Montgomery County

Specification Download Acknowledgement

Request for Proposal

Third Party Claims Administration Services for the Montgomery County Medical, Cafeteria Plan and an Optional Fully Insured Group Health Plan

Project # 18-55

Risk Management

VENDORS MUST IMMEDIATELY RETURN THIS FORM BY EMAIL: purchasing@mctx.org

Vendor Responsibilities

- Vendors must download and complete any addenda
- Vendors must submit responses in accordance with requirements stated on cover of document
- Vendor must submit 1295 form with Bid/Proposal

  Detailed information regarding 1295 can be found under item 49 in the attached Terms and Conditions.
  Texas Ethics Commission website for 1295:
  https://www.ethics.state.tx.us/whatsnew/elf_info_form1295.htm

For completing the 1295:

Contract ID: 2660 Description: Project 18-55

Montgomery County will not be responsible for inaccurate or incomplete specifications and/or addenda pertaining to any bid/proposal that is received electronically.

Legal Name of Contracting Company

Contact Person

Complete Mailing Address

Telephone Number

Email Address

Signature

Date

GILBERT D. JALOMO, JR., CPPB
OFFICE OF COUNTY PURCHASING AGENT
MONTGOMERY COUNTY

501 N. Thompson
Suite 405
Conroe, Texas 77301

936.539.7980
FAX: 936.760.6976
www.mctx.org

June 15, 2018

Request for Proposal

Sealed proposals one (1) original and (5) electronic responses will be received in the Office of the Montgomery County Purchasing Agent, Attn: Gilbert D. Jalomo, Jr., CPPB, 501 N. Thompson, Suite 405, Conroe, Texas 77301 until 2:00 p.m., July 11, 2018. Proposals will be publicly opened and respondents' names read aloud at 2:15 p.m. for the following:

PROJECT 18-55
THIRD PARTY CLAIMS ADMINISTRATION SERVICES FOR THE MONTGOMERY COUNTY MEDICAL, CAFETERIA PLAN AND AN OPTIONAL FULLY INSURED GROUP HEALTH PLAN
RISK MANAGEMENT

Prospective vendors may obtain specifications from the Office of the Montgomery County Purchasing Agent located at 501 N. Thompson, Suite 405, Conroe, Texas 77301 any time after 8:00 a.m. on June 15, 2018. Specifications are also available via download at the Purchasing website: www.mctx.org.

The right is reserved, as the interest of Montgomery County Commissioners' Court may require rejecting any one or all proposals and to waive any informality in proposals received. All proposals received after the above designated closing time will be returned unopened.

Pricing and other evaluation factors will be taken into consideration as set forth in the request for proposal.

Montgomery County is an Affirmative Action/Equal Opportunity Employer.

Vendors are responsible for monitoring the Purchasing Department website at www.mctx.org for any Addenda which may be issued.

For questions relating to the specifications or the submission of this proposal, contact Kelly Vidal, Assistant County Purchasing Agent via email: Kelly.Vidal@mctx.org; or by calling 936.760-6905.

Sincerely,

Kelly Vidal, CPPB
Assistant County Purchasing Agent

KV/nw

MONTGOMERY COUNTY
REQUEST FOR PROPOSAL
GENERAL TERMS AND CONDITIONS

PLEASE READ THIS ENTIRE DOCUMENT CAREFULLY, YOU ARE RESPONSIBLE FOR FULFILLING ALL SPECIFICATIONS AND REQUIREMENTS.

1. **COMPLETION OF DOCUMENT:** MONTGOMERY COUNTY is aware of the time and effort you expend in preparing and submitting proposals to the County. Please let us know of any proposal requirements which are causing you difficulty in responding to our proposal. We want to make the process as easy as possible so that all responsible vendors can compete for the County's business.

   Fill out completely and return the number of documents specified in the invitation in a sealed envelope properly marked with TITLE OF PROPOSAL AND PROJECT NUMBER, stating, and clearly stating DO NOT OPEN IN MAIL ROOM. Original proposal shall be clearly marked **"ORIGINAL"** and contain all original signatures.

   Electronic Signatures can be accepted on documentation that requires signatures. If there is a question regarding the authenticity of the signature Montgomery County Reserves the right to request verification.

   Proposer shall provide with this proposal response, all documentation required herein. Failure to provide this information may result in rejection of proposal.

2. **MINIMUM STANDARDS FOR RESPONSIBLE PROSPECTIVE PROPOSERS**: A prospective proposer must affirmatively demonstrate proposer's responsibility. A prospective proposer must meet the following requirements:

   a) have adequate financial resources, or ability to obtain such resources as required;
   b) be able to comply with the required or proposed schedule;
   c) have a satisfactory record of performance;
   d) be otherwise qualified and eligible to receive an award.

   Montgomery County may request representation and other information sufficient to determine proposer's ability to meet the minimum standards listed above.

3. **REFERENCES:** Montgomery County requests proposer to supply, with this Request for Proposals, a list of references where like services have been supplied by their firm. Include name of firm, contact person, address, telephone number and fax number.

4. **AWARD:** The Commissioners' Court of Montgomery County (County) reserves the right to award the contract to the BEST AND MOST RESPONSIBLE PROPOSAL in accordance with laws of the State of Texas, to waive any formality or irregularity, to make awards to more than one proposer, to reject all proposals or require new proposals if in the best interest of the County. By law, County is not obligated to accept a non-compliant low proposal. County reserves the right to award proposals on the lump sum or "unit price" basis, whichever is in the best interest of Montgomery County.

   To obtain results, or if you have any questions, please contact the Purchasing Office at 936.539.7980.

5. **CONTRACT FULFILLMENT:** The Commissioners' Court of Montgomery County must, by law, award all contracts, and the Commissioners' Court must sign all contracts and agreements before they become binding on the County. This proposal and all of its content becomes part of the contract between the awarded vendor and Montgomery County for the time period designated.

6. **CHANGE ORDERS:** No oral statement of any person shall modify or otherwise change, or affect the terms, conditions or specifications stated in the resulting contract. All Change Orders to the contract will be made in writing by the Purchasing Agent and approved by Commissioners' Court.

7. **PRICING:** Prices for services shall be firm for the duration of the contract and shall be stated in the contract. Prices shall be all inclusive, unless specifically approved in writing by the Commissioners' Court. All invoices shall detail services performed and have supporting documentation as required by the County Auditor. Invoices shall be issued for each Purchase Order, must be originals or certified copies of original, and shall be mailed directly to the Montgomery County Auditor, P.O. Box 539, Conroe, TX, 77305.

8. **TERMINATION:** During the term of the contract, County retains the right to immediately cancel any agreement between the parties should services performed by proposer not meet specifications. County also retains the right to cancel the agreement due to budget restraints. In any case, County may terminate any agreement upon thirty (30) days written notice deposited in the United States mail.

9. **PAYMENT TERMS:** Unless otherwise specified by Montgomery County Commissioners' Court, payment terms will be "Net 30" after receipt of product(s), material(s), service(s) or invoice, whichever is later.

10. **RECORDS:** Contractors shall maintain records for one year after project has been accepted by Montgomery County, or any longer term specified in the contract.

11. **FUNDING OUT:** It is expressly understood and agreed that County has available the total maximum sum of funds hereinafter certified available by the County Auditor for the purpose of satisfying County's obligations under the terms and provisions of the agreement; and not withstanding anything to the contrary or that may be construed to the contrary, the liability of County is limited to said sum, plus additional amounts of funds from time to time certified available for the purpose of satisfying the County's obligations under the terms and provisions of this agreement. The sole and exclusive remedy of proposer shall be to terminate the agreement.

    Funds for payment have been provided through the Montgomery County budget approved by the Montgomery County Commissioners' Court for this fiscal year only. State of Texas Statutes prohibit the obligation and expenditure of public funds beyond the fiscal year for which a budget has been approved. Therefore, anticipated orders or other obligations that may arise past the end of the current Montgomery County fiscal year shall be subject to budget approval.

12. **TAXES:** County is a body corporate and political subdivision under the laws of the State of Texas and claims exemption from Limited Sales and Use Tax to the State of Texas, under Texas Tax Code Ann. Section 151.309, as amended. Exemption Certificates will be provided to proposer upon request. County is subject to Federal Excise Tax.

13. **LICENSES:** Proposer is responsible for obtaining and keeping current requisite licenses and permits necessary for the activities under this agreement, including ensuring that any drivers employed by proposer are properly licensed.

14. **ASSIGNMENT:** County shall have the right to sell, transfer or assign, in whole or in part, all of its rights and obligations hereunder. In such event and upon the assumption of such transfer of County's obligations hereunder, no further liability or obligation shall thereafter accrue against County. The successful proposer shall not sell, assign, transfer or convey this contract, in whole or in part, without the prior written consent of Montgomery County Commissioners' Court or appointed agent.

15. **NOTICE:** All notices required hereunder shall be deemed to have been properly given when made in writing and sent by mail with adequate postage in the United States mail.

16. **WAIVER:** The failure of either Party hereto, in any or more than one instance, to insist upon the performance of any term, covenant, or condition of this RFP or the contract or to exercise any right or privilege, or the waiver by either Party of any breach of any of the terms, covenants, or conditions of the agreement, shall not be construed as thereafter waiving that or any other such term, covenant, condition, right or privilege, but the same shall continue and remain in full force and effect as if no such forbearance or waiver had occurred.

17. **TEXAS LAW:** The contract will be governed and construed according to the laws of the State of Texas and is performable in Montgomery County, Texas. The successful proposer and Montgomery County agree that both Parties have all rights, duties, and remedies available as stated in the Uniform Commercial Code.

18. **COMPLIANCE WITH LAW:** The contract and all services performed thereunder must comply with all federal, state, county and local laws concerning the same types of services.

19. **TORT CLAIM:** The County shall be responsible only for the acts or failure to act of its own employees, agents, or servants; provided, however, such responsibility shall be subject to the terms, provisions and limitations of the Constitution and Laws of the State of Texas, particularly the Texas Tort Claims Act. In no event will the County be held to waive any immunity, defense or liability cap available to it by law.

20. **INDEMNIFICATION:** The Parties agree that under the Constitution and Laws of the State of Texas, the County cannot enter into a contract whereby it agrees to indemnity any other Party; therefore, all references of any kind to the County indemnifying, holding or saving harmless for any reason whatsoever is of no effect.

    Proposer agrees to defend and indemnify the County and all of its officials, employees, agents and invitees from and against all claims, demands, actions, damages, losses and expenses, including court costs and reasonable attorney's fees, and any and all loss, damage, injury, or death arising out of or in connection with and during the performance of services under the contract and pursuant to this RFP. Proposer is to maintain sufficient insurance coverage on its personnel and property, and require its subcontractors to maintain sufficient insurance to cover the above eventualities.

    A report of any loss, damage, injury or death to any person or property in any way arising under this agreement shall be sent by certified or registered mail to the County Attorney's Office within ten (10) days from an event. Such written report shall be a full and complete account of the incident.

    In addition, proposer represents and warrants unto County that the use or construction of any and all tools, equipment, products, or services furnished by proposer or used by proposer in the performance of services under the contract shall not infringe upon any patent or license which has been issued or applied for; accordingly, the proposer shall indemnify and hold County harmless from and against any and all claims, demands, and causes of action of any kind and character in favor of or made by

any patentee, licensee, or claimant of any right or priority to any such tool, equipment, product or service.

21. **SPECIFICATIONS:** In the event any conflict arises between specifications of the RFP, the proposal or the final approved Contract, the specifications of the RFP shall rule and take precedence, unless specifically indicated and approved in writing by the County.

    The apparent silence of these RFP specifications as to any detail or the apparent omission of a detailed description concerning any point, shall be regarded as meaning that only the best commercial practices are to prevail. All interpretations of the RFP specifications shall be made on the basis of this statement.

22. **INSURANCE:** County may request Proposer to provide, before award, Certificates of Insurance relating to the following categories of insurance, if required by law:

    a) Workers' Compensation
    b) Comprehensive General Liability Insurance
    c) Automobile Liability Insurance
    d) Professional Liability

    Montgomery County requests that the Vendor maintain in force such insurance as will protect themselves and the County from claims which may arise out of, or result from the execution of, the work, whether such execution be by themselves, their employees, subcontractors, or by anyone for whose acts may be liable.

23. **CONFLICT OF INTEREST:** Potential contractors are advised that they may have disclosure requirements pursuant to Texas Local Government Code, Chapter 176. This law requires persons desiring to do business with the County to disclose:

    a) an employment or other business relationship with a local government officer of the County, or a family member of an officer, that results in the officer or family member receiving taxable income; or

    b) any gift or gifts to a local government officer of the County, or a family member of an officer, that have an aggregate value of more than $100 (one hundred dollars) during the preceding twelve-month period. Gifts of food, lodging, transportation, or entertainment, which an officer or family member accepted as a guest, need not be disclosed.

24. **INTERLOCAL PARTICIPATION:** Additional governmental entities may purchase from the contract, contingent upon mutual agreement between the contractor and other governmental entities. In that event, the contractor agrees to accept purchase orders from those participating entities and to invoice each entity separately.

25. **CHANGE OF OWNERSHIP**: Should there be any change in ownership or management of the contractor during the term of the contract, the contract may be cancelled by the County without mutual agreement with the new owner or manager to continue the contract under its present provisions and prices. The contract is non-transferable or assignable with the express written consent of the County.

26. **ANNUAL CONTRACTS:** Responders may be disqualified and their response not considered, among other reasons, for any of the following specific reasons:

    a) The Responder being interested in any litigation between both parties.
    b) The Responder being in arrears on any existing contract or having defaulted on a previous contract.

c) Lack of competency as revealed by a financial statement, experience and equipment, questionnaires, etc.
d) Uncompleted work, which in the judgment of the County, will prevent or hinder the prompt completion of additional work, if awarded.

Due Care and diligence has been used in preparation of this information, and it is believed to be substantially correct. However, the responsibility for determining the full extent of the exposure and the verification of all information presented herein shall rest solely with the proposer. Montgomery County and its representatives will not be responsible for any errors or omissions in these specifications, nor the failure on part of the proposer to determine the full extent of the exposures.

27. **SCANNED OR RE-TYPED RESPONSE:** If in its response, Responder either electronically scans, re-types or in some way reproduces the County's published proposal package, then in the event of any conflict between the terms and provisions of the County's published proposal package, or any portion thereof, and the terms and provisions of the response made by Responder, the County's proposal package ***as published*** shall control. Furthermore, if an alteration of any kind to the County's published proposal package is only discovered after the contract is executed and is not being performed, the contract is subject to immediate cancellation.

28. **DIGITAL FORMAT:** If Responder obtained the proposal specifications in digital format in order to prepare a response, ***the proposal must be submitted in hard copy*** according to instructions contained in this proposal package. If, in its proposal response, Responder makes any changes whatsoever to the County's published proposal specifications, the County's proposal specifications ***as published*** shall control. Furthermore, if an alteration of any kind to the County's published proposal package is only discovered after the contract is executed and is not being performed, the contract is subject to immediate cancellation.

29. **CONTACT RESTRICTIONS:** Responders shall not contact any County personnel, **to include all entities/persons contracted to do business with the County**, during the process, other than Gilbert D. Jalomo, Jr., Purchasing Agent, without the express permission from the Office of the County Purchasing Department. Any Responder who has made site visits, contacted personnel, or distributed any literature without authorization may be disqualified. The County Purchasing Department may initiate discussion with Responders. Discussions may not be initiated by Responders. The County Purchasing Department expects to conduct discussions with Responder personnel authorized to contractually obligate the Responder with an offer.

30. **DISCLOSURE OF INTERESTED PARTIES:**
Per Government Code, Statute §2252.908, effective January 1, 2016 all contracts executed by Commissioners Court, regardless of the dollar amount, will require completion of Form 1295 "Certificate of Interested Parties" by the participating vendor. Form 1295 is also required for any and all contract amendments, extensions or renewals. Vendors are required to visit the Texas Ethics Commissions (TEC) website (https://www.ethics.state.tx.us/whatsnew/elf_info_form1295.htm) and file a 1295 Certificate. After filing the form with the TEC, it must be printed, signed and notarized and included with the bid/proposal submission.

31. **PROHIBITION ON INVESTMENT IN COMPANIES THAT BOYCOTT ISRAEL**
Prohibition on contracts with companies boycotting Israel per Government Code 2270 Definitions:
(1) "Boycott Israel" has the meaning assigned by Section 808.001.
(2) "Company" has the meaning assigned by Section 808.001.
(3) "Governmental entity" has the meaning assigned by Government Code, Section 2251.001.

PROVISION REQUIRED IN CONTRACT. A governmental entity may not enter into a contract with a company for goods or services unless the contract contains a written verification from the company that it:
(1) does not boycott Israel; and
(2) will not boycott Israel during the term of the contract.

32. **PROHIBITION ON CONTRACTING WITH A COMPANY DOING BUSINESS WITH IRAN, SUDAN, OR A FOREIGN TERRORIST ORGANIZATION**

Prohibition on contracts with certain companies per Government Code 2252.151
Definitions:

"Company" has the meaning assigned by Section 806.001.
"Foreign terrorist organization" means an organization designated as a foreign terrorist organization by the United States secretary of state as authorized by 8 U.S.C. Section 1189.
"Governmental contract" means a contract awarded by a governmental entity for general construction, an improvement, a service, or a public works project for a purchase of supplies, materials, or equipment. The term includes a contract to obtain a professional or consulting service subject to Government Code, Chapter 2254.
"Governmental entity" has the meaning assigned by Government Code, Section 2252.001.

Section 2252.152 - Contracts with companies engaged in business with Iran, Sudan, or foreign terrorist organization prohibited. A governmental entity may not enter into a governmental contract with a company that is identified on a list prepared and maintained under Section 806.051, 807.051, or 2252.153.

Section 2252.153 – Listed Companies. The comptroller shall prepare and maintain, and make available to each governmental entity, a list of companies known to have contracts with or provide supplies o services to a foreign terrorist organization.

Form 10.1

COUNTY PURCHASING AGENT

Montgomery County, Texas

Gilbert D. Jalomo, Jr., CPPB
County Purchasing Agent

P: 936-539-7980
F: 936-760-6976

VENDOR INFORMATION

Federal ID# or SS#		Dun and Bradstreet #
Type of Business	Corporation/LLC Sole Proprietor/Individual Partnership Tax Exempt Oranization	
Legal Company Name		
Remittance Address		
City/State/Zip		
Physical Address		
City/State/Zip		
County	Montgomery Other:	
Phone/Fax Number		
Contact Person		
E-mail		
The Company listed Above is a (check all that apply and attach certificate if applicable)	DBE-Disadvantaged Business Enterprise Certification# SBE-Small Business Enterprise Certification# HUB-Texas Historically Underutilized Bus Certification# WBE-Women's Business Enterprise Certification# MBE-Minority Business Enterprise Certification#	
Company's gross annual receipts	<$500,000 $500,000-4,999,999 $5,000,000-$16,999,999 $17,000,000-$22,399,999 >$22,400,000	
Commodities (Please enter all that apply		
Has this company ever defaulted, been declared to be in default, or failed to complete any work awarded?	YES NO Explain:	
Has this company ever paid (or had withheld from payment) liquidated damages?	YES NO Explain:	
Has this company ever been charged with or paid a fine for non-compliance of State and/or Federal statutes or regulations?	YES NO Explain:	
If applicable, list pending claims and/or litigation against or involving project owners at time of submitted bid/proposal. Include project name, owner and explanation.		

Form **W-9**
(Rev. December 2014)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give Form to the requester. Do not send to the IRS.

Print or type
See Specific Instructions on page 2.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification; check only **one** of the following seven boxes:
☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate
☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶
Note. For a single-member LLC that is disregarded, do not check LLC; check the appropriate box in the line above for the tax classification of the single-member owner.
☐ Other (see instructions) ▶

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):
Exempt payee code (if any)
Exemption from FATCA reporting code (if any)
(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the instructions for line 1 and the chart on page 4 for guidelines on whose number to enter.

Social security number
☐☐☐ – ☐☐ – ☐☐☐☐

or

Employer identification number
☐☐ – ☐☐☐☐☐☐☐

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 3.

Sign Here **Signature of U.S. person ▶** **Date ▶**

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. Information about developments affecting Form W-9 (such as legislation enacted after we release it) is at *www.irs.gov/fw9*.

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following:

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See *What is backup withholding?* on page 2.

By signing the filled-out form, you:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),

2. Certify that you are not subject to backup withholding, or

3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income, and

4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct. See *What is FATCA reporting?* on page 2 for further information.

Note. If you are a U.S. person and a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien;
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States;
- An estate (other than a foreign estate); or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax under section 1446 on any foreign partners' share of effectively connected taxable income from such business. Further, in certain cases where a Form W-9 has not been received, the rules under section 1446 require a partnership to presume that a partner is a foreign person, and pay the section 1446 withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid section 1446 withholding on your share of partnership income.

In the cases below, the following person must give Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States:

- In the case of a disregarded entity with a U.S. owner, the U.S. owner of the disregarded entity and not the entity;
- In the case of a grantor trust with a U.S. grantor or other U.S. owner, generally, the U.S. grantor or other U.S. owner of the grantor trust and not the trust; and
- In the case of a U.S. trust (other than a grantor trust), the U.S. trust (other than a grantor trust) and not the beneficiaries of the trust.

Foreign person. If you are a foreign person or the U.S. branch of a foreign bank that has elected to be treated as a U.S. person, do not use Form W-9. Instead, use the appropriate Form W-8 or Form 8233 (see Publication 515, Withholding of Tax on Nonresident Aliens and Foreign Entities).

Nonresident alien who becomes a resident alien. Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the payee has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement to Form W-9 that specifies the following five items:

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.
2. The treaty article addressing the income.
3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.
4. The type and amount of income that qualifies for the exemption from tax.
5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

Example. Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a nonresident alien or a foreign entity, give the requester the appropriate completed Form W-8 or Form 8233.

Backup Withholding

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS 28% of such payments. This is called "backup withholding." Payments that may be subject to backup withholding include interest, tax-exempt interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, payments made in settlement of payment card and third party network transactions, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will not be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester,
2. You do not certify your TIN when required (see the Part II instructions on page 3 for details),
3. The IRS tells the requester that you furnished an incorrect TIN,
4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or
5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See *Exempt payee code* on page 3 and the separate Instructions for the Requester of Form W-9 for more information.

Also see *Special rules for partnerships* above.

What is FATCA reporting?

The Foreign Account Tax Compliance Act (FATCA) requires a participating foreign financial institution to report all United States account holders that are specified United States persons. Certain payees are exempt from FATCA reporting. See *Exemption from FATCA reporting code* on page 3 and the Instructions for the Requester of Form W-9 for more information.

Updating Your Information

You must provide updated information to any person to whom you claimed to be an exempt payee if you are no longer an exempt payee and anticipate receiving reportable payments in the future from this person. For example, you may need to provide updated information if you are a C corporation that elects to be an S corporation, or if you no longer are tax exempt. In addition, you must furnish a new Form W-9 if the name or TIN changes for the account; for example, if the grantor of a grantor trust dies.

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of $50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a $500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of federal law, the requester may be subject to civil and criminal penalties.

Specific Instructions

Line 1

You must enter one of the following on this line; **do not** leave this line blank. The name should match the name on your tax return.

If this Form W-9 is for a joint account, list first, and then circle, the name of the person or entity whose number you entered in Part I of Form W-9.

a. **Individual.** Generally, enter the name shown on your tax return. If you have changed your last name without informing the Social Security Administration (SSA) of the name change, enter your first name, the last name as shown on your social security card, and your new last name.

Note. ITIN applicant: Enter your individual name as it was entered on your Form W-7 application, line 1a. This should also be the same as the name you entered on the Form 1040/1040A/1040EZ you filed with your application.

b. **Sole proprietor or single-member LLC.** Enter your individual name as shown on your 1040/1040A/1040EZ on line 1. You may enter your business, trade, or "doing business as" (DBA) name on line 2.

c. **Partnership, LLC that is not a single-member LLC, C Corporation, or S Corporation.** Enter the entity's name as shown on the entity's tax return on line 1 and any business, trade, or DBA name on line 2.

d. **Other entities.** Enter your name as shown on required U.S. federal tax documents on line 1. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on line 2.

e. **Disregarded entity.** For U.S. federal tax purposes, an entity that is disregarded as an entity separate from its owner is treated as a "disregarded entity." See Regulations section 301.7701-2(c)(2)(iii). Enter the owner's name on line 1. The name of the entity entered on line 1 should never be a disregarded entity. The name on line 1 should be the name shown on the income tax return on which the income should be reported. For example, if a foreign LLC that is treated as a disregarded entity for U.S. federal tax purposes has a single owner that is a U.S. person, the U.S. owner's name is required to be provided on line 1. If the direct owner of the entity is also a disregarded entity, enter the first owner that is not disregarded for federal tax purposes. Enter the disregarded entity's name on line 2, "Business name/disregarded entity name." If the owner of the disregarded entity is a foreign person, the owner must complete an appropriate Form W-8 instead of a Form W-9. This is the case even if the foreign person has a U.S. TIN.

Line 2

If you have a business name, trade name, DBA name, or disregarded entity name, you may enter it on line 2.

Line 3

Check the appropriate box in line 3 for the U.S. federal tax classification of the person whose name is entered on line 1. Check only one box in line 3.

Limited Liability Company (LLC). If the name on line 1 is an LLC treated as a partnership for U.S. federal tax purposes, check the "Limited Liability Company" box and enter "P" in the space provided. If the LLC has filed Form 8832 or 2553 to be taxed as a corporation, check the "Limited Liability Company" box and in the space provided enter "C" for C corporation or "S" for S corporation. If it is a single-member LLC that is a disregarded entity, do not check the "Limited Liability Company" box; instead check the first box in line 3 "Individual/sole proprietor or single-member LLC."

Line 4, Exemptions

If you are exempt from backup withholding and/or FATCA reporting, enter in the appropriate space in line 4 any code(s) that may apply to you.

Exempt payee code.

- Generally, individuals (including sole proprietors) are not exempt from backup withholding.
- Except as provided below, corporations are exempt from backup withholding for certain payments, including interest and dividends.
- Corporations are not exempt from backup withholding for payments made in settlement of payment card or third party network transactions.
- Corporations are not exempt from backup withholding with respect to attorneys' fees or gross proceeds paid to attorneys, and corporations that provide medical or health care services are not exempt with respect to payments reportable on Form 1099-MISC.

The following codes identify payees that are exempt from backup withholding. Enter the appropriate code in the space in line 4.

1—An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2)

2—The United States or any of its agencies or instrumentalities

3—A state, the District of Columbia, a U.S. commonwealth or possession, or any of their political subdivisions or instrumentalities

4—A foreign government or any of its political subdivisions, agencies, or instrumentalities

5—A corporation

6—A dealer in securities or commodities required to register in the United States, the District of Columbia, or a U.S. commonwealth or possession

7—A futures commission merchant registered with the Commodity Futures Trading Commission

8—A real estate investment trust

9—An entity registered at all times during the tax year under the Investment Company Act of 1940

10—A common trust fund operated by a bank under section 584(a)

11—A financial institution

12—A middleman known in the investment community as a nominee or custodian

13—A trust exempt from tax under section 664 or described in section 4947

The following chart shows types of payments that may be exempt from backup withholding. The chart applies to the exempt payees listed above, 1 through 13.

IF the payment is for . . .	THEN the payment is exempt for . . .
Interest and dividend payments	All exempt payees except for 7
Broker transactions	Exempt payees 1 through 4 and 6 through 11 and all C corporations. S corporations must not enter an exempt payee code because they are exempt only for sales of noncovered securities acquired prior to 2012.
Barter exchange transactions and patronage dividends	Exempt payees 1 through 4
Payments over $600 required to be reported and direct sales over $5,000[1]	Generally, exempt payees 1 through 5[2]
Payments made in settlement of payment card or third party network transactions	Exempt payees 1 through 4

[1] See Form 1099-MISC, Miscellaneous Income, and its instructions.

[2] However, the following payments made to a corporation and reportable on Form 1099-MISC are not exempt from backup withholding: medical and health care payments, attorneys' fees, gross proceeds paid to an attorney reportable under section 6045(f), and payments for services paid by a federal executive agency.

Exemption from FATCA reporting code. The following codes identify payees that are exempt from reporting under FATCA. These codes apply to persons submitting this form for accounts maintained outside of the United States by certain foreign financial institutions. Therefore, if you are only submitting this form for an account you hold in the United States, you may leave this field blank. Consult with the person requesting this form if you are uncertain if the financial institution is subject to these requirements. A requester may indicate that a code is not required by providing you with a Form W-9 with "Not Applicable" (or any similar indication) written or printed on the line for a FATCA exemption code.

A—An organization exempt from tax under section 501(a) or any individual retirement plan as defined in section 7701(a)(37)

B—The United States or any of its agencies or instrumentalities

C—A state, the District of Columbia, a U.S. commonwealth or possession, or any of their political subdivisions or instrumentalities

D—A corporation the stock of which is regularly traded on one or more established securities markets, as described in Regulations section 1.1472-1(c)(1)(i)

E—A corporation that is a member of the same expanded affiliated group as a corporation described in Regulations section 1.1472-1(c)(1)(i)

F—A dealer in securities, commodities, or derivative financial instruments (including notional principal contracts, futures, forwards, and options) that is registered as such under the laws of the United States or any state

G—A real estate investment trust

H—A regulated investment company as defined in section 851 or an entity registered at all times during the tax year under the Investment Company Act of 1940

I—A common trust fund as defined in section 584(a)

J—A bank as defined in section 581

K—A broker

L—A trust exempt from tax under section 664 or described in section 4947(a)(1)

M—A tax exempt trust under a section 403(b) plan or section 457(g) plan

Note. You may wish to consult with the financial institution requesting this form to determine whether the FATCA code and/or exempt payee code should be completed.

Line 5

Enter your address (number, street, and apartment or suite number). This is where the requester of this Form W-9 will mail your information returns.

Line 6

Enter your city, state, and ZIP code.

Part I. Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. If you are a resident alien and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see *How to get a TIN* below.

If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN. However, the IRS prefers that you use your SSN.

If you are a single-member LLC that is disregarded as an entity separate from its owner (see *Limited Liability Company (LLC)* on this page), enter the owner's SSN (or EIN, if the owner has one). Do not enter the disregarded entity's EIN. If the LLC is classified as a corporation or partnership, enter the entity's EIN.

Note. See the chart on page 4 for further clarification of name and TIN combinations.

How to get a TIN. If you do not have a TIN, apply for one immediately. To apply for an SSN, get Form SS-5, Application for a Social Security Card, from your local SSA office or get this form online at *www.ssa.gov*. You may also get this form by calling 1-800-772-1213. Use Form W-7, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or Form SS-4, Application for Employer Identification Number, to apply for an EIN. You can apply for an EIN online by accessing the IRS website at *www.irs.gov/businesses* and clicking on Employer Identification Number (EIN) under Starting a Business. You can get Forms W-7 and SS-4 from the IRS by visiting IRS.gov or by calling 1-800-TAX-FORM (1-800-829-3676).

If you are asked to complete Form W-9 but do not have a TIN, apply for a TIN and write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

Note. Entering "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon.

Caution: *A disregarded U.S. entity that has a foreign owner must use the appropriate Form W-8.*

Part II. Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if items 1, 4, or 5 below indicate otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). In the case of a disregarded entity, the person identified on line 1 must sign. Exempt payees, see *Exempt payee code* earlier.

Signature requirements. Complete the certification as indicated in items 1 through 5 below.

1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983. You must give your correct TIN, but you do not have to sign the certification.

2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983. You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.

3. Real estate transactions. You must sign the certification. You may cross out item 2 of the certification.

4. Other payments. You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments made in settlement of payment card and third party network transactions, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), IRA, Coverdell ESA, Archer MSA or HSA contributions or distributions, and pension distributions. You must give your correct TIN, but you do not have to sign the certification.

What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account)	The actual owner of the account or, if combined funds, the first individual on the account[1]
3. Custodian account of a minor (Uniform Gift to Minors Act)	The minor[2]
4. a. The usual revocable savings trust (grantor is also trustee)	The grantor-trustee[1]
b. So-called trust account that is not a legal or valid trust under state law	The actual owner[1]
5. Sole proprietorship or disregarded entity owned by an individual	The owner[3]
6. Grantor trust filing under Optional Form 1099 Filing Method 1 (see Regulations section 1.671-4(b)(2)(i)(A))	The grantor*
For this type of account:	**Give name and EIN of:**
7. Disregarded entity not owned by an individual	The owner
8. A valid trust, estate, or pension trust	Legal entity[4]
9. Corporation or LLC electing corporate status on Form 8832 or Form 2553	The corporation
10. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
11. Partnership or multi-member LLC	The partnership
12. A broker or registered nominee	The broker or nominee
13. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity
14. Grantor trust filing under the Form 1041 Filing Method or the Optional Form 1099 Filing Method 2 (see Regulations section 1.671-4(b)(2)(i)(B))	The trust

[1] List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

[2] Circle the minor's name and furnish the minor's SSN.

[3] You must show your individual name and you may also enter your business or DBA name on the "Business name/disregarded entity" name line. You may use either your SSN or EIN (if you have one), but the IRS encourages you to use your SSN.

[4] List first and circle the name of the trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.) Also see *Special rules for partnerships* on page 2.

*Note. Grantor also must provide a Form W-9 to trustee of trust.

Note. If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.

Secure Your Tax Records from Identity Theft

Identity theft occurs when someone uses your personal information such as your name, SSN, or other identifying information, without your permission, to commit fraud or other crimes. An identity thief may use your SSN to get a job or may file a tax return using your SSN to receive a refund.

To reduce your risk:

- Protect your SSN,
- Ensure your employer is protecting your SSN, and
- Be careful when choosing a tax preparer.

If your tax records are affected by identity theft and you receive a notice from the IRS, respond right away to the name and phone number printed on the IRS notice or letter.

If your tax records are not currently affected by identity theft but you think you are at risk due to a lost or stolen purse or wallet, questionable credit card activity or credit report, contact the IRS Identity Theft Hotline at 1-800-908-4490 or submit Form 14039.

For more information, see Publication 4535, Identity Theft Prevention and Victim Assistance.

Victims of identity theft who are experiencing economic harm or a system problem, or are seeking help in resolving tax problems that have not been resolved through normal channels, may be eligible for Taxpayer Advocate Service (TAS) assistance. You can reach TAS by calling the TAS toll-free case intake line at 1-877-777-4778 or TTY/TDD 1-800-829-4059.

Protect yourself from suspicious emails or phishing schemes. Phishing is the creation and use of email and websites designed to mimic legitimate business emails and websites. The most common act is sending an email to a user falsely claiming to be an established legitimate enterprise in an attempt to scam the user into surrendering private information that will be used for identity theft.

The IRS does not initiate contacts with taxpayers via emails. Also, the IRS does not request personal detailed information through email or ask taxpayers for the PIN numbers, passwords, or similar secret access information for their credit card, bank, or other financial accounts.

If you receive an unsolicited email claiming to be from the IRS, forward this message to *phishing@irs.gov*. You may also report misuse of the IRS name, logo, or other IRS property to the Treasury Inspector General for Tax Administration (TIGTA) at 1-800-366-4484. You can forward suspicious emails to the Federal Trade Commission at: *spam@uce.gov* or contact them at *www.ftc.gov/idtheft* or 1-877-IDTHEFT (1-877-438-4338).

Visit IRS.gov to learn more about identity theft and how to reduce your risk.

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons (including federal agencies) who are required to file information returns with the IRS to report interest, dividends, or certain other income paid to you; mortgage interest you paid; the acquisition or abandonment of secured property; the cancellation of debt; or contributions you made to an IRA, Archer MSA, or HSA. The person collecting this form uses the information on the form to file information returns with the IRS, reporting the above information. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation and to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their laws. The information also may be disclosed to other countries under a treaty, to federal and state agencies to enforce civil and criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism. You must provide your TIN whether or not you are required to file a tax return. Under section 3406, payers must generally withhold a percentage of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to the payer. Certain penalties may also apply for providing false or fraudulent information.

BIDDER/OFFEROR SELF CERTIFICATION

1.) The Bidder/Offeror certifies that the manufactured good(s) furnished will meet or exceed the specifications, and/or that the services rendered will comply with the terms of the solicitation or contract.

2.) The Bidder/Offeror certifies that it has read all of the bid, proposal, or contract documents and agrees to abide by the terms, certifications, and conditions thereof.

Description of Commodity or Service:____________________________________

SIGNATURE ____________________________

NAME________________________________

TITLE________________________________

COMPANY______________________________

DATE_________________________________

Israel Boycott Statement Explanation

1. Prohibition on Investment in companies that boycott Israel

1.1 Prohibition on contracts with companies boycotting Israel per Government Code 2270 Definitions:

(1) "Boycott Israel" has the meaning assigned by Section 808.001.

(2) "Company" has the meaning assigned by Section 808.001.

(3) "Governmental entity" has the meaning assigned by Government Code, Section 2251.001.

PROVISION REQUIRED IN CONTRACT. A governmental entity may not enter into a contract with a company for goods or services unless the contract contains a written verification from the company that it:

(1) does not boycott Israel; and

(2) will not boycott Israel during the term of the contract.

2. Prohibition on contracting with a company doing business with Iran, Sudan, or a foreign terrorist organization

2.1 Prohibition on contracts with certain companies per Government Code 2252.151
Definitions:

(1) “Company” has the meaning assigned by Section 806.001.

(2) “Foreign terrorist organization” means an organization designated as a foreign terrorist organization by the United States secretary of state as authorized by 8 U.S.C. Section 1189.

(3) “Governmental contract” means a contract awarded by a governmental entity for general construction, an improvement, a service, or a public works project for a purchase of supplies, materials, or equipment. The term includes a contract to obtain a professional or consulting service subject to Government Code, Chapter 2254.

(4) “Governmental entity” has the meaning assigned by Government Code, Section 2252.001.

2.2 Section 2252.152 - Contracts with companies engaged in business with Iran, Sudan, or foreign terrorist organization prohibited. A governmental entity may not enter into a governmental contract with a company that is identified on a list prepared and maintained under Section 806.051, 807.051, or 2252.153.

2.3 Section 2252.153 – Listed Companies. The comptroller shall prepare and maintain, and make available to each governmental entity, a list of companies known to have contracts with or provide supplies o services to a foreign terrorist organization.

Mandatory

Israel Boycott Statement

Date: ____

Name of Individual: ____________________________________

Title: ____

Business Name of Proponent: _____________________________

County of Proponent: ___________________________________

Individual on oath swears that the following statements are true:

1. Individual has the authorization by Proponent to make this statement for Proponent.
2. Individual is fully aware of the facts stated in this statement.
3. Individual can read the English language.
4. In accordance with Texas Government Code Section 2270.002, this company does not boycott Israel and will not boycott Israel during the term of this contract.

____
Signature of Individual

____
Address

REFERENCES

1. COMPANY NAME: ________________________________
   CONTACT PERSON: ________________________________
   ADDRESS: ________________________________
   ____
   PHONE NO.: ________________________________
   FAX NO.: ________________________________
   EMAIL ADDRESS: ________________________________

2. COMPANY NAME: ________________________________
   CONTACT PERSON: ________________________________
   ADDRESS: ________________________________
   ____
   PHONE NO.: ________________________________
   FAX NO.: ________________________________
   EMAIL ADDRESS: ________________________________

3. COMPANY NAME: ________________________________
   CONTACT PERSON: ________________________________
   ADDRESS: ________________________________
   ____
   PHONE NO.: ________________________________
   FAX NO.: ________________________________
   EMAIL ADDRESS: ________________________________

4. COMPANY NAME: ________________________________
   CONTACT PERSON: ________________________________
   ADDRESS: ________________________________
   ____
   PHONE NO.: ________________________________
   FAX NO.: ________________________________
   EMAIL ADDRESS: ________________________________

5. COMPANY NAME: ________________________________
   CONTACT PERSON: ________________________________
   ADDRESS: ________________________________
   ____
   PHONE NO.: ________________________________
   FAX NO.: ________________________________
   EMAIL ADDRESS: ________________________________

____
COMPANY NAME

MONTGOMERY COUNTY
REQUEST FOR PROPOSAL
FOR
Third Party Claims Administration Services for the Montgomery County Medical, Cafeteria Plan and an Optional Fully Insured Group Health Plan

1.0 INTRODUCTION:

Montgomery County, Texas (hereafter referred to as the ("County") seeks Proposals for selection of firm ("Respondent") to provide Third Party Administration Services for the Montgomery County Employee Medical and Cafeteria Plan ("Project") in accordance with the terms, conditions and requirements set forth in this RFP. Additionally, the County will accept proposals for an optional fully insured group health plan.

2.0 PROPOSAL CONTACT:

This Proposal is being issued by the County Purchasing Agent on behalf of Montgomery County, Texas. Thus, responses should be directed to the Purchasing Agent, as outlined below. Respondents are specifically directed NOT to contact any County personnel for meetings, conferences or technical discussions that are related to this Proposal other than specified herein. Unauthorized contact of any County personnel will likely be cause for rejection of the Respondent's proposal. All communications regarding the Proposal shall be directed to the County's Proposal Contact. Communication with the Proposal Contact is permitted via email, facsimile, or written correspondence.

PROPOSAL CONTACT:

Gilbert Jalomo, CPPB
County Purchasing Agent
Re: Project# 18-55
501 N. Thompson, Suite 405
Conroe, TX 77301
Gilbert.Jalomo@mctx.org

3.0 PROPOSAL SUBMISSION:

3.1 Questions concerning this RFP must be submitted in writing to:

Questions concerning this RFP must be submitted in writing to Proposal Contact. Responses to questions will be issued in writing only, verbal questions and responses will not be considered. Deadline for submission of questions and/or clarification is**,**

July 3, 2018, 2:00 p.m. (Central). Requests received after the deadline will not be responded to due to the time constraints of this Proposal process.

3.2 When submitting a proposal in response to this request the following are required:

3.2.1 One (1) original, five (5) electronic response on a flash drive. The flash drive must contain only one (1) file in PDF format and must match the written response identically. Failure to provide proper a flash drive will result in disqualification.

3.2.2 Insure that this RFP is included in your proposal and that all the information requested on the cover of this RFP is completed.

3.2.3 Provide a title page showing the RFP subject, name of Respondent, address, telephone number, fax number and email address. An officer of the firm must sign the title page.

3.2.4 Provide all required elements as stated and send to the following address:

Montgomery County
Purchasing Agent's Office
Re: Project# 18-55, *Third Party Claims Administration Services*
501 N. Thompson, Suite 405
Conroe, TX 77301

3.3 Proprietary Information:

If a proposal includes any proprietary content or information that the Respondent does not want disclosed to the public, such content or information must be clearly identified on every page on which it is found. Content or information so identified will be used by County officials and representatives solely for the purpose of evaluating proposals and conducting contract negotiations.

3.4 Cost of Proposal Preparation:

The cost of preparing a response to this RFP is not reimbursable to Respondent.

3.5 Modification or Withdrawal of Proposals:

Any proposal may be withdrawn or modified by written request of the Respondent prior to the deadline for submission. Modifications received after the submission deadline will not be considered. Respondents will be accorded fair and equal treatment with respect to any opportunity for discussion and revision. Revisions will be permitted after submission and before final contract award for the purpose of obtaining the best and final offer.

3.6 Preparation of Proposal:

Proposals must be in correct format and complete. Respondents are expected to address all items in as much detail as necessary for County representatives to make a fair evaluation of the company and the proposal.

3.7 Confidentiality of Proposals:

Proposals will be opened on the date specified on the cover page and kept confidential during the process of negotiations. Only the names of the Respondents will be made public at time of opening. All proposals that have been submitted shall be open for public inspection only after final contract award, subject to the requirements of the Texas Public Information Act.

3.8 Contract Award:

Award of contract will be made by Montgomery County Commissioners' Court to the responsible company(s) who has been determined to be the best evaluated offer resulting from negotiations. Montgomery County reserves the right to reject any or all proposals and is not obligated to award a contract pursuant to this request for proposals.

3.9 Exceptions to the RFP:

Any and all exceptions, conditions or qualifications to the provisions contained herein must be clearly identified as such together with reasons for taking exception, and inserted in the proposal along with associated costs.

4.0 INSURANCE:

4.1 All Respondents must submit, with RFP, a current certificate of insurance indicating coverage in the amounts stated below. In lieu of submitting a certificate of insurance, Respondents may submit, with RFP, a notarized statement from an Insurance company, authorized to conduct business in the State of Texas, and acceptable to the County, guaranteeing the issuance of an insurance policy, with the coverage stated below, to the contractor named therein, if successful, upon award of this Contract. Failure to provide current insurance certificate or notarized statement will result in disqualification of submittal.

4.2 The certificates of insurance to be satisfactory to the County, naming the contractor and its employees as insured:

4.2.1 Workers Compensation in accordance with the laws of the State of Texas. Substitutes to genuine Workers' Compensation Insurance will not be allowed.

4.2.2 Employers' Liability insurance with limits of not less than $1,000,000 per injury by accident, $1,000,000 per injury by disease, and $1,000,000 per bodily injury by disease.

4.2.3 Commercial general liability insurance with a limit of not less than $1,000,000 each occurrence and $2,000,000 in the annual aggregate. Policy shall cover liability for bodily injury, personal injury, and property damage and products/completed operations arising out of the business operations of the policyholder.

4.2.4 Professional Liability insurance with limits not less than $2,000,000 each claim/annual aggregate.

4.3 County and the members of Commissioners Court shall be named as additional insured to all required coverage except for Workers' Compensation and Professional Liability (if required). All Liability policies written on behalf of contractor shall contain a waiver of subrogation in favor of County and members of Commissioners Court.

4.4 If required coverage is written on a claims-made basis, contractor warrants that any retroactive date applicable to coverage under the policy precedes the effective date of the Contract and that continuous coverage will be maintained or an extended discovery period will be exercised for a period of 2 years beginning from the time the work under this Contract is completed.

4.5 Contractor shall not commence any portion of the work under this Contract until it has obtained the insurance required herein and certificates of such insurance have been filed with and approved by Montgomery County.

4.6 No cancellation of or changes to the certificates, or the policies, may be made without sixty (60) days prior, written notification to Montgomery County.

5.0 TENTATIVE SCHEDULE OF EVENTS:

Release of RFP:	June 15 2018
Deadline for Questions:	July 3, 2018
Submission Due Date:	July 11, 2018

6.0 EVALUATION FACTORS:

Contract award will be made to the Respondent, whose proposal is determined to be the best evaluated offer resulting from negotiations, taking into consideration the relative importance of service, price and other evaluation factors set forth in this RFP and in accordance with The County Purchasing Act of the TEXAS LOCAL GOVERNMENT CODE.

6.1 Basic Requirements: Initially, the proposal will be examined to determine if it "qualifies" in that it meets the basic requirement for consideration. This review will pertain to such matters as adequate responsiveness to the RFP, necessary signatures, completeness, and clarity with respect to such essential factors as price. Failure of the proposal to meet the basic requirements of a proposal may disqualify it from further consideration.

6.2 Evaluation of Qualifying Proposals: Having determined that a proposal meets the basic requirements, the Evaluation Committee will then evaluate it with respect to each of the following elements:

Proposal Presentation and Completeness (Maximum 20 points): The Evaluation Committee will review the proposal for its completeness, see how the respondent will approach the task of initiating and then fully implementing its program, look at the proposed health care delivery system in all its facets including how desired results will be attained. In all, proposal's clarity, understanding of issues, completeness of program, and demonstration of assurance of performance as to quality and efficiency will be weighted when scoring this category.

Qualifications/Experience/References (Maximum 45 points): Included in this criterion of the evaluation will be: Length of time respondent has been in the business of Employee Benefits Administration or Providing and Administering a Fully Insured Plan (if responding to this option); current and recent history of past performance by the Respondent of a similar nature to the performance offered in response to the RFP; any evidence submitted (letters of reference) regarding the quality of past performance and the reliability of responsiveness of the Respondent; the apparent capabilities of the Respondent to perform well in the execution of its obligations under a contract with the County as evidenced by its leadership and management personnel, size of organization, length of time in business, past performance, and other current contractual obligations defining the Respondents capability to undertake and successfully fulfill the obligations proposed to be undertaken by its submission of a proposal in response to this RFP. Respondent should outline experience with clients of the same size and/or same vicinity/state as this County. Provide a minimum of three (3) letters of reference from current clients, preferably Texas Counties and a minimum of two (2) references from former clients.

Price (Maximum 35 points): Price per employee per month to provide medical, dental and cafeteria plan administration service or for an Optional Fully Insured Plan.

7.0 EVALUATION CRITERIA:

In order to facilitate the analysis of responses to this Proposal, Respondents are required to prepare their proposals in accordance with the instructions outlined in this part. Proposals should be prepared as simply as possible and provide a straightforward, concise description of the Respondent's capabilities to satisfy the requirements of the Proposal. Emphasis should be concentrated on accuracy, completeness, and clarity of content. All parts, pages, figures, and tables should be numbered and clearly labeled.

7.1 Respondents are required to follow the outline below when preparing their proposals:

Title Page
Table of Contents
Executive Summary

1. Response to Questions Concerning:
    a. Medical Administration
    b. Cafeteria Plan Administration

2. Reference Letters and References from current and past clients.

3. Optional Fully Insured Group Health Plan.

4. Other Options which may be of interest to the County (i.e. Dental, Vision).

5. Pricing.

7.2 Any exceptions to the Proposal requirements shall be identified in the applicable section.

7.3 Executive Summary - This section should be limited to a brief narrative highlighting the company's background and experience. Narrative should clearly demonstrate compliance with Respondent qualifications listed in the RFP specifications. Include length of time the company has been in business and provide examples of past projects. Include a list of current and/or pending installations, including number of licensed users.

8.0 EVALUATION PROCESS:

8.1 After the proposals are received, the evaluation team shall evaluate each proposal that was submitted on time, and the evaluation shall be based on the criteria listed in the proposal. Selection committee members will conduct a quantitative evaluation according to a numerical ranking system and a qualitative evaluation for over all proposal content and its conformance to requirements. The entire evaluation committee will then meet to discuss the strong and weak points of each proposal to assure that it has been evaluated fairly, impartially and comprehensively. Following

this initial evaluation, the evaluation team may recommend contract award without further discussion with Respondents, or the firms submitting the top rated proposals may be asked to make an oral presentation to the evaluation team for the propose of further clarification and evaluation of the proposals.

8.2 If site visits and interviews are scheduled, the representatives of the firm who will be directly assigned to the account must be present at the interview.

8.3 The evaluation team shall not disclose any information included in a firm's proposal to another firm during the RFP process and shall not disclose any information for the purpose of bringing one firm's proposal up to that of a competitor's proposal.

8.4 Montgomery County reserves the right to reject any and all proposals received for any reason that would be to the benefit of Montgomery County.

8.5 All proposals submitted are to be valid for a period of one-hundred twenty (120) days.

8.6 Site visits may be required. Respondents may be required to facilitate such visits; however, County will be responsible for all travel costs associated with any and all site visits.

9.0 AWARD:

Proposals will be opened on the date specified on the cover page and kept confidential until the Montgomery County Commissioners Court awards a final negotiated contract. Only the names of the Respondents will be read aloud during the opening. All proposals that have been submitted shall be open to public inspection after the contract award.

10.0 ADDITIONAL REQUIRED FORMS:

All Respondents submitting are required to complete the attached and return with submission:

10.1 Vendor Information Form
10.2 W9 Form
10.3 Bidder/Offeror Self Certification
10.4 Israel Boycott Statement

11.0 ATTACHMENTS:

11.1 General Questionnaire
11.2 Medical/Cafeteria Plan Administration Questionnaire
11.3 Optional Fully Insured Group Health Plan

12.0 EXHIBITS:

12.1 Montgomery County Medical and Dental plan statistical data
12.2 Montgomery County Cafeteria plan enrollment by category
12.3 Current Montgomery County Medical Plan Document
12.4 Current Montgomery Cafeteria Plan Document.

ATTACHMENT 11.1

GENERAL QUESTIONNAIRE FOR THIRD PARTY ADMINISTRATORS

1. Please give a history of your firm, including ownership, length of time in the contract claims administration business, physical location and satellite operation locations

2. Please provide a list of all companies/organizations that you have a financial interest in and a description of that financial interest.

3. Please include a copy of your most recent audited financial statement (including P&L and balance sheet) (Please mark as Confidential) and SAS70 report for the previous 3 years.

4. Please send a copy of your Third Party Administrators Errors and Omission Policy and disclose if you currently have, or have had in the past, any litigation involving your claims service and the disposition of that litigation.

5. Please list the number of employees you employ by department and job function.

6. Please list all employee benefit related organizations that your firm belongs to and the length of time.

7. Please give the total number of employee lives that you currently administer, month-by-month for the past twelve (12) months.

8. Please list all states where you are currently a licensed T.P.A.

9. Please list all states where you currently have clients.

10. Please list all fully insured carriers with which you have draft book authority.

11. Please list all Stop loss carriers with which you are approved.

12. Please list all PPO(s) with which you currently work.

13. Please list all Pre-Certification/Utilization Review/Case Management companies that you currently administer claims in conjunction with your clients benefit plans.

14. Please list all Prescription Benefit Management companies with which you currently work.

15. Please list all political subdivisions in Texas for which you currently administer medical and cafeteria plans with including years doing business, the name of a contact and telephone number; i.e., state, county, city, school district, etc.

16. Please complete the Medical and Cafeteria Plan Administration Questionnaire (Attachment

2). Please add a section in your response to this RFP and title it Optional Services if you wish to offer additional services. Any Optional Services you offer must be listed here with the name of the service and a complete description of the service. If there is a charge for the optional service, it must be disclosed in this section. If a charge/fee for an Optional Service cannot be quoted at this time due to a lack of information, please state in your proposal:" Additional information is required for a charge/fee quote"

ATTACHMENT 11.2

MEDICAL AND CAFETERIA PLAN CLAIMS ADMINISTRATION QUESTIONNAIRE

MEDICAL ADMINISTRATION

1. Where is your claims payment office located that would serve the Plan? Would benefit checks and explanation of benefits forms be mailed from the claims office or elsewhere? Please provide a sample EOB.

2. How many employees would you assign to our account? Which of them would be dedicated to our account only? State titles and explain function with brief biographies on each.

3. What is the minimum experience for hiring a claims processor at your firm? How much experience (minimum and average) would the personnel assigned to our account have?

4. Have you developed your own claims payment software, or do you use vendor software? Describe your system; identify the vendor if a vendor is used. Do you own or lease your claim software? Explain any special features of the system you use.

5. If any of your claim adjudication is manual, please explain.

6. Is your claim system and firm compliant with HIPAA Privacy requirements?

7. Is your claims system capable of handling a group with different plan designs?

8. Describe procedure used to screen for duplicate charges

9. Explain your coordination of benefits procedures and state your average percentage of recovery on all health benefit accounts now handled, in relation to claims paid. If possible, estimate your anticipated dollar amount of recovery on this account.

10. What is your average claims turnaround time? Specify in calendar days for both average and maximum allowed turnaround. Define all terminology used. If a claim is not "clean" when first received, explain the procedures used and the time required to correspond for additional information.

11. Do you furnish your explanation of benefits with the payment check or separately? Explain procedures and who receives copies.

12. Do you furnish your explanation of benefits with the payment check or separately? Explain procedures and who receives copies.

13. Do you generate your own usual and customary fee date, or do you use vendor data? If so, who? How often is it updated? Can you pay at differing percentiles if requested by the client?

14. Do you have the capability to process medical claims with Medicare pricing?

15. Describe the standard procedures used for subrogation investigation.

16. What services does your firm usually offer for claims on which subrogation may be possible? If options are available, explain and indicate fees

17. Do you batch claim payments?

18. Please explain what type of claims filing system you use.

19. Will you reimburse the County for all payments due to overpayment of a claim if refund cannot be received from provider within 6 months?

20. Describe your clinical editing capabilities to detect unbundling, up coding, duplicate claims payment and other erroneous claims filing practices, including fraud and other abuses

21. Please explain your internal audit procedures and at what level these audits begin. Please explain if you have external audits performed and will you provide copies of those audits?

22. Do you have a catastrophic backup plan? Please explain

23. Please explain all claim/eligibility system security and your company's security

24. Do you have a service by which providers may verify participant coverage? If so, what hours and days does it operate? Do you have a toll free number? If the service is not operated 24 hours/7 days a week, would you be willing to expand it?

25. Provide any third party actuarial studies or any other objective outside data available that assess the effectiveness of your TPA service for other clients with similar plans in obtaining accurate payment of claims.

26. Is postage included in your monthly fee per participant?

27. Please include samples with a description of the standard types of management reports and frequency you provide for your clients, and any fees that are charged for reports. Please explain what ad hoc report capabilities you have and any associated fees.

28. Please explain all Internet/Webpage capabilities your firm offers to employees and the County including security for these capabilities

29. What is the banking arrangement for transfer of funds that you would use for this account?

30. Include a description of your preferred banking arrangement. Be certain to address the following:

Who sets up the bank account and pays the banking charges?
How is the Client assessed banking charges if its own bank is not used to write checks?
How are funds to be remitted?
Minimum balance requirement?
Frequency of bank account funding?
Timing on claims funding?
Funding to claims through any bulk payment arrangement?
Reconciliation procedures

31. Are any alternative banking arrangements available? If so, describe briefly.

32. Are you able to use drafts and print on Client's stock?

33. Assuming direct claims submission, describe your procedures for handling eligibility?

34. How often do you require updated eligibility from your Clients?

35. How long do you anticipate it taking to set up eligibility for this Client?

36. What online eligibility capabilities are available to the Client?

37. Can you receive eligibility files electronically? If the County provides a full eligibility feed to the new administrator, how long before the effective date does your firm need to receive this data?

38. Can your system track each dependent by the dependent's name and the dependent's social security number?

39. Specify how you would prefer to receive the data (i.e. tape, disk electronically).

40. Please provide the specifications of your preferred method.

41. If any costs are associated with your preferred method, would you be willing to assume that cost?

42. Estimate your minimum start-up time from date of contract award to date you could commence processing claims. Do you presently have the needed personnel, equipment and facilities? If not, how do you propose to obtain them?

43. Do you provide COBRA administration in your basic fee? If not, please state additional fee.

44. Please include a copy of your company's HIPAA policy including a copy of the training your employees receive.

45. Will you provide an administrative manual for the Risk Management Department?

46. Will you produce I.D. cards, benefit booklets and is there a cost? If yes, please explain any costs associated with this item.

47. Will you produce and timely file IRS form 1099 for providers?

48. Please include a sample monthly invoice for your services.

49. May additional vendors be added to your monthly invoice in order to consolidate billing?

50. Can you invoice monthly for COBRA participants Retiree participants and Survivor participants? Please explain in detail what you would do if a COBRA, Retiree participant and Survivor participant does not pay their monthly premium in a timely fashion.

51. Will you provide a contact person to answer legal questions and explain changes in benefits required by the federal government?

52. Does your firm have personnel available to assist in annual enrollments? Please explain any costs associated with this.

53. Please describe the PPACA - Health Reform Services you will provide to self-insured clients and the associated costs as applicable.

54. Furnish your proposed fee structure, and explain the details and costs of any services or options offered. Explain if additional fees will be imposed for processing runoff claims in the event of termination. Unless you state otherwise, it will be assumed that all TPA services discussed in your proposal are included in the basic fee quoted. The County would prefer a composite basic fee (PEPM) for medical claim administration. If you have a separate fee for COBRA participants or any other category of participation in the medical program, please include the fee or it will be assumed all participants in the medical program will have the same fee as the composite basic fee (PEPM).

55. Include a sample of your administrative service contract for medical claim administration.

CAFETERIA PLAN ADMINISTRATION

1. Is your cafeteria plan administration component integrated within your medical/dental claims/administration system?

2. Include with this proposal any forms, documents and brochures that you will provide the County.

3. Include costs for any services, brochures, forms and audio-visual material, which you will provide assistance in developing.

4. What experience does your organization have with Section 125 Plans and for what period of time have you administered such plans?

5. If there are any questions from the County or its employees relating to this program, will you provide easy access to the answers? Does this include staff support and toll free access to the staff? Describe your consumer service program in detail.

6. Can you provide a printed copy of any employee's contribution and expense status if requested, on demand?

7. In order to provide the services at the level of fees indicated in your proposal, would you require any minimum amount of participants in the Section 125 Plan?

8. Describe a typical medical expense reimbursement claim. How would you expect it to be reported, what documentation would you require, to whom would a claim be submitted and where, how long thereafter on the average would a check be issued and to whom would it be issued? How frequently are reimbursement claims processed? Would you issue checks directly to a provider?

9. Describe a typical dependent care expense reimbursement claim; how would you expect it be reported, what documentation would you require, to whom would the claim be submitted and where, how long thereafter on the average would a check be issued and to whom would it be issued?

10. Is your company's primary business a plan administrator, or selling products? If you sell products would you require that the County allow you the opportunity to sell your products? Is your administrative cost affected if you do not sell your products? If allowed the opportunity, what type marketing opportunity would you require of employees or the County? What type products would you require be offered?

11. What assistance would you require of the County's payroll and accounting department in implementing and administering the Plan?

12. What kind of frequency of reporting would you provide to participants regarding their accounts, deposits, claims, etc.?

13. What kind of reporting would you provide the County and what frequency?

14. What happens to unused balances in the participant's account at the end of the year?

15. Do you provide all enrollment forms, claim forms, etc?

16. Do you have a minimum monthly participation amount? Maximum monthly contribution amounts?

17. Do you maintain separate bookkeeping accounts by participant for each plan option?

18. Do you allow claims to be submitted as incurred, or in increments, or both?

19. Can you receive eligibility electronically?

20. The County would prefer a composite basic fee (PEPM) for Cafeteria Plan administration by category. Please state your fee for participation in the premium reduction account. Please state your fee for participation in the child care account. Please state your fee for participation in the medical reimbursement account.

21. Include a sample of your administrative service contract for Cafeteria Plan administration.

ATTACHMENT 11.3
OPTIONAL FULLY INSURED PLAN

Insurance coverage proposed shall be provided to all current plan participants including enrolled dependents. Coverage will maximize group savings while maintaining a benefit plan comparable to the current self-funded medical, dental and cafeteria plans.

Respondents must provide a responsive billing and accounting process.

The responder to this RFP will provide a breakdown for both “In-Network” and “Out-of-Network” benefits, and compare their proposal to that of the current Montgomery County Plan, as follows:

Benefit Description

Deductibles - Single and Family
Coinsurance - % paid by plan
Maximum of out-of-pocket expenses per calendar year
Lifetime maximum

Inpatient Services

Unlimited days of care in semi-private room
Physician services
Intensive care
Ancillary services, lab tests, x-rays, anesthesia, medications
Maternity care
Newborn care

Outpatient Services

Any physician office visit, diagnosis and treatment
Lab & X-ray – Diagnostic
Lab & X-ray – Preventive
Lab & X-ray – Routine (mammograms, Pap Smear, PSA including screening and lab test, Colonoscopy)
Colonoscopies – Diagnostic
Advanced Imaging Procedures (e.g. MRI, CT, and PET scans)
Physical exams and well-child care
Immunizations/flu shots
Covered surgical procedures
Maternity care
Gynecological exam (routine)
Physical, Speech, or Occupational Therapy
Outpatient facility fees
Ambulance (medically necessary) Emergency Room Services

Emergency/urgent/acute care
Non-emergency care Other Services
Home health/hospice care
Skilled nursing facility
Human tissue & organ transplants (limited transportation and lodging benefits available)
Durable medical equipment
Oral surgery (limited benefits)
Routine eye exams
Chiropractic care

Prescription Drugs

Up to 30-day supply co-pay (Tier 1-Select Generic/Tier 1-Standard/Tier 2/Tier 3/Tier 4)
Up to 31-90 day supply co-pay (Tier 1-Select Generic/Tier 1-Standard/Tier 2/Tier 3/Tier 4)

Mental Health Services/Substance Abuse Services

All eligible inpatient and outpatient services

The responder to this RFP will also present a proposal for a possible Health Savings Arrangement (HSA) and/or a possible Health Reimbursement Account (HRA) to be used in conjunction with any health insurance plan proposals offered. In addition, the responder to this RFP will provide a separate proposal for a third party administrator to amend the County's Section 125 plan, and to handle claims that would be paid using the HSA, HRA, or a combination of both. Said proposal to include the name, address, and contact person for the third party administrator, as well as the costs associated with updating the County's Section 125 plan, and to administer the plan on an annual basis.

If more than one health insurance plan is offered, the responder to this RFP must indicate whether or not employees can have the choice of plans available (also known as a "Dual Option" program), or whether or not the County must choose just one plan for all employees and their dependents.

The responder to this RFP must indicate whether or not an employee assistance program is offered. If such a program is offered, the responder must give the details of the benefits of the program, and, if applicable, the rate associated with such.

The responder to this RFP must indicate whether a "Wellness Plan" is offered as part of the health insurance benefit, to include:

a. A Wellness Incentive Grant
b. Employee Assistance Program Grants
c. On-site classes by qualified educators
d. Assistance with wellness program development
e. Ongoing resources (including meetings and conferences) for wellness coordinators
f. Classes for employees
g. Wellness quarterly newsletter

The responder to this RFP must submit a proposal that includes COBRA administration, to include COBRA eligibility notifications and tracking, and acceptance of COBRA payments and monitoring of payments.

The responder must submit a proposal that provides coverage for retirees of the County who are not yet eligible for Medicare, or who are on Medicare, and indicate what type of group Medicare supplemental coverage the insurer offers.

The responder to this RFP shall provide current rates of insurance proposals to that of any insurance proposal offered for consideration. The rates shall be listed for the following coverage:

- Family – to include two adults with or without children;
- Adult with child(ren); and
- Single adult.

The responder shall also provide the rate history for any insurance proposal offered for consideration, for the last three years beginning with year 2015.

General Questions

1. Please indicate if any benefit or eligibility limitations will apply to new members who have any pre-existing medical conditions. If so, what are the extent and duration of these limitations?
2. Can an employee be denied coverage for any reason?
3. Can an employee be charged a higher premium if he/she has a health condition?
4. Describe how you transition care for those with existing health conditions.
5. How are employees able to access care out of state? Out of the country?
6. Describe any applicable pre-authorization requests for in-network and out-of-network hospital admittance.

Pharmacy

1. Do you use a formulary? If yes, describe what type, how frequently it is updated and the process for additions/deletions.
2. What Pharmacy Benefit Manager (PBM) firm(s) do you use most often? Why?
3. What type of reporting is available?
4. What is the rebate structure?
5. What is the pricing structure, including all administrative fees and dispensing fees?
6. Have you negotiated transparency pricing with any of the Pharmacy Benefit Managers you work with?
7. Describe your mail-order drug program.

Wellness/prevention

1. Describe your company's experience in providing wellness services.

2. Fully describe your wellness services.
3. How do you measure the effectiveness of your wellness services?
4. How many employees do you have in your in-house wellness department?
5. What are your key wellness initiatives for this year?
6. Do you offer rebates based on participation in wellness services?
7. Do you offer onsite health screenings? What is the cost?
8. Are preventive services a standard offering? If yes, describe how they are integrated into your plans.
9. Are preventive services capped? If yes, at what dollar amount?

Network

1. Provide a Geo Access report for the proposed network(s) based on the zip codes in the enclosed census.
2. What are your network access fees?
3. Are referrals required to see specialists?
4. Can employees access provider quality ratings?
5. Can employees access general provider information (i.e., board certification, language spoken, years in practice, hospital privileges, etc.)?
6. What is the average discount, net of all access fees, cost-containment savings and member liability, for physicians? For hospitals in the counties in which our employees reside?
7. Describe your transition of care policy.

Customer Service

1. Where is the call center that will service our account located?
2. What are your customer service hours of operation?
3. Can employees submit questions via e-mail? If yes, what is the normal response time? Are the e-mails secure?

Additional Company Information

1. Provide your company’s name, address, phone number and e-mail address.
2. List your company’s regional offices in Michigan.
3. Provide a contact name and information for the person to whom we can direct questions.
4. Briefly describe your company’s history.
5. What is your company’s ownership structure?
6. What is your company’s tax status?
7. In what ways does your company recognize and respond to the social needs of your employees and community?

Account Team

Please include contact information for each of the following:

1. Customer Service and Claims Processing Questions
2. Employer Services
3. Fax # for Billing and Enrollment
4. Fax # for Client Services
5. Account Manager ─ direct dial number and e-mail address
6. Sales Coordinator ─ direct dial number and e-mail address
7. Client Services Manager ─ direct dial number and e-mail address
8. Enrollment and Billing Team
9. Address for Premium Payments
10. Address for Enrollment
11. Address for Claims Processing
12. Sales Department

Claims

1. Where is your claims processing center located?
2. What is your current claim backlog (in days) at the designated claim office?

Reporting

1. Provide a sample reporting package.
2. Are you capable of producing ad hoc reports? If yes, what is the turnaround time? Is there a charge?
3. Provide a sample Summary Plan Description

Eligibility/Enrollment

1. How is your enrollment process handled?
2. Do you have representatives who can be on site to assist with enrollment?
3. Are employee kits available during enrollment? If so, what is the fee and what do the kits include? Please provide a sample enrollment kit.
4. Following the receipt of complete enrollment information, when will ID cards be available for new members?
5. In what formats will you accept eligibility information?
6. How frequently can eligibility information be updated?
7. Is online enrollment available?

Disease Management/Utilization Management

1. How do you define health management? Disease management? Case management?
2. List the diseases your disease management program covers.
3. How do you identify potential candidates for the disease management program?
4. Is laboratory data integrated into your programs?
5. Where is your disease management staff located?
6. Is the entire staff board certified?
7. Describe how you use a holistic approach in your disease management programs.

8. How do you use predictive modeling?
9. What is the benchmark for Return on Investment (ROI) of the disease management program?
10. What is your organization's methodology for determining ROI?

HIPAA/Privacy

1. Confirm that your company meets all federal requirements and HIPAA regulations on data standards, code sets and Protected Health Information (PHI) for non-routine disclosures and authorized releases of PHI.
2. Do you have a contingency/disaster plan in place to prevent unauthorized access to Protected Health Information?

Website

1. What services and information can employees access online?
2. Can employees set up personalized accounts?
3. What online tools are available for employer use?
4. Training for County Staff.

Are the proposal specifications met? Yes_______ No________

Can you provide the following insurance?

(a) Worker's Compensation Yes____ No_____
(b) Comprehensive General Liability Yes____ No_____
(c) Automobile Liability Insurance Yes____ No_____

ADDENDA

If applicable, bidder acknowledges receipt of the following Addenda:

Addendum #1______ Date________Addendum #2____ Date_______

Addendum #3______ Date________Addendum #4____ Date_______

____
COMPANY NAME

Exhibit 12.1

Employee Medical Enrollment Counts 2018 of 2157 FT EE participate on Medical Plan	Low Deductible	High Deductible
Employee Only	213	702
Employee & Spouse	55	213
Employee & 1 Child	N/A	N/A
Employee & Children	55	266
Employee & Family	84	430
Retiree Medical Enrollment Counts 341 Retirees participate on Medical Plan		
Retiree Only	35	178
Retiree & Spouse	25	83
Retiree & 1 Child	N/A	N/A
Retiree & Children	1	6
Retiree & Family	2	11
COBRA Medical Enrollment Counts 9 COBRA Medical participants		
Employee Only	0	5
Employee & Spouse	1	1
Employee & 1 Child	N/A	N/A
Employee & Children	0	1
Employee & Family	0	1
COBRA DHMO Dental Enrollment Counts 20 COBRA DHMO participants		
Employee Only	10	
Employee +1	9	
Employee +2 or more	1	
COBRA Indemnity Dental Enrollment Counts 7 COBRA Indemnity participants		
Employee Only	3	
Employee +1	3	
Employee +2 or more	1	
COBRA PPO Dental Enrollment Counts 3 COBRA PPO participants		
Employee Only	2	
Employee +1	1	
Employee +2 or more	0	
COBRA Vision Plan 1 Enrollment Counts 10 COBRA Plan 1 participants		
Employee Only	6	
Employee + Family	4	
COBRA Vision Plan 2 Enrollment Counts 13 COBRA Plan 2 participants		
Employee Only	11	
Employee + Family	2	
DHMO Dental Enrollment Counts 1094 FT EE participate on DHMO		
Employee Only	536	
Employee + 1	252	
Employee + 2 or more	306	
Indemnity Dental Enrollment Counts 276 FT EE particpate on Indemnity		
Employee Only	134	
Employee + 1	54	
Employee + 2 or more	88	
PPO Dental Enrollment Counts 220 FT EE participate on PPO		
Employee Only	84	
Employee + 1	58	
Employee + 2 or more	78	
IRS Section 125 Cafeteria Plan 1547 FT EE participate on IRS Sec 125 /Of the total participation 230 also participate in Part B and 23 also participate in Part C		
Part A – Premium Reduction (Total)	1547	
Part B – Medical Reimbursement	230	
Part C – Dependent Care	23	
Vision participation is provided for any carrier/TPA that includes Vision as an Option		
12/12/24 Vision Plan 1 Enrollment Counts		
Employee Only	432	
Employee + Family	297	
12/12/12 Vision Plan 2 Enrollment Counts		
Employee Only	237	
Employee + Family	388	

Exhibit 12.2

This must be filled out by each employee

2018 MONTGOMERY COUNTY, TEXAS

SECTION 125 CAFETERIA PLAN ELECTION FORM

Annual Election for the period of January 1, 2018 through December 31, 2018

NOTE: Salary reductions currently in effect DO NOT automatically continue into the next plan year. You must fill out a new election form each year during the scheduled enrollment period WHETHER YOU PARTICIPATE OR NOT.

☐ **NO, I hereby acknowledge that I have been informed about the Section 125 Plan. I decline to participate in any part of the Section 125 Plan for the year 2018 and understand that my waiver will remain in effect for the plan year 2018. IF YOU CHECK NO, PLEASE SIGN AT THE BOTTOM OF PAGE.**

☐ **YES, I hereby elect to participate in the Section 125 Plan and agree to abide by the terms, conditions and limitations of the plan. If electing to participate, I agree to have my gross pay reduced by the current premiums for medical, dental, and/or vision. IF YOU CHECK YES, PLEASE FILL IN SECTIONS A, B, & C IF YOU WISH TO PARTICIPATE IN THOSE CATEGORIES, SIGN THE BOTTOM OF THE PAGE.**

A. **Medical/Dental/Vision Premium Account**: Payment with pre-tax dollars of the premiums for participation in the Montgomery County medical, dental, and/or vision plans. If you choose to participate in part B or C below you will be automatically enrolled in part A.

☐ **YES, I elect to have my pre-tax salary reduced by any premiums deducted from my paycheck for participation in the Montgomery County employee/dependent medical, dental, and/or vision plans at the rates for 2018.**

B. **Medical Reimbursement Account:** **Payroll Frequency BI-Weekly ☐ Monthly ☐**

Provides for eligible reimbursements - with pre-tax dollars of certain medical/dental/vision expenses incurred during the Plan year for which you are not otherwise reimbursed.

☐ **YES, I elect to have my salary reduced (on a pre-taxed basis) by $ __________per pay period and credited to my Medical Reimbursement Account. This is based on 24 pay periods or 12 pay periods for District Judges.**

NOTE: If enrolling, maximum eligible salary reduction is $2,650.00 annually or $110.41 (per maximum of 24 pay periods) or $220.83 (per maximum of 12 pay periods/District Judges only).

C. **Dependent Care Expense Account:** **Payroll Frequency BI-Weekly ☐ Monthly ☐**

Provides for reimbursement - with pre-tax dollars of certain employment-related child/day care and other eligible dependent care expenses during the Plan year.

☐ **YES, I elect to have my monthly salary reduced (on a pre-tax basis) by $ _________per pay period and credit to my Dependent Care Expense Account. This is based on 24 pay periods or 12 pay periods for District Judges.**

NOTE: If enrolling, the maximum eligible salary reduction is:
For couples filing a joint tax return - $5,000 annually = $208.33 (per maximum of 24 pay periods) or $416.66 (per maximum of 12 pay periods/District Judges only).
For filing a separate tax return - $2,500 annually = $104.16 (per maximum of 24 pay periods) or $208.33 (per maximum of 12 pay periods/District Judges only).

Monthly administration fees for participation are as follows:

Premium Reduction	$ .85 (PAID BY COUNTY)	Medical Reimbursement Account	$1.75
Dependent Care Account	$1.75	All Eligible Expenses (A, B, & C)	$3.50

READ BEFORE SIGNING

I hereby certify that the above information to be correct and true to the best of my knowledge. I understand that any amounts remaining in my medical reimbursement plan account, will be forfeited in accordance with current plan provision and tax laws. I further understand that any advanced payments made by the employer, Montgomery County, Texas during the plan year for eligible expenses submitted by me, and which have not been repaid by authorized payroll deductions at the time of termination of employment, shall be deducted from my final paycheck. I further understand that Medical Reimbursement Account reduction(s) will be in effect for the plan year and cannot be revoked during the plan year unless I experience a change in my family status or termination of my spouse's employment according to the I.R.S. Regulations.

PRINT NAME:____**SS #**____________________**DEPT #**___________

EMPLOYEE SIGNATURE:____________________________________**EMPLOYEE #**_____________**DATE**____________

#4

JUL 11 2017

Exhibit 12.3

Montgomery County, Texas, (the "Employer"), hereby amends and restates the Montgomery County Employee Benefit Plan (the "Plan") effective as of July 11, 2017. 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 dully authorized officers with the effective date of the 11th day of July 2017.

County Judge

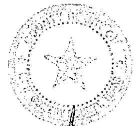
Commissioner Precinct 1

Commissioner Precinct 2

Commissioner Precinct 3

Commissioner Precinct 4

I hereby certify that this is a true and correct copy of the original record on file in my office.



Mark Turnbull, County Clerk
Montgomery County, Texas

Deputy

Issued JUL 11 2017

Exhibit 12.3

MONTGOMERY COUNTY

EMPLOYEE BENEFIT PLAN DOCUMENT

Table of Contents

Section	Page
Plan Administrator's Discretionary Authority	1
The Plan is a "Grandfathered" Plan	1
Schedule of Benefits and Summary Plan Description	2-8
Life Insurance, Accidental Death and Dismemberment	2
Low Medical Deductible Plan Option	2
High Medical Deductible Plan Option	3
Co-Insurance Percentage Levels (Inside and Outside the P.P.O.)	4-5
In-Patient Hospital Expenses	4
Other Medical Expenses	4-8
Extended Care	5
Annual Health Screening Benefit / Well Care Per Calendar Year	5
Outpatient, Non-emergency Office Visits (Medical) at Preferred Providers Only	6
Prescription Drug Expense Coverage With Drug Card	7-8
Benefit Plan Maximums	8
Cost Containment Provisions	9-16
Preferred Provider Organization (P.P.O.)	10
Pre-Certification	10
Utilization Review	10-11
Mental Health, Substance Abuse or Alcoholism Benefits	11-12
Out-Patient Diagnostic Testing	12
Pre-AdmissionTesting	12
Weekend Admissions	12
Second and Third Surgical Opinions	13
Out-Patient Surgery	13
Home Health Care Benefits	13-14
Hospice Benefits	14
Solid Organ and/or Tissue Transplant Event Benefit	15-16
Employee Assistance Program (E.A.P)	17
Plan Information	18
Article I - Plan Definitions	19-24
Article II - Participation in Health Care Benefits	25-34
A. Employee Participation	25-26
1. Employee Waiver of Participation in this Plan	25
2. Eligibility for Health Care Benefits	25
3. Waiting Period/Effective Date of Health Care Benefits Newly Hired Employees	25
B. Dependent Participation	26
C. Special Enrollments	26-27
1. Special Enrollment for Loss of Other Medical Coverage	26-27
2. Special Enrollment for Family Status Change	27
D. Late Entrants	27-28
E. Termination of Health Care Benefits	28
F. Age Discrimination in Employment Act	28
G. Continuation of Coverage (C.O.B.R.A.)	28-30
H. Health Insurance Portability and Accountability Act (H.I.P.A.A.) Exemption	30

Table of Contents (Cont.)

Section .... Page

- I. Health Insurance Portability and Accountability Act (H.I.P.A.A.) Privacy Rule........ 30-32
- J. Continuation of Coverage under the Uniformed Services Employment and Re-employment Rights Act........ 33
- K. Dual Coverage........ 33
- L. Retiree Participation........ 34

Article III - Health Care Benefits........ 35-37

Article IV - Limitations and Exclusions........ 38-40

Article V - Coordination of Benefits/Subrogation........ 41-44

- A. Coordination of Benefits........ 41-43
- B. Subrogation and Reimbursement........ 43-44

Article VI - Miscellaneous Provisions........ 45-49

- How to File a Claim........ 45
- Third Party Liability........ 46
- Leave of Absence........ 46
- Deductible Amount and Carry Over Provisions........ 46-47
- Presenting Claims for Benefits........ 47
- Requesting a Review of Claims Denied........ 47
- Appointment of Authorized Representative by Claimant........ 47
- Notice of Non-Discrimination........ 48-49

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 H.I.P.A.A. Compliant Fax 936-538-8169. You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov .

Exhibit 12.3

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

Low Medical Deductible Plan Option Deductibles:

Inside PPO Plan deductible can be used to satisfy Outside P.P.O. Plan deductible:	Inside P.P.O	Outside P.P.O
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 Co-Insurance Provisions per Calendar Year:

Inside the P.P.O. Co-Insurance Provisions

If a Participant utilizes Preferred Providers, Inside the P.P.O, 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 co-insurance provisions have been satisfied, the Plan will pay 100% of Eligible Expenses per Participant. The maximum Inside the P.P:O. Co-insurance out-of-pocket of Eligible Expenses is $2,000.00 per Participant per calendar year subject to Plan provisions. No Family Co-Insurance Maximum applies.

Outside the P.P.O. Co-Insurance Provisions

If a Participant utilizes providers outside the P.P.O., all Eligible Expenses will be paid by the Plan at 50% of the Maximum Eligible Expenses and the Participant will pay 50% of the Maximum Eligible Expenses 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 co-insurance have been satisfied, the Plan will pay 100% of Eligible Expenses per Participant. The maximum Outside the P.P.O. co-insurance out-of-pocket of Eligible Expenses is $7,500.00 per Participant per calendar year. No Family Co-Insurance Maximum applies.

Inside or Outside the P.P.O. Co-Insurance Provisions

Whether Inside or Outside the P.P.O., any Expenses other than qualified and Eligible Expenses will be disallowed and cannot be used to satisfy deductibles or the Participant's maximum medical co-insurance 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 co-insurance provision or any required deductibles. These provisions apply to each Participant.

High Medical Deductible Plan Option

High Medical Deductible Plan Option Deductibles:

	Inside P.P.O	Outside P.P.O
Inside PPO Plan deductible can be used to satisfy Outside PPO Plan deductible:		
Deductible per Participant per calendar year, with three (3) month carryover provision:	**$1000.00**	**$2000.00**
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 P.P.O. Co-Insurance Provisions

If a Participant utilizes Preferred Providers, Inside the P.P.O., 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 co-insurance provisions have been satisfied, the Plan will pay 100% of Eligible Expenses per Participant. The maximum Inside P.P.O. co-insurance out-of-pocket for Eligible Expenses is $1,000.00 per Participant per calendar year with a Family Co-insurance Maximum of three (3) covered individuals that must satisfy the calendar year co-insurance per family.

Outside the P.P.O. Co-Insurance Provisions

If a Participant utilizes Providers Outside the P.P.O., all Eligible Expenses will be paid by the Plan at 50% of the Maximum Eligible Expenses and the Participant will pay 50% of the Maximum Eligible Expenses 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 co-insurance have been satisfied, the Plan will pay 100% of Eligible Expenses per Participant. The maximum Outside the P.P.O. co-insurance out-of-pocket of Eligible Expenses is $3,750.00 per Participant per calendar year with a Family Co-insurance Maximum of three (3) covered individuals that must satisfy the calendar year co-insurance per family.

Inside or Outside the P.P.O. Co-Insurance Provisions

Whether Inside or Outside the P.P.O., any Expenses other than qualified and Eligible Expenses will be disallowed and cannot be used to satisfy the Participant's deductibles or maximum medical co-insurance 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 co-insurance 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 OUT-PATIENT SURGERIES OR A 50% REDUCTION IN BENEFITS WILL OCCUR**

	Co-Insurance Percentage Plan Pays	
	Inside P.P.O.	Outside P.P.O.
***In-Patient Hospital Expenses**		
1. Average semi-private room All Medically Necessary Hospital Services including blood, plasma, and intensive care	90%	50%
2. Anesthesiologist Expenses	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. Must access E.A.P. before these benefits are eligible (see page 17) You must utilize and receive inpatient services from Preferred Providers Inside the PPO or benefits will be disallowed.	80%	0%
Other Medical Expenses		
1. *Surgery – Inpatient	90%	50%
2. *Surgery – Outpatient	90%	80%
3. Pre-Admission Testing, including X-Ray and Lab (Outpatient) (see page 12)	100%	80%
4. Second & Third Surgical Opinion (see page 13)	100%	100%
5. Other Eligible Expenses Except outpatient mental health care, alcohol and substance abuse	90%	50%
6. Outpatient Mental Health Care*	80%	0%
Maximum Eligible Expense per Visit Including Alcohol and Substance Abuse conditions, Psychiatrist Expenses and Day Treatments. *E.A.P. benefits must be accessed before outpatient mental health care benefits will be eligible by this Plan.	$80.00 Per Visit	
7. Chiropractic Expenses	50%	50%
Maximum visits per calendar year; *Any additional visits require Pre-certification for medical necessity.	18 Visits* / Annually	
8. Allergy Treatment	90%	50%
With a calendar year maximum	$1,000.00 / Annually	

	Co-Insurance Percentage Plan Pays	
	Inside P.P.O.	Outside P.P.O.
9. Elective Sterilization Vasectomy Tubal Ligation and Hysteroscopic Sterilization (see page 40, #52)	90%	50%

10. *Extended Care

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:

	Inside P.P.O.	Outside P.P.O.
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	

11. 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 birth to the sixth (6th) birthday, will be subject to the $25.00 office co-pay 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 birth to the sixth (6th) birthday. 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 co-insurance 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 (P.S.A.) 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** out-patient office visits at a **Preferred Provider only**. Participants are required to pay the $25.00 office visit co-pay 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 birth to the sixth (6th) birthday**, paid at 100% for immunizations required by law for attendance in Daycare as provided in Texas Insurance Code Chapter 1367, Subchapter B and as provided in Texas Administrative Code Title 25, Part 1, Chapter 97, Subchapter B, Rule 97.61 and Rule 97.72. Other Eligible well care expenses incurred at time of visit are subject to applicable Well Care Benefit provisions including copays, deductible, and co-insurance. (For Eligible **Child Immunizations Ages 6 and older –** see page 37, Article III Health Care Benefits, #24.-b.)

12. 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 co-payment 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 co-payment that is paid after the deductible has been satisfied cannot be used to satisfy co-insurance provisions. The balance of the medical Physician's charge for an office visit due after the $25.00 office visit co-pay 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 co-insurance provisions of the Plan Option that you participate in. Children immunizations required by law for attendance in school (Kindergarten through 12th Grade) in the State of Texas as provided in Texas Administrative Code Title 25, Part 1, Chapter 97, Subchapter B, Rule 97.61 and Rule 97.72, will be an Eligible Expense at Preferred Providers only, subject to copays, deductible and co-insurance. **Child Immunization Expenses required by law for attendance in school (Kindergarten through 12th Grade) in the State of Texas incurred Outside the P.P.O are excluded.** (For Eligible **Child Immunizations birth to the sixth (6th) birthday –** see page 37, Article III Health Care Benefits, #24.-a.)

Example of an Out-Patient Non-Emergency Preferred Provider Office Visit

P.P.O Medical Physician's Charge	$100.00
Minus P.P.O. Discount/Reduction	-$ 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 Expenses if billed Outside the P.P.O., after a Participant's deductible is satisfied.

13. Outpatient, Non-emergency Office Visits (Medical) Outside the P.P.O.

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 P.P.O. at the 50% co-insurance level subject to the Maximum Eligible Expense for the service the Participant received.

14. Emergency Room at a Preferred Provider Hospital or at an Outside the P.P.O. Hospital (Inside the P.P.O. Service Area)

All Eligible Expenses associated with an Accidental Injury or Emergency Illness when incurred at the Emergency room of a Preferred Provider Hospital or an Outside the P.P.O. Hospital will be paid at 90%, including Physician's Expenses, subject to the applicable deductible and co-insurance provisions. $150.00 Emergency room co-pay will be assessed in addition to any calendar year deductible. If the Participant is admitted to the Hospital directly from the Emergency room, all additional Eligible Expenses incurred during that confinement will be paid by the Plan at 90% if billed by a Preferred Provider or 50% of the Maximum Eligible Expenses if billed Outside the P.P.O. and the $150.00 Emergency Room co-pay will be waived. **Pre-certification is required for any Hospital admission or a 50% reduction in benefits will occur**.

15. Accidental Injury or Emergency Illness (Outside the P.P.O. Service Area)

If the Participant incurs an Accidental Injury or Emergency Illness and is outside the P.P.O. service area (not within 100 miles of a P.P.O. facility), Eligible Expenses will be paid as if the Participant were inside the P.P.O. after the Participant has met the applicable deductible and co-insurance provisions. Pre-certification is required for any Hospital admission, or a 50% reduction in benefits will occur.

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

If you reside Outside the P.P.O Service Area and there are no Preferred Providers within 100 miles, benefits will be paid at the 75% co-insurance level to $15,000.00 rather than the 50% co-insurance level, subject to all applicable deductibles of the Plan Option that you participate in subject to the Maximum Eligible Expenses for the location where the services were incurred. All other Plan provisions and limitations remain the same.

17. 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 co-insurance 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. The list is subject to change.

<u>Retail Pharmacy - 30 day supply or less only</u>

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

<u>Maxor Mail Order Pharmacy – Greater than a 30 day supply</u>

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

*Co-pays are required for refills.
**If your Prescription cost is less than the minimum co-pay, you will pay the actual cost of the Prescription.

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 the MAXOR Mail Order pharmacy, you may receive up to a 90-day supply prescribed by your Physician for the $15.00, $25.00, or $35.00 co-pay. 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 co-pays, do not apply toward deductibles or co-insurance 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;
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), 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).

18. 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

19. Benefit Plan Annual Maximum Benefits

The following annual maximums apply to each Plan Participant:

Benefit	Maximum
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**

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

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

Specialty Transplant Network / Centers of Excellence (pages 15-16)
Must be approved by **HealthFirst T.P.A./MM Solutions, Inc.: 1-866-810-7613 the Precertification/Utilization Review Organization.**

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

Utilization Review (pages10-11)
Overview
1. Definitions
2. Types of Review
3. Compliance Guidelines
4. Mental & Nervous, Alcohol & Substance Abuse Guidelines
5. Control of Medical Care

Mental Health, Substance Abuse or Alcoholism Benefits (see page 4 In-Patient Hospital Expenses #4), (page 4 Other Medical Expenses #5), (page 4 Outpatient Mental Health Care #6), (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).

A Participant is required to contact the Employee Assistance Program (E.A.P.) before accessing mental health and substance abuse benefits of the Plan. The E.A.P. counselor will assess your needs and work in conjunction with a mental health coordinator at HealthFirst T.P.A./MM Solutions, Inc. to manage your treatment.

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 P.P.O. or the E.A.P. will result in a 0% benefit pay out from the Plan. Services provided by any provider, unless specifically referred to that provider by the E.A. P. or HealthFirst T.P.A./MM Solutions, Inc. will result in a 0% benefits pay out from the Plan.

Out-Patient Diagnostic Testing (page 12)

Pre-Admission Testing (page 12)

Weekend Admissions (page 12)

Second Surgical Opinion (page 13)

Outpatient Surgery (page 13)

Home Health Care Benefits (pages 13-14)

Hospice Benefits (pages 14)

Solid Organ and/or Tissue Transplant Event Benefit (pages 15-16)

Employee Assistance Program (E.A.P.) (see page 4 In-Patient Hospital Expenses #4), (page 4 Other Medical Expenses #5), (page 4 Outpatient Mental Health Care #6), (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)

Preferred Provider Organization (P.P.O.)

Aetna Signature Administrators P.P.O. is an organization called a P.P.O. 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 P.P.O. This Plan participates with Aetna Signature Administrators P.P.O.. Participants may access a Preferred Provider listing of Hospitals, Physicians and Ancillary Providers by going online @ 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 P.P.O. will update the directory. It is responsibility of the Participant to verify and ensure the provider is Inside the P.P.O. 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

HealthFirst T.P.A./MM Solutions, Inc. 1-866-810-7613

Overview

The Pre-certification Program is administered by HealthFirst T.P.A./MM Solutions, Inc. **A Participant must call HealthFirst T.P.A./MM Solutions, Inc. to comply with the Pre-certification Program provisions below. 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 out-patient 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 out-patient 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

HealthFirst T.P.A./MM Solutions, Inc. 1-866-810-7613

Overview

Utilization Review is the review of a Participant's Hospital confinement by the Plan through HealthFirst T.P.A./MM Solutions, Inc. 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. HealthFirst T.P.A./MM Solutions, Inc. 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 HealthFirst T.P.A./MM Solutions, Inc. 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 HealthFirst T.P.A./MM Solutions, Inc.:
   - 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, HealthFirst T.P.A./MM Solutions, Inc. 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 -** HealthFirst T.P.A./MM Solutions, Inc. 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 HealthFirst T.P.A./MM Solutions, Inc. 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 -** HealthFirst T.P.A./MM Solutions, Inc. must be notified by the Participant, Physician, or a Personal Representative by telephone immediately prior to actual admission.
3. **Emergency Admission -** HealthFirst T.P.A./MM Solutions, Inc. 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 In-Patient Hospital Expenses #4), (page 4 Other Medical Expenses #5), (page 4 Outpatient Mental Health Care #6), (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).

Participants in the Montgomery County Employee Benefit Plan will be required to contact Deer Oaks E.A.P. Services at 1-866-327-2400 or T.D.D. 1-800-735-2989 (24 hour-7 days a week) in order to access the mental health/substance abuse benefits. If benefits received from the E.A.P. are exhausted and continuation of services are required, the E.A.P. will refer you to the mental health coordinator at HealthFirst T.P.A. /MM Solutions. If access to the P.P.O and the Montgomery County Employee Benefit Plan is required, HealthFirst T.P.A. /MM Solutions will coordinate this referral. You will be subject to all plan provisions, deductibles and co-insurance provisions when accessing the Montgomery County Employee Benefit Plan. 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 Expenses 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 Expenses 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 Expense 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.

Out-Patient Diagnostic Testing

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

Out-Patient Surgery Pre-Certification is Required

Whenever possible, Participants are encouraged to have necessary surgery performed on an out-patient basis. Eligible Expenses incurred in connection with out-patient 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 Co-insurance Percentage of 80% outside the P.P.O. 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 -P.P.O.

"**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.

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 P.P.O. or 50% Outside P.P.O. of the Medically Necessary, Maximum Eligible Expenses 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 in-patient 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 (R.N.), a licensed practical nurse (L.P.N.), or a licensed vocational nurse (L.V.N.);
2. home health aides under supervision of a R.N.;
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 <u>Pre-Certification is Required</u>

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 Expenses 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 (R.N.) 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.

Effective March 1, 2015
Solid Organ and/or Tissue Transplant Event Benefit <u>Pre-Certification is Required</u>
Schedule of Benefits

Precertification/Utilization Review Organization - HealthFirst T.P.A./MM Solutions, Inc.: 1-866-810-7613 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 - **HealthFirst T.P.A./MM Solutions, Inc. 1-866-810-7613.**

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 #17).

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. C.O.B.R.A. 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.

<u>Co-Insurance Percentage Plan Pays</u>
<u>Inside SPECIALTY TRANSPLANT NETWORK Only</u>

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 Co-insurance out of pocket limits for that plan; however **NO BENEFITS WILL BE CONSIDERED AS ELIGIBLE EXPENSES OR PAYABLE BY THIS PLAN IF HealthFirst T.P.A./MM Solutions, Inc.: 1-800-749-2714 or 281-999-9600 the Precertification/Utilization Review Organization OR Specialty Transplant Network IS NOT UTILIZED.**

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

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 **HealthFirst T.P.A./MM Solutions, Inc.: 1-866-810-7613 the Precertification/Utilization Review Organization**. **<u>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.</u>**

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 **HealthFirst T.P.A./MM Solutions, Inc.: 1-866-810-7613 the Precertification/Utilization Review Organization** or **<u>NO BENEFITS WILL BE CONSIDERED ELIGIBLE</u>**. <u>For Transplant Event purposes, the Aetna Signature Administrators P.P.O. on your benefit plan ID card **IS NOT** the Specialty Transplant network.</u> 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 **HealthFirst T.P.A./MM Solutions, Inc.: 1-866-810-7613 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 **HealthFirst T.P.A./MM Solutions, Inc.: 1-866-810-7613 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 **HealthFirst T.P.A./MM Solutions, Inc.: 1-866-810-7613 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.

Exhibit 12.3

Employee Assistance Program (E.A.P.)
Deer Oaks E.A.P. Services at 1(866)327-2400 or T.D.D. 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 (E.A.P.) counselors. This program will assist Participants in obtaining mental health and substance abuse counseling. The E.A.P. 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 E.A.P. These visits are not subject to any deductible regardless of the High or Low Medical Deductible Plan Options you have chosen to participate in. After the Participant has received the eight (8) free visits through the E.A.P., the E.A.P. provider will coordinate your benefits with HealthFirst T.P.A./MM Solutions, Inc. to access the network of Preferred Providers. Participants are required to contact the E.A.P. in order to access the mental health and substance abuse benefits of the Plan. The E.A.P. provider is Deer Oaks E.A.P. Services at 1(866)327-2400 or T.D.D. 1(800)735-2989 (24 hours-7 days a week) or accessed online @ www.deeroaks.com/deer-oaks-employee-assistance-program.

Exhibit 12.3

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 H.I.P.A.A. 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 Telephone: (512)454-2681 or 1(800)252-9653 Fax: (512)459-1552
Website @ http://www.boonchapman.com/

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

PRE-CERTIFICATION/UTILIZATION REVIEW
HealthFirst T.P.A./MM Solutions, Inc.
821 ESE Loop 323, Suite 200
Tyler, TX 75701 Telephone: 1(866)810-7613

PRESCRIPTION DRUG CARD PROGRAM
MAXORPLUS, Ltd.
320 S. Polk St., Suite 200, Amarillo, Texas 79101 Telephone: 1(800)687-0707 or T.T.Y. 1(866)427-5573 Fax: 1(806)324-5493
MAXOR Mail Order Pharmacy
P.O. Box 32050, Amarillo, TX 79120-2050 Telephone: 1(800)687-8629 Physician RX Fax: (866)589-7656
Website @ http://www.maxor.com/

EMPLOYEE ASSISTANCE PROGRAM (E.A.P.)
Deer Oaks E.A.P. Services
126 East Main Plaza, Suite 8
San Antonio, Texas 78205 Telephone: (24HR) 1(866)327-2400 or T.D.D. 1(800)735-2989
Website @ http://www.deeroaks.com/pages.asp?id=4

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 Expense 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.

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.

Co-Insurance 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 (E.A.P.) 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 (H.I.P.A.A) Election Under 45 C.F.R. §146.180(f)** (see page 30, (H.I.P.A.A) 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 co-insurance 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 Co-insurance Maximum means that the maximum of three (3) covered family members must satisfy their individual co-insurance after meeting their annual deductible on the High Medical Deductible Plan Option and then the co-insurance will be considered satisfied for all covered family members for that Calendar Year. Satisfaction of the Family Co-insurance Maximum is based on the date Expenses are incurred. The Family Co-insurance 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.

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 in-patient 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 (R.N.);
   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 (R.N.) 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 (R.N.s) 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 P.P.O 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-one (31) 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-one (31) 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 Expense is an amount determined at the discretion of the Plan Administrator or its delegates considering:

1. For Inside P.P.O. claims, the negotiated Preferred Provider allowable.
2. For Outside P.P.O. claims, the amount agreed to by the non-network provider and Plan Administrator or its delegate. If the amount has not be negotiated, then one of the following amounts will apply:
   a. For Outside P.P.O. hospital claims the lesser of billed charges or 100% of the published rates allowed by Medicare for the same or similar service or supply;
   b. For Outside P.P.O. professional claims and other providers the lesser of billed charges or 100% of the published rates allowed by Medicare for the same or similar service or supply;
   c. For Outside P.P.O. claims submitted by providers that don't participate in Medicare, for care provided in non-standard settings and for services and supplies not covered by Medicare the Payer Compass equivalency tables, Payer Compass approximation tool,

Payer Compass cross walks or the Optum360 Essential RBRVS Schedule will be considered at corresponding percentile listed above; or

d. In determining the Maximum Eligible Expense for any Outside P.P.O. claim, the Plan Administrator or its delegate may consider any other relevant factor, including but not limited to the Average Wholesale Price, the invoice price, Medicare cost data, Medicare cost-to-charge ratios, the amount Medicaid would allow for the same or similar service and the Fair Health Data Base; or

e. For Outside P.P.O. dental claims – the lesser of billed charges or the 90th percentile of what Fair Health's Data Base shows for the same or similar service.

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 Covered Person'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 covered Person'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 P.P.O.

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

Outside P.P.O. 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 (P.P.O.) adopted by this Plan.

Preferred Provider Organization (P.P.O.) 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-one (31) 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-one (31) 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-one (31) 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-one (31) 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 34, L. Retiree Participation).

f. A**ll 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 29, 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 31 days of gaining that Dependent. If notification is given after 31 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-one (31) 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-one (31) 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-one (31) 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-one (31) days of the date you become eligible. If you or your eligible Dependents fail to enroll within thirty-one (31) 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 (C.O.B.R.A.) 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. C.O.B.R.A. 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 (C.O.B.R.A.) 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 Covered Persons 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 Persons 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 C.O.B.R.A. (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 Covered Persons 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.

C.O.B.R.A. Election and C.O.B.R.A. 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; and
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 Covered Person to whom a Qualifying Event has not occurred. If coverage of similarly situated Covered Persons 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 Covered Person 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 that 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 (H.I.P.A.A) Election Under 45 C.F.R. §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 C.F.R. 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.

Exhibit 12.3

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 C.F.R. § 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 C.F.R. § 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 C.F.R. § 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 C.F.R. § 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 ("U.S.E.R.R.A.").

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 ("U.S.E.R.R.A.").

An Employee has the right to elect Continuation of Coverage under U.S.E.R.R.A. 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 U.S.E.R.R.A.'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 U.S.E.R.R.A., 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 U.S.E.R.R.A., 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 U.S.E.R.R.A. 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 U.S.E.R.R.A.

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 C.O. B.R.A. 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 currently offers County Paid / Subsidized Health Benefits for Employees that can meet additional requirements at the time of retirement. Please call the County Risk Management Department for a complete copy of "Qualifications for County Paid / Subsidized Health Benefits" as approved in Commissioners Court on 2/25/2008 and 12/21/2009. For Employees hired on or after October 1, 2009 please see "Qualifications for County Paid / Subsidized Health Benefits for Employees hired on or after October 1, 2009" as approved in Commissioners Court on 12/21/2009. 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 Expenses 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 (C.R.N.A.) 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 Expenses 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 R.N. 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, including oral contraceptives, and injectable contraceptives (Depo-Provera injections, Norplant implants, but not the removal) for the purposes of birth control and obtainable only on a physician's written prescription (see pages 7-8, Other Medical Expenses #17);

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 are immunizations required by law for:

a. **Birth to the sixth (6th) birthday,** paid at 100% for attendance in Daycare in the State of Texas as provided in Texas Administrative Code Title 25, Part 1, Chapter 97, Subchapter B, Rule 97.61 and Rule 97.72 and as provided in Texas Insurance Code Chapter 1367 Subchapter B (see page 5, Other Medical Expenses, #11, h.); and

b. **Ages 6 and older** for attendance in school (Kindergarten through 12th Grade) in the State of Texas as provided in Texas Administrative Code Title 25, Part 1, Chapter 97, Subchapter B, Rule 97.61 and Rule 97.72. These immunizations will be covered for eligible Dependent children at a Preferred Provider only, subject to copays, deductible, and co-insurance. **Child Immunization Expenses under Article III, #24 b. incurred Outside the P.P.O are excluded** (see page 6 Other Medical Expenses #12);

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 (H.I.P.A.A) Election Under 45 C.F.R. 146.180(f) (See pages 30, Article II Participation in Health Care Benefits, H.;

26. The treatment of temporomandibular joint dysfunction or TMJ syndrome will be limited to $1,000.00 per calendar year per Participant;

27. Solid Organ and/or Tissue Transplants subject to the provisions and benefits. (see pages 15-16, 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).

ARTICLE IV
LIMITATIONS AND EXCLUSIONS

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

1. In excess of the Maximum Eligible Expense, 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. For dental treatment, except necessary repair of sound natural teeth as a consequence of accidental injury or surgical removal of bony impacted wisdom teeth;
9. For 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, #11);
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 of $1000.00 per calendar year per participant for the treatment of temporomandibular joint dysfunction or TMJ syndrome (see page 37, Article III Health Care Benefits, #26);
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, fertility drugs, contraceptives other than birth control pills or Depo-Provera injections for purposes of birth control or Norplant implants for the purposes of birth control but not the removal of Norplant implants (see page 36, Article III Health Care Benefits #21);

22. For vitamins, except physician prescribed for prenatal care when necessary, 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 all associated costs will be limited to one procedure per covered participant under this medical plan.

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 Covered Person;

33. Incurred outside the United States if the Covered Person 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 #19 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 $1000.00 annually;

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

50. For Adult immunizations and Child Immunizations other than those required for children under Article III Eligible Expenses #24 (see page 37)

51. For Newborn Well Care or Well Baby Checkup Expenses beyond the limits in the Schedule of Benefits. (see page 4, In-Patient Hospital Expenses #3 and page 5, Other Medical Expenses #11 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 Expense 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. <u>When This Section Applies</u> - "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 Covered Persons, 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 Covered Person 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 “Covered Person”) 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 Covered Person 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 Covered Person 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 covered person 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 Covered Person in order to enforce the Plan’s subrogation rights.

The Covered Person and anyone acting on his behalf shall provide the Plan with information it deems necessary to protect its right of subrogation. The Covered Person 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 Covered Person shall do nothing to prejudice the Plan's subrogation rights and shall cooperate with the Plan in the enforcement of its rights. Neither a Covered Person 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 covered person.

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 #248
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 (E.O.B.) will be sent to the Employee as a result of each claim submission. The E.O.B. 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 covered Person, 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 Covered Person has medical Expenses:

1. Incurred as the result of negligence or intentional acts of a third party; and
2. For which the Covered Person makes a claim for benefits under this Plan; the Covered Person 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 Covered Person 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 Covered Person from the third party or its insurer.

The repayment agreement will be binding upon the Covered Person 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 Covered Person 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.

P.P.O. Physician Referrals

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

Deductible Amount and Carry Over Provisions

The calendar year deductible amount of $500.00 (non P.P.O.) or $250.00 (P.P.O.), considered the Low Medical Deductible Plan Option or $2000.00 (non P.P.O.) or $1000.00 (P.P.O.) considered the High Medical Deductible Plan Option 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 Covered Person 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 اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-936-539-7886 (رقم

هاتف الصم والبكم:.

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।

Exhibit 12.3

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

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

સુચના: 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, ໂດຍບໍ່ເສັຽຄ່າ,

ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-936-539-7886.

Exhibit 12.4

#2
9E7
DEC 17 2012

CAFETERIA PLAN

PREMIUM REDUCTION OPTION *PLUS*

FLEXIBLE SPENDING ACCOUNTS

PLAN DOCUMENT

AS ADOPTED BY
MONTGOMERY COUNTY, TEXAS

CAFETERIA PLAN

PREMIUM REDUCTION OPTION *PLUS*

FLEXIBLE SPENDING ACCOUNTS

SUMMARY PLAN DESCRIPTION

AS ADOPTED BY

MONTGOMERY COUNTY, TEXAS

TABLE OF CONTENTS

1. INTRODUCTION 1

2. GENERAL INFORMATION ABOUT THE PLAN 1

- Q-1. What is the purpose of the plan? 1
- Q-2. What benefits are offered through the Plan? 1
- Q-3. Who can participate in the Plan? 1
- Q-4. What tax advantages can I gain by participating in the Plan? 1
- Q-5. How do I become a Participant? 2
- Q-6. What are the enrollment periods? 2
- Q-7. How long am I committing to if I elect to be a participant? 3
- Q-8. What happens if I fail to return my Benefit Election Form? 3
- Q-9. Can I change my election during the Plan Year? 3
- Q-10. What happens if I go on leave of absence? 6
- Q-11. What happens if I go on a Qualified Leave under Family and Medical Leave Act? 6

3. HEALTH PREMIUM REIMBURSEMENT ACCOUNTS 7

- Q-1. Who can elect an HPRA? 7
- Q-2. What individually owned health policies are qualified to be paid under a HPRA? 7
- Q-3. How do I become a Participant? 7
- Q-4. What happens if I fail to return my Benefit Election Form? 7
- Q-5. How do I receive Reimbursement under an HPRA? 8
- Q-6. Can I change the election during the year? 8
- Q-7. What happens if I still have a balance in my HPRA at the end of the Plan Year? 8

4. CASH BENEFITS 8

5. HEALTH FSA BENEFITS 8

- Q-1. Who can participate in the Health FSA? 8
- Q-2. How do I become a Participant? 9
- Q-3. What happens if I fail to return my Benefit Election Form? 9
- Q-4. How is my Health FSA Account funded? 9
- Q-5. What annual benefits are available under the Health FSA, and how much will they cost? 9
- Q-6. How are my Health FSA benefits paid for? 9
- Q-7. What amounts will be available for reimbursement at any particular time during the Plan Year? 9
- Q-8. How do I receive Reimbursement under the Health FSA? 9
- Q-9. What is an "Eligible Expense"? 10
- Q-10. Who is an "eligible dependent" for whom I can claim expenses for reimbursement? 10
- Q-11. When must a reimbursable expense be incurred? 10
- Q-12. Can I change the election during the year? 10
- Q-13. What happens if I still have a balance in my Account at the end of the Plan Year? 10
- Q-14. Can I continue coverage in my Account? 11

6. DEPENDENT CARE ASSISTANCE BENEFIT 12

Q-1. Who can participate in a DCAP? 12
Q-2. How do I become a Participant? 12
Q-3. What happens if I fail to return my Benefit Election form? 12
Q-4. How is my DCAP Account funded? 12
Q-5. Are there any other limits on what DCAP benefits are tax free? 12
Q-6. Is there any other way I can save taxes on my DCAP expenses? 12
Q-7. What is the Household and Dependent Care Credit? 13
Q-8. Would I be better off with a DCAP or claiming the Household and Dependent Care Credit? 13
Q-9. If I participate in the DCAP, can I claim the Household and Dependent Care Credit on my federal income tax return? 13
Q-10. Who is an "eligible dependent" for whom I can claim reimbursement? 13
Q-11. What is an "eligible expense"? 13
Q-12. How do I receive my benefits under the DCAP? 14
Q-13. Will I be taxed on the DCAP benefits I receive? 15
Q-14. Can a relative provide the service? 15
Q-15. Can I change my election if I change day care providers during the year and the rates are different? 15
Q-16. Can I change my election if a relative starts keeping my children for free? 15
Q-17. What happens if I still have a balance in my DCAP Account at the end of the Plan Year? 15

8. CLAIMS PROCEDURES 15

9. ERISA RIGHTS 16

10. PLAN INFORMATION SUMMARY 17

Section 125 Cafeteria Plan

1. Introduction

Your employer ("Employer") is pleased to sponsor an employee benefit program known as a Cafeteria Plan ("Plan") for you and your fellow employees. It is called a Cafeteria Plan because you can choose from a selection of different insurance and fringe benefit programs according to your needs. Your Employer gives you this opportunity to use a salary conversion arrangement through which you can use pre-tax dollars to pay for your benefits instead of paying for the benefits through after-tax payroll deductions. By paying for the benefits with pre-tax dollars, you save money by not having to pay social security and income taxes on your salary reduction. However, you still have the option of paying for your benefits with after-tax dollars.

This Summary Plan Description ("SPD") describes the basic features of the Plan; how it operates, and how you can get the maximum advantage from it. This SPD only summarizes the Plan's key parts and briefly describes your rights as a Participant, and is not designed to be a part of the official plan documents. If a conflict exists between the plan documents and this SPD, the plan documents will apply.

2. General Information about the Plan

Q-1. What is the purpose of the plan?

This Plan is designed to allow eligible employees to choose one or more of the benefits offered through the Plan and, using funds provided through employee salary reduction, to pay for the selected benefits with pre-tax dollars. It is established for the exclusive benefit of Participants.

Q-2. What benefits are offered through the Plan?

The Plan can offer one or more of the following four types of benefits ("Benefit Package Options"). See Section 10 below for the specific Benefit Package Options offered under this Plan.

1. Insurance premium benefits
2. Health Premium Reimbursement Account Benefits (See Section 3 below.)
3. Health FSA benefits (See Section 5 below.)
4. Dependent Care Assistance benefits (See Section 6 below.)

You will receive information materials before each enrollment period explaining the various benefit options your Employer is offering for the next Plan Year.

Q-3. Who can participate in the Plan?

Any employee (as defined by the Plan) of the Employer who satisfies the Eligibility Requirements established by the Employer in the Plan's Adoption Agreement, (as summarized in Section 10 below), is eligible to participate in this Plan. An eligible employee can become a Participant by electing at least one Benefit Package Option offered under the Plan (see Section 2, Q-2 above).

A Participant will cease to be a Participant if (1) the Plan terminates, (2) the Participant ceases to be eligible for the Plan (except for continuation coverage under COBRA), (3) the Participant revokes an election to participate, or (4) the Participant's employment is terminated or the participant is laid off.

Q-4. What tax advantages can I gain by participating in the Plan?

By participating in the Plan, you will not have to pay income tax or Social Security tax on your elections. Following is an illustration of how a hypothetical employee saved on taxes by participating in a cafeteria plan. Let's assume our hypothetical employee makes $2,500 each month and has 28% withheld for federal withholding and 7.65% for Social Security. The employee's take-home pay before participating in the Plan is $1,609 a month. Out of that, $348 a month is paid for insurance

benefits, $100 for Health FSA, and $200 for Dependent Care FSA. The employee decides to participate in the cafeteria plan. By participating in the Plan and paying contributions on a pre-tax basis under the Plan, the employee saved $230 a month. Here is a table to better illustrate the example.

BREAKDOWN OF PAY CHECK AND DEDUCTIONS	NOT PARTICIPATING IN CAFETERIA PLAN	PARTICIPATING IN CAFETERIA PLAN
Gross Monthly Pay	**$2,500.00**	**$2,500.00**
Less Premium for Major Medical		(348.00)
Less Medical/Dental Expenses		(100.00)
Less Day Care Expenses		(200.00)
Taxable Income	**2,500.00**	**1,852.00**
Less 28% Federal Withholding	(700.00)	(519.00)
Less 7.65% Social Security Tax	(191.00)	(142.00)
Less Premium for Major Medical	(348.00)	
Less Health FSA Expenses	(100.00)	
Less Day Care Expenses	(200.00)	
Spendable Income	**$961.00**	**$1,191.00**

The employee saved $230 a month or $2,760 a year by participating in Plan!

This savings results in extra spendable income and this occurs because the employee participated in the Plan and made the required employee contributions *before* the taxes were withheld. This is just one example of the possible tax savings under the Plan.

Q-5. How do I become a Participant?

You become a Participant by signing a Benefit Election Form indicating that you elect one or more of the Benefit Package Options available under the Plan that are listed in Section 10 below and agree to a salary reduction to pay for your elected benefits with pre-tax dollars. You will then submit the Benefit Election Form to your Employer during the applicable Enrollment Periods described in Q-6 below. Participation in this Plan will be effective as described in Q-6 below. Coverage under the Benefit Package Options that you elect will begin as set forth in the summary plan descriptions for each Benefit Package Option that you elect.

Q-6. What are the enrollment periods?

There are three enrollment periods:

1. *Enrollment Period prior to the Effective Date.* This is the enrollment period that occurs before the Plan's Effective Date (as described in the Adoption Agreement). An Election made during this Enrollment Period is effective on the Effective Date.
2. *Initial Enrollment Period.* The Initial Enrollment Period is the period during which newly eligible employees enroll in the Plan. The Initial Enrollment Period is described in the enrollment material provided by the Plan Administrator. An election to participate that is made during this enrollment period will be effective on the Plan Entry Date.
3. *Annual Enrollment Period.* The Annual Enrollment Period is the period each year in which participants may elect to change and/or continue their elections or eligible employees may elect to participate for the next Plan Year. The Annual Enrollment Period is described in your enrollment material that you will receive prior to the Annual Enrollment Period. An election to participate made during this period will be effective on the anniversary date.

Elections that you make or are deemed to make during the Annual Enrollment Period will be effective on the Anniversary Date, which is identified in Section 10 below. If you have the ability to enroll by phone or Internet, separate enrollment periods may be set for paper, telephone, and Internet. Your Employer will tell you what enrollment periods are established for each.

See Q-8 below for what happens when you fail to return a Benefit Election Form during the enrollment period.

Q-7. How long am I committing to if I elect to be a participant?

You will be signing up for a Plan Year which is usually 12 months. The first Plan Year and the last Plan Year may be for a shorter period. See Section 10 below for the exact dates of your Plan Year.

Q-8. What happens if I fail to return my Benefit Election Form?

If you are not currently participating in the Plan and you fail to return a Benefit Election Form before the end of the applicable Enrollment Period, it will be assumed that you have elected to receive your full compensation in cash and you cannot elect to become a Participant until the next Annual Enrollment Period. The only exception to this is if you have experienced one of the qualifying events listed in Q-9 below. If so, you must submit an Employee Statement of Qualifying Event form (stating the event) and a Personal Benefit Election Change Request Form (stating the changes in elections) within 30 days of the event to enroll.

If you are currently participating in the Plan and fail to submit a Benefit Election Form by the end of the Annual Enrollment Period for the next Plan Year, your elections for the next Plan Year will depend on which benefits you currently have.

1. If you have currently elected insurance premium benefits, it will be assumed that you want to continue these benefits for the next Plan Year (and contribute your share of the cost on a pre-tax basis).
2. If you have currently elected a Health Premium Reimbursement Account, it will be assumed that you do not want to continue participation and the premiums will no longer be deducted.
3. If you have currently elected to participate in a Health FSA, it will be assumed that you do not want to continue participation in the Health FSA for the next Plan Year.
4. If you have currently elected to participate in a Dependent Care Assistance Plan (DCAP), it will be assumed that you do not want to continue participation in the DCAP for the next Plan Year.

Q-9. Can I change my election during the Plan Year?

Generally, you cannot change your election to participate in the Plan or vary the benefits you have selected during the Plan Year, although your election will terminate if you are no longer working for the Employer or you are no longer eligible. You may change your elections only during the Annual Enrollment Period, and then the change will not be effective until the beginning of the next Plan Year.

There are several important exceptions to this general rule. You may change or revoke your previous elections during the Plan Year if you experience one of the events listed below:

Please refer to the Change of Status Matrix (distributed with this SPD) for a table of the qualifying events, the benefits affected by each event, and the possible changes in elections that may take place for each benefit. If you have a qualifying event, you must submit an Employee Statement of Qualifying Event form (stating the event) and a Personal Benefit Election Change Request Form (stating the changes in elections) within 30 days of the event to enroll.

1. **Change in Status.** If one or more of the following Changes in Status occur, you may revoke your old election and make a new election, provided that both the revocation and new election are on account of and correspond with the Change in Status (as described below). Those occurrences which qualify as a Change in Status include the events described below, as well as any other events which the Plan Administrator determines are permitted under subsequent IRS regulations:
   - Change in your legal marital status (such as marriage, legal separation, annulment, divorce, or death of your Spouse),

- Change in the number of your tax Dependents (such as the birth of a child, adoption or placement for adoption of a Dependent, or death of a Dependent),
- Any of the following events that change the employment status of you, your Spouse, or your Dependent that affect benefit eligibility under a cafeteria plan (including this Plan) or other employee benefit plan of yours, your Spouse, or your Dependents. Such events include any of the following changes in employment status: termination or commencement of employment, a strike or lockout, a commencement of or return from an unpaid leave of absence, a change in worksite, switching from salaried to hourly-paid, union to non-union, or part-time to full-time; incurring a reduction or increase in hours of employment; or any other similar change which makes the individual become (or cease to be) eligible for a particular employee benefit,
- Event that causes your Dependent to satisfy or cease to satisfy an eligibility requirement for a particular benefit (such as attaining a specified age, getting married, or ceasing to be a student), or
- Change in your, your Spouse's, or your Dependent's place of residence.

If a Change in Status occurs, you must inform the Plan Administrator and complete a new election for Pre-Tax Contributions within 30 days of the occurrence.

If you wish to change your election based on a Change in Status, you must establish that the revocation is on account of and corresponds with the Change in Status. The Plan Administrator (in its sole discretion) shall determine whether a requested change is on account of and corresponds with a Change in Status. As a general rule, a desired election change will be found to be consistent with a Change in Status event if the event affects coverage eligibility (for the Dependent Care FSA, the event may also affect eligibility for the dependent care exclusion). A Change in Status affects coverage eligibility if it results in an increase or decrease in the number of dependents who may benefit under the plan. In addition, you must also satisfy the following specific requirements in order to alter your election based on that Change in Status:

- *Loss of Dependent Eligibility.* For accident and health benefits (e.g., health, dental and vision coverage, accidental death and dismemberment coverage, and Health FSA benefits), a special rule governs which type of election changes is consistent with the Change in Status. For a Change in Status involving your divorce, annulment, or legal separation from your Spouse; the death of your Spouse or your Dependent; or your Dependent ceasing to satisfy the eligibility requirements for coverage, your election to cancel accident or health benefits for any individual other than your Spouse involved in the divorce, annulment, or legal separation, your deceased Spouse or Dependent, or your Dependent that ceased to satisfy the eligibility requirements, would fail to correspond with that Change in Status. Hence, you may only cancel accident or health coverage for the affected Spouse or Dependent.

  Example: Employee Mike is married to Sharon, and they have one child. The employer offers a calendar year cafeteria plan that allows employees to elect no health coverage, employee-only coverage, employee-plus-one-dependent coverage, or family coverage. Before the plan year, Mike elects family coverage for himself, his wife Sharon, and their child. Mike and Sharon subsequently divorce during the plan year; Sharon loses eligibility for coverage under the plan, while the child is still eligible for coverage under the plan. Mike now wishes to cancel his previous election and elect no health coverage. The divorce between Mike and Sharon constitutes a Change in Status. An election to cancel coverage for Sharon is consistent with this Change in Status. However, an election to cancel coverage for Mike and/or the child is not consistent with this Change in Status. In contrast, an election to change to employee-plus-one-dependent coverage would be consistent with this Change in Status.

  However, if you, your Spouse, or a Dependent elects COBRA continuation coverage under the Employer's plan, you may be able to increase your contribution to pay for such coverage.
- *Gain of Coverage Eligibility under Another Employer's Plan.* For a Change in Status in which you, your Spouse, or your Dependent gain eligibility for coverage under another employer's cafeteria plan (or qualified benefit plan) as a result of a change in your marital status or a change in your, your Spouse's, or your Dependent's employment status, your election to cease or decrease coverage for that individual under the Plan would correspond with that Change in Status *only* if coverage for that individual becomes effective or is increased under the other employer's plan.
- *Dependent Care FSA Benefits.* With respect to the Dependent Care FSA benefit (when offered by the Plan), you may change or terminate your election only if (1) such change or termination is made on account of and corresponds with a Change in Status that affects eligibility for coverage under the Plan; *or* (2) your election change is on account of and corresponds with a Change in Status that affects the eligibility of dependent care assistance expenses for the available tax exclusion.

Example: Employee Mike is married to Sharon, and they have a 12-year-old daughter. The employer's plan offers a dependent care expense reimbursement program as part of its cafeteria plan. Mike elects to reduce his salary by $2,000 during a plan year to fund dependent care coverage for his daughter. In the middle of the plan year when the daughter turns 13 years old, however, she is no longer eligible to participate in the dependent care program. This event constitutes a Change in Status. Mike's election to cancel coverage under the dependent care program would be consistent with this Change in Status.

- *Group Term Life Insurance, Disability Income, or Dismemberment Benefits.* In the case of group term life insurance or disability income and dismemberment benefits, if you experience any Change in Status (as described above), you may elect to either increase or decrease coverage.

  Example: Employee Mike is married to Sharon and they have one child. The employer's plan offers a cafeteria plan which funds group-term life insurance coverage (and other benefits) through salary reduction. Before the plan year Mike elects $10,000 of group-term life insurance. Mike and Sharon subsequently divorce during the plan year. The divorce constitutes a Change in Status. An election by Mike either to increase or to decrease his group-term life insurance coverage would each be consistent with this Change in Status.

2. **Special Enrollment Rights.** If you, your Spouse and/or a Dependent are entitled to special enrollment rights under a group health plan, you may change your election to correspond with the special enrollment right. Thus, for example, if you declined enrollment in medical coverage for yourself or your eligible Dependents because of outside medical coverage and eligibility for such coverage is subsequently lost due to certain reasons (such as legal separation, divorce, death, termination of employment, reduction in hours, or exhaustion of COBRA period), you may be able to elect medical coverage under the Plan for yourself and your eligible Dependents who lost such coverage. Furthermore, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may also be able to enroll yourself, your Spouse, and your newly acquired Dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. An election change that corresponds with a special enrollment must be prospective, unless the special enrollment is attributable to the birth, adoption, or placement for adoption of a child, which may be retroactive up to 30 days. Please refer to the group health plan description for an explanation of special enrollment rights.

3. **Certain Judgments, Decrees, and Orders.** If a judgment, decree, or order from a divorce, separation, annulment, or custody change requires your Dependent child (including a foster child who is your tax Dependent) to be covered under this Plan, you may change your election to provide coverage for the Dependent child. If the order requires that another individual (such as your former Spouse) cover the Dependent child, and such coverage is actually provided, you may change your election to revoke coverage for the Dependent child.

4. **Entitlement to Medicare or Medicaid.** If you, your Spouse, or a Dependent becomes entitled to Medicare or Medicaid, you may cancel that person's accident or health coverage. Similarly, if you, your Spouse, or a Dependent who has been entitled to Medicare or Medicaid loses eligibility for such, you may, subject to the terms of the underlying plan, elect to begin or increase that person's accident or health coverage.

5. **Change in Cost.** If the Plan Administrator notifies you that the cost of your coverage under the Plan *significantly* increases or decreases during the Plan Year, regardless of whether the cost change results from action by you (such as switching from full-time to part-time) or the Employer (such as reducing the amount of Employer contributions for a certain class of employees), you may make certain election changes. If the cost significantly increases, you may choose either (a) to make an increase in your contributions, (b) revoke your election and receive coverage under another Benefit Package Option which provides similar coverage, or (c) drop coverage altogether if no similar coverage exists. If the cost significantly decreases, you may revoke your election and elect to receive coverage provided under the option that decreased in cost. For *insignificant* increases or decreases in the cost of Benefit Package Options, however, the Plan Administrator will automatically adjust your election contributions to reflect the minor change in cost. The Plan Administrator (in its sole discretion) will determine whether the requirements of this section are met. The Change in Cost provisions do not apply to Health FSA benefits.

Example: Employee Mike is covered under an indemnity option of his employer's accident and health insurance coverage. If the cost of this option significantly increases during a period of coverage, the Employee may make a corresponding increase in his payments or may instead revoke his election and elect coverage under an HMO option.

6. **Change in Coverage**. If the Plan Administrator notifies you that your coverage under the Plan is significantly curtailed you may revoke your election and elect coverage under another Benefit Package Option which provides similar coverage. If the significant curtailment amounts to a complete loss of coverage, you may also drop coverage if no other similar coverage is available. Further, if the Plan adds or significantly improves a benefit option during the Plan Year, you may revoke your election and elect to receive on a prospective basis coverage provided by the newly-added or significantly improved option, so long as the newly added or significantly improved option provides similar coverage. Also, you may make an election change that is on account of and corresponds with a change made under another employer plan (including a plan of the Employer or another employer), so long as: (a) the other employer plan permits its participants to make an election change permitted under the IRS regulations; or (b) this Plan permits you to make an election for a period of coverage which is different from the period of coverage under the other employer plan. Finally, you may change your election to add coverage under this Plan for yourself, your Spouse, or your Dependent if such individual(s) loses coverage under any group health coverage sponsored by a governmental or educational institution. The Plan Administrator (in its sole discretion) will determine whether the requirements of this section are met. The Change in Coverage provisions do not apply to Health FSA benefits.

   Additionally, the Plan's Administrator may modify your election(s) downward during the Plan Year if you are a Key Employee or Highly Compensated Individual (as defined by the Internal Revenue Code), if necessary to prevent the Plan from becoming discriminatory within the meaning of the federal income tax law.

Q-10. What happens if I go on leave of absence?

If you go on leave of absence *with* pay, your participation in the Plan will continue and your contributions to the Plan will continue to be deducted from your paycheck.

If you go on leave of absence *without* pay (LWOP), your participation in the Plan will cease (except as discussed in Q-11 below). The Employer may, on a uniform and nondiscriminatory basis, require all employees returning from leave within 30 days to have their elections in effect before the leave automatically reinstated (after they have satisfied any applicable eligibility requirements) when they return. If you return after more than 30 days, you can make new elections.

Q-11. What happens if I go on a Qualified Leave under Family and Medical Leave Act?

(a) If you go on a qualifying unpaid leave under the Family and Medical Leave Act of 1993 (FMLA), to the extent required by the FMLA, the Employer will continue to maintain your Benefit Package Options providing health coverage (including the Health FSA) on the same terms and conditions as though you were still active (i.e., the Employer will continue to pay its share of the premium to the extent the Employee opts to continue coverage).

(b) If you opt to continue your group health coverage, you may pay your share of the premium with after-tax dollars while on leave (or pre-tax dollars to the extent you receive compensation during the leave), or you may be given the option to pre-pay all or a portion of your share of the premium for the expected duration of the leave on a pre-tax salary reduction basis out of your pre-leave Compensation by making a special election to that effect before the date such Compensation would normally be made available to you (provided, however, that pre-tax dollars may not be utilized to fund coverage during the next Plan Year), or by other arrangements agreed upon between you and the Plan Administrator (e.g., the Plan Administrator may fund coverage during the leave and withhold amounts upon your return). If the Employer requires all Participants to continue coverage during the leave, you may elect to discontinue your share of the required contributions until you return from leave. Upon return from such leave, you will be permitted to reenter the Plan on the same basis you were participating in the Plan before your leave, or as otherwise required by the FMLA. Notwithstanding the preceding sentence, your coverage that is terminated during the leave may be automatically reinstated provided that health coverage for employees on non-FMLA leave is automatically reinstated upon return from leave.

(c) The employer may, on a uniform and consistent basis, continue your group health coverage for the duration of the leave following your failure to pay the required contribution. Upon return from leave, you will be required to repay the contribution in a manner agreed upon by you and your Employer.

(d) If you are commencing or returning from unpaid FMLA leave, your election under this Plan for Benefit Package Options providing non-health benefits shall be treated in the same manner that elections for non-health Benefit Package Options are treated with respect to Participants commencing and returning from an unpaid non-FMLA leave.

3. Health Premium Reimbursement Accounts

If listed as a benefit offered under the Plan in Section 10 below, you can elect a Health Premium Reimbursement Account (HPRA) to pay for individually owned health policies such as dental, vision, disability, accidental death and dismemberment (AD&D), and other accident and health insurance policies (including cancer, dread disease, heart, stroke, first occurrence, or other health indemnification type policies) adopted by the Employer.

An HPRA is not a separate benefit in and of itself, but is a mechanism whereby premiums are qualified through the ordinary operation of this cafeteria plan. The employer may further exercise the option to pay the premiums directly to the underlying carriers rather than through employee reimbursement.

Q-1. Who can elect an HPRA?

If you are eligible to be a participant in the Cafeteria Plan, you can participate in a Health Premium Reimbursement Account (HPRA) to pay for qualified individually owned health policies if this type of benefit is offered by your employer. (See Section 10 below for a list of the benefits offered by your employer.)

Q-2. What individually owned health policies are qualified to be paid under a HPRA?

The individual insurance that you purchase outside of any employer plan must meet the following conditions: (a) the individual insurance policy must be determined by the Plan Administrator to be a "Qualified Benefit" (as defined by Code Section 125) before the beginning of the Plan Year or, if you are a new hire, before the effective date of your participation in the Plan; (b) the insurance policy must be a policy that provides accident or health insurance (for example, health, dental, vision, and disability) as defined by the Internal Revenue Code; (c) the contract must be an individually purchased contract and not an employer- sponsored insurance plan; (d) you must be the policyholder of the insurance policy (if applicable, your spouse or dependents who would otherwise be eligible for coverage under the Employer's group health plan may also be covered under the individual accident or health insurance policy); and (e) the premium for the insurance coverage must be billed directly to you.

Q-3. How do I become a Participant?

During the applicable Enrollment Periods described in Q-6 of Section 2, you must (a) provide the Plan Administrator with a copy of the individual accident or health insurance policy that you have purchased for yourself (or yourself and your dependents who are otherwise eligible for coverage under the Employer's group health plan) outside of any employer plan and (b) indicate on the Benefit Election Form the premium amount that you will expect to pay during the Plan Year for such individual accident or health insurance policy. The Plan Administrator will notify you if the insurance policy is determined to be a "qualified benefit" under the Plan. See Q-6 of Section 2 for your effective date of participation. The effective date of coverage may vary by Enrollment Period.

Q-4. What happens if I fail to return my Benefit Election Form?

If you are not currently participating in the Plan and fail to return a Benefit Election Form before the end of the applicable Enrollment Period, it will be assumed that you have elected to receive your full compensation in cash and you cannot elect to participate in the HPRA until the next Plan Year. The only exception to this is if you have experienced one of the qualifying events listed in Q-9 under Section 2. If so, you must submit an Employee Statement of Qualifying Event form (stating the event) and a Personal Benefit Election Change Request Form (stating the changes in elections) within 30 days of the event to enroll.

If you have currently elected a HPRA, it will be assumed that you do not want to continue participation and the premiums will no longer be deducted.

See Q-8 under Section 2 for further discussion.

Q-5. How do I receive Reimbursement under an HPRA?

If you elect to participate in an HPRA, you will have to take certain steps to be reimbursed for your eligible premiums. You will be supplied with the necessary claim forms. In addition to the claim form, you must submit to the Plan Administrator a statement from the insurance carrier indicating that you have paid the Eligible Individual Premium Expenses for which you are requesting reimbursement unless the Employer is paying the carrier directly. In that case, you must submit a statement or invoice from the carrier indicating the amount of the premium and the period of coverage. You will be reimbursed for your premium in the next check processing cycle. Your Plan Administrator will advise you how often the checks are processed.

The amount of your reimbursement will depend on your current Account Balance (deductions to date minus any previous reimbursement). If your Account Balance is equal to or exceeds your claim, your claim for eligible expenses will be reimbursed in full. If your claim exceeds your current Account balance, the excess part of the claim will be carried over into the following pay cycles to be paid as your balance can cover it. In other words, as additional salary conversion amounts are credited to your Account raising your Account Balance, a reimbursement check will be processed automatically for any unpaid portions of any properly submitted claims. Remember, no expenses can be reimbursed that exceed the payments you have made up to that date minus any previous reimbursements.

You cannot be reimbursed for any expenses incurred before the Plan Effective Date, before your Benefit Election Form becomes effective, or after the Claim Submission Grace Period or Closing Period, whichever is applicable. Also, no check will be written if the current amount payable is less than the Minimum Check Amount as specified in Section 10, below. The Minimum Check Amount will not apply for processing the final checks during any Plan Year.

At the end of the Plan Year, you will have a closing period (as stated in Section 10 below) to turn in claims for premiums incurred during the Plan Year. No claims can be submitted for reimbursement after that time. Your Employer may set a different claims submission grace period for terminated employees; if so, you will find this information in Section 10 below.

Q-6. Can I change the election during the year?

Only if you experience one of the qualifying events listed in Q-9 under Section 2 above, and follow the procedures outlined within that question.

Q-7. What happens if I still have a balance in my HPRA at the end of the Plan Year?

Any unused amounts left in your HPRA at the end of the Plan Year will be forfeited and given to your Employer to offset administration expenses. Also, any uncashed reimbursement checks will be forfeited if not cashed by the end of the Plan Year following the Plan Year in which the expenses for which the check was disbursed was incurred.

4. Cash Benefits

During any one Plan Year, the Maximum Contribution Amount total a Participant can elect cannot exceed the sum of the Benefit Package Options offered under Section 10 below. Any part of this annual benefit limit you do not apply toward tax-free benefits (or the remainder of your annual pay if less than the unused portion of the Maximum Contribution Amount) will be paid to you as regular, taxable salary.

5. Health FSA Benefits

Participation in the Medical Reimbursement Plan (Health FSA), if listed as a benefit offered under the Plan in Section 10 below, allows you to purchase a specific level of Health FSA benefits, paying for coverage through the Benefit Election Form with the Employer, in lieu of a corresponding amount of current pay, which means that the contribution you make will be with pre-tax funds. This arrangement helps you because the level of coverage you elect is nontaxable, and you save social security and income taxes on the amount of premiums you pay.

Q-1. Who can participate in the Health FSA?

If you are eligible to be a participant in the Cafeteria Plan, you can participate in the Health FSA.

Q-2. How do I become a Participant?

You can participate by electing the Health FSA during the applicable Enrollment Periods described in Q-6 of Section 2. See Q-6 of Section 2 to determine when your participation will begin. Effective date of participation will vary by Enrollment Period. Once you elect benefits under a Health FSA, a Health FSA will be set up in your name to record your benefits and the premiums you pay for such benefits during the Plan Year.

Q-3. What happens if I fail to return my Benefit Election Form?

If you are not currently participating in the Plan and fail to return a Benefit Election Form before the end of the enrollment period, it will be assumed that you have elected to receive your full compensation in cash and you cannot become a Participant until the next Plan Year. The only exception to this is if you have experienced one of the qualifying events listed in Q-9 under Section 2 above. If so, you must submit an Employee Statement of Qualifying Event form (stating the event) and a Personal Benefit Election Change Request Form (stating the changes in elections) within 30 days of the event to enroll.

If you have currently elected to participate in a Health FSA, it will be assumed that you do not want to continue participation in the Health FSA and the deductions will cease.

See Q-8 under Section 2 above for further discussion.

Q-4. How is my Health FSA Account funded?

After you submit a Benefit Election Form specifying the amount you want deducted each pay period, that amount will be deducted from your pay and credited to your Health FSA each pay period. This money will be available for reimbursement of medical expenses. The available amount in your Health FSA Account at any particular time will be the total amount elected for the Plan Year under your Health FSA less any reimbursements you may have already received.

Q-5. What annual benefits are available under the Health FSA, and how much will they cost?

You can choose any amount of annual benefits falling within the limits set in Section 10 below. You will be required to make annual contribution corresponding to your chosen benefit level.

Q-6. How are my Health FSA benefits paid for?

You can specify on the Benefit Election Form the amount of Health FSA benefits you wish to pay for with your salary reduction each year. This will be your Annual Election, and cannot exceed the maximum for a Health FSA set in 10 below.

The reimbursement benefits payable to you are actually funded by your employer. Thus, you can submit a claim and be reimbursed for the full amount of the coverage you have elected (less any claims previously filed during the Plan Year) at any time during the Plan Year unless you stop making contributions.

For example, if you have elected an annual salary conversion of $2,400 for eligible Health FSA benefits, then $2,400 would be put in your Health FSA Account during the Plan Year. If you are paid semi-monthly, $100 a payday or $200 a month would be placed in the Health FSA Account to pay for these expenses, but your reimbursements would not depend on the amount you have paid in. You can file for all or part of this $2,400 reimbursement at any time during the Plan Year.

Q-7. What amounts will be available for reimbursement at any particular time during the Plan Year?

If you have continued to pay the periodic premiums due for this benefit, the full annual amount of coverage you have elected, less any reimbursements already received during the Plan Year, will be available at any time during the Plan Year.

Q-8. How do I receive Reimbursement under the Health FSA?

If you elect to participate in this Health FSA, you will have to take certain steps to be reimbursed for your eligible medical expenses. You will be supplied with claim forms. When you incur an eligible expense payable from your Health FSA, fill out a claim form and submit it to the Plan Administrator. If you have paid the premiums for the coverage you have elected, you will be reimbursed for your eligible expenses in the processing cycle following the pay period in which you submitted the claim. Remember, the amount you are reimbursed during the Plan Year cannot exceed the annual benefit amount you elected. Also, no check will be written if the current amount payable to the Participant for claims is less than the Minimum Check

Amount as specified in Section 10 below. The Minimum Check Amount will not apply when processing claims submitted during the last month of the Plan year or during the closing period.

At the end of the Plan Year, you will have a closing period (as stated in Section 10 below) to turn in claims for expenses incurred during the Plan Year. No claims can be submitted for reimbursement after the closing period ends. Your Employer may set a different closing period, called a "claims submission grace period" for employees terminating during the Plan Year; if so, you will find this information in Section 10 below.

Please read and follow your Claims Filing Instructions carefully to ensure the prompt processing of your claims. Please note that you can submit a claim for more than what you have paid in to date. The reimbursement will be made so long as (1) the claim is equal to or less than the annual elected amount less any previous payments; and (2) the claim is not paid for or payable from any other source.

Q-9. What is an "Eligible Expense"?

An "eligible expense" means any item defined as "medical care" under Internal Revenue Code Section 213d , and which was not paid or payable by another source. The only exceptions are: (1) expenses for qualified long-term care services, (2) expenses incurred for cosmetic surgery unless necessary to alleviate or prevent a physical or mental condition, and (3) a Participant's insurance premium payments for health coverages, including premiums paid for health coverage under a plan maintained by the employer or the employee's spouse or dependent. (Health Insurance Premiums are eligible benefits under a Cafeteria Plan as stand-alone benefits, as discussed in Section 3 above.)

A partial list of eligible expenses included with the Claims Filing Instructions will help you determine if an expense is an "eligible expense". If you have any doubts, you can also consult IRS Publication 17, "Your Federal Income Tax", or your personal tax advisor.

Q-10. Who is an "eligible dependent" for whom I can claim expenses for reimbursement?

You can claim reimbursement for eligible medical expenses incurred by you, your legal spouse, and any individual for whom you will provide more than one-half of that dependent's support for the Plan Year (i.e. an individual who is dependent as defined by Section 152 of the Code). Also, if you are the divorced parent of a child, the child is considered a dependent of both parents.

Q-11. When must a reimbursable expense be incurred?

Eligible expenses reimbursed under the Plan must be incurred during the Participant's period of coverage under the Plan. Expenses are treated as having been incurred when the Participant is provided with the medical care that gives rise to the medical expenses, not when the Participant is formally billed or charged for the services or pays for the medical care. During your current participation year, you cannot be reimbursed for any expenses incurred before the Plan Effective Date, before your Salary Reduction and Election Form becomes effective, expenses incurred after the date that you stop being eligible under this Health FSA (except as described in Q-14 below) or for any expense incurred after the close of the Plan Year.

Q-12. Can I change the election during the year?

Only if you experience one of the qualifying events listed in Q-6 under Section 2 above and follow the procedures outlined within that question.

Q-13. What happens if I still have a balance in my Account at the end of the Plan Year?

Any unused amounts left in your Account at the end of the Plan Year will be forfeited and returned to your employer to offset administrative expenses and future costs. Also, any uncashed reimbursement checks will be forfeited if not cashed by the end of the Plan Year following the Plan Year in which the expenses for which the check was disbursed was incurred.

Q-14. Can I continue coverage in my Account?

Yes, you may be eligible for "continuation coverage" under the Plan. "Continuation Coverage" means your right, or your Spouse and/or Dependents' right, to continue to be covered under the Health FSA Plan if participation otherwise would end due to the occurrence of a "Qualifying Event." A Qualifying Event is:

- Termination of your employment (other than by reason of gross misconduct), or reduction of your work hours,
- Your death,
- Divorce or legal separation from your Spouse, or
- Your Dependent ceases to be a dependent.

In case of a Qualifying Event (other than a change in your employment status or your death), it will be your obligation to inform the Plan Administrator of its occurrence within 60 days of the later of the Qualifying Event or the date that you lose coverage as a result of the occurrence. The Plan Administrator, in turn, has a legal obligation to furnish you or your Spouse, as the case may be, with written election forms to continue the coverages provided at stated premium costs with respect to the Health FSA Plan. You will have 60 days from the later of the date coverage ends or the date that we send the notice to make an election.

Generally, if you or your dependents experience a qualifying event, you and/or your covered dependents will be eligible for continuation coverage for the remainder of the Plan Year in which the Qualifying Event occurs provided that the maximum annual reimbursement amount you have available on the day before the qualifying event is greater than the amount that you have contributed up to the day before the qualifying event. In some cases, you may continue coverage for longer (18 or 36 months, depending on the qualifying event) regardless of your account balance on the day before the qualifying event. You will be notified by the Plan Administrator of your COBRA rights after you experience a qualifying event.

COBRA coverage will end on the earliest of the following to occur:

- The maximum duration of COBRA coverage,
- The date the employer terminates all group health plans,
- The date the covered individual fails to pay the required contribution. The first contribution is due no later than 45 days after the election to continue coverage is made. All other contributions are due 30 days after the due date for that month.
- After you elect COBRA continuation coverage, the date that you become covered under another plan under which you are not subject to a pre-existing exclusion or limitation,
- After electing COBRA continuation coverage, the date that you become entitled to Medicare.

The COBRA notification you receive from the Plan Administrator will provide greater detail about your and your covered dependents' right to elect coverage.

Q-15. What if I take a qualifying leave of absence under the FMLA?

Coverage under the Health FSA Plan will be continued during an unpaid leave of absence under the Family and Medical Leave Act of 1993 ("FMLA") in accordance with the rules and regulations of the FMLA and Q-11 of Section 2. Moreover, if you have the option and choose not to continue coverage during an FMLA leave of absence or coverage is lost for the remainder of the leave as a result of a failure to pay a required contribution, you have the right to the following reinstatement options:

(i) You may elect to reinstate the maximum annual reimbursement that you elected provided that any contributions missed during the leave period are repaid upon return from leave. The coverage level reinstated will be reduced by reimbursements received for expenses incurred prior to the date coverage terminates, or

(ii) The Participant may elect to reinstate the maximum annual reimbursement amount that you elected reduced by contributions not made during the leave. Under this option (ii), the contribution for the remaining period following the return from leave will be equal to the contribution required prior to leave. The coverage level reinstated will be reduced further by any reimbursements received for expenses incurred prior to the date coverage terminated.

(iii) Under no circumstances will expenses incurred during the period during which coverage was not effective be reimbursed.

6. Dependent Care Assistance Benefit

Another important component of your Employer's Cafeteria Plan is the Dependent Care Assistance Plan. Participation in this Plan allows you to receive income tax-free reimbursement for some or all of your work-related dependent care expenses under a related Dependent Care Assistance Plan (DCAP). A DCAP allows you to provide a source of pre-tax funds to reimburse you for your eligible expenses. You do this by entering into a salary conversion agreement (Benefit Election Form) with the Employer instead of receiving a corresponding amount of your regular pay. This arrangement saves you money; you pay less social security and income taxes because the salary conversion paying for your elected benefits is not taxable.

Q-1. Who can participate in a DCAP?

If you are eligible to be a participant in the Cafeteria Plan, you can participate in the DCAP. If you are married, your spouse must also work, go to school full time, or be incapable of self-care for you to be eligible. The dependent care services can take place either inside or outside of your home as stated below.

Q-2. How do I become a Participant?

You can participate by electing the DCAP Benefit during the applicable Enrollment Periods. See Q-6 of Section 2 for your effective date of participation. Effective dates of participation vary by Enrollment Period. Once you elect benefits under this DCAP, a Dependent Care Expense Reimbursement Account (DCAP Account) will be set up in your name to record your benefits and the contributions you make for such benefits during the Plan Year.

Q-3. What happens if I fail to return my Benefit Election form?

If you are not currently participating in the Plan and fail to return a Benefit Election Form before the end of the enrollment period, it will be assumed that you have elected to receive your full compensation in cash and you cannot become a Participant until the next Plan Year. The only exception to this is if you have experienced one of the qualifying events listed in Q-9 under Section 2 above. If so, you must submit an Employee Statement of Qualifying Event form (stating the event) and a Personal Benefit Election Change Request Form (stating the changes in elections) within 30 days of the event to enroll.

If you have currently elected to participate in a DCAP and you fail to return the Benefit Election Form, it will be assumed that you do not want to continue participation in the DCAP and the deductions will cease.

See Q-8 under Section 2 above for further discussion.

Q-4. How is my DCAP Account funded?

After you submit a Benefit Election Form specifying the amount you want deducted each pay period, that amount will be deducted from your pay and credited to your DCAP Account each pay period. This money will be available for reimbursement of your dependent care expenses. The available amount in your DCAP Account at any particular time will be the amount credited to your DCAP Account to date less any reimbursements you may have already received.

Q-5. Are there any other limits on what DCAP benefits are tax free?

In addition to the dollar limitations in Section 10 below, the maximum amount of DCAP benefits you may exclude from income during any calendar year cannot be more than:

- If you are **not** married as of the end of the year, your earned income for the year, or
- If you **are** married at the end of the year, the **lesser** of your earned income for the year, or your spouse's earned income. If your spouse is a full-time student or is disabled, your spouse is considered under the federal tax rules to have a monthly earned income of $200 (if you have only one dependent), or $400 (if you have two or more Dependents).

Q-6. Is there any other way I can save taxes on my DCAP expenses?

Yes, you can claim the Household and Dependent Care Credit when filing your federal income tax return.

Q-7. What is the Household and Dependent Care Credit?

The Household and Dependent Care Credit is an allowance for taking a percentage of your annual eligible work-related dependent care expenses as a credit against your federal income tax liability under the Internal Revenue Code. In determining the tax credit, you may take into account only $2,400 of such expenses for one dependent or $4,800 for two or more dependents. Depending on your adjusted gross income, the percentage could be as much as 30% of your qualifying expenses (to a maximum credit amount of $720 for one dependent, or $1,420 for two or more dependents), to a minimum of 20% of such expenses (producing a maximum credit of $480 for one dependent, or $960 for two or more dependents). (Remember, the adjusted gross income is the combined income for those who are married and filing a joint federal tax return.) The maximum 30% rate is reduced by 1% (but not below 20%) for each $2,000 portion (or any fraction of $2,000) of your adjusted gross income over $10,000.

Example: If you have $3,600 in eligible expenses for one dependent and your combined adjusted gross income is $20,000; you calculate the credit by applying the appropriate percentage to the first $2,400 of the expenses. You determine this percentage by subtracting one percentage point from 30% for each $2,000 your adjusted gross income exceeds $10,000. Your gross income is $20,000, or $10,000 more than the $10,000 maximum. Divide this $10,000 by $2,000 to see how many percentage points to subtract from 30% (one percentage point for each $2,000). In this case, you will subtract 5% from 30%, leaving you with 25%. Your tax credit would be 25% of $2,400 or $600. If you had incurred the same expenses for two or more dependents, your credit would be $3,600 X 25% or $900, because the entire expense would have been taken into account since it is less than the $4,800 ceiling.

Q-8. Would I be better off with a DCAP or claiming the Household and Dependent Care Credit?

If your income tax bracket does not exceed 15%, you will probably profit by not paying for the DCAP benefits through your DCAP and instead claiming the credits for dependent care and earned income. As a rule, the more income taxes you are required to pay, the more profitable it is to participate in the DCAP.

However, each Participant will have to determine the decision between taxable and tax-free benefits under the DCAP individually since the actual determination of the preferable tax method depends on a number of factors such as one's tax filing status (such as married, single, or head of household) and number of dependents.

Q-9. If I participate in the DCAP, can I claim the Household and Dependent Care Credit on my federal income tax return?

If you participate in both, each dollar that you receive under the DCAP FSA reduces the amount of expenses that may be taken into consideration under the Household and Dependent Care Credit (that is, the $2,400 and $4,800 amount).

Example: If you had $5,000 in dependent care expenses for 2001 for two children, but only elected $2000 for your DCAP, you would still be eligible for a partial tax credit. You would calculate your tax credit by subtracting $2,000 (amount reimbursed by DCAP) from $4,800 (the maximum allowed for the Household and Dependent Care Credit). This would leave you with $2,800, your basis for the Household and Dependent Care Credit. You would then apply the formula for the credit as stated in Q-7 above.

Example: If you had $10,000 in dependent care expenses for 2001 and claimed the maximum $5,000 under a DCAP, you cannot claim the other $5,000 as a Household and Dependent Care Credit on your federal income tax return.

Q-10. Who is an "eligible dependent" for whom I can claim reimbursement?

You can be reimbursed for work-related dependent care expenses for (1) a child under age 13 living with you and for whom you can claim a personal dependent exemption on your federal income tax return; and (2) a dependent or spouse who is mentally or physically incapable of personal care.

Q-11. What is an "eligible expense"?

You can be reimbursed for work-related dependent care expenses for (1) a dependent under age 13 living with you and whom you can claim as a dependent on your federal income tax return; and (2) a dependent or spouse who is mentally or physically incapable of personal care.

Generally, these expenses must meet *all* the following conditions to qualify as eligible Dependent Care expenses:

1. The expenses are for services rendered after the date of your Dependent Care election and before the end of the Plan Year.
2. The individual for whom you incurred the expenses is a:
   - Dependent under age 13 whom you are entitled to a personal tax exemption as a dependent, or
   - Spouse or other tax dependent who is physically or mentally incapable of personal care.
3. The expenses are incurred to enable you to be gainfully employed.
4. If the expenses are incurred for services outside your household for a Dependent who is age 13 or older, that Dependent must spend at least 8 hours a day in your home.
5. If the incurred expenses are for services provided by a dependent care center (that is, a facility that provides care for more than six individuals not residing at the facility), the center must comply with all applicable state and federal laws.
6. The expenses cannot be paid or payable to a child of yours who is under age 19 at the end of the year when the services were rendered or to an individual for whom you or your spouse is entitled to a personal tax exemption as a dependent.
7. This reimbursement (plus all other Dependent Care reimbursements during the same year) may not exceed the least of the following limits:
   - $5,000,
   - $2,500 if you are married, but you and your Spouse file separate tax returns,
   - Your taxable compensation (after your salary reduction under the Plan), or
   - If you are married, your Spouse's actual or deemed earned income.

Your Spouse will be deemed to have earned income of $200 (for one Eligible Dependent) or $400 (for two Eligible Dependents) for each month the Spouse is either (1) physically or mentally incapable of personal care or (2) a full-time student. Your spouse is considered to be a full-time student if the spouse is deemed a full-time student by the "educational institution" attended by the spouse during each of five calendar months during a Plan Year. An educational institution is any educational institution which normally maintains a regular faculty and curriculum and normally has a regularly enrolled body of student in attendance at the place where its educational activities are regularly carried on.

You are encouraged to consult your personal tax advisor or IRS Publication 17 "Your federal Income Tax" for further information or clarification.

Q-12. How do I receive my benefits under the DCAP?

If you elect to participate in this Plan, you will have to take certain steps to be reimbursed for your eligible dependent care expenses. You will be supplied with claim forms. When you incùr an eligible expense payable from your DCAP Account, fill out a claim form and submit it to the Plan Administrator and include a statement showing the dates of service, the name of the Dependent, and the amount. You will be reimbursed for your eligible expenses in the next check processing cycle. Your Plan Administrator will advise you how often the checks are processed.

The amount of your reimbursement will depend on your current Account Balance (deductions to date minus any previous reimbursements). If your Account Balance is equal to or exceeds your claim, your claim for eligible expenses will be reimbursed in full. If your claim exceeds your current Account balance, the excess part of the claim will be carried over into the following pay cycles to be paid as your balance can cover it. In other words, as additional salary conversion amounts are credited to your Account raising your Account Balance, a reimbursement check will be processed automatically for any unpaid portions of any properly submitted claims. Remember, no expenses can be reimbursed that exceed the payments you have made up to that date minus any previous reimbursements.

You cannot be reimbursed for any expenses incurred before the Plan Effective Date, before your Benefit Election Form becomes effective, or after the end of the Plan Year. You may be able to submit claims for reimbursement of an eligible expense incurred after the date that you terminate or cease to be eligible for this Plan up to your account balance on the date

that you stopped being eligible. Also, no check will be written if the current amount payable to the Participant for claims is less than the Minimum Check Amount as specified in Section 10 below. The Minimum Check Amount will not apply for processing the final checks during any Plan Year.

At the end of the Plan Year, you will have a closing period (as stated in Section 10 below) to turn in claims for expenses incurred during the Plan Year. No claims can be submitted for reimbursement after the closing period ends. Your Employer may set a claims submission grace period for terminated employees; if so, you will find this information in Section 10 below.

Q-13. Will I be taxed on the DCAP benefits I receive?

You will not normally be taxed on your DCAP benefits up to the limits set out in Q-5 and Q-11 above. However, before you can qualify for tax-free treatment, you are required to list the names and taxpayer identification numbers of any persons providing your dependent care services during the calendar year for which you have claimed a tax-free reimbursement. (Be sure to fill out all the spaces on your claim!)

Q-14. Can a relative provide the service?

Yes, unless the relative is your child who is under 19 at the end of the year or the relative is an individual for whom you or your spouse is entitled to a personal tax exemption as a dependent.

Q-15. Can I change my election if I change day care providers during the year and the rates are different?

Yes, this will be considered a Change of Coverage (see Q-9 under Section 2 above). You will need to submit an Employee Statement of Qualifying Event form (stating the event) and a Personal Benefit Election Change Request Form (stating the changes in elections) within 30 days of the event to change the day care provider and the rates.

Q-16. Can I change my election if a relative starts keeping my children for free?

Yes, this will also qualify for the Change of Coverage discussed above. You would submit a Change of Status Form changing providers with the rate being changed to zero. NOTE: You will not be able to change your election as a result of a cost increase or decrease imposed by a relative.

Q-17. What happens if I still have a balance in my DCAP Account at the end of the Plan Year?

Any unused amounts left in your Account at the end of the Plan Year cannot be carried over into the next year, but will be forfeited and returned to your employer to offset administrative expenses and future costs. Also, any uncashed reimbursement checks will be forfeited if not cashed by the end of the Plan Year following the Plan Year in which the expenses for which the check was disbursed was incurred.

8. Claims Procedures

If your claim is for a benefit under one of the component Benefit Package Options, you will generally proceed under the claims procedure applicable under the component Benefit Package Option. The following is the claims procedures for the Health FSA and the DCAP. Also, if you are denied a benefit under this Plan (such as the ability to pay for premiums on a pre-tax basis) due to an issue germane to your coverage under this Plan (i.e., such as a determination of: a Change in Status; a "significant" change in premiums charged; or eligibility and participation matters under the Cafeteria Plan document), the claims procedure under this Plan will apply, and you will be notified in writing by the Plan's Administrator within 90 days of the date you submitted your claim if the claim is denied. Such notification will set out the reasons your claim was denied, and further advise you of what steps, if any, you might take to validate the claim. It will further advise you of your right to request an administrative review of the denial of the claim. You may request a review any time within the 60-day period after you have received notice that the claim was denied. You or your authorized representative will have the opportunity to review any important documents held by the Administrator, and to submit comments and other supporting information. In most cases, a decision will be reached within 60 days of the date of your request for a review.

9. ERISA Rights

This Plan is not a welfare benefit plan as defined in the Employee Retirement Income Security Act (ERISA). However, certain component benefits (such as the Health FSA Plan) may be governed by ERISA. ERISA provides that you, as a Plan Participant, will be entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.
- Obtain, upon written request to the plan administrator, copies of all documents governing the operation of the plan, including insurance contracts and collective bargaining agreement, and copies of the latest annual report (Form 5500 series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

- Continue health coverage for you, your spouse, or your dependents if there is a loss of coverage under the plan as a result of a qualifying event. However, you or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.
- Obtain reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage under another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases (if you requested continuation coverage), before losing coverage (if you requested continuation coverage), or up to 24 months after losing coverage (if you requested continuation coverage). Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Employee Benefit Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit from the Plan, or from exercising your rights under ERISA.

Enforcement of Your Rights

If your claim for a welfare benefit under an ERISA-covered plan is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees (for example, if it finds your claim is frivolous).

Assistance with Your Questions

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance obtaining documents from the Plan Administrator, you should contact the nearest office of the U.S. Department of Labor, Pension and Welfare Benefits Administration listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Ave., N.W., Washington, D.C., 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

10. Plan Information Summary

Please refer to the Addendum attached to this document for Section 10, the Plan Information Summary.

Montgomery County, Texas
Section 125 Cafeteria Plan
PLAN INFORMATION SUMMARY

Effective Date: 01/01/2013

Employer Organization

Name of Organization: Montgomery County, Texas
Federal Employer ID Number: 74-6000558
Date Incorporated: Governmental Entity / 1836
Mailing Address: 501 N. Thompson #202
City, State, Zip: Conroe, TX 77301
Street Address: 501 N. Thompson #202
Street Zip: 77301
Form of Organization: Government
Organized in the state of: TX

Plan Design Options

Plan Information

Plan Number: 501
Plan Name: Montgomery County, TX Flexible Benefit Plan
Original Effective Date: 07/01/1992
Plan Year Runs*: 01/01 - 12/31
Plan Restated and Amended: 01/01/2013

*This Plan is designed to run on a 12-month plan year period as stated above. A Short Plan Year may occur when the Plan is first established, when the plan year period changes, or at the termination of a Plan.

Plan Administrator: Montgomery County, Texas

Plan Service Provider: Boon-Chapman
Street Address: PO Box 9201
City, State, Zip: Austin, TX 78766
Contact: Terri Garza
Phone: (800) 252-9653

Benefits Coordinator

Name: Virginia Little
Title: Director of Risk Management
Phone: (936) 760-6935
Company Name: Montgomery County, Texas
Street Address: 501 N. Thompson #202
City, State, Zip: Conroe, TX 77301

Acceptance of Legal Process

Name:	Virginia Little
Title:	Director of Risk Management
Phone:	(936) 760-6935
Company Name:	Montgomery County, Texas
Street Address:	501 N. Thompson #202
City, State, Zip:	Conroe, TX 77301

The appointed Plan Service Provider in conjunction with the Administrator will perform the functions of accounting, record keeping, changes of participant family status, and any election or reporting requirements of the Internal Revenue Code.

ELIGIBILITY REQUIREMENTS

a) Except as provided in (b) below, the Classification of eligible employees consists of All employees.

(b) Employees excluded from this classification group are those individual employees who fall into one or more of the following categories below:

Individuals under 18 years of age.

Employees who work less than 30.0 hours per week.

Employees who are employed less than 1 month per year.

Service Period Requirement

For All plan years, eligibility is the following:

90 days service requirement

PLAN ENTRY DATE

The Plan Entry Date is the date when an employee who has satisfied the Eligibility Requirements may commence participation in the Plan. The Plan Entry Date is the later of the date the Employee files a Salary Reduction Agreement during the applicable Enrollment Period or 1st of Month after requirements are met.

BENEFIT PACKAGE OPTIONS

The following Benefit Package Options are offered under this Plan:

Major Medical Plan.

The terms, conditions, and limitations of the Core Health Benefits offered will be as set forth in and controlled by the Group/Individual Medical Insurance Policy or Policies.

Dental and Vision Care Plans.

The terms, conditions, and limitations of the Non-Core Supplemental Health Benefits offered will be as set forth in and controlled by the Group/Individual Medical Insurance Policy or Policies.

Unreimbursed Medical Plans.

The terms, conditions, and limitations will be as set forth in and controlled by the Plan Document. Each year each participant may elect in writing on a form filed with the plan administrator on or before the date he first becomes eligible to participate

Dependent Care Plans.

The terms, conditions, and limitations will be as set forth in and controlled by the Plan Document. Each year each participant may elect in writing on a form filed with the plan administrator on or before the date he first becomes eligible to participate

FLEXIBLE SPENDING ACCOUNT ELECTIONS

The Closing Period is the period of time that begins after the Plan Year ends during which the employee can submit claims for payment of Qualified Expenses incurred during the Plan Year. This Closing Period begins at the end of the Plan year and terminates 90 days after the end of the plan year.

The Claims Submission Grace Period is the period of time after an employee terminates employment (or loses eligibility to participate in the Plan) during which the employee can submit claims for expenses incurred while the employee remained a participant. The Claim Submission Grace Period begins on the employee's termination and ends 0 days after the date of termination.

Amounts contributed for reimbursement benefits are segregated for record keeping and accounting purposes only, and this process does not constitute a separate fund or entity as the reimbursements are made from the general assets of the plan sponsor.

Health FSA

(a) The maximum annual reimbursement amount an Employee may elect for any Plan Year is $2500.00.

(b) The maximum annual reimbursement amount that a Participant may receive during the year is the annual reimbursement amount elected by the Employee on the Salary Reduction Agreement for Health FSA coverage, not to exceed the amount set forth in (a) above.

(c) Minimum Contribution for this Benefit per Plan Year per Employee is $240.00.

(d) In order to receive reimbursement under the Health FSA, the claim or claims must equal or exceed the Minimum Check Amount. If a claim or claims submitted by the Participant do not equal or exceed this amount, the claim or claims will be held until the accumulated claims equal or exceed the Minimum Check Amount, except that claims submitted for reimbursement during the last month of the Plan Year or during the Closing Period or Claims Submission Grace Period, whichever is applicable, will not be subject to the Minimum Check Amount. The Minimum Check Amount under this Plan is hereby set as $0.00.

Dependent Care Assistance Plan

(a) The maximum annual reimbursement amount a Participant may elect under the Dependent Care Assistance Plan for any Plan Year is the lesser of the maximum established by the Plan described in (b) below or the statutory maximum specified in Code Section 129 (as described in your summary plan description).

(b) The maximum annual reimbursement amount established by the Dependent Care Assistance Plan is as follows: $5000.00 for married filing jointly or single and $2500.00 for married filing separately.

(c) The maximum annual reimbursement that a Participant may receive during the year is the annual reimbursement amount elected by the Participant on the Salary Reduction Agreement, not to exceed the amount in (a) above.

(d) Minimum Contribution for the Benefit per Plan Year per Employee is $240.00.

(e) In order to receive reimbursement under the Dependent Care Assistance Plan, the claim or claims must equal or exceed the Minimum Check Amount. If a claim or claims submitted by the Participant do not equal or exceed this amount, the claim or claims will be held until the accumulated claims equal or exceed the Minimum Check Amount, except that claims submitted for reimbursement during the last month of the Plan Year or during the Closing Period or Claims Submission Grace Period, whichever is applicable, will not be subject to the Minimum Check Amount. The Minimum Check Amount under this Plan is hereby set as $0.00.

INCORPORATED BY REFERENCE

The actual terms and the conditions of the separate benefits offered under this Plan are contained in separate, written documents governing each respective benefit, and will govern in the event of a conflict between the individual plan document and the Employer's Cafeteria Plan adopted through this Agreement as to substantive content. To that end, each such separate document, as amended or subsequently replaced, is hereby incorporated by reference as if fully recited herein.

Signature: Virginia K. Little Date: 01/01 /2013
Name: Virginia K. Little
Title: Director of Risk Management

Executed at: Montgomery County, Texas
501 N. Thompson #202
Conroe, TX 77301

Change of Status Matrix: Acceptable Events and Actions for Mid-Year Changes

This matrix outlines the qualifying events under Section 125 which allow election changes during the Plan Year and the permissible changes allowed for each Plan Class. You will see codes, footnotes, or endnotes showing restrictions or qualifications following each action. The code definitions can be found on page 9. The endnotes (also defined on page 9) contain information that is referred to on more than one page. Information that only refers to one place is placed in footnotes with that information shown at the bottom of that particular page. The P/C column refers to Personal or Corporate events and are defined on the ***Statement of Qualifying Event Form*** attached to the ***Personal Benefit Election Change Request Form*** or the ***Corporate Benefit Election Change Order Form,*** whichever is applicable. This matrix does not address changes to individually owned policies under a Health Premium Reimbursement Plan. To find allowable changes, look under the Plan Class pertinent to the individually owned policy.

Event	P/C	Plan Class 5.1 Core Health	Plan Class 5.2 Sup Health	Plan Class 5.3 GTL	Plan Class 5.4 STD	Plan Class 5.5 LTD	Plan Class 5.7 Health FSA	Plan Class 5.8 DCAP	Plan Class 5.11 Dental	Plan Class 5.12 Vision	Plan Class 5.13 AD&D
1. STATUS CHANGES											
1.1 Change in Employee's Legal Marital Status											
1.1.1 Employee Gains Spouse: Marriage	P-1	Add sp/dep: H1,C,T Drop dependents: C1 Drop Coverage: C1	Add sp/dep: H2,C,T Drop dependents: C1 Drop Coverage: C1	Add Coverage: EN Increase coverage: EN Drop Coverage: EN Decrease coverage: EN	Add Coverage: EN Increase coverage: EN Drop Coverage: EN Decrease coverage: EN	Add Coverage: EN Increase coverage: EN Drop Coverage: EN Decrease coverage: EN	Increase coverage: C,H2 Decrease coverage[1]: C	Add Coverage[2]: C2 Increase coverage[2]: C2 Drop Coverage[3]: C2 Decrease coverage[3]: C2	Add sp/dep: C,H2,T Drop Coverage: C1 Drop sp/dep: C1	Add sp/dep: C,H2,T Drop Coverage: C1 Drop sp/dep: C1	Add Coverage: EN Increase coverage: EN Drop Coverage: EN Decrease coverage: EN
1.1.2 Lose Spouse: Divorce, Legal Separation, Annulment, Death of Spouse	P-2	Add Coverage[4]: C,H1 Add dependents[4]: H1,C Revoke election only for spouse: C	Add Coverage[4]: C,H2 Add dependents[4]: C,H2 Revoke election only for spouse: C	Add Coverage: EN Increase coverage: EN Drop Coverage: EN Decrease coverage: EN	Add Coverage: EN Increase coverage: EN Drop Coverage: EN Decrease coverage: EN	Add Coverage: EN Increase coverage: EN Drop Coverage: EN Decrease coverage: EN	Add Coverage:C, H2 [5] Increase Coverage: C, H2[5] Decrease coverage[6]: C,H2	Add Coverage[2]: C2 Increase Coverage[2]: C2 Drop Coverage[7]: C2 Decrease coverage[7]: C2	Add Coverage[4]: C,H2 Add dependents[4]: C,H2 Revoke election only for spouse: C	Add Coverage[1]: C,H2 Add dependents[2]: C,H2 Revoke election only for spouse: C	Add Coverage: EN Increase coverage: EN Drop Coverage: EN Decrease coverage: EN
1.2 Change in Number of Employee's Dependents											
1.2.1 Gain Dependent: Birth, Adoption, Legal Guardianship	P-3	Add Coverage: H1,T,C Add sp/dep: H1,T,C	Add Coverage: H2 T,C Add sp/dep: C,H2,T	Add Coverage: EN Increase coverage: EN Drop Coverage: EN Decrease coverage: EN	Add Coverage: EN Increase coverage: EN Drop Coverage: EN Decrease coverage: EN	Add Coverage: EN Increase coverage: EN Drop Coverage: EN Decrease coverage: EN	Add Coverage: C,H2 Increase coverage: C, H2	Add Coverage: C2 Increase coverage C2,	Add Coverage: H2,T,C Add sp/dep: H2,T,C	Add Coverage: H2 T ,C Add sp/dep: H2,T,C	Add Coverage: EN Increase coverage: EN Drop Coverage: EN Decrease coverage: EN

Change of Status Matrix: Acceptable Events and Actions for Mid-Year Changes

Event	P/C	Plan Class 5.1 Core Health	Plan Class 5.2 Sup Health	Plan Class 5.3 GTL	Plan Class 5.4 STD	Plan Class 5.5 LTD	Plan Class 5.7 Health FSA	Plan Class 5.8 DCAP	Plan Class 5.11 Dental	Plan Class 5.12 Vision	Plan Class 5.13 AD&D
1.2.2 Lose Dependent: Death, Placement for Adoption	P-4	Drop affected dependent: C	Drop affected dependent: C	Add Coverage: EN Increase coverage: EN Drop Coverage: EN Decrease coverage: EN	Add Coverage: EN Increase coverage: EN Drop Coverage: EN Decrease coverage: EN	Add Coverage: EN Increase coverage: EN Drop Coverage: EN Decrease coverage: EN	Decrease coverage[8]: C	Decrease coverage[6]	Drop affected dependent: C	Drop affected dependent: C	Add Coverage: EN Increase coverage: EN Drop Coverage: EN Decrease coverage: EN
1.3 Change in Employment Status of Employee, Spouse, or Dependent that Affects Eligibility*											
1.3.1 Employee Gains Eligibility under Employer's Plan	P-5	Add Coverage: EY,C,T	Add Coverage: EY,C,T	Add Coverage: EN Increase coverage: EN Drop Coverage: EN Decrease coverage: EN	Add Coverage: EN Increase coverage: EN Drop Coverage: EN Decrease coverage: EN	Add Coverage: EN Increase coverage: EN Drop Coverage: EN Decrease coverage: EN	Add Coverage: EY,C	Add Coverage: EY,C2	Add Coverage: EY,C,T	Add Coverage: EY,C,T	Add Coverage: EN Increase coverage: EN Drop Coverage: EN Decrease coverage: EN
1.3.2 Employee Maintains Prior Eligibility under Employer's Plan after return from termination or unpaid leave within 30 days.	C-2	Reinstate prior election at termination unless another event has occurred that allows a change[9]	Reinstate prior election at termination unless another event has occurred that allows a change[9]	Reinstate prior election at termination unless another event has occurred that allows a change[9]	Reinstate prior election at termination unless another event has occurred that allows a change[9]:	Reinstate prior election at termination unless another event has occurred that allows a change[9]	Reinstate prior election at termination unless another event has occurred that allows a change[9] [10]	Reinstate prior election at termination unless another event has occurred that allows a change[9]	Reinstate prior election at termination unless another event has occurred that allows a change[9]:	Reinstate prior election at termination unless another event has occurred that allows a change[9]	Reinstate prior election at termination unless another event has occurred that allows a change[9]
1.3.3 Employee Rehired or returns from non-FMLA leave without pay after 30 days[19]	P-5	Employee may make new election.	Employee may make new election.	Employee may make new election.	Employee may make new election.	Employee may make new election.	Employee may make new election.	Employee may make new election.	Employee may make new election.	Employee may make new election.	Employee may make new election.
1.3.4 Employee Loses Eligibility under Employer's Plan through Change in Employment	C-1	Drop Coverage[11]	Drop Coverage[11]	Drop Coverage[11]	Drop Coverage[11]	Drop Coverage[11]	Drop Coverage[11]	Drop Coverage[11]	Drop Coverage[11]	Drop Coverage[11]	Drop Coverage[11]

* Can be such events as starting or ending employment; switching between part time and full time, hourly and salary; starting or ending strike/lockout; or any other event causing gain or loss of eligibility.

Change of Status Matrix: Acceptable Events and Actions for Mid-Year Changes

Event	P/C	Plan Class 5.1 Core Health	Plan Class 5.2 Sup Health	Plan Class 5.3 GTL	Plan Class 5.4 STD	Plan Class 5.5 LTD	Plan Class 5.7 Health FSA	Plan Class 5.8 DCAP	Plan Class 5.11 Dental	Plan Class 5.12 Vision	Plan Class 5.13 AD&D
1.3.5 Spouse/Dependent Gains Eligibility under their Employer's Plan	P-6	Drop Coverage[12] Drop sp/dep[12]	Drop Coverage[12] Drop sp/dep[12]	Add Coverage: EN Increase coverage: EN Drop Coverage: EN Decrease coverage: EN	Add Coverage: EN Increase coverage: EN Drop Coverage: EN Decrease coverage: EN	Add Coverage: EN Increase coverage: EN Drop Coverage: EN Decrease coverage: EN	Decrease coverage[12]: C	Add Coverage[13] Increase coverage[13] Drop Coverage[12]	Drop Coverage[12] Drop sp/dep[12]	Drop Coverage[12] Drop sp/dep[12]	Add Coverage: EN Increase coverage: EN Drop Coverage: EN Decrease coverage: EN
1.3.6 Spouse/Dependent Loses Eligibility under their Employer's Plan	P-7	Add Coverage[14]: T,H1 Add sp/dep[14]: T, H1,	Add Coverage[14]: T, H2 Add sp/dep[14]: T, H2	Increase coverage: EN Decrease coverage: EN	Increase coverage: EN Decrease coverage: EN	Increase coverage: EN Decrease coverage: EN	Add Coverage[14]: H2 Increase coverage[14]: H2	Add Coverage[14] Increase coverage[14] Drop Coverage[15]	Add Coverage[14]: T, H2 Add sp/dep[14]: T, H2	Add Coverage[14]: T, H2 Add sp/dep[14]: T, H2	Increase coverage: EN Decrease coverage: EN
1.4 Event Causing Employee's Dependent to Satisfy or Cease to Satisfy Eligibility Requirement*											
1.4.1 Dependent Gains Eligibility under Employee's Plan	P-8	Add dependents: C,T	Add dependents: C,T	Increase coverage: EN Decrease coverage: EN	Increase coverage: EN Decrease coverage: EN	Increase coverage: EN Decrease coverage: EN	Add Coverage[16]: C Increase coverage[16]: C	Add Coverage[8]: C2 Increase coverage[8]: C2	Add dependents: C,T	Add dependents: C,T	Increase coverage: EN Decrease coverage: EN
1.4.2 Dependent Loses Eligibility under Employee's Plan	P-9	Drop affected dependent: C	Drop affected dependent: C	Increase coverage: EN Decrease coverage: EN	Increase coverage: EN Decrease coverage: EN	Increase coverage: EN Decrease coverage: EN	Decrease coverage: [8] C	Decrease coverage[8]: C2	Drop affected dependent: C	Drop affected dependent: C	Increase coverage: EN Decrease coverage: EN
1.5 Change in Place of Residence of Employee, Spouse, or Dependent											
1.5.1 Move by Employee Causes Gain of Eligibility	P-10	Add Coverage: EY,C	Add Coverage: EY,C	Increase coverage: EN Decrease coverage: EN	Increase coverage: EN Decrease coverage: EN	Increase coverage: EN Decrease coverage: EN	Increase coverage[17]: C Decrease coverage[17]: C	Not applicable.	Add Coverage: EY,C	Add Coverage: EY,C	Increase coverage: EN Decrease coverage: EN
1.5.2 Move by Employee causes Loss of Eligibility	P-11	Drop and elect similar coverage: E,C,DY	Drop and elect similar coverage: E, C,DY	Increase coverage: EN Decrease coverage: EN	Increase coverage: EN Decrease coverage: EN	Increase Coverage: EN Decrease Coverage: EN	Increase coverage[17]: C Decrease coverage[17]: C	Not applicable.	Drop and elect similar coverage: E, C,DY	Drop and elect similar coverage: E, C,DY	Increase Coverage: EN Decrease Coverage: EN
1.5.3 Employee moves out of HMO Service Area*	P-12	Drop and elect similar coverage: E,C,DY	Drop and elect similar coverage: E,C,DY	Increase coverage: EN Decrease coverage: EN	Increase coverage: EN Decrease coverage: EN	Increase coverage: EN Decrease coverage: EN	No change allowed.[18]	Not applicable	Drop and elect similar coverage: E,C,DY	Drop and elect similar coverage: E,C,DY	Increase coverage: EN Decrease coverage: EN

* Can be such actions as attaining a specified age; switching between single and married, student or non-student, or any other event causing gain or loss of eligibility.

Change of Status Matrix: Acceptable Events and Actions for Mid-Year Changes

Event	P/C	Plan Class 5.1 Core Health	Plan Class 5.2 Sup Health	Plan Class 5.3 GTL	Plan Class 5.4 STD	Plan Class 5.5 LTD	Plan Class 5.7 Health FSA	Plan Class 5.8 DCAP	Plan Class 5.11 Dental	Plan Class 5.12 Vision	Plan Class 5.13 AD&D
1.5.4 Spouse's or Dependent's move causes gain of eligibility	P-13	Add sp/dep: EY,C	Add sp/dep: EY,C	Increase Coverage: EN Decrease Coverage: EN	Increase Coverage: EN Decrease Coverage: EN	Increase Coverage: EN Decrease Coverage: EN	Increase coverage[17]: C Decrease coverage[17]: C	Not applicable.	Add sp/dep: EY,C	Add sp/dep: EY,C	Increase Coverage: EN Decrease Coverage: EN
1.5.5 Spouse's or Dependent's move causes loss of eligibility	P-14	Drop sp/dep: E,C	Drop sp/dep: E,C	Increase Coverage: EN Decrease Coverage: EN	Increase Coverage: EN Decrease Coverage: EN	Increase Coverage: EN Decrease Coverage: EN	Increase coverage[17]: C Decrease coverage[17]: C	Not applicable.	Drop sp/dep: E,C	Drop sp/dep: E,C	Increase Coverage: EN Decrease Coverage: EN
2. SMALL COST CHANGES[19]											
2.1 Small Cost Changes[19]											
2.1.1 Employer- Initiated Automatic Small Cost Changes: Includes Collective Bargaining	C-3	Increase or Decrease Cost	Increase or Decrease Cost	Increase or Decrease Cost	Increase or Decrease Cost	Increase or Decrease Cost	No change allowed.	Not applicable	Increase or Decrease Cost	Increase or Decrease Cost	Increase or Decrease Cost
2.1.2[20] Employer-Submitted Automatic Small Cost Changes for Individuals[†]	C-4	Increase or Decrease Cost	Increase or Decrease Cost	Increase or Decrease Cost	Increase or Decrease Cost	Increase or Decrease Cost	No change allowed.	Not applicable	Increase or Decrease Cost	Increase or Decrease Cost	Increase or Decrease Cost
2.1.3 Employee-Initiated Small Cost Changes: DCAP Provider or Personal Policy	P-15, 16	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Increase or Decrease Cost[‡ 19]	Not applicable	Not applicable	Not applicable
3. SIGNIFICANT COST CHANGES[19]											
3.1 Significant Cost Increases[19]											
3.1.1a[20] Employer-Submitted Significant Cost Increase	C-3	Increase Costs	Increase Costs	Increase Costs	Increase Costs	Increase Costs	No change allowed.	Not applicable	Increase Costs	Increase Costs	Increase Costs

* Notice that the employee has the option of dropping the election even when similar coverage is available.
† Includes pre-established cost change parameters such as increases in life insurance triggered by salary increase or credit provisions, changes resulting from employee satisfying requirement such as stop smoking, or any similar event which changes cost of premium.
‡ No change allowed if day care provider is a relative of the employee.

Change of Status Matrix: Acceptable Events and Actions for Mid-Year Changes

Event	P/C	Plan Class 5.1 Core Health	Plan Class 5.2 Sup Health	Plan Class 5.3 GTL	Plan Class 5.4 STD	Plan Class 5.5 LTD	Plan Class 5.7 Health FSA	Plan Class 5.8 DCAP	Plan Class 5.11 Dental	Plan Class 5.12 Vision	Plan Class 5.13 AD&D
3.1.1b Permitted Response by Employee to Employer-Submitted Significant Cost Increase	P-17	Drop and elect similar coverage: DY	Drop and elect similar coverage: DY	Drop and elect similar coverage: DY	Drop and elect similar coverage: DY	Drop and elect similar coverage: DY	No change allowed.	Not applicable	Drop and elect similar coverage: DY	Drop and elect similar coverage: DY	Drop and elect similar coverage: DY
3.2 Significant Cost Decreases[19]											
3.2.1a Employer-Submitted Significant Cost Decrease		Decrease Costs	Decrease Costs	Decrease Costs	Decrease Costs	Decrease Costs	No change allowed	Not applicable	Decrease Costs	Decrease Costs	Decrease Costs
3.2.1b Permitted Response by Employee to Significant Cost Decrease	P-18	Revoke similar coverage and elect. Add Coverage	Revoke similar coverage and elect. Add Coverage	Revoke similar coverage and elect. Add Coverage	Revoke similar coverage and elect. Add Coverage	Revoke similar coverage and elect. Add Coverage	No change allowed	Not applicable	Revoke similar coverage and elect. Add Coverage	Revoke similar coverage and elect. Add Coverage	Revoke similar coverage and elect. Add Coverage
4. SIGNIFICANT CURTAILMENT OF COVERAGE											
4.1 Significant Coverage Curtailment											
4.1.1a Employer-Initiated Significant Coverage Curtailment	C-5	Document coverage curtailment	Document coverage curtailment	Document coverage curtailment	Document coverage curtailment	Document coverage curtailment	No change allowed.	No change allowed.	Document coverage curtailment	Document coverage curtailment	Document coverage curtailment
4.1.1b Permitted Response by Employee to Significant Coverage Curtailment	P-19	Drop and elect similar coverage: DN	Drop and elect similar coverage: DN	Drop and elect similar coverage: DN	Drop and elect similar coverage: DN	Drop and elect similar coverage: DN	No change allowed.	No change allowed.	Drop and elect similar coverage: DN	Drop and elect similar coverage: DN	Drop and elect similar coverage: DN
4.1.1c Permitted Response by Employee to Curtailment Resulting in Loss of Coverage*	P-20	Drop and elect similar coverage: DY	Drop and elect similar coverage: DY	Drop and elect similar coverage: DY	Drop and elect similar coverage: DY	Drop and elect similar coverage: DY	No change allowed.	No change allowed	Drop and elect similar coverage: DY	Drop and elect similar coverage: DY	Drop and elect similar coverage: DY
5. ADDITION OR IMPROVEMENT OF BENEFIT PACKAGE OPTION											
5.1 Change in Benefits Offered under Cafeteria Plan											
5.1.1a Employer Adds New Benefit or Option	C-6	Enter Benefit/Coverage Change into System	Enter Benefit/Coverage Change into System	Enter Benefit/Coverage Change into System	Enter Benefit/Coverage Change into System	Enter Benefit/Coverage Change into System	No change allowed.	Enter Benefit/Coverage Change into System	Enter Benefit/Coverage Change into System	Enter Benefit/Coverage Change into System	Enter Benefit/Coverage Change into System

* Complete loss of coverage under the benefit package option or other coverage option (such as HMO ceasing to be available where employee reside or employee losing coverage because of overall annual or lifetime limitation). Plan has discretion to treat the following as a loss of coverage: substantial decrease in medical care providers, reduction in benefits for specific type of medical condition that employee or dependents are being treated , and similar fundamental coverage loss (this leaves room for additional reasons).

Change of Status Matrix: Acceptable Events and Actions for Mid-Year Changes

Event	P/C	Plan Class 5.1 Core Health	Plan Class 5.2 Sup Health	Plan Class 5.3 GTL	Plan Class 5.4 STD	Plan Class 5.5 LTD	Plan Class 5.7 Health FSA	Plan Class 5.8 DCAP	Plan Class 5.11 Dental	Plan Class 5.12 Vision	Plan Class 5.13 AD&D
5.1.1b Permitted Response by Employee to Addition of New Benefit or Option	P-21	Revoke similar coverage and elect. Add Coverage	Revoke similar coverage and elect. Add Coverage	Revoke similar coverage and elect. Add Coverage	Revoke similar coverage and elect. Add Coverage	Revoke similar coverage and elect. Add Coverage	No change allowed.	Revoke similar coverage and elect. Add Coverage	Revoke similar coverage and elect. Add Coverage	Revoke similar coverage and elect. Add Coverage	Revoke similar coverage and elect. Add Coverage
5.1.2a Employer Drops Existing Benefit or Option	C-7	Enter Benefit/Coverage Change into System	Enter Benefit/Coverage Change into System	Enter Benefit/Coverage Change into System	Enter Benefit/Coverage Change into System	Enter Benefit/Coverage Change into System	No change allowed.	Enter Benefit/Coverage Change into System	Enter Benefit/Coverage Change into System	Enter Benefit/Coverage Change into System	Enter Benefit/Coverage Change into System
5.1.2b Permitted Response by Employee to Drop of Existing Benefit or Option	P-19	Elect similar coverage	Elect similar coverage	Elect similar coverage	Elect similar coverage	Elect similar coverage	No change allowed.	Elect similar coverage	Elect similar coverage	Elect similar coverage	Elect similar coverage
5.1.3a Employer Replaces one Benefit or Option with Similar Benefit or Option	C-8	Enter Benefit/Coverage Change into System	Enter Benefit/Coverage Change into System	Enter Benefit/Coverage Change into System	Enter Benefit/Coverage Change into System	Enter Benefit/Coverage Change into System	No change allowed.	Enter Benefit/Coverage Change into System	Enter Benefit/Coverage Change into System	Enter Benefit/Coverage Change into System	Enter Benefit/Coverage Change into System
5.1.3b Permitted Response by Employee to Replacement of Benefit or Option	P-20	No change allowed unless considered significant cost increase or coverage curtailment.*	No change allowed unless considered significant cost increase or coverage curtailment.*	No change allowed unless considered significant cost increase or coverage curtailment.*	No change allowed unless considered significant cost increase or coverage curtailment.*	No change allowed unless considered significant cost increase or coverage curtailment.*D	No change allowed.	No change allowed unless considered significant cost increase or coverage curtailment.*	No change allowed unless considered significant cost increase or coverage curtailment.*	No change allowed unless considered significant cost increase or coverage curtailment.*	No change allowed unless considered significant cost increase or coverage curtailment.*
5.1.4a Significant Improvement of Benefit or Option		Enter event in system.	Enter event in system.	Enter event in system.	Enter event in system.	Enter event in system.	No change Allowed	Not Applicable	Enter event in system.	Enter event in system.	Enter event in system.
5.1.4b Permitted Response by Employee to Significant Improvement of Benefit or Option	P-22	Revoke similar coverage and elect. Add Coverage	Revoke similar coverage and elect. Add Coverage	Revoke similar coverage and elect. Add Coverage	Revoke similar coverage and elect. Add Coverage	Revoke similar coverage and elect. Add Coverage	No change allowed.	Not applicable.	Revoke similar coverage and elect. Add Coverage	Revoke similar coverage and elect. Add Coverage	Revoke similar coverage and elect. Add Coverage
5.15 Employee changes DCAP providers	P-21	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Change Deductions to reflect new rates†	Not applicable	Not applicable	Not applicable

* See significant cost change or coverage curtailment section for employee options.

† Deductions can be changed to zero if relative is keeping child for free.

Change of Status Matrix: Acceptable Events and Actions for Mid-Year Changes

Event	P/C	Plan Class 5.1 Core Health	Plan Class 5.2 Sup Health	Plan Class 5.3 GTL	Plan Class 5.4 STD	Plan Class 5.5 LTD	Plan Class 5.7 Health FSA	Plan Class 5.8 DCAP	Plan Class 5.11 Dental	Plan Class 5.12 Vision	Plan Class 5.13 AD&D
5.16 DCAP Provider FN changed rates	P-22	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Change Deductions to reflect new rates*			
6. CHANGE IN COVERAGE UNDER ANOTHER EMPLOYER PLAN†											
6.1 Change in Coverage of Spouse or Dependent under Another Employer Plan‡											
6.1.1 Another Employer Plan Adds or Increases Coverage[20]	P-23, P-25	Drop Coverage[21] Drop sp/dep[21]	Drop Coverage[21] Drop sp/dep[21]	Drop Coverage[21] Decrease coverage[21]	Drop Coverage[21] Decrease coverage[21]	Drop Coverage[21] Decrease coverage[21]	No change allowed.	Drop Coverage[21] Decrease coverage[21]	Drop Coverage[21] Drop sp/dep[21]	Drop Coverage[21] Drop sp/dep[21]	Drop Coverage[21] Decrease coverage[21]
6.1.2 Another Employer Plan Drops or Decreases Coverage[20]	P-24 P-26	Add Coverage[22] Add sp/dep[22]	Add Coverage[22] Add sp/dep[22]	Add Coverage[22] Increase coverage: [22]	Add Coverage[22] Increase coverage: [22]	Add Coverage[22] Increase coverage: [22]	No change allowed.	Add Coverage[22] Increase coverage: [22]	Add Coverage[22] Add sp/dep[22]	Add Coverage[22] Add sp/dep[22]	Add Coverage[22] Increase coverage: [22]
6.1.3 Open Enrollment under Employer Plan of Spouse or dependent'	P-27	Add Coverage[22] Add sp/dep[22] Drop Coverage[21] Drop sp/dep[21]	Add Coverage[22] Add sp/dep[22] Drop Coverage[21] Drop sp/dep[21]	Add Coverage[22] Increase coverage[22] Drop Coverage[21] Decrease coverage[21]	Add Coverage[22] Increase coverage[22] Drop Coverage[21] Decrease coverage[21]	Add Coverage[22] Increase coverage[22] Drop Coverage[21] Decrease coverage[21]	No change allowed.	Add Coverage[22] Increase coverage[22] Drop Coverage[21] Decrease coverage[21]	Add Coverage[22] Add sp/dep[22] Drop Coverage[21] Drop sp/dep[21]	Add Coverage[22] Add sp/dep[22] Drop Coverage[21] Drop sp/dep[21]	Add Coverage[22] Increase coverage[22] Drop Coverage[21] Decrease coverage[21]
6.1.4 Employee, Spouse, or Dependent loses coverage under group health plan of a governmental or educational institution‡	P-29 P-30	Add Coverage§ Add affected dependent	Add Coverage** Add affected dependent	Not Applicable	Not Applicable	Not Applicable	No change allowed.	Not Applicable	Add Coverage** Add affected dependent	Add Coverage** Add affected dependent	Not Applicable

* DCAP Provider cannot be relative.
* Rates cannot be changed if the Day Care Provider is a relative.
† The employer plan can be a cafeteria plan or qualified benefits plan of the same employer or of another employer,
‡ Includes (a) A State's child health insurance program (SCHIP) under Title XXI of the Soicial Security Act, (b) a medical care program of an Indian Tribal government (as defined in Section 7701(a)(40)), the Indian Health Service, or a tribal organization, (c) a State health benefits risk pool, or (d) a Foreign government group health plan.
§ Evidently, only the affected person can be added. If so, the only time coverage previously not elected can only be added if the affected individual is the employee.

Change of Status Matrix: Acceptable Events and Actions for Mid-Year Changes

Event	P/C	Plan Class 5.1 Core Health	Plan Class 5.2 Sup Health	Plan Class 5.3 GTL	Plan Class 5.4 STD	Plan Class 5.5 LTD	Plan Class 5.7 Health FSA	Plan Class 5.8 DCAP	Plan Class 5.11 Dental	Plan Class 5.12 Vision	Plan Class 5.13 AD&D
7. FMLA LEAVE											
7.1 Commencement of FMLA Leave											
7.1.1 Employee begins FMLA Leave	P-31	Revoke election and make another election as provided under FMLA	Revoke election and make another election as provided under FMLA	Revoke election and make another election as provided under FMLA	Revoke election and make another election as provided under FMLA	Revoke election and make another election as provided under FMLA	Revoke election and make another election as provided under FMLA	Revoke election and make another election as provided under FMLA	Revoke election and make another election as provided under FMLA	Revoke election and make another election as provided under FMLA	Revoke election and make another election as provided under FMLA
7.2 Return from FMLA Leave											
7.2.1 Employee returns from FMLA Leave	P-32	Make new election if coverage terminated under FMLA	Make new election if coverage terminated under FMLA	Make new election if coverage terminated under FMLA	Make new election if coverage terminated under FMLA	Make new election if coverage terminated under FMLA	Make new election if coverage terminated under FMLA	Make new election if coverage terminated under FMLA	Make new election if coverage terminated under FMLA	Make new election if coverage terminated under FMLA	Make new election if coverage terminated under FMLA
8. COBRA EVENTS											
8.1 COBRA (or similar state law continuation) Events											
8.1.1 Employee COBRA Event with Employee remaining eligible for Cafeteria Plan*	P-33	Increase coverage[23]	Increase coverage[23]	No change allowed	No change allowed	No change allowed	No change allowed	No change allowed	Increase coverage [23]	Increase coverage [23]	No change allowed.
8.1.2 Spouse/Dependent COBRA Event†.	P-34	Increase coverage [23 24]	Increase coverage[23 24]	No change allowed	No change allowed	No change allowed	No change allowed	No change allowed	Increase coverage [23 24]	Increase coverage [23 24]	Increase coverage [23 24]
9. JUDGMENT, DECREE, OR ORDER											
9.1 Judgment, Decree, or Order Requires Coverage of Code § 152 Dependent Child to be Provided by Employee											
9.1.1 Judgment, Decree, or Order Requires Coverage under Employee's Plan	P-35	Add Coverage: C Add affected dependent	Add Coverage: C Add affected dependent	No change allowed.	No change allowed.	No change allowed.	Add Coverage: C Increase coverage	No change allowed.	Add Coverage: C Add affected dependent	Add Coverage: C Add affected dependent	No change allowed.

* Such as reduction in work hours resulting in employee no longer eligible for employer contribution credit.

† Such as dependent reaching maximum age under group plan and employee continues coverage for dependent under COBRA.

Change of Status Matrix: Acceptable Events and Actions for Mid-Year Changes

Event	P/C	Plan Class 5.1 Core Health	Plan Class 5.2 Sup Health	Plan Class 5.3 GTL	Plan Class 5.4 STD	Plan Class 5.5 LTD	Plan Class 5.7 Health FSA	Plan Class 5.8 DCAP	Plan Class 5.11 Dental	Plan Class 5.12 Vision	Plan Class 5.13 AD&D
9.2 Judgment, Decree, or Order Requires Coverage of Code § 152 Dependent to be Provided by Spouse, Former Spouse, or Other Person											
9.2.1 Judgment, Decree, or Order Requires Spouse, Former Spouse, or Other Person to Provide Coverage	P-36	Drop affected dependent: C3	Drop affected dependent: C3	No change allowed.	No change allowed.	No change allowed.	Decrease coverage: C3	No change allowed.	Drop affected dependent: C3	Drop affected dependent: C3	No change allowed.
10. ENTITLEMENT TO MEDICARE OR MEDICAID*											
10.1 Employee or Employee's Spouse or Dependent Becomes Entitled to Medicare and Medicaid *											
10.1.1 Employee Becomes Entitled	P-37	Drop Coverage	No change allowed.	No change allowed.	No change allowed.	No change allowed.	Decrease coverage: C Increase coverage[25]	No change allowed.	No change allowed.	No change allowed.	No change allowed.
10.1.2 Spouse/Dependent under Employer's Plan Becomes Entitled	P-38	Drop sp/dep:	No change allowed.	No change allowed.	No change allowed.	No change allowed.	Decrease coverage: C Increase coverage[25]	No change allowed.	No change allowed.	No change allowed.	No change allowed.
10.2 Employee or Employee's Sp/dep Loses Eligibility for Medicare and Medicaid											
10.2.1 Employee Loses Eligibility	P-39	Add Coverage: C	No change allowed.	No change allowed.	No change allowed.	No change allowed.	Increase coverage: C Decrease[26] coverage	No change allowed.	No change allowed.	No change allowed.	No change allowed.
10.2.2 Spouse/Dependent under Employer's Plan Loses Eligibility	P-40	Add sp/dep: C	No change allowed.	No change allowed.	No change allowed.	No change allowed.	Increase coverage: C Decrease coverage[26]	No change allowed.	No change allowed.	No change allowed.	No change allowed.
11. ADMINISTRATIVE EVENTS											
11.1 Correcting Obvious Errors†											
11.1.1 Employee mistake in an making election	C-9	Make administrative changes as needed.	Make administrative changes as needed.	Make administrative changes as needed.	Make administrative changes as needed.	Make administrative changes as needed.	Make administrative changes as needed.	Make administrative changes as needed.	Make administrative changes as needed.	Make administrative changes as needed.	Make administrative changes as needed.

* Other than coverage solely for pediatric vaccines.
† Must have "clear and convincing" evidence.

Change of Status Matrix: Acceptable Events and Actions for Mid-Year Changes

Event	P/C	Plan Class 5.1 Core Health	Plan Class 5.2 Sup Health	Plan Class 5.3 GTL	Plan Class 5.4 STD	Plan Class 5.5 LTD	Plan Class 5.7 Health FSA	Plan Class 5.8 DCAP	Plan Class 5.11 Dental	Plan Class 5.12 Vision	Plan Class 5.13 AD&D
11.1.2 Employer mistake in recording election	C-10	Make administrative changes as needed.	Make administrative changes as needed.	Make administrative changes as needed.	Make administrative changes as needed.	Make administrative changes as needed.	Make administrative changes as needed.	Make administrative changes as needed.	Make administrative changes as needed.	Make administrative changes as needed.	Make administrative changes as needed.
11.2 Employee Fails Medical Underwriting											
11.2.1 Participant fails medical underwriting	C-11	Not applicable	Revoke coverage as of date it was added.	Revoke coverage as of date it was added.	Revoke coverage as of date it was added.	Revoke coverage as of date it was added.	Not applicable	Not applicable	Not applicable	Not applicable	Revoke coverage as of date it was added.
11.3 Adjustments to Meet Federal Requirements[19]											
11.3.1 Changes needed to maintain plan's status under Code § 125 or to prevent violation of the nondiscrimination rules.	C-12	Make administrative changes as needed: C	Make administrative changes as needed: C	Make administrative changes as needed: C	Make administrative changes as needed: C	Make administrative changes as needed: C	Make administrative changes as needed: C	Make administrative changes as needed: C	Make administrative changes as needed: C	Make administrative changes as needed: C	Make administrative changes as needed: C

Notes:

- Change in eligibility for non-employer-sponsored coverage (other than Medicare and Medicaid) will not allow a change.
- Dependent is defined to be a tax dependent under Code § 152 except, for accident or health coverage, any child to whom Code § 152(e) applies is treated as a dependent of both parents.
- Health FSA coverage can never be changed solely on account of a change in cost or coverage under another plan.
- Increase coverage can be increases in volume, dollar, or amount.
- A plan may treat coverage by another employer, such as a spouse's or dependent's employer, as similar coverage.

Change of Status Matrix: Acceptable Events and Actions for Mid-Year Changes

CODES USED IN MATRIX

C....... Must be consistent with change.

C1..... Only if coverage for individual becomes effective or is increased under the other employer's plan.

C2..... Consistency rule is satisfied if the election change is on account of and corresponds with a change of status that either (1) affects eligibility for coverage under an employer's plan or (2) affects eligibility of DCAP expenses for tax exclusions under Code § 129.

C3 ... Coverage for the affected dependent cannot be dropped unless the coverage is actually picked up by the spouse, former spouse, or other person.

DY .... Can drop altogether if alternative coverage is not available.

DN .... Cannot drop even if alternative coverage is not available.

D....... Can drop even if alternative coverage is available.

E....... Eligibility must be affected.

EN .... Eligibility need not be impacted.

EY..... Eligibility must be gained.

H1..... HIPAA special enrollment rights apply. (Retroactive election changes are only allowed for changes resulting from birth, adoption, or placement for adoption submitted within 30 days of event.)

H2..... HIPAA special enrollment rights likely do not apply.

H3..... HIPAA special enrollment rights do not apply.

PD .... Must be addressed in Plan Document.

T....... Tag-Along Rule applies (can change for dependents who were previously eligible for coverage).

---

[1] If employee or dependents become eligible dependents under new spouse's health plan.

[2] If change creates or increases need for child care.

[3] If spouse is not employed or makes DCAP FSA election on spouse's employer's Plan

[4] If eligibility is lost under spouse's plan as a result of the divorce, legal separation, annulment or death

[5] Only if coverage is lost under spouse's major medical plan.

[6] To take into account expenses of affected spouse.

[7] If change decreases or negates need for day care

[8] To take into account expenses of affected dependent.

[9] Can have Plan Documents prohibit participation until next plan year.

[10] Balances and current annual election remain the same and employee cannot be made to make up missed contributions.

[11] Underlying coverages ceases in accordance with component plan.

[12] If added to spouse's or dependent's coverage.

[13] If spouse previously did not work.

[14] If dropped from spouse's or dependent's coverage.

[15] If spouse no longer works.

[16] Only if dependent gains eligibility under Health FSA.

[17] If underlying health coverage change occurs.

[18] Not even if underlying health coverage change occurs.

[19] Must be addressed in plan documents.

[20] Includes cost changes resulting from actions taken by employee, such as switching from full-time to part-time or vice-versa.

[21] If employee, spouse, or dependent have received corresponding increased coverage or added coverage under other employer's plan.

[22] If employee, spouse, or dependent have received corresponding decreased coverage or dropped coverage under other employer's plan.

[23] To cover increased amount of employee's contribution.
[24] If individual still qualifies as tax dependent of employee.
[25] Only if prior employer coverage was more comprehensive.
[26] On if the employer plan is more comprehensive.