Affairs to have been incurred in or aggravated during the performance of service in the uniformed services are excluded from the ban on exclusions and waiting periods; however, the Employee and any dependents must be reinstated as to all other medical conditions covered by the Plan.

Contact the County Risk Management Department regarding Continuation of Coverage under USERRA

K. Dual Coverage Precluded

No person will be covered under the Plan simultaneously:

1. As both an Employee and a Dependent; or
2. As a Dependent of more than one Employee.

L. Retiree Participation

Retiree Coverage/Continuation of Coverage / Chapter 175 of the Local Government Code

1. 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.

2. 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.

3. 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.

4. 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.

5. 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.

6. 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.

7. 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.

8. 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 when they attain the age of 65. 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.

9. 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.

10. 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:

    a. 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.
    b. 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.
    c. 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.
    d. 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 Article II, L. 1. through 9., 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.

Article III
Health Care Benefits

Eligible Medical and Mental Health Care Expenses

The following are considered eligible for reimbursement under the Health Care Benefits Plan unless they are specifically excluded under the Schedule of Benefits. These Eligible Expenses are limited to the Medically Necessary, Maximum Eligible Charges incurred as a result of accidental Injury or Sickness. An expense will be considered to be incurred at the time the service or the supply is provided. All Eligible Expenses must be incurred for the treatment of an accidental Injury or Sickness. The following are considered Eligible Expenses.

1. The hospital's charge for an average semi-private room;

2. Intensive Care Unit or Coronary Care Unit Expenses when deemed Medically Necessary and recommended by a physician;

3. Miscellaneous hospital services and supplies directly related to the sickness or injury causing the hospital confinement;

4. Administration of Anesthesia - fees charged by a physician or Certified Registered Nurse Anesthetist (CRNA) for administration or anesthetics;

5. Local ambulance service, including air ambulance to and from the hospital provided that it is medically necessary;

6. Fees charged by a Physician or a Physician Assistant for medical care or specified treatment of an accidental injury or sickness;

7. Expenses for a birthing center and the medically necessary supplies used there during a patient's stay;

8. Pre-admission diagnostic testing performed within four (4) days of hospital confinement for use during hospitalization;

9. Expenses by a hospital or alcohol dependency treatment center which provides a program for the treatment of alcohol dependency pursuant to a written treatment plan approved and monitored by a physician and which facility is also:

   (See limits shown in the Schedule of Benefits and Cost Containment Section).

   a. Affiliated with a hospital under a contractual agreement with an established system for patient referral; or

   b. Accredited as such a facility by the Joint Commission on Accreditation of Hospitals; or

   c. Licensed as an alcohol treatment program by the Texas Commission on Alcoholism; or

   d. Licensed, certified, or approved as an alcohol dependency treatment program or center by any other state agency having legal authority to so license, certify or approve;

10. Fees charged by a Surgeon, Assistant Surgeon or Surgical Technician for surgical procedures. Assistant Surgeon's fees will be eligible if the procedure required an Assistant Surgeon or the facility where the surgery was performed requires an Assistant Surgeon. Assistant Surgeon fees will be limited to a maximum payment of twenty-five percent (25%) of Medically Necessary, Maximum Eligible Charges of the Surgeon as determined by the Plan or twenty-five (25%) of the negotiated discounted fee of a Preferred Provider Physician;

11. Services of an Outpatient Surgical Facility;

12. Professional Nursing Services - fees charged for professional services by a Registered Nurse (RN), Licensed Vocational Nurse (LVN) or a Licensed Practical Nurse (LPN), excluding services by one that is a member of the patient's immediate family provided that;
    a. These services are ones which can be performed for compensation only by a person holding an RN license, LVN license, or other license requiring a higher level of medical skill and training;
    b. The level of skill of an RN or LVN is medically necessary;
    c. The Expenses are only for the portion of time for which such level of skill is Medically Necessary; and
    d. Provided treatment is recommended by the attending physician;

    Examples of private-duty nursing services not covered are those simply for the convenience of the patient or patient's family or those consisting primarily of such acts as bathing, feeding, mobilizing, exercising, homemaking, giving medication, or acting as a companion or sitter;

13. Physiotherapy rendered by a physiotherapist other than one that ordinarily resides in the patient's home or is a member of the patient's immediate family, provided such treatment is recommended by the attending physician;

14. Diagnostic procedures, radiology, oxygen, and blood transfusions to the extent blood Expenses are not reduced by blood donations;

15. Artificial limbs, artificial eyes, trusses, braces and crutches including replacement when required because of pathological change but not repair or maintenance. Replacement of any of the aforementioned artificial devices shall be limited to one replacement every five (5) years for adults. Dependent children's prosthetic replacements will be determined by their physician and the Plan, but not to exceed one replacement for a pathological change every two (2) years;

16. Rental of iron lung, Tens Unit, and other similar durable therapeutic medical equipment (which can be used only for the diagnosed medical condition and only by the person for whom it is prescribed) or the purchase cost when it is more reasonable than to cover the cost of rental of the equipment;

17. Room and board and normal nursing care provided by an extended care facility if:

    a. After being in a hospital for three (3) consecutive days or more, and within fourteen (14) consecutive days of termination of that confinement a Participant becomes confined in the Extended Care Facility; and

    b. The attending physician certifies twenty-four hour nursing care is necessary for recuperation from the injury or sickness, which required the Hospital Confinement;

    c. Is approved by and is a participating Extended Care Facility of Medicare; and

    d. Has organized facilities for medical treatment and provides twenty-four hour nursing service under the full-time supervision of a physician or Registered Graduate Nurse; and

    e. Maintains daily clinical records on each patient and has available the services of a physician under an established agreement; and

    f. Provides appropriate methods of dispensing and administering drugs and medicine; and

    g. Has transfer arrangements with one or more hospitals, a utilization review plan in effect and operational policies developed with the advice of, and reviewed by, a professional group including at least one physician; and

    h. Not to exceed the Daily Room Rate for Extended Care shown in the Schedule of Benefits for each day of such confinement, in lieu of any other payment under this benefit. Payment will continue for a Maximum Period of Payment for Extended Care, as set forth in the Schedule of Benefits, but only so long as the attending physician certifies such confinement remains necessary for recuperation; and the facility is licensed pursuant to state and local laws and is operated primarily for the purpose of providing skilled nursing care and treatment for individuals convalescing from injury or sickness; and

    i. Excluding any institution, that is other than incidentally a rest home, a home for the aged, or a place for the treatment of mental disease, substance abuse or alcoholism;

18. Services provided by a legally qualified physician or qualified speech therapist for restoration of speech or rehabilitory speech therapy for speech loss or impairment due to an illness, other than a functional nervous disorder. If the speech loss or impairment is due to a congenital anomaly, surgery to correct the anomaly must have been performed prior to the therapy;

19. Home Health Care provided by a Home Health Care Agency upon the order of the Physician when services can be provided at home as an alternative to a hospital confinement with the exception of meals, personal comfort items, and housekeeping service;

20. Dental treatment, except orthodontia and periodontal Expenses, which result from necessary services for the correction of damage to sound, natural teeth caused by accidental injury and treatment is begun or recommended within six (6) months of the accidental injury;

21. Legal drugs including compound medications and medicine obtainable only on a physician's written prescription (see pages 7-8, Other Medical Expenses #18);

22. Expenses incurred for treatment while confined to a Hospice for medical Expenses incurred for the physical and emotional needs of terminally ill patients;

23. Benefits for Eligible Expenses incurred will be payable according to the Schedule of Benefits in effect on the day the Expenses are incurred;

24. Eligible child immunizations for:
    a. **Birth to the sixth (6th) birthday,** paid at 100% (see page 5, Other Medical Expenses, #12, h.); and
    b. **Ages six (6) to the later of the eighteenth (18th) birthday or through twelfth (12th) grade** will be paid at 100% at a Preferred Provider only. **Child Immunization Expenses under Article III, #24 b. incurred Outside the PPO are subject to copays, deductible and coinsurance** (see page 5, Other Medical Expenses #12, h.);

25. Eligible conditions for mental illness under this Plan shall be defined by the International Classification of Diseases 10th Edition (ICD-10) Codes as determined by the Plan Administrator in accordance with the Affordable Care Act subject to exemptions claimed by the Montgomery County Employee Benefit plan as permitted under the Health Insurance Portability & Accountability Act of 1996 (HIPAA) Election Under 45 CFR 146.180(f) (See page 30, Article II Participation in Health Care Benefits, H.;

26. The treatment of temporomandibular joint dysfunction or TMJ syndrome will be limited as stated in the Schedule of Benefits per calendar year per Participant (see page 8, Other Medical Expenses #20);

27. Solid Organ and/or Tissue Transplants subject to the provisions and benefits. (See pages 16-17, Solid Organ and/or Tissue Transplant Event Benefit);

28. Stem cell transplants for the treatment of breast cancer, high dose chemotherapy or bone marrow transplants. Donor Expenses for these non-excluded procedures will be considered eligible, if the donor is a covered participant under this plan and if the hospital and physician customarily charge a transplant recipient for such care and services;

29. 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. (See page 38, Article IV Limitations and Exclusions, #7);

30. Cochlear implants, including the fitting and associated diagnostics, when deemed Medically Necessary (prior authorization is recommended).

31. Contraception medications, injections and devices, including but not limited to birth control pills, Depo-Provera injections, Norplant implants, and intrauterine devices (IUD);

ARTICLE IV
LIMITATIONS AND EXCLUSIONS

Unless otherwise specifically included, benefits will not be paid for Expenses:

1. In excess of the Maximum Eligible Charge, as determined by the Plan;

2. Resulting from sickness covered by a Workers' Compensation Act or similar law;

3. Resulting from accidental injury or illness arising out of or in the course of employment for wages or profit;

4. Resulting from war, declared or undeclared, any act of war, or any type of military conflict;

5. Resulting from any intentionally self-inflicted injury whether sane or insane;

6. For services furnished by a hospital or facility operated by the United States Government or any authorized agency of the United States Government, or furnished at the expense of such government or agency;

7. For eye refraction's or eye examinations for the correction of vision or fitting of glasses or contact lenses, furnishing or replacement of glasses or contact lenses, or for hearing examinations beyond the limits allowable in the State of Texas in Texas Insurance Code Chapter 1367 Subchapter C, or for the furnishing of hearing aids;

8. or dental treatment, except necessary repair of sound natural teeth as a consequence of accidental injury or surgical removal of bony impacted wisdom teeth;

9. or treatment to 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;

10. For cosmetic surgery, unless required because of an accidental injury or because of a congenital malformation of a dependent child;

11. For the diagnosis or treatment of mental, nervous, or emotional disorders, including drug and alcohol related disorders whether as an outpatient or as an inpatient; beyond the limits in the Schedule of Benefits subject to the definition of mental illness in (see page 37, Article III Health Care Benefits, #25);

12. For health check-ups, routine physical examinations or nutritional supplements not medically necessary for the treatment of an injury or illness beyond the limits specified in the Major Medical Benefits Schedule of Benefits & Summary Plan Description (see page 5, Other Medical Expenses, #12);

13. Resulting from care or treatment not reasonably necessary for the care and treatment of sickness or accidental injury;

14. For any Expenses incurred for mandibular or maxillofacial surgery due to growth defects, jaw disproportions or appliances or restorations used solely to increase vertical dimension, reconstruct occlusion, except when these conditions are a direct result of an accident or because of a congenital malformation of a dependent child up to a maximum benefit as stated in the Schedule of Benefits per calendar year per participant for the treatment of temporomandibular joint dysfunction or TMJ syndrome (see page 37, Article III Health Care Benefits, #26 and page 8, Other Medical Expenses #20);

15. For housekeeping or custodial care;

16. For orthognathic disorders;

17. For Illness or Injury caused by, or contributed to, engagement in an illegal occupation or commissions or attempt to commit a felony;

18. For enrollment in a health, athletic, or similar club or smoking cessation or similar program;

19. For purchase or rental of supplies of common use such as: exercise cycles, air purifiers, air conditioners, water purifiers, hypo-allergenic pillows or mattresses, or waterbeds;

20. For purchase or rental of: motorized transportation equipment, escalators or elevators, saunas, steam baths, swimming pools, hot tubs, blood pressure kits, blood sugar kits or any convenience item;

21. For In vitro fertilization, artificial insemination, surgical reversal of elective sterilization and fertility drugs;

22. For vitamins (except prenatal vitamins prescribed by a Participant's Physician to be used during pregnancy or vitamins prescribed by a Participant's Physician if deemed Medically Necessary for an Injury or Illness not otherwise excluded), for dietary supplements, minerals, any drugs that can be purchased without a written prescription;

23. For sex transformation, or the treatment of or for trans-sexual purposes;

24. 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;

25. For treatment of obesity; but not morbid obesity. In addition to other medical requirements determined by the Contract Claims Administrator and the pre-certification company, the weight requirement for morbid obesity shall be defined as a minimum of 100 pounds over your normal body weight as determined by your physician. Surgical procedures and associated costs will be limited to one procedure per covered participant under this medical plan as stated in the Schedule of Benefits. Treatment for complications arising from this surgery is not included in the one procedure limit. However, revision surgery is included in the one procedure limit (see page 8, Other Medical Expenses #20);

26. For recreational or educational therapy, vocational therapy or non-medical self-care or self-help training;

27. For radial keratotomy;

28. For chelation therapy;

29. For Experimental procedures;

30. For an elective or therapeutic abortion unless such abortion is necessary due to an acute life-threatening condition with respect to a pregnant Covered Employee, Covered Spouse, or dependent;

31. For services, supplies or treatments not recognized by the American Medical Association as generally accepted and medically necessary for the diagnosis and/or treatment of an active illness or injury; or Expenses for procedures, surgical or otherwise, which are specifically listed by the American Medical Association as having no medical value;

32. For services rendered by a physician, nurse, or licensed therapist if such physician, nurse, or licensed therapist is a Close Relative of the Participant;

33. Incurred outside the United States if the Participant traveled to such a location for the sole purpose of obtaining medical services, drugs or supplies;

34. For physician fees for any treatment, which is not rendered by or in the physical presence of a physician;

35. For experimental procedures, drugs, or research studies or for any services or supplies not considered legal in the United States;

36. For replacement of a lost, missing, or stolen prosthetic device;

37. For Treatment of eating disorders; beyond the limits in the Schedule of Benefits subject to the definition of mental illness in (see page 37, Article III Health Care Benefits #25);

38. Incurred as a result of or in connection with diagnosis or treatment of a learning disability or learning impairment by any name called. This exclusion includes, but is not limited to, Expenses for initial testing; room and board by a Remedial Clinic; remedial education or training, Educational Therapy (including multisensory teaching techniques); periodic achievement tests; tutoring; rental or purchase of books, tools, equipment, implements, or supplies of any kind; travel; recreational activities; beyond the limits in the Schedule of Benefits subject to the definition of mental illness on page 37, Article III Health Care Benefits, #25. Attention deficit disorder will be considered a learning disorder and is not covered except for medications or for medical examinations to measure appropriateness of medications by a licensed physician and the initial office visit to determine diagnosis;

39. For any Expenses in connection with growth hormone deficiencies, including diagnosis and treatment, unless this condition is incurred by a dependent child;

40. For Solid Organ and/or Tissue Transplants except for those covered under provisions of the Solid Organ and/or Tissue Transplant Benefit section of this Plan (see page 15-16 Solid Organ and/or Tissue Transplant Event Benefit) Those provisions include additional exclusions of Expenses for:

a. A Solid Organ and/or Tissue Transplant that was not precertified;
b. A Solid Organ and/or Tissue Transplant not performed at a Specialty Transplant Network / Centers of Excellence;
c. Personal Services such as Transportation / Donor Transportation, Lodging / Donor Lodging, Meals / Donor Meals;
d. Harvesting or storage of organs, without the expectation of immediate transplantation for an existing Illness;
e. Medical care and service expenses that are not considered medically necessary or a standard of care as associated with respect to the Solid Organ and/or Tissue Transplant Event or donation;

41. Incurred for massage therapy or acupuncture;

42. For any elective surgery that is not medically necessary;

43. For any services or Expenses made in connection with a mental and nervous condition, substance abuse or alcoholism; beyond the limits in the Major Medical Benefits Schedule of Benefits & Summary of Plan Definitions subject to the definition of mental illness (see page 37, #25);

44. For Weight loss programs beyond the limits in the Schedule of Benefits (see page 8, Other Medical Expenses #20 and page 39, Article IV Limitations and Exclusions #25);

45. For 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;

46. For wigs, unless hair loss is due to radiation or chemotherapy with a diagnosis of cancer;

47. For Breast prosthesis, breast implants, tramflap surgery or bras unless a medically necessary mastectomy was performed. No more than two (2) bra replacements per year;

48. For Allergies or the treatment of allergies in excess of amount stated on the Schedule of Benefits (see page 8, Other Medical Expenses #20);

49. Resulting for any pregnancy or the resulting childbirth for a dependent child;

50. For Adult immunizations;

51. For Newborn Well Care or Well Baby Checkup Expenses beyond the limits in the Schedule of Benefits (see page 4, Inpatient Hospital Expenses #3 and page 5, Other Medical Expenses #12 g. and h.). Tests for a newborn that are required in the State of Texas at the time of birth for newborn children will be eligible subject to the plan provisions;

52. For the cost of any appliance, device or implant related to a Hysteroscopic sterilization;

53. For Routine circumcision.

Article V
Coordination of Benefits/Subrogation

A. Coordination of Benefits

All of the Benefits provided under the Plan are subject to these provisions, with the exception of outpatient Prescription Drugs. No coordination of benefits will be allowed for outpatient Prescription Drugs provided through a Prescription Drug card or submitted during your first (1st) eighteen 18 months of coverage under this Plan for reimbursement.

1. Applicability

a. This Coordination of Benefits ("COB") provision applies to This Plan when an Employee or the Employee's covered Dependent has health care coverage under more than one Plan. "Plan" and "This Plan" are defined below.

b. If this COB provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of This Plan are determined before or after those of another Plan. The benefits of This Plan:

(i) Shall not be reduced when, under the order of benefit determination rule, This Plan determines its benefits before another Plan; but

(ii) May be reduced when, under the order of benefit determination rules, another Plan determines its benefits first. The above reduction is described in Section IV. - "Effect on Benefits," of This Plan.

2. Definitions

a. Plan means any Plan providing benefits or services for or by reason of medical or dental care or treatment, which benefits or services are provided:

(i) Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.

(ii) Coverage under a governmental Plan or required or provided by law, including Medicare (Title XVIII, Social Security Act of 1965, as amended). This does not include a state Plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act as amended from time to time). It also does not include any Plan when, by law, its benefits are excess to those of any private insurance program or other non-governmental program.

(iii) This Plan will assume that any person that attains the age of 65 will receive full Medicare coverage. Full Medicare coverage will be defined as both Part A and optional Part B and any other optional benefits available through Medicare.

Each contract or other arrangement for coverage under (i) or (ii) is a separate Plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate Plan.

b. **This Plan** is the part of the group contract that provides benefits for health care Expenses.

c. **Primary Plan/Secondary Plan** - The order of benefits determination rules state whether This Plan is a Primary Plan or Secondary Plan as to another Plan covering the person.

When This Plan is a Primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan's benefits.

When This Plan is a Secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of the other Plan's benefits.

When there are more than two Plans covering the person, This Plan may be a Primary Plan as to one or more other Plans, and may be a Secondary Plan as to a different Plan or Plans.

d. Allowable Expense means any Medically Necessary, Maximum Eligible Charge for an item of Expense for health care, when the item of Expense is covered at least in part by one or more Plans covering the person for whom the claim is made. The difference between the cost of a private Hospital room and the cost of a semi-private Hospital room is not considered an Allowable Expense under the above definition unless, the patient's stay in a private Hospital room is Medically Necessary either in terms of generally accepted medical practice, or as specifically defined in the Plan.

When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

e. Claim Determination Period means a Calendar Year. However, it does not include any part of a year during which a person has no coverage under This Plan, or any part of a year before the date this COB provision or a similar provision takes effect.

3. Order of Benefit Determination Rules (Coordination of Benefits)

a. **General** - When there is a basis for a claim under This Plan and another Plan, This Plan is a Secondary Plan, which has, its benefits determined after those of the other Plan, unless:
   (i) The other Plan has rules coordinating its benefits with those of This Plan; and
   (ii) Both those rules and This Plan's rules, subparagraph b) below, require that This Plan's benefits be determined before those of the other Plan.

b. **Rules** - This Plan determines its order of benefits using the first of the following rules which applies:
   (i) **Non-Dependent/Dependent** - The benefits of the Plan which covers the person as an Employee, member or subscriber (that is, other than as a Dependent) are determined before those of the Plan which covers the person as a Dependent.

   (ii) **Dependent Child/Parents Not Separated or Divorced** - Except as stated in subparagraph b) (iii) below, when This Plan and another Plan cover the same child as a Dependent of different persons, called "parents":
      (a) The benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in that year; but
      (b) If both parents have the same birthday, the benefits of the Plan, which covered the parent longer, are determined before those of the Plan, which covered the other parent for a shorter period of time.

   (iii) **Dependent Child/Separated or Divorced Parents** - If two or more Plans cover a person as a Dependent child of divorced or separated parents, benefits for the child are determined in this order:
      (a) First, the Plan of the parent with custody of the child;
      (b) Then, the Plan of the spouse of the parent with custody of the child; and
      (c) Finally, the Plan of the parent not having custody of the child.

   However, if the specific terms of a court decree state that one of the parents is responsible for the health care Expenses of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. This paragraph does not apply with respect to any Claim Determination Period or Plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

   (iv) **Active/Inactive Employee** - The benefits of a Plan, which covers a person as an Employee that is neither laid off nor retired (or as that Employee's Dependent) are determined before those of a Plan, which covers that person as a laid off or retired Employee (or as that Employee's Dependent).

   If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule (iv) is ignored.

   (v) **Longer/Shorter Length of Coverage** - If none of the above rules determines the order of benefits, the benefits of the Plan which covered an Employee, member or subscriber longer are determined before those of the Plan which covered that person for the shorter period of time.

4. Effect on Benefits

a. **When This Section Applies** - "Effect on Benefits" #4 applies when, in accordance with "Order of Benefit Determination Rules" #3 (see page 42), this Plan is a Secondary Plan as to one or more other Plans. In that event the benefits of This Plan may be reduced under this section. Such other Plan or Plans are referred to as "the other Plans" in b) immediately below.

b. **Reduction in This Plan's Benefits** - The benefits of This Plan will be reduced when the sum of:
   (i) The benefits that would be payable for the Allowable Expenses under this Plan in the absence of this COB provision; and

   (ii) The benefits that would be payable for the Allowable Expenses under the other Plans, in the absence of a provision with a purpose like that of this COB provision, whether or not claim is made.

c. **Medicare Coordination of Benefits**
   (i) If you are age 65 or over and a full time Employee of Montgomery County, Texas, This Plan will be the primary payer. If your Dependent Spouse is 65 or over and covered under your Plan while you are a full time Employee, This Plan will be the primary payer; and

   (ii) For all other Participants, the benefits payable by the Plan for Eligible Expenses will be reduced by the amount for which such persons are eligible for comparable benefits under Full Medicare Coverage. This Plan will assume that any person age 65 and over will have full Medicare coverage (Part A and Part B and any other optional coverage offered by Medicare). The benefits of This Plan would be reduced after both Part A and Part B of Medicare has paid. In the event you have not chosen the optional coverage offered by Medicare, This Plan would still assume and pay eligible benefits as if full Medicare coverage had already been applied.

Exceed those Allowable Expenses in a Claim Determination Period. In that case, the benefits of This Plan will be reduced so that they and the benefits payable under the other Plans do not total more than those Allowable Expenses.

When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

5. Right to Receive and Release Necessary Information

Certain facts are needed to apply these COB rules. The Contract Administrator has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. Each person claiming benefits under this plan must give the Contract Administrator any facts it needs to pay the claim.

6. Facility of Payment

A payment made under another Plan may include an amount, which should have been paid under This Plan. If it does, the Contract Administrator may pay that amount to the organization that made the payment. That amount will then be treated as though it was a benefit paid under This Plan. The Contract Administrator will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

7. Right of Recovery

Whenever any benefit payments have been made by the Plan in excess of the maximum amount required under the terms of this Plan Document, the Contract Administrator shall have the right to recover all such excess amounts from any persons, insurance companies, or other payees, and the Participant shall make a good-faith attempt to assist in such recovery. Further, the Contract Administrator shall have the right to recover any excess payments from any future benefits payable to the Employee or his Dependents.

8. Exception

The Coordination of Benefits provision will not apply to a claim of less than $50.00. If additional Expenses are incurred which raise the claim to more than $50.00, then the Coordination of Benefits provision will apply to the entire claim.

B. Subrogation and Reimbursement

In the event that the Plan provides benefits for Injury, Illness, or other loss, (the "Injury") to any person, the Plan shall be subrogated to have the right to be reimbursed from all past, present and future rights of recovery that person or his heirs, guardians, executors, or other representatives (individually or collectively called "Participant") may have arising out of the injury. The Plan's right of subrogation and right of reimbursement includes, without limitation, all rights of recovery a Participant has:

Against any person, insurer, or other entity that provides, or is in any way responsible for providing, payment, compensation, or indemnification arising out of the injury;

Arising under state, federal, or local law;

Pursuant to any motor vehicle insurance or uninsured motorist or underinsured motorist insurance or coverage;

Under premises medical payments insurance or coverage or under homeowner's renters, or owner's, landlord's, and tenant's (OLT) medical payments or liability insurance or coverage;

Pursuant to school, athletic team, club, special event, sporting event, travel, or any other specific risk accident insurance or coverage; and

Under worker's compensation laws or regulations or pursuant to any group accident and health insurance policy or any pre-paid health or accident benefit plan; and

Or from any source whatsoever.

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.

The Participant and anyone acting on his behalf shall provide the Plan with information it deems necessary to protect its right of subrogation. The Participant is required to contact the Plan prior to the settlement of an injury claim in order to determine the then-current amount of the Plan's subrogation claim. The Participant shall do nothing to prejudice the Plan's subrogation rights and shall cooperate with the Plan in the

enforcement of its rights. Neither a Participant nor his attorney is authorized to accept subrogation reimbursement payments on behalf of the Plan or to settle or otherwise compromise the Plan's subrogation rights without the Plan's written consent, and the Plan will not be responsible for any Expenses or fees incurred in connection with a recovery unless it shall have agreed in writing to pay such Expenses or fees. The amount of the Plan's subrogation interest shall be deducted first from any recovery obtained by or on behalf of a Participant.

The Plan Sponsor has full and final discretionary authority to determine eligibility for benefits and to interpret plan rules and provision, including its subrogation and coordination rules subject to applicable law. The Plan sponsor is also vested with full and final discretionary authority to reduce, settle or otherwise compromise the amount of the Plan's subrogation interest where, in the sole discretion of the Plan sponsor, circumstances warrant such reduction.

Article VI
Miscellaneous Provisions

How to File a Claim

The covered Employee should submit a completed claim form directly to Boon-Chapman, Inc. The covered Employee should maintain a copy of all material submitted.

1. Send in Expense or Expenses as soon as possible. We do suggest holding small Expenses until a minimum of $50 is accumulated.
2. Attach all Expenses to a fully completed Claim Form. These statements should be "itemized", that is, they should at least show the minimum information:
   a. Name of the provider of service;
   b. The date and type of service;
   c. Diagnosis;
   d. The cost of service; and
   e. The name of the person that received the service.
3. Complete the "other insurance" portion of the claim form. Failure to do this can result in a delay in processing the claim.
4. Claim forms and itemized statement of Expenses should be forwarded by the Employee directly to:

Boon-Chapman Benefit Administrators, Inc.
Attn: Claims Department / Group #002248
P. O. Box 9201
Austin, Texas 78766
1-800-252-9653
www.boonchapman.com

Request for additional information or denial action will be sent directly to the covered Employee. Payment will be sent directly to the covered Employee or provider of service, whichever is applicable.

An Explanation of Benefits (EOB) will be sent to the Employee as a result of each claim submission. The EOB will outline covered services and how the benefit calculation was accomplished.

Choice of Physicians

An Employee or covered Dependent will have the choice of any physician. The physician-patient relationship will not be disturbed in any way.

Payment of Benefits

All benefits for Eligible Expenses incurred will be paid to the Employee except that the Employee may authorize benefits to be paid to the facility or person furnishing services. All benefits are payable to the Employee if living, otherwise to the surviving wife, husband, mother, father, child, or children, or estate.

Notice of Claim

Notice given by or on behalf of the claimant to The Plan, or to any other authorized agent of the Employer, with information sufficient to identify the participating Employee, shall be deemed notice to the Plan.

Claim Forms

The Plan upon receipt of such notice will furnish to the Employee such forms as are usually furnished by it for filing proofs of loss. If such forms are not so furnished within thirty (30) days after the receipt of such notice, the Employee shall be deemed to have complied with the requirements of the Plan as to proof of loss, upon submitting, within the time fixed in the Plan for filing proofs of loss, written proof covering the occurrence, character and extent of the loss of which claim is made.

Proof of Loss

Written proof of loss must be furnished to the Contract Administrator, within ninety (90) days after the date of such loss. Failure to furnish said proof within such time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the Participant, later than one year from the date the claim incurred.

Time of Payment of Claims

All accrued benefits for Expenses incurred will be paid subsequent to receipt of written proof.

Physical Examinations

The Contract Administrator acting on behalf of the Plan shall have the right and opportunity to require the examination of the Employee or Dependent when and so often as it may reasonably required during the pendency of claim hereunder. The Plan may also require an autopsy in the case of a death when law does not forbid it.

Legal Actions

No actions at law or in equity shall be brought to recover on the Plan prior to the expiration of sixty (60) days after proof of loss has been filed in accordance with the requirements of the Plan, nor shall such action be brought at all unless brought within two (2) years from the expiration of the time within which proof of loss is required by the Plan.

Third Party Liability

If a Participant has medical Expenses:

1. Incurred as the result of negligence or intentional acts of a third party; and
2. For which the Participant makes a claim for benefits under this Plan; the Participant or legal representative of a minor or person declared to be legally incompetent, must agree in writing to repay the Plan or Employer from any amount of money received by the Participant from the third party or its insurer.

Repayment will be only to the extent of benefits paid by the Plan, but not more than the amount of the payment received by the Participant from the third party or its insurer.

The repayment agreement will be binding upon the Participant or the legal representative of a minor, or person that is declared legally incompetent, whether or not payment received from the third party or its insurer is the result of:

1. A legal judgment;
2. An arbitration award;
3. A compromise settlement; or
4. Any other arrangement.

The repayment agreement is equally binding upon the Participant regardless of whether or not the third party or its insurer has admitted liability or the medical Expenses are itemized in the third party payment.

Leave of Absence

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.)

Assignment of Benefits

Benefits for medical Expenses (except for outpatient prescription drugs) covered under the Plan may be assigned by a Plan Participant to the person or institution rendering the services for which the Expenses were incurred. No such assignment will bind the Plan unless it is in writing and unless it has been received by the Plan prior to the payment of the benefit assigned. The Plan will not be responsible for determining whether any such assignment is valid. Payment of benefits, which have been assigned, will be made directly to the assignee unless a written request not to honor the assignment signed by the Plan Participant and the assignee has been received before the proof of loss is submitted. Any payment made in accordance with the provision of this Section shall fully discharge the liability of the Plan to the extent of such payment.

PPO Physician Referrals

In the event that a Preferred Provider Organization (PPO) physician refers outside the PPO network, the Plan Administrator, at its discretion, will have the option of applying the PPO coinsurance provision. It is the Employee's responsibility to always notify the PPO and to receive benefits within the PPO network.

Deductible Amount and Carry Over Provisions

The calendar year deductible amounts stated in the Schedule of Benefits for the Plan Option enrolled will be deducted from the covered Expenses before benefits are computed, unless the "Major Medical Benefits Schedule of Benefits & Summary Plan Description" indicates otherwise. In the event a Plan Participant is Hospital confined on December 31, satisfaction of a deductible for the following year shall not be applied until after the date of discharge.

The deductible applies separately to each Plan Participant in each calendar year, subject to the following conditions:

1. When two or more covered family members are injured in the same accident, only one deductible will be applied in any calendar year to the Expenses directly resulting from injuries sustained in that accident;

2. Covered Medical Eligible Expenses incurred by any Plan Participant in the last three (3) months of any calendar year, and applied to satisfy the deductible for that calendar year, may also be used toward satisfaction of the deductible in the next calendar year, if no other claims had been incurred and paid previously in the year. This provision applies to individual Plan Participants only and does not apply to those individual family participants that did not have to satisfy a calendar year deductible under the Family Deductible Maximum;
3. **HIGH MEDICAL DEDUCTIBLE PLAN OPTION ONLY** - When three covered family members satisfy their individual deductibles, the deductible will be considered satisfied for all covered family members for that Calendar Year. Satisfaction of the family deductible is based on the date Expenses are incurred. The family deductible also applies when both Spouses are Montgomery County, Texas Employees and covered by this Plan; and
4. The Plan reserves the right to allocate the deductible to any Covered Medical Eligible Expenses and to apportion the benefits to the Participant and any assignees.

Employee Hospital Audit Program

Any Employee that participates in the Plan will be eligible for this benefit. AFTER THE CONTRACT CLAIMS ADMINISTRATOR HAS MADE FINAL PAYMENT ON BEHALF OF THE PLAN TO THE HOSPITAL you will be paid 50% of any amount that you can identify as a billing error on your Hospital bill up to a maximum payment of $1,000.00 per year. You must present to the Risk Management Department a copy of your itemized bill from the hospital showing the services that were billed in error along with your Explanation of Benefit (EOB) showing what was paid by the Plan and your reasons why you believe the services were billed in error.

Presenting Claims for Benefits

If you think you are eligible for a benefit described in this Plan, you have to file a claim. Forms necessary for filing proof of loss for claims are available from The County Risk Management Department. Completed claims must be filed with the Contract Clams Administrator.

The instructions on the claim form should be followed carefully. This will expedite the processing of the claim. Be sure all questions are answered fully and any required medical statements and bills be submitted with the claim form. Failure to provide complete and accurate information required on the claim form may constitute fraud and will be dealt with accordingly.

The Plan has thirty (30) days to process your claim after it is received. In some cases, however, more time may be needed. If this happens, you will be notified that an additional processing period is required.

Requesting a Review of Claims Denied

If your claim is denied, you will be notified in writing by the Contract Claims Administrator. This written notice will tell you the reason for the denial. It will also point out what additional information is needed, if any, which could change the decision to deny the claim. Finally, the notice will tell you how you can have the decision reviewed.

If you have not received a response from the Contract Claims Administrator regarding your claim within ninety (90) days of filing the claim or if your claim has been denied, you can send a written appeal to the Contract Claims Administrator for a review of the denied claims which under other circumstances could be covered under the Plan. You have sixty-one (61) days to appeal from the time you are notified of the denial or sixty-one (61) days from the end of the processing period, if you have not received a response by that time. Send your written appeal with supporting documentation to:

Boon-Chapman Benefit Administrators, Inc.
Attn: Claims Appeal Department / Group # 002248
P.O. Box 9201
Austin, Texas 78766

Those reviewing your claim have to act within sixty (60) days of receiving your request. However, in special cases, they may be allowed one hundred and twenty (120) days. The final decision will be sent to you in writing, together with an explanation of how the decision was made. If you are not satisfied with the result of your appeal, you may file a suit and serve process on The Montgomery County Employee Benefit Plan (see Plan Information - page 18).

Appointment of Authorized Representative by a Claimant

As a Participant Claimant, you are permitted to appoint an authorized representative to act on your behalf with respect to a benefit claim or appeal of a denial. An assignment of benefits by you to a provider will not constitute appointment of that provider as an authorized representative. To appoint such a representative, you must complete a form, which can be obtained from the Plan Administrator or the Contract Administrator. In the event you designate an authorized representative, all future communications from the Plan will be with the representative, rather than you, unless you direct the Plan Administrator, in writing, to the contrary.

Notice of Non-Discrimination

Montgomery County Employee Benefit Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Montgomery County Employee Benefit Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Montgomery County Employee Benefit Plan:

1. Provides free aids and services to people with disabilities to communicate effectively with us, such as:
   a. Qualified sign language interpreters
   b. Written information in other formats (large print, audio, accessible electronic formats, other formats)
2. Provides free language services to people whose primary language is not English, such as:
   a. Qualified interpreters
   b. Information written in other languages
3. If you need these services, contact the Director of Human Resources

If you believe that Montgomery County Employee Benefit Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Director of Human Resources, 501 N Thompson #400, Conroe, TX 77301, Phone 936-539-7886, Fax 936-788-8396, You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Director of Human Resources is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

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

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

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-936-539-7886.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-936-539-7886.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-936-539-7886。

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.

1-936-539-7886 번으로 전화해 주십시오.

ملحوظة: إذا كنت تتحدث اللغة اذكر ،اللغوية المساعدة خدمات فإن لك تتوافر .بالمجان اتصل برقم(1-936-539-7886 رقم)

.والبكم الصم هاتف:

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال
1-936-539-7886

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-936-539-7886.

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-936-539-7886.

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-936-539-7886
पर कॉल करें।

توجه: اگر شما اسپانیایی صحبت می کنند، شما می خدمات کمک زبان
رایگان در دسترس هستند. پاسخ 1-(936-539-7886).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-936-539-7886.

સૂચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-936-539-7886

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-936-539-7886.

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-936-539-7886 まで、お電話にてご連絡ください。

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ,

ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-936-539-7886.

Price Search Tool

For assistance in finding high quality and lower cost providers, Montgomery County plan participants may access Healthcare Bluebook by visiting www.healthcarebluebook.com/cc/boonchapman or from your smartphone. To access the app on your smartphone, download the app from your app store (Android or iOS) and enter company code "bcc" when requested. You may also call Healthcare Bluebook at (800) 341-0504 for assistance. Use of a "green" (high quality, low cost) provider may result in you receiving a Rewards check!

IMPORTANT: Some of the providers listed may not participate in the Plan's PPO network. Therefore, please **always** verify your provider's network (PPO) status first by visiting www.aetna.com/asa or call Boon-Chapman at (800) 252-9653.

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APR 1 4 2020

Montgomery County, TX
COVID-19 Addendum No. 1 to The Third Amended Medical Plan Document

Effective Date: March 12, 2020

This COVID-19 Addendum No. 1 ("Addendum") to the Montgomery County, Texas, Third Amended Medical Plan ("Plan") Document is hereby executed by and between Montgomery County, Texas and Boon-Chapman Benefits Administrators Inc., and is deemed attached, incorporated within and made a part of said Plan Document. This Addendum addresses the following enhanced health benefits associated with the 2019 Novel Coronavirus (COVID-19), in compliance with applicable provisions of the Families First Coronavirus Response Act (the "FFCRA"), Coronavirus Aid, Relief, and Economic Security Act ("CARES Act") and guidance from the Centers for Disease Control and Prevention ("CDC"). This Addendum shall be made effective as of March 12, 2020 and remain in effect until December 31, 2020, unless modified or extended by legislation and/or applicable future addendum(s)/amendment(s) to the Plan Document. Notwithstanding the above, if an earlier effective date is mandated by legislation as governing under a certain aspect(s) of this Addendum, such date shall be deemed effective for the aspect(s) so affected.

In an effort to ensure continuous compliance with evolving legislation, this application and interpretation of this Addendum shall be in compliance with, and deemed to automatically conform as required by, then prevailing law, regulation or order/judgment of a court of competent jurisdiction governing provisions of the Plan, including, but not limited to, provisions relating to maximums, exclusions and/or limitations. In the event that any local, state or federal law, regulation, directive, and/or judgment of a court of competent jurisdiction causes the Plan Administrator to pay claims which are otherwise limited or excluded under the Plan and this Addendum as stated, such payments shall nevertheless be considered as being in accordance with the terms of the Plan Document for the effective duration of this Addendum.

The following are applicable changes to the Plan's provisions, to the extent so stated:

1. Under the **Schedule of Benefits and Summary Plan Description** section, the following are added:

Benefit Description	**Inside PPO**	**Outside PPO**	**Additional Limitations and Explanations**
Testing for the 2019 Novel Coronavirus (COVID-19) including the administration of, and items or services furnished to an individual during the visit that result in an order for or administration of the test.	100%, Deductible waived		Includes testing in any place of service as identified by the FFCRA and CARES Act, including a physician's office, emergency room, urgent care or a telehealth visit. Precertification is not required. The Plan's Maximum Eligible Charges will apply.
Treatment of the 2019 Novel Coronavirus (COVID-19)	**No change to Plan's standard provisions**	**No change to Plan's standard provisions**	Subject to FFCRA, CARES Act and all applicable legislation, as amended.
Telemedicine Visits (Non COVID-19 related)	**Covered as per Plan's Inside PPO in-person office visit benefit**	**Covered as per Plan's Outside PPO in-person office visit benefit**	In-network telemedicine or virtual appointments, conducted remotely are highly encouraged at this time in order to limit person to person contact.

2. This Plan's benefit language including covered expenses, exclusions and definitions are modified to include coverage for the following:

2019 Novel Coronavirus (COVID-19). Covered Expenses associated with testing for and treatment of COVID-19 include the following:

- *Diagnostic Tests.* The following items are covered without any type of Pre-Certification or prior authorization requirements:
    - In vitro diagnostic products for the detection of SARS-CoV-2 or the diagnosis of the virus that causes COVID-19 that are approved, cleared, or authorized under section 510(k), 513, 515 or 564 of the Federal Food, Drug, and Cosmetic Act, including all costs relating to the administration of such in vitro diagnostic products.
    - 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 but only to the extent such items and services relate to the furnishing or administration of such product or to the evaluation of such individual for purposes of determining the need of such individual for such product.
- *Inpatient Hospital Quarantines.* In instances where Participants diagnosed with the COVID-19 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 nevertheless 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/telemedicine 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 particularly recommended if a Participant believes he or she has COVID-19 symptoms.
- *Non-Emergency Ambulance Transportation.* The Plan will cover limited, Medically Necessary, non-emergency ambulance transportation relating to COVID-19 diagnosis or treatment.

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 eligible benefits covered by the Plan, not otherwise stated herein, in accordance with the Plan's stated provisions.

Telehealth/telemedicine visits for medically necessary reasons other than COVID-19 related conditions are highly encouraged and are covered as any other applicable in-person office visit, in accordance with the Plan's and this Addendum's stated provisions.

3. In the **Continuation of Coverage (COBRA)** section, the following provision has been added and expires as of December 31, 2020, unless extended by legislation:

Employer Continuation Coverage
Eligible Participants may seek to continue coverage upon the occurrence of leave in accordance with the Families First Coronavirus Response Act ("FFCRA") including the Emergency Family and Medical Leave Expansion Act and Emergency Paid Sick Leave Act. Coverage will continue for the duration of the permitted leave under the FFCRA, as amended, and in accordance with applicable Montgomery County employee policy(ies).

Executed this 14 day of September 2021

MONTGOMERY COUNTY, TEXAS

Mark J. Keough, County Judge

Robert C. Walker, Commissioner Pct. 1

Charlie Riley, Commissioner Pct. 2

James Noack, Commissioner Pct. 3

James Metts, Commissioner Pct. 4

BOON-CHAPMAN

BENEFIT ADMINISTRATORS, INC.

Authorized Agent- Signature

Stacey R. Minton

Authorized Agent- Printed Name

Vice President, Sales & Account Mgmt

Title

Attest:

Mark Turnbull, County Clerk

APPROVED AS TO FORM:

Michael Howard
Risk Management Director

COMMISSIONER'S COURT
STATE OF TEXAS
MONTGOMERY COUNTY

Attachment:

'EXHIBIT A(1)(d)- FIFTH AMENDED MEDICAL PLAN DOCUMENT'