STATE OF TEXAS §
§
COUNTY OF FORT BEND §

THIRD AMENDMENT TO
AGREEMENT FOR THIRD PARTY CLAIMS ADMINISTRATION SERVICES
PURSUANT TO RFP 16-086

THIS THIRD AMENDMENT OF THE AGREEMENT FOR THIRD PARTY CLAIMS ADMINISTRATION SERVICES PURSUANT TO RFP 16-086 is made and entered into by and between FORT BEND COUNTY, TEXAS, is made and entered into is entered into by and between Fort Bend County, (hereinafter "County"), a body corporate and politic under the laws of the State of Texas, and Boon Chapman Benefit Administrators, Inc., (hereinafter "Boon Chapman") a company authorized to conduct business in the State of Texas.

W I T N E S S E T H

WHEREAS, on or about December 20, 2016, the Parties entered into AGREEMENT FOR THIRD PARTY CLAIMS ADMINISTRATION SERVICES PURSUANT TO RFP 16-086, which was amended on September 26, 2017 and again amended November 20, 2017 attached hereto as "Exhibit One" and "Exhibit "Two," both incorporated by reference:

WHEREAS, the Parties reserved the right during the course of the Agreement or any renewal period to add any service that was offered as an optional service by Contractor in Contractor's original response to RFP 16-086, but not included as part of the Original Agreement;

WHEREAS, the Parties now desire to amend to renew that Agreement and add an optional service; and

NOW THEREFORE, for and in consideration of the mutual benefits to be derived by the parties hereto, County, and Contractor agree as follows:

A. The Agreement is hereby renewed; effective January 1, 2018 and shall terminate on December 31, 2018. Terms, conditions, pricing and additional renewal periods shall remain the same except as noted herein. Upon termination, this Agreement may be renewed on the same terms and conditions at County's sole discretion. Either party shall have the right to terminate this Agreement as provided in Exhibit One.

B. Section One, Services to be Provided by Boon Chapman is amended as follows:

1.1 Boon Chapman shall perform Third Party Claims Administration Services (hereinafter "Services") for the Fort Bend County Medical, Dental and Cafeteria plans (hereinafter "Benefit Plans") (that meet or exceed the minimum

requirements of RFP 16-086 with the exception of Section 5.0 and Section 6.0) (attached and incorporated as Exhibit A) and as described in the Scope of Work (attached and incorporated as Exhibit B). Effective January 1, 2018, Boon Chapman shall perform Pharmacy Benefit Management ("PBM") services as described in the PBM Scope of Work (attached and incorporated as Exhibit G. Effective January 1, 2018, Boon Chapman shall perform Stop-Loss coverage services as described in the Stop Loss Scope of Work (attached and incorporated as Exhibit H).

C. Section 5, Limit of Appropriation, is amended to permit additional funding to the total maximum annual compensation that Boon Chapman may become entitled to under the Agreement. The Parties agree that Section 5.1 shall now read:

> Boon Chapman does further understand and agree, said understanding and agreement also being of the absolute essence of this Agreement, that the total maximum annual compensation that Boon Chapman may become entitled to for capitated fees, unless there is an increase in enrollment, and the total maximum sum that County may become liable to pay to Boon Chapman shall not under any conditions, circumstances, or interpretations thereof exceed $2,000,000.00.

D. Section 25, Conflict, is amended as follows:

> In the event there is a conflict, the following have priority with regard to the conflict: first: this document titled "THIRD AMENDMENT OF THE AGREEMENT FOR THIRD PARTY CLAIMS ADMINISTRATION SERVICES PURSUANT TO RFP 16-086;" second: "AGREEMENT FOR THIRD PARTY CLAIMS ADMINISTRATION SERVICES PURSUANT TO RFP 16-086**;"** third: Exhibit D Business Associates Agreement; fourth: RFP 16-086 fifth: Exhibit C: Fee Schedule; and sixth: Exhibit G: PBM Scope of Work. Exhibit E: Security Policies and Exhibit F: Boon Chapman Original Response dated May 16, 2016, Optional Services will have no priority with regard to any conflict because they are included only for reference.

E. Except as modified herein, any prior executed document remain in full force and effect and has not been modified or amended.

IN TESTIMONY OF WHICH, THIS AMENDMENT shall be effective upon execution of all parties.

"County"
FORT BEND COUNTY

By: _____
Robert E. Hebert, County Judge

ATTEST:

Date: _____

_____
Laura Richard, County Clerk

"Contractor"
Boon Chapman Benefit Administrators, Inc.,

By: _____

Name: _____

Title: _____

Date: _____

ATTEST:

_____ Date: _____
Name

AUDITOR'S CERTIFICATE

I hereby certify that funds are available in the amount of_____ to accomplish and pay the obligation of Fort Bend County under this contract.

_____
Robert Edward Sturdivant, County Auditor

Attachments

Exhibit One: AGREEMENT FOR THIRD PARTY CLAIMS ADMINISTRATION SERVICES PURSUANT TO RFP 16-086 AND FIRST AMENDMENT TO AGREEMENT FOR THIRD PARTY CLAIMS ADMINISTRATION SERVICES PURSUANT TO RFP 16-086

Exhibit Two: SECOND AMENDMENT TO AGREEMENT FOR THIRD PARTY CLAIMS ADMINISTRATION SERVICES PURSUANT TO RFP 16-086

Exhibit H: Stop Loss Scope of Work

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EXHIBIT ONE:

AGREEMENT FOR THIRD PARTY CLAIMS ADMINISTRATION SERVICES PURSUANT TO RFP 16-086 AND FIRST AMENDMENT TO AGREEMENT FOR THIRD PARTY CLAIMS ADMINISTRATION SERVICES PURSUANT TO RFP 16-086

STATE OF TEXAS §
§
COUNTY OF FORT BEND §

AGREEMENT FOR THIRD PARTY CLAIMS ADMINISTRATION SERVICES
PURSUANT TO RFP 16-086

THIS AGREEMENT is made and entered into by and between Fort Bend County, (hereinafter "County"), a body corporate and politic under the laws of the State of Texas, and Boon Chapman Benefit Administrators, Inc., (hereinafter "Boon Chapman"), a company authorized to conduct business in the State of Texas.

WITNESSETH

WHEREAS, County desires that Boon Chapman provide Third Party Claims Administration Services for the Fort Bend County Medical, Dental and Cafeteria plans pursuant to RFP 16-086; and

WHEREAS, Boon Chapman represents that it is qualified and desires to perform such services.

NOW, THEREFORE, in consideration of the mutual covenants and conditions set forth below, the parties agree as follows:

AGREEMENT

Section 1. Services to be Provided by Boon Chapman

1.1 Boon Chapman shall perform Third Party Claims Administration Services (hereinafter "Services") for the Fort Bend County Medical, Dental and Cafeteria plans (hereinafter "Benefit Plans") (that meet or exceed the minimum requirements of RFP 16-086 with the exception of Section 5.0 and Section 6.0) (attached and incorporated as Exhibit A) and as described in the Scope of Work (attached and incorporated as Exhibit B).

1.2 The Parties reserve the right to add any service that was offered as an optional service by Boon Chapman in Boon Chapman's original response to RFP 16-086, but not included as part of this Original Agreement, during the course of the Agreement or any renewal period. A copy of the Boon Chapman Original Response dated May 16, 2016, Optional Services is attached as Exhibit F for reference only to document those services and prices that were offered by Boon Chapman for future consideration. Additional services may only be added by a written amendment to this Agreement, signed by both Parties.

1.3 It is understood and agreed that County retains complete authority and responsibility for the Benefit Plans, their operation, and the benefits provided there under, and that

Boon Chapman is empowered to act on behalf of County in connection with the Benefit Plans only to the extent expressly stated in this Agreement or as agreed to in writing by Boon Chapman and County.

Section 2. Personnel

2.1 Boon Chapman represents that it presently has, or is able to obtain, adequate qualified personnel in its employment for the timely performance of the Services required under this Agreement and that Boon Chapman shall furnish and maintain, at its own expense, adequate and sufficient personnel, in the opinion of County, to perform the Services when and as required and without delays.

2.2 All employees of Boon Chapman shall have such knowledge and experience as will enable them to perform the duties assigned to them. Any employee of Boon Chapman who, in the opinion of County, is incompetent or by his conduct becomes detrimental to the project shall, upon request of County, immediately be removed from association with the project.

Section 3. County Responsibilities

3.1 It is mutually understood that the effective performance of Services by Boon Chapman under this Agreement will require that the County furnish to Boon Chapman timely reports and information in a form and manner specified by Boon Chapman. Such reports and information shall include timely additions, deletions and changes in eligibility, including address and name changes.

3.2 If County fails to furnish any required information promptly, Boon Chapman shall not be responsible for any delay in the performance of the actuarial, claim, and underwriting services caused by this failure, if the delay is due to County's negligent failure to provide the information.

3.3 County will establish an account for the Services at a bank of County's choice. The amounts needed for this account shall be determined upon Boon Chapman providing County with a list of all Benefit Plans costs at the inception of the Benefit Plans, monthly thereafter and as requested. This will include the cost for coverage of each covered person. The list will be maintained by Boon Chapman and adjusted regularly, based on additions, deletions, and changes provided to Boon Chapman by County.

A. Claims will be paid from this account.

B. County will deposit funds to the account sufficient to cover claims as they are adjudicated and processed by Boon Chapman. County, by execution of this agreement, expressly authorizes Boon Chapman to issue drafts on the account

for payment of benefits. Boon Chapman will not release such drafts until sufficient funds are deposited to cover them.

C. County may deposit funds into the account for payments of insurance and or reinsurance premiums, administrative expenses, and other charges related to the Benefit Plans that may be authorized by County.

D. County may authorize and instruct Boon Chapman to issue drafts on the account for payment of such expenses that shall have been authorized by County.

3.4 County will remit funds for payments of insurance and or reinsurance premiums, on behalf of the Services, County or covered persons, administrative services, and other expenses that have been authorized by County and that Boon Chapman has agreed to disburse to the appropriate parties. The funds shall be provided to Boon Chapman not later than the tenth day after the first day of the month in which they are due. The funds may be remitted directly to Boon Chapman or deposited into the bank account referenced in this Section of the Agreement.

3.5 County shall give written notice to all Covered Persons of the identity of Boon Chapman and the relationship of Boon Chapman to County.

Section 4. Compensation and Payment

4.1 Boon Chapman shall be compensated in accordance with the Service and Fee schedule attached and incorporated as Exhibit C. The Parties acknowledge and agree that County is exempt from taxes.

4.2 County will pay Boon Chapman based on the following procedures: Monthly, Boon-Chapman will send the County invoice for the fees described in Exhibit C showing the amounts due for services performed in a form acceptable to County. County shall review such invoices and approve them within 30 calendar days with such modifications as are consistent with this Agreement and forward same to the Auditor for processing. County shall pay each such approved invoice within thirty (30) calendar days. County reserves the right to withhold payment pending verification of satisfactory work performed.

Section 5. Limit of Appropriation

5.1 Boon Chapman does further understand and agree, said understanding and agreement also being of the absolute essence of this Agreement, that the total maximum annual compensation that Boon Chapman may become entitled to for capitated fees, unless there is an increase in enrollment, and the total maximum sum that County may become liable to pay to Boon Chapman shall not under any conditions, circumstances, or interpretations thereof exceed $835,000.

5.2 Notwithstanding anything contained in this Agreement to the contrary, in the event no funds or insufficient funds are appropriated or budgeted or otherwise available during a fiscal year for fees under this Services Agreement or for payment of costs and expenses for Covered Persons under this Services Agreement, County shall immediately notify Boon Chapman in writing of such occurrence and this Agreement shall terminate on the last day of the month for which appropriations have been received or made without penalty or expense to County, except as to portions of fees or expenses which have been incurred and for which funds have been appropriated or budgeted from a prior year or are otherwise available.

Section 6. Modifications and Waivers

6.1 The parties may not amend or waive this Agreement, except by a written agreement executed by both parties.

6.2 No failure or delay in exercising any right or remedy or requiring the satisfaction of any condition under this Agreement, and no course of dealing between the parties, operates as a waiver or estoppel of any right, remedy, or condition.

6.3 The rights and remedies of the parties set forth in this Agreement are not exclusive of, but are cumulative to, any rights or remedies now or subsequently existing at law, in equity, or by statute.

Section 7. Term and Termination

7.1 The term of this Agreement shall be for a period of twelve months, commencing on January 1, 2017, and ending at the close of business on December 31, 2017, with five additional one-year renewal options at County's sole discretion. Renewals shall be under on the same terms and conditions, except that pricing may be negotiated in accordance with Exhibit C. Either party shall have the right to terminate this Agreement as provided herein.

7.2 Termination for Convenience: County may terminate this Agreement at any time upon thirty (30) days written notice issued by County.

7.3 Termination for Default

A. County may terminate the whole or any part of this Agreement for cause if Boon Chapman materially breaches any of the covenants or terms and conditions set forth in this Agreement or fails to perform any of the other provisions of this Agreement or so fails to make progress as to endanger performance of this Agreement in accordance with its terms, and in any of these circumstances does not cure such breach or failure to County's reasonable satisfaction within a

period of ten (10) calendar days after receipt of notice from County specifying such breach or failure.

B. If, after termination, it is determined by County that for any reason whatsoever that Boon Chapman was not in default, or that the default was excusable, services may continue in accordance with the terms and conditions of this Agreement or the rights and obligations of the parties shall be the same as if the termination had been issued for the convenience of the County in accordance with this Section.

7.4 Upon termination of this Agreement, County shall compensate Boon Chapman for those services which were provided under this Agreement prior to its termination and which have not been previously invoiced to County. Boon Chapman's final invoice for said services will be presented to and paid by County in the same manner set forth in the Compensation Section above.

7.5 If County terminates this Agreement as provided in this Section, no fees of any type, other than fees due and payable at the Termination Date, shall thereafter be paid to Boon Chapman.

Section 8. Ownership and Reuse of Documents

8.1 All documents, data, reports, graphic presentation materials, etc., developed for County by Boon Chapman as a part of its work under this Agreement, shall become the property of County upon completion of this Agreement, or in the event of termination or cancellation thereof, at the time of payment for work performed.

8.2 County's right of ownership under this Section shall not include Contractor's proprietary underlying research or data used for compilation of the materials for County.

8.3 At all times during the Agreement and upon termination, Boon Chapman shall promptly furnish copies of all such data and material to County on request but no later than 15 days after the request was received. Contractor shall mark any materials believed to be proprietary prior to delivery of same.

Section 9. Inspection of Books and Records

Boon Chapman will permit County, or any duly authorized agent of County, to inspect and examine the books and records of Boon Chapman for the purpose of verifying the Services performed County's right to inspect survives the termination of this Agreement for a period of four years.

Section 10. Insurance

10.1 Prior to commencement of the Services, Boon Chapman shall furnish County with properly executed certificates of insurance which shall evidence all insurance required and provide that such insurance shall not be canceled, except on 60 days' prior written notice to County. Boon Chapman shall provide certified copies of insurance endorsements and/or policies if requested by County. Boon Chapman shall maintain such insurance coverage from the time Services commence until Services are completed and provide replacement certificates, policies and/or endorsements for any such insurance expiring prior to completion of Services. Boon Chapman shall obtain such insurance written on an Occurrence form from such companies having Bests rating of A/VII or better, licensed or approved to transact business in the State of Texas, and shall obtain such insurance of the following types and minimum limits:

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

B. Employers' Liability insurance with limits of not less than $500,000 per injury by accident, $500,000 per injury by disease, and $500,000 per bodily injury by disease.

C. 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 and property damage and products/completed operations arising out of the business operations of the policyholder.

D. Third Party Claims Administration Professional Liability insurance with limits not less than $2,000,000 each claim/annual aggregate.

E. Crime coverage with limits of $500,000 per occurrence/$1,000,000 in aggregate.

10.2 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). Workers Compensation shall contain a waiver of subrogation in favor of County and members of Commissioners Court.

10.3 If required coverage is written on a claims-made basis, Boon Chapman 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.

10.4 Boon Chapman 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 Fort Bend County.

10.5 No cancellation of or changes to the certificates, or the policies, may be made without thirty (30) days prior, written notification to Fort Bend County.

10.6 Approval of the insurance by Fort Bend County shall not relieve or decrease the liability of Boon Chapman.

Section 11. Indemnity

11.1 **BOON CHAPMAN SHALL SAVE HARMLESS COUNTY FROM AND AGAINST ALL CLAIMS, LIABILITY, AND EXPENSES, INCLUDING REASONABLE ATTORNEY'S FEES, ARISING FROM ACTIVITIES OF BOON CHAPMAN, ITS AGENTS, SERVANTS OR EMPLOYEES, PERFORMED UNDER THIS AGREEMENT THAT RESULT FROM THE GROSSLY NEGLIGENT ACT, ERROR, OR OMISSION OF BOON CHAPMAN OR ANY OF BOON CHAPMAN'S AGENTS, SERVANTS OR EMPLOYEES.**

11.2 Boon Chapman shall timely report all such matters to Fort Bend County and shall, upon the receipt of any such claim, demand, suit, action, proceeding, lien or judgment, not later than the fifteenth day of each month; provide Fort Bend County with a written report on each such matter, setting forth the status of each matter, the schedule or planned proceedings with respect to each matter and the cooperation or assistance, if any, of Fort Bend County required by Boon Chapman in the defense of each matter.

11.3 Boon Chapman's duty to defend, indemnify and hold Fort Bend County harmless shall not abate or end by reason of the expiration or termination of any contract unless otherwise agreed by Fort Bend County in writing. The provisions of this section shall survive the termination of the contract and shall remain in full force and effect with respect to all such matters no matter when they arise.

11.4 The provision by Boon Chapman of insurance shall not limit the liability of Boon Chapman under an agreement.

11.5 Loss Deduction Clause - Fort Bend County shall be exempt from, and in no way liable for, any sums of money which may represent a deductible in any insurance policy. The payment of deductibles shall be the sole responsibility of Boon Chapman and/or trade Boon Chapman providing such insurance.

Section 12. Confidential and Proprietary Information

12.1 Boon Chapman acknowledges that it and its employees or agents may, in the course of performing their responsibilities under this Agreement, be exposed to or acquire information that is confidential to County. Any and all information of any form obtained by Boon Chapman or its employees or agents from County in the performance of this Agreement that the County has informed Boon-Chapman is confidential shall be deemed to be confidential information of County ("Confidential Information"). Any reports or other documents or items (including software) that result from the use of the Confidential Information by Boon Chapman shall be treated with respect to confidentiality in the same manner as the Confidential Information. Confidential Information shall be deemed not to include information that (a) is or becomes (other than by disclosure by Boon Chapman) publicly known or is contained in a publicly available document; (b) is rightfully in Boon Chapman's possession without the obligation of nondisclosure prior to the time of its disclosure under this Agreement; or (c) is independently developed by employees or agents of Boon Chapman who can be shown to have had no access to the Confidential Information.

12.2 Boon Chapman agrees to hold Confidential Information in strict confidence, using at least the same degree of care that Boon Chapman uses in maintaining the confidentiality of its own confidential information, and not to copy, reproduce, sell, assign, license, market, transfer or otherwise dispose of, give, or disclose Confidential Information to third parties or use Confidential Information for any purposes whatsoever other than the provision of Services to County hereunder, and to advise each of its employees and agents of their obligations to keep Confidential Information confidential. Boon Chapman shall use its best efforts to assist County in identifying and preventing any unauthorized use or disclosure of any Confidential Information. Without limitation of the foregoing, Boon Chapman shall advise County immediately in the event Boon Chapman learns or has reason to believe that any person who has had access to Confidential Information has violated or intends to violate the terms of this Agreement and Boon Chapman will at its expense cooperate with County in seeking injunctive or other equitable relief in the name of County or Boon Chapman against any such person. Boon Chapman agrees that, except as directed by County, Boon Chapman will not at any time during or after the term of this Agreement disclose, directly or indirectly, any Confidential Information to any person, and that upon termination of this Agreement or at County's request, Boon Chapman will promptly turn over to County all documents, papers, and other matter in Boon Chapman's possession which embody Confidential Information.

12.3 Boon Chapman acknowledges that a breach of this Section, including disclosure of any Confidential Information, or disclosure of other information that, at law or in equity, ought to remain confidential, will give rise to irreparable injury to County that is inadequately compensable in damages. Accordingly, County may seek and obtain injunctive relief against the breach or threatened breach of the foregoing undertakings,

in addition to any other legal remedies that may be available. Boon Chapman acknowledges and agrees that the covenants contained herein are necessary for the protection of the legitimate business interest of County and are reasonable in scope and content.

12.4 Boon Chapman in providing all services hereunder agrees to abide by the provisions of any applicable Federal or State Data Privacy Act.

12.5 Boon Chapman expressly acknowledges that County is subject to the Texas Public Information Act, TEX. GOV'T CODE ANN. §§ 552.001 et seq., as amended, and notwithstanding any provision in the Agreement to the contrary, County will make any information related to the Agreement, or otherwise, available to third parties in accordance with the Texas Public Information Act. Any proprietary or confidential information marked as such provided to County by Boon Chapman shall not be disclosed to any third party, except as directed by the Texas Attorney General in response to a request for such under the Texas Public Information Act, which provides for notice to the owner of such marked information and the opportunity for the owner of such information to notify the Attorney General of the reasons why such information should not be disclosed. The terms and conditions of the Agreement are not proprietary or confidential information.

12.6 In accordance with the services being provided under the Services Agreement, Boon Chapman will have access to, create and/or receive certain Protected Health Information thus necessitating a written agreement that meets the applicable requirements of the privacy and security rules promulgated by the Federal Department of Health and Human Services. County and Boon Chapman mutually agree to satisfy the foregoing regulatory requirements through execution of the Business Associates Agreement incorporated and attached as Exhibit D to the Services Agreement. As of the effective dates set forth therein, the provisions of Business Associates Agreement supersede any other provision of the Services Agreement, which may be in conflict with such Business Associates Agreement on or after the applicable effective date.

12.7 Contractor has represented that Contractor has implemented the attached Security Policies and has further represented that they meet or exceed industry standards in Data Privacy and Security. A copy of the current policies is attached as Exhibit E for reference only to document the policies that Contractor represents meet or exceed industry standards and upon which County has relied in selecting Contractor. Contractor shall ensure that these policies are updated if law or industry standards mandate stricter requirements. Upon request, a copy of any updated policies will be provided to County without delay. Contractor shall also ensure all employees are trained to adhere to the requirements of their current polices and as may be updated during the course of the Agreement.

12.8 Upon termination of this Service Agreement, Boon Chapman shall provide notice to all affected individuals and facilitate the transfer of any needed records to any subsequent Service Provider as directed by County. Copies of records shall be made available in accordance with law and this Agreement. Boon Chapman may charge reasonable copy fees for copies provided that the charges do not exceed the amounts set by the Texas Public Information Act.

Section 13. Independent Contractor

13.1 In the performance of work or services hereunder, Boon Chapman shall be deemed an independent contractor, and any of its agents, employees, officers, or volunteers performing work required hereunder shall be deemed solely as employees of Boon Chapman or, where permitted, of its subcontractors.

13.2 Boon Chapman and its agents, employees, officers, or volunteers shall not, by performing work pursuant to this Agreement, be deemed to be employees, agents, or servants of County and shall not be entitled to any of the privileges or benefits of County employment.

Section 14. Notices

14.1 Each party giving any notice or making any request, demand, or other communication (each, a "Notice") pursuant to this Agreement shall do so in writing and shall use one of the following methods of delivery, each of which, for purposes of this Agreement, is a writing: personal delivery, registered or certified mail (in each case, return receipt requested and postage prepaid), or nationally recognized overnight courier (with all fees prepaid).

14.2 Each party giving a Notice shall address the Notice to the receiving party at the address listed below or to another address designated by a party in a Notice pursuant to this Section:

County:	Fort Bend County Attn: County Judge 401 Jackson Street Richmond, Texas 77469
With a copy to:	Fort Bend County Attn: Risk Management Director 301 Jackson Street, Suite 224 Richmond, Texas 77469

Boon Chapman: Boon-Chapman
Attn: Kevin Chapman, President
9401 Amberglen Blvd.
Building I, Suite 100
Austin, Texas 78729

14.3 Notice is effective only if the party giving or making the Notice has complied with this requirements of this Section and if the addressee has received the Notice. A Notice is deemed received as follows:

A. If the Notice is delivered in person, or sent by registered or certified mail or a nationally recognized overnight courier, upon receipt as indicated by the date on the signed receipt.
B. If the addressee rejects or otherwise refuses to accept the Notice, or if the Notice cannot be delivered because of a change in address for which no Notice was given, then upon the rejection, refusal, or inability to deliver.

Section 15. Compliance with Laws

The parties shall comply with all federal, state, and local laws, statutes, ordinances, rules and regulations, and the orders and decrees of any courts or administrative bodies or tribunals in any matter affecting the performance of this Agreement, including, without limitation, Worker's Compensation laws, minimum and maximum salary and wage statutes and regulations, licensing laws and regulations.

Section 16. Performance Warranty

16.1 Boon Chapman warrants to County that Boon Chapman has the skill and knowledge ordinarily possessed by well-informed members of its trade or profession practicing in the greater Houston metropolitan area and Boon Chapman will apply that skill and knowledge with care and diligence to ensure that the Services provided hereunder will be performed and delivered in a manner to meet or exceed the professional standards of the industry.

Section 17. Assignment and Delegation

17.1 Except as otherwise specified in this Agreement:

A. Neither party may assign any of its rights under this Agreement, except with the prior written consent of the other party. That party shall not unreasonably withhold its consent. All assignments of rights by Boon Chapman are prohibited under this subsection, whether they are voluntarily or involuntarily, without first obtaining written consent from County.

B. Neither party may delegate any performance under this Agreement, except with the prior written consent of the other party.

17.2 Any purported assignment of rights or delegation of performance in violation of this Section is void.

Section 18. Applicable Law

The laws of the State of Texas govern all disputes arising out of or relating to this Agreement. The parties hereto acknowledge that venue is proper in Fort Bend County, Texas, for all legal actions or proceedings arising out of or relating to this Agreement and waive the right to sue or be sued elsewhere. Nothing in the Agreement shall be construed to waive the County's sovereign immunity.

Section 19. Successors and Assigns

County and Boon Chapman bind themselves and their successors, executors, administrators and assigns to the other party of this Agreement and to the successors, executors, administrators and assigns of the other party, in respect to all covenants of this Agreement.

Section 20. Third Party Beneficiaries

This Agreement does not confer any enforceable rights or remedies upon any person other than the parties.

Section 21. Severability

If any provision of this Agreement is determined to be invalid, illegal, or unenforceable, the remaining provisions remain in full force, if the essential terms and conditions of this Agreement for each party remain valid, binding, and enforceable.

Section 22. Publicity

Contact with citizens of Fort Bend County, media outlets, or governmental agencies shall be the sole responsibility of County. Under no circumstances whatsoever, shall Boon Chapman release any material or information developed or received in the performance of the Services hereunder without the express written permission of County, except where required to do so by law.

Section 23. Captions

The section captions used in this Agreement are for convenience of reference only and do not affect the interpretation or construction of this Agreement.

Section 24. Entire Agreement

This Agreement contains the entire Agreement among the parties and supercedes all other negotiations and agreements, whether written or oral. Attached hereto is Exhibit A: *RFP 16-086*; Exhibit B: *Services;* Exhibit C: *Fee Schedule;* Exhibit D: *Business Associates Agreement*; all of which are incorporated by reference as if set forth herein verbatim for all purposes. Exhibit E: *Security Policies* and Exhibit F: *Boon Chapman Original Response dated May 16, 2016, Optional Services* are included for reference only.

Section 25. Conflict

In the event there is a conflict, the following have priority with regard to the conflict: first: this document titled *"AGREEMENT FOR THIRD PARTY CLAIMS ADMINISTRATION SERVICES PURSUANT TO RFP 16-086;"* second: Exhibit D *Business Associates Agreement;* third: *RFP 16-086* fourth: Exhibit C: *Fee Schedule;* and fifth: Exhibit B: *Services;* Exhibit E: *Security Policies* and Exhibit F: *Boon Chapman Original Response dated May 16, 2016, Optional Services* will have no priority with regard to any conflict because they are included only for reference.

Remainder left blank

Execution page follows

Section 26. Execution.

IN WITNESS WHEREOF, the parties hereto have signed or have caused their respective names to be signed to multiple counterparts to be effective on the _____ day of _____, 2016.

FORT BEND COUNTY

Robert E. Hebert, County Judge

ATTEST:

Laura Richard, County Clerk

COMMISSIONERS COURT FORT BEND COUNTY TEXAS

BOON-CHAPMAN
BENEFIT ADMINISTRATORS, INC.,

Authorized Agent- Signature

Kevin S. Chapman

Authorized Agent- Printed Name

President

Title

12/12/2016

Date

APPROVED:

Wyatt Scott
Risk Management Director

Exhibits:

Exhibit A:	**RFP 16-086**
Exhibit B:	**Services**
Exhibit C:	**Fee Schedule**
Exhibit D:	**Business Associates Agreement**
Exhibit E:	**Security Policies**
Exhibit F:	**Boon Chapman Original Response dated May 16, 2016, Optional Services**

AUDITOR'S CERTIFICATE

I hereby certify that funds are available in the amount of $835,000 to accomplish and pay the obligation of Fort Bend County under this contract.

Robert Ed Sturdivant, County Auditor

i:\mtr\risk management\tpa\10.17.16 third party claims administration service -.docx rev 12.5.16

Exhibit A:
RFP 16-086

Fort Bend County Specification Download Acknowledgment

Request for Proposals
Third Party Claims Administration Services
for the Fort Bend County Medical, Dental and Cafeteria plans
RFP 16-086

VENDORS MUST IMMEDIATELY RETURN THIS FORM BY FAX TO 281-341-8645

Vendor Responsibilities:

- Vendors are responsible to download and complete any addendums. (Addendums will be posted on the Fort Bend County Website no later than 48 hours prior to Opening)
- Vendors will submit responses in accordance with requirements stated on cover of document.
- Vendors may not submit responses via email or fax.

Legal Name of Contracting Company

Contact Person

Complete Mailing Address

Telephone Number Facsimile Number

Email Address

Signature Date

Fort Bend County, Texas
Request for Proposals

Third Party Administration Services
for the Fort Bend County Medical, Dental and Cafeteria Plans
RFP 16-086

SUBMIT PROPOSALS TO:

Fort Bend County
Purchasing Department
Travis Annex
301 Jackson, Suite 201
Richmond, TX 77469

****NOTE:**
All correspondence must include the term "Purchasing Department" in address to assist in proper delivery

SUBMIT NO LATER THAN:

Thursday, May 12, 2016
1:30 PM (Central)

LABEL ENVELOPE:

RFP 16-086
TPA Services

ALL RFPS MUST BE RECEIVED IN AND TIME/DATE STAMPED BY THE PURCHASING OFFICE OF FORT BEND COUNTY BEFORE THE SPECIFIED TIME/DATE STATED ABOVE.

RFPS RECEIVED AS REQUIRED WILL THEN BE OPENED AND THE NAMES OF THE RESPONDING VENDORS PUBLICLY READ.

RFPS RECEIVED AFTER THE SPECIFIED TIME WILL BE RETURNED UNOPENED.

Results will not be given by phone.
Results will be provided after final agreement approved by Commissioners Court.

Fort Bend County is always conscious and extremely appreciative of your effort in the preparation of this RFP.

Requests for information must be in writing and directed to:

Gilbert Jalomo, CPPB
Purchasing Agent
gilbert.jalomo@fortbendcountytx.gov

Prepared: 4/8/16
Issued: 4/13/16

Respondent Information

Legal Name of Contracting Company

Federal ID Number (Company or Corporation) or Social Security Number (Individual)

Telephone Number Facsimile Number

Complete Mailing Address (for Correspondence)

City, State and Zip Code

Complete Remittance Address (if different from above)

City, State and Zip Code

Authorized Representative and Title (printed)

Authorized Representative's Email Address

Signature of Authorized Representative Date

1.0 INTRODUCTION:

Fort Bend County, Texas (hereafter referred to as the ("County") seeks Proposals for selection of firm ("Respondent") to provide Third Party Administration Services for the Fort Bend County Employee Medical, Dental and Cafeteria Plan ("Project") in accordance with the terms, conditions and requirements set forth in this RFP.

2.0 PROPOSAL CONTACT:

This Proposal is being issued by the County Purchasing Agent on behalf of Fort Bend 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
Fort Bend County Travis Annex
301 Jackson, Suite 201
Richmond, Texas 77469
Gilbert.Jalomo@fortbendcountytx.gov

3.0 GUIDELINES:

By virtue of submitting a proposal, interested parties are acknowledging:

3.1 The County reserves the right to reject any or all proposals if it determines that select proposals are not responsive to the RFP. The County reserves the right to reconsider any proposal submitted at any phase of the procurement. It also reserves the right to meet with select Respondents at any time to gather additional information. Furthermore, the County reserves the right to delete or add scope up until the final contract signing.

3.2 All Respondents submitting proposals agree that their pricing is valid for a minimum of one-hundred twenty (120) days after proposal submission to the County. Furthermore, the County is by statute exempt from the State Sales Tax and Federal Excise Tax; therefore, proposal prices shall not include taxes.

3.3 This Proposal does not commit the County to award nor does it constitute an offer of employment or a contract for services. Costs incurred in the submission of this

proposal, or in making necessary studies or designs for the preparation thereof, are the sole responsibility of the Respondents. Further, no reimbursable cost may be incurred in the anticipation of award. Proposals containing elaborate artwork, expensive paper and binding and expensive visual or other presentations are neither necessary nor desired.

3.4 In an effort to maintain fairness in the process, all inquiries concerning this procurement are to be directed only to the County's Purchasing Agent in writing. Attempts to contact any members of the County's Commissioners' Court or any other County employee to influence the procurement decision may lead to immediate elimination from further consideration.

3.5 When responding to this Proposal, follow all instructions carefully. Submit proposal contents according to the outline specified and submit all hard copy and electronic documents according to the instructions. Failure to follow these instructions may be considered a non-responsive proposal and may result in immediate elimination from further consideration.

4.0 PROPOSAL SUBMISSION:

4.1 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, **Wednesday, April 27, 2016 at 3:00PM** (Central). Requests received after the deadline will not be responded to due to the time constraints of this Proposal process.

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

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

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

4.2.3 Provide a title page showing the RFP subject, name of Respondent, address, telephone number, fax number and email address. The title page must be signed by an officer of the firm.

4.2.4 Provide all required elements as stated.

4.3 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 Fort Bend County officials and representatives solely for the purpose of evaluating proposals and conducting contract negotiations.

4.4 Cost of Proposal Preparation:

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

4.5 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.

4.6 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 Fort Bend County representatives to make a fair evaluation of the company and the proposal.

4.7 Confidentiality of Proposals:

Proposals will be opened on the date specified on the cover page and kept secret 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.

4.8 Contract Award:

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

4.9 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.

5.0 INSURANCE:

5.1 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 Fort Bend 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.

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

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

5.2.2 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.

5.2.3 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.

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

5.3 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.

5.4 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.

5.5 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 Fort Bend County.

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

6.0 INDEMNIFICATION:

Respondent shall save harmless County from and against all claims, liability, and expenses, including reasonable attorney's fees, arising from activities of Respondent, its agents, servants or employees, performed under this agreement that result from the negligent act, error, or omission of Respondent or any of Respondent's agents, servants or employees.

6.1 Respondent shall timely report all such matters to Fort Bend County and shall, upon the receipt of any such claim, demand, suit, action, proceeding, lien or judgment, not later than the fifteenth day of each month; provide Fort Bend County with a written report on each such matter, setting forth the status of each matter, the schedule or planned proceedings with respect to each matter and the cooperation or assistance, if any, of Fort Bend County required by Respondent in the defense of each matter.

6.2 Respondent's duty to defend, indemnify and hold Fort Bend County harmless shall be absolute. It shall not abate or end by reason of the expiration or termination of any contract unless otherwise agreed by Fort Bend County in writing. The provisions of this section shall survive the termination of the contract and shall remain in full force and effect with respect to all such matters no matter when they arise.

6.3 In the event of any dispute between the parties as to whether a claim, demand, suit, action, proceeding, lien or judgment appears to have been caused by or appears to have arisen out of or in connection with acts or omissions of Respondent, Respondent shall never-the-less fully defend such claim, demand, suit, action, proceeding, lien or judgment until and unless there is a determination by a court of competent jurisdiction that the acts and omissions of Respondent are not at issue in the matter.

6.4 Respondent's indemnification shall cover, and Respondent agrees to indemnify Fort Bend County, in the event Fort Bend County is found to have been negligent for having selected Respondent to perform the work described in this request.

6.5 The provision by Respondent of insurance shall not limit the liability of Respondent under an agreement.

6.6 Respondent shall cause all trade contractors and any other contractor who may have a contract to perform construction or installation work in the area where work will be performed under this request, to agree to indemnify Fort Bend County and to hold it harmless from all claims for bodily injury and property damage that arise may from said Respondent's operations. Such provisions shall be in form satisfactory to Fort Bend County.

6.7 Loss Deduction Clause - Fort Bend County shall be exempt from, and in no way liable for, any sums of money which may represent a deductible in any insurance policy. The payment of deductibles shall be the sole responsibility of Respondent and/or trade contractor providing such insurance.

7.0 TENTATIVE SCHEDULE OF EVENTS:

Release of RFP:	April 13, 2016
Deadline for Questions:	April 27, 2016 @ 3PM
Submission Due Date:	May 12, 2016 @ 1:30PM
Evaluation of Submissions, Site Visits and Evaluations:	June 13-30, 2016
Commissioners Court Permission to Negotiate:	July 12, 2016
Negotiations:	Beginning July 13, 2016
Final Contract Approval Commissioners Court:	August 23, 2016

8.0 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.

8.1 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.

8.2 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; 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) or readily attainable 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.

Price (Maximum 35 points): Price per employee per month to provide medical, dental and cafeteria plan administration services.

9.0 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.

9.1 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. Dental Administration
   c. Cafeteria Plan Administration

2. Price

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

9.3 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.

10.0 EVALUATION PROCESS:

10.1 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.

10.2 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.

10.3 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.

10.4 Fort Bend County reserves the right to reject any and all proposals received for any reason that would be to the benefit of Fort Bend County.

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

10.6 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.

11.0 AWARD:

Proposals will be opened on the date specified on the cover page and kept secret until the Fort Bend 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.

12.0 TEXAS ETHICS COMMISSION FORM 1295:

12.1 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", per the new Government Code Statute §2252.908. All vendors submitting a response to a formal Bid, RFP, SOQ or any contracts, contract amendments, renewals or change orders are required to complete the Form 1295 online through the State of Texas Ethics Commission website. Please visit: https://www.ethics.state.tx.us/whatsnew/elf_info_form1295.htm.

12.2 On-line instructions:

12.2.1 Name of governmental entity is to read Fort Bend County.

12.2.2 Identification number used by the governmental entity is the solicitation number: RFP16-086.

12.2.3 Description is the title of the solicitation: TPA Services.

12.3 Selected Respondent will be required to provide the Form 1295 within three (3) calendar days from notification. In the event the vendor does not provide the document in the stated time period the vendor's response will be marked as disqualified and the next highest evaluated Respondent will be contacted.

13.0 ADDITIONAL REQUIRED FORMS:

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

13.1 Respondent Form

13.2 W9 Form

13.3 Tax Form/Debt/Residence Certification

14.0 ATTACHMENTS:

1. General Questionnaire
2. Medical/Dental/Cafeteria Plan Administration Questionnaire

15.0 EXHIBITS:

1. Fort Bend County Medical and Dental plan statistical data
2. Fort Bend County Cafeteria plan enrollment by category
3. Current FBC Medical Plan Document
4. Current FBC Dental Plan Document

5. Current FBC Cafeteria Plan Document.

ATTACHMENT 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. Successful vendor must have a completed 1295 form from The Texas Ethics Commission on file with Fort Bend County prior to award by Commissioners Court

4. 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.

5. 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.

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

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

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

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

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

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

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

13. Please list all PPO's with which you currently work.

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

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

16. Please list all E.A.P organizations with which you work.

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

18. Please provide a list of all clients that have terminated the last three (3) years, give reason for termination and a contact person.

19. Please complete the Medical, Dental and Cafeteria Plan Administration Questionnaire. 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 2

MEDICAL, DENTAL, 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.

DENTAL ADMINISTRATION

1. Is your dental claims payment system a component of your medical claim system or is it a separate system?

2. Is any part of your dental claims payment system manual? If so, please explain.

3. Do you generate your own dental usual and customary fee data, 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?

4. What percentile do you use for payment of dental claims and can clients pick alternate percentiles?

5. Will the system automatically deny any (all) non-covered items based on the procedure codes entered by the processor?

6. Are claims routinely coded using standard ADA codes? What other coding protocols are used?

7. How long has your firm been processing dental claims?

8. Are the same internal and external audit processes the same as medical claims? If not, please explain

9. Please include resumes on the dental claims team personnel

10. Please provide a sample EOB for a dental claim

11. Can you receive eligibility in the same electronic method as the medical plan?

12. The County would prefer a composite basic fee (PEPM) for dental claim administration.

13. Include a sample of your administrative service contract for dental.

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 Fort Bend 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 Fort Bend County or its employees relating to this program,

will you provide easy access to the answers? This includes 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, will 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 Fort Bend 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 Fort Bend County? What type products would you require be offered?

11. What assistance would you require of Fort Bend 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.

OPTIONAL SERVICES

Please explain all optional services your firm can offer by name, with a full description of the service and any additional charges involved. 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".

FORT BEND COUNTY

2015	JAN	FEB	MAR	APRIL	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	YTD Totals
Plan Benefits Paid													
Medical Claims	$1,723,419	$1,737,759	$1,367,103	$1,603,306	$1,685,663	$2,243,314	$1,500,365	$1,826,255	$1,354,291	$1,550,801	$1,310,202	$1,902,587	$19,805,085
Dental Claims	127,631	130,406	156,305	129,999	114,345	146,321	184,333	125,336	141,667	113,943	116,519	169,212	1,655,016
Total Monthly Paid	**$ 1,851,050**	**$ 1,868,165**	**$ 1,523,408**	**$ 1,733,305**	**$ 1,800,029**	**$ 2,389,635**	**$ 1,684,697**	**$ 1,951,591**	**$ 1,495,958**	**$ 1,664,743**	**$ 1,426,721**	**$ 2,070,799**	**$ 21,460,101**
# of Medical Claims Paid	4,512	5,689	4,845	4,879	4,910	5,319	4,979	4,644	4,341	5,362	4,122	5,594	59,196
# of Dental Claims Paid	702	675	787	626	567	759	973	649	754	659	692	823	8,666
Monthly Medical Enrollment													YTD Average
Employee Only	1,154	1,149	1,119	1,129	1,133	1,133	1,134	1,128	1,120	1,132	1,134	1,138	1134
Spouse	257	258	268	278	277	278	281	275	281	283	279	278	274
Child	565	567	582	589	589	588	589	584	584	584	585	586	583
Family	333	333	346	341	349	350	354	354	355	356	354	358	349
Total Monthly Enrollment	**2,309**	**2,307**	**2,315**	**2,337**	**2,348**	**2,349**	**2,358**	**2,341**	**2,340**	**2,355**	**2,352**	**2,360**	**2339**
Monthly Dental Enrollment													YTD Average
Employee Only	1,142	1,139	1,110	1,118	1,122	1,132	1,127	1,123	1,121	1,135	1,134	1,137	1128
Spouse	482	481	478	481	483	483	484	479	479	480	481	480	481
Child	325	323	336	338	338	336	336	336	336	336	339	342	335
Family	344	347	373	370	369	366	370	369	370	368	369	372	366
Total Monthly Enrollment	**2,293**	**2,290**	**2,297**	**2,307**	**2,312**	**2,317**	**2,317**	**2,307**	**2,308**	**2,319**	**2,323**	**2,331**	**2310**

2014	JAN	FEB	MAR	APRIL	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	YTD Totals
Plan Benefits Paid													
Medical Claims	$1,730,728	$1,402,521	$1,565,823	$2,005,744	$1,413,242	$1,780,931	$1,641,936	$1,256,778	2,002,231	2,032,931	$1,198,157	$2,115,937	$20,149,009
Dental Claims	170,383	128,088	164,278	162,979	133,417	131,387	147,217	150,290	132,587	148,228	100,121	140,809	1,709,784
Total Monthly Paid	**$ 1,901,111**	**$ 1,530,609**	**$ 1,730,101**	**$ 2,168,723**	**$ 1,546,659**	**$ 1,912,318**	**$ 1,789,203**	**$ 1,409,068**	**2,134,818**	**2,181,159**	**$ 1,298,278**	**$ 2,256,746**	**$ 21,858,793**
# of Medical Claims Paid	4,419	4,522	4,725	4,920	4,703	4,230	4,647	4,689	6,126	6,275	4,273	5,798	59,327
# of Dental Claims Paid	814	618	833	799	676	719	806	757	741	728	568	693	8,752
Monthly Medical Enrollment													YTD Average
Employee Only	1,033	1,047	1,026	1,031	1,052	1,053	1,058	1,075	1,082	1,089	1,090	1,090	1061
Spouse	292	289	302	303	301	301	301	301	301	302	298	298	299
Child	462	458	446	451	454	461	460	456	460	459	463	468	458
Family	408	405	445	446	455	456	453	454	450	453	451	452	444
Total Monthly Enrollment	**2,195**	**2,199**	**2,219**	**2,231**	**2,262**	**2,271**	**2,272**	**2,286**	**2,293**	**2,303**	**2,302**	**2,308**	**2262**
Monthly Dental Enrollment													YTD Average
Employee Only	1,050	1,054	1,026	1,032	1,047	1,052	1,059	1,068	1,067	1,079	1,075	1,080	1057
Spouse	484	483	494	498	499	500	501	503	501	500	503	502	497
Child	325	321	314	317	314	314	311	307	309	305	310	310	313
Family	350	346	373	369	375	374	373	371	367	370	369	369	367
Total Monthly Enrollment	**2,209**	**2,204**	**2,207**	**2,216**	**2,235**	**2,240**	**2,244**	**2,249**	**2,244**	**2,254**	**2,257**	**2,261**	**2235**

Fort Bend County
Section 125 Cafeteria Plan
ADOPTION AGREEMENT
Effective Date: 01/01/2007

Item I: Adoption

The Employer hereby establishes a Qualified "Cafeteria Plan" as set forth pursuant to Section 125 of the Internal Revenue Code. The Benefit Package Options listed in Item VII below have been incorporated into this Plan by reference. Nothing in this Adoption Agreement shall be intended to override the terms of the Plan Document to which this Adoption Agreement is attached.

Item II: Employer Organization

Name of Organization:	Fort Bend County
Federal Employer ID Number:	74-6001969
Mailing Address:	301 Jackson
City, State, Zip:	Richmond, TX 77469
Street Address:	301 Jackson
Street Zip:	Richmond, TX 77469
Form of Organization:	Government
Organized in the state of:	TX

Item III: Plan Elections

Plan Information

Plan No.:	502
Plan Name:	Fort Bend County 125 Flexible Benefits
Original Effective Date:	04/01/1989
Plan Year Runs*:	01/01 - 12/31
Plan Restated and Amended:	01/01/2007

*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:	Fort Bend County
Plan Service Provider:	Boon-Chapman
Street Address:	12301 Research Blvd., Suite 400
City, State, Zip:	Austin, TX 78759
Contact:	Terri Garza
Phone:	(800) 252-9653

Item IV: 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 40.0 hours per week.

Service Period Requirement

For All plan years, eligibility is the following:

First of the month following the 90th day after hire.

Item V: 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 or Date requirements are met.

Item VI: Contacts and Responsibilities

Benefits Coordinator

Name:	
Title:	Director of Risk Management
Phone:	(281) 341-8630
Company Name:	Fort Bend County
Street Address:	301 Jackson
City, State, Zip:	Richmond, TX 77469

Acceptance of Legal Process

Name:	
Title:	County Attorney
Phone:	(281) 341-4555
Company Name:	Fort Bend County
Street Address:	301 Jackson
City, State, Zip:	Richmond, TX 77469

Item VII - 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.

Non-Core Supplemental Health Benefits.

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

Item IX - 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 60 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 60 days after the end of the plan year.

Health FSA

(a) The maximum annual reimbursement amount an Employee may elect for any Plan Year is $2600.00.

(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 $0.00.

(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, the Closing Period, or the Claims Submission Grace Period, whichever is applicable, will not be subject to the Minimum Check Amount. There is no Minimum Check Amount under this Plan.

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 Appendix A of the Plan).

(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 $0.00.

(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. There is no Minimum Check Amount under this Plan.

Item X - Incorporation 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: _____ Date: 12/12/06
Name: ROBERT HEBERT
Title: COUNTY JUDGE

Executed at: Fort Bend County
301 Jackson
Richmond, TX 77469

CAFETERIA PLAN

PREMIUM REDUCTION OPTION *PLUS*

FLEXIBLE SPENDING ACCOUNTS

PLAN DOCUMENT

AS ADOPTED BY
FORT BEND COUNTY

TABLE OF CONTENTS

Section 125 Cafeteria Plan

1. INTRODUCTION

1.1 PURPOSE OF PLAN

The purpose of this Plan (as defined in Section 2.26) is to provide Employees of the Company a choice between cash and the non-taxable Benefit Package Options referenced herein under Section 6. The Plan is intended to qualify as a "cafeteria plan" under Section 125 of the Internal Revenue Code, as amended from time to time. It is the intent this Plan will be maintained for the exclusive benefit of the Company's Eligible Employees (as defined in Section 2.17 herein), their Dependents, and beneficiaries. The Employer further intends that the terms of this Plan, including those relating to the underlying Insurance Benefits, Medical Expense Reimbursement Plan, and the Dependent Care Assistance Plan, be legally enforceable by Eligible Employees. If elected by the Employer, the Dependent Care Assistance Plan is intended to qualify as a Code Section 129 dependent care assistance plan, and, if elected by the Employer, the Medical Expense Reimbursement Plan is intended to qualify as a Code Section 105 medical expense reimbursement plan. Although reprinted within this document, the Dependent Care Assistance Plan and the Medical Expense Reimbursement Plan are separate written plans for purposes of administration and all reporting and nondiscrimination requirements imposed by Sections 105 and 129 of the Code and all applicable provisions of ERISA.

2. DEFINITIONS

The following words and phrases used in this Plan have the meanings set forth unless a different meaning is clearly required by the context.

2.1 ADMINISTRATOR

An Administrator is an Employer and/or other person or committee who has been so designated by the Employer in the Summary Plan Description. The Administrator is also referred to as the Plan Administrator.

2.2 AFFILIATED EMPLOYER

An Affiliated Employer is any Employer who, within the context of Code Section 414(b), (c), or (m) of the Code, will be treated with the Employer as a single employer for purposes of Code Section 125.

2.3 ANNIVERSARY DATE

The Anniversary Date is the first day of any subsequent Plan Year.

2.4 BENEFIT ELECTION FORM

The Benefit Election Form is an agreement whereby the Eligible Employee participates by electing to reduce and/or deduct from the Employee's Compensation to receive selected benefits under Section 6 below. The Benefit Election Form is also known as a Salary Reduction Agreement.

2.5 BENEFIT PACKAGE OPTION(S)

The Benefit Package Option(s) are those Qualified Benefits available to a Participant under this Plan as set forth in the Summary Plan Description.

2.6 CHANGE IN STATUS

Change in status means any of the events described in the Summary Plan Description, as well as any other events included under subsequent changes to Code Section 125 or regulations issued under Code Section 125, that the Plan Administrator (in its sole discretion) decides to recognize on a uniform and consistent basis as a reason to change the election mid-year. Note: See the Summary Plan Description for requirements that must be met to permit certain mid-year election changes due to a Change in Status.

2.7 Claim Submission Grace Period

The Claim Submission Grace Period is the period during which Participants who terminate coverage during the Plan Year can file claims after participation in a Benefit Package Option has terminated. If set forth in the Summary Plan Description, a separate Claims Submission Grace Period can be established for Participants terminating coverage during the Plan Year and will take precedence over the Closing Period with respect to those who terminate employment. If a Claims Submission Grace Period is not set forth in the Summary Plan Description, terminated employees can file claims until the end of the applicable Closing Period for expenses incurred before termination.

2.8 Closing Period

The period of time beginning at the end of the Plan Year in which a Participant may submit claims incurred during the Plan Year. The Closing Period is as specified in the Summary Plan Description. (See Claim Submission Grace Period above.)

2.9 Code

The Internal Revenue Code as amended from time to time.

2.10 Commissioners Court

Commissioners Court

2.11 Company

The organization named in the Summary Plan Description as the "Employer."

2.12 Compensation

The cash wages paid to an Employee by the Employer prior to:

(a) any salary deferral elections made under Code Sec. 401(k), 403(b), 408(k) or 457 (if any) plans,

(b) any salary reduction elections made under this Plan, and

(c) any salary reduction elections made under a Code Section 132 transportation fringe benefit plan maintained by the Employer.

2.13 Contributions

Contributions are amounts withheld from a Participant's Compensation before any applicable state and federal taxes have been deducted or, if permitted by the Employer, after all applicable state and federal taxes have been deducted, in accordance with the Participant's Salary Reduction Agreement, to apply towards the cost of the Benefit Package Options selected by the Participant.

2.14 Dependent

A dependent is any individual who is a tax dependent of the Participant as defined in Code Section 152(a), provided, however, that in the case of a divorced Employee, the Dependent shall be defined (a) as in Code Section 21(e)(5) (i.e. dependent of the parent with custody) for purposes of the Dependent Care Expense Account Plan; and (b) for purposes of accident or health coverage, a child shall be considered a Dependent of both parents. Nothing in this Section 2.14 is intended to restrict the definition of Dependent established by each Benefit Package Option.

2.15 Effective Date

Date specified in the Summary Plan Description on which the Plan is applicable to the Eligible Employees.

2.16 Election Period

The period established by the Plan Administrator in which an election can be made to participate in the Plan pursuant to Sections 4.2, 4.3 and 4.4 herein.

2.17 Eligible Employee

An Employee who meets the Eligibility Requirements set forth in the Summary Plan Description.

2.18ELIGIBILITY REQUIREMENTS

Those requirements setting forth the minimum conditions necessary to be able to participate in the Plan as set forth in the Summary Plan Description.

2.19EMPLOYEE

Any individual who is considered to be in a legal employer-employee relationship with the Employer for federal withholding tax purposes. Such terms include "former employees" for the limited purpose of allowing continued eligibility for benefits hereunder for the remainder of the Plan Year in which an employee ceases to be employed by the Employer provided the component Benefit Package Option allows for such continuation and any required contributions are made. The term "Employee" shall not include any leased employee (as Code Section 414(n) defines that term) or an individual classified by the employer as a contract worker, independent contractor, temporary employee, seasonal or casual employee, whether or not any such persons deemed by a court to be in a legal employer-employee relationship with the Employer. In addition, the term "Employee" shall not include any self-employed individual who receives from the Employer "net earnings from self employment" within the meaning of Code Section 401(c)(2) unless such individual is also an Employee or an individual covered under a collective bargaining agreement and the collective bargaining agreement specifically provides for participation herein.

2.20EMPLOYER

The Employer is the Company and any Affiliated Employer that adopts the Plan pursuant to the Company's authorization. When the Plan provides that the "Employer" has a certain power (e.g., the appointment of an Plan Administrator, entering into a contract with a third party insurer, or amendment or termination of the Plan), the term "Employer" shall mean only the Company. Affiliated Employers who adopt the Plan shall be bound by the Plan as adopted and subsequently amended unless they clearly withdraw from participation herein.

2.21ENTRY DATE

The date participation in the Plan actually commences after the Eligibility Requirements have been met. This date is set forth in the Summary Plan Description.

2.22HIGHLY COMPENSATED INDIVIDUAL

An individual defined under Section 105(h), 125(e)(2), and 414(q) of the Code as a "highly compensated individual" or a "highly compensated employee."

2.23INSURANCE BENEFITS

Employer-sponsored Benefit Package Options provided pursuant to one or more insurance policies issued by an insurance carrier or pursuant to a self-funded arrangement other than the Medical Expense Reimbursement Plan, the Dependent Care Expense Reimbursement Plan, and the Health Premium Reimbursement Account referenced in Section 6 herein.

2.24KEY EMPLOYEE

An individual who is a "key employee" as defined in Section 125(b)(2) of the Code.

2.25PARTICIPANT

Any Eligible Employee participating in the Plan in accordance with Section 3 below.

2.26PLAN

This document as set forth herein, together with all documents incorporated by reference, including the Summary Plan Description, attachments, amendments, and supplements hereto. The Plan will be known by the name and number set forth in the Summary Plan Description.

2.27PLAN YEAR

Twelve-month period commencing and ending on the dates indicated in the Summary Plan Description and each anniversary thereof. The first Plan Year will commence on the Effective Date of the Plan and may be for less than twelve

months. A period of less than twelve months may be a Plan Year for the initial or final Plan Years, and a transition period to a different Plan Year.

2.28 Qualified Benefits

Any benefit not included in the gross income of the Employee by reason of an express provision of Chapter 1 of the Code (other than Sections 106(b), 117, 124, 127, or 132), including (a) any group-term life insurance coverage that is includible in gross income only by virtue of exceeding the dollar limitation on nontaxable coverage under Code Section 79, (b) a Health Savings Account (described in Section 2.24 herein); and (c) any other benefit permitted by the Income Tax Regulations. Long-Term Care insurance shall not be a qualified benefit hereunder.

2.29 Reimbursement Account

The funding mechanism by which amounts are withheld from an Employee's Compensation and retained for future reimbursement of Reimbursable Expenses. No money shall actually be allocated to any individual Reimbursement Accounts elected by the Participant; any such Reimbursement Accounts shall be of a memorandum nature maintained by the Administrator for accounting purposes and shall not be representative of any identifiable trust assets. No interest will be credited to or paid on amounts credited to Reimbursement Accounts.

2.30 Reimbursable Expense

Any out-of-pocket Eligible Medical Expense (as defined in Appendix B of this Document) and/or Dependent Care Expense (as defined in Appendix A of this Document) of a Participant that qualifies for reimbursement under either the Medical Expense Reimbursement Plan described in Appendix B of this Document or the Dependent Care Assistance Plan described in Appendix A of this Document.

2.31 Salary Reduction Agreement

The Agreement whereby the Eligible Employee participates in the Plan by electing to reduce and/or deduct from the Employee's Compensation in exchange for receiving selected Benefit Package Options. The Salary Reduction Agreement is also known as a Benefit Election Form.

2.32 Spouse

Spouse is an individual who is legally married to a Participant (and who is treated as a spouse under the Code).

2.33 Summary Plan Description or "SPD"

The document and all appendices incorporated into and made a part of the SPD that is adopted by the Employer and attached to this Plan Document as Attachment I, as amended from time to time. The SPD and appendices are incorporated hereto by reference.

3. Eligibility and Participation

3.1 Eligibility Requirements

Each Employee, who has satisfied the Eligibility Requirements set forth in the SPD, is eligible to participate in the Plan on the dates set forth in the SPD. Eligibility for the component Benefit Package Options is subject to the additional requirements, if any, specified in the applicable governing documents for the Benefit Package Options. The provisions of this Plan are not intended to override any exclusion, eligibility requirement, or waiting period specified in the applicable Benefit Package Options.

3.2 Participation Termination

A Participant will cease to be a Participant as of the earlier of the dates set forth in the SPD.

3.3 Non-FMLA Leave of Absence

If a Participant goes on an unpaid leave of absence that does not affect eligibility under this Plan or the Benefit Package Options chosen by the Participant, then the Participant will continue to participate and the contributions due for the Participant will be paid by one or more of the payment options described in the SPD and implemented by the Employer on a uniform and

consistent basis in accordance with the Employer's internal policy and procedure. If a Participant goes on an unpaid leave that affects eligibility under this Plan or the Benefit Package Options chosen by the Participant, the election change rules in Section 4.6 will apply. If such policy requires coverage to continue during the leave but permits a Participant to discontinue contributions while on leave, the Participant will, upon returning from leave, be required to repay the contributions not paid by the Participant during the leave.

3.4 Qualified Leave under Family and Medical Leave Act

Notwithstanding any provision to the contrary in this Plan, if a Participant goes on a qualifying leave under the Family and Medical Leave Act of 1993 (the "FMLA"), then to the extent required by the FMLA, the Participant will be entitled to continue the Participant's Benefit Package Options that provide health coverage (including Health FSA benefits to the extent offered under the Plan) on the same terms and conditions as if the Participant were still an active employee. The requirements for continuing coverage, procedures for FMLA leave and payment options provided by the Employer (as described above) will be set forth in the SPD and will be administered in accordance with the regulations issued under Code Section 125 and in accordance with the FMLA.

3.5 Automatic Termination of Election and Reinstatement of Participation

Termination of employment or cessation of eligibility shall automatically revoke any Salary Reduction Agreement. Rules governing elections for former participants rehired during the same Plan Year shall be set forth in the SPD.

4. Election of Benefits

4.1 Election of Benefits

To become a Participant, an Eligible Employee must elect under this Plan to receive one or more of the Benefit Package Options set forth in the attached SPD by signing a Benefit Election Form and any enrollment form for the Benefit Package Option, as required by the Plan Administrator, in accordance with the procedure described in Sections 4.2, 4.3, and 4.4 below.

4.2 Election Period Prior to Effective Date

An Employee who has satisfied the Eligibility Requirements on the Effective Date of the Plan must complete a Benefit Election Form during the Election Period immediately preceding the Effective Date of the Plan in order to become a Participant on the Effective Date of the Plan. If the Plan is amended and restated during a Plan Year, Participants' elections (either to participate or not to participate) in effect immediately preceding the amended and restated Effective Date, as set forth in the SPD, shall be continued for the remainder of the Plan Year, except as otherwise provided in Sections 3.5 and 4.6 herein.

4.3 Annual Election Period

Each Employee, who is a Participant in this Plan or who is eligible to become a Participant in this Plan, shall be notified, prior to each Anniversary Date of this Plan, of his right to (i) become a Participant in this Plan, (ii) continue participation in this Plan, or (iii) modify or cease participation in this Plan, and shall be given a reasonable period of time in which to exercise such right. Such period of time shall be known as the "Annual Election Period." The Annual Election Period shall be set forth in the enrollment material. An annual election shall be made by submitting a Benefit Election Form to the Plan Administrator during the Annual Election Period, and shall be effective for the entire Plan Year beginning on the Anniversary Date, subject to Section 4.6 herein.

An Eligible Employee who is not a current Participant in the Plan and who fails to return a Benefit Election Form to the Plan Administrator on or before the end of the Annual Election Period will be deemed to have elected to receive his or her full Compensation in cash. An Employee who is currently participating and who fails to return a completed Benefit Election Form to the Plan Administrator changing the Employee's Benefit Package Option elections on or before the end of the Annual Election Period will be deemed to have made the same election of Benefit Package Options in the subsequent Plan Year as was in effect in the current year (with the following exceptions), and will also be deemed to have agreed to a reduction in Compensation for the subsequent Plan Year equal to the Participant's share of the cost of each such benefit. Notwithstanding the foregoing, annual elections for participation in the Medical Expense Reimbursement Plan, Dependent Care Assistance Plan, and Health Care Premium Expense Reimbursement must be made by submitting a Benefit Election Form electing such benefits during the Annual Election Period—there are no deemed elections with respect to any of these three Benefit Package Options.

4.4 Initial Election Period

An Employee who becomes eligible to become a Participant in this Plan after the Effective Date, must complete, sign, and file a Benefit Election Form with the Plan Administrator during the Election Period established by the Employer. This period shall be known as the Initial Election Period. Except as provided in the SPD for HIPAA special enrollment rights in the event of birth, adoption, or placement for adoption, the Contribution elections made by the Participant during the Initial Election Period shall be prospectively effective as of the Plan Entry Date set forth in the SPD, and shall end on the last day of the Plan Year in which such participation began, subject to Sections 3.5 and 4.6 herein. Coverage under the component Benefit Package Options will be effective in accordance with the eligibility requirements contained in such Benefit Package Options. An Eligible Employee who fails to make an election during this Initial Election Period may elect to participate at a later date in accordance with Sections 4.3 and 4.6 herein.

4.5 Changes by Administrators

If the Plan Administrator determines, before or during any Plan Year, that the Plan may fail to satisfy any nondiscrimination requirement imposed by the Code or any limitation on benefits provided to Key Employees, the Plan Administrator will take such action as the Plan Administrator deems appropriate, under rules uniformly applicable to similarly situated Participants, to assure compliance with such requirement or limitation. Such action may include, with limitation, a modification of elections by Highly Compensated and/or Key Employees with or without the consent of such Employees.

4.6 Revocation of Elections

A Participant shall not make any changes to his or her Contribution election under the Plan, or to the Participant's elected allocation of Benefit Credits (if applicable), except for election changes permitted under this Section 4.6, for changes made during the Annual Election Period (Section 4.3), changes caused by termination of participation (Section 3.2) and changes pursuant to the Family and Medical Leave Act (Section 3.4).

Except as provided in the SPD for HIPAA special enrollment rights in the event of birth, adoption, or placement for adoption, all election changes shall be effective on a prospective basis only (i.e., election changes will become effective no earlier than the first day of the first pay period coinciding with or immediately following the date that the election change was filed, but, as determined by the Plan Administrator, election changes may become effective later to the extent the coverage in the applicable component plan commences later).

The circumstances under which a Participant may change his election under this Plan shall be set forth in the SPD.

5. Contributions

5.1 Contributions for Elected Benefit Package Options

By signing and completing the Benefit Election Form, the Participant agrees to reduce the Participant's cash Compensation by such amounts as are necessary to provide for the elected Benefit Package Options. These amounts will then be contributed by the Employer on the Employee's behalf as employer contributions.

5.2 Source of Contributions

The Employer shall withhold Contributions equal to the cost of the elected Benefit Package Options less any applicable Benefit Credits for coverage of the Participant and/or the Participant's Spouse or Dependents. The required Contributions hereunder shall be set forth in the enrollment material. Contributions shall be applied to fund benefits as soon as administratively feasible. The maximum amount of Contributions plus any available Benefit Credits shall not exceed the aggregate cost of the Benefit Package Options elected.

5.3 Allocations Irrevocable During Plan Year

Except as provided in Sections 3.5, 4.6, and 5.4, neither the Contributions withheld nor the Benefit Credits (if applicable) allocated towards the cost of Benefit Package Options by the Participant can be changed during the Plan Year.

5.4 Reduction of Certain Elections to Prevent Discrimination

If the Plan Administrator determines, before or during any Plan Year, that the Plan may fail to satisfy for such Plan Year any requirement imposed by the Code or any limitation on Pre-tax Contributions allocable to Key Employees or to Highly

Compensated Individuals, the Plan Administrator shall take such action(s) as he deems appropriate, under rules uniformly applicable to similarly situated Participants, to assure compliance with such requirement or limitation. Such action may include, without limitation, a modification or revocation of a Highly Compensated Individual's or Key Employee's election without the consent of such Employee.

5.5 Adjustment of Elections due to Contribution Changes

The Plan Administrator may automatically increase or decrease on a prospective basis the amount of a Participant's Salary Reduction Agreement during the Plan Year in response to an insignificant change (as determined by the Plan Administrator) in the Contribution required for the Insurance Benefits elected hereunder, commensurate with the time that the change is effective.

If the Plan Administrator determines a Contribution increase to be significant, the Plan Administrator will notify the Participants of their permitted actions as set forth under Section 4.6 above. Unless the Participant is entitled to and makes a change of election under Section 4.6 above, the adjusted Contribution amount will be in effect until the end of the Plan Year.

5.6 Credits and Debits to Medical Expense Reimbursement Accounts

Each Participant's Medical Expense Reimbursement Account ("Health Care Account"), if applicable, will be credited and debited as set forth in Appendix B of this Document.

5.7 Credits and Debits to Dependent Care Expense Reimbursement Accounts

Each Participant's Dependent Care Expense Reimbursement Account ("Dependent Care Account"), if applicable, will be credited and debited as set forth in Appendix A to this document.

6. Benefit Package Options

The maximum benefit a Participant may elect under this Plan shall not exceed the sum of the following Benefit Package Options. The benefits offered under the Plan will be set forth in the SPD.

6.1 Insurance Benefits

The Employer shall withhold from a Participant's Compensation an amount equal to the Contributions required from the Participant (less any applicable Benefit Credits) for coverage of the Participant and/or the Participant's Spouse or Dependents under the Benefit Package Options consisting of Insurance Benefits elected by the Participant and maintained by the Employer as set forth in the SPD. The Insurance Benefits are subject to the terms and conditions of the applicable Benefit Package Options, which are incorporated herein.

6.2 Medical Expense Reimbursement Benefit (Health FSA)

Health FSA benefits shall be made available under the Plan to the extent listed as a Benefit Package Option in the SPD. This benefit provides payment to the Participant in cash as reimbursement for Eligible Medical Expenses as defined in Appendix B of this document.

6.3 Dependent Care Assistance Plan (DCAP FSA)

Dependent Care FSA benefits will be made available under this Plan to the extent listed as a Benefit Package Option in the SPD. This benefit provides payment to the Participant in cash as reimbursement for Dependent Care Expenses as described in Appendix A.

7. Plan Administration

7.1 Appointment of Administrators

The Plan will be administered by the Plan Administrator as named in the SPD. If a Plan Administrator is not named, the Employer shall be the Plan Administrator.

7.2 Allocation of Responsibility for Administration

The Plan Administrator shall have the exclusive right to interpret the Plan and to decide all matters arising hereunder, including the right to make determinations of fact, and construe and interpret possible ambiguities, inconsistencies, or omissions in the Plan and the SPD issued in connection with the Plan. In the case of an insured Benefit Package Option, the insurer shall be the named fiduciary with respect to benefit claim determinations hereunder, and with respect to benefit, claims shall have all of the powers of the Plan Administrator described herein. All determinations of the Plan Administrator with respect to any matter hereunder shall be conclusive and binding on all persons. Without limiting the generality of the foregoing, the Plan Administrator shall have the following powers and duties to:

(a) Require any person to furnish such reasonable information as the Plan Administrator may request for the purpose of the proper administration of the Plan as a condition to receiving any benefits under the Plan,

(b) Make and enforce such rules and regulations and prescribe the use of such forms as the Plan Administrator shall deem necessary for the efficient administration of the Plan,

(c) Decide on questions concerning the Plan and the eligibility of any Employee to participate in the Plan and to make or revoke elections under the Plan, in accordance with the provisions of the Plan,

(d) Determine the amount of benefits which shall be payable to any person in accordance with the provisions of the Plan, to inform the Employer, insurer as appropriate, of the amount of such benefits, and to provide a full and fair review to any Participant whose claim for benefits has been denied in whole or in part,

(e) Designate other persons to carry out any duty or power, which may or may not otherwise be a fiduciary responsibility of the Plan Administrator, under the terms of the Plan,

(f) Keep records of all acts and determinations, and to keep all such records, books of account, data, and other documents as may be necessary for the proper administration of the Plan, and

(g) Do all things necessary to operate and administer the Plan in accordance with its provisions.

7.3 Provision for Third-Party Plan Service Providers

The Plan Administrator, subject to approval of the Employer, may employ the services of such persons as it may deem necessary or desirable in connection with the operation of the Plan and to rely upon all tables, valuations, certificates, reports, and opinions furnished thereby. Unless otherwise provided in the service agreement, obligations under this Plan shall remain the obligation of the Employer.

7.4 Fiduciary Liability

To the extent permitted by law, the Plan Administrator shall not incur any liability for any acts or for failure to act except for their own willful misconduct or willful breach of this Plan.

7.5 Compensation of Plan Administrator

Unless otherwise determined by the Employer and permitted by law, any Plan Administrator who is also an employee of the Employer shall serve without compensation for services rendered in such capacity, but all reasonable expenses incurred in the performance of their duties shall be paid by the Employer.

7.6 Bonding

Unless otherwise determined by the Employer or unless required by any federal or state law, the Plan Administrator shall not be required to give any bond or other security in any jurisdiction in connection with the administration of this Plan.

7.7 Payment of Administrative Expenses

All reasonable expenses incurred in administering the Plan are currently paid by the Employer.

7.8 Funding Policy

The Employer shall have the right to enter into a contract with one or more insurance companies for the purposes of providing any benefits under the Plan and to replace any of such insurance companies or contracts. Any dividends, retroactive rate adjustments, or other refunds of any type, which may become payable under any such insurance contract, shall not be assets of

the Plan but shall be the property of, and will be retained by the Employer. The Employer will not be liable for any loss or obligation relating to any insurance coverage except as is expressly provided by this plan. Such limitation shall include, but not be limited to, losses or obligations, which pertain to the following:

(a) Once insurance is applied for or obtained, the Employer will not be liable for any loss which may result from the failure to pay premiums to the extent premium notices are not received by the Employer;

(b) To the extent premium notices are received by the Employer, the Employer's liability for the payment of such premiums will be limited to such premiums and will not include liability for any other loss which result from such failure;

(c) The Employer will not be liable for the payment of any insurance premium or any loss, which may result from the failure to pay an insurance premium if the benefits available under this plan are not enough to provide for such premium cost at the time it is due. In such circumstances, the Employee will be responsible for and see to the payment of such premiums. The Employer will undertake to notify a Participant if available benefits under this plan are not enough to provide for an insurance premium, but will not be liable for any failure to make such notification;

(d) When employment ends, the Employer will have no liability to take any step to maintain any policy in force except as may be specifically required otherwise in this plan, and the Employer will not be liable for or responsible to see to the payment of any premium after employment ends.

7.9 Disbursement Reports

The Plan Administrator shall issue directions to the Employer concerning all benefits, which are to be paid from the Employer's general assets pursuant to the provisions of the Plan.

7.10 Indemnification

The Plan Administrator shall be indemnified by the Employer against claims, and the expenses of defending against such claims, resulting from any action or conduct relating to the administration of the Plan except claims arising from gross negligence, willful neglect, or willful misconduct.

7.11 Statements

The Plan Administrator may periodically furnish each Participant with a statement, showing the amounts paid or expenses incurred by the Employer in providing Health Care and/or Dependent Care Reimbursement and the respective Reimbursement Account balance(s).

8. Claims Procedures

The Plan has established procedures for reviewing claims denied under this Plan and those claims review procedures are set forth in the SPD. The Plan's claim review procedures set forth in the SPD shall only apply to issues germane to the pre-tax Contributions made under this Plan (i.e. determinations of Change in Status events, changes in cost or coverage, eligibility and participation matters under this document) and to the extent offered under the Plan, claims for benefits under the Reimbursement Accounts. Only after exhaustion of the claims procedure as provided under this Plan may any person pursue any other legal or equitable remedy.

9. Plan Amendment and Termination

9.1 Permanency

While the Employer fully expects that this Plan will continue indefinitely, permanency of the Plan will be subject to the Employer's right to amend or terminate the Plan, as provided in Sections 9.2 and 9.3 below.

9.2 Employer's Right to Amend

The Employer reserves the right to:

(a) Amend the Plan at any time and from time-to-time, and retroactively, if deemed necessary or appropriate for any reason whatsoever; and

(b) Modify or amend in whole; or in part any or all of the provisions of the Plan; provided, however, that, no such modification or amendment shall make it possible for any balances in a Participant's Account to be used for, or diverted to, purposes other than for the exclusive benefit of the Participants and their beneficiaries under the Plan.

9.3 Employer's Right to Terminate

The Employer reserves the right to discontinue or terminate the Plan without prejudice at any time without prior notice. Such decision to terminate the Plan shall be made in writing and shall be approved by the Commissioners Court (or a duly authorized officer) in accordance with its normal procedures for transacting business.

9.4 Determination of Effective Date of Amendment or Termination

Any such amendment, discontinuance, or termination shall be effective as of such date as the Board of Directors (or a duly authorized officer) shall determine. Subject to Section 4.4 of Appendix A and Section 5.4 of Appendix B, no amendment, discontinuance, or termination shall allow the return to any Employer of any balance in a Participant's Account nor its use for any purpose other than for the exclusive benefit of the Participants and their beneficiaries.

10. Miscellaneous Provisions

10.1 Information to be Furnished

As may reasonably be requested from time to time for the purpose of administration of the Plan, Participants will sign documents and provide the Company and Plan Administrators with pertinent information and evidence.

10.2 Limitation of Rights

Neither the establishment of the Plan nor any amendment thereof nor the payment of any benefits will be construed as giving to any Participant or other person any legal or equitable right against the Company or Plan Administrator except as provided herein.

10.3 Not an Employment Contract

Neither this Plan nor any action taken with respect to it confers upon any person the right of employment or continued employment with any Employer.

10.4 Governing Law

This Plan will be construed, administered, and enforced according to applicable federal law and, unless preempted by ERISA, the laws of the state named in the SPD.

10.5 Postmortem Payments

Any Benefit payable under the Plan after the death of a Participant will be paid to the surviving Spouse (if any), otherwise to the Participant's estate. If there is doubt as to the right of any beneficiary to receive any amount, the Plan Administrator may retain such amount until the rights thereto are determined, without liability for any interest thereon, or it may pay such amount into any court of appropriate jurisdiction, in either of which events neither the Plan Administrator nor any Employer shall be under any further liability to any person.

10.6 Non-alienation of Benefits

No benefit under the Plan will be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, or charge; and any attempt to do so will be void except as otherwise set forth in the component Benefit Package Options.

10.7 Mental or Physical Incompetency

If the Plan Administrator determines that any person entitled to payments under the Plan is incompetent by reason of physical or mental disability, the Plan Administrator may cause all payments thereafter becoming due to such person to be made to any other person for the Participant's benefit, without responsibility to follow the application of amounts so paid. Payments made pursuant to this Section will completely discharge the Plan Administrator and Employer from further liability hereunder.

10.8 Inability to Locate Payee

If the Plan Administrator is unable to make payment to any Participant or other person to whom a payment is due under the Plan because the identity or whereabouts of such Participant or other person cannot be ascertained after reasonable efforts have been made to identify or locate such person (including a notice of the payment so due mailed to the last known address of each Participant or other person as shown on the records of the Employer), such payment and all subsequent payments otherwise due to such Participant or other person will be forfeited seven (7) years after the date any such payment first became due.

10.9 Requirement for Proper Forms

All communications in connection with the Plan made by a Participant will become effective only when duly executed on any forms as may be required and furnished by, and filed with, the Plan Administrator.

10.10 Source of Payments

The Employer and any insurance company contracts purchased or held by the Employer will be the sole sources of benefits under the Plan. No Employee or beneficiary will have any right to, or interest in, any assets of the Employer upon termination of employment or otherwise, except as provided from time to time under the Plan, and then only to the extent of the benefits payable under the Plan to such Employee or beneficiary.

10.11 Multiple Functions

Any person or group of persons may serve in more than one fiduciary capacity with respect to the Plan.

10.12 Tax Effects

Neither the Employer nor the Plan Administrator makes any warranty or other representation as to whether any payments made to or on behalf of any Participant hereunder will be treated as excludable from gross income for state or federal income tax purposes.

10.13 Gender, Number, and Headings

Masculine pronouns include the feminine as well as the neuter genders, and the singular shall include the plural, unless indicated otherwise by the context. The Section headings contained herein are for convenience of reference only, and are not to be construed as defining or limiting the matter contained hereunder.

10.14 Code and ERISA Compliance

It is intended that this Plan meet all applicable requirements of the Code and ERISA, and of all regulations issued hereunder. (ERISA does not generally apply to the DCAP component.) This Plan shall be construed, operated, and administered accordingly, and in the event of any conflict between any part, clause, or provision of this Plan and the Code and/or ERISA, the provisions of the Code and ERISA shall be deemed controlling, and any conflicting part, clause, or provision of this Plan shall be deemed superseded to the extent of the conflict.

10.15 Incorporation by Reference

The actual terms and conditions of the separate Benefit Package Options 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 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.

10.16 Severability

Should a court of competent jurisdiction subsequently invalidate any part of this Plan, the remainder thereof shall be given effect to the maximum extent possible.

APPENDIX A:
DEPENDENT CARE ASSISTANCE PLAN

1. PURPOSE

This Dependent Care Assistance Plan (DCAP) has been established by the Employer as a dependent care assistance program under Section 129 of the Internal Revenue Code for the benefit of Employees who participate in the Cafeteria Plan (the Plan) and who, pursuant to the election procedures set forth in the Plan, choose to make contributions to a dependent care expense reimbursement spending account (Dependent Care Account) established pursuant to this DCAP. A Participant may utilize his Dependent Care Account to reimburse eligible expenses for the custodial care of a child or other eligible dependent, when such custodial care is needed to enable the Participant and his Spouse (if applicable) to remain employed. This DCAP is intended to provide reimbursement of dependent care expenses that are excludable from the Participants' gross incomes under Section 129 of the Code. This DCAP is a component of, and incorporated by reference into, the Plan.

2. DEFINITIONS

Unless otherwise specified, terms that are capitalized in this Appendix A have the same meaning as the defined terms in the Plan. The definitions of terms defined in this Appendix A, but not defined in Section 2 of the Plan shall be applicable only with respect to this Appendix A. To the extent a term is defined both in the Plan and in this Appendix A, the term as defined in the Plan shall govern the interpretation of the Plan and the term as defined in this Appendix A shall govern the interpretation of this Appendix A.

2.1 DEPENDENT CARE ASSISTANCE ACCOUNT

The Reimbursement Account referenced in Section 6.3 of the Plan.

2.2 DEPENDENT CARE EXPENSES

Dependent Care Expenses means those expenses incurred after the Employee's effective date of participation in the DCAP to the extent that the expenses incurred satisfy the conditions set forth in the SPD.

2.3 EDUCATIONAL INSTITUTION

Any educational institution that normally maintains a regular faculty and curriculum and normally has a regularly enrolled body of students in attendance at the place where its educational activities are regularly carried out.

2.4 ELIGIBLE DAY CARE CENTER

A day care center providing full- or part-time care for more than six individuals (other than individuals who reside at the day care center) on a regular basis during the calendar year, and which:

(a) complies with all applicable laws and regulations of the state and town, city, or village in which it is located; and

(b) receives a fee, payment, or grant for services for any of the individuals to whom it provides services (regardless of whether such facility is operated for profit).

2.5 QUALIFYING INDIVIDUAL

A Qualifying Individual is an individual who satisfies the conditions set forth in the SPD.

2.6 PARTICIPANT

An individual Employee who participates in this DCAP in accordance with Section 3 of the Plan.

2.7 PROGRAM AGREEMENT

The agreement between the Participant and the Employer that sets forth the terms of use of an electronic payment card offered by the Employer and chosen by the Participant to pay for Eligible Dependent Care Expenses.

2.8 Spouse

The person to whom the Participant is legally married, but shall not include an individual legally separated from a Participant under a decree of legal separation, nor a spouse living apart from the Participant in accordance with the special rules of Code Section 21(c)(4).

2.9 Student

An individual who during each of five calendar months during a Plan Year is enrolled as a full-time student at an Educational Institution.

3. Participation

3.1 Commencement of Participation

Each Employee who satisfies the Eligibility Requirements set forth in the SPD shall be eligible to participate in this DCAP on the dates set forth in the SPD.

3.2 Cessation of Participation

A Participant will cease to be a Participant in the DCAP as of the earliest of dates set forth in the SPD.

3.3 Election of Benefits

A Participant may elect to contribute to a Dependent Care Assistance Account under this DCAP and to receive reimbursement for Dependent Care Expenses by filing a Benefit Election Form in accordance with the procedures established under the Plan.

3.4 Plan Limits

The Plan Administrator may establish procedures to limit the amount of a Participant's contributions to this DCAP in order to prevent the amount of such contributions exceeding the maximum annual amount which the Participant may receive in reimbursement of Dependent Care Expenses as described in Section 3.6 below.

3.5 Other Administrative Documentation

The Plan Administrator may require the Participant, on an annual basis, to file a statement or otherwise acknowledge that he intends to file Form 2441 with the Internal Revenue Service. In addition, if the Participant elects to contribute more than $2,500 to his Dependent Care Assistance Account, the Plan Administrator may require the Participant to verify that he is either unmarried or that, if married, he does not intend to file a separate federal tax return.

3.6 Maximum Contribution Amounts

The maximum amount, which the Participant may receive in the form of dependent care assistance under this DCAP with respect to Dependent Care Expenses incurred in any calendar year, shall be set forth in the SPD.

4. Dependent Care Assistance Accounts

4.1 Establishment of Accounts

The Employer will establish and maintain on its books a Dependent Care Assistance Account for each Plan Year with respect to each Participant who has elected to receive reimbursement of Dependent Care Expenses incurred during the Plan Year.

4.2 Crediting and Debiting of Accounts

Each Participant's Dependent Care Expense Reimbursement Account ("Dependent Care Account") will be credited with Contributions allocated thereto by the Participant on the Benefit Election Form and/or any Benefit Credits allocated thereto by the Employer (or by the Participant to the extent permitted in the SPD or enrollment material). The Dependent Care Account will be debited for reimbursement amounts disbursed to the Participant in accordance with this Appendix A. In the event that the amount in the Dependent Care Account is less than the amount of reimbursable claims at any time during the Plan Year, the excess part of the claim will be carried over into following months (within the same Plan Year), to be paid out as the Dependent Care Account balance becomes adequate. In no event will the amount of reimbursements of Dependent Care

Expenses exceed the amount elected to be credited to the Dependent Care Account for any Plan Year. Any amount allocated to the Dependent Care Account shall be forfeited by the Participant and restored to the Employer if it has not been applied to provide Dependent Care Expense Reimbursements for the Plan Year within the Claims Submission Grace Period or the Closing Period set forth in the SPD, whichever is applicable. Amounts so forfeited shall be used as set forth in Section 4.4 of this Appendix A.

4.3 Source of Payments

All Dependent Care Expenses shall be paid exclusively from the amounts in each Employee's Dependent Care Account funded by Contributions and/or Benefit Credits (if applicable) allocated thereto pursuant to the Benefit Election Form.

4.4 Forfeiture of Dependent Care Assistance Accounts

If any balance remains in the Participant's Dependent Care Assistance Account for a Plan Year after all reimbursements, such balance shall not be carried over to reimburse the Participant for any Dependent Care Expenses incurred during a subsequent Plan Year, and shall not be available to the Participant in any other form or manner, but shall revert back to the Employer to be used in a manner permitted by applicable law.

5. Payment of Dependent Care Assistance

5.1 Claims for Reimbursement

A Participant who has elected to receive dependent care assistance for a Plan Year may apply to the Plan Administrator, or its designated claims administration representative, for reimbursement of Dependent Care Expenses. The application shall be in such form as the Plan Administrator (or its designated claims administration representative) may prescribe. The application shall be accompanied by a written statement or invoice from an independent third party stating or indicating that the expense has been incurred and the amount of the expense. The Plan Administrator, or its designated claims administration representative, may also require as part of the application such other information or documentary evidence (e.g., bills, receipts, canceled checks) as it may deem necessary or desirable to ascertain the eligibility of a Participant's claim for reimbursement. Alternatively, the participant may choose to pay for claims using an electronic payment card as set forth in the SPD.

5.2 Reimbursement or Payment of Expenses

The Participant shall be reimbursed from the Participant's Dependent Care Assistance Account, at such time and in such manner as the Plan Administrator or its claims administration representative may prescribe, but no less frequently than monthly, for Dependent Care Expenses incurred during the Plan Year by a Participant, for which the Participant makes written application and submits documentation in accordance with the terms of the SPD. The Plan Administrator (or its designated representative) may, at its option or in accordance with the Participant's written direction, pay any such Dependent Care Expenses directly to the provider of services with respect to such expenses in lieu of reimbursing the Participant. No reimbursement or payment under this Section 5.2 of expenses incurred during a Plan Year shall at any time exceed the balance of the Participant's Dependent Care Assistance Account for the Plan Year at the time of the reimbursement or payment, nor shall any reimbursement or payment be made if the Participant's claim is for an amount less than the minimum reimbursable amount as may be established by the Plan Administrator. The amount of any Dependent Care Expenses not reimbursed or paid as a result of the minimum reimbursable amount described in the preceding sentence shall be carried over and reimbursed or paid only if and when the Participant's unreimbursed claims equal or exceed such minimum and the balance in the Participant's Dependent Care Assistance Account permits such reimbursement or payment. Notwithstanding the preceding sentence, claims for expenses incurred during a Plan Year that are submitted for reimbursement during the earlier of the end of a terminated employee's grace period or the last month of the Plan Year or within the three months (or such other reasonable period as may be established by the Plan Administrator) following the close of the Plan Year (or which are carried over to the last month of the Plan Year in accordance with the preceding sentence) shall be paid regardless of whether they equal or exceed the minimum reimbursable amount, provided the balance in the Participant's Dependent Care Assistance Account permits such reimbursement or payment.

5.3 Report(s) to Participants

The Plan Administrator shall furnish or cause to be furnished to each Participant (or former Participant) who has received dependent care assistance under this DCAP during the Plan Year a written statement showing the amount of such assistance

paid during such year with respect to the Participant (or former Participant). Such reports must be furnished at least annually, but may be provided more frequently.

5.4 Limitation on Reimbursements or Payments with Respect to Certain Participants

Notwithstanding any other provisions of this Plan, the Plan Administrator may limit the amounts reimbursed or paid with respect to any Participant who is a Highly Compensated Individual (within the meaning of Code Section 414(q)) to the extent the Plan Administrator deems such limitation to be necessary to assure compliance with any nondiscrimination provision of the Code. Such limitation may be imposed whether or not it results in a forfeiture.

6. Administration

6.1 Administrator

The administration of the DCAP shall be under the supervision of the Plan Administrator, the responsibilities of which are set forth in Section 7 of the Plan. It shall be a principal duty of the Plan Administrator to see that the DCAP is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in the DCAP without discrimination among them. The powers ascribed to the Plan Administrator under the Plan shall likewise apply with respect to their duties under this DCAP, and are incorporated herein by reference.

6.2 Records

The Plan Administrator shall keep or cause to be kept accurate and complete books and records with respect to the operations and administration of this DCAP.

6.3 Reliance on Determinations, etc.

In administering the DCAP, the Plan Administrator and/or its delegate will be entitled, to the extent permitted by law, to rely conclusively on all certificates, determinations, opinions, and reports which are furnished by any accountant, counsel, claims administrator, or other expert who is employed or engaged by the Plan Administrator.

6.4 Denied Claims Procedure Under the Plan

The Plan has established procedures for reviewing claims denied under the DCAP and those claims review procedures are set forth in the SPD.

6.5 Preservation of Remedies

After exhaustion of the claims procedure as provided under this Plan, nothing is to prevent any person from pursuing any other legal or equitable remedy. Any suit [for benefits] must be brought within one year after the date the Plan Administrator (or his designee) has made a final denial (or deemed denial) of the claim. Notwithstanding any other provision herein, any suit for benefits must be brought within two years after the date the claim arose.

6.6 Excess Reimbursement

If it is determined that a Participant has received payments under this Plan that exceed the amount of Dependent Care Expenses that have been substantiated by such Participant during the Plan Year, the Plan Administrator shall give the Participant prompt written notice of any such excess amount, and the Participant shall repay the amount of such excess to the Employer within sixty (60) days of receipt of such notification.

7. Amendment and Termination

The Employer reserves the right at any time or times to amend or terminate the provisions of the DCAP, to any extent and in any manner that it may deem advisable, as specified in the Plan.

8. Miscellaneous

8.1 Funding Status of DCAP

Except as may otherwise be required by law or under the terms of the Plan:

(a) Any amount, by which a Participant's taxable compensation is reduced by reason of an election made under this DCAP, will remain part of the general assets of the Employer.

(b) The benefits provided hereunder will be paid solely from the general assets of the Employer.

(c) Nothing herein will be construed to require any Employer or the Plan Administrator to maintain any fund or segregate any amount for the benefit of any Participant.

(d) No Participant or other person shall have any claim against, right to, or security, or other interest in any fund, account, or asset of the Employer from which any payment under the DCAP may be made.

Notwithstanding the foregoing, the Employer may establish one or more voluntary employees beneficiary association (VEBA) trusts within the meaning of Code Section 501(c)(9) for the purpose of funding benefits to be provided under this DCAP.

8.2 ASSIGNMENT

The Participant may, if permitted by the Plan Administrator, authorize the DCAP to pay a Participant's reimbursement of Dependent Care Expenses directly to the provider of services with respect to such expenses. Except as provided in the foregoing sentence or as set forth in the Program Agreement, a Participant may not assign, alienate, anticipate, or commute any payment with respect to any reimbursements of Dependent Care Expenses which a Participant is entitled to receive from the DCAP and, further, except as may be prescribed by law, no benefits shall be subject to any attachments or garnishments of or for a Participant's debts or contracts except for recovery of overpayments made on the Participant's behalf by this DCAP.

8.3 NO GUARANTEE OF TAX CONSEQUENCE

Neither the Plan Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under this DCAP will be excludable from the Participant's gross income for federal or state income tax purposes, or that any other federal or state tax treatment will apply to or be available to any Participant. It shall be the obligation of each Participant to determine whether each payment under the DCAP is excludable from the Participant' s gross income for federal and state income tax purposes, and to notify the Employer if the Participant has reason to believe that any such payment is not so excludable.

8.4 INDEMNIFICATION OF EMPLOYER BY PARTICIPANTS

If any Participant receives one or more payments or reimbursements under this DCAP that are not for Dependent Care Expenses, such Participant shall indemnify and reimburse the Employer for any liability it may incur for failure to withhold federal or state income tax or Social Security tax from such payments or reimbursements.

APPENDIX B:
MEDICAL EXPENSE REIMBURSEMENT PLAN

1. PURPOSE

This Medical Expense Reimbursement Plan (the Health FSA Plan) has been established by the Employer to help provide full and complete medical care for those Employees who participate in the Employer's cafeteria plan (Plan) and who, pursuant to the election procedures set forth in the Plan, choose to make contributions to a medical expense reimbursement account established pursuant to this Health FSA Plan. This Health FSA Plan is intended to provide reimbursement of deductibles, co-payments, and coinsurance amounts that a Participant may be required to pay pursuant to the medical care, dental, and vision Benefit Package Option elected under the Plan, as well as reimbursement of other medical and hospitalization expenses covered by this Plan. The Employer intends that the Health FSA Plan qualify as a Code Section 105 self-insured medical reimbursement plan, and that the benefits provided under the Health FSA Plan be eligible for exclusion from the Participant's income for federal income tax purposes under Section 105(b) of the Code. This Health FSA Plan is a component of, and incorporated by reference into, the Plan.

2. DEFINITIONS

Unless otherwise specified, terms that are capitalized in this Appendix B have the same meaning as the defined terms in the Plan. The definitions of terms defined in this Appendix B, but not defined in Section 2 of the Plan, shall be applicable only with respect to

this Appendix B. To the extent a term is defined both in the Plan and in this Appendix B, the term as defined in the Plan shall govern the interpretation of the Plan and the term as defined in this Appendix B shall govern the interpretation of this Appendix B.

2.1 Coverage Amount

The amount of medical reimbursement coverage elected by the Participant for the Plan Year under Section 4 of Appendix B herein.

2.2 Dependent

For the purpose of this Appendix B only, a "Dependent" shall have the meaning assigned to it by the SPD.

2.3 Eligible Medical Expense

Eligible Medical Expenses shall have the meaning assigned to it by the SPD.

2.4 Medical Expense Reimbursement Account

The Reimbursement Account described in Section 6.2 of the Plan.

2.5 Participant

A participant is an individual who participates in this Health FSA Plan in accordance with Section 3 of the Plan.

2.6 Program Agreement

The agreement between the Participant and the Employer that sets forth the terms of use of an electronic payment card offered by the Employer and chosen by the Participant to pay for Eligible Medical Expenses.

3. Participation

3.1 Commencement of Participation

Each Employee who satisfies the Eligibility Requirement set forth in the SPD shall be eligible to participate in this Health FSA Plan on the dates set forth in the SPD.

3.2 Cessation of Participation

A Participant will cease to be a Participant as of the earliest of the dates set forth in the SPD.

3.3 Coverage During a Leave of Absence

Coverage under the Health FSA Plan will be governed by the rules set forth in the SPD.

4. Elections

4.1 Election of Benefits

A Participant may elect to contribute to a Medical Reimbursement Account under this Health FSA Plan and to receive reimbursements of Eligible Medical Expenses not in excess of the Plan Limits described in Section 4.2 below elected by filing a Benefit Election Form in accordance with the procedures set forth in the SPD.

4.2 Plan Limits

A Participant may elect to receive payments or reimbursements of Eligible Medical Expenses incurred in any Plan Year up to any dollar amount specified by the Participant, but not exceeding the maximum annual reimbursement amount set forth in the SPD.

4.3 Duration of Elections

Once effective, any election (and related Benefit Election Form) with respect to this Health FSA Plan shall remain in effect until the end of the Plan Year for which it was made, except as provided in Section 3.4, 3.5 or 4.6 of the Plan herein.

5. Medical Reimbursement Accounts

5.1 Establishment of Accounts

The Employer will establish and maintain on its books a Health Care Account for each Plan Year with respect to each Participant who has elected to receive reimbursement of Eligible Medical Care Expenses incurred during the Plan Year.

5.2 Crediting and Debiting of Accounts

Each Participant's Health Care Account will be credited with Contributions allocated thereto by the Participant on the Benefit Election Form for Eligible Medical Expenses and any Benefit Credits allocated thereto by the Employer (or where applicable, by the Participant) not to exceed the maximum annual reimbursement set forth in the SPD. The Health Care Account will be debited for reimbursement amounts disbursed to the Participant in accordance with this Appendix B. The entire amount elected by the Participant on the Benefit Election Form as an annual amount for the Plan Year for Eligible Medical Expenses less any reimbursement from the Health Care Account already disbursed shall be available to the Participant at any time during the Plan Year without regard to the balance in the Health Care Account (provided that the periodic Contributions have been paid). Thus, the maximum amount of reimbursement available at any particular time during the Plan Year will not relate to the amount which a Participant has had credited to the Health Care Account at that time. In no event will the amount of Eligible Medical Expenses reimbursed in any Plan Year exceed the annual amount specified for the Plan Year in Benefit Election Form for the Medical Expense Reimbursement Plan. Any amount allocated to the Health Care Account shall be forfeited by the Participant and restored to the Employer if it has not been applied to provide reimbursement of Eligible Medical Expenses within the Claims Submission Grace Period or Closing Period set forth in the SPD, whichever is applicable. Amounts so forfeited shall be used in accordance with Section 5.4 herein.

5.3 Source of Payments

All Eligible Medical Expenses shall be paid exclusively from the amounts in each Employee's Health Care Account funded by Contributions and any Benefit Credits (if applicable) allocated to the Health Care Account pursuant to the Benefit Election Form.

5.4 Forfeiture of Health Care Accounts

If any balance remains in the Participant's Health Care Account for a Plan Year after all reimbursements hereunder, the Participant shall forfeit such balance. Said balance shall be used in a manner permitted by the applicable rules and regulations.

6. Payment of Eligible Medical Care Expenses

6.1 Claims for Reimbursement

A Participant who has elected to receive medical care reimbursements for a Plan Year may apply to the Plan Administrator, or its designated claims administration representative, for reimbursement of Eligible Medical Care Expenses. The application shall be in such form as the Plan Administrator (or its designated claims administration representative) may prescribe.

The application shall be accompanied by a written statement or invoice from an independent third party stating or indicating that the expense has been incurred, the date the service was rendered, and the amount of the expense. The Plan Administrator, or its designated claims administration representative, may also require as part of the evidence application such other information or documentation as it may deem necessary or desirable to ascertain the eligibility of a Participant's claim for reimbursement (e.g., bills, receipts, canceled checks). Alternatively, the participant may choose to pay for claims using an electronic payment card as set forth in the SPD.

6.2 Reimbursement or Payment of Expenses

The Participant shall be reimbursed from the Participant's Medical Reimbursement Account, at such time and in such manner as the Plan Administrator or its claims administration representative may prescribe, but no less frequently than monthly, for Eligible Medical Expenses incurred during the Plan Year while a Participant, for which the Participant makes written

application and submits documentation in accordance with Section 6.1 above. The Plan Administrator (or its claims administration representative) may, at its option or in accordance with the Participant's written direction, pay any such Eligible Medical Expenses directly to the person providing or supplying medical care in lieu of reimbursing the Participant. No reimbursement or payment will be made if the Participant's claim for reimbursement or payment is for an amount less than the minimum reimbursable amount as specified in the SPD. The amount of any Eligible Medical Expenses not reimbursed or paid as a result of the minimum reimbursable amount described in the preceding sentence shall be carried over and reimbursed or paid only if and when the Participant's unreimbursed claims equal or exceed such minimum. Notwithstanding the preceding sentence, claims for expenses incurred during a Plan Year that are submitted for reimbursement during the last month of the Plan Year or within the Claims Submission Grace Period or Closing Period (whichever is applicable) shall be paid regardless of whether they equal or exceed the minimum reimbursable amount, provided they do not exceed the remaining balance of the Participant's Health Care Account.

6.3 Report(s) to Participants

The Plan Administrator shall furnish or cause to be furnished to each Participant (or former Participant) who has received reimbursement of Eligible Medical Expenses under this Health FSA Plan during the Plan Year a written statement showing the amount of such assistance paid during such year with respect to the Participant (or former Participant). Such reports must be furnished at least annually, but may be provided more frequently.

6.4 Limitation on Reimbursements or Payments with Respect to Certain Participants

Notwithstanding any other provisions of this Health FSA Plan, the Plan Administrator may limit the amounts reimbursed or paid with respect to any Participant who is a Highly Compensated Individual (within the meaning of Code Section 105(h)(5) or 125(e)) to the extent the Plan Administrator deems such limitation to be necessary to assure compliance with any nondiscrimination provision of the Code. Such limitation may be imposed whether or not it results in a forfeiture.

6.5 Excess Reimbursements

If, as of the end of any Plan Year, it is determined that a Participant has received payments under this Plan that exceed the amount of Eligible Medical Expenses that have been substantiated by such Participant during the Plan Year, the Plan Administrator shall give the Participant prompt written notice of any such excess amount, and the Participant shall repay the amount of such excess to the Employer within sixty (60) days of receipt of such notification.

7. COBRA Continuation Coverage

The SPD includes provisions that shall be applicable to the Health FSA to the extent the Health FSA is a "group health plan" as defined by Code Section 4980B and 5000(b)(1) and the regulations promulgated hereunder and is offered under the Plan. The intent of those provisions (as incorporated in this Article) is to extend continuation rights required by COBRA. To the extent greater rights are provided for in the SPD, that portion of the SPD is void.

8. Administration

8.1 Administration

The administration of the Health FSA Plan shall be under the supervision of the Plan Administrator, the responsibilities of which are set forth in the Plan. It shall be a principal duty of the Plan Administrator to see that the Health FSA Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in the Health FSA Plan without discrimination among them. The powers ascribed to the Plan Administrator under the Plan, including without limitation the power and discretion to interpret its terms and to delegate responsibilities among themselves and to others, shall likewise apply with respect to their duties under this Health FSA Plan, and are incorporated herein by reference.

8.2 Records

The Plan Administrator shall keep or cause to be kept accurate and complete books and records with respect to the operations and administration of this Health FSA Plan.

8.3 Reliance on Determinations, etc.

In administering the Health FSA Plan, the Plan Administrator will be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, determinations, opinions, and reports which are furnished by any accountant, counsel, claims administrator providing medical utilization management services, or other expert who is employed or engaged by the Plan Administrator.

8.4 Denied Claims Procedure Under the Plan

The Plan has established procedures for reviewing claims denied under this Plan and those claims review procedures are set forth in the SPD.

8.5 Preservation of Remedies

After exhaustion of the claims procedure as provided under this Plan, nothing is to prevent any person from pursuing any other legal or equitable remedy. Any suit [for benefits] must be brought within one year after the date the Plan Administrator (or his designee) has made a final denial (or deemed denial) of the claim. Notwithstanding any other provision herein, any suit for benefits must be brought within two years after the date the claim arose.

9. Amendment and Termination

The Employer reserves the right at any time or times to amend or terminate the provisions of this Health FSA Plan, to any extent and in any manner that it may deem advisable, as specified in the Plan.

10. Miscellaneous

10.1 Funding Status of Health FSA Plan

Except as may otherwise be required by law or under the terms of the Plan,

(a) Any amount by which a Participant's taxable Compensation is reduced by reason of an election made under this Health FSA Plan will remain part of the general assets of the Employer.

(b) The benefits provided hereunder will be paid solely from the general assets of the Employer.

(c) Nothing herein will be construed to require any Employer or the Plan Administrator to maintain any fund or segregate any amount for the benefit of any Participant.

(d) No Participant or other person shall have any claim against, right to, or security or other interest in, any fund, account or asset of the Employer from which any payment under the Health FSA Plan may be made.

Notwithstanding the foregoing, the Employer may establish one or more voluntary employees beneficiary association (VEBA) trusts within the meaning of Code Section 501(c)(9) for the purpose of funding benefits to be provided under this Health FSA Plan.

10.2 Assignment

The Participant may, if permitted by the Plan Administrator, authorize the Health FSA Plan to pay a Participant's or Dependent's reimbursement directly to the physician or hospital who provided the Participant or Dependent with covered care and treatment. Except as provided in the foregoing sentence or as set forth in the Program Agreement, a Participant may not assign, alienate, anticipate, or commute any payment with respect to any reimbursements of Eligible Medical Expenses which a Participant or Dependent is entitled to receive from the Health FSA Plan and, further, except as may be prescribed by law, no benefits shall be subject to any attachments or garnishments of or for a Participant or Dependent's debts or contracts, except for recovery of overpayments made on the Participant's or Dependent's behalf by this Health FSA Plan.

10.3 No Guarantee of Tax Consequence

Neither the Plan Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under this Health FSA Plan will be excludable from the Participant's gross income for federal or state income tax purposes, or that any other federal or state tax treatment will apply to or be available to any Participant. It shall be the obligation of each Participant to determine whether each payment under the Health FSA Plan is excludable from the

Participant's gross income for federal and state income tax purposes, and to notify the Employer if the Participant has reason to believe that any such payment is not so excludable.

10.4 INDEMNIFICATION OF EMPLOYER BY PARTICIPANTS

If any Participant receives one or more payments or reimbursements under this Plan that are not for Eligible Medical Expenses, such Participant shall indemnify and reimburse the Employer for any liability it may incur for failure to withhold federal or state income tax or Social Security tax from such payments or reimbursements.

11. HIPAA PRIVACY

11.1 SCOPE AND PURPOSE

The Health FSA (the "Plan") will use protected health information ("PHI") to the extent of and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Specifically, the Plan will use and disclose PHI for purposes related to health care treatment, payment for health care and health care operations as set forth below.

11.2 EFFECTIVE DATE

This Article VIII is effective on April 14, 2003 or such later effective date of the Privacy Rules with respect to the client.

11.3 USE AND DISCLOSURE OF PHI

(a) General. The Plan will use PHI to the extent of and in accordance with the uses and disclosures permitted by HIPAA, including but not limited to health care treatment, payment for health care, health care operations and as required by law. The Privacy Notice will list the specific uses and disclosure of PHI that will be made by the Plan.

(b) Disclosure to the Employer. The Plan will disclose PHI to the Employer, or where applicable, an Affiliate only upon receipt of written certification from the Employer that:

(i) The Plan document has been amended to incorporate the provisions in this Article XI; and

(ii) The Employer agrees to implement the provisions in Section 11.04 herein.

11.4 CONDITIONS IMPOSED ON EMPLOYER

Notwithstanding any provision of the Plan to the contrary, the Employer agrees:

(a) Not to use or disclose PHI other than as permitted or required by this Article VIII or as required by law;

(b) To ensure that any agents, including a subcontractor, to whom the Employer provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Employer with respect to PHI received or created on behalf of the Plan;

(c) Not use or disclose an individual's PHI for employment-related purposes (including hiring, firing, promotion, assignment or scheduling) unless authorized by the Individual;

(d) Not to use or disclose an Individual's PHI in connection with any other non-health benefit program or employee benefit plan of the Employer unless authorized by the Individual;

(e) To report to the Plan any use or disclosure of PHI that is inconsistent with this Article VIII, if it becomes aware of an inconsistent use or disclosure;

(f) To provide Individuals with access to PHI in accordance with 45 C.F.R. § 164.524;

(g) To make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 C.F.R. § 164.526;

(h) To make available the information required to provide an accounting of disclosures in accordance with 45 C.F.R. § 164.528;

(i) To make internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for purposes of determining the Plan's compliance with HIPAA;

(j) If feasible, to return or destroy all PHI received from the Plan that the Employer maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made. If return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible; and

(k) To ensure adequate separation between the Plan and Employer as required by 45 C.F.R. § 164.504(f)(2)(iii) and described in this Article XI.

11.5 Designated Employees Who May Receive PHI

In accordance with the Privacy Rules, only certain Employees who perform Plan administrative functions may be given access to PHI. Those Employees who have access to PHI from the Plan are listed in the Privacy Notice, either by name or individual position.

11.6 Restrictions on Employees with Access to PHI

The Employees who have access to PHI listed in the Privacy Notice may only use and disclose PHI for Plan Administration functions that the Employer performs for the Plan, as set forth in the Privacy Notice, including but not limited to, quality assurance, claims processing, auditing, and monitoring.

11.7 Policies and Procedures

The Employer will implement Policies and Procedures setting forth operating rules to implement the provisions hereof.

11.8 Organized Health Care Arrangement

The Plan Administrator intends the Plan to form part of an Organized Health Care Arrangement along with any other Benefit under a covered health plan (under 45 C.F.R. § 160.103) provided by the Employer.

11.9 Privacy Official

The Plan shall designate a Privacy Official, who will be responsible for the Plan's compliance with HIPAA. The Privacy Official may contract with or otherwise utilize the services of attorneys, accountants, brokers, consultants, or other third party experts as the Privacy Official deems necessary or advisable. In addition, and notwithstanding any provision of this Plan to the contrary, the Privacy Official shall have the authority to and be responsible for:

(a) Accepting and verifying the accuracy and completeness of any certification provided by the Employer under this Article VIII

(b) Transmitting the certification to any third parties as may be necessary to permit them to disclose PHI to Employer;

(c) Establishing and implementing policies and procedures with respect to PHI that are designed to ensure compliance by the Plan with the requirements of HIPAA;

(d) Establishing and overseeing proper training of the Plan, or Employer personnel who will have access to Protected Heath Information;

(e) Any other duty or responsibility that the Privacy Official, in his or her sole capacity, deems necessary or appropriate to comply with the provisions of HIPAA and the purposes of this Article XI.

11.10 Noncompliance

The Employer shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions for personnel who do not comply with the provisions of this Article VIII.

11.11 Definitions

As used in this Article VIII, each of the following capitalized terms shall have the respective meaning given below:

"Individual" means the person who is the subject of the heath information created, received or maintained by the Plan or Employer.

"Organized Health Care Arrangement" means the relationship of separate legal entities as defined in 45 C.F.R. §160.103.

"Privacy Notice" means the notice of the Plan's privacy practices distributed to Plan participants in accordance with 45 C.F.R. § 164.520, as amended from time to time.

"Privacy Rules" means the privacy provisions of HIPAA and the regulations in 45 C.F.R. Parts 160 and 164.

"Protected Health Information or PHI" means individually identifiable health information as defined in 45 C.F.R. § 160.103.

11.12 INTERPRETATION AND LIMITED APPLICABILITY

This Article VIII serves the sole purpose of complying with the requirements of HIPAA and shall be interpreted and construed in a manner to effectuate this purpose. Neither this Article XI nor the duties, powers, responsibilities, and obligations listed herein shall be taken into account in determining the amount or nature of the Benefits provided to any person covered under this Plan, nor shall they inure to the benefit of any third parties. To the extent that any of the provisions of this Article VIII are no longer required by HIPAA, they shall be deemed deleted and shall have no further force or effect.

11.13 SERVICES PERFORMED FOR THE EMPLOYER

Notwithstanding any other provision of this Plan to the contrary, all services performed by a business associate for the Plan in accordance with the applicable service agreement shall be deemed to be performed on behalf of the Plan and subject to the administrative simplification provisions of HIPAA contained in 45 C.F.R. parts 160 through 164, except services that relate to eligibility and enrollment in the Plan. If a business associate of the Plan performs any services that relate to eligibility and enrollment to the Plan, these services shall be deemed to be performed on behalf of the Employer in its capacity as Plan Sponsor and not on behalf of the Plan.

Fort Bend County
Section 125 Cafeteria Plan
PLAN INFORMATION SUMMARY
Effective Date: 01/01/2007

Employer Organization

Name of Organization:	Fort Bend County
Federal Employer ID Number:	74-6001969
Mailing Address:	301 Jackson
City, State, Zip:	Richmond, TX 77469
Street Address:	301 Jackson
Street Zip:	Richmond, TX 77469
Form of Organization:	Government
Organized in the state of:	TX

Plan Design Options

Plan Information

Plan Number:	502
Plan Name:	Fort Bend County 125 Flexible Benefits
Original Effective Date:	04/01/1989
Plan Year Runs*:	01/01 - 12/31
Plan Restated and Amended:	01/01/2007

*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:	Fort Bend County
Plan Service Provider:	Boon-Chapman
Street Address:	12301 Research Blvd., Suite 400
City, State, Zip:	Austin, TX 78759
Contact:	Terri Garza
Phone:	(800) 252-9653

Benefits Coordinator

Name:	
Title:	
Phone:	(281) 341-8630
Company Name:	Fort Bend County
Street Address:	301 Jackson
City, State, Zip:	Richmond, TX 77469

Acceptance of Legal Process

Name:
Title:
Phone: (281) 342-4555
Company Name: Fort Bend County
Street Address: 301 Jackson
City, State, Zip: Richmond, TX 77469

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 40.0 hours per week.

Service Period Requirement

For All plan years, eligibility is the following:

First of the month following the 90th day after hire.

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 Date requirements are met.

Signature: _____ Date: 12/12/06

Name: ROBERT HEBERT

Title: COUNTY JUDGE

Executed at: Fort Bend County
301 Jackson
Richmond, TX 77469

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.

Non-Core Supplemental Health Benefits.

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 60 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 60 days after the end of the plan year.

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 $2600.00.

(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 $0.00.

(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. There is no Minimum Check Amount under this Plan.

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 $0.00.

(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. There is no Minimum Check Amount under this Plan.

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.

CAFETERIA PLAN

PREMIUM REDUCTION OPTION *PLUS*

FLEXIBLE SPENDING ACCOUNTS

SUMMARY PLAN DESCRIPTION

AS ADOPTED BY

FORT BEND COUNTY

TABLE OF CONTENTS

Section 125 Cafeteria Plan

Part 1. Introduction

Your employer ("Employer") is pleased to sponsor an employee benefit program known as a Cafeteria Plan ("Plan") for certain eligible employees of the Employer. 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 may 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. The Plan is established pursuant to a plan document into which this SPD is incorporated (i.e. the plan document and this SPD constitute the plan document). However, if a conflict exists between the plan document and this SPD, the plan document will control.

Part 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 types of benefits ("Benefit Package Options").

- Pre-tax contributions for qualified benefits ("Benefit Package Options") offered under the Plan (as set forth in Part 6 below), which may include a Health FSA and/or Dependent Care FSA

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 that term is defined in the Plan Document) of the Employer who satisfies the Eligibility Requirements established by the Employer in the Plan Information Summary (as summarized in Part 6 below), is eligible to participate in this Plan.. [The employer may have separate election requirements for the cafeteria plan, e.g. the employer may require a salary reduction agreement in addition to the health insurance application]

You will cease to be a Participant if (1) the Plan terminates, (2) You cease to be eligible for the Plan (e.g. the Participant's employment is terminated), (3) You revoke your election to participate, or (4) the Plan is amended to exclude you or the class of employees of which you are a member. You may be entitled to temporarily continue coverage under one or more of the Benefit Package Options that provide group health coverage. Refer to the applicable plan summaries for more information on COBRA continuation coverage.

Q-4 What happens if I terminate employment (or cease to be eligible) and then am rehired (become eligible again) during the same Plan Year?

If you terminate your employment or you cease to be eligible for any reason, including (but not limited to) disability, retirement, layoff or voluntary resignation, and then you are rehired or again become eligible within 30 days or less of the date of a termination of employment or cessation of eligibility, then you will be reinstated in the Plan (assuming you otherwise satisfy the eligibility requirements of the Plan) with the same elections you had before termination (subject to any restrictions imposed under the applicable Benefit Package Options). If you are rehired or again become eligible more than 30 days following termination of employment or cessation of eligibility and you are otherwise eligible to participate in the Plan, then you may make new elections.

Q-5 What happens if I take a leave of absence?

(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 on the same terms and conditions as though you were still active (e.g., the Employer will continue to pay its share of the contribution to the extent you opt to continue coverage).

(b) Your Employer may elect to continue all coverage for Participants while they are on paid leave (provided Participants on non-FMLA paid leave are required to continue coverage). If so, you will pay your share of the contributions by the method normally used during any paid leave (for example, with Pre-tax Contributions if that is what was used before the FMLA leave began).

(c) In the event of unpaid FMLA leave (or paid leave where coverage is not required to be continued), if you opt to continue your group health coverage, you may pay your share of the contribution with after-tax dollars while on leave, or you may be given the option to pre-pay all or a portion of your share of the contribution for the expected duration of the leave with Pre-tax Contributions from 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-payments of Pre-tax Contributions may not be utilized to fund coverage during the next Plan Year, or by other arrangements agreed upon between you and the Plan Administrator (for example, the Plan Administrator may fund coverage during the leave and withhold amounts from your compensation upon your return from leave). The payment options provided by the Employer will be established in accordance with Code Part 125, FMLA, and the Employer's internal policies and procedures regarding leaves of absence. Alternatively, the Employer may require all Participants to continue coverage during the leave. If so, you may elect to discontinue your share of the required contributions until you return from leave. Upon return from leave, you will be required to repay the contribution not paid during the leave in a manner agreed upon with the Administrator.

(d) If your coverage ceases while on FMLA leave (e.g., for non-payment of required contributions), you will be permitted to re-enter the Plan upon return from such leave on the same basis as you were participating in the Plan prior to the leave, or as otherwise required by the FMLA. Your coverage under the Benefit Package Options providing health coverage may be automatically reinstated provided that coverage for Employees on non-FMLA leave is automatically reinstated upon return from leave.

(e) 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 Employer.

(f) 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 unpaid non-FMLA leave.

(g) If you go on an unpaid non-FMLA leave of absence (e.g., personal leave, sick leave, etc.) that does not affect eligibility in this Plan or a Benefit Package Option offered under this plan, then you will continue to participate and the contribution due will be paid by pre-payment before going on leave, by after-tax contributions while on leave, or with catch-up contributions after the leave ends, as may be determined by the Administrator. If you go on an unpaid leave that affects eligibility under this Plan or a Benefit Package Option, the election change rules in Part 2.Q-11 below will apply. The Plan Administrator will have discretion to determine whether taking an unpaid non-FMLA leave of absence affects eligibility.

Q-6 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. Following 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-7 How do I become a Participant?

You become a Participant by completing and submitting a Benefit Election Form (or Salary Reduction Agreement) to the Plan Administrator (or its designee identified on the election form) during one of the applicable enrollment periods described in Q-8 Q-8 below. Your effective date of participation is also described in Q-8 Q-8 below. Coverage under the Benefit Package Options that you elect will begin only as set forth in the summary plan descriptions (or other written material) for each Benefit Package Option that you elect.

Q-8 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 of the Plan.
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.

   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-10 below for what happens when you fail to return a Benefit Election Form during the enrollment period.

Q-9 How long is my election to participate (or not to participate) effective?

Your elections (either to participate or not) are for the entire Plan Year, which is usually 12 months. The first Plan Year and the last Plan Year may be for a shorter period. See Part 6 below for the exact dates of your Plan Year.

Q-10 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 or following the date you experience a change in status that allows you to enroll mid Plan Year (assuming you timely change your election). 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 to pay for one of your Benefit Package Options (other than Health FSA and/or Dependent Care FSA) with pre-tax contributions, it will be assumed that you want to these elections for the next Plan Year (and contribute your share of the cost on a pre-tax basis, adjusted to reflect any increase in the contribution).
2. 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.
3. 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-11 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. **Changes 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 change 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, you may increase your election to pay for COBRA coverage under the Employer's plan for yourself (if you still have pay) or any other individual who lost coverage but is a still a tax dependent (e.g. a child who lives with you and to whom you provide over half of their support but who has lost eligibility under the Plan). *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 back to the date of the birth, adoption, or placement for adoption. 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 Part 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 Part are satisfied. The Change in Coverage provisions do not apply to Health FSA benefits.

With the exception of special enrollment resulting from birth, placement for adoption or adoption, all election changes are prospectively effective from the date of the election or such later time as determined by the Plan Administrator. 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-12 What happens if a claim for benefits under the Plan is denied?

If you are denied a benefit under this Plan (e.g. election changes, eligibility for pre-tax benefits), you should proceed in accordance with the following claims review procedures. If you are denied a benefit under one of the Benefit Package Options, you should proceed in accordance with the claims review procedures established for that particular Benefit Package Option.

Step 1: *Notice is received from Plan Service Provider.* If your claim is denied, you will receive written notice from the Plan Service Provider that your claim is denied as soon as reasonably possible but no later than 30 days after receipt of the claim. The Plan Service Provider may take up to an additional 15 days to review your claim. You will be provided written notice of the need for additional time prior to the end of the 30-day period.

Step 2: *Review your notice carefully.* Once you have received your notice from the Plan Service Provider, review it carefully. The notice will contain:

- the reason(s) for the denial and the Plan provisions on which the denial is based;
- a description of any additional information necessary for you to perfect your claim, why the information is necessary, and your time limit for submitting the information;
- a description of the Plan's appeal procedures and the time limits applicable to such procedures;
- a right to request all documentation relevant to your claim;

Step 3: *If you disagree with the decision, you may file an appeal.* If you do not agree with the decision, and you wish to appeal, you must file a written appeal in accordance with the Notice referenced in Step 1 no later than 180 days of receipt of that Notice. You should submit all information identified in the notice of denial as necessary to perfect your claim and any additional information that you believe would support your claim.

Step 4: *Notice of Denial following appeal.* If the claim is again denied, you will be notified in writing. . If there is only one level of appeal, notice of the denial will be sent no later than 60 days after the appeal is received. See below for more information if the Plan has established two levels of appeal.

Step 5: *Review your notice carefully.* You should take the same action that you took in Step 2 described above. The notice will contain the same type of information that is provided in the first notice of denial.

Step 6 *(if there is a second level of appeal as indicated in the notice of denial referenced in Step One and/or Four above)*: If you still disagree with the decision, and you wish to appeal, you must file a second level appeal with the Plan Administrator within the time allotted for appealing as set forth in the notice of denial from the Plan Service Provider (referenced in Step 4). You should gather any additional information that is identified in the notice as necessary to perfect your claim and any other information that you believe will support your claim.

If the Plan Administrator denies your second level appeal, you will receive notice within 30 days after the Plan Administrator receives your claim. The notice will contain the same type of information that was referenced in Step 2 above.

Q-13 What effect will Plan participation have on Social Security and other benefits?

Plan participation will reduce the amount of your taxable compensation. Accordingly, there could be a decrease in your Social Security benefits and/or other benefits (e.g., pension, disability and life insurance) that are based on taxable compensation.

Part 3. Health FSA Benefits

Participation in the Medical Reimbursement Plan (Health FSA), if listed as a benefit offered under the Plan (see Part 6 below), allows you to purchase a specific level of Health FSA benefits, paying for coverage with pre-tax dollars elected on the Benefit Election Form in lieu of a corresponding amount of current pay. 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 Part 2.Q-8. See Part 2.Q-8 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 Care Account will be set up in your name to record your benefits and the contributions you make for such benefits during the Plan Year. No actual account is established; it is merely a bookkeeping account.

Once you become a participant, you may receive reimbursements for Eligible Medical Expenses incurred by you and your Eligible Dependents (see Part 3.Q-10 below for more information on Eligible Dependents.)

Q-3 When does coverage under the Health FSA end?

You continue to participate in the Health FSA until i) you elect not to participate; ii) the end of the Plan Year unless you make an election during the annual election period iii) you no longer satisfy the eligibility requirements described in Part 6 below; (iv) you terminate employment with the employer; or (v) the Plan is terminated or it is amended to exclude you or the class of employees of which you are a member. You may be entitled to temporarily continue your coverage under the Health FSA once your coverage ends for certain reasons. See Q-14 below for more information.

Q-4 What happens if I take a leave of absence?

Generally, the rules described in Part 2.Q-4 above apply. However, if your Health FSA coverage ceases during your FMLA leave, you will be entitled to elect whether to be reinstated in the Health FSA, at the same coverage level in effect before the FMLA leave (with increased contributions for the remaining period of coverage) or at Health FSA level that is reduced pro-rata for the period of FMLA leave during which you did not make any contributions. Under either scenario, expenses incurred during the period that your Health FSA coverage was not in effect are not eligible for reimbursement under this Health FSA.

Q-5 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 elect to participate until the next Annual Enrollment Period or you experience a change in status event that permits you to enroll in the Plan during the Plan Year. .

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 as of the first day of the next Plan Year (unless you elect to stop participating before then).

See Part 2.Q-10 above for further discussion.

Q-6 How do I pay for Health FSA reimbursements?

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 Care Account each pay period. This money will be available for

reimbursement of eligible medical expenses. The available amount in your Health Care 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. For example, if you have elected an annual salary conversion of $2,400 for eligible Health FSA benefits, then $2,400 would be credited to your Health FSA Account during the Plan Year. If you are paid semi-monthly, $100 a payday or $200 a month would be credited to 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 annual benefits are available under the Health FSA, and how much will they cost?

You can choose any amount of annual benefits you desire within the limits set forth in Part 6 below. You will be required to make annual contributions corresponding to your chosen benefit level.

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

Under this Health FSA, you may have two types of reimbursement options. You can complete and submit a written claim for reimbursement ("Traditional Paper Claims"). Alternatively, you may be able to use an electronic payment card ("Electronic Payment Card") to pay the expense. In order to be eligible for the Electronic Payment Card, you must agree to abide by the terms and conditions of the Electronic Payment Card Program (the "Program") as set forth herein and in the Electronic Payment Program Agreement (the "Program Agreement") including any fees applicable to participate in the program, limitations as to card usage, the Plan's right to withhold and offset for ineligible claims, etc). The following is a summary of how reimbursement under the traditional paper claims works. If payment using an electronic payment card is available under this Plan, you will be provided an Appendix to this SPD that explains how it works.

Traditional Paper Claims: When you incur an Eligible Medical Expense, you file a claim with the Plan's Third Party Administrator by completing and submitting a Request for Reimbursement Form. You may obtain a Request for Reimbursement Form from the Plan Administrator or the Third Party Administrator. You must include with your Request for Reimbursement Form a written statement from an independent third party (e.g. a receipt, EOB, etc) associated with each expense that indicates the following:

a)The nature of the expense (e.g. what type of service or treatment was provided). If the expense is for an over the counter drug, the written statement must indicate the name of the drug.

b)The date the expense was incurred

c)The amount of the expense.

You will be reimbursed for your eligible expenses according to the schedule in your enrollment material for the amount available for reimbursement. 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 Part 8 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 Part 6 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 Part 6 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 reimbursements; and (2) the claim is not paid for or has not been reimbursed from any other source.

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

An "Eligible Medical Expense" is an expense that has been incurred by you and/or your eligible dependents that satisfies the following conditions:

a) The expense is for "medical care" as defined by Code Section 213(d);

b) The expense has not been reimbursed by any other source and you will not seek reimbursement for the expense from any other source.

The Code generally defines "medical care" as any amounts incurred to diagnose, treat or prevent a specific medical condition or for purposes of affecting any function or structure of the body. This includes, but is not limited to, both prescription and over the counter drugs (and over the counter products & devices). Not every health related expense you or your eligible dependents incur constitutes an expense for "medical care." For example, an expense is not for "medical care", as that term is defined by the Code, if it is merely for the beneficial health of you and/or your eligible dependents (e.g. vitamins or nutritional supplements that are not taken to treat a specific medical condition) or for cosmetic purposes unless necessary to correct a deformity arising from illness, injury, or birth defect. You may, in the discretion of the Plan Service Provider/Plan Administrator, be required to provide additional documentation from a health care provider showing that you have a medical condition and/or the particular item is necessary to treat a medical condition. Expenses for cosmetic purposes are also not reimbursable unless they are necessary to correct an abnormality caused by illness, injury or birth defect.

In addition, certain expenses that might otherwise constitute "medical care" as defined by the Code are not reimbursable under any Health FSA (per IRS regulations):

a) Health insurance premiums; and

b) Expenses incurred for qualified long term care services.

c) Any other expenses that are specifically excluded by the Employer per a list attached and incorporated into the SPD by the Employer

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

You can claim reimbursement for eligible medical expenses incurred by your legal spouse (as determined in accordance with state law to the extent consistent with the federal Defense of Marriage Act), any individual who would qualify as a tax dependent of yours under Code Part 152, and any child for whom you are required to provide health coverage pursuant to a Qualified Medical Support Order. Also, children of divorced parents are considered to be a dependent of both parents to the extent that both parents together provide over half of the child's support.

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 Part 2.Q-11 above and follow the procedures outlined within that section.

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 within 90 days of issue.

Q-14 Can I continue coverage in my Account?

Federal law requires most employers sponsoring group health plans to offer employees and their families the opportunity for a temporary extension of health care coverage (called "continuation coverage") at group rates in certain instances where coverage under the plans would otherwise end. These rules apply to the Health FSA, unless the Employer is a small-employer within the meaning of the applicable regulations. The Plan Administrator can tell you whether the Employer is a small employer (and thus not subject to these rules).

If you are a participant in the Health FSA, then you have a right to choose continuation coverage under the Health FSA if you lose your coverage because of:

- a reduction in your hours of employment;
- a voluntary or involuntary termination of your employment (for reasons other than gross misconduct), or
- a military leave of absence that lasts 31 days or longer (in accordance with USERRA).

If you are the spouse of a Participant, then you have the right to choose continuation coverage for yourself if you lose coverage for any of the following reasons:

- the death of your spouse;
- a voluntary or involuntary termination of your spouse's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment; or
- the divorce or legal separation from your spouse.

In the case of a Dependent child of a participant, he or she has the right to choose continuation coverage if coverage is lost for any of the following reasons:

- the death of the employee;
- a voluntary or involuntary termination of the employee's employment (for reasons other than gross misconduct) or reduction in the employee's hours of employment;
- his or her parents' divorce or legal separation; or
- he or she ceases to be a dependent child.

A child who is born to, or placed for adoption with, the employee during a period of continuation coverage is also entitled to continuation coverage under COBRA. Those who are entitled to continue coverage under COBRA are called "Qualified Beneficiaries".

If you choose continuation coverage, you may continue the level of coverage you had in effect immediately preceding the qualifying event. However, if Plan benefits are modified for similarly situated active employees, then they will be modified for you and other Qualified Beneficiaries as well. You will be eligible to make a change in your benefit election with respect to the Plan upon the occurrence of any event that permits a similarly situated active employee to make a benefit election change during a Plan Year.

If you do not choose continuation coverage, your coverage under the Health FSA will end with the date you would otherwise lose coverage.

You or your covered dependents (including your spouse) must notify the employer of a divorce, legal separation, or a child losing dependent status under the Plan within 60 days of the later of the date of the event or the date on which coverage is lost because of the event. When the Plan Administrator (or its COBRA Administrator identified in the Plan Information Appendix) is notified that one of these events has occurred, the Plan Administrator will in turn notify you that you have the right to choose continuation coverage. Notice to an employee's spouse is treated as notice to any covered Dependents who reside with the spouse.

The COBRA Participant and/or covered dependent is responsible for notifying the Plan Administrator if he or she becomes covered under another group health plan.

Each qualified beneficiary is entitled to make a separate election for continuation coverage under the Plan. In order to elect continuation coverage, you must complete the election form(s) provided to you by the Plan Administrator. You have 60 days from the date you would lose coverage for one of the reasons described above or the date you are sent notice of your right to elect continuation coverage, whichever is later, to inform the Plan Administrator that you wish to continue coverage. Failure to return the election form within the 60-day period will be considered a waiver, and you will not be allowed to elect continuation coverage.

You will have to pay the entire cost of your continuation coverage. The cost of your continuation coverage will not exceed 102% of the applicable premium for the period of continuation coverage. The first premium payment after electing continuation coverage will be due 45 days after making your election. Subsequent premiums must be paid within a 30-day grace period following the due date. Failure to pay premiums within this time period will result in automatic termination of your continuation coverage. Claims incurred during any period will not be paid until your premium payment is received for that period. If you timely elect continuation coverage and pay the applicable premium, however, then continuation coverage will relate back to the first day on which you would have lost regular coverage.

The maximum period for which coverage may be continued will be until the end of the Plan Year in which the qualifying event occurs. To the extent that Nonelective Employer contributions are provided, the maximum duration of coverage may be 18 or 36 months from the qualifying event (depending on the type of qualifying event). You will be notified of the duration of continuation coverage when you have a qualifying event. However, continuation coverage may end earlier for any of the following reasons:

- The contribution for your continuation coverage is not paid on time or it is insufficient (Note: If your payment is insufficient by the lesser of 10% of the required COBRA premium, or $50, you will be given 30 days to cure the shortfall);
- The date that you first become covered under another group health plan under which you are not subject to a pre-existing condition exclusion limitation, after you elect continuation coverage;
- The date that you first become entitled to Medicare, after you elect continuation coverage; or
- The date the employer no longer provides group health coverage to any of its employees

Q-15 What happens if a claim for benefits under the Health FSA is denied?

If you are denied a benefit under the Health FSA, you should proceed in accordance with the following claims review procedures.

Step 1: *Notice is received from Plan Service Provider.* If your claim is denied, you will receive written notice from the Plan Service Provider that your claim is denied as soon as reasonably possible but no later than 30 days after receipt of the claim. For reasons beyond the control of the Plan Service Provider, the Plan Service Provider may take up to an additional 15 days to review your claim. You will be provided written notice of the need for additional time prior to the end of the 30-day period. If the reason for the additional time is that you need to provide additional information, you will have 45 days from the notice of the extension to obtain that information. The time period during which the Plan Service Provider must make a decision will be suspended until the earlier of the date that you provide the information or the end of the 45-day period.

Step 2: *Review your notice carefully.* Once you have received your notice from the Plan Service Provider, review it carefully. The notice will contain:

- the reason(s) for the denial and the Plan provisions on which the denial is based;
- a description of any additional information necessary for you to perfect your claim, why the information is necessary, and your time limit for submitting the information;
- a description of the Plan's appeal procedures and the time limits applicable to such procedures;
- a right to request all documentation relevant to your claim;

Step 3: *If you disagree with the decision, file an Appeal.* If you do not agree with the decision of the Plan Service Provider, you may file a written appeal. You should file your appeal no later than 180 days of receipt of the notice described in Step 1. If the Plan has established only one level of review, you should file your appeal with the Plan Administrator. If the Plan has established two levels of appeal, you should file your appeal with the Plan Service Provider. The notice of denial reference in Step 1 above will indicate whether the plan has 1 or 2 levels of appeal. Regardless, you should submit all information identified in the notice of denial as necessary to perfect your claim and any additional information that you believe would support your claim.

Step 4: *Notice of Denial is received from claims reviewer.* If the claim is again denied, you will be notified in writing. If the plan has established two levels of appeal as set forth in the notice of denial, the notice will be sent no later than 30 days after receipt of the appeal by the Plan Service Provider. Otherwise, notice of the denial will be sent no later than 60 days after the appeal is received by the Plan Administrator.

Step 5: *Review your notice carefully.* You should take the same action that you take in Step 2 described above. The notice will contain the same type of information that is provided in the first notice of denial provided by the Plan Service Provider.

Step 6 (if there is a second level of appeal as indicated in the notice of denial): *If you still disagree with the Plan Service Provider's decision, file a 2nd Level Appeal with the Plan Administrator.* If you still do not agree with the Plan Service Provider's decision, you may file a written appeal with the Plan Administrator within the allotted number of days set forth in the notice of denial from the Plan Service Provider. You should gather any additional information that is identified in the notice as necessary to perfect your claim and any other information that you believe will support your claim.

If the Plan Administrator denies your 2nd Level Appeal, you will receive notice within 30 days after the Plan Administrator receives your claim. The notice will contain the same type of information that was referenced in Step 2 above.

Important Information

Other important information regarding your appeals:

- Each level of appeal will be independent from the previous level (i.e. the same person(s) or subordinates of the same person(s) involved in a prior determination will not be involved in a subsequent decision);
- On each level of appeal, the claims reviewer will review relevant information that you submit even if it is new information;
- You cannot file suit in federal court until you have exhausted these appeals procedures.

Q-16 Will my health information be kept confidential?

Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), group health plans such as the Health FSA and the third party service providers are required to take steps to ensure that certain "protected health information" is kept confidential. You may receive a separate notice that outlines the health privacy policies of the Plan.

Part 4. 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.

Q-2 How do I become a Participant?

You can participate by electing the DCAP Benefit during the applicable Enrollment Periods. See Part 2.Q-8 above 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 When does coverage under the DCAP end?

You continue to participate in the Dependent Care FSA until (i) you elect not to participate; (ii) you no longer satisfy the eligibility requirements described in the Plan Information Summary; (iii) the end of the Plan Year unless you make an election to participate during the annual election period; (iv) you terminate employment with the employer (there are special rules for terminating employees), or (v) the Plan is terminated or amended to exclude you or the class of employees of which you are a member. However, you may be able to continue to submit claims for reimbursements for Eligible Employment Related Expenses incurred after the date that you terminate employment up to balance in your Dependent Care Account as of the date you terminate employment.

Q-4 What happens if I take a leave of absence?

Generally, the rules described in Part 2.Q-4 above of this SPD apply to the Dependent Care FSA.

Q-5 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-11 under Part 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-10 under Part 2 above for further discussion.

Q-6 How are my DCAP reimbursements paid?

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-7 Are there any other limits on what DCAP benefits are tax free?

In addition to the dollar limitations in Part 6 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.

Q-8 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-9 What is the Household and Dependent Care Credit?

The household and dependent care credit is an allowance for a percentage of your annual, Eligible Employment Related Expenses as a credit against your federal income tax liability under the U.S. Tax Code. In determining what the tax credit would be, you may take into account only $3,000 of such expenses for one Qualifying Individual, or $6,000 for two or more Qualifying Individuals. Depending on your adjusted gross income, the percentage could be as much as 35% of your Eligible Employment Related Expenses (to a maximum credit amount of $1050 for one Qualifying Individual or $2100 for two or more Qualifying Individuals,) to a minimum of 20% of such expenses. The maximum 35% rate must be reduced by 1% (but not below 20%) for each $2,000 portion (or any fraction of $2,000) of your adjusted gross incomes over $15,000.

Illustration: Assume you have one Qualifying Individual for whom you have incurred Eligible Employment Related Expenses of $3,600, and that your adjusted gross income is $21,000. Since only one Qualifying Individual is involved, the

credit will be calculated by applying the appropriate percentage to the first $3,000 of the expenses. The percentage is, in turn, arrived at by subtracting one percentage point from 35% for each $2,000 of your adjusted gross income over $15,000. The calculation is: 35% -- [($21,000 - 15,000)/$2,000 X 1%] = 32%. Thus, your tax credit would be $3,000 X 32% = $960. If you had incurred the same expenses for two or more Qualifying Individuals, your credit would have been $3,600 X 32% = $1152, because the entire expense would have been taken into account, not just the first $3,000.

Q-10 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 $3,000 and $6,000 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 $6000 (the maximum allowed for the Household and Dependent Care Credit). This would leave you with $4000, your basis for the Household and Dependent Care Credit. You would then apply the formula for the credit as stated in Q-9 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-11 Under what circumstances can I receive reimbursement under the DCAP"?

You can be reimbursed for work-related dependent care expenses provided all the following conditions are satisfied:

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 "Qualifying Individual". A "Qualifying Individual" is a:
   - Child under age 13 for whom you are entitled to a personal tax exemption as a dependent (or if you are divorced, a child who resides with you without regard to whether you are entitled to the exemption), 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 $250 (for one Eligible Dependent) or $500 (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 that 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?

Under this DCAP, you may have two types of reimbursement options. You can complete and submit a written claim for reimbursement ("Traditional Paper Claims"). Alternatively, you may be able to use an electronic payment card ("Electronic Payment Card") to pay the expense. In order to be eligible for the Electronic Payment Card, you must agree to abide by the terms and conditions of the Electronic Payment Card Program (the "Program") as set forth herein and in the Electronic Payment Program Agreement (the "Program Agreement") including any fees applicable to participate in the program, limitations as to card usage, the Plan's right to withhold and offset for ineligible claims, etc). The following is a summary of how traditional paper claims reimbursement works. If payment using an electronic payment card is available under this Plan, you will be provided an Appendix to this SPD that explains how it works.

Traditional Paper Claims: When you incur an Eligible Employment Related Expense, you file a claim with the Plan Service Provider by completing and submitting a Request for Reimbursement Form. You may obtain a Request for Reimbursement Form from the Plan Service Provider. You must include with your Request for Reimbursement Form a written statement from an independent third party (e.g. a receipt or invoice) associated with each expense that indicates the following:

a)The date the expense was incurred

b)The amount of the expense.

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 Part 8 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 Part 6 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 Part 8 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-7 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 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 Part 2.Q-11 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-15 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-16 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 within 90 days of issue.

Q-17 What happens if my claim for DCAP benefits is denied?

If you are denied a claim reimbursement under the Plan (e.g. election changes, eligibility for pre-tax benefits), you should proceed in accordance with the following claims review procedures. If you are denied a claim under one of the Benefit Package Options, you should proceed in accordance with the claims review procedures established for that particular Benefit Package Option.

Step 1: Notice is received from Plan Service Provider. If your claim is denied, you will receive written notice from the Plan Service Provider that your claim is denied as soon as reasonably possible but no later than 30 days after receipt of the claim. For reasons beyond the control of the Plan Service Provider, the Plan Service Provider may take up to an additional 15 days to review your claim. You will be provided written notice of the need for additional time prior to the end of the 30-day period.

Step 2: *Review your notice carefully.* Once you have received your notice from the Plan Service Provider, review it carefully. The notice will contain:

- the reason(s) for the denial and the Plan provisions on which the denial is based;
- a description of any additional information necessary for you to perfect your claim, why the information is necessary, and your time limit for submitting the information;
- a description of the Plan's appeal procedures and the time limits applicable to such procedures;
- a right to request all documentation relevant to your claim;

Step 3: *If you disagree with the decision, you may file an appeal.* If you do not agree with the decision of the Plan Service Provider, you may file a written appeal. You should file your appeal no later than 180 days of receipt of the notice described in Step 1. If the Plan has established only one level of review, you should file your appeal with the Plan Administrator. If the Plan has established two levels of appeal, you should file your appeal with the Plan Service Provider. The notice of denial reference in Step 1 above will indicate whether the plan has 1 or 2 levels of appeal. Regardless, you should submit all information identified in the notice of denial as necessary to perfect your claim and any additional information that you believe would support your claim.

Step 4: *Notice of Denial is received from claims reviewer.* If the claim is again denied, you will be notified in writing. If the plan has established two levels of appeal as set forth in the notice of denial, the notice will be sent no later than 30 days after receipt of the appeal by the Plan Service Provider. Otherwise, notice of the denial will be sent no later than 60 days after the appeal is received by the Plan Administrator.

Step 5: *Review your notice carefully.* You should take the same action that you take in Step 2 described above. The notice will contain the same type of information that is provided in the first notice of denial provided by the Plan Service Provider.

Step 6 *(If there is a second level of appeal as indicated in the notice of denial): If you still disagree with the Plan Service Provider's decision, file a second level appeal with the Plan Administrator.* If you still do not agree with the Plan Service Provider's decision, you may file a written appeal with the Plan Administrator within the time allotted for appealing as set forth in the notice of denial from the Plan Service Provider. You should gather any additional information that is identified in the notice as necessary to perfect your claim and any other information that you believe will support your claim.

If the Plan Administrator denies your second level appeal, you will receive notice within 30 days after the Plan Administrator receives your claim. The notice will contain the same type of information that was referenced in Step 2 above.

Part 5. 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:

1. **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.

2. **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.
   - (if the Health FSA is subject to HIPAA) 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.

3. **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.

4. **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).

5. 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.

Part 6. Plan Information Summary

Please refer to the Addendum attached to this document for Part 6, the Plan Information Summary.

AMENDMENT I
TO THE
FORT BEND COUNTY
FLEXIBLE SPENDING ACCOUNT
PLAN DOCUMENT

7. PLAN ADMINISTRATION - Flexible Spending Account is hereby amending the follows:

7.7 Payment of Administrative Expenses

Administrative fees for Healthcare Reimbursement and Dependent Care Reimbursement Accounts are the full responsibility of the Employee not the Employer.

Such modification is to correct the Plan Document to accurately reflect a long standing policy and practice of assessment of administrative fees for reimbursement accounts.

In witness whereof, we have executed the Plan Amendment by its duly authorized office, this 8 day of January, 2008.

FORT BEND COUNTY

BY: _____
Robert Hebert

TITLE: County Judge

ATTEST: _____
Dianne Wilson, County Clerk

AMENDMENT II
TO THE
FORT BEND COUNTY
FLEXIBLE SPENDING ACCOUNT
PLAN DOCUMENT

Item IX - Flexible Spending Account Elections is hereby amending the following:

Health FSA

(a) The maximum annual reimbursement amount an Employee may elect for any Plan Year is $3000.00.

Such modification is effective 1/1/2009.

In witness whereof, we have executed the Plan Amendment by its duly authorized office, this _____ day of _____, 2008.

Court Date September 23, 2008.

FORT BEND COUNTY

By: _____
Robert Hebert

Title: County Judge

Date: March 11, 2009

Attest: _____
Dianne Wilson, County Clerk

AMENDMENT III

TO THE

CAFETERIA PLAN

PREMIUM REDUCTION OPTION PLUS
FLEXIBLE SPENDING ACCOUNTS

As adopted by
Fort Bend County

Item VIII, Adoption Agreement, Flexible Spending Account Elections, Health FSA is hereby amended as follows:

(a) The maximum annual reimbursement amount an Employee may elect for any Plan Year is $2,500.00.

Such modifications are effective January 1, 2013

In witness whereof, we have executed the Plan Amendment by its duly authorized office, this 28 day of August, 2012.

RECEIVED
FORT BEND COUNTY
RISK MANAGEMENT
2012 AUG 31 PM 4:13

Fort Bend County

By: _____
Robert E. Hebert

Title: County Judge

Witness: _____
Attest: Dianne Wilson
County Clerk

COMMISSIONERS COURT
TEXAS
FORT BEND COUNTY, TEXAS

AMENDMENT IV

TO THE

CAFETERIA PLAN

PREMIUM REDUCTION OPTION PLUS
FLEXIBLE SPENDING ACCOUNTS

As adopted by
Fort Bend County

Flexible Spending Account Elections, Health FSA is hereby amended as follows:

(a) Service period requirements

For all plan years, eligibility is the following:

First of the month, following the 58th day after hire.

Such modifications are effective January 1, 2014

In witness whereof, we have executed the Plan Amendment by its duly authorized office, this 16 day of December, 2014.

Fort Bend County

By: Robert Hebert

Robert Hebert

Title: County Judge

Witness: Dianne Wilson

DIANNE WILSON,
Fort Bend County Clerk

COMMISSIONERS COURT
FORT BEND COUNTY, TEXAS

2014 DEC 19 AM 11:19

FORT BEND COUNTY TEXAS

FORT BEND COUNTY
EMPLOYEE BENEFIT MEDICAL
PLAN DOCUMENT

JANUARY 1, 2016

Fort Bend County, the Employer, hereby amends and restates effective January 1, 2016 the self-funded Fort Bend County Employee Benefit Medical Plan ("Medical Plan") formed under Chapter 172 of the Local Government Code. The plans provide medical and prescription drug benefits for the eligible Employees of the Employer, including Elected Officials, and their eligible Dependents.

Eligible Retirees and Dependents are eligible to participate in the plan in accordance with the rules established and approved by Fort Bend County Commissioners Court and Chapter 175 of the Local Government Code.

Eligible Survivors may participate in the plan in accordance with the rules established and approved by Fort Bend County Commissioners Court and Chapter 615 of the Local Government Code ("LGC 615 Survivor").

The purpose of the plan is to provide reimbursement for a Participant's Eligible Expenses incurred as a result of treatment for illness and injury. In consideration of any required Participant contributions, the Employer agrees to make payment as provided in the plan document. The Employer has the right to periodically amend the plan document. The plan document constitutes the entire Medical Plan.

The Employer has caused this instrument to be executed by its duly authorized officers with the effective date of 1st day of January 2016.

County Judge

County Commissioner, Precinct 1

County Commissioner, Precinct 2

County Commissioner, Precinct 3

County Commissioner, Precinct 4

Approved by Commissioners Court on
23rd day of February 2016

Attest:

COMMISSIONERS COURT FORT BEND COUNTY, TEXAS

2/26/2016 - Original sent to Sandy Kucera, Risk Management

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PLAN ADMINISTRATOR'S DISCRETIONARY AUTHORITY

The benefits provided under the Medical Plan are for the exclusive benefit of the eligible Employees/Dependents, eligible Retirees/Dependents, and Survivors as defined by LGC 615. 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 Medical Plan which it 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 Medical Plan and to make any other changes that it deems necessary or appropriate. Changes in the Medical 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 provisions of the plan, in its discretion, including correcting any error or defect, supplying any omission, reconciling any inconsistency, and making all finds of fact including, without limitation, any factual determination that may impact eligibility or a claim for benefits. In the event that a Preferred Provider Organization (PPO) physician refers outside the network, the Plan Administrator, at its discretion, will have the option of applying the PPO coinsurance provision. It is the plan participant's responsibility to determine if a provider is within the PPO network. All decisions, 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 MEDICAL PLAN IS A "GRANDFATHERED" PLAN

The Medical Plan believes it is a "grandfathered health plan" under the Patient Protection and Affordable Care Act ("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 Medical 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 281-341-8630. You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

FORT BEND COUNTY
EMPLOYEE BENEFIT MEDICAL PLAN
AND SUMMARY PLAN DESCRIPTION

ARTICLE I
SCHEDULE OF BENEFITS

A. MEDICAL SCHEDULE OF BENEFITS
OPTION A – LOW DEDUCTIBLE / OPTION B – HIGH DEDUCTIBLE

OPTION A – LOW DEDUCTIBLE

	DEDUCTIBLE	
	INSIDE PPO	**OUTSIDE PPO**
Per person per calendar year, with a maximum of five (5) per family. With three (3) month carry-over provision (see "Deductible Amount and Carry-Over Provisions"). Inside PPO plan deductible can be used to satisfy Outside PPO plan deductible.	**$300.00**	**$700.00**
Separate per Hospital confinement deductible at Non-PPO Hospital.	**N/A**	**$500.00**

OPTION A / COINSURANCE PROVISION PER CALENDAR YEAR
INSIDE PPO vs. OUTSIDE PPO

INSIDE PPO COINSURANCE PROVISION: If you utilize PPO providers, all Eligible Expenses will be paid by the Plan at **80%** and the Participant will pay at **20%** up to the first **$19,000.00** of Eligible Expenses (unless otherwise stated in the Schedule of Benefits), after the applicable deductibles have been satisfied. When Eligible Expenses reach **$19,000.00 after the applicable deductibles and coinsurance provisions have been satisfied,** the Plan will pay **100%** of Eligible Expenses. If a Participant (including an Employee) has coverage under another group health plan, then no Out-of-Pocket (OOP) Maximum shall apply under this Plan. This provision does not apply to Medicare coverage. **The maximum coinsurance paid by Participant at 20% is $3,800.00 per Participant with a family maximum of five (5) per family per Plan Year.**

OUTSIDE PPO COINSURANCE PROVISION: If you utilize providers Outside PPO, all Eligible Expenses will be paid by the Plan at **50%** and the Participant will pay at **50%** up to the first **$20,000.00** of Eligible Expenses (unless otherwise stated in the Schedule of Benefits), after the applicable deductibles have been satisfied. When Eligible Expenses reach **$20,000.00**, the Plan will pay **100%** of Eligible Expenses. If a Participant (including an Employee) has coverage under another group health plan, then no Out-of-Pocket (OOP) Maximum shall apply under this Plan. This provision does not apply to Medicare coverage. **The maximum coinsurance paid by Participant at 50% is $10,000.00 per Participant with a family maximum of five (5) per family per Plan Year.**

Whether Inside or Outside PPO, any expenses other than Eligible Expenses will be disallowed and cannot be used to satisfy deductibles or your medical coinsurance provisions. **Any expense related to mental health care, substance abuse, alcoholism and outpatient prescription drugs purchased with your Fort Bend County Employee Benefit Plan ID card will not be applied to your maximum medical coinsurance provision or calendar year deductibles. These provisions apply to each covered Participant.**

If you are a Dependent or a Retiree and reside Outside PPO Service Area (there are no PPO providers within 100 miles of Participant's residence) Participant will be subject to the calendar year deductible plus Participant's percentage of coinsurance, subject to any additional benefit limitations of this Plan. There will be an additional **$500.00** per confinement deductible if admitted to a Hospital Outside PPO. All Eligible Expenses will be paid by the Plan at **70%** coinsurance and the Participant will pay **30%** up to the first **$20,000.00** of Eligible Expenses (unless otherwise stated in the Schedule of Benefits), after the applicable deductibles have been satisfied. When Eligible Expenses reach **$20,000.00,** the Plan will pay **100%** of Eligible Expenses. If a Participant (including an Employee) has coverage under another group health plan, then no Out-of-Pocket (OOP) Maximum shall apply under this Plan. This provision does not apply to Medicare coverage. **The maximum coinsurance paid by Participant at 30% is $6,000.00 per Participant with a family maximum of five (5) per family per Plan Year.**

OPTION B – HIGH DEDUCTIBLE

	DEDUCTIBLE	
	INSIDE PPO	**OUTSIDE PPO**
Per person per calendar year, with a maximum of three (3) per family. With three (3) month carry-over provision (see "Deductible Amount and Carry-Over Provisions"). Inside PPO plan deductible can be used to satisfy Outside PPO plan deductible.	**$850.00**	**$1,000.00**
Separate per Hospital confinement deductible at Non-PPO Hospital.	**N/A**	**$500.00**

OPTION B / COINSURANCE PROVISION PER CALENDAR YEAR
INSIDE PPO vs. OUTSIDE PPO

INSIDE PPO COINSURANCE PROVISION: If you utilize PPO providers, all Eligible Expenses will be paid by the Plan at **80%** and the Participant will pay at **20%** up to the first **$12,500.00** of Eligible Expenses (unless otherwise stated in the Schedule of Benefits), after the applicable deductibles have been satisfied. When Eligible Expenses reach **$12,500.00 after the applicable deductibles and coinsurance provisions have been satisfied,** the Plan will pay **100%** of Eligible Expenses. If a Participant (including an Employee) has coverage under another group health plan, then no Out-of-Pocket (OOP) Maximum shall apply under this Plan. This provision does not apply to Medicare coverage. **The maximum coinsurance paid by Participant at 20% is $2,500.00 per Participant with a family maximum of three (3) per family per Plan Year.**

If a Covered Person goes into a PPO Hospital with a PPO doctor admitting, or if a Covered Person goes to a PPO hospital for outpatient services with a PPO doctor performing the service, the ancillary services (i.e., pathology, x-ray, anesthesiology, assistant surgeons, on-call specialists, etc.) performed by non-network providers who may be used by the hospital will be paid as if in-network.

OUTSIDE PPO COINSURANCE PROVISION: If you utilize providers Outside PPO, all Eligible Expenses will be paid by the Plan at **50%** and the Participant will pay at **50%** up to the first **$15,000.00** of Eligible Expenses (unless otherwise stated in the Schedule of Benefits), after the applicable deductibles have been satisfied. When Eligible Expenses reach **$15,000.00**, the Plan will pay **100%** of Eligible Expenses. If a Participant (including an Employee) has coverage under another group health plan, then no Out-of-Pocket (OOP) Maximum shall apply under this Plan. This provision does not apply to Medicare coverage. **The maximum coinsurance paid by Participant at 50% is $7,500.00 per Participant with a family maximum of three (3) per family per Plan Year.**

Whether Inside or Outside PPO, any expenses other than Eligible Expenses will be disallowed and cannot be used to satisfy deductibles or your medical coinsurance provisions. **Any expense related to mental health care, substance abuse, alcoholism and outpatient prescription drugs purchased with your Fort Bend County Employee Benefit Plan ID card will not be applied to your maximum medical coinsurance provision or calendar year deductibles. These provisions apply to each covered Participant.**

If you are a Dependent or a Retiree and reside Outside PPO Service Area (there are no PPO providers within 100 miles of Participant's residence) Participant will be subject to the calendar year deductible plus Participant's percentage of coinsurance, subject to any additional benefit limitations of this Plan. There will be an additional **$500.00** per confinement deductible if admitted to a Hospital Outside PPO. All Eligible Expenses will be paid by the Plan at **70%** coinsurance and the Participant will pay **30%** up to the first **$15,000.00** of Eligible Expenses (unless otherwise stated in the Schedule of Benefits), after the applicable deductibles have been satisfied. When Eligible Expenses reach **$15,000.00,** the Plan will pay **100%** of Eligible Expenses. If a Participant (including an Employee) has coverage under another group health plan, then no Out-of-Pocket (OOP) Maximum shall apply under this Plan. This provision does not apply to Medicare coverage. **The maximum coinsurance paid by Participant at 30% is $4,500.00 per Participant with a family maximum of three (3) per family per Plan Year.**

DEDUCTIBLE AMOUNT AND CARRY-OVER PROVISONS: The applicable deductible for Plan Option A or Plan Option B will be deducted from the Eligible Expenses before benefits are computed, unless the "SCHEDULE OF BENEFITS" indicates otherwise. In the event a 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 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 Eligible Expenses directly resulting from injuries sustained in that accident;

2. If Participant incurs Eligible Expenses in October, November and December that apply toward the calendar year deductible and Participant has not incurred any Eligible Expenses or received any credit towards Participant's deductible between January and the last day of September of the same year, then any Eligible Expenses that will apply toward Participant's deductible in October, November and December will be carried over to the next year's deductible in the form of a credit. Any expenses paid by this Plan toward

"Annual Health Screening Benefits / Well Care" as described in the Plan will not apply to this carry-over provision.

3. When five (5) covered family members on the Plan Option A or three (3) covered family members on the Plan Option B satisfy their individual deductibles, the deductible will be considered satisfied for all covered family members. Satisfaction of the family deductible is based on the date Eligible Expenses are incurred. The family deductible also applies when both Spouses are Fort Bend County Employees and covered by this Plan; if both Spouses are covered by different County health plan options, then the deductible from the plan with the highest number of family member deductible maximums will apply.

4. The Plan reserves the right to allocate the deductible to any Eligible Expenses and to apportion the benefits to the Participant and any assignees.

5. Any deductible movement between Plan Option A and Plan Option B after a separation of service from the County and when one Spouse continues County employment and is participating in this Plan is referenced in Article V.

AFTER YOU SATISFY EITHER THE OPTION A – LOW DEDUCTIBLE OR OPTION B – HIGH DEDUCTIBLE, AS APPLICABLE, THE FOLLOWING BENEFITS WILL BE PAID BY THIS PLAN AT THE STATED PERCENTAGE LEVELS BELOW:

*PRECERTIFICATION IS REQUIRED FOR HOSPITAL ADMISSIONS OR A 50% REDUCTION IN BENEFITS WILL OCCUR.

	COINSURANCE PERCENTAGE PLAN PAYS	
	INSIDE PPO	**OUTSIDE PPO**
IN-PATIENT HOSPITAL EXPENSES*		
1. **Average Semi-Private Room** – All usual Hospital Services including blood, plasma and intensive care	**80%**	**50%**
2. **Anesthesiologist Charges**	**80%**	**50%**
3. **Mental Health Care, Alcohol & Substance Abuse** – See cost containment section for any additional limitations. Participant must access E.A.P. before these benefits are eligible. (See Article II, section D, and Article VI)	**80%**	**0%**
OTHER MEDICAL EXPENSES		
1. **Surgery* – In-patient**	**80%**	**50%**
2. **Surgery – Outpatient** (See Article II)	**80%**	**70%**
3. **Preadmission Testing – Outpatient** (See Article II)	**100%**	**70%**
4. **Outpatient Testing** (See Article II)	**80%**	**50%**
5. **Second & Third Surgical Opinions** (See Article II)	**100%**	**100%**
6. **All other Eligible Expenses except Outpatient Mental Health Care, Alcohol & Substance Abuse**	**80%**	**50%**

	COINSURANCE PERCENTAGE PLAN PAYS	
	INSIDE PPO	**OUTSIDE PPO**
7. Chiropractic Charges – Calendar Year Maximum of eighteen (18) visits and additional visits require pre-certification* through PrimeDx for medical necessity	**80%**	**50%**
8. Physical Therapy / Rehabilitation – Calendar Year Maximum of eighteen (18) visits and additional visits require precertification* for medical necessity	**80%**	**50%**
9. Elective Sterilization (Vasectomy & Tubal Ligation)	**80%**	**50%**
10. Outpatient Mental Health Care –	**80%**	**0%**
Participant's Copay per Office Visit	**$30.00**	
Alcohol & Substance Abuse including Psychiatrist Charges and Day Treatments	**80%**	**0%**

EAP Benefits must be accessed before outpatient mental health care benefits will be eligible by this Plan (see Article II). Benefits may be used only at PPO providers with prior approval from PrimeDx. Charges will not be eligible for payment if services are received at a provider Outside PPO, except as noted below for Dependents residing Outside the PPO Service Area.

Dependents that reside Outside PPO Service Area (there are no PPO providers within 100 miles of your residence) will have benefits paid by the Plan at the **70%** coinsurance level. All other provisions and limitations remain the same. Benefits must be accessed by calling the Employee Assistance Program (see Article II).

11. Outpatient Dialysis Services

The Plan does not use a preferred provider organization for dialysis services. The deductible will apply unless otherwise noted in this section.

Reimbursement

100% of MEC

IMPORTANT NOTE: The definition of MEC is different for Outpatient Dialysis Services than other services. Please review the definition of "Maximum Eligible Charges" also referred to as "MEC", which is contained in the Section titled "Definitions" for details.

The annual deductible and out of pocket maximum amounts listed under PPO/Out of Area apply.

Limitations/Requirements

A Covered Person must: 1) notify PrimeDx when Dialysis treatment begins; 2) notify PrimeDx when diagnosed with End Stage Renal Disease ("ERSD"); and 3) enroll in Part A and B of Medicare when diagnosed with ESRD. While a Covered Person has ESRD and the Plan is primary, the Plan will pay or reimburse the Covered Person for Medicare Part B premiums.

12. Outpatient Prescription Drugs

Outpatient prescription drugs must be filled with your Fort Bend County Employee Benefit Plan ID card. Reimbursement will not be allowed under this Medical Plan. Copays and any additional Rx charges cannot be used to satisfy deductibles or coinsurance maximums. See Article I, B, Outpatient Prescription Drug Schedule of Benefits.

13. Vision Benefit

ANNUAL EYE EXAM ONLY: The refraction fee is not a covered expense. No other services or benefits are available. This benefit will be paid at **80%** coinsurance subject to the applicable calendar year deductible and **$30.00** office visit copay if a PPO provider performs the exam. If this exam is performed by a provider Outside PPO, benefits will be payable at **50%** coinsurance subject to the applicable per person calendar year deductible.

14. Annual Health Screening Benefits / Well Care / PPO Providers Only

Participants beginning at age three (3) years who reside within the PPO Service Area are eligible to receive the following benefits without a **medical** diagnosis as indicated below. The benefits listed below will not be subject to the **$30.00** office copay and will be paid by the Plan at **100%**, not to exceed **$750.00** per covered person 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. Any expenses up to the **$750.00** limit cannot be used to satisfy the calendar year deductible or maximum coinsurance provisions of the Plan. Any expenses incurred at a provider Outside PPO will be the responsibility of the Participant. **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.** Charges in excess of the **$750.00** limit, for any one or a total of all benefits listed below, will be paid subject to the appropriate deductible and coinsurance provisions of the Plan.

Retirees and Dependents beginning at age three (3) years who reside Outside PPO Service Area (there are no PPO providers within 100 miles of your residence) will have this benefit provided by the Plan at the **70%** coinsurance level, to a maximum Plan payment of **$750.0** per person per year and will not be subject to any deductibles. Any out-of-pocket expense that you incur for this benefit cannot be used to satisfy your deductible or coinsurance provisions. Charges in excess of the **$750.00** limit, for any one or a total of all benefits listed below, will be paid subject to the appropriate deductible and coinsurance provisions of the Plan.

a) Mammograms **at a Preferred Provider,** including interpretation by radiologist **at a Preferred Provider.**
b) Pap Smear including office visit and HPV vaccine, age nineteen (19) years and older, **at a Preferred Provider.**
c) Bone density testing including office visit **at a Preferred Provider.**
d) Colon Rectal and prostate screenings which include office visit, diagnostic proctoscopy, occult blood work and prostate specific antigen (P.S.A.) test **at a Preferred Provider.**
e) Immunizations: Adult, age nineteen (19) years and older, immunization benefits are limited to annual flu shots, tetanus booster shots and HPV vaccine, including office visit **at a Preferred Provider. Immunizations for dependents under the age of nineteen (19) years are not covered under the annual wellness benefit.**
f) Annual physicals: Benefits will be limited to urinalysis, lab work, blood work, stress test, electrocardiogram and chest x-rays **at a Preferred Provider.**

15. Outpatient, Non-Emergency Office Visit (Medical) PREFERRED PROVIDER ONLY

The Participant is required to pay $30.00 per visit toward the medical Physician's charge for an office visit, and if incurred prior to satisfying the calendar year deductible, the $30.00 may be used to satisfy the calendar year deductibles of the Plan option that you participate in. **The $30.00 copay will be assessed every time you utilize a PPO Physician, regardless if you have satisfied your calendar year deductible.** The balance of physician's charges due after the $30.00 per visit copayment has been made will be paid by the Plan at 100%. This $30.00 copay can be applied to satisfy any calendar year deductible requirements. **If your calendar year deductible has been satisfied, this copay will continue to be assessed each time you have a PPO physician office visit.**

1. All eligible Expenses incurred during an office visit, other than Physician's charges, shall be subject to the deductible and coinsurance provisions of the Plan option that you participate in. **Children's immunizations will be an Eligible Expense at PPO Providers only. The only allowable immunizations are those immunizations that are recommended by the Center for Disease Control and required for attendance in school in the State of Texas as listed in Title 25 Health Services subsection 97.61-97.72 of the Texas Administrative Code. Immunization charges incurred at a non-PPO Provider will be excluded.**

EXAMPLE – Outpatient Non-Emergency PPO Office Visit

Medical Physician's charge	**$80.00**
Minus PPO discount	**-$20.00**
Balance of Physician's charge after discount	**$60.00**
Minus Participant copay	**-$30.00**
Plan pays 100% of balance	**$30.00**

Other Eligible Expenses incurred during office visit: Lab, X-Ray, injections, and any other Eligible Expenses. After patient deductible is satisfied, the Plan pays at the 80% coinsurance level Inside PPO or at the **50%** coinsurance level Outside PPO.

16. Non-PPO Outpatient Office Visits (Medical)

The Participant will be required to satisfy the Outside PPO 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 by a non-PPO Provider at the **50%** coinsurance level.

17. Emergency Room – Preferred Provider Only

All Eligible Expenses associated with an accidental Injury or Emergency Illness when incurred an the Emergency room of a Preferred Provider Hospital will be paid at 80%, including Physician's charges, subject to applicable deductible and coinsurance provisions. If the Participant is admitted to the Hospital, then all additional Eligible Expenses incurred during that confinement would be paid at 80% after the deductible is satisfied if billed by a PPO Provider or 50% if billed by a non-PPO Provider after the applicable deductibles are satisfied.

18. Accidental Injury or Emergency Illness at an Emergency Room or Hospital – Outside PPO Area

All Eligible Expenses associated with an accidental Injury or Emergency Illness incurred at a non-PPO Emergency room or Hospital while Outside PPO Service Area (there are no PPO providers within 100 miles of your residence) will be paid at the 80% coinsurance level. The non-PPO calendar year deductible will not be waived for this accidental Injury or Emergency Illness. **The $500.00 non-PPO per confinement deductible will be waived if you are admitted to the Hospital directly from the Emergency room. Precertification will be required for any Hospital confinement, otherwise benefits will be paid by the Plan at the 50% coinsurance level.**

19. Dependents and Retirees Residing Outside PPO Service Area – Office Visit/Non-Emergency or Scheduled Hospital Admission

If you reside Outside PPO Service Area and there are not Preferred Providers within 100 miles, benefits will be paid at the **70%** coinsurance level to the maximums of the Plan Option you participate in, subject to the applicable calendar year deductible. All other Plan provisions will remain the same. **Precertification will be required for any Hospital confinement, otherwise benefits will be paid by the Plan at the 50% coinsurance level. The $500.00 per Hospital confinement deductible will not be waived.**

20. Extended Care – Plan Option A / Plan Option B

	COINSURANCE PERCENTAGE PLAN PAYS	
	INSIDE PPO	**OUTSIDE PPO**
a) Skilled nursing facility services - Maximum of one hundred-twenty (120) days per calendar year.	**80%**	**50%**
b) Home Health Care - Maximum of one hundred-twenty (120) days per calendar year.	**80%**	**50%**
c) Hospice - Maximum of one hundred-twenty (120) days per calendar year.	**80%**	**50%**

B. OUTPATIENT PRESCRIPTION DRUG SCHEDULE OF BENEFITS

This coverage is provided by a prescription drug plan and pays benefits for Prescription Drugs bought for the medical care of a Plan Participant's Sickness or Injury and is separate from the medical benefits under the Plan. Copays and any additional Prescription Drug charges cannot be used to satisfy deductibles or coinsurance maximums. Information on how to access the Prescription Drug benefit is on the Fort Bend County Employee Benefit Plan ID card. Participants will be required to use their ID card to fill all outpatient Prescription Drugs and pay the following amounts:

RETAIL PHARMACY (30 Days Supply or Less Only)

Generic $12.00*
Preferred Brand Name $30.00*
Non-Preferred Brand Name $50.00*
Specialty** $125.00*

MAXOR MAILORDER PHARMACY (for up to a 90-day supply)

Generic $24.00*
Preferred Brand Name $60.00*
Non-Preferred Brand Name $100.00*
Specialty** $250.00*

* Copay per prescription per participant. If your prescription costs less than the required copay, you will pay the the actual cost of the medication. *Note:* Copayments are required for refills.

There is no copay required for syringes.

**Medication requiring special handling and additional patient monitoringused for disease states not considered common, is chronic in nature and has a cost higher than traditional medications.

The MaxorPlus formulary determines the pricing category of your Prescription Drug. Contact **MaxorPlus at 1-800-687-0707** or visit www.maxorplus.com to determine if your Prescription Drug is listed as a Generic, Preferred Brand Name, Non-Preferred Brand or Specialty copay tier. The formularies are subject to change and it is the Participant's responsibility to verify the current Maxor category of their Prescription Drug.

Not all charges are eligible; see Eligible Expenses below. A person's eligibility under this coverage may be extended after the date that person ceases to be a Participant. See Retiree Participation or COBRA (Article V). 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 Plan Participant.

The Fort Bend County Employee Benefit Plan ID card will be honored by most local pharmacies. MaxorPlus, Ltd. will be responsible for contracting with all pharmacies that will accept the ID card. They may be contacted at 1-800-687-0707. Except as provided by the "step therapy" provisions of this Plan, Prescriptions must be filled with a generic medication *in order to be covered unless doctor has specified"brand necessary" or "brand medically necessary." The Participant will be required to pay the difference in the price of the generic versus the brand name Prescription Drug in addition to the copay, when a brand name medication is requested due to patient preference.

Any amounts spent on prescriptions, whether actual costs or copays, do not apply toward deductibles or coinsurance provisions under the Plan.

This Plan will not coordinate benefits with any other entity or plan in regard to outpatient prescription drugs purchased with your drug card.

A prescription drug means:

1. A medical 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.

ELIGIBLE PRESCRIPTION DRUG EXPENSES

A Prescription Drug is considered an eligible expense under the Plan if it meets all of the following conditions, unless it is specifically excluded under the Schedule of Benefits:

1. It is prescribed in writing by a licensed physician;
2. It is purchased while the person is a Participant;
3. It is dispensed by a pharmacy or any other person or organization licensed to dispense drugs in the U.S.A.

PRESCRIPTION DRUG LIMITATIONS AND EXCLUSIONS

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

1. A prescription or a refill of a prescription that is more than a limit of a 30-day supply at a retail pharmacy or more than a 90-day supply through mail order;
2. A refill of a prescription that is:
   a) In excess of the number specified by the Physician); or
   b) Exceeds the quantity limits allowed by this Plan; (see for example: sexual dysfunction medications and contraceptives) or
   c) Furnished more than one year after the date of the Physician's original order of the Prescription Drug;
3. Drugs for sexual dysfunction of inadequacy unless not primary diagnosis;
4. Drugs or medicines for which reimbursement is provided under any Workers Compensation law, or by any municipal, state, or federal program;
5. Medications that require "step therapy" or the use of other medications first before "stepping up" to more costly medications without compliance with the step requirement. Medications that require step therapy include, but are not limited to, Proton Pump Inhibitors (PPI), Nasal Steroids, Statin Medications, Angiotensin Receptor Blockers, Acne Oral Antibiotics, Topical Antifungals, Topical Acne Products, and Sleeping Medications: Step therapy under this plan requires that generic medication must be tried first (**step 1**) for a three (3) month period prior to a brand name drug being filled (**step 2**). Over the counter (OTC) medications will also be covered as step 1 for PPI and Nasal Steroid classes. This includes, but is not limited to, Proton Pump Inhibitors (PPI), Nasal Steroids, Statin Medications, Angiotensin Receptor Blockers, Acne Oral Antibiotics, Topical Antifungals, Topical Acne Products, and Sleeping Medications);
6. Medications on the Maxor Excluded Drug List. The list, which is subject to change, contains certain high cost medications that have older generic versions available as lower-cost alternatives and therefore are not a covered expense under the Plan. The Maxor Excluded Drugs list may be accessed at www.maxorplus.com or by calling 1-800-687-0707.
7. Medications requiring prior authorization without compliance with the MaxorPlus prior authorization protocol. The list of medications requiring prior authorizations (PA) list is available at www.maxorplus.com or by calling 1-800-687-0707, the list is subject to change.

8. Medicines or drugs which are lawfully obtainable without a prescription written by a licensed Physician ("over the counter" medications), including vitamins cosmetics, and dietary supplements, or drugs that have an over the counter equivalent; however insulin and prescribed prenatal vitamins are covered.

9. The administration or injection of any drug including injectable insulin;

10. Medicines or drugs prescribed for the treatment of infertility, nicotine addiction (except while participating in one of the nicotine cessation program(s) that has been approved in advance by the Plan Administrator), hair loss, or to change skin pigmentation;

11. Weight loss medications for the treatment of obesity; but not morbid obesity. The weight requirement for morbid obesity shall be defined as a minimum of 100 pounds over the normal body weight for your height, as determined by your Physician

12. Replacement of lost, stolen, or damage prescriptions;

13. Drugs or medications which are covered under Medical Benefits (Article VI);), including medical devices appliances, and supplies;

14. Any generally excluded charges shown in the Limitations and Exclusions (Article VI), even if not specifically identified above.

ARTICLE II
COST CONTAINMENT PROVISIONS

The Plan encourages all Participants to seek the best and most efficient medical care available. The following cost containment features are designed with that goal in mind.

A. PREFERRED PROVIDER ORGANIZATIONS (PPO)

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

Under the Plan, maximum benefits can be obtained by utilizing the large selection of Preferred Providers, Hospitals and facilities listed in the Aetna Signature Administrators PPO. Participant may access these Physicians, Hospitals and ancillary providers by going on-line at www.aetna.com/asa or the Fort Bend County's network link http://www.fortbendcountytx.gov/index.aspx?page=319 or call **1-800-252-9653** for more information.

Please read the front and back of your card carefully so that you may obtain the maximum benefit from this Plan. The participant has unrestricted access to any practitioner or facility within this directory (referral not needed except for services for mental health, substance abuse or alcoholism benefits). It is the Participant's responsibility to verify if the provider is within the PPO.

When a Participant chooses a provider, simply call for an appointment and identify yourself as a Participant in the Aetna Signature Administrators PPO for Physicians, Hospitals and ancillary providers. The Participant's identification card provided by your Employer should be presented at the time of your appointment. During the year, Aetna Signature Administrators PPO will update their directory. Please make sure you verify your provider before each Physician's or Ancillary's appointment or Hospital admission. It is the Participant's responsibility to ensure the provider is within the PPO.

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

B. PRECERTIFICATION

Participant should call **PrimeDx** at **1-800-477-4625** to comply with the precertification provisions below.

Expenses incurred while confined to a Hospital as an in-patient are subject to the precertification provisions, consisting of Preadmission Evaluation and Concurrent Review. This precertification program must be utilized on all Hospital admissions to receive maximum medical benefits. Precertification is required before being admitted to the Hospital. Non-compliance will result in a reduction of benefits.

For purposes of precertification, "Preadmission Evaluation" means a process that utilizes Physician-developed criteria and standards for determining the Appropriateness of reimbursement for non-Emergency in-patient Hospital admissions, the length of Hospital stay that will be considered Medically Necessary, and Maximum Eligible Charges for eligible medical benefits. To receive maximum medical benefits, all in-patient Hospital admissions must be reviewed and documented in advance.

Length of stay is determined by the attending Physician and is evaluated by the precertification program. Admission to a Hospital without prior determination of length of stay or an extended length of stay without review by the program will result in benefits being paid at the 50% coinsurance level for all Eligible Expenses incurred for that Hospital stay. These additional expenses will not apply to your deductible or coinsurance provisions.

Pre–certification authorizes Medical Necessity only and does not guarantee payment of benefits. The Claims Administrator will determine if the procedure is eligible under the Plan. The Participant or their medical provider may request a pre-determination of a claim prior to incurring medical treatment.

C. UTILIZATION REVIEW

Participant should call **PrimeDx** at **1-800-477-4625** to satisfy the utilization review requirements described below.

1. General Overview

"Utilization Review" is the review of a Hospital confinement by the Plan (through PrimeDx) prior to the date of such confinement and/or during such confinement. The purpose is to possibly avoid unnecessary Hospital confinements and/or reduce the length of some confinements without affecting the quality of treatment. PrimeDx will review the Hospital confinement with your Physician; however, in all cases the necessity of Hospital confinement and length of stay is determined by Participant and their Physician, not the Contract Administrator or the Plan. In order for PrimeDx to review a Hospital confinement with the Participant's Physician, they must be advised of such confinement. Notification of such 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. If a Participant does not go through Utilization Review, benefits will be paid at the 50% coinsurance level for all Eligible Expenses incurred for that Hospital stay.

2. For purposes of Utilization Review, the following definitions apply:

a) Compliance is notifying PrimeDx: (1) ten (10) Working Days prior to a Scheduled Admission; (2) by the thirty-sixth (36^{th}) week for pregnancy; (3) immediately prior to admission for an Urgent Admission; or (4) within forty-eight (48) hours of an Emergency Admission (seventy-two (72) hours on weekends or holidays); (5) when receiving initial dialysis treatment; (6) when receiving initial treatment for End Stage Renal Disease, (7) when receiving chemotherapy.

b) 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.

c) Urgent Admission is a Hospital admission that is not an Emergency Admission, but is necessary within at least seventy-two (72) hours from the time a Physician recommends such Hospital confinement.

d) Scheduled Admission is a Hospital admission that a Physician has recommended that is neither an Emergency nor Urgent Admission.

e) Working Day is any day Monday through Friday, excluding national legal holidays.

3. **Types of Review**

a) Preadmission Certification – Review is performed prior to a Scheduled Admission.

b) Concurrent Review – Review is performed for Scheduled and non-Scheduled Admissions during confinement.

c) Discharge Planning – Where Appropriate arrangements are made to facilitate the earliest possible discharge.

d) Medical Case Management – Alternate treatment plans are developed that meet the medical needs of the Participant and are more cost-effective than standard treatment forms.

4. **Compliance Guidelines**

A PARTICIPANT'S FAILURE TO COMPLY WITH THESE STEPS WILL RESULT IN "NON-COMPLIANCE" WITH PLAN PROVISIONS AND LIMITED BENEFITS WILL BE PAID.

a) Scheduled Hospital Admission Including Pregnancy – The Participant or a personal representative must notify PrimeDx by telephone well before such Scheduled Admission so that the attending Physician can submit the Preadmission Certification form to PrimeDx at least ten (10) Working Days prior to Scheduled Admission. Pregnancies must have the Preadmission Certification process complete by the thirty-sixth (36^{th}) week of pregnancy.

b) Urgent Admission – The Participant, Physician, or a personal representative must notify PrimeDx by telephone immediately prior to actual admission.

c) Emergency Admission – The Participant, Physician, or a personal representative must notify PrimeDx within forty-eight (48) hours of admission (seventy-two (72) hours on weekends or legal holidays).

Once the Participant has complied with these provisions, PrimeDx will proceed to work with the Physician and Hospital in the Participant's behalf for necessary medical care in compliance with the Physician recommendations.

D. MENTAL AND NERVOUS, ALCOHOL AND SUBSTANCE ABUSE GUIDELINES

As a Participant in the Plan, Participant is required to contact the E.A.P. in order to access their mental health/substance abuse benefits before accessing benefits under the Plan. The E.A.P. counselor will assess your needs and determine what steps need to be taken in order to help resolve your situation. Your E.A.P. provider is Deer Oaks EAP Services and they can be reached toll free at 1-866-327-2400.

Should Participant need to access the Aetna Signature Administrators PPO network of providers, the E.A.P. provider will coordinate Participant's benefits with referral to PrimeDx. Participant must contact PrimeDx to discuss Participant's benefit options at 1-866-810-7614 (see Article II). Participant may only use providers with the Aetna Signature Administrators PPO network and with prior approval from PrimeDx.

In the event of an Emergency in-patient Hospital admission or a scheduled in-patient Hospital admission, Participant must utilize the providers approved by PrimeDx or benefits will be disallowed. Hospital Providers for Emergency Hospital admissions may be obtained from **ONLY** the Aetna Signature Administrators PPO website. Retirees and their Dependents participating in the Plan are not eligible for E.A.P. benefits; therefore, they are exempt from the E.A.P. referral requirement, however, they must use Preferred Providers or benefits will be disallowed.

Receiving evaluation and/or outpatient treatment for services from any non-Aetna Signature Administrators PPO provider will result in a 0% benefit pay out from the Plan. Services provided by any provider unless specifically referred to that in-network provider by the E.A.P. or PrimeDx will result in a 0% benefits pay out from the Plan.

1. **Acute Care Hospital Confinements (Preadmission Certification Required)**

   a) Psychotic state or eminent danger – The Plan will cover Maximum Eligible Charges for a maximum of five (5) days in-patient care unless condition necessitates locked-door treatment in seclusion and/or under twenty-four (24) hour watch, in which case coverage will continue until such locked-door treatment or twenty-four (24) hour watch is no longer necessary;

   b) Detoxification – The Plan will cover Maximum Eligible Charges for in-patient care necessary 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 – The Plan will cover Maximum Eligible Charges for a maximum of five (5) days of in-patient care for all diagnoses not listed in paragraph 1 or 2 above;

   d) Eating disorders or chronic pain disorders – The Plan will cover Maximum Eligible Charges for a maximum of five (5) days in-patient care unless a condition of physical health that (regardless of psychiatric or substance abuse diagnosis) would necessitate in-patient care, in which case coverage will be provided in accordance with the Plan's coverage of such physical condition; and

   e) Condition of physical health – The Plan will cover Maximum Eligible Charges Maximum Eligible Charges for in-patient care necessary to treat a condition of physical health that (regardless of a psychiatric or substance diagnosis) would necessitate in-patient care, in accordance with the Plan's coverage of such physical condition.

2. **In-Patient Treatment or Therapies Requiring Precertification**

   a) Psychological testing;

   b) Aversion therapy;

   c) Multiple psychotherapy sessions per day. Without precertification, the Maximum Eligible Charges for a maximum of one (1) session per day will be covered;

   d) Home therapy passes;

   e) Experimental use of medication (non-traditional) – the term experimental includes the following:

      1) Any drug classified as experimental;

      2) A non-experimental drug being used in a fashion contrary to standard medical practice in relationship to the diagnosis of the case; and

      3) A non-experimental drug given in a dosage level contrary to standard medical practice in relationship to the diagnosis of the case.

   f) Other in-patient approaches not listed may be Eligible Expenses pending review through precertification of the therapy types delivered and the hours per week of therapy delivered by the facility.

3. **Subacute (Residential) In-Patient Confinements (Precertification Required)**

   Subacute (residential) in-patient confinements will be considered Medically Necessary when outpatient treatment is not effective or programmatic in-patient treatment is needed without the need for an acute-care confinement. Subacute care includes treatment modalities listed as residential in-patient; social model inpatient; social psychiatric residential; light psychiatric; group home; halfway in-patient treatment and psychiatric health facility.

4. **Treatment or Therapies Requiring Precertification as Outpatient Care**

   a) Psychological testing;

   b) Day treatment considered Medically Necessary when outpatient treatment is not effective or programmatic treatment is necessary without the need for in-patient care;

   c) Multiple sessions per week;

   d) Necessary when used to prevent Hospitalization or re-Hospitalization;

   e) For a severe multiple problem family situation; and

   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; and

   c) Health and well-being enhancement programs (i.e. weight control programs; and nicotine cessation programs other than as allowed under prescription benefits); stress reduction programs; marriage enrichment programs; and programs significantly educational in nature and not giving special emphasis and treatment to a diagnosed illness).

6. **The Attending Physician Retains Full Control Over The Medical Treatment Provided**

   If there is a potential conflict with the Contract Administrator of 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.

E. OUTPATIENT DIAGNOSTIC TESTING

Diagnostic Tests - The Plan will pay 50% coinsurance for any eligible testing that is performed on an outpatient basis if a non-PPO Provider performs the service. The Plan will pay 80% coinsurance if a PPO Provider performs the service.

F. PREADMISSION TESTING

Outpatient Surgery - The Plan will pay 100% of Eligible Expenses for outpatient x-rays and lab tests performed by a PPO Provider prior to surgery and will pay 50% of Maximum Eligible Charges for tests performed by a non-PPO Provider. Eligible Expenses for preadmission testing will be reimbursed as medical benefits. The calendar year deductible will not apply.

In-Patient Surgery – The Plan will pay 100% of Eligible Expenses for Preadmission Testing by a PPO Provider or 70% of the Maximum Eligible Charges for Preadmission Testing by a non-PPO Provider. "Preadmission Testing" means diagnostic, X-ray and laboratory exams made in contemplation of and within four (4) days of a scheduled surgery, which is performed within the 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 would 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.

G. 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 charges 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.

Utilization Review is required within seventy-two (72) hours for an Emergency Hospital admission.

H. SECOND AND THIRD SURGICAL OPINIONS

The Benefit Percentage for charges for second and third surgical opinions is 100% if the second and third opinions are performed within 45 days of the first opinion. The Benefit Percentage is also 100% for third surgical opinion if the second surgical opinion does not confirm the recommendations of the Physician who 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 who 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 who recommended and will perform the surgery.

I. OUTPATIENT SURGERY

Whenever possible, Participants are encouraged to have necessary surgery performed on an outpatient basis. "Outpatient" services and supplies means services and supplies furnished by the Surgery Center or by a Hospital on the day the procedure is performed. When incurred in connection with outpatient surgery, the following will be covered as medical benefits after the deductible is satisfied, at a benefit percentage of 80% Inside PPO or 70% Outside PPO (including Surgery Centers).

1. All related Eligible Expenses for outpatient services, including lab fees, biopsies, and supplies by a Surgery Center or outpatient department of a Hospital for Eligible Expenses incurred on the day surgery is performed on a Participant;

2. Eligible Expenses related to the outpatient surgery, including anesthesiologist charges incurred at a Surgery Center, participating PPO Hospital, or other facilities in connection with an outpatient surgery; and

3. Fees by surgeons for surgery performed on an outpatient basis.

J. HOME HEALTH CARE BENEFITS

Precertification is Required – Participants are encouraged to receive care at home, when possible, rather than in a Hospital. 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 twenty-four (24) hour period will be eligible for payment as one Home Health Care visit. The amount paid will be **80%** Inside PPO or **50%** Outside PPO of the Maximum Eligible Charges for Home Health Care. Home Health Care must be provided in accordance with a Home Health Care Plan, once established.

No Home Health Care benefits will be paid unless the Participant's attending Physician certifies that:

1. Confinement in a Hospital or skilled nursing facility would be required if Home Health Care was not provided;

2. The Participant's immediate family or other Participant residing with him or her are not able to provide proper care of the Participant without undue hardship; and

3. Home Health Care will be provided or coordinated by a Home Health Care Agency.

No Home Health Care benefits are payable for Home Health Care:

1. Provided by any member of the Participant's immediate family or any person who resides with the Participant;

2. That is custodial or housekeeping in nature; or

3. That involves services or supplies not included in the Home Health Care Plan prescribed by a Physician.

K. HOSPICE BENEFITS

Precertification of Required – Terminally ill Participants are provided coverage for necessary care without Hospital confinement. The Plan covers a Participant's Eligible Expenses for Hospice Benefits. A Participant is eligible for Hospice Benefits if the Participant is terminally ill, the attending Physician expects him or her to live no more than six (6) months after the date services are performed, and the attending Physician has recommended a formal program of Hospice care. The amount paid will be **80%** of Eligible Expenses for Hospice Benefits provided by PPO Providers or **50%** of Eligible Expenses for Hospice Benefits provided by non-PPO Providers. Some charges may be payable under other provisions of this Plan.

L. EMPLOYEE ASSISTANCE PROGRAM ("E.A.P.")

All Participants (except Retirees, Dependents of Retirees, and Local Government Code 615 Surviving Dependent(s)) are offered assistance in a variety of areas and referrals to E.A.P. counselors. This program will assist you in obtaining mental health and substance abuse counseling. **If you participate in the Plan, you will be required to contact the E.A.P. provider in order to access your mental health/substance abuse benefits.** The E.A.P. counselor will assess your needs and determine what steps need to be taken in order to help resolve your situation. You are eligible to receive eight (8) free visits at a provider referred through the E.A.P. Should Participants need to access the Aetna Signature Administrators PPO network of Physician providers, the E.A.P. provider will coordinate your benefits with PrimeDx. **Your E.A.P. provider is Deer Oaks EAP Services and they can be reached toll free at 1-866-327-2400.**

ARTICLE III
PLAN INFORMATION

EMPLOYER
Fort Bend County
Fort Bend County Courthouse
Richmond, TX 77469
Telephone: 1-281-341-8630

PLAN ADMINISTRATOR/PLAN SPONSOR AND AGENT FOR SERVICES OF LEGAL PROCESS/VENUE
Fort Bend County
Attention: County Attorney's Office
Fort Bend County Courthouse
Richmond, TX 77469
Telephone 1-281-341-4555

PLAN NAME
Fort Bend County Employee Benefit Medical Plan – This is an employee benefit plan formed under Chapter 172 of the Local Government Code, providing Comprehensive Medical Benefits and Prescription Drug Benefits.

PLAN NUMBER/IDENTIFICATION – 949

BENEFIT YEAR – January 1 through December 31

PLAN YEAR – January 1 through December 31

CONTRACT CLAIMS ADMINISTRATOR
Boon-Chapman Benefit Administrators Inc.
P. O. Box 9201
Austin, TX 78766
Physical Address:
9401 Amberglen Boulevard, Building I, Suite 100
Austin, TX 78729
Telephone: 1-512-454-2681 or 1-800-252-9653
Facsimile: 1-512-459-1552
Web address: www.boonchapman.com

PREFERRED PROVIDER ORGANIZATIONS
Aetna Signature Administrators PPO
Web address: www.aetna.com/asa

PRECERTIFICATION/UTILIZATION REVIEW
PrimeDx
P. O. Box 9201
Austin, TX 78766
Telephone: 1-800-477-4625

PRESCRIPTION DRUG CARD PROGRAM/
PHARMACY BENEFIT MANAGER

MaxorPlus, Ltd.
320 S. Polk Street, Suite 200
Amarillo, TX 79101
Telephone: 1-800-687-0707
Web address: www.maxorplus.com

Maxor Mail Order Pharmacy
P. O. Box 32050
Amarillo, TX 79120-2050
Telephone: 1-800-687-8629
Web address: www.maxor.com

EMPLOYEE ASSISTANCE PROGRAM

Deer Oaks EAP Services, LLC
7272 Wurzbach Road, Suite 601
San Antonio, TX 78240
Telephone: 1-866-327-2400

FINANCING OF THE BENEFITS PLAN

You and your Employer contribute to the Plan, if you chose to participate. The amount of the contribution is determined by the claims experience of those who participate in the Plan and the contribution level is determined by Fort Bend County Commissioners Court. The Court reserves the right to adjust the contribution level of the Employer or the Participants at any time. The benefit year begins January 1 and runs through December 31.

ARTICLE IV
DEFINITIONS

Active Service means the Employee is performing in the customary manner, all of the regular duties of employment on a full-time basis either at the customary place of employment or at some location to where that employment requires travel on a scheduled work day, or if the Employee is absent from work solely by reason of vacation and at the time coverage would otherwise become effective, 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 that is not a scheduled work day only if the Employee was performing in the customary manner all of the regular duties of employment on the last preceding scheduled work day. In no event will an Employee be considered in Active Service if he has effectively terminated employment with the Employer. An eligible Dependent will be considered in Active Service on any day if the Dependent is then engaging in all the normal activities of a person in good health, and the Dependent is not confined in a medical facility. (This paragraph will not apply to a newborn child.) An Elected Official by virtue of office is deemed to be Active Service throughout their term once sworn into office and the officeholder is considered a full-time budgeted position regardless of hours worked.

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.

Appropriate or Appropriateness refers to the classification of a medical service as customary and usual for the treatment of any given medical condition. Such services must be commonly recognized by the medical profession as an accepted standard for that type and level of care.

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

Business Associate shall generally have the same meaning as the term "business associate" at 45 CFR 160.103.

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

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

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.

Commissioners Court means the Commissioners Court of Fort Bend County, Texas.

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

County Judge means the County Judge of Fort Bend County, Texas.

Covered Entity shall generally have the same meaning as the term "covered entity" at 45 CFR 160.103, and reference to the party to this Plan, shall mean Fort Bend County Employee Benefit Plan.

Creditable Coverage means the medical coverage that an individual had/has from any of the following sources: a group health plan, health insurance coverage, Medicare, Medicaid, medical for members and former members of the uniformed services and their dependents, a medical care program of the Indian Health Service or tribal organization, a state health benefits risk pool, certain other state-sponsored arrangements established primarily to provide medical benefits to persons who have difficulty in obtaining affordable coverage because of a medical condition, a health plan offered under the Federal Employees Health Benefits Program, a public health plan, or a health benefit plan under the Peace Corps Act, provided the coverage did not consist solely of excepted benefits under federal law. (Shown by providing a written Certificate of Coverage from the source or entity that provided the coverage.)

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, 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 covered expenses a Participant must pay during the year before the plan begins to consider expenses for reimbursement.

Dependent means any one or more of the following:

1. The lawful Spouse of an Employee;
2. Natural children of the Employee, including legally adopted children and step-children, who have not attained age twenty-six (26);
3. Unmarried natural children of the Employee, including legally adopted children and step-children, who have attained age twenty-six (26), reside with the Employee, are principally dependent upon the Employee for support and maintenance, are incapable of self-sustaining employment due to mental or physical disability, provided such disability commenced prior to attainment of age twenty-six (26), and Dependent was covered prior to attainment of such age. Proof of dependency or mental or physical disability must be furnished by you when required by the Plan Administrator;
4. Natural child of an Employee who is subject to a current order of a court or Office of the Attorney General (OAG) to provide health benefits for such natural child, who have not attained age twenty-six (26);
5. Grandchild of the Plan Participant who is a dependent of the Plan Participant for federal income tax purposes at the time application for coverage of the child is made; who has not attained age twenty-six (26);
6. Grandchild of a Plan Participant who is a dependent of the Plan Participant for federal income tax purposes at the time application for coverage of the child is made; and who have attained age twenty-six (26), reside with the Employee, are principally dependent upon the Employee for support and maintenance, are incapable of self-sustaining employment due to mental or physical disability, provided such disability commenced prior to attainment of age twenty-six (26), and child was covered prior to attainment of such age (proof of dependency or mental or physical disability must be furnished by you when required by the Plan Administrator); or
7. Child for whom the Plan Participant must provide medical support under a court order issued under Chapter 154, Family Code, or enforceable by a court in the State of Texas, stating Employee must

provide medical support for child, and child has not attained age eighteen (18) or graduated from high school, whichever occurs later.

Dialysis Services means any service, supply, equipment or drug utilized in connection with hemodialysis or peritoneal dialysis.

Elected Official means a person who is elected to serve Fort Bend County and who by virtue of their office is entitled to participate in the County's Medical Plan. They will be included in the reference to "Employee" within the Plan; exceptions will be noted with specific reference to Elected Official.

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

Emergency refers to a situation in which Medically Necessary health services 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 Assistance Program (E.A.P.) means an organization that assists Participants (except Retirees, Dependents of Retirees and Local Government Code 615 Surviving Dependent(s)) in managing a variety of problems they may encounter, both on the job and off the job.

Employee means persons who meet the qualifications to participate in the Plan as indicated in the eligibility section of the Plan for the Employer and are entitled to compensation for such services. Any individual who is considered to be in an employer-employee relationship with the Employer on the payroll records of the Employer for purposes of federal income tax withholding. The term "Employee" will not include any person during any period that such person was classified on the Employer's records as other than an Employee. The term "Employee" will not include anyone classified on the Employer's records as an independent contractor, agent, leased employee, contract employee, temporary employee or similar classification, regardless of a determination by a governmental agency that any such person is or was a common law employee of an Employer. For purposes of this definition, (a) a "leased employee" means any person, regardless of whether or not he is a "leased employee" as defined in Code Section 414(n)(2), whose services are supplied by an employment, leasing, or temporary service agency and who is paid by or through an agency or third-party, and (b) an "independent contractor" means any person rendering service to the Employer and whom the Employer treats as an independent contractor by reporting payments for the person's services on IRS Form 1099 (or its successor), regardless of whether any agency (governmental or otherwise) or court concludes that the person is, or was, a common law employee of the Employer even if such determination has a retroactive effect.

Furthermore, Employees who are non-resident aliens and who receive no earned income (within the meaning of Code Section 911(d)(2) from an Employer which constitutes income from sources within the United States (within the meaning of Code Section 861(a)(3)) will not be considered Employees who are eligible to participate in this Plan.

An Employee in a full time (minimum 30 hours worked per week) Fort Bend County budgeted position which includes budgeted benefits may be eligible to participate in this Plan.

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. Preventative 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.

Family Status Change events 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. It is the Employee's responsibility to notify Risk Management of the change in writing and to complete the necessary form(s). Verbal notification is unacceptable.

Health Breach Notification Rule shall mean 16 CFR Part 318.

Health Care Benefits means the medical, prescription drug and dental benefits provided under the Plans.

HIPAA Rules means the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Part 160 and Part 164.

Home Health Care includes one or more of the following:

1. Part-time or intermittent home nursing care by or under the supervision of a registered nurse (RN);

2. Part-time or intermittent home health aide services which are Medically Necessary as part of the Home Health Care Plan. Services must be rendered under the supervision of a registered nurse (RN) or medical social worker, and consist solely of caring for the Participant;

3. Physical, respiratory, occupational or restorative speech therapy, not to include speech development therapy in connection with learning disabilities;

4. Medical supplies, drugs and medications prescribed by a Physician or laboratory services by or on behalf of a Hospital under the Home Health Care Plan. This is true to the extent such items would be covered under the Plan if the Participant had been Hospitalized;

5. Nutritional counseling provided by or under the supervision of a registered dietician, where such services are Medically Necessary as part of the Home Health Care Plan, including nutritional supplements such as diet substitutes intravenously or through hyperalimentation as determined to be Medically Necessary; or

6. The evaluation of the need for, and development of, a Home Health Care Plan by a registered nurse (RN), Physician or medical social worker, for Home Health Care when approved or requested by the attending Physician.

Home Health Care Agency means an entity that:

1. Is state licensed;
2. Is a Certified Rehabilitation Agency;
3. Qualifies under Medicare; and
4. Meets all of the follow:
   a) Is mainly involved in Home Health Care delivery, including skilled nursing care;

b) Has a staff including at least one supervisor registered nurse (RN);
c) Has an administrator; and
d) Maintains daily health records for all patients.

Home Health Care Plan is a plan of Home Health Care that (1) is established and initially approved in writing by the attending Physician while the Participant was Hospital confined, (2) is needed for care of a condition that caused the Participant to be Hospital confined, (3) begins within 14 days following the termination of such confinement, and (4) is reviewed at least every two months by the attending Physician, unless the attending Physician finds that a longer time between reviews is sufficient.

Hospice means a licensed or certified agency that:

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

Hospice Benefits include the following services provided by a Hospice:

1. Room and board;
2. Physician services and/or nursing care by a Registered Nurse, Licensed Practical Nurse or a Licensed Vocational Nurse. Private duty nursing care provided by, or under the supervision of, a registered nurse (RN);
3. Part-time or intermittent home health aide services by employees of the Hospice;
4. Social work performed by a licensed social worker; and
5. Nutritional services, including special meals to include nutritional advice by a dietitian, and nutritional supplements such as diet substitutes administered intravenously or through hyperalimentation as determined to be medically necessary.
6. Physical therapy, occupational therapy, speech therapy or respiratory therapy.

"Hospice Benefits" do not include the following:

1. Services provided by volunteers or other who do not usually charge for their services;
2. Services by a person who lives in the Participant's home or is a Close Relative;
3. Any period during which the Participant is not under the care of a Physician; and
4. Bereavement counseling.

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 or more Physicians available at all times;
3. Has twenty-four (24) hour a day nursing services by Registered Nurses (RNs) or other nursing services when assumed under the complete responsibility of the Physician in charge;
4. Maintains in-patient 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, 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.

Inside PPO means receiving eligible services from Preferred Providers.

Late Entrant means an Employee who 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 Dependent of an Employee who is a Late Entrant and a Dependent who does not enroll in the Plan within the first thirty-one (31) days after such Dependent is eligible to enroll. If you and/or your Dependent(s) do not enroll for benefits at the initial time you are eligible for benefits, then you and/or your Dependent(s) will be considered Late Entrants.

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

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

With regard to charges made by a provider of service participating in the Plan's PPO program, "Maximum Eligible Charge" shall mean the rates negotiated between the preferred provider organization and the participating providers.

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

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

The Maximum Eligible Charge for Outpatient Dialysis Services thereafter, is the lesser of:

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

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

Medically Necessary or Medical Necessity means when a service, treatment, device, drug, or supply 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:

1. Be rendered in connection with an Injury or Illness;
2. Be consistent with the diagnosis and treatment of your condition; and
3. Be in accordance with the standards of good medical practice.

To be Medically Necessary, Covered Expenses must also be 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 or 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:

1. It is provided only as a convenience to the Covered Person or provider;
2. It is not appropriate treatment for the Covered Person's diagnosis or symptoms;
3. It exceeds (in scope, duration or intensity) that level of care that is needed to provide safe, adequate and appropriate diagnosis or treatment;
4. It 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. "Investigative, Experimental or for Research Purposes: means 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
5. It involves the use of a drug or substance not formally approved by the United States Food & Drug Administration, even if approval is not required, or if 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;
6. Is generally, commonly, and customarily regarded by experts who 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 peer-reviewed scientific literature generally recognized by the relevant medical community; or
7. 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.

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 (contact the Plan Administrator for the authoritative literature used);
2. A Covered Person's medical records;
3. Protocol pursuant to which the treatments is to be delivered; or
4. Any regulations and publications set forth by any United State Federal or State governmental agency.

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

Outside PPO means receiving eligible services from providers who are not Preferred Providers

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

Participant means those Full-Time Employees or Retirees and their eligible Dependents and Local Government Code 615 Surviving Dependent(s) who have enrolled in the Plan in accordance with Plan procedures and are entitled to benefits under this Plan.

PHI shall mean Protected Health Information, as enacted pursuant to *HIPAA*.

Physician means any professional practitioner who 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.

Plan Administrator means Fort Bend County, who has contracted with a third party vendor for the administration of claims under this medical plan document.

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

Preexisting Condition means, as determined by the Plan Administrator, any Illness, Injury, or other condition of a Participant (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received, excluding pregnancy, and including all complications that can reasonably be determined to be related to such conditions which existed at any time during the twelve (12) months prior to your effective date of coverage under this Plan. Genetic information on a Participant will not be considered a Preexisting Condition. For services received prior to January 1, 2014, the Preexisting Condition Exclusion period may be reduced or eliminated for any enrollee nineteen (19) years old and over who has Creditable Coverage without a Significant Break in Coverage. For any enrollee further effective January 1, 2014, a Preexisting Condition will not be applied.

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

Preferred Provider Organization (PPO) is a group of health care providers (Physicians and/or Hospitals) who, 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); 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.

Retiree means any person who meets the definition of Retiree as defined by the Fort Bend County Commissioners Court.

Sickness means any physical or mental Illness, including pregnancy.

Significant Break in Coverage means, a period of sixty-three (63) consecutive days or more, during all of which an individual did not have any Creditable Coverage.

Spouse means a person to whom an Employee is lawfully married, but shall not include an individual separated from the Employee under a divorce decree. To the extent recognized by Texas law, "spouse" shall also include a common law spouse provided that the requirements for common law marriage have been met. The Employee must provide proof of a common law marriage to include but is not limited to a declaration of informal marriage filed with the County Clerk.

Surgery Center means a free-standing surgical facility that:

1. Meets licensing standards;
2. Is equipped and operated for general surgery;
3. Makes charges 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 who practice surgery in an area Hospital and dentists who perform oral surgery;
7. Has at least two operating rooms and one 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:
    a) Provides an ongoing quality assurance program with review Physicians who do not own or direct the facility;
    b) 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.

Waiting Period means the first of the month following fifty-eight (58) days, which begins on the date the enrollee meets the eligibility requirements.

Well-Baby Care means medical treatment, services or supplies rendered to a Newborn or a child up to two (2) years old solely for the purpose of health maintenance and not for the treatment of an Illness or Injury.

ARTICLE V
ELIGIBILITY AND PARTICIPATION

A. EMPLOYEE PARTICIPATION

1. Waiver of Participation in this Plan

An Employee has the right to waive their medical coverage under this Plan. Dependent coverage will not be available if Employee coverage is not selected. If an eligible Employee or Dependent elects to waive participation and later decides to enroll in the Plan beyond 31 days of first becoming eligible to participate in the Plan, the Employee and the Employee's Dependents will be Late Entrants and required to comply with any and all Plan provisions for enrollment in the Plan as Late Entrants. Coverage under the Plan for Late Entrants will be effective on the first (1st) day of the month following completion of the Waiting Period provided the employee is in Active Service (Elected Official is deemed to be "Active Service" once sworn into office) on that date, otherwise the effective date will be deferred until return to Active Service.

2. Eligibility

All Employees in a full time budgeted position, who are in Active Service at their customary place of employment on the day their health care benefits become effective, and who complete the Waiting Period, shall be eligible to participate in the Plan. Eligible Employees will be required to notify the Risk Management Department in writing or by online enrollment, complete any necessary enrollment elections within the first thirty (30) days of employment or eligibility to participate in the Plan and supply all necessary documentation as required by the Plan within the first thirty (30) days of employment or eligibility to participate in the Plan. Also, see Special Enrollment guidelines. If the requirements are not met within the time frame allowed, enrollment will be denied.

Elected Officials, who complete the required Waiting Period, shall be eligible to participate in the Plan. Eligible Elected Officials will be required to notify the Risk Management Department in writing, complete any necessary enrollment applications and supply all necessary documentation as required by the Plan within the first thirty (30) days of employment or eligibility to participate in the Plan.

Elected Officials and employees in a full time budgeted position eligible for retirement through the Texas County and District Retirement System (TCDRS) and under the age of sixty-five (65) years.

Elected Officials and employees in a full time budgeted position eligible for retirement through the Texas County and District Retirement System (TCDRS) and age sixty-five (65) and older will be covered under the Medicare Supplement Plan (Chapter 175 of the Local Government Code). These retirees will retain, through the Fort Bend County Employee Benefit Plan, only prescription drug benefits. In the event the Medicare Supplement Plan ceases to provide medical coverage, Fort Bend County Commissioners Court will make the determination to revert the retirees' supplemental coverage back to the County Plan or to another Medicare Supplement Plan.

All other persons are excluded.

3. Effective Date of Coverage

Coverage will become effective for an eligible Employee on the first (1st) day of the month following completion of the Waiting Period, or if none, upon the date of eligibility (provided the Employee is in Active Service on that date, otherwise the Effective Date will be deferred until return to Active Service).

Employees with a change of status from part-time to full-time or from temporary to regular will be subject to the same Waiting Period beginning the date their status changes. Employees who previously waived their benefit participation and decide to participate at a later date may only enroll during the annual enrollment period as a Late Entrant and will be subject to the Waiting Period (which will start as of January 1st the following year). Payment of any contribution toward the cost of coverage under the Plan, if required by the Employer, must be made prior to coverage becoming effective.

Any person who is currently covered under this Plan shall not be required to satisfy a new waiting period for medical coverage if all of the following conditions are met: (1) satisfied any required waiting period; (2) has not had a lapse of coverage; (3) who assumes a full-time position (hired, appointed or elected); and (4) becomes eligible for benefits under this Plan. If the person is a spouse covered as a dependent of a deceased Employee who has a dependent child currently covered under this Plan, the eligible dependent shall not be required to satisfy a new waiting period for medical coverage if conditions (1) and (2) above are met.

4. Termination of Coverage

Except as provided in the Continuation of Coverage in compliance with COBRA section or continuation of coverage under Retiree participation Article V, C, an Employee's coverage under the Plan will terminate at 11:59 p.m. on the earliest of the following dates:

a) The date at the end of the period for which the Employee made the last required contribution for coverage under the Plan;
b) The last day of the month in which the Employee terminates employment (except for termination for the violation of any County Policy, which will result in the immediate termination of this Plan's benefits) or retires;
c) The date on which the Employee no longer satisfies the eligibility requirements under the Plan;
d) The date on which the Plan is terminated or amended, resulting in the Employee's loss of coverage;
e) The date of the Employee's death; or
f) The date on which the Employee falsifies information provided to the Plan, fraudulently or deceptively uses Plan services, or knowingly permits such fraud or deception by another person.

Notwithstanding the foregoing, a termination of coverage may 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.

Participation may be continued for an Employee on an Employer approved leave of absence. See Article V, section H, Article IX, section D, and the Fort Bend County Employee Information Manual.

5. Changes in Health Care Benefits will be effective on the date the Plan is amended.

B. DEPENDENT PARTICIPATION

An Employee participating in the Plan may cover their Dependent who meets the definition of Dependent (see Article IV) and the following requirements.

Required Documentation

Documents must be submitted to Risk Management before eligibility is approved.

a) **Spouse:** Certified Marriage License or Certified Informal Marriage Certificate, Social Security Number,

and Spousal Eligibility Verification form including Certificate of Coverage (if applicable) for proof of enrollment in primary plan.

b) **Natural/Adopted Child:** Certified Birth Certificate, which shows name of mother and father (mother or father must be the Employee); Certified, signed and filed, Adoption Decree or Placement for Adoption Order (parent must be the Employee), original Certified Birth Certificate and new Certified Birth Certificate with the name change, etc., with certified, signed and filed, supporting documents for changes; court order (signed by a Judge or the Attorney General) or order for support by the Attorney General, and Social Security Number.

c) **Stepchild:** Certified Birth Certificate which shows name of mother and father, Certified Marriage License showing that Employee is legally married to Stepchild's parent and Stepchild's Social Security Number.

d) **Grandchild:** Certified Birth Certificate; Social Security Number; and proof that the child is a dependent of the Plan Participant for federal income tax purposes at the time application for coverage of the child is made.

e) **Court Ordered Child:** Certified Birth Certificate; Social Security Number; and Certified, signed and filed court order issued under Chapter 154, Family Code, or enforceable by a court in the State of Texas, stating Plan Participant must provide medical support for child.

2. Eligibility

A Dependent will be eligible to participate in the Plan during or on:

a) The date the Employee is eligible for benefits under the Plan, if on that date he has such Eligible Dependents;

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 thirty-one (31) days of gaining that Dependent;

c) If a Dependent, other than a 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; or

d) In no event will the Dependent's coverage begin before the Employee's coverage.

Primary coverage under the Plan is not available to an Employee's Spouse who is eligible at any time for medical coverage through the Spouse's employer. However, an Employee's Spouse is eligible for secondary coverage under this Plan provided that the Employee's Spouse is enrolled in their employer's medical plan, required documents (Spousal Eligibility Verification form and Certificate of Insurance) are submitted in accordance with this Plan, and the Spouse meets all other Plan provisions.

As defined in Chapter 615 of the Local Government Code (LGC), LGC 615 Survivor(s) are eligible to continue medical coverage under this Plan at the time of the Employee's death, but not enroll as a new Participant. Primary coverage under the Plan is not available to a Surviving Spouse of an Employee who is eligible at any time for medical coverage through the surviving Spouse's employer. However, a Surviving Spouse is eligible for secondary coverage under this Plan provided that the Surviving Spouse is enrolled in their employer's medical plan, required documents (Spousal Eligibility Verification form and Certificate of Insurance) are submitted in accordance with this Plan, and the Spouse meets all other Plan provisions.

In the event a husband and wife are both eligible to participate in the Plan as Employees, only one Employee will be eligible to cover any eligible Dependent child they might have. If the Employee covering a Dependent terminates their employment, the terminated Employee and Dependent(s) may be added to the existing coverage of the remaining Employee, provided that there is no lapse in coverage and they are added immediately (Article

V). In the event that the Dependent addition results in a change of benefit plan option they shall be required to meet the deductible and coinsurance provisions of the benefit plan option in which they will participate. Any deductible and coinsurance provisions previously met will be applied to the benefit plan option in which they will be participating. In the event that deductible credits or coinsurance credits do not satisfy the provisions of the new benefit plan option, the Dependent will be required to meet the difference between their credits and the remaining amounts necessary to meet the new deductible and coinsurance amounts. If moving from a higher deductible and coinsurance benefit plan option to a lower deductible and coinsurance benefit plan option, should deductible and coinsurance credits exceed the requirements of the new benefit plan option, the credits will be considered to have satisfied the benefit plan option requirements and paid amounts exceeding new benefit plan option's deductible and coinsurance requirements will not be considered reimbursable.

3. Changes in Dependent Health Care Benefits

Changes in the Health Care Benefits will be effective for Dependents only if the Employee is still eligible and the Dependent is not confined in a Hospital, or other institution. Employee and Dependent must be covered under the same benefit plan option.

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 and the Contract Administrator has received due proof such child is mentally or physically incapacitated such that they are incapable of earning their own living and is dependent upon the Employee for their support, participation will continue so long as the incapacity continues and the Plan remains in full force and effect. The Plan has the right to periodically require that the Employee show proof of the incapacity of the Dependent as determined by the Plan Administrator.

4. Termination of Coverage

Except as provided in the Continuation of Coverage in Compliance with COBRA section, a Dependent's coverage will terminate at 11:59 p.m. on the earliest of the following dates:

a) The date the Employee's coverage terminates;
b) 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;
c) The date on which the Dependent ceases to be an eligible Dependent as defined by the Plan;
d) The date on which the Dependent Spouse satisfies the benefit Waiting Period, after Dependent Spouse is hired or status changes to a benefit eligible position as an Employee of Fort Bend County;
e) The date on which the Plan is terminated or amended, resulting in the Dependent's loss of coverage;
f) The date of the Dependent's death; or
g) The date on which the Employee or Dependent falsifies information provided to the Plan, fraudulently or deceptively uses Plan services, or knowingly permits such fraud or deception by another person.

An Employee cannot terminate a Spouse during a separation until a divorce is final. A certified divorce decree must be submitted before any paperwork can be processed. The termination date will be the effective date the certified divorce decree was signed and dated by the Judge.

Notwithstanding the foregoing, a termination of coverage may only be effective retroactively if the Employee or Dependent (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 for coverage under the Plan when due.

C. RETIREE PARTICIPATION

1. Eligibility

Retirees eligible for retirement through the Texas County and District Retirement System (TCDRS), and their eligible Dependents, will be eligible to participate in this Plan subject to the rules established by and approved by Fort Bend County Commissioners Court and Chapter 175 of the Local Government Code.

All eligible Retirees under the age of sixty-five (65) years will be covered under the Fort Bend County Employee Benefit Medical Plan ("Medical Plan"). Coverage under the "Medical Plan" for Employees retiring who are sixty-five (65) years or older will terminate at 11:59 p.m. on the last day of the month in which the Employee retires.

All eligible Retirees age sixty-five (65) years or older will be covered under the Medicare Supplement Plan (Chapter 175 of the Local Government Code). These Retirees will retain, through the Fort Bend County Employee Benefit Medical Plan, only prescription drug benefits. In the event the Medicare Supplement Plan ceases to provide medical coverage, Fort Bend County Commissioner Court would make the determination to revert the Retirees' supplemental coverage back to the "Medical Plan" or to another Medicare Supplement Plan.

Rehired Retirees employed with Fort Bend County in a full-time budgeted position who are age sixty-five (65) years or older, who chose to retain retiree benefits upon becoming eligible for active benefits, and who cease to be eligible for benefits under the Medicare Supplement Plan may participate until termination of full-time employment with Fort Bend County. At that time retiree coverage will revert back to the Medicare Supplement Plan.

2. Retiree's Dependent(s)

All Dependent Spouses, age sixty-five (65) or older, of Retirees will be covered under the Medicare Supplement Plan. These Dependent Spouses of Retirees will retain, through Fort Bend County Employee Benefit Medical Plan only Prescription Drug benefits. In the event the Medicare Supplement Plan ceases to provide medical coverage, Fort Bend County Commissioners Court would make the determination to revert the Retirees' Dependent Spouse's supplemental coverage back to the County Plan or to another Medicare Supplement Plan. In the event of the Retiree's death, the Dependent Spouse may elect to continue the Medicare Supplement Plan, and the Fort Bend County Employee Benefit Medical Plan Prescription Drug benefits will terminate.

Effective September 11, 2001, Retirees who are married to a County Employee when they retire will be allowed to add the remaining Spouse/Employee and any covered Dependents to their coverage when the Spouse terminates their employment. The remaining Employee and eligible dependents will be required to have the same medical and dental benefits as the Retiree for at least the twelve (12) months preceding their termination of employment.

Primary coverage under the Plan is not available to a Retiree's Spouse who is eligible at any time for medical coverage through the Spouse's employer. However, a Retiree's Spouse is eligible for secondary coverage under this Plan provided that the Retiree's Spouse is enrolled in their employer's medical plan, required documents (Spousal Eligibility Verification form and Certificate of Insurance) are submitted in accordance with this Plan, and the Spouse meets all other Plan provisions.

3. Changes in Retiree's Dependent Health Care Benefits

Retiree and Dependent(s), under the age of sixty-five (65) years, must be covered under the same benefit plan option.

All Dependents other than a Dependent Spouse, age sixty-five (65) or older, of a Retiree are ineligible to participate in the Medicare Supplement Plan or Fort Bend County Employee Benefit Medical Plan.

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 and the Contract Administrator has received due proof such child is mentally or physically incapacitated such that they are incapable of earning their own living and is dependent upon the Retiree for their support, participation up to the age of sixty-five (65) years will continue so long as the incapacity continues and the Plan remains in full force and effect. The Plan has the right to periodically require that the Retiree show proof of the incapacity of the Dependent as determined by the Plan Administrator.

4. Termination of Coverage

Except as provided in the Continuation of Coverage in Compliance with COBRA section, a Dependent's coverage will terminate at 11:59 p.m. on the earliest of the following dates:

a) The date the Retiree's coverage terminates;
b) The Retiree 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;
c) The date on which the Dependent ceases to be an eligible Dependent as defined by the Plan;
d) The date on which the Dependent Spouse satisfies the benefit Waiting Period, after Dependent Spouse is hired or status changes to a benefit eligible position as an Employee of Fort Bend County;
e) The last day of the month in which the Dependent Child, who is no longer eligible due to age, attains the age of twenty-six (26);
f) The date on which the Plan is terminated or amended, resulting in the Dependent's loss of coverage;
g) The date of the Dependent's death; or
h) The date on which the Retiree or Dependent falsifies information provided to the Plan, fraudulently or deceptively uses Plan services, or knowingly permits such fraud or deception by another person.

A Retiree cannot terminate a Spouse during a separation until a divorce is final. A certified divorce decree must be submitted before any paperwork can be processed. The termination date will be the effective date of the certified divorce decree.

Retirees who terminate coverage on themselves or Dependent(s) under this Plan will not be able to re-enroll in the terminated coverage.

Notwithstanding the foregoing, a termination of coverage may only be effective retroactively if the Retiree or Dependent (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 for coverage under the Plan when due.

D. ANNUAL ENROLLMENT

Eligible Employees and their Eligible Dependent(s) may enroll for coverage during an Annual Enrollment period. Coverage for Eligible Employees and their Eligible Dependent(s) enrolling during an Annual Enrollment period will become effective January 1 of the following Plan Year, unless the Employee and/or Dependent(s) had a break in coverage or after declining an earlier opportunity to enroll and subsequently are enrolling for the first time, in which event the Employee and/or Dependent(s) will be subject to the enrollment requirements during Annual Enrollment and must also satisfy the Waiting Period, which begins January 1 of the

following Plan Year and benefits will be effective April 1 (the first of the month following the waiting period) of the following Plan Year. If an Eligible Employee has not yet begun work for the Employer, the Employee and their Eligible Dependent(s) are subject to the enrollment requirements and the Waiting Period, in which event coverage will become effective on the first of the month following completion of the Waiting Period if actively at work on that date, or on the first of the month following the day the Employee actually begins work. "Annual Enrollment period" shall mean a specific period during the month of October in each Plan Year. If an Eligible Employee is on Leave of Absence at the time of the Annual Enrollment period and continuously continues to monthly pay Plan Participant contributions timely with no break in coverage, they may re-enroll during the Annual Enrollment period for the following Plan Year. If an Employee on Leave of Absence has a break in coverage, they may not re-enroll during the Annual Enrollment period, but may re-enroll as a Late Entrant within thirty (30) days from the date the Employee actually returns to work, in which event coverage will become effective on the first of the month following completion of the Waiting Period if actively at work on that date and enrollment requirements were met, or on the first of the month following the day the Employee actually begins work.

E. SPECIAL ENROLLMENT (Eligible Employee not currently enrolled in the Plan.)

Except as otherwise required by law, if an Eligible Employee does not enroll for coverage for the Employee and/or the Employee's Eligible Dependents within thirty (30) days of becoming eligible for coverage and subsequently wishes to elect such coverage, in appropriate circumstances the Employee may do so under the Plan's special enrollment rules.

An Eligible Employee may enroll for coverage for the Employee and all Eligible Dependents at any time provided that:

1. The Employee is eligible for coverage under the Plan, but is not currently enrolled; and
2. The Employee declined coverage under the Plan when it was offered previously and gave the existence of alternative health coverage as the reason for not enrolling on the Employee's enrollment form; and
3. The alternative coverage has terminated.

A completed enrollment form must be submitted by the Employee within thirty (30) days after the loss of the alternative health coverage for the following:

1. COBRA continuation coverage has been exhausted; or
2. Loss of eligibility for the alternative coverage (for reasons other than the individual's failure to pay premiums or for cause); or
3. the termination of employer contributions toward the cost of coverage

A completed enrollment form must be submitted by the Employee within the sixty (60) days after the loss of the alternative health coverage for the following:

1. Termination of Medicaid or Children's Health Insurance Coverage (CHIP) due to loss of eligibility; or
2. Employee or dependents become eligible for a premium assistance subsidy under Medicaid or CHIP and the employee requests coverage under the Plan

4. Enrollment in the Plan will be effective the first day of the first calendar month beginning after the date on which the Plan receives the completed enrollment form.

In addition, an Eligible Employee may enroll for coverage for the Employee and all Eligible Dependents at any time provided that:

1. The Employee is eligible for coverage under the Plan, but is not currently enrolled; and
2. The Employee declined coverage under the Plan when it was offered previously; and
3. Another individual (a spouse or child) has become an Eligible Dependent of the Employee through marriage, birth, adoption, or placement for adoption. In this case, the Employee must submit a completed enrollment form and required documentation within thirty-one (31) days of the marriage, birth, adoption or placement for adoption. Enrollment in the Plan will be effective on the date (1) of the Employee's marriage; (2) of the new Dependent's birth; or (3) of the new Dependent's adoption or placement for adoption with the Employee.

F. LATE ENTRANTS / FAMILY STATUS CHANGE / DEPENDENT DELETION

All Late Entrants are required to satisfy the waiting period (fifty-eight (58) days). If approved as a new Participant in the Plan, the earliest date that a Late Entrant's coverage may take effect will be the first day of the month following fifty-eight (58) days after the Late Entrant's waiting period begins. The Plan reserves the right to approve or deny any Late Entrant applicant. If additional information is received by the Plan after the Late Entrant's acceptance that would disqualify the Late Entrant from coverage, the Plan will have the right to terminate coverage back to the original effective date and the Employer will refund any contribution that was already made towards said coverage. The Employee will be responsible for paying all claims paid by the Plan on behalf of the ineligible person.**Mid-Year Late Entrants** – Participants who do not participate in the Section 125 Plan may add eligible Dependents mid-year with a Family Status Change. All new Participants will be considered Late Entrants and must fulfill the requirements as stated above. The fifty-eight (58) days waiting period for the Late Entrant will begin on the date Risk Management receives all required documentation.

Annual Enrollment Late Entrants – An Employee may enroll eligible Dependent(s) during the annual enrollment period without a Family Status Change. All new Participants will be considered Late Entrants and must fulfill the requirements as stated above. The fifty-eight (58) days waiting period for the Late Entrant will begin on January 1st of the following year. Required documents must be submitted by the deadline, which will be set for each annual enrollment period.

Family Status Change – An Employee who participates in the Section 125 Plan may add eligible Dependent(s) mid-year only if there is a qualified Family Status Change and the Participant has all required documentation turned into Risk Management within thirty-one (31) days of the Family Status Change event. Qualified Family Status Changes for adding an eligible Dependent include, but are not limited to, marriage, birth, adoption, or placement for adoption as specified by Section 125 of the Internal Revenue Code. In the event of birth, adoption, placement for adoption, court ordered child or Office of the Attorney General (OAG) order, benefits for the eligible Dependents will be effective on the date of the Family Status Change (date of birth; date court order is signed for adoption, placement for adoption, or court ordered child; date ordered by OAG) and Plan Participant contributions will be due beginning on that date, which may be retroactive. In the event of a dependent's loss of medical coverage at their place of employment, Employee may submit a completed enrollment form and required documents prior to the dependent's loss of medical coverage, making the coverage effective the date following the other coverage termination date. If the Employee submits the enrollment form and required documents after the loss of coverage but before the end of the thirty-one (31) day notification requirement, the coverage effective date would be the first of the month after receipt of the documentation. All Family Status Changes, with the exception of birth, adoption, placement for adoption, court ordered child or OAG order, are effective the first day of the following month after meeting all Plan provisions and contributions may not be collected retroactive.

Dependent Deletion – An Employee must delete a Dependent that is no longer eligible to remain on the Plan at the time they become ineligible. Dependents who are not eligible are those who are (1) children twenty-six (26) years of age or older and who are not eligible for coverage due to a mental or physical disability and (2) ex-Spouses and ex-step-children. In the case of divorce, a certified divorce decree is required before the Plan will terminate the Dependents no longer eligible. If a spouse is eligible at any time for their employer's medical plan, but does not enroll, the spouse will no longer be eligible to participate in this Plan and coverage will be terminated. If additional information is received by the Plan that would disqualify the dependent from coverage, the Plan will have the right to terminate coverage back to the original effective date and the Employer will refund any contribution that was already made towards said coverage. The Employee/Retiree/LGC 615 Survivor will be responsible for paying all claims paid by the Plan on behalf of the ineligible person.

It is the Employee's responsibility to notify Risk Management of a Dependent who is no longer eligible and complete the proper form(s). Notification is subject to COBRA notification requirements. Verbal notification is unacceptable. The Plan will refund Plan Participant contributions paid after effective date and prior to the submission and receipt in Risk Management of the proper forms within required time frames of the life event. In addition, the Employee will be responsible for paying all claims paid by the plan on behalf of the ineligible person.

Special Enrollment Periods in Compliance with the Patient Protection and Affordable Care Act ("PPACA")

Notwithstanding any provision of the Plan to the contrary, the Plan will permit an eligible Employee or eligible Dependent to elect to enroll in the Plan if the following conditions is met:

1. A Dependent child terminated coverage, was denied coverage or was not eligible for coverage under the Plan because, under the terms of the Plan, the availability of Dependent coverage of children ended before the attainment of age twenty-six (26) and the Dependent child is now eligible for coverage under the Plan effective as of January 1, 2011.

If an eligible Employee or eligible Dependent satisfies either (1) or (2), as applicable, the eligible Employee or eligible Dependent will be given an opportunity to enroll in the Plan that starts on the later of (a) the date the eligible Employee or eligible Dependent satisfies (1) or (2) above or (b) the first day of the annual enrollment period for the 2011 Plan Year and, in either case, continues for thirty (30) days after such start date. This opportunity will be provided beginning not later than January 1, 2011 and coverage will be effective not later than January 1, 2011.

Any eligible Employee or eligible Dependent enrolling in the Plan in accordance with PPACA must be treated as if the eligible Employee or eligible Dependent were a special enrollee, as provided under HIPAA's portability provisions. Accordingly, the eligible Employee or eligible Dependent (and the eligible Employee through whom the eligible Dependent is otherwise eligible for coverage under the Plan) must be offered all the benefit plan options available to similarly situated individuals who did not lose coverage as described in (1) or (2) above. The eligible Employee or eligible Dependent also cannot be required to pay more for coverage than similarly situated individuals who did not lose coverage as described in (1) or (2) above.

G. CONTINUATION OF COVERAGE IN COMPLIANCE WITH COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985)

1. Continuation of Coverage

Coverage that may be continued under this section includes medical coverage, if provided under this Plan. For purposes of this section, a "Covered Person" is a Participant who is covered under the Plan due to his

status as an Employee or Retiree and a "Covered Dependent" is a Dependent who is a Participant. Under this section, the following Participants whose coverage would otherwise end may continue to be covered under the Plan:

a) Covered Dependents of a Covered Person who dies.
b) A covered Person and their Covered Dependents upon the Covered Person's termination of employment (other than termination for gross misconduct), or whose work hours have been reduced to less than the minimum required for coverage under the Plan.
c) A Covered Dependent Spouse upon divorce from the Covered Person.
d) A Covered Dependent child loses coverage due to attainment of the maximum age to which Dependents may be covered under this Plan.

2. Notice Requirements – Employer/Employee

a) When eligibility for continuation results from a Covered Person's death, termination, reduction in working hours, or entitlement to Medicare, the Covered Person or Dependent will notify the Employer of that event. Notice must be given to Risk Management within thirty (30) days of the Covered Person's death, termination, reduction of working hours, or entitlement to Medicare.
b) When eligibility for continuation results from a covered Spouse being divorced from a Covered Person (Employee) or a Dependent child's attainment of the maximum age for coverage under the Plan, the covered person or Dependent must notify the Employer of that event within sixty (60) days of the event.
c) Within thirty (30) days of receiving notice, the Employer will notify the COBRA administrator of the termination of coverage. Within fourteen (14) days of receiving the notice from the Employer, the COBRA administrator will mail the covered person information regarding their right to continue benefits.
d) After receiving that notice, the Covered Person or Dependent has sixty (60) days in which to decide whether to elect continued benefits. These sixty (60) days begins on the later of:
   1) The date coverage under the Plan would otherwise end; or
   2) The date the person receives notice from the Employer of their rights under the law.

   If the Covered Person or Dependent chooses to have continued benefits, they must advise the Employer in writing of this decision. The Employer must receive this written notice before the end of sixty (60) days.
e) Within forty-five (45) days after the date of the Covered Person or Dependent notifies the Employer that they have chosen to continue medical insurance, the Participant must pay the first premium. The first payment will be the amount needed to provide coverage from the date continued benefits begin to the date that the first payment is made. Thereafter, premiums for the continued benefits are to be paid monthly on the day of each month stated by the Employer.
f) A Covered Person's Dependent must pay the premium for a coverage being continued.

3. Length of Continuation

a) For Covered Persons who are terminated or have their hours reduced, coverage may be continued for up to eighteen (18) months after the termination or reduction in hours. For all others who qualify for continuation of benefits, coverage may be continued for up to thirty-six (36) months after the event, which makes the Covered Person eligible for continued benefits. Continuation will end on the earliest of:
   1) The end of the eighteen (18) or thirty-six (36) month period noted above;
   2) The date the Employer's Plan terminates;
   3) Failure to make payment for coverage as required above;

4) The date the person becomes covered under any other group health Plan as a result of employment, re-employment or re-marriage;
5) The date the person becomes entitled to benefits under Medicare.

b) The following applies when this Plan replaces another Plan of group medical coverage. If, on the day before the effective date of the Employer's coverage under this Plan, eligible Employee or Dependent coverage is being continued under that prior Plan under COBRA (the Consolidated Omnibus Budget Reconciliation Act of 1985):
   1) That person will have the right to become covered under this Plan. Coverage may be provided until the end of the period for which the person could have been covered under the prior Plan if it had not been replaced; and
   2) Any benefits otherwise payable under this section will be reduced by any amounts for which the person is eligible under the Plan.

H. HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT OF 1996 (HIPAA) ELECTION UNDER 42 U.S.C. §300 GG-21

Federal law imposes upon group health plans certain limitations of (1) Preexisting Condition exclusion periods, (2) special enrollment periods for individuals (and Dependents) losing other coverage, (3) prohibitions against discriminating against individual Participants and beneficiaries based on health status, (4) standards relating to mothers and Newborns, (5) parity in the application of certain limits to mental health benefits, and (6) required coverage for reconstructive surgery following mastectomies.

Federal law allows a non-federal governmental self-funded plan (such as the Fort Bend County Employee Benefit Medical Plan for Employees of Fort Bend County, Texas) to exempt its Plan in whole or in part from these requirements: (1) Standards relating to mothers and Newborns, (2) parity in the application of certain limits to mental health benefits, and (3) required coverage for reconstructive surgery following mastectomies. Fort Bend County has requested that the entire Fort Bend County Employee Benefit Plan be exempt under 42 U.S.C. §300gg-21.

Fort Bend County may 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.

1. HIPAA Privacy Rule

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. "Protected Health Information" means information, including genetic information, that is created or received by the Plan which (a) relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual, (b) identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual, and (c) is transmitted or maintained in any form or medium.

2. 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 by the Plan in connection with the HIPAA Privacy Rule (e.g., entering into business associate contracts; accepting

certification from the Plan Sponsor).

3. 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:

a) 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;
b) The Plan Documents have been amended to incorporate the Plan provisions set forth in this section; and
c) The Plan Sponsor agrees to comply with the Plan provisions as described by this section.

4. 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, and 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.

Notify participants of any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor, or any Business Associate of the Plan Sponsor becomes aware, in accordance with the Health Breach Notification Rule (16 CFR Part 318).

Notify the Federal Trade Commission of any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor, or any Business Associate of the Plan Sponsor becomes aware, in accordance with the Health Breach Notification Rule (16 CFR Part 318).

Obtain authorization prior to the sale of any PHI.

"Plan Administration" activities are limited to activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend or terminate the Plan or solicit bids from prospective issuers. "Plan Administration" functions include quality assurance, claims processing, auditing, monitoring and management of care-out plans, such as vision and dental. It does not include any employment-related functions or functions in connection with any other benefit or benefit plans.

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

The Plan Sponsor will make the Protected Health Information of the member who 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. §164.524.

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.

6. 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 health information to the Plan Sponsor, if the Plan Sponsor requests the summary health information for the purpose of:

a) Obtaining premium bids from health plans for providing health insurance coverage under the Plan; or
b) 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.

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

The Plan Sponsor hereby authorizes and directs the Plan, through the Plan Administrator or the third party administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters ("MGUs") for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the privacy standards.

8. 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 who may be given access by the Director of Risk Management as the Plan's HIPAA Privacy Officer to members' Protected Health Information received from the Plan or from a health insurance issuer. (Classes may include, for example: Analyst/Administrators; Service Personnel; Information Technology Personnel; Clerical Personnel; Supervisors/Managers; Quality Assurance Unit.)

a) Director of Risk Management
b) Risk Management Personnel
c) Financial Accountants
d) Legal Advisors who represent the Plan
e) Part-time/Temporary Clerical support
f) Information Technology Personnel

This list reflects the Employees, classes of Employees, or other workforce members of the Plan Sponsor who 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.

9. 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:

a) Plan Sponsor shall implement administrative, physical, and technical safeguards that reasonable 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;
b) 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;
c) 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
d) Plan Sponsor shall report to the Plan any Security Incidents of which it becomes aware as described below:
    1) 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
    2) 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.
    3) Notify participants of any PHI Security Incident of which the Plan Sponsor, or any Business Associate of the Plan Sponsor becomes aware, in accordance with the Health Breach Notification

Rule (16 CFR Part 318); and

4) Notify the Federal Trade Commission of any PHI Security Incident of which the Plan Sponsor or any Business Associate of the Plan Sponsor becomes aware, in accordance with the Health Breach Notification Rule (16DFR Part 318).

I. DUAL COVERAGE PRECLUDED

No person will be covered under the Plan simultaneously:

a) As both an Employee and a Dependent, if eligible for County coverage;
b) As a Dependent of more than one Employee.

J. UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT

The Plan will comply with the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") with regard to continuation rights during an approved military leave of absence and reenrollment rights on return from such military leave of absence.

1. An Employee who is not at work because of a period of duty in the Uniformed Services (as defined in USERRA), may, at the Employee's election, continue coverage under the Plan during the period of absence, so long as the Employee satisfies the necessary provisions and makes any required Participant contribution as provided under USERRA.

2. The maximum period of coverage for an Employee, an Employee's Spouse and/or Dependent(s), if any, under the Plan during a period of duty in the Uniformed Services will be governed by the applicable limitation and provisions contained in USERRA unless more generous limitations are provided under the Employer's leave of absence policy.

3. An Employee who elects to continue coverage under the Plan will pay:

   a) The Employee's share, if any, for coverage under the Plan if the Employee performs service in the Uniformed Services for up to thirty-one (31) days; or
   b) One hundred-two percent (102%) of the full premium or cost under the Plan (determined in the same manner as the applicable COBRA continuation coverage premium under Section 4980B(f)(4) of the Code) if the employee performs service in the Uniformed Services for thirty-one (31) days or more.

4. During the period of service in the Uniformed Services, the Employee may pay the necessary costs associated with coverage under the Plan, if any, by:

   a) Remitting payment to the Employer monthly for which the Participant contributions would have been deducted from the Employee's paycheck had the Employee not been absent serving in the Uniformed Services, provided that any delinquent payments must be made within thirty (30) days after their due date (premiums are due on the first day of the month);
   b) At the Employee's request, prepaying the amounts that will become due during the period of service in the Uniformed Services out of one or more of the Employee's paychecks preceding such period of service in the Uniformed Services; or
   c) Pre-approved arrangement with the Plan Administrator and in accordance with administrative policies adopted by the Plan Administrator wherein the Employer pays the Employee's Participant contributions during the Employee's period of service in the Uniformed Services. Upon return from such service, the Employee will reimburse the Employer for such previous payments.

Any Employee who is a Participant, who is not at work because of service in the Uniformed Services and who returns to active employment within the relevant time period determined under USERRA, will be eligible to return to work and immediately participate in the same benefit options and coverage level for dependents under the Plan which the Participant had elected to participate in prior to serving in the Uniformed Services, subject to any changes in the Plan that affect the workforce as a whole, provided that the Participant returns to employment with the same benefit eligibility status that he held prior to serving in the Uniformed Services, and provided further, that the Participant makes all required elections to participate in the Plan on a timely basis. Except to the extent provided in administrative policies adopted by the Plan Administrator (or the Employer, if applicable), the maximum period of health care coverage available to a Participant (and his Dependents) while on a USERRA leave of absence will end on the earlier of (1) the last day of the maximum coverage period prescribed under USERRA (or if required by USERRA's discrimination rules, the last day of the longest period that the Employer's leave of absence policy permits Plan coverage to continue) or (2) the day after the date upon which the person fails to apply for a return to a position of employment within the time required under Section 4312(a) of USERRA. For purposes of determining eligibility for health benefits (and only if the Participant pays the full amount which the Employer is permitted to charge the Participant for health coverage under USERRA), a Participant who experiences a reduction in hours or termination of employment solely due to a USERRA leave will continue to be considered qualified as a Participant under the Plan until the earliest date that the termination of their health benefits is permitted under USERRA.

ARTICLE VI
MEDICAL BENEFITS

B. ELIGIBLE 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 and Maximum Eligible Charges incurred as a result of accidental Injury or Sickness. An expense will be considered to be incurred at the time the service or the supply is provided. All Eligible Expenses must be incurred for the treatment of an accidental Injury or Sickness. The following are considered Eligible Expenses.

1. The Hospital's charge for an average semi-private room;
2. Intensive Care Unit or Coronary Care Unit charges 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 charges by a Physician or a Physician Assistant for medical care or specified treatment of an accidental Injury or Sickness;
7. Charges for a birthing center and the Medically Necessary supplies used there during a patient's stay;
8. Preadmission diagnostic testing performed within four (4) days of Hospital confinement for use during Hospitalization;
9. Charges by a PPO Hospital or PPO 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:
   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 the eligible, Medically Necessary and Reasonable or Maximum

Eligible Charges of the Surgeon as determined by the plan or twenty-five percent (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 who is a member of the patient's immediate family provided that;

    a) The services are ones which can be performed for compensation only by a person holding an RN license, LVN license, or other license requiring a higher level of medical skill and training;
    b) The level of skill of an RN or LVN is Medically Necessary;
    c) The charges are only for the portion of time for which such level of skill is medically required; 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 whom ordinarily resides in the patient's home or who 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 charges 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 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 with 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 (24) 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 (24) 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, which 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 rehabilitative speech therapy for speech loss or impairment due to an Illness or accident, 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 *periodontia expenses, which result from necessary services for the correction of damage to sound, natural teeth caused by accidental Injury which occurred while the Participant was covered by the Plan and treatment is begun or recommended within six (6) months of the accidental Injury, or the surgical removal of bony impacted wisdom teeth. *Orthodontia and Periodontia treatment, which results from Medically Necessary services for the correction of Mandibular Hyperplasis with Malocclusion will have a Plan benefit limit of $15,000.00 per lifetime per Participant including any related medical procedures or surgical procedures (such limit will not apply to pediatric services);

21. Legal drugs and medicine, including the only following contraceptives: oral implant, injectable and transdermal (but not the removal of transdermal contraceptives) for the purposes of birth control and obtainable only on a Physician's written prescription. Copay exceptions for these contraceptives are as follows: Depo Provera Contraceptive – 90 day supply allowed at retail for two (2) retail copays; Estring – 90 day supply allowed at retail for two (2) retail copays; Seasonique/Seasonale – 91 day supply allowed at retail for two (2) retail copays). Outpatient Prescription Drugs must be purchased with your Prescription Drug card. No reimbursement will be made for outpatient Prescription Drugs submitted to this benefit Plan;

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

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

24. The Plan will pay for routine nursery care (Well-Baby Care) at the time of delivery including medical checkups until the age twenty-four (24) months. Routine Well-Baby Care checkups are not part of the annual wellness benefit.

25. Routine immunizations will be covered for eligible dependent children age 0 to 18, as recommended by the Center for Disease Control and State of Texas Minimum State Vaccine for Students. HPV for children age seven (7) to eighteen (18) and Rotavirus for children age zero (0) to six (6) will be eligible;

26. The Plan will pay for the purchase of a nebulizer up to the maximum purchase price of **$100.00**. The Participant will be required to pay a copay of **$30.00** and the Plan will pay the balance at **100%**. This will be subject to proof of medical necessity as approved by the contract claims administrator;

27. Eligible conditions for mental Illness under this Plan shall be defined by the latest edition of the International Classification of Diseases (ICD-9) Codes. Eligible mental Illness conditions shall begin at 290 through and including 319 of the ICD-9 Code Book;

28. The treatment of temporomandibular joint dysfunction or TMJ syndrome will be limited to $1,000.00 per lifetime per Participant, unless such treatment is considered an essential health benefit under the Affordable Care Act because it is rehabilitative, habilitative or pediatric oral care.

29. Services and supplies provided in connection with human organ or tissue transplant procedures (including high dose chemotherapy, bone marrow or stem cell transplants for the treatment of cancer), subject to the following conditions:

    a) A second opinion must be obtained prior to undergoing the transplant procedure. This mandatory second opinion must concur with the attending Physician's finding that this procedure is Medically Necessary. The Physician rendering this second opinion must be qualified to render such a service either through experience, specialist training or education, or such similar criteria, and must not be affiliated in any way with the Physician who will be performing the actual surgery;
    b) If the donor is covered under this Plan, eligible medical expenses incurred by the donor will be considered for benefits only if the recipient is a Participant under this Plan;
    c) When recipient is covered by this Plan, eligible medical expenses incurred by the recipient will be considered for benefits. Expenses incurred by the donor who is not ordinarily covered under this Plan according to Participant eligibility requirements will not be considered Eligible Expenses;
    d) Benefits will be provided only when the Hospital and Physician customarily charge a transplant recipient for such care and services;
    e) Eligible Non-PPO charges for services and supplies in connection with human organ or tissue transplant procedures will never be paid by the Plan at **100%**;
    f) Benefits payable will be subject to all Plan provisions and limited to the maximum as stated in the schedule of benefits;
    g) No benefits will be payable for the purchase, storage, or transportation of any organ to be used for transplant.

30. A Participant will be paid **50%** of any amount that the Participant can identify as an error on the Participant's Hospital bill up to a maximum payment of **$1,000.00** per calendar year.

C. LIMITATIONS AND EXCLUSIONS

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

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

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

3. Resulting from accidental Injury 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. However, with respect to any Injury which is otherwise covered by the Plan, the Plan will not deny benefits otherwise provided for treatment of the Injury if the Injury results from an act of domestic violence or a medical condition (including both physical and mental health conditions);

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, with the exception of a V.A. Hospital;

7. For eye refractions or eye examinations for the correction of vision or fitting of glasses or contact lenses, furnishing or replacement of glasses or contact lenses;

8. For routine hearing examinations in which there is no medical diagnosis requiring the examination, or the furnishing of hearing aids beyond the limits in the Schedule of Benefits;

9. For dental treatment, except as cited in Article VI, A;

10. For treatment to the feet resulting from bursitis, tendonitis, tarsalgia, metatarsalgia, weak, unstable or flat feet, bunions, corns and calluses, unless an open cutting operation is performed; or for treatment of toenails, unless at least part of the nail root or matrix is removed, or purchase of orthopedic shoes or other orthotic devices for support of the feet unless an open cutting operation is performed. The initial office visit, including x-rays, for the purposes of diagnosis will be allowed;

11. For Cosmetic Procedures, unless required because of an accidental Injury;

12. For the diagnosis or treatment of mental, nervous, or emotional disorders, including drug and alcohol related disorders whether as an outpatient or as an in-patient; beyond the limits in the Schedule of Benefits subject to the definition of mental Illness in Article IV;

13. For health check-ups, routine physical examinations beyond the limits specified in the Schedule of Benefits, or nutritional supplements not Medically Necessary for the treatment of an Injury or Illness;

14. Resulting from care or treatment not reasonably necessary for the care and treatment of Sickness or accidental Injury;

15. 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 in a direct result of an accident up to a maximum benefit of $1,000.00 per lifetime of the Participant (Article IV) for the treatment of temporomandibular joint dysfunction or TMJ syndrome, but such maximum will not apply if such treatment is considered an essential health benefit under the Affordable Care Act because it is rehabilitative, habilitative or pediatric oral care.

16. Housekeeping or Custodial Care;

17. Charges for orthognatic disorders, except Orthodontia and Periodontia treatment, which results from Medically Necessary services for the correction of Mandibular Hyperplasis with Malocclusion, including any related medical procedures or surgical procedures;

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

19. Enrollment in a health, athletic, or similar club or nicotine cessation or similar program (except participation in one of the nicotine cessation programs that have been approved in advance by the Plan Administrator);

20. Purchased or rented supplies of common use such as exercise cycles, air purifies, air conditioners, water purifiers, hypoallergenic pillows or mattresses, or waterbeds or convenience items;

21. Purchase or rental of motorized transportation equipment, escalators or elevators, saunas, steam baths, swimming pools, hot tubs, blood pressure kits, blood sugar test machines (except syringes, test strips, and lancets);

22. In vitro fertilization, artificial insemination, surgical reversal of elective sterilization, fertility drugs, contraceptives other than as stated in Section B, Eligible Expenses.

23. Vitamins (except prenatal vitamins prescribed by a doctor) or dietary supplements, minerals, any drugs that can be purchased without a written prescription;

24. Sex transformation, or the treatment of or for trans-sexual purposes;

25. Treatment for sexual dysfunctions 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;

26. Treatment of obesity; but not morbid obesity. In addition to other medical requirements, 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. Payment for non-surgical treatment for morbid obesity shall be limited to one procedure per lifetime. Surgical procedures and all associated costs will be limited to one procedure per lifetime of the Participant.

27. Recreational or educational therapy, vocational therapy or non-medical self-care or self-help training;

28. Radial keratotomy or keratoplasty;

29. Chelation therapy;

30. Experimental procedures, see definition of Medical Necessity;

31. 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;

32. Charges that are not Medically Necessary 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 charges for procedures, surgical or otherwise, which are specifically listed by the American Medical Association as having no medical value;

33. Charges for services rendered by a Physician, nurse, or licensed therapist if such Physician, nurse, or licensed therapist is a Close Relative of the Participant.

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

35. Charges for Physician fees for any treatment, which is not rendered by or in the physical presence of a Physician;

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

37. Treatment of eating disorders; beyond the limits in the Schedule of Benefits subject to the definition of mental Illness in Article IV;

38. Charges incurred as a result of or in connection with diagnosis or treatment of a learning disability or learning impairment by any name called, including but not limited to autism, mental retardation or behavioral problems. This exclusion includes, but is not limited to, charges 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 in Article IV. Attention deficit disorder is considered a learning disorder and is not covered except for medication as covered under "Outpatient Prescription Drugs" or for medical examinations to measure Appropriateness of medications;

39. For any charges in connection with growth hormone deficiencies, including diagnosis and treatment;

40. Charges for the purchase, storage or transportation of organs that is being used for transplant purposes;

41. Charges or expenses incurred for massage therapy or acupuncture;

42. For any elective surgery that is not Medically Necessary, except for eligible elective sterilization as specified in this Plan;

43. For any services or charges made in connection with a mental and nervous condition, substance abuse or alcoholism; beyond the limits in the Schedule of Benefits subject to the definition of mental Illness in Article IV;

44. Weight loss programs beyond the limits in the Article VI, B;

45. Sleep disorders unless there is medical diagnosis. If there is not a sleep apnea or other medical diagnosis after the testing, only the office visit and the testing for diagnosis on an outpatient basis will be considered Eligible Expense.

46. Adult immunizations other than what are listed in the Schedule of Benefits;

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

48. Breast prosthesis, breast implants, tram flap surgery or bras unless a Medically Necessary mastectomy was performed. No more than two (2) bra replacements per year.

ARTICLE VII
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.

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 area determined before or after those of another Plan. The benefits of This Plan:

1) Shall not be reduced when, under the order of benefit determination rule, This Plan determines its benefits before another plan; but
2) May be reduced when under the order of benefit determination rules, another Plan determines its benefits first. The above reduction is described in Article VII, "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:

1) 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.
2) 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 periodically amended). 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.
3) This Plan will assume that any person who 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 (1) or (2) is a separate Plan. Also, if an arrangement has two parts and COB rules apply only to the 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 necessary, reasonable and customary 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 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:

1. The other Plan has rules coordinating its benefits with those of this Plan; and
2. 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:

1. **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.
2. **Dependent Child/Parents Not Separated or Divorced** - Except as stated in section (3) 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.
3. **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.

4. **Active/Inactive Employee** - The benefits of a Plan, which covers a person as an Employee who 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 "b)" is ignored.

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

4. Effect on Benefits

a) **When This Section Applies** - This section 4 applies when, in accordance with section 3, "Order of Benefit Determination Rules", 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:
   1. The benefits that would be payable for the Allowable Expenses under this Plan in the absence of this COB provision; and
   2. The benefits that would be payable for the Allowable Expenses under the other Plans, in absence of a provision with a purpose like that of this COB provision, whether or not claim is made;
   3. 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.

c) **Medicare Coordination of Benefits** -
   1. If you are age sixty-five (65) or over and a full time Employee of Fort Bend County, This Plan will be the primary payer. If your Dependent Spouse is sixty-five (65) or over and covered under your Plan while you are a full time Employee, this Plan will be the primary payer; and
   2. For all other Participants who are eligible to be covered under Medicare or disability Medicare, 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 sixty-five (65) and over will have full Medicare coverage (Part A, Part B, or Part C if elected, and any other optional coverage offered by Medicare). The benefits of this Plan would be reduced after 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.

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. The Contract Administrator needs to tell, or get the consent of, any person to do this. 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, which made that 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 Plan Administrator shall have the right to recover all such excess amounts from any persons, insurance companies, or other payees, and the Participant shall make a good-faith attempt to assist in such recovery. Further, the Plan Administrator shall have the right to recover any excess payments from any future benefits payable to the Employee or their Dependent(s).

The Plan Administrator may, in its sole discretion, pay benefits for care or services pending a determination of whether or not such care or services are covered hereunder. Such payment will not affect or waive any exclusion, and to the extent such care or services have been provided, the Plan shall be entitled to recoup and recover the amount paid from the Covered Person or the provider of service in the event it is determined that such care or services are not covered hereunder. The Covered Person or his parent or guardian shall execute and deliver to the Plan all assignments and other documents necessary or useful to the Plan Administrator for the purpose of enforcing its rights under this provision.

If the amount of the payments made by the Contract Administrator is more than should have been paid under this COB provision, it may recover the excess from one or more of:

a) The person or persons it has paid or for whom it has paid;
b) Insurance companies; or
c) Other organizations.

The "amount of the payments made" includes the reasonable cash value of any benefit provided in the form of services.

B. SUBROGATION AND REIMBURSEMENT

The Plan reserves all its subrogation and reimbursement rights, at law and in equity, to the full extent not contrary to applicable law, as determined by the Plan Administrator. At its discretion The Plan Administrator may, designate a third party provider or other person or entity to exercise the rights described in this section on behalf of the Plan. In addition, the Plan Administrator may, in its discretion and on a case-by-case basis, waive or limit any of the subrogation and reimbursement rights set forth in this section on behalf of the Plan to the extent deemed appropriate. Any such waiver or limitation in a particular case will not limit or diminish in any way the Plan's rights in any other instance or at any other time.

1. Benefits Subject to this Provision

This section B will apply to all benefits provided under the Plan. For purposes of this section, terms are defined as follows:

a) "Recovery" means any and all monies and property paid by a Third Party to (i) the Participant, (ii) the Participant's attorney, assign, legal representative, or Beneficiary, (iii) a trust of which the Participant is a beneficiary, or (iv) any other person or entity on behalf of the Participant, by way of judgment, settlement, compromise or otherwise (no matter how those monies or property may be characterized, designated or allocated and irrespective of whether a finding of fault is made as to the Third Party) to compensate for any losses or damages caused by, resulting from, or in connection with, the injury or illness.

b) "Reimbursement" means repayment to the Plan for medical or other benefits that it has paid to or on behalf of the Participant toward care and treatment of the injury or illness and for the expenses incurred by the Plan in collecting this amount, including the Plan's equitable rights to recovery.

c) "Subrogation" means the Plan's right to pursue the Participant's claims against a Third Party for any or all medical or other benefits or charges paid by the Plan.

d) "Third Party" will include the party or parties who caused the injury or illness; the insurer, guarantor or other indemnifier or indemnitor of the party or parties who caused the injury or illness; a Participant's own insurer, such as an uninsured, underinsured, medical payments, no fault, homeowner's, renter's or any other liability insurer; a workers' compensation insurer; and any other individual or entity that is or may be liable or legally or equitably responsible for Reimbursement or payment in connection with the injury or illness.

2. When this Provision Applies

A Participant may incur medical or other charges related to any injury or illness caused by the act or omission of a Third Party. Consequently, such Third Party may be liable or legally or equitably responsible, for payment of charges incurred in connection with the injury or illness. If so, the Participant may have a claim against that Third Party for payment of the medical or other charges. In that event, the Plan will be secondary payer, not primary, and the Plan will be subrogated to all rights the Participant may have against that Third Party.

Furthermore, the Plan will have a right of first and primary Reimbursement enforceable by an equitable lien against any Recovery paid by the Third Party. The equitable lien will be equal to one hundred percent (100%) of the amount of benefits paid by the plan for the Participant's injury or illness and expenses incurred by the Plan in enforcing the provisions of this section B (including, without limitation, attorneys' fees and costs of suit, and without regard to the outcome of such an action), regardless of whether or not the participant has been made whole by the Third Party. This equitable lien will attach to the Recovery regardless of whether (a) the Participant receives the Recovery or (b) the Participant's attorney, a trust of which the Participant is a beneficiary, or other person or entity receives the Recovery on behalf of the Participant.

As a condition to receiving benefits under the Plan, the Participant hereby agrees to immediately notify the Plan Administrator, in writing, of whatever benefits are payable under the Plan that arise out of any injury or illness that provides, or may provide, the Plan with Subrogation and/or Reimbursement rights under this section B.

The Plan's equitable lien supersedes any right that the Participant may have to be "made whole." In other words, the Plan is entitled to the right of firsts Reimbursement out of any Recovery the Participant procures, or may be entitled to procure, regardless of whether the Participant has received compensation for any or all of his damages or expenses, including any of his attorneys' fees or costs. Additionally, the Plan's right of first and primary Reimbursement will not be reduced for any reason, including attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise. The Plan is not responsible for a Participant's legal fees and costs, is not required to share in any way for any payment of such fees and costs, and its equitable lien will not be reduced by any such fees and costs. As a condition to coverage and receiving benefits under the Plan, the Participant agrees that acceptance of benefits, as well as participation in the Plan, is constructive notice of the provisions of this section B, and Participant hereby automatically grants an equitable lien to the Plan to be imposed upon and against all rights of Recovery with respect to Third Parties, as described above.

In addition to the foregoing, the Participant:

a) Authorizes the Plan to sue, compromise and settle in the Participant's name to the extent of the amount of medical or other benefits paid for the injury or illness under the Plan, and the expenses incurred by the Plan in collecting this amount, and assigns to the Plan the Participant's rights to Recovery when the provisions of this section B, apply;
b) Must notify the Plan in writing of any proposed settlement and obtain the Plan's written consent before signing any release or agreeing to any settlement; and
c) Must cooperate fully with the Plan in its exercise of its rights under this section B, do nothing that would interfere with or diminish those rights, and furnish any information as required by the Plan to exercise or enforce its rights hereunder.

Furthermore, the Plan Administrator reserves the absolute right and discretion to require a Participant who may have a claim against a Third Party for payment of medical or other charges that were paid, or are payable, by the Plan to execute and deliver a Subrogation and Reimbursement agreement acceptable to the Plan Administrator (including execution and delivery of a Subrogation and Reimbursement agreement by any parent or guardian on behalf of a covered Dependent, even if such Dependent is of majority age) and, subject to section B, 5, that acknowledges and affirms: (i) the conditional nature of medical or other benefits payments which are subject to Reimbursement and (ii) the Plan's right of full Subrogation and Reimbursement, as provided in this section B ("S&R Agreement").

When a right of Recovery exists, and as a condition to any payment by the Plan (including payment of future benefits for the same or other illnesses or injuries), the Participant will execute an deliver all required instruments and papers, including any S&R Agreement provided by the Plan, as well as doing and providing whatever else is needed, to secure the Plan's rights of Subrogation and Reimbursement, before any medical or other benefits will be paid by the Plan for the injury or illness. The Plan may file a copy of an S&R Agreement signed by the Participant and his attorney (and if applicable, signed by the parent or guardian on behalf of the covered Dependent) with such other entities, or the Plan may notify any other parties of the existence of Plan's equitable lien; provided, the Plan's rights will not be diminished if it fails to do so.

To the extent the Plan requires execution of an S&R Agreement by a Participant (and his attorney, as applicable), a Participant's claim for any medical or other benefits for any injury or illness will be incomplete until an executed S&R Agreement is submitted to the Plan Administrator. Such S&R Agreement must be submitted to the Plan Administrator within the time frame applicable to the particular type of benefits claimed by the Participant, as specified in the Plan's claims procedures. Any failure to timely submit the required S&R Agreement in accordance with the Plan's claims procedures will constitute the

basis for denial off the Participant's claim for benefits for the injury or illness, and will be subject to the Plan's claims appeal procedures. The Plan Administrator may determine, in its sole discretion, that it is in the Plan's best interests to pay medical or other benefits for the injury or illness before an S&R Agreement and other papers are signed and actions taken (for example, to obtain a prompt payment discount); however, in that event, any payment by the Plan of such benefits prior to or without obtaining a signed S&R Agreement or other papers will not operate as a waiver of any of the Plan's Subrogation and Reimbursement rights and the Plan still will be entitled to Subrogation and Reimbursement. In addition, the Participant will do nothing to prejudice the Plan's right to Subrogation and Reimbursement, and hereby acknowledges that participation in the Plan precludes operation of the "made whole" and "common fund" doctrines. A Participant who receives any Recovery as an absolute obligation to immediately tender the Recovery (to the extent of 100% of the amount of benefits paid by the Plan for the Participant's injury or illness and expenses incurred by the Plan in enforcing the provisions of this section B, including attorneys' fees and costs of suit, regardless of an action's outcome) to the Plan under the terms of this section B. A Participant who receives any such Recovery and does not immediately tender the Recovery to the plan will be deemed to hold such Recovery in constructive trust for the Plan because the Participant is not the rightful owner of such Recovery to the extent the Plan has not been fully reimbursed. By participating in the Plan, or receiving benefits under the Plan, the Participant automatically agrees, without further notice, to all the terms and conditions of this section B, and any S&R Agreement.

The Plan Administrator has maximum discretion to interpret the terms of the section B, and to make changes in its interpretation as it deems necessary or appropriate.

3. Amount Subject to Subrogation or Reimbursement

Any amounts Recovered will be subject to Subrogation or Reimbursement, even if the payment the Participant receives is for, or is described as being for, damages other than medical expenses or other benefits paid, provided or covered by the Plan. This means that any Recovery will be automatically deemed to first cover the Reimbursement, and will not be allocated to or designated as reimbursement for any other costs or damages the Participant may have incurred, until the Plan is reimbursed in full and otherwise made whole. In no case will the amount subject to Subrogation or Reimbursement exceed the amount of medical or other benefits paid for the injury or illness under the Plan and the amount of medical or other benefits paid for the injury or illness under the Plan and the expenses incurred by the Plan in collecting this amount. The Plan has a right to recover in full, without reduction for attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise, even if the Participant does not receive full compensation for all of his charges and expenses.

4. When Recovery Includes the Cost of Past or Future Expenses

In certain circumstances, a Participant may receive a Recovery that includes amounts intended to be compensation for past and/or future expenses for treatment of the illness or injury that is the subject of the Recovery. The Plan will not cover any expenses for which compensation was provided through a previous Recovery. This exclusion will apply to the full extent of such Recovery or the amount of the expenses submitted to the Plan for payment, whichever is less. Participation in the Plan also precludes operation of the "made whole" and "common fund" doctrines in applying the provisions of this section B.

It is the responsibility of the Participant to inform the Plan Administrator when expenses incurred are related to an illness or injury for which a Recovery has been made. Acceptance of benefits under this Plan for which the Participant has already received a Recovery will be considered fraud, and the Participant will be subject to any sanctions determined by the Plan Administrator, in its discretion, to be appropriate. The

Participant is required to submit full and complete documentation of any such Recovery in order for the Plan to consider eligible expenses that exceed the Recovery.

5. When a Participant Retains an Attorney

If the Participant retains an attorney, the Plan will not pay any portion of the Participant's attorneys' fees and costs associated with the Recovery, nor will it reduce its Reimbursement pro-rata for the payment of the Participant's attorneys' fees and costs. Attorneys' fees will be payable from the Recovery only after the Plan has received full Reimbursement.

The Plan Administrator reserves the absolute right and discretion to require the Participant's attorney to sign an S&R Agreement as a condition to any payment of benefits under the Plan and as a condition to any payment of future Plan benefits for the same or other illnesses or injuries. Additionally, pursuant to such S&R Agreement, the Participant's attorney must acknowledge and consent to the fact that the "made whole" and "common fund" doctrines are inoperable under the Plan, and the attorney must agree not to assert either doctrine in his pursuit of Recovery.

Any Recovery paid to the Participant's attorney will be subject to the Plan's equitable lien, and thus an attorney who receives any Recovery has an absolute obligation to immediately tender the Recovery (to the extent of 100% of the amount paid by the Plan for the Participant's injury or illness and expenses incurred by the Plan in enforcing the provisions of this section B, including attorneys' fees and costs of suit regardless of an action's outcome) to the Plan under the terms of this section B. A Participant's attorney who receives any such Recovery and does not immediately tender the recovery to the Plan will be deemed to hold the Recovery in constructive trust for the Plan because neither the Participant nor his attorney is the rightful owner of the Recovery to the extent the Plan has not received full Reimbursement.

6. When a Participant Does Not Comply

When a Participant does not comply with the provisions of this section B, the Plan Administrator will have the power and authority, in its sole discretion, to (i) deny payment of any claims for benefits by or on behalf of the Participant and (ii) deny or reduce future benefits payable (including payment of future benefits for the same or other injuries or illnesses) under the Plan by the amount due as Reimbursement to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for the same or other injuries or illnesses) under any other group benefits plan maintained by the Plan Sponsor. The reductions will equal the amount of the required Reimbursement. If the Plan must bring an action against a Participant to enforce the provisions of this section B, the Participant will be obligated to pay the Plan's attorneys' fees and costs regardless of the action's outcome.

ARTICLE VIII
CLAIMS PROCEDURES

A. HOW TO FILE A CLAIM

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

1. Send in expense or expenses as soon as possible. We do recommend holding small expenses until a minimum of $50.00 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 who 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
   P. O. Box 9201
   Austin, TX 78766

   Additional Contact Information: 1-800-252-9653; www.boonchapman.com

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

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

B. PAYMENT OF BENEFITS

All benefits for 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.

C. 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.

D. 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.

E. 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.

F. TIME OF PAYMENT OF CLAIM

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

G. PHYSICAL EXAMINATIONS

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

H. PRESENTING CLAIMS FOR BENEFITS

If Participant thinks they are eligible for a benefit described in this Plan, Participant must file a claim. Forms required for filing proof of loss for claims are available at Risk Management or can be found at the EConnect website http://econnect.co.fort-bend.tx.us/, under Departments, Risk Management, and Forms. Completed forms must be filed with the Contract Claims Administrator at least annually.

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 are 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 the claim after it is received. In some cases, however, more time may be needed. If this happens, Participant will be notified that an additional processing period is required.

I. REQUESTING A REVIEW OF CLAIMS DENIED

If Participant's claim is denied, Participant will be notified in writing. This written notice will tell the Participant 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 the Participant how they can have the decision reviewed.

If Participant has not received a response from the Contract Claims Administrator regarding the claim within ninety (90) days of filing the claim or if the claim has been denied, Participant can send a written appeal to the

Contract Claims Administrator for a review of the denied claim(s). Participant has sixty-one (61) days to appeal from the time a participant is notified of a denial.

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

Appointment of Authorized Representative – A Claimant is permitted to appoint an authorized representative to act on his behalf with respect to a benefit claim or appeal of a denial. An assignment of benefits by a Claimant to a provider will not constitute appointment of that provider as an authorized representative. To appoint such a representative, the Claimant must complete a form, which can be obtained from the Plan Administrator or the Contract Administrator. In the event a Claimant designates an authorized representative, all future communications from the Plan will be with the representative, rather than the Claimant, unless the Claimant directs the Plan Administrator, in writing, to the contrary.

J. 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 three (3) years from the expiration of the time within which proof of loss is required by the Plan.

K. THIRD PARTY LIABILITY

If a Participant has medical charges:

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

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

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

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

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

ARTICLE IX
GENERAL PROVISIONS

A. INTERPRETATION OF THE PLAN

In the event any benefit summary contained herein differs from the official text of the Plan, the official text shall prevail. Some differences from the official text may occur due to the need to restate the Plan briefly in the summaries, compared to a lengthier and detailed official text, and due to normal time lapse between amendment of the Plan and updating of the appropriate summary. The Plan Administrator has the responsibility for interpretation of the Plan and the interpretation shall be final.

B. AMENDMENT AND TERMINATION OF THE PLAN

The Commissioners Court shall each have the right, authority and power to make, at any time, and from time to time, any amendment to the Plan; provided, however, no amendment shall prejudice any claim under the Plan that was incurred but not paid prior to the amendment date, unless the person or entity as responsible above for the amendment, as applicable, determines such amendment is necessary to comply with applicable law.

The Commissioners Court shall have the right, authority and power to terminate the Plan at any time, in whole or in part, without prior notice, to the extent deemed advisable in its discretion; provided, however, such termination shall not prejudice any claim under the Plan that was incurred but not paid prior to the termination date unless the Commissioners Court determines it is necessary to comply with applicable law.

C. 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.

D. 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.

E. ASSIGNMENT OF BENEFITS

Benefits for medical expenses (except for outpatient prescription drugs) covered under the Plan may be assigned by a 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 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.

F. RATE REDUCTION

An Employee who voluntarily participates in a health risk assessment which includes biometric testing ("HRA") will be eligible for a rate reduction in the next Plan year if the assessment (HRA) and screening are completed by October 31. Written confirmation, which does not include personal health information, from a medical provider must be received in Risk Management by October 31 of each year in order to be eligible for the rate reduction in the following Plan Year. Dependents are not eligible to participate in the rate reduction. HRA's and biometric screenings are available at no cost to employees at the Fort Bend County Employee Health and Wellness Center; however the HRA and biometric screening may be performed by a medical provider of the Employee's choice subject to the Plan's provisions.

FORT BEND COUNTY
EMPLOYEE BENEFIT DENTAL
PLAN DOCUMENT

JANUARY 1, 2012

Fort Bend County, the Employer, hereby amends and restates effective January 1, 2012 the self-funded Fort Bend County Employee Benefit Dental Plan (the "Plan") formed under Chapter 172 of the Local Government Code. The plan provides dental benefits for the eligible Employees of the Employer and their eligible Dependents.

Eligible Retirees and Dependents may participate in the plan in accordance with the rules established and approved by Fort Bend County Commissioners Court.

Eligible Survivors may participate in the plan in accordance with the rules established and approved by Fort Bend County Commissioners Court and Chapter 615 of the Local Government Code ("LGC 615 Survivor").

The purpose of the plan is to provide reimbursement for a Participant's Eligible Expenses incurred as a result of treatment for dental care. In consideration of any required Participant contributions, the Employer agrees to make payment as provided in the plan document. The Employer has the right to periodically amend the plan document. The plan document constitutes the entire Dental Plan.

The Employer has caused this instrument to be executed by its duly authorized officers with the effective date of January 1, 2012.

County Judge

County Commissioner, Precinct 1

County Commissioner, Precinct 2

County Commissioner, Precinct 3

County Commissioner, Precinct 4

COMMISSIONERS COURT FORT BEND COUNTY, TEXAS

Approved by Commissioners Court on September 25, 2012

Attest:

Dianne Wilson

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ARTICLE VIII General Provisions

PLAN ADMINISTRATOR'S DISCRETIONARY AUTHORITY

The benefits provided under the Dental Plan are for the exclusive benefit of eligible Employees/Dependents, eligible Retirees/Dependents, and Survivors as defined by LGC 615. 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 Dental Plan which it deems to be necessary or appropriate, 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 Dental Plan and to make any other changes that it deems necessary or appropriate. Changes in the Dental Plan may occur in any or all parts of the plan, including, but not limited to, benefit coverage, deductibles, maximums, co-payments, 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 provisions of the plan, including correcting 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 decisions, 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.

FORT BEND COUNTY
EMPLOYEE BENEFIT DENTAL PLAN
AND SUMMARY PLAN DESCRIPTION

ARTICLE I
SCHEDULE OF BENEFITS

A. DENTAL SCHEDULE OF BENEFITS

	DEDUCTIBLE
Type I Services	-0-
Type II, III, IV and V Services*	$100.00

*The deductible can be satisfied by any combination of Type II, III, IV and V Services. The $100.00 calendar year per person deductible has a maximum of $300.00 per family per calendar year.

TYPE OF SERVICES	PLAN PAYS
I	100%
II	80%
III	50%
IV	50%
V	80%

Type I routine oral examinations and prophylaxis expenses must be used during the 180 days prior to incurring any Type II, III, IV or V benefits.

Maximum benefit payable for any combination of Type I, II, III, and V Services each Calendar Year is $1,500.00.

Maximum lifetime benefit for Type IV Services is $1,500.00.

The amount payable by the Plan will be the percent specified in the Schedule of Benefits, subject to the maximum Dental Benefit.

The deductible for a calendar year will be satisfied when Eligible Expenses equal to the deductible, in the schedule above, have been incurred in connection with dental care during the calendar year. If you incur eligible claims or expenses in October, November and December that apply toward the calendar year deductible and you have not incurred any eligible claims or expenses or received any credit towards your deductible between January and the last day of September of the same year, then any eligible claims or expenses that will apply toward your deductible in October, November and December will be carried over to the next year's deductible in the form of a credit. Any expenses paid by this Plan toward Type I Services will not apply to this carry-over provision.

The total benefits payable under this Plan for all Type I, II, III and V Services furnished for a Participant in any one calendar year will not exceed the amount specified in the schedule above.

In no event will the total benefits payable for Type IV Services incurred, while the individual is a Participant, exceed the maximum lifetime benefit for Type IV Services specified in the Schedule of Benefits for a participating eligible Dependent child.

B. ELIGIBLE EXPENSES

Benefits for Eligible Dental Expenses incurred will be payable according to the Schedule of Benefits, unless specifically excluded, in effect on the day the expenses are incurred.

Expense incurred on the date a dental service or treatment is performed, except for the following services or treatments:

- Dentures or bridgework on the date the impressions are taken;
- Crowns, inlays, onlays on the date the teeth are first prepared;
- Root canal therapy on the date the pulp chamber is opened; and
- Active orthodontic care on the date the appliances are inserted.

Administration of Anesthesia – fees charged by a Dentist and Dental Specialist for administration or anesthetics.

Fees charged by a Dentist, Dental Specialist, or Dental Hygienist (excluding Denturist) for dental care or specified treatment of an accidental Injury or dental disease.

Legal drugs and medicine are obtainable only on a Physician's written prescription. Out-patient Prescription Drugs must be purchased with your Fort Bend County Employee Benefit Plan ID card. No reimbursement will be made for out-patient Prescription Drugs submitted to this benefit Plan.

1. TYPE I SERVICES:

Preventative and Emergency Expenses

The following expenses will be payable at the percent shown in the Schedule of Benefits in excess of the deductible, if any:

a) Routine oral examinations and prophylaxis (scaling and cleaning of teeth) must be used not more than once each in any period of one hundred-eighty (180) consecutive days, with a window of one hundred-fifty (150) to two hundred-ten (210) days allowed;
b) Topical application of fluoride (direct application of fluoride to the exposed surfaces of the teeth to inhibit tooth decay), not more than once in any period of one hundred-eighty (180) consecutive days;
c) Space maintainers (a fixed or removable appliance designed to prevent adjacent and opposing teeth from moving) that replace prematurely lost deciduous teeth for qualified Dependent children under nineteen (19) years of age;
d) Emergency treatment of temporary relief of pain, which does not provide a definite cure; and
e) Bitewing x-ray, not more than once in a period of one hundred-eighty (180) consecutive days.

Limitation of Type I Services

Payment will be made based on the applicable percentage, toward the cost of procedures Medically Necessary to eliminate oral disease and the replacement of missing teeth.

2. TYPE II SERVICES:

Diagnostic and Restorative Expenses

The following expenses will be payable at the percent shown in the Schedule of Benefits in excess of the deductible, if any:

a) X-rays:
   1) Full mouth series or panoramic, not more than once in any period of thirty-six (36) consecutive months;
   2) Periapical x-rays, only when not performed on the same date as the complete series or panoramic x-rays; and
   3) Miscellaneous dental x-rays required in connection with diagnosis of a specific condition with orthodontic diagnostic procedures and Orthodontic Treatment;
b) Extractions;
c) Oral surgery;
d) Amalgam, silicate, acrylic, synthetic porcelain, and composite filling restorations to restore diseased or accidentally broken teeth;
e) Endodontic treatment (those procedures usually employed for prevention and treatment of diseases of the dental pulp and the area surrounding the tip of the tooth root), including root canal therapy;
f) Treatment of periodontal and other diseases of the gums and other tissues of the mouth;
g) Inlays, onlays, gold fillings, or crown restoration to restore diseased or accidentally broken teeth, but only when the tooth, as a result of extensive caries or fracture, cannot be restored with an amalgam, silicate, acrylic, synthetic porcelain, or composite filling restoration;
h) Repair or recementing of crowns, inlays, bridgework or dentures;
i) Relining or rebasing of dentures more than six months after the installation of an initial or replacement denture, not more than one relining or rebasing in any period of thirty-six (36) consecutive months;
j) Injection of antibiotic drugs by the attending dentist;
k) Administration of general anesthetics, including intravenous sedation, when Medically Necessary due to a concurrent, hazardous medical condition and administered in connection with oral or dental surgery;
l) Sealants to permanent teeth, materials other than fluoride painted on the grooves of the teeth in an attempt to prevent future decay, but limited to children up to age sixteen (16), replacement no less than thirty-six (36) consecutive months; and
m) Appliances for bruxism.

Limitation of Type II Services

If you or your covered Dependent should choose a more costly type of restoration, such as porcelain veneer, crowns or jackets, but the tooth can be restored with a material such as amalgam, the Plan will pay the applicable percentage of the charge for less costly procedure and the Participant will be responsible for any remaining expense.

3. TYPE III SERVICES:

Prosthodontics or Reconstructive Expenses

The following expenses will be payable at the percent shown in the Schedule of Benefits in excess of the deductible, if any:

a) Initial installation of fixed bridgework, including inlays and crowns as abutments, but only if required to replace one or more natural teeth extracted while the Participant is a covered individual;
b) Initial installation of partial or full removable dentures to replace one or more natural teeth extracted while the Participant is a covered individual, including precision attachment which can be justified as functionally and Medically Necessary with study models and radiographs, and any adjustments during the six (6) month period following installation; and
c) Replacement of an existing partial or full removable denture or bridgework by a new denture or by new bridgework, but only if satisfactory evidence is presented that:
   1) Replacement or addition of teeth is required to replace one or more teeth extracted after the existing denture or bridgework was installed and while the Participant is a covered individual;
   2) Existing denture or bridgework cannot be made serviceable and was installed at least five (5) years prior to its replacement; or
   3) Existing denture is an immediate temporary denture, which cannot be made permanent, and replacement by a permanent denture takes place within twelve (12) months from the date of initial installation of the immediate temporary denture.

Limitations of Type III Services

a) Partial Dentures: If a cast chrome or acrylic partial denture will restore the dental arch satisfactorily, payment of the applicable percentage of the cost of such procedure will be made toward the charge for a more elaborate or precision appliance selected by the covered individual and the dentist. The balance of the cost remains the responsibility of the covered individual.
b) Precision Attachments: Benefits will not be provided for precision attachments when used for cosmetic purposes.
c) Dentures: If in the provision of denture services, the covered individual and the dentist decide on personalized restorations or specialized techniques as opposed to standard procedures, payment of the applicable percentage of the cost of the standard denture services will be made toward that treatment and the balance of the cost remains the responsibility of the covered individual.
d) Replacement of existing Dentures or Fixed Bridgework: Replacement of an existing denture will be a Covered Dental Expense only if the existing denture is unserviceable and cannot be made serviceable. Payment based on the applicable percentage will be made toward the cost of services, which are Medically Necessary to render such appliances serviceable. Replacement of prosthodontic appliances will be a Covered Dental Expense only if at least five (5) years have elapsed since the date of the initial installation of that appliance.

4. TYPE IV SERVICES:

The following expenses will be payable at the percent shown in the Schedule of Benefits in excess of the deductible, if any:

Orthodontic Treatment consisting of appliance, surgical, functional myofunctional, and other related treatment, including incidental oral examinations, of dental irregularities which result from abnormal growth and development of teeth, gums, or jaws as a result of accidental Injury which requires repositioning, except for preventative treatment, of teeth to establish normal occlusion. Related oral examinations, surgery and extraction's included as Type I, II or III Services are not considered Orthodontic Treatment. Benefits are payable for Dependent children under nineteen (19) years of age only.

Limitations of Type IV Services

a) If Orthodontic Treatment is terminated for any reason before completion, the obligation to pay benefits will cease with payment to the date of termination. If such services are resumed, benefits for the

services will be resumed to the extent of the remaining lifetime benefit applicable to the covered individual being treated.

b) Payment of benefits for Orthodontic Treatment will be only for months in which a participant is a covered individual.

c) No payment will be made for Orthodontic Treatment which commenced prior to the covered individual's effective date.

5. TYPE V SERVICES:

The following expenses will be payable at the percent shown in the Schedule of Benefits in excess of the deductible, if any:

a) Surgical removal of impacted teeth if partially or completely covered by bone;
b) Extraction of seven or more natural teeth within a period of fifteen (15) consecutive days;
c) Frenectomy;
d) Osseous surgery;
e) Gingivectomy; and
f) Alveolectomy.

C. LIMITATIONS AND EXCLUSIONS

Dental conditions or procedures, which were started, diagnosed or existed before Participant became eligible to participate in this Plan, will be subject to a Pre-existing Condition limitation. A Pre-existing Condition shall be defined as any dental condition or procedure, which began or was diagnosed or existed during the previous twelve (12) months prior to Participant becoming eligible to participate in this program. No Type II, III, IV or V expenses will be eligible for benefits for those conditions or procedures until Participant has satisfied twelve (12) continuous months of coverage. During this period of time Participant will be eligible for Type I Services only for those Pre-existing Conditions or procedures.

If a patient chooses a more expensive treatment than is needed to correct a dental problem according to accepted standards of dental practice, the benefit payment will be based on the cost of the treatment which provides professionally satisfactory results at the most cost effective level.

Unless otherwise specifically included, no benefits shall be payable under this Plan with respect to expenses incurred for:

1. The portion of any charge for any service in excess of the Reasonable and Customary Charge;
2. Any services or supplies other than those specifically covered under the provisions of the Plan;
3. Veneers (the coating or covering of plastic or porcelain on the outside of and bonded to a crown or false tooth to cause it to blend with the color of surrounding teeth), or similar properties of crowns and pontics placed on or replacing teeth, other than the ten (10) upper and lower anterior teeth;
4. Services or supplies that are cosmetic in nature, including charges for personalization or characterization of dentures;
5. Prosthetic devices, including bridges, and crowns for a Participant, and the fitting thereof, which are ordered while such Participant is not covered under this Plan or which were ordered while such Participant was covered under this Plan but are finally installed or delivered to such Participant more than sixty (60) days following termination of coverage.
6. Treatment by other than a dentist, except that scaling or cleaning of teeth and topical application of fluoride may be performed by a licensed dental hygienist if the treatment is rendered under the supervision and guidance of the dentist;
7. The replacement of a lost, missing or stolen prosthetic device, or the replacement or repair of an orthodontic appliance;

8. Services charged for, but not received, because of an individual's failure to appear for a scheduled appointment;
9. Any duplicate prosthetic device or any other duplicate appliance;
10. Implantology (an insert set firmly or deeply into or on to the part of the bone that surrounds and supports the teeth); and periodontal splinting;
11. Charges for dentures and bridgework, including crowns and inlays forming the abutments, when such charges are incurred for the replacement of teeth which were lost or missing prior to the Participant becoming a covered individual under the Plan;
12. A plaque control program (a series of instructions on the care of teeth) or oral hygiene or dietary instructions;
13. Services or supplies for which the individual is not required to make payment;
14. Services or supplies which are not Medically Necessary, according to accepted standards of dental practice or which are not recommended or approved by the attending dentist;
15. Services or supplies which do not meet accepted standards of dental practice including charges for services or supplies which are experimental in nature;
16. Resulting from care or treatment not reasonably necessary for the care and treatment of Dental Disease or accidental Injury;
17. Any services or supplies received because of oral disease or Injury arising out of or in the course of employment and entitling the covered individual to benefits under any Worker's Compensation, Jones' Act, Longshoremen and Harbor Worker's Compensation Act, or Occupation Disease Act or Law;
18. For any procedures that have not been formally approved by the Federal Food and Drug Administration and/or the American Dental Association, and are experimental or for research purposes, or for procedures that require an informed Consent Form;
19. Drugs labeled "Caution-limited by a federal law to investigational use" or experimental drugs even though a charge is made to the covered individual; drugs that have no FDA approved drugs or dosage regimens used for indication or routes of administration outside of FDA approval;
20. Services or supplies received as a result of dental disease, defect or Injury due to an act of war, declared or undeclared; or by participation in a riot;
21. Resulting from accidental Injury arising out of or in the course of employment for wages or profit;
22. Resulting from any intentionally self-inflicted Injury whether sane or insane;
23. Illness or Injury caused by, or contributed to, engagement in an illegal occupation or commissions or attempt to commit a felony;
24. Charges incurred outside the United States if the Participant traveled to such a location for the sole purpose of obtaining dental services, drugs or supplies;
25. Charges for experimental procedures, drugs, or research studies or for any services or supplies not considered legal in the United States;
26. Charges for services or supplies which are, or could be, furnished, paid for or otherwise provided for (i) by reason of the past or present service of any person in the armed forces of a government, or (ii) under any law of a government, national or otherwise, except where the payments or benefits are provided under a plan specifically established by a government for its own civilian Employees or their Dependents. The amount of any such charges will be deducted from the family member's expenses unless the family member is legally obligated to pay the charge;
27. Services or supplies furnished through a medical department, clinic or similar facility provided or maintained by the covered individual's Employer, unless the individual is legally obligated to pay the charge;
28. Services or supplies for which benefits are payable under any other group plan;
29. Services or supplies furnished by a Close Relative of the Participant; or
30. Services that are not specifically listed under Type I, II, III, IV or V.

ARTICLE II
PREDETERMINATION OF BENEFITS

The Plan encourages all Participants to seek the best and most efficient dental care available. The Participant or their dental provider may request a predetermination of a claim prior to incurring dental treatment. Predetermination of a claim does not guarantee payment of benefits. The Claims Administrator will determine if the procedure is eligible under the Plan.

Before starting a dental treatment for which the charge is expected to be $200.00 or more, a predetermination of benefits form is recommended. A regular dental claim form is used for the predetermination of benefits. The Dentist must itemize all recommended services and costs and attach all supporting x-rays to the form. The Claims Administrator will notify the Dentist and the Participant of the benefits payable under the Plan. The Participant and the Dentist can then decide on the course of treatment, knowing in advance how much the Plan will pay.

If the description of the procedures to be performed, x-rays and an estimate of the Dentist's fees are not submitted in advance, the Plan reserves the right to make a determination of benefits payable taking into account alternative procedures, services or courses of treatment, based on accepted standards of dental practice. If verification of necessity of dental services cannot reasonably be made, the benefits may be for a lesser amount than would otherwise have been payable.

ARTICLE III
PLAN INFORMATION

EMPLOYER
Fort Bend County
Fort Bend County Courthouse
Richmond, Texas 77469
Telephone: 1-281-341-8630

PLAN ADMINISTRATOR/PLAN SPONSOR AND AGENT FOR SERVICES OF LEGAL PROCESS/VENUE
Fort Bend County
Attention: County Attorney's Office
Fort Bend County Courthouse
Richmond, Texas 77469
Telephone 1-281-341-4555

PLAN NAME
Fort Bend County Employee Benefit Dental Plan – This is an employee benefit plan formed under Chapter 172 of the Local Government Code, providing Dental Benefits.

PLAN NUMBER/IDENTIFICATION – 949

BENEFIT YEAR – January 1 through December 31

PLAN YEAR – January 1 through December 31

CONTRACT CLAIMS ADMINISTRATOR
Boon-Chapman Benefit Administrators Inc.
P. O. Box 9201
Austin, Texas 78766
Physical Address:
9401 Amberglen Boulevard, Building I, Suite 100
Austin, TX 78729
Telephone: 1-512-454-2681 or 1-800-252-9653
Facsimile: 1-512-459-1552
Web address: www.boonchapman.com

FINANCING OF THE BENEFITS PLAN
You and your employer contribute to the Plan, if you chose to participate. The amount of the contribution is determined by the claims experience of those who participate in the Plan and the contribution level is determined by Fort Bend County Commissioners Court. The Court reserves the right to adjust the contribution level of the Employer or the Participants at any time. The benefit year begins January 1 and runs through December 31.

ARTICLE IV
DEFINITIONS

Active Service means an Employee is performing in the customary manner all of the regular duties of employment on a full-time basis either at the customary place of employment or at some location to where that employment requires travel on a scheduled work day, or if the Employee is absent from work solely by reason of vacation and at the time coverage would otherwise become effective, 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 that is not a scheduled work day only if the Employee was performing in the customary manner all of the regular duties of employment on the last preceding scheduled work day. In no event will an Employee be considered in Active Service if he has effectively terminated employment with the Employer. An eligible Dependent will be considered in Active Service on any day if the Dependent is then engaging in all the normal activities of a person in good health of the same age and sex, and the Dependent is not confined in a medical facility. (This paragraph will not apply to a newborn child.) An Elected Official by virtue of office is deemed to be Active Service throughout their term once sworn into office and the officeholder is considered a full-time budgeted position regardless of hours worked.

Alternate Procedure is the most cost effective treatment of a dental condition which will provide a professionally acceptable result as determined by national standards of dental practice. Consideration is given to the current clinical oral condition based upon the diagnostic material submitted by the dentist.

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.

Appropriate or Appropriateness refers to the classification of a dental service as customary and usual for the treatment of any given dental condition. Such services must be commonly recognized by the dental profession as an accepted standard for that type and level of care.

Benefit Maximums means total plan payments for each covered person are limited to certain maximum benefit amounts. A benefit maximum can apply to specific benefit categories or to all benefits. A benefit maximum also applies to a specific time period, such as annual or lifetime. When the word lifetime appears in this plan in reference to benefit maximums, it refers to the period of time you participate in this plan.

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

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

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

Commissioners Court means the Commissioners Court of Fort Bend County, Texas.

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

County Judge means the County Judge of Fort Bend County, Texas.

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

Dental Hygienist is a person who is licensed to practice dental hygiene, practicing within the scope of their license, and not a close relative.

Dentist is a person who is licensed to practice dentistry or oral surgery, practicing within the scope of their license and not a close relative.

Dependent means any one or more of the following:

1. The lawful Spouse of an Employee;
2. Unmarried natural children of the Employee under the age of nineteen (19), including legally adopted children and step-children who reside with the Employee, and are principally dependent on the Employee for support;
3. Unmarried natural children of the Employee, including legally adopted children and step-children who reside with the Employee, have attained the age of nineteen (19) and up to the age of twenty-five (25), and are full-time students in an accredited public or private secondary school, college, university, trade school or business school, and are principally dependent on the Employee for support (coverage will terminate on last day of full-time student status);
4. Unmarried natural children of the Employee, including legally adopted children and step-children, who have attained age nineteen (19), reside with the Employee, and are principally dependent upon the Employee for support and maintenance, are incapable of self-sustaining employment due to mental or physical disability, provided such disability commenced prior to attainment of age nineteen (19), and Dependent was covered prior to attainment of such age. Proof of dependency or mental or physical disability must be furnished by you when required by the Plan Administrator;
5. Unmarried natural child of an Employee who is subject to a current order of a court or Attorney General for the State of Texas to provide dental benefits for such natural child;
6. Unmarried Grandchild of the Plan Participant who is a dependent of the Plan Participant for federal income tax purposes at the time application for coverage of the child is made; who has not attained age nineteen (19), or have attained the age of nineteen (19) and up to the age of twenty-five (25) and are full-time students in an accredited public or private secondary school, college, university, trade school or business school, and are principally dependent on the Employee for support (coverage will terminate on last day of full-time student status);
7. Unmarried Grandchild of a Plan Participant who is a dependent of the Plan Participant for federal income tax purposes at the time application for coverage of the child is made; and who have attained age twenty-five (25), reside with the Employee, are principally dependent upon the Employee for support and maintenance, are incapable of self-sustaining employment due to mental or physical disability, provided such disability commenced prior to attainment of age twenty-five (25), and child was covered prior to attainment of such age (proof of dependency or mental or physical disability must be furnished by you when required by the Plan Administrator); or
8. Child for whom the Plan Participant must provide medical support under a court order issued under Chapter 154, Family Code, or enforceable by a court in the State of Texas, stating Employee must provide dental support for child, and child has not attained age eighteen (18) or graduated from high school, whichever occurs later; and is unmarried.

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

Emergency Treatment refers to an urgent and unplanned visit in which dental services are provided for the temporary relief of acute pain.

Employee means persons who meet the qualifications to participate in the Plan as indicated in the eligibility section of the Plan for the Employer and are entitled to compensation for such services. Any individual who is considered to be in an employer-employee relationship with the Employer on the payroll records of the Employer for purposes of federal income tax withholding. The term "Employee" will not include any person during any period that such person was classified on the Employer's records as other than an Employee. The term "Employee" will not include anyone classified on the Employer's records as an independent contractor, agent, leased employee, contract employee, temporary employee or similar classification, regardless of a determination by a governmental agency that any such person is or was a common law employee of an Employer. For purposes of this definition, (i) a "leased employee" means any person, regardless of whether or not he is a "leased employee" as defined in Code Section 414(n)(2), whose services are supplied by an employment, leasing, or temporary service agency and who is paid by or through an agency or third-party, and (ii) an "independent contractor" means any person rendering service to the Employer and whom the Employer treats as an independent contractor by reporting payments for the person's services on IRS Form 1099 (or its successor), regardless of whether any agency (governmental or otherwise) or court concludes that the person is, or was, a common law employee of the Employer even if such determination has a retroactive effect.

Furthermore, employees who are non-resident aliens and who receive no earned income (within the meaning of Code Section 911(d)(2) from an Employer which constitutes income from sources within the United States (within the meaning of Code Section 861(a)(3)) will not be considered Employees who are eligible to participate in this Plan.

Elected Official means a person who is elected to serve Fort Bend County and who by virtue of their office is entitled to participate in the County's Dental Plan. They will be included in the reference to "Employee" within the Plan, exceptions will be noted with specific reference to Elected Official.

Family Status Change events 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. It is the Employee's responsibility to notify Risk Management of the change in writing and to complete the necessary form(s). Verbal notification is unacceptable.

Full-Time Student means a Participant's dependent child who is enrolled in and regularly attends an accredited public or private secondary school, college, university, trade school or business school for the minimum number of credit hours required by that college, university, trade school or business school in order to maintain full-time student status.

Injury means a condition caused by accidental means, which results in damage to the Participant's body from an external force.

Late Entrant means an Employee who 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 Dependent of an Employee who is a Late Entrant and a Dependent who does not enroll in the Plan within the first thirty-one (31) days after such Dependent is eligible to enroll. If you and/or your Dependent(s) do not enroll for benefits at the initial time you are eligible for benefits, then you and/or your Dependent(s) will be considered Late Entrants.

Medically Necessary means a procedure or service that is:

1. Appropriate to the diagnosis;
2. Consistent with the location of services and the level of care provided;
3. Reasonably safe;

4. Widely accepted by the practicing peer group;
5. Based upon scientific criteria;
6. Not of an experimental, investigative or research nature; and
7. As determined by this Plan.

Oral Surgery constitutes the necessary procedures for surgery in the oral cavity, including preoperative and postoperative care.

Ordered means, in the case of dentures, that impressions have been taken from which the denture will be prepared; and in the case of fixed bridgework, restorative crowns, inlays and onlays, that the teeth which will serve as abutments or support or which are being restored have been fully prepared to receive, and impressions have been taken from which will be prepared the bridgework, crowns, inlays or onlays.

Orthodontic Treatment means prevention and correction of dental irregularities resulting from the abnormal growth and development of the teeth or as a result of accidental Injury requiring repositioning (except for preventative treatment) of teeth to establish normal occlusion.

Participant means those Full-Time Employees or eligible Retirees and their eligible Dependents, and Local Government Code 615 Survivor(s) who have enrolled in the Plan in accordance with Plan procedures and are entitled to benefits under this Plan.

Pre-existing Condition means, as determined by the Plan Administrator, any Illness, Injury, or other condition of a Participant (whether physical or mental) including pregnancy, and including all complications that can reasonably be determined to be related to such conditions which existed at anytime during the twelve (12) months prior to your effective date of coverage under this Plan. Genetic information on a Participant will not be considered a Pre-existing Condition.

Reasonable or Usual and Customary Charges means the plan provides benefits only for covered expenses that are equal to or less than the reasonable or usual and customary charge in the geographic area where services or supplies are provided. Any amount that exceeds the reasonable or usual and customary charge is not recognized by the plan for any purpose.

Retiree means any person who meets the definition of Retiree as defined by the Fort Bend County Commissioners Court.

Spouse means a person of the opposite sex 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, to the extent such state law requirements are consistent with the federal Defense of Marriage Act, P.L. 104-199, but shall not include an individual separated from the Employee under a divorce decree. Under current Texas law, "spouse" shall also include a common law spouse provided that the requirements for common law marriage have been met. The Employee must provide proof of a common law marriage to include but is not limited to a declaration of informal marriage filed with the County Clerk.

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

Treatment Plan means a Dentist's report on a form satisfactory to the Plan Administrator which, (i) itemizes the dental services recommended by the Dentist for the necessary dental care of a person, (ii) shows the charge for each dental service and (iii) when requested by the Plan Administrator, is accompanied by supporting preoperative x-rays and any additional information requested by the Plan Administrator.

Waiting Period means for a regular enrollee, the first of the month after 90 days of continuous Active Service beginning on the first day of eligibility for coverage under the Plan (other than satisfaction of the Waiting

Period requirement). For a Late Entrant, the term "Waiting Period" means the 90 day period of time between the date of enrollment in the Plan and the effective date of coverage under the Plan.

ARTICLE V
ELIGIBILITY AND PARTICIPATION

A. EMPLOYEE PARTICIPATION

1. Waiver of Participation in this Plan

An Employee has the right to waive their dental coverage under this Plan. Dependent coverage will not be available if Employee coverage is not selected. If an eligible Employee or Dependent elects to waive participation and later decides to enroll in the Plan beyond 31 days of first becoming eligible to participate in the Plan, the Employee and the Employee's Dependents will be Late Entrants and required to comply with any and all Plan provisions for enrollment in the Plan as Late Entrants. Coverage under the Plan for Late Entrants will be effective on the first (1st) day of the month following completion of the Waiting Period provided the employee is in active service (Elected Official is deemed to be "Active Service" once sworn into office) on that date, otherwise the effective date will be deferred until returned to Active Service. A Late Entrant will also be subject to the twelve (12) months (beginning from the effective date of coverage under the Plan) Pre-existing Condition exclusion.

2. Eligibility

All Employees in a full time budgeted position, who are in Active Service at their customary place of employment on the day their health care benefits become effective, and who complete the Waiting Period shall be eligible to participate in the Plan. Eligible Employees will be required to notify the Risk Management Department in writing, complete any necessary enrollment applications and supply all necessary documentation as required by the Plan within the first sixty (60) days of employment or eligibility to participate in the Plan.

Elected Officials who complete the required Waiting Period shall be eligible to participate in the Plan. Eligible Elected Officials will be required to notify the Risk Management Department in writing, complete any necessary enrollment applications and supply all necessary documentation as required by the Plan within the first sixty (60) days of employment or eligibility to participate in the Plan.

All other persons are excluded.

3. Effective Date of Coverage

Coverage will become effective for an eligible Employee on the first (1st) day of the month following completion of the Waiting Period, or if none, upon the date of eligibility (provided the Employee is in Active Service on that date, otherwise the Effective Date will be deferred until return to Active Service) subject to the Pre-existing Conditions exclusion. Employees with a change of status from part-time to full-time or from temporary to regular will be subject to the same Waiting Period beginning the date their status changes and subject to the exclusion of Pre-existing Conditions. Employees who previously waived their benefit participation and decide to participate at a later date may only enroll during the annual enrollment period as a Late Entrant and will be subject to the Waiting Period (which will start as of January 1st the following year) and subject to the exclusion of Pre-existing Conditions. Payment of any contribution toward the cost of coverage under the Plan, if required by the Employer, must be made prior to coverage becoming effective.

4. Termination of Coverage

Except as provided in the Continuation of Coverage in compliance with COBRA section, an Employee's coverage under the Plan will terminate at 11:59 p.m. on the earliest of the following dates:

a) The date at the end of the period for which the Employee made the last required contribution for coverage under the Plan;
b) The last day of the month in which the Employee terminates employment or retires;
c) The date on which the Employee no longer satisfies the eligibility requirements under the Plan;
d) The date on which the Plan is terminated or amended, resulting in the Employee's loss of coverage;
e) The date of the Employee's death; or
f) The date on which the Employee falsifies information provided to the Plan, fraudulently or deceptively uses Plan services, or knowingly permits such fraud or deception by another person.

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

Participation may be continued for an Employee on an Employer approved leave of absence. See the Fort Bend County Employee Information Manual.

5. **Changes in Dental Benefits** will be effective for all Employees in Active Service on the date the Plan is amended. For Employees on leave of absence or on disability leave, the change will be delayed until the Employee returns to Active Service.

B. DEPENDENT PARTICIPATION

An Employee participating in the Plan may cover their Dependent who meets the definition of Dependent (see Article IV) and the following requirements.

1. Required Documentation for Proof of Dependent

Documents must be submitted to Risk Management before eligibility is approved.

a) **Spouse:** Certified Marriage License or Certified Informal Marriage Certificate, and Social Security Number.
b) **Natural/Adopted Child:** Certified Birth Certificate, which shows name of mother and father (mother or father must be the Employee); Certified, signed and filed, Adoption Decree (parent must be the Employee), original Certified Birth Certificate and new Certified Birth Certificate with the name change, etc., with certified, signed and filed, supporting documents for changes; court order (signed by a Judge or the Attorney General) or order for support by the Attorney General for the State of Texas; Social Security Number; and proof of full time student status.
c) **Stepchild:** Certified, signed and filed Divorce Decree stating the individual responsible for Dependent dental coverage; proof of residency (certified school record); Certified Birth Certificate which shows name of mother and father, Certified Marriage License showing that Employee is legally married to Stepchild's parent; Stepchild's Social Security Number; and proof of full time student status.
d) **Grandchild:** Certified Birth Certificate; Social Security Number; proof of full time student status; and proof the child is a dependent of the Plan Participant for federal income tax purposes at the time application for coverage of the child is made.
e) **Court Ordered Child:** Certified Birth Certificate; Social Security Number; proof of full time student status (over age eighteen (18)); and Certified, signed and filed court order issued under Chapter 154, Family Code, or enforceable by a court in the State of Texas, stating Plan Participant must provide dental support for child.

2. Eligibility

A Dependent will be eligible to participate in the Plan during or on:

a) The date the Employee is eligible for benefits under the Plan, if on that date the Employee has such Eligible Dependents; or
b) The date the Employee gains an Eligible Dependent, if on that date the Employee is covered by the Plan, and has made any necessary contributions; and has notified the Plan within thirty-one (31) days of gaining that Dependent.
c) If a Dependent, other than a 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; and
d) In no event will the Dependent's coverage begin before the Employee's coverage.

LGC 615 Survivor(s) are eligible to continue dental coverage under this Plan at the time of the Employee's death, but not enroll as a new Participant.

The Risk Management Department must be notified in writing of Eligible Dependents, complete any necessary enrollment applications and supply all necessary documentation as required by the Plan within the first sixty (60) days of employment or eligibility to participate in the Plan.

In the event a husband and wife are both eligible to participate in the Plan as Employees, only one Employee will be eligible to cover any eligible Dependent child(ren) they might have. If the Employee covering a Dependent terminates their employment, the terminated Employee and Dependent(s) may be added to the existing coverage of the remaining Employee, provided that there is no lapse in coverage and they are added immediately (Article V, G).

3. Changes in Dependent Health Care Benefits

Changes in the Health Care Benefits will be effective for Dependents only if the Employee is still eligible and the Dependent is not confined in a Hospital, or other institution. Employee and Dependent must be covered under the same benefit package.

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 and the Contract Administrator has received due proof such child is mentally or physically incapacitated such that they are incapable of earning their own living and is dependent upon the Employee for their support, participation will continue so long as the incapacity continues and the Plan remains in full force and effect. The Plan has the right to periodically require that the Employee show proof of the incapacity of the Dependent as determined by the Plan Administrator.

4. Termination of Coverage

Except as provided in the Continuation of Coverage in Compliance with COBRA section, a Dependent's coverage will terminate at 11:59 p.m. on the earliest of the following dates:

a) The date the Employee's coverage terminates;
b) 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;
c) The date on which the Dependent ceases to be an eligible Dependent as defined by the Plan;
d) The date on which the Plan is terminated or amended, resulting in the Dependent's loss of coverage;
e) The date of the Dependent's death; or
f) The date on which the Employee or Dependent falsifies information provided to the Plan, fraudulently or deceptively uses Plan services, or knowingly permits such fraud or deception by another person.

LGC 615 Survivor(s) who terminate coverage under this Plan will not be able to re-enroll in the terminated coverage.

An Employee cannot terminate a Spouse during legal separation until the divorce is final. A certified divorce decree must be submitted before any paperwork can be processed. The termination date will be the effective date of the certified divorce decree.

Notwithstanding the foregoing, a termination of coverage may only be effective retroactively if the Employee or Dependent (i) performs an act, practice or omission that constitutes fraud, (ii) makes an intentional misrepresentation of material fact, or (iii) fails to make a required contribution for coverage under the Plan when due.

C. RETIREE PARTICIPATION

Elected Officials and employees in a full time budgeted position eligible for retirement through the Texas County and District Retirement System (TCDRS) and in accordance with the rules established and approved by Fort Bend County Commissioners Court.

Eligible Retirees and their eligible Dependents (except for deceased Retiree's survivors) will be eligible to participate in this Plan subject to the rules established by and approved by Fort Bend County Commissioners Court (i.e. Employee Information Manual Section 511).

Eligible Employees who retire before the end of a month, once retired will continue to participate in the employee dental plan through the end of that month as an active employee. On the first day of the month following retirement, the Retiree and their eligible Dependents may continue coverage in the FBC Dental plan in a Retiree status.

Effective September 11, 2001, Retirees who are married to a County Employee when they retire will be allowed to add the remaining Spouse/Employee and any covered Dependents to their coverage when the Spouse terminates their employment. The remaining Employee and eligible Dependents will be required to have the same dental benefits as the Retiree for at least the twelve (12) months preceding their termination of employment. The Retiree will be eligible to cover all other eligible Dependents; other than the remaining Spouse, when they retire.

Employee/Dependent Termination of Coverage rules apply to Retiree/Dependent.

Retirees who terminate coverage on themselves or Dependent(s) under this Plan will not be able to re-enroll in the terminated coverage.

D. LATE ENTRANTS / FAMILY STATUS CHANGE / DEPENDENT DELETION

All Late Entrants are required to satisfy the waiting period (ninety (90) days). The waiting period begins upon receipt of required enrollment and documentation by Risk Management. Original form(s) must be submitted to Risk Management, a fax or scanned email will not be accepted. Forms are available on the County Wide Web (CWW) site under Risk Management. If approved as a new Participant in the Plan, the earliest date that a Late Entrant's coverage may take effect will be the first day of the month following ninety (90) days after the Late Entrant's waiting period begins. The Plan reserves the right to approve or deny any Late Entrant applicant. If additional information is received by the Plan after the Late Entrant's acceptance that would disqualify the Late Entrant from coverage, the Plan will have the right to terminate coverage back to the original effective date and the Employer will refund any contribution that was already made towards said coverage. The Employee will be responsible for paying all claims paid by the Plan on behalf of the ineligible person.

Mid-Year Late Entrants – Participants who do not participate in the Section 125 Plan may add eligible Dependents mid-year with a Family Status Change. All new Participants will be considered Late Entrants and

must fulfill the requirements as stated above. The ninety (90) day waiting period for the Late Entrant will begin on the date Risk Management receives all required documentation.

Annual Enrollment Late Entrants – An Employee may enroll eligible Dependent(s) during the annual enrollment period without a Family Status Change. All new Participants will be considered Late Entrants and must fulfill the requirements as stated above. The ninety (90) day waiting period for the Late Entrant will begin on January 1st of the following year. Required documents must be submitted by the deadline, which will be set for each annual enrollment period. Late Entrant applications are due within two (2) weeks of the deadline, which will be set for each annual enrollment period.

Family Status Change – An Employee who participates in the Section 125 Plan may add eligible Dependent(s) mid-year only if there is a qualified Family Status Change and the Participant has all required documentation turned into Risk Management within thirty-one (31) days of the Family Status Change event. Qualified Family Status Changes for adding an eligible Dependent include, but are not limited to, marriage, birth, adoption, or a change in a Spouse or Dependent's employment status as specified by Section 125 of the Internal Revenue Code.

In the event of birth, adoption, or marriage, benefits for the eligible Dependents will be effective on the date of the Family Status Change. For example, when adding a Spouse due to marriage, the effective date of coverage will be the date of marriage on the certified marriage license or informal marriage certificate and premiums will be due beginning on that date.

In the event of a change in a Spouse's or Dependent's employment, all new Participants will be considered Late Entrants and must fulfill the requirements as stated above. The ninety (90) day waiting period for the Late Entrant will begin on the date Risk Management receives all required documentation.

Dependent Deletion – An Employee must delete a Dependent that is no longer eligible to remain on the Plan at the time they become ineligible. Dependents who are not eligible are those who are (i) children nineteen (19) years of age or older and who are not full-time students in an accredited public or private secondary school, college, university, trade school or business school, and are principally dependent on the Employee for support, (ii) children twenty-five (25) years of age or older and who are not eligible for coverage due to a mental or physical disability, (iii) children who are married, (iv) ex-Spouses and ex-step-children, and (v) step-children who do not reside with the employee. In the case of divorce, a certified divorce decree is required before the Plan will terminate the Dependents no longer eligible.

It is the Employee's responsibility to notify Risk Management of a Dependent who is no longer eligible and complete the proper form(s). Notification is subject to COBRA notification requirements. Verbal notification is unacceptable. The Plan will refund Plan Participant contributions paid after effective date and prior to the submission and receipt in Risk Management of the proper forms within required time frames of the life event. In addition, the Employee will be responsible for paying all claims paid by the Plan on behalf of the Dependent during the ineligible period.

E. CONTINUATION OF COVERAGE IN COMPLIANCE WITH COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985)

1. Continuation of Coverage

Coverage that may be continued under this section includes dental coverage provided under this Plan. For purposes of this section, a "Covered Person" is a Participant who is covered under the Plan due to his status as an Employee or Retiree and a "Covered Dependent" is a Dependent who is a Participant. Under this section, the following Participants whose coverage would otherwise end may continue to be covered under the Plan:

a) Covered Dependents of a Covered Person who dies.
b) A covered Person and their Covered Dependents upon the Covered Person's termination of employment (other than termination for gross misconduct), or whose work hours have been reduced to less than the minimum required for coverage under the Plan.
c) A Covered Dependent Spouse upon divorce from the Covered Person.
d) A Covered Dependent child loses coverage due to attainment of the maximum age to which Dependents may be covered under this Plan.

2. Notice Requirements – Employer/Employee

a) When eligibility for continuation results from a Covered Person's death, termination, reduction in working hours, or entitlement to Medicare, the Covered Person or Dependent will notify the Employer of that event. Notice must be given to Risk Management within thirty (30) days of the Covered Person's death, termination, reduction of working hours, or entitlement to Medicare.
b) When eligibility for continuation results from a covered Spouse being divorced from a Covered Person (Employee) or a Dependent child's marriage or attainment of the maximum age for coverage under the Plan, the covered person or Dependent must notify the Employer of that event within sixty (60) days of the event.
c) Within thirty (30) days of receiving notice, the Employer will notify the COBRA administrator of the termination of coverage. Within fourteen (14) days of receiving the notice from the Employer, the COBRA administrator will mail the covered person information regarding their right to continue benefits.
d) After receiving that notice, the Covered Person or Dependent has sixty (60) days in which to decide whether to elect continued benefits. These sixty (60) days begins on the later of:
   1) The date coverage under the Plan would otherwise end; or
   2) The date the person receives notice from the Employer of their rights under the law.

   If the Covered Person or Dependent chooses to have continued benefits, they must advise the Employer in writing of this decision. The Employer must receive this written notice before the end of sixty (60) days.
e) Within forty-five (45) days after the date of the Covered Person or Dependent notifies the Employer that they have chosen to continue dental insurance, the first premium must paid. The first payment will be the amount needed to provide coverage from the date continued benefits begin to the date that the first payment is made. Thereafter, premiums for the continued benefits are to be paid monthly on the day of each month stated by the Employer.
f) A Covered Person's Dependent must pay the premium for a coverage being continued.

3. Length of Continuation

a) For Covered Persons who are terminated or have their hours reduced, coverage may be continued for up to eighteen (18) months after the termination or reduction in hours. For all others who qualify for continuation of benefits, coverage may be continued for up to thirty-six (36) months after the event, which makes the Covered Person eligible for continued benefits. Continuation will end on the earliest of:
   1) The end of the eighteen (18) or thirty-six (36) month period noted above;
   2) The date the Employer's Plan terminates;
   3) Failure to make payment for coverage as required above;
   4) The date the person becomes covered under any other group health Plan as a result of employment, re-employment or re-marriage;
   5) The date the person becomes entitled to benefits under Medicare.

b) The following applies when this Plan replaces another Plan of group dental coverage. If, on the day before the effective date of the Employer's coverage under this Plan, eligible Employee or Dependent coverage is being continued under that prior Plan under COBRA (the Consolidated Omnibus Budget Reconciliation Act of 1985):
   1) That person will have the right to become covered under this Plan. Coverage may be provided until the end of the period for which the person could have been covered under the prior Plan if it had not been replaced; and
   2) Any benefits otherwise payable under this section will be reduced by any amounts for which the person is eligible under the Plan.

F. HEALTH INSURANCE PROTABILITY & ACCOUNTABILITY ACT OF 1996 (HIPAA) ELECTION UNDER 42 U.S.C. §300 GG-21

Federal law imposes upon group health plans (including Dental plans) certain limitations of (1) Pre-existing Condition exclusion periods, (2) special enrollment periods for individuals (and Dependents) losing other coverage, (3) prohibitions against discriminating against individual Participants and beneficiaries based on health status, (4) standards relating to mothers and Newborns, (5) parity in the application of certain limits to mental health benefits, and (6) required coverage for reconstructive surgery following mastectomies.

Federal law allows a non-federal governmental self-funded plan (such as the Fort Bend County Employee Benefit Dental Plan for Employees of Fort Bend County, Texas) to exempt its Plan in whole or in part from these requirements: (1) Limitations on pre-existing condition exclusion periods, (2) special enrollment periods for individuals (and dependents) losing other coverage, (3) prohibitions against discriminating against individual participants and beneficiaries based on health status, (4) standards relating to mothers and Newborns, (5) parity in the application of certain limits to mental health benefits, and (6) required coverage for reconstructive surgery following mastectomies. Fort Bend County has requested that the entire Fort Bend County Employee Benefit Dental Plan be exempt under 42 U.S.C. §300gg-21.

Fort Bend County 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.

1. HIPAA Privacy Rule

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. "Protected Health Information" means information, including genetic information, that is created or received by the Plan which (a) relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual, (b) identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual, and (c) is transmitted or maintained in any form or medium.

2. 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 by the Plan in connection with the HIPAA Privacy Rule (e.g., entering into business associate contracts; accepting certification from the Plan Sponsor).

3. 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:

a) The Plan Document has been amended to establish the permitted and required uses an disclosures of such information by the Plan Sponsor, consistent with the "504" provisions;
b) The Plan Document has been amended to incorporate the Plan provisions set forth in this section; and
c) The Plan Sponsor agrees to comply with the Plan provisions as described by this section.

4. 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, and 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 Document (as amended) and in the "504" provisions, of which the Plan Sponsor becomes aware.

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

The Plan Sponsor will make the Protected Health Information of the member who 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. §164.524.

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.

6. 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 health information to the Plan Sponsor, if the Plan Sponsor requests the summary health information for the purpose of:

a) Obtaining premium bids from health plans for providing health insurance coverage under the Plan; or
b) 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 Document as provided for in the "504" provisions.

7. 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 who may be given access by the Director of Risk Management as the Plan's HIPAA Privacy Officer to members' Protected Health Information received from the Plan or from a health insurance issuer. (Classes may include, for example: Analyst/Administrators; Service Personnel; Information Technology Personnel; Clerical Personnel; Supervisors/Managers; Quality Assurance Unit.)

a) Director of Risk Management
b) Risk Management Personnel
c) Financial Accountants
d) Legal Advisors who represent the Plan
e) Part-time/Temporary Clerical support
f) Information Technology Personnel

This list reflects the Employees, classes of Employees, or other workforce members of the Plan Sponsor who 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.

8. 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:

a) Plan Sponsor shall implement administrative, physical, and technical safeguards that reasonable 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;
b) 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;
c) 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
d) Plan Sponsor shall report to the Plan any Security Incidents of which it becomes aware as described below:
e) 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
f) 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.

G. DUAL COVERAGE PRECLUDED

No person will be covered under the Plan simultaneously:

a) As both an Employee and a Dependent, if eligible for County coverage;
b) As a Dependent of more than one Employee/Retiree.

H. UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT

The Plan will comply with the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") with regard to continuation rights during an approved military leave of absence and reenrollment rights on return from such military leave of absence.

1. An Employee who is not at work because of a period of duty in the Uniformed Services (as defined in USERRA), may, at the Employee's election, continue coverage under the Plan during the period of absence, so long as the Employee satisfies the necessary provisions and makes any required Participant contribution as provided under USERRA.

2. The maximum period of coverage for an Employee, an Employee's Spouse and/or Dependent(s), if any, under the Plan during a period of duty in the Uniformed Services will be governed by the applicable limitation and provisions contained in USERRA unless more generous limitations are provided under the Employer's leave of absence policy.

3. An Employee who elects to continue coverage under the Plan will pay:

a) The Employee's share, if any, for coverage under the Plan if the Employee performs service in the Uniformed Services for up to thirty-one (31) days; or
b) One hundred-two percent (102%) of the full premium or cost under the Plan (determined in the same manner as the applicable COBRA continuation coverage premium under Section 4980B(f)(4) of the Code) if the employee performs service in the Uniformed Services for thirty-one (31) days or more.

4. During the period of service in the Uniformed Services, the Employee may pay the necessary costs associated with coverage under the Plan, if any, by:

a) Remitting payment to the Employer, due the first day of each month for which the Participant contributions would have been deducted from the Employee's paycheck had the Employee not been absent serving in the Uniformed Services, provided that any delinquent payments must be made within thirty (30) days after their due date;
b) At the Employee's request, prepaying the amounts that will become due during the period of service in the Uniformed Services out of one or more of the Employee's paychecks preceding such period of service in the Uniformed Services; or
c) Pre-approved arrangement with the Plan Administrator and in accordance with administrative policies adopted by the Plan Administrator wherein the Employer pays the Employee's Participant contributions during the Employee's period of service in the Uniformed Services. Upon return from such service, the Employee will reimburse the Employer for such previous payments.

Any Employee who is a Participant, who is not at work because of service in the Uniformed Services and who returns to active employment within the relevant time period determined under USERRA, will be eligible to return to work and immediately participate in the same benefit options and coverage level (i.e., same dependents if currently eligible) under the Plan which the Participant had elected to participate in prior to serving in the Uniformed Services, subject to any changes in the Plan that affect the workforce as a whole, provided that the Participant returns to employment with the same benefit eligibility status that he held prior to serving in the Uniformed Services, and provided further, that the Participant makes all required elections to participate in the Plan on a timely basis. Except to the extent provided in administrative policies adopted by the Plan Administrator (or the Employer, if applicable), the maximum period of health care coverage available to a Participant (and their Dependents) while on a USERRA leave of absence will end on the earlier of (i) the last day of the maximum coverage period prescribed under USERRA (or if required by USERRA's discrimination rules, the last day of the longest period that the Employer's leave of absence policy permits Plan coverage to continue) or (ii) the day after the date upon which the person fails to apply for a return to a position of employment within the time required under Section 4312(a) of USERRA. For purposes of determining eligibility for health benefits (and only if the Participant pays the full amount which the Employer is permitted to charge the Participant for health coverage under USERRA), a Participant who experiences a reduction in hours or termination of employment solely due to a USERRA leave will continue to be considered qualified as a Participant under the Plan until the earliest date that the termination of their health benefits is permitted under USERRA.

ARTICLE VI
COORDINATIONOF BENEFITS / SUBROGATION

A. COORDINATION OF BENEFITS

All of the Benefits provided under the Plan are subject to these provisions, with the exception of out-patient Prescription drugs. No coordination of benefits will be allowed for out-patient Prescription Drugs.

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 area determined before or after those of another Plan. The benefits of This Plan:

   1) Shall not be reduced when, under the order of benefit determination rule, This Plan determines its benefits before another plan; but
   2) May be reduced when under the order of benefit determination rules, another Plan determines its benefits first. The above reduction is described in Article V, #4, "Effect on Benefits" of This Plan.

2. Definitions

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

   1) 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.
   2) 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 periodically amended). 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.
   3) This Plan will assume that any person who 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 (1) or (2) is a separate Plan. Also, if an arrangement has two parts and COB rules apply only to the 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 necessary, reasonable and customary 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 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:

1. The other Plan has rules coordinating its benefits with those of this Plan; and
2. 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:

1. 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.
2. Dependent Child/Parents Not Separated or Divorced except as stated in section (3) 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.
3. 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.
   d) Active/Inactive Employee-The benefits of a Plan, which covers a person as an Employee who 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 "d)" is ignored.

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

4. Effect on Benefits

a) When This Section Applies - This Section 4 applies when, in accordance with Section 3, "Order of Benefit Determination Rules", 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:
   1. The benefits that would be payable for the Allowable Expenses under this Plan in the absence of this COB provision; and
   2. The benefits that would be payable for the Allowable Expenses under the other Plans, in absence of a provision with a purpose like that of this COB provision, whether or not claim is made;

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. The Contract Administrator needs to tell, or get the consent of, any person to do this. 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, which made that 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 Plan Administrator shall have the right to recover all such excess amounts from any persons, insurance companies, or other payees, and the Participant shall make a good-faith attempt to assist in such recovery. Further, the Plan Administrator shall have the right to recover any excess payments from any future benefits payable to the Employee or their Dependent(s).

The Plan Administrator may, in its' sole discretion, pay benefits for care or services pending a determination of whether or not such care or services are covered hereunder. Such payment will not affect or waive any exclusion, and to the extent such care or services have been provided, the Plan shall be entitled to recoup and recover the amount paid from the Covered Person or the provider of service in the event it is determined that such care or services are not covered hereunder. The Covered Person or his parent or guardian shall execute

and deliver to the Plan all assignments and other documents necessary or useful to the Plan Administrator for the purpose of enforcing its' rights under this provision.

If the amount of the payments made by the Contract Administrator is more than should have been paid under this COB provision, it may recover the excess from one or more of:

a) The person or persons it has paid or for whom it has paid;
b) Insurance companies; or
c) Other organizations.

The "amount of the payments made" includes the reasonable cash value of any benefit provided in the form of services.

B. SUBROGATION AND REIMBURSEMENT

The Plan reserves all its subrogation and reimbursement rights, at law and in equity, to the full extent not contrary to applicable law, as determined by the Plan Administrator. At its' discretion, the Plan Administrator may designate a third party provider or other person or entity to exercise the rights described in this section on behalf of the Plan. In addition, the Plan Administrator may, in its discretion and on a case-by-case basis, waive or limit any of the subrogation and reimbursement rights set forth in this section on behalf of the Plan to the extent deemed appropriate. Any such waiver or limitation in a particular case will not limit or diminish in any way the Plan's rights in any other instance or at any other time.

1. Benefits Subject to this Provision

This Section B will apply to all benefits provided under the Plan. For purposes of this section, terms are defined as follows:

a) "Recovery" means any and all monies and property paid by a Third Party to (i) the Participant, (ii) the Participant's attorney, assign, legal representative, or Beneficiary, (iii) a trust of which the Participant is a beneficiary, or (iv) any other person or entity on behalf of the Participant, by way of judgment, settlement, compromise or otherwise (no matter how those monies or property may be characterized, designated or allocated and irrespective of whether a finding of fault is made as to the Third Party) to compensate for any losses or damages caused by, resulting from, or in connection with, the injury or illness.
b) "Reimbursement" means repayment to the Plan for medical or other benefits that it has paid to or on behalf of the Participant toward care and treatment of the injury or illness and for the expenses incurred by the Plan in collecting this amount, including the Plan's equitable rights to recovery.
c) "Subrogation" means the Plan's right to pursue the Participant's claims against a Third Party for any or all medical or other benefits or charges paid by the Plan.
d) "Third Party" will include the party or parties who caused the injury or illness; the insurer, guarantor or other indemnifier or indemnitor of the party or parties who caused the injury or illness; a Participant's own insurer, such as an uninsured, underinsured, medical payments, no fault, homeowner's, renter's or any other liability insurer; a workers' compensation insurer; and any other individual or entity that is or may be liable or legally or equitably responsible for Reimbursement or payment in connection with the injury or illness.

2. When this Provision Applies

A Participant may incur medical or other charges related to any injury or illness caused by the act or omission of a Third Party. Consequently, such Third Party May be liable or legally or equitably responsible, for payment of charges incurred in connection with the injury or illness. If so, the Participant may have a

claim against that Third Party for payment of the medical or other charges. In that event, the Plan will be secondary payer, not primary, and the Plan will be Subrogated to all rights the Participant may have against that Third Party.

Furthermore, the Plan will have a right of first and primary Reimbursement enforceable by an equitable lien against any Recovery paid by the Third Party. The equitable lien will be equal to one hundred percent (100%) of the amount of benefits paid by the plan for the Participant's injury or illness and expenses incurred by the Plan in enforcing the provisions of this Section B (including, without limitation, attorneys' fees and costs of suit, and without regard to the outcome of such an action), regardless of whether or not the participant has been made whole by the Third Party. This equitable lien will attach to the Recovery regardless of whether (a) the Participant receives the Recovery or (b) the Participant's attorney, a trust of which the Participant is a beneficiary, or other person or entity receives the Recovery on behalf of the Participant.

As a condition to receiving benefits under the Plan, the Participant hereby agrees to immediately notify the Plan Administrator, in writing, of whatever benefits are payable under the Plan that arise out of any injury or illness that provides, or may provide, the Plan with Subrogation and/or Reimbursement rights under this Section B.

The Plan's equitable lien supersedes any right that the Participant may have to be "made whole." In other words, the Plan is entitled to the right of firsts Reimbursement out of any Recovery the Participant procures, or may be entitled to procure, regardless of whether the Participant has received compensation for any or all of his damages or expenses, including any of his attorneys' fees or costs. Additionally, the Plan's right of first and primary Reimbursement will not be reduced for any reason, including attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise. The Plan is not responsible for a Participant's legal fees and costs, is not required to share in any way for any payment of such fees and costs, and its equitable lien will not be reduced by any such fees and costs. As a condition to coverage and receiving benefits under the Plan, the Participant agrees that acceptance of benefits, as well as participation in the Plan, is constructive notice of the provisions of this Section B, and Participant hereby automatically grants an equitable lien to the Plan to be imposed upon and against all rights of Recovery with respect to Third Parties, as described above.

In addition to the foregoing, the Participant:

a) Authorizes the Plan to sue, compromise and settle in the Participant's name to the extent of the amount of medical or other benefits paid for the injury or illness under the Plan, and the expenses incurred by the Plan in collecting this amount, and assigns to the Plan the Participant's rights to Recovery when the provisions of this Section B, apply;
b) Must notify the Plan in writing of any proposed settlement and obtain the Plan's written consent before signing any release or agreeing to any settlement; and
c) Must cooperate fully with the Plan in its exercise of its rights under this Section B, do nothing that would interfere with or diminish those rights, and furnish any information as required by the Plan to exercise or enforce its rights hereunder.

Furthermore, the Plan Administrator reserves the absolute right and discretion to require a Participant who may have a claim against a Third Party for payment of medical or other charges that were paid, or are payable, by the Plan to execute an deliver a Subrogation and Reimbursement agreement acceptable to the Plan Administrator (including execution and delivery of a Subrogation and Reimbursement agreement by any parent or guardian on behalf of a covered Dependent, even if such Dependent is of majority age) and, subject to Section B, 5, that acknowledges and affirms: (i) the conditional nature of medical or other

benefits payments which are subject to Reimbursement and (ii) the Plan's right of full Subrogation and Reimbursement, as provided in this Section B ("S&R Agreement").

When a right of Recovery exists, and as a condition to any payment by the Plan (including payment of future benefits for the same or other illnesses or injuries), the Participant will execute an deliver all required instruments and papers, including any S&R Agreement provided by the Plan, as well as doing and providing whatever else is needed, to secure the Plan's rights of Subrogation and Reimbursement, before any medical or other benefits will be paid by the Plan for the injury or illness. The Plan may file a copy of an S&R Agreement signed by the Participant and his attorney (and if applicable, signed by the parent or guardian on behalf of the covered Dependent) with such other entities, or the Plan may notify any other parties of the existence of Plan's equitable lien; provided, the Plan's rights will not be diminished if it fails to do so.

To the extent the Plan requires execution of an S&R Agreement by a Participant (and his attorney, as applicable), a Participant's claim for any medical or other benefits for any injury or illness will be incomplete until an executed S&R Agreement is submitted to the Plan Administrator. Such S&R Agreement must be submitted to the Plan Administrator within the timeframe applicable to the particular type of benefits claimed by the Participant, as specified in the Plan's claims procedures. Any failure to timely submit the required S&R Agreement in accordance with the Plan's claims procedures will constitute the basis for denial off the Participant's claim for benefits for the injury or illness, and will be subject to the Plan's claims appeal procedures.

The Plan Administrator may determine, in its sole discretion, that it is in the Plan's best interests to pay medical or other benefits for the injury or illness before an S&R Agreement and other papers are signed and actions taken (for example, to obtain a prompt payment discount); however, in that event, any payment by the Plan of such benefits prior to or without obtaining a signed S&R Agreement or other papers will not operate as a waiver of any of the Plan's Subrogation and Reimbursement rights and the Plan still will be entitled to Subrogation and Reimbursement. In addition, the Participant will do nothing to prejudice the Plan's right to Subrogation and Reimbursement, and hereby acknowledges that participation in the Plan precludes operation of the "made whole" and "common fund" doctrines. A Participant who receives any Recovery as an absolute obligation to immediately tender the Recovery (to the extent of 100% of the amount of benefits paid by the Plan for the Participant's injury or illness and expenses incurred by the Plan in enforcing the provisions of this Section B, including attorneys' fees and costs of suit, regardless of an action's outcome) to the Plan under the terms of this Section B. A Participant who receives any such Recovery and does not immediately tender the Recovery to the plan will be deemed to hold such Recovery in constructive trust for the Plan because the Participant is not the rightful owner of such Recovery to the extent the Plan has not been fully reimbursed. By participating in the Plan, or receiving benefits under the Plan, the Participant automatically agrees, without further notice, to all the terms and conditions of this Section B, and any S&R Agreement.

The Plan Administrator has maximum discretion to interpret the terms of the Section B, and to make changes in its interpretation as it deems necessary or appropriate.

3. Amount Subject to Subrogation or Reimbursement

Any amounts Recovered will be subject to Subrogation or Reimbursement, even if the payment the Participant receives is for, or is descried as being for, damages other than medical expenses or other benefits paid, provided or covered by the Plan. This means that any Recovery will be automatically deemed to first cover the Reimbursement, and will not be allocated to or designated as reimbursement for any other costs or damages the Participant may have incurred, until the Plan is reimbursed in full and otherwise made whole. In no case will the amount subject to Subrogation or Reimbursement exceed the amount of medical or other benefits paid for the injury or illness under the Plan and the amount of medical or other benefits paid for the

injury or illness under the Plan and the expenses incurred by the Plan in collecting this amount. The Plan has a right to recover in full, without reduction for attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise, even if the Participant does not receive full compensation for all of his charges and expenses.

4. When Recovery Includes the Cost of Past or Future Expenses

In certain circumstances, a Participant may receive a Recovery that includes amounts intended to be compensation for past and/or future expenses for treatment of the illness or injury that is the subject of the Recovery. The Plan will not cover any expenses for which compensation was provided through a previous Recovery. This exclusion will apply to the full extent of such Recovery or the amount of the expenses submitted to the Plan for payment, whichever is less. Participation in the Plan also precludes operation of the "made whole" and "common fund" doctrines in applying the provisions of this Section B.

It is the responsibility of the Participant to inform the Plan Administrator when expenses incurred are related to an illness or injury for which a Recovery has been made. Acceptance of benefits under this Plan for which the Participant has already received a Recovery will be considered fraud, and the Participant will be subject to any sanctions determined by the Plan Administrator, in its discretion, to be appropriate. The Participant is required to submit full and complete documentation of any such Recovery in order for the Plan to consider eligible expenses that exceed the Recovery.

5. When a Participant Retains an Attorney

If the Participant retains an attorney, the Plan will not pay any portion of the Participant's attorneys' fees and costs associated with the Recovery, nor will it reduce its Reimbursement pro-rata for the payment of the Participant's attorneys' fees and costs. Attorneys' fees will be payable from the Recovery only after the Plan has received full Reimbursement.

The Plan Administrator reserves the absolute right and discretion to require the Participant's attorney to sign an S&R Agreement as a condition to any payment of benefits under the Plan and as a condition to any payment of future Plan benefits for the same or other illnesses or injuries. Additionally, pursuant to such S&R Agreement, the Participant's attorney must acknowledge and consent to the fact that the "made whole" and "common Fund" doctrines are inoperable under the Plan, and the attorney must agree not to assert either doctrine in his pursuit of Recovery.

Any Recovery paid to the Participant's attorney will be subject to the Plan's equitable lien, and thus an attorney who receives any Recovery has an absolute obligation to immediately tender the Recovery (to the extent of 100% of the amount paid by the Plan for the Participant's injury or illness and expenses incurred by the Plan in enforcing the provisions of this Section B, including attorneys' fees and costs of suit regardless of an action's outcome) to the Plan under the terms of this Section B. A Participant's attorney who receives any such Recovery and does not immediately tender the recovery to the Plan will be deemed to hold the Recovery in constructive trust for the Plan because neither the Participant nor his attorney is the rightful owner of the Recovery to the extent the Plan has not received full Reimbursement.

6. When a Participant Does Not Comply

When a Participant does not comply with the provisions of this Section B, the Plan Administrator will have the power and authority, in its sole discretion, to (i) deny payment of any claims for benefits by or on behalf of the Participant and (ii) deny or reduce future benefits payable (including payment of future benefits for the same or other injuries or illnesses) under the Plan by the amount due as Reimbursement to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for the same or other injuries or illnesses) under any other group benefits plan maintained by the Plan

Sponsor. The reductions will equal the amount of the required Reimbursement. If the Plan must bring an action against a Participant to enforce the provisions of this Section B, the Participant will be obligated to pay the Plan's attorneys' fees and costs regardless of the action's outcome.

ARTICLE VII
CLAIMS PROCEDURES

A. HOW TO FILE A CLAIM

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

1. Send in expense or expenses as soon as possible. We do recommend holding small expenses until a minimum of $50.00 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) The cost of service; and
   d) The name of the person who 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
   P. O. Box 9201
   Austin, TX 78766

   Additional Contact Information: 1-800-252-9653; www.boonchapman.com

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

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

B. PAYMENT OF BENEFITS

All benefits for 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.

C. 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.

D. 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.

E. 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.

F. TIME OF PAYMENT OF CLAIM

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

G. PRESENTING CLAIMS FOR BENEFITS

If Participant thinks they are eligible for a benefit described in this Plan, Participant must file a claim. Forms required for filing proof of loss for claims are available at Risk Management or can be found at County Wide Website Risk Management link http://cww.co.fortbend.tx.us/departments/risk_management/RM_forms.htm. Complete forms must be filed with the Contract Claims Administrator at least annually.

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 the claim after it is received. In some cases, however, more time may be needed. If this happens, Participant will be notified that an additional processing period is required.

H. REQUESTING A REVIEW OF CLAIMS DENIED

If Participant's claim is denied, Participant will be notified in writing. This written notice will tell the Participant 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 the Participant how they can have the decision reviewed.

If Participant has not received a response from the Contract Claims Administrator regarding the claim within ninety (90) days of filing the claim or if the claim has been denied, Participant can send a written appeal to the Contract Claims Administrator for a review of the denied claim(s) which under other circumstances could be covered under the Plan. Participant has sixty-one (61) days from the end of the processing period, if Participant has not received a response by that time.

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

I. 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 three (3) years from the expiration of the time within which proof of loss is required by the Plan.

J. THIRD PARTY LIABILITY

If a Participant has medical charges:

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

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

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

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

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

ARTICLE VIII
GENERAL PROVISIONS

A. INTERPRETATION OF THE PLAN

In the event any benefit summary contained herein differs from the official text of the Plan, the official text shall prevail. Some differences from the official text may occur due to the need to restate the Plan briefly in the summaries, compared to a lengthier and detailed official text, and due to normal time lapse between amendment of the Plan and updating of the appropriate summary. The Plan Administrator has the responsibility for interpretation of the Plan and the interpretation shall be final.

B. AMENDMENT AND TERMINATION OF THE PLAN

The Commissioners Court shall each have the right, authority and power to make, at any time, and from time to time, any amendment to the Plan; provided, however, no amendment shall prejudice any claim under the Plan that was incurred but not paid prior to the amendment date, unless the person or entity as responsible above for the amendment, as applicable, determines such amendment is necessary to comply with applicable law.

The Commissioners Court shall have the right, authority and power to terminate the Plan at any time, in whole or in part, without prior notice, to the extent deemed advisable in its discretion; provided, however, such termination shall not prejudice any claim under the Plan that was incurred but not paid prior to the termination date unless the Commissioners Court determines it is necessary to comply with applicable law.

C. CHOICE OF PHYSICIANS

An Employee or covered Dependent will have the choice of any Dentist licensed to practice in the United States. The Dentist-patient relationship will not be disturbed in any way.

D. 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.

E. ASSIGNMENT OF BENEFITS

Benefits for dental expenses covered under the Plan may be assigned by a 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 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.

Fort Bend County - Cafeteria Plan Participant Count by Category

2014	January	February	March	April	May	June	July	August	September	October	November	December
Pre-Tax Premiums	1487	1516	1608	1640	1676	1699	1717	1753	1774	1803	1833	1855
Dependent Day Care Reimbursement	19	20	20	20	22	23	22	21	21	20	20	20
Medical Reimbursement	327	334	330	330	335	337	334	332	332	330	328	326

2015	January	February	March	April	May	June	July	August	September	October	November	December
Pre-Tax Premiums	1747	1765	1853	1886	1909	1929	1963	1979	2009	2045	2067	2082
Dependent Day Care Reimbursement	24	25	25	26	25	25	24	22	22	22	22	22
Medical Reimbursement	344	348	343	346	344	346	342	335	333	334	331	334

COUNTY PURCHASING AGENT
Fort Bend County, Texas

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

(281) 341-8640
Fax (281) 341-8642 or 341-8645

Vendor Information

Federal ID # or S.S #		Dun and Bradstreet #
Type of Business	___ Corporation/LLC ___ Sole Proprietor/Individual ___ Partnership ___ Tax Exempt Organization	
Legal Company Name	Year Business was Established _____	
Remittance Address		
City/State/Zip		
Physical Address		
City/State/Zip		
County	___ Fort Bend County Other:	
Phone/Fax Number	Phone: Fax:	
Contact Person		
E-mail		
Special Notes		
The Company listed above is a (check all that apply and attached certificate).	___ DBE-Disadvantaged Business Enterprise **Certification #** _____ ___ SBE-Small Business Enterprise **Certification #** _____ ___ HUB-Texas Historically Underutilized Business **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	
NAICs codes (Please enter all that apply).		

PLEASE NOTE: W-9 needs to be attached in order to be entered into our system

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.

Job No.: **RFQ** _____

TAX FORM/DEBT/ RESIDENCE CERTIFICATION
(for Advertised Projects)

Taxpayer Identification Number (T.I.N.): _____

Company Name submitting Bid/Proposal: _____

Mailing Address: _____

Are you registered to do business in the State of Texas? Yes No

If you are an individual, list the names and addresses of any partnership of which you are a general partner or any assumed name(s) under which you operate your business

_____

_____

I. **Property:** List all taxable property in Fort Bend County owned by you or above partnerships as well as any d/b/a names. Include real and personal property as well as mineral interest accounts. (Use a second sheet of paper if necessary.)

Fort Bend County Tax Acct. No.*	Property address or location**
_____	_____
_____	_____
_____	_____
_____	_____

** This is the property account identification number assigned by the Fort Bend County Appraisal District.*

*** For real property, specify the property address or legal description. For business personal property, specify the address where the property is located. For example, office equipment will normally be at your office, but inventory may be stored at a warehouse or other location.*

II. **Fort Bend County Debt** - Do you owe any debts to Fort Bend County (taxes on properties listed in I above, tickets, fines, tolls, court judgments, etc.)?

Yes No If yes, attach a separate page explaining the debt.

III. **Residence Certification** - Pursuant to Texas Government Code §2252.001 *et seq.*, as amended, Fort Bend County requests Residence Certification. §2252.001 *et seq.* of the Government Code provides some restrictions on the awarding of governmental contracts; pertinent provisions of §2252.001 are stated below:

(3) "Nonresident bidder" refers to a person who is not a resident.

(4) "Resident bidder" refers to a person whose principal place of business is in this state, including a contractor whose ultimate parent company or majority owner has its principal place of business in this state.

I certify that _____ is a Resident Bidder of Texas as defined in Government Code
[Company Name]
§2252.001.

I certify that _____ is a Nonresident Bidder as defined in Government Code
[Company Name]
§2252.001 and our principal place of business is _____.
[City and State]

Exhibit B:
Services

EXHIBIT B: SERVICES

SECTION 1 — ADMINISTRATIVE SERVICES MEDICAL AND DENTAL PLAN

Boon Chapman shall provide County with the following services as required for the administration and operation for each of the benefit plans identified in RFP 16-086.

A. ACCOUNT SERVICES

1. DEVELOPMENT, COMMUNICATION, AND INSTALLATION FOR EACH OF THE BENEFIT PLANS IDENTIFIED IN RFP 16-086

a. Recommendations as to initial development and design of each Plan and Plan Document and future revisions thereof; as requested by County.
b. Cost projections of benefits and administration; as requested by County.
c. Assistance in preparation of employee communications material and benefit booklets; as requested by County.
d. Communication and enrollment of employees and dependents through meetings provided and arranged by County; as requested by County.
e. Development and design of forms and procedures for processing requests for benefits payment; as requested by County.
f. Boon Chapman will submit any advertising relating to the Plan to County for approval prior to its use.

2. REPORTS AND RECORDS: PREPARATION OF SUCH ACCOUNTING REPORTS AS ARE NEEDED IN THE FINANCIAL MANAGEMENT AND ADMINISTRATIVE CONTROL OF THE PLAN, SUCH AS INCLUDING BUT NOT LIMITED TO: PROJECTIONS OF INITIAL AND RENEWAL UNIT COST AND TOTAL COST AND LISTINGS OF BENEFITS PAID.

B. BOON CHAPMAN MAY PROVIDE COUNTY WITH THE OTHER SPECIAL SERVICES TO WHICH THE PARTIES MUTUALLY AGREE AS DOCUMENTED IN A WRITTEN AMENDMENT TO THE AGREEMENT.

C. MEDICAL AND DENTAL PLAN CLAIMS ADMINISTRATION

(See Exhibit C for pricing)

1. Boon Chapman shall, in accordance with the terms of County's Plan Document(s):
   a. Process medical and dental benefits with respect to Covered Persons and determine the amount due and payable;
   b. Process any written requests, issues or comments received from Covered Persons on appeals of denied benefits and forward the information to County for review and decision;
   c. Upon receipt of County's decision of benefit appeals, calculate any amount due and payable and make payment, or issue a denial notice, all in accordance with written instructions of County;
   d. Issue checks in payment of benefits to Covered Persons or to such other person or assignee entitled thereto;
   e. Maintain records and files of benefit payments for each Covered Person;

f. Submit reports of benefit payments as agreed upon with County at mutually agreeable times.

2. When so directed by County, Boon Chapman shall suspend payment of benefits until resumption is authorized by County.
3. Any protest of a benefit payment that the County would reasonably expect to be notified of shall be brought to the immediate attention of County.
4. Boon-Chapman shall not be liable for or be required to use its funds for the payment of claims under the Plan. Boon-Chapman shall not be considered the insurer or underwriter of the liability of the County to provide benefits for the Plan's Covered Persons, and the County shall have the final responsibility and liability for payment of claims in accordance with the provisions of the Plan. Boon Chapman shall review claim denials as outlined in County's Plan document. The County shall be responsible for all expenses of the operation of the Plan, except as provided under this Agreement.
5. If a payment is made to or on behalf of an ineligible person or if an overpayment is made to a covered person, Boon-Chapman shall attempt, with full cooperation and assistance of the County, to recover such payment through reimbursement or from future benefits that become due to such person or entity, but shall not be responsible for such payment or overpayment unless it was due to gross negligence of the Boon-Chapman.

D. MEDICAL PLAN UTILIZATION MANAGEMENT/ PRE-AUTHORIZATION
See Exhibit C for pricing)

1. Pre-Authorization/Inpatient Utilization Management
   a. Inpatient Hospital Pre-Authorization, including mental nervous and/or chemical dependency. When Boon-Chapman receives notification of an acute care hospital admission before the admission, Boon-Chapman will attempt to communicate with the appropriate health care providers to determine the diagnosis, proposed treatment and requested length of stay. Using clinical knowledge and clinical criteria Boon-Chapman will review whether the proposed admission and length of stay is medically necessary and advise the covered person or the health care provider of its decision.
   b. Concurrent Review, including mental nervous and/or chemical dependency. Boon-Chapman will review requests for approval of additional days for on-going hospital admissions and approve such days when appropriate.
   c. Lower Level Care Admission: Boon-Chapman will review admission to skilled nursing facility, rehabilitation facility, long term acute care facility to determine whether they are medically necessary and advise the covered person or the health care provider of its decision.
   d. Retrospective Review: If Boon-Chapman receives notification of an acute care hospital admission, emergency admission or lower level care admission including mental nervous and/or chemical dependency after the initial admission, Boon Chapman will attempt to communicate with the appropriate health care providers to determine the diagnosis, proposed treatment and requested length of stay. Using clinical knowledge and clinical criteria Boon-Chapman will review whether the admission and length of stay is medically

necessary and advise the covered person or the health care provider of its decision.

e. Coordination with Fort Bend County Employee Benefit Plan and Employee Assistance Program ("EAP"): Boon Chapman will work with patient, provider, and EAP to facilitate a smooth transfer to a network provider after EAP visits are exhausted and benefits are to be rendered under the medical plan.

2. Outpatient Utilization Management: Boon Chapman will review mutually agreed upon outpatient surgeries and services, diagnostic tests, mental nervous and/or chemical dependency services that are outlined in the plan document.
3. Prime DX: Boon Chapman will perform its utilization duties under the Agreement Sections D2 and D3 by and through PrimeDx, a Utilization Management company, wholly owned by Boon-Chapman. However, Boon Chapman will remain responsible for the execution of those duties according to the terms of this Agreement. PrimeDx's hours of operation will be no less than Monday through Thursday, 8am to 6pm Central time Friday, 8am to 5pm Central time.
4. Case Management: Case management services including mental nervous and/or chemical dependency are available to those members with catastrophic illnesses, chronic diseases, acute episodes of illness, traumatic injuries or individuals requiring multiple healthcare services. It also includes a covered person becoming a candidate for an organ transplant or becoming pregnant under high-risk circumstances. If Boon Chapman determines, that an alternative plan of treatment or a fee negotiation for services will likely result in cost savings to County, it will encourage the physician or covered person to use the alternative treatment plan or the services available at a discounted fee. If the physician or covered person chooses not to do so, Boon Chapman's responsibilities with respect to alternative plan of treatment will be complete. County will reimburse Boon Chapman for the cost of any outside medical review.

E. MEDICAL PLAN/MEDICARE REPRICING SERVICES
(See Exhibit C for pricing)

1. Boon Chapman will limit the allowable charges for non-network hospital and facility charges, as directed by County's Director of Risk Management, which will be an agreed percentage of what Medicare would allow, for a fee of 10% of savings. The savings will be calculated as the difference between the Medicare allowable and what the Fort Bend County Employee Benefit Plan's liability would have been if the Fort Bend County Employee Benefit Plan had paid at the non-network coinsurance benefit level, based on billed charges If the Fort Bend County Employee Benefit Plan, in its discretion, agrees to allow a higher payment amount after the provider has been paid the Medicare allowable rate, Boon Chapman will refund County its fee, prorated to the extent of the adjustment.
2. Boon Chapman will reprice dialysis claims to a percentage of Medicare as directed by County's Director of Risk Management,

F. MEDICAL AND DENTAL PLAN RETIREE PREMIUM COLLECTION SERVICES
(See Exhibit C for pricing)

Boon Chapman will bill and collect monthly premiums from Fort Bend County Retirees on any benefit plan offered or sponsored by Fort Bend County.

G. MEDICAL AND DENTAL PLAN COBRA ADMINISTRATIVE SERVICES:
(See Exhibit C for pricing)

1. Boon Chapman shall provide County with the following services as required for the administration of the continuation of coverage provisions of COBRA for certain employees and their dependents:
    a. Provide the following forms, which are necessary to administer continuation of coverage:
        i. Notice of right to continue coverage;
        ii. Continuation enrollment form;
        iii. Payment Coupons; and
        iv. Termination notices
    b. Provide direct contact with the continuing individuals on behalf of County.
    c. Make available to County actuarial services to determine a reasonable rate amount. County shall reimburse Contract Claims Administrator for reasonable actuarial services that County authorizes.
    d. Send notification of continuation to qualified individuals to the last known address, within ten working days of receiving notice of qualifying event.
    e. Collect premiums from continuing individuals. Contract Claims Administrator will have no responsibility to remit any premiums not collected from any continuing individual.
    f. Remit premiums collected to the Plan.
    g. Notify County when a participant's COBRA coverage ends.
    h. Provide County with a monthly list of COBRA participants.
    i. Provide County with information about changes in COBRA that affect the services being performed under this agreement.
2. It is mutually understood that it is the responsibility of County to notify Boon Chapman in a form provided by County within three working days after County is aware of a COBRA qualifying event.

H. MEDICAL PLAN OUT-PATIENT PRESCRIPTION DRUG CARD ADMINISTRATION
(See Exhibit C for pricing)

Boon-Chapman will transmit eligibility to the appropriate prescription benefit management company, include prescription information on the employee ID card, and respond to benefit inquiries.

I. MEDICAL PLAN DIALYSIS REPRICING
(See Exhibit C for pricing)

Boon Chapman will reprice dialysis claims to a percentage of Medicare as directed by County's Director of Risk Management.

J. MEDICAL PLAN DISEASE MANAGEMENT SERVICES
(See Exhibit C for pricing)

Boon Chapman, working through PrimeDx, will evaluate medical and pharmacy claims to identify Plan participants that have selected chronic conditions that warrant disease management. The nursing staff will provide disease specific education and facilitate coordination of care with the objective of improving Plan participant health and reducing Plan costs. Boon Chapman/PrimeDx staff may provide on-site disease management activities as needed. If Boon Chapman is unable to contact a Plan Participant, County will assist Boon Chapman upon request.

K. MEDICAL PLAN PROVIDER NEGOTIATIONS NON P.P.O
(See Exhibit C for pricing)

At the direction of the County, Boon Chapman will attempt to obtain discounts from out-of-network providers in order to decrease both Plan costs and balance billing to the member. Negotiated claims will be processed at the out of network coinsurance level, and all negotiations will be signed off on by the provider. Savings will be measured as follows: The actual monetary difference between what the FBC medical plan would have paid, according to the most current plan document versus the negotiated discount obtained by Boon Chapmans Cost Containment Unit. The percentage of savings payment to Boon Chapman will be as stated on Exhibit C

L. MEDICAL PLAN TRANSPARENCY TOOL
(See Exhibit C for pricing)

Offer the services of Healthcare Bluebook, or other similar vendors. Using this service, participants search procedures to find out how much cost should be in a service area and use Fair Price information to compare procedure costs which should assist in reducing out-of-pocket costs every time when receiving medical care. Services also include viewing of quality metrics, allowing the participants to get the highest quality care at the lowest price.

M. MEDICAL PLAN HIGH TOUCH CUSTOMER SERVICE
(See Exhibit C for pricing)

Boon Chapman will provide a Member Champion to provide patient advocacy services which will assist members and their dependents with navigating the complicated field of medical and dental insurance. Specific tasks include, but are not limited to: working directly with members and their dependents to help them understand medical terminology and medical bills, researching network providers, researching possible solutions for patients, discussing explanation of benefits and contacting medical or dental providers on behalf of a patient to gather information and negotiate payment plans, bill reductions, etc. The Member Champion would also proactively contact members when we need additional

information and before certain claim denials and perform other tasks as directed to provide superior customer service.

N. EXCEPT AS OTHERWISE STATED IN THIS SECTION (SECTION N), THE FOLLOWING SERVICES WILL BE OFFERED AT NO ADDITIONAL FEE OR CHARGE BY BOON CHAPMAN. IF A PRODUCT OR SERVICE IS OFFERED BY A VENDOR OTHER THAN BOON CHAPMAN FOR ANY OF THE AREAS BELOW, THOSE VENDORS RATES OR FEES MUST BE APPROVED BY SIGNED CONTRACT AMENDMENT PRIOR TO ANY IMPLEMENTATION.

1. **Medical and Dental Plan Subrogation Services**
   Identify claims with potential third party liability and work with plan participant and legal counsel, if applicable, to attempt recovery of claims.

2. **Medical Plan Reinsurance/Stop-Loss**
   Assist in marketing, analysis and placement of reinsurance.

3. **Medical and Dental Plan P.P.O/E.P.O./H.M.O Networks**
   Assist in marketing, analysis, placement and administration of networks

4. **Prescription Benefit Management Selection Services**
   Assist in marketing, analysis and placement of program, which may include a fee that must be approved in advance, and in writing, by the County Director of Risk Management

5. **Medical Plan Medical Tourism**
   i. *Domestic* –Assist participants in obtaining applicable outpatient surgical care at Surgery Center of Oklahoma or other facilities that use "transparent pricing". We will work with the County to implement and communicate Plan language to incent participants to use this facility. Provide Medical Plan language. Applicable Plan benefits apply to services rendered.
   ii. *International* –Assist participants in obtaining applicable care Health City Cayman Islands or other like facilities. We will work with the County to implement and communicate Plan language to incent participants to use this facility. Provide Plan language. Applicable Plan benefits apply to services rendered.

6. **Medical Plan Hospital Bill Audit**
   Assist in the evaluation, procurement, contracting, and implementation of the services of a hospital bill audit company to scrub bills to find billing code errors, gross overcharges, and other types of common billing errors for an additional fee. If the county decides to engage an outside auditor Boon-Chapman will reasonably cooperate with an outside auditor but may charge an additional fee. Any such fees described in this Section must be approved in advance, and in writing, by the County Director of Risk Management.

7. **Employee Assistance Programs**
   Assist in the evaluation, procurement, contracting, and implementation of Employee Assistance Programs.

8. **Ancillary Products**
   Assist in the evaluation, procurement, contracting, and implementation of insured ancillary products, including but not limited to, short term disability, long term disability, life, accidental death and dismemberment, insured vision programs and long term care coverage. Additional information is required for a charge/fee quote. If the County chooses to self-fund the vision benefit, we can assist with plan design and contribution recommendations

9. **Debit card for Cafeteria Plan/Section 125 Plan**
   The Benny Prepaid Benefits Card is a special-purpose MasterCard® Card or Visa® Card that gives participants an easy, automatic way to pay for eligible health care or benefit expenses. The Card lets participants electronically access the pre-tax amounts set aside in their respective employee benefits accounts such as Flexible Spending Accounts (FSAs), Health Reimbursement Accounts (HRAs), and Health Savings Accounts (HSAs). There is a $5 additional fee for replacement card charged to cardholder, which may be adjusted upon notice.

10. **Patient-Centered Outcomes Research Institute Fee**
    Provide necessary census reporting to the County so that County can complete the required Internal Revenue Service form.

11. **Medical Plan Medicare Part D reporting**
    Creditable coverage disclosure to Centers for Medicare and Medicaid "CMS" Assist in the online annual reporting to CMS.

12. **Medical Plan Section 6055/6056 reporting**
    Assist in the evaluation, procurement, contracting, and implementation of a vendor to track and/or provide appropriate tax forms.

13. **Benefit administration outsourcing (if requested by County)**
    Offer combined billing and online enrollment services. Additional information will be needed to determine the fee at the time of a request for this service.

14. **Medicare Part D retiree drug subsidy recovery assistance (if requested by County)**
    Assist in subsidy recoupment. The fee for this service is $2.00 per retiree per month, plus the cost of the actuarial attestation.

SECTION 3 — ADMINISTRATIVE SERVICES CAFETERIA PLAN/ IRS SECTION 125

See Exhibit C for pricing

A. BOON CHAPMAN SHALL PROVIDE COUNTY WITH THE FOLLOWING ADMINISTRATIVE SERVICES FOR OPERATION OF THE PLAN:

1. Receipt of contributions for employees from County and their deposit in a special bank account;
2. Posting of contributions to each employee's account by benefit;
3. Issuing of payments from employee's benefit account for designated benefits or reimbursement to employees for eligible expenses, to the extent that funds are available;
4. Posting of disbursements to employee's benefit account;
5. Providing County and each employee with a record of contributions, disbursements, and account balances on a quarterly basis; and
6. Providing County with a record of bank account transactions monthly.

B. BOON CHPAMAN SHALL KEEP ALL RECORDS FILES, RECORDS, AND REPORTS PREPARED AND MAINTAINED BY BOON CHAPMAN FOR THE PROVISION OF THE ADMINISTRATIVE SERVICES CAFETERIA PLAN/ IRS SECTION 125 SHALL BE KEPT IN STRICT ACCORDANCE WITH AGREEMENT FOR THIRD PARTY CLAIMS ADMINISTRATION SERVICES PURSUANT TO RFP 16-086 AND AS REQUIRED BY THE INTERNAL REVENUE SERVICE.

EXHIBIT B: SCOPE OF WORK

SECTION 1 — ADMINISTRATIVE SERVICES MEDICAL AND DENTAL PLAN

Boon Chapman shall provide County with the following services as required for the administration and operation for each of the benefit plans identified in RFP 16-086.

A. ACCOUNT SERVICES

1. **DEVELOPMENT, COMMUNICATION, AND INSTALLATION FOR EACH OF THE BENEFIT PLANS IDENTIFIED IN RFP 16-086**

    a. Recommendations as to initial development and design of each Plan and Plan Document and future revisions thereof; as requested by County.
    b. Cost projections of benefits and administration; as requested by County.
    c. Assistance in preparation of employee communications material and benefit booklets; as requested by County.
    d. Communication and enrollment of employees and dependents through meetings provided and arranged by County; as requested by County.
    e. Development and design of forms and procedures for processing requests for benefits payment; as requested by County.
    f. Boon Chapman will submit any advertising relating to the Plan to County for approval prior to its use.

2. **REPORTS AND RECORDS: PREPARATION OF SUCH ACCOUNTING REPORTS AS ARE NEEDED IN THE FINANCIAL MANAGEMENT AND ADMINISTRATIVE CONTROL OF THE PLAN, SUCH AS INCLUDING BUT NOT LIMITED TO: PROJECTIONS OF INITIAL AND RENEWAL UNIT COST AND TOTAL COST AND LISTINGS OF BENEFITS PAID.**

B. BOON CHAPMAN MAY PROVIDE COUNTY WITH THE OTHER SPECIAL SERVICES TO WHICH THE PARTIES MUTUALLY AGREE AS DOCUMENTED IN A WRITTEN AMENDMENT TO THE AGREEMENT.

C. MEDICAL AND DENTAL PLAN CLAIMS ADMINISTRATION
(See Exhibit C for pricing)

1. Boon Chapman shall, in accordance with the terms of County's Plan Document(s):
    a. Process medical and dental benefits with respect to Covered Persons and determine the amount due and payable;
    b. Process any written requests, issues or comments received from Covered Persons on appeals of denied benefits and forward the information to County for review and decision;
    c. Upon receipt of County's decision of benefit appeals, calculate any amount due and payable and make payment, or issue a denial notice, all in accordance with written instructions of County;
    d. Issue checks in payment of benefits to Covered Persons or to such other person or assignee entitled thereto;
    e. Maintain records and files of benefit payments for each Covered Person;

f. Submit reports of benefit payments as agreed upon with County at mutually agreeable times.

2. When so directed by County, Boon Chapman shall suspend payment of benefits until resumption is authorized by County.
3. Any protest of a benefit payment shall be brought to the immediate attention of County.
4. If Boon Chapman issues payment to, or on behalf of, a party and the payment is not in accordance the requirements of the Plans (which shall referred to as "Excess Payments," Boon Chapman shall attempt to recover such Excess Payment through reimbursement or from future benefits that become due to the party receiving the payment or benefit.
   a. Boon Chapman shall conduct initial collection activities including notification of Excess Payments made. If, after sixty (60) days from date of initial collection notification, reimbursement has not occurred, Boon Chapman shall notify County's Risk Management Director and turn the matter over to County for resolution.
   b. Boon Chapman shall, for any payment caused to be made as a result of Boon Chapman error and, upon nonpayment of Excess Payments exceeding one hundred twenty (120) days, either a) forward payment to County from Boon Chapman funds; or b) file to secure recovery under Boon Chapman's professional insurance policies with such recovery payable to County. Credits to County for Excess payments will not be allowed.
   c. County shall cooperate with and reasonably assist Boon Chapman's efforts to recover any Excess Payment from any person (including but not limited to current or former employees of County) who benefited from such Excess Payment, to the fullest extent allowed by law.

D. MEDICAL PLAN UTILIZATION MANAGEMENT/ PRE-AUTHORIZATION
See Exhibit C for pricing)

1. Pre-Authorization/Inpatient Utilization Management
   a. Inpatient Hospital Pre-Authorization, including mental nervous and/or chemical dependency. When Boon-Chapman receives notification of an acute care hospital admission before the admission, Boon-Chapman will attempt to communicate with the appropriate health care providers to determine the diagnosis, proposed treatment and requested length of stay. Using clinical knowledge and clinical criteria Boon-Chapman will review whether the proposed admission and length of stay is medically necessary and advise the covered person or the health care provider of its decision.
   b. Concurrent Review, including mental nervous and/or chemical dependency. Boon-Chapman will review requests for approval of additional days for on-going hospital admissions and approve such days when appropriate.
   c. Lower Level Care Admission: Boon-Chapman will review admission to skilled nursing facility, rehabilitation facility, long term acute care facility to determine whether they are medically necessary and advise the covered person or the health care provider of its decision.

d. Retrospective Review: If Boon-Chapman receives notification of an acute care hospital admission, emergency admission or lower level care admission including mental nervous and/or chemical dependency after the initial admission, Boon Chapman will attempt to communicate with the appropriate health care providers to determine the diagnosis, proposed treatment and requested length of stay. Using clinical knowledge and clinical criteria Boon-Chapman will review whether the admission and length of stay is medically necessary and advise the covered person or the health care provider of its decision.

e. Coordination with Fort Bend County Employee Benefit Plan and Employee Assistance Program ("EAP"): Boon Chapman will work with patient, provider, and EAP to facilitate a smooth transfer to a network provider after EAP visits are exhausted and benefits are to be rendered under the medical plan.

2. Outpatient Utilization Management: Boon Chapman will review mutually agreed upon outpatient surgeries and services, diagnostic tests, mental nervous and/or chemical dependency services that are outlined in the plan document.
3. Prime DX: Boon Chapman will perform its utilization duties under the Agreement Sections D2 and D3 by and through PrimeDx, a Utilization Management company, wholly owned by Boon-Chapman. However, Boon Chapman will remain responsible for the execution of those duties according to the terms of this Agreement. PrimeDx's hours of operation will be Monday through Friday, 8am to 7pm Central time.
4. Case Management: Case management services including mental nervous and/or chemical dependency are available to those members with catastrophic illnesses, chronic diseases, acute episodes of illness, traumatic injuries or individuals requiring multiple healthcare services. It also includes a covered person becoming a candidate for an organ transplant or becoming pregnant under high-risk circumstances. If Boon Chapman determines, that an alternative plan of treatment or a fee negotiation for services will likely result in cost savings to County, it will encourage the physician or covered person to use the alternative treatment plan or the services available at a discounted fee. If the physician or covered person chooses not to do so, Boon Chapman's responsibilities with respect to alternative plan of treatment will be complete. County will reimburse Boon Chapman for the cost of any outside medical review.

E. MEDICAL PLAN/MEDICARE REPRICING SERVICES
(See Exhibit C for pricing)

1. Boon Chapman will limit the allowable charges for non-network hospital and facility charges to an agreed percentage [recommendation 200 %] of what Medicare would allow for a fee of 10% of savings. The savings will be calculated as the difference between the Medicare allowable and what the Fort Bend County Employee Benefit Plan's liability would have been if the Fort Bend County Employee Benefit Plan had paid at the non-network coinsurance benefit level, based on billed charges If the Fort Bend County Employee Benefit Plan, in its discretion, agrees to allow a higher payment amount after the provider has been paid the Medicare allowable rate, Boon Chapman will refund County its fee, prorated to the extent of the adjustment.

2. Boon Chapman will reprice dialysis claims to a percentage of Medicare [recommendation 125%] (when the Fort Bend County plan is primary).

F. MEDICAL AND DENTAL PLAN RETIREE PREMIUM COLLECTION SERVICES
(See Exhibit C for pricing)

Boon Chapman will bill and collect monthly premiums from Fort Bend County Retirees on any benefit plan offered or sponsored by Fort Bend County.

G. MEDICAL AND DENTAL PLAN COBRA ADMINISTRATIVE SERVICES:
(See Exhibit C for pricing)

1. Boon Chapman shall provide County with the following services as required for the administration of the continuation of coverage provisions of COBRA for certain employees and their dependents:
    a. Provide the following forms, which are necessary to administer continuation of coverage:
        i. Notice of right to continue coverage;
        ii. Continuation enrollment form;
        iii. Payment Coupons; and
        iv. Termination notices
    b. Provide direct contact with the continuing individuals on behalf of County.
    c. Make available to County actuarial services to determine a reasonable rate amount. County shall reimburse Contract Claims Administrator for reasonable actuarial services that County authorizes.
    d. Send notification of continuation to qualified individuals to the last known address, within ten working days of receiving notice of qualifying event.
    e. Collect premiums from continuing individuals. Contract Claims Administrator will have no responsibility to remit any premiums not collected from any continuing individual.
    f. Remit premiums collected to the Plan.
    g. Notify County when a participant's COBRA coverage ends.
    h. Provide County with a monthly list of COBRA participants.
    i. Provide County with information about changes in COBRA that affect the services being performed under this agreement.
2. It is mutually understood that it is the responsibility of County to notify Boon Chapman in a form provided by County within three working days after County is aware of a COBRA qualifying event.

H. MEDICAL PLAN OUT-PATIENT PRESCRIPTION DRUG CARD ADMINISTRATION
(See Exhibit C for pricing)

Boon-Chapman will transmit eligibility to the appropriate prescription benefit management company, include prescription information on the employee ID card, and respond to benefit inquiries.

I. MEDICAL PLAN DIALYSIS REPRICING
(See Exhibit C for pricing)

Boon Chapman will reprice dialysis claims to a percentage [recommendation 125%] of Medicare when the Fort Bend County plan is primary payor.

J. MEDICAL PLAN DISEASE MANAGEMENT SERVICES
(See Exhibit C for pricing)

Boon Chapman, working through PrimeDx, will evaluate medical and pharmacy claims to identify Plan participants that have selected chronic conditions that warrant disease management. The nursing staff will provide disease specific education and facilitate coordination of care with the objective of improving Plan participant health and reducing Plan costs. Boon Chapman/PrimeDx staff may provide on-site disease management activities as needed. If Boon Chapman is unable to contact a Plan Participant, County will assist Boon Chapman upon request.

K. MEDICAL PLAN PROVIDER NEGOTIATIONS NON P.P.O
(See Exhibit C for pricing)

At the direction of the County, Boon Chapman will attempt to obtain discounts from out-of-network providers in order to decrease both Plan costs and balance billing to the member. Negotiated claims will be processed at the out of network coinsurance level, and all negotiations will be signed off on by the provider. Savings will be measured as follows: The actual monetary difference between what the FBC medical plan would have paid, according to the most current plan document versus the negotiated discount obtained by Boon Chapmans Cost Containment Unit. The percentage of savings payment to Boon Chapman will be as stated on Exhibit C

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Offer the services of Healthcare Bluebook, or other similar vendors. Using this service, participants search procedures to find out how much cost should be in a service area and use Fair Price information to compare procedure costs which should assist in reducing out-of-pocket costs every time when receiving medical care. Services also include viewing of quality metrics, allowing the participants to get the highest quality care at the lowest price.

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Boon Chapman will provide a Member Champion to provide patient advocacy services which will assist members and their dependents with navigating the complicated field of medical and dental insurance. Specific tasks include, but are not limited to: working directly with members and their dependents to help them understand medical terminology and medical bills, researching network providers, researching possible solutions for patients, discussing explanation of benefits and contacting medical or dental providers on behalf of a patient to gather information and negotiate payment plans, bill reductions, etc. The Member Champion would also proactively contact members when we need additional information and before certain claim denials and perform other tasks as directed to provide superior customer service.

N. EXCEPT AS OTHERWISE STATED IN THIS SECTION (SECTION N), THE FOLLOWING SERVICES WILL BE OFFERED AT NO ADDITIONAL FEE OR CHARGE BY BOON CHAPMAN. IF A PRODUCT OR SERVICE IS OFFERED BY A VENDOR OTHER THAN BOON CHAPMAN FOR ANY OF THE AREAS BELOW, THOSE VENDORS RATES OR FEES MUST BE APPROVED BY SIGNED CONTRACT AMENDMENT PRIOR TO ANY IMPLEMENTATION.

1. **Medical and Dental Plan Subrogation Services**
   Identify claims with potential third party liability and work with plan participant and legal counsel, if applicable, to attempt recovery of claims.

2. **Medical Plan Reinsurance/Stop-Loss**
   Assist in marketing, analysis and placement of reinsurance.

3. **Medical and Dental Plan P.P.O/E.P.O./H.M.O Networks**
   Assist in marketing, analysis, placement and administration of networks

4. **Prescription Benefit Management Selection Services**
   Assist in marketing, analysis, placement and administration of program

5. **Medical Plan Medical Tourism**
   i. *Domestic* –Assist participants in obtaining applicable outpatient surgical care at Surgery Center of Oklahoma or other facilities that use "transparent pricing". We will work with the County to implement and communicate Plan language to incent participants to use this facility. Provide Medical Plan language. Applicable Plan benefits apply to services rendered.
   ii. *International* –Assist participants in obtaining applicable care Health City Cayman Islands or other like facilities. We will work with the County to implement and communicate Plan language to incent participants to use this facility. Provide Plan language. Applicable Plan benefits apply to services rendered.

6. **Medical Plan Hospital Bill Audit**
   Assist in the evaluation, procurement, contracting, and implementation of the services of a hospital bill audit company to scrub bills to find billing code errors, gross overcharges, and other types of common billing errors. If the county decides to engage an outside auditor

7. **Employee Assistance Programs**
   Assist in the evaluation, procurement, contracting, and implementation of Employee Assistance Programs.

8. **Ancillary Products**
   Assist in the evaluation, procurement, contracting, and implementation of insured ancillary products, including but not limited to, short term disability, long term disability, life, accidental death and dismemberment, insured vision programs and long term care coverage. Additional information is required for a charge/fee quote. If the County chooses to self-fund the vision benefit, we can assist with plan design and contribution recommendations

9. **Debit card for Cafeteria Plan/Section 125 Plan**
   The Benny Prepaid Benefits Card is a special-purpose MasterCard® Card or Visa® Card that gives participants an easy, automatic way to pay for eligible health care or benefit expenses. The Card lets participants electronically access the pre-tax amounts set aside in their respective employee benefits accounts such as Flexible Spending Accounts (FSAs), Health Reimbursement Accounts (HRAs), and Health Savings Accounts (HSAs). There is no fee for the additional card.

10. **Medical Plan Required Government Reporting**
    Assist in reporting membership counts the Federal Department of Health and Human Services and in providing necessary census reporting for the Internal Revenue Service

11. **Medical Plan Medicare Part D reporting**
    Creditable coverage disclosure to Centers for Medicare and Medicaid "CMS" Assist in the online annual reporting to CMS.

12. **Medical Plan Section 6055/6056 reporting**
    Assist in the evaluation, procurement, contracting, and implementation of a vendor to track and/or provide appropriate tax forms.

13. **Benefit administration outsourcing (if requested by County)**
    Offer combined billing and online enrollment services. Additional information will be need to determine the fee at the time of a request for this service.

14. **Medicare Part D retiree drug subsidy recovery assistance (if requested by County)**
    Assist in subsidy recoupment. The fee for this service is $2.00 per retiree per month, plus the cost of the actuarial attestation.

SECTION 2 HIPAA Services

A. **NOTIFY IN WRITING, EACH NEW HEALTH PLAN PARTICIPANT, OF THEIR PRE-EXISTING CONDITION EXCLUSION PERIOD AND THEIR RIGHTS TO ITS REDUCTION THROUGH EVIDENCE OF PRIOR CREDITABLE COVERAGE.**

B. **OBTAIN FROM GROUP OR NEW HEALTH PLAN PARTICIPANT, EVIDENCE OF PRIOR CREDITABLE COVERAGE AND/OR ASSIST THE NEW HEALTH PLAN PARTICIPANT IN SECURING SUCH EVIDENCE.**

C. **CALCULATE, DETERMINE, RECORD AND APPLY ACTUAL PRE-EXISTING CONDITION EXCLUSION PERIOD AFTER APPLYING PRIOR CREDITABLE COVERAGE.**

D. **PROVIDE CUSTOMER SERVICE SUPPORT TO HEALTH PLAN PARTICIPANTS REGARDING HIPAA QUESTIONS AND ISSUES.**

E. **CALCULATE AND PROVIDE CERTIFICATES OF CREDITABLE COVERAGE TO THESE HEALTH PLAN PARTICIPANTS TERMINATING FROM THE HEALTH PLAN.**

F. **MONITOR AND IMPLEMENT PROCEDURES TO INSURE HEALTH PLAN COMPLIANCE AS MAY BE NECESSARY DUE TO REGULATORY CHANGES AND NEW CASE LAW.**

SECTION 3 — ADMINISTRATIVE SERVICES CAFETERIA PLAN/ IRS SECTION 125
See Exhibit C for pricing

A. **BOON CHAPMAN SHALL PROVIDE COUNTY WITH THE FOLLOWING ADMINISTRATIVE SERVICES FOR OPERATION OF THE PLAN:**

1. Receipt of contributions for employees from County and their deposit in a special bank account;
2. Posting of contributions to each employee's account by benefit;
3. Issuing of payments from employee's benefit account for designated benefits or reimbursement to employees for eligible expenses, to the extent that funds are available;
4. Posting of disbursements to employee's benefit account;
5. Providing County and each employee with a record of contributions, disbursements, and account balances on a quarterly basis; and
6. Providing County with a record of bank account transactions monthly.

B. **BOON CHPAMAN SHALL KEEP ALL RECORDS FILES, RECORDS, AND REPORTS PREPARED AND MAINTAINED BY BOON CHAPMAN FOR THE PROVISION OF THE ADMINISTRATIVE SERVICES CAFETERIA PLAN/ IRS SECTION 125 SHALL BE KEPT IN STRICT ACCORDANCE WITH AGREEMENT FOR THIRD PARTY CLAIMS ADMINISTRATION SERVICES PURSUANT TO RFP 16-086 AND AS REQUIRED BY THE INTERNAL REVENUE SERVICE.**

Exhibit C:
Fee Schedule

EXHIBIT C: FEE SCHEDULE

County and Boon Chapman hereby agree to the compensation schedules set forth below as being the sole compensation to Boon Chapman for the performance of its obligations under this Agreement. Monthly fees are based upon Plan Participant/Enrollment (as specified below) as of the beginning of each month.

Boon Chapman will guarantee the following rates for three (3) years starting with the effective date of this Agreement. Thereafter any rate escalation will be negotiated but will not exceed 5% per cumulative annual renewal period and Boon Chapman will provide ninety (90) working days' notice prior to any rate escalation; excluding any amounts imposed by mandatory federal, state or local regulatory requirements or restrictions. Boon Chapman is also entitled to a fair and reasonable fee for additional service or expense required because of new governmental regulations which will be negotiated between the Parties.

MEDICAL AND DENTAL PLAN

Service	Cost
Medical Plan Claim Administration and COBRA Administration (combined)	$16.75/per enrolled employee/retiree per month
Dental Plan Claim Administration	$3.75/per enrolled employee/retiree per month
Out Patient Prescription Drug Card Administration	$0.50/per prescription per month
Medical Plan Pre-Certification / Utilization Management	$3.20 /per enrolled employee/retiree per month
Retiree Billing and Rate Collection	$3.00/per enrolled retiree per month
Medicare Repricing (See Exhibit B)	10% of savings which must be calculated and reported by Contractor to County on a monthly basis
Dialysis Repricing (See Exhibit B)	$100.00 per day of dialysis treatment repriced
Provider Negotiations non PPO (See Exhibit B)	25% of savings which must be calculated and reported by Contractor to County on a monthly basis
Disease Management	$4.50/per enrolled employee/retiree per month
Transparency Tool	$1.00/per enrolled employee/retiree per month
High Touch Customer Service	$1.00/per enrolled employee/retiree per month
Subrogation if requested	30% of recoveries
Medical Plan Hospital Bill Audit (if requested)	At agreed upon hourly fees
Enrollment Meetings	$150 per individual per 8-hour day; $80 per individual per 4-hour assignment; $25 per hour for assignments of less than 4 hours.
Employee Communication Materials	Printing, supplies postage at cost and labor
Claims Run Out Fees	Three times the administrative fees due in the last month of the contract

CAFETERIA / I.R.S. SECTION 125 PLAN

Service	Cost
Premium Reduction Account	$0.00 per employee participant per month
Medical Reimbursement Account	$3.00 per employee participant per month
Dependent Day Care Account	$3.00 per employee participant per month
Replacement Cards	$5 each charged to cardholder not to County

Services not listed on this cost sheet must be approved in advance by written amendment to the **AGREEMENT FOR THIRD PARTY CLAIMS ADMINISTRATION SERVICES PURSUANT TO RFP 16-086.**

Exhibit D:

Business Associates Agreement

STATE OF TEXAS §

§

COUNTY OF FORT BEND §

BUSINESS ASSOCIATE AGREEMENT

I. INTRODUCTION

A. Parties

This Business Associate Agreement ("Agreement") is entered into as of January 1, 2017 by and between the County of Fort Bend, Texas and Boon Chapman Benefit Administrators, Inc., located at 9401 Amberglen Blvd., Building I, Suite 100, Austin, Texas 78729.

B. Underlying Agreement

Business Associate and Covered Entity are parties to the AGREEMENT FOR THIRD PARTY CLAIMS ADMINISTRATION SERVICES PURSUANT TO RFP 16-086 ("Underlying Agreement") to which Business Associate provides certain services to Covered Entity.

C. HIPAA.

In relation to the performance of services, Business Associate may receive protected health information from Covered Entity or otherwise have access to protected health information that must be kept confidential in accordance with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and regulations promulgated thereunder, as may be amended from time to time. Therefore, in consideration of the foregoing premises and the mutual covenants and conditions set forth below and in the Underlying Agreement, Business Associate and Covered Entity, agree to the terms and conditions set forth in this Agreement.

II. DEFINITIONS

A. **"Business Associate"** shall mean Boon Chapman, located at 9401 Amberglen Blvd., Building I, Suite 100, Austin, Texas 78729.

B. **"Catch-all definition"** shall mean that terms used, but not otherwise defined, in this Agreement shall have the same meaning as those terms in the Privacy Rule.

C. **"Covered Entity"** shall mean Fort Bend County.

D. **"Disclosure"** shall mean the release, transfer, provision of access to, or divulging in any other manner, of Protected Health Information, outside Business Associate's organization, i.e., to anyone other than its employees who have a need to know or have access to the PHI or EPHI.

E. **"Individual"** shall have the same meaning as the term "individual" in 45 CFR 160.103 and shall include a person who qualifies as a personal representative in accordance with 45 CFR 164.502 (g).

F. **"Individually Identifiable Health Information"** means information collected from an individual that is created by or received by Covered Entity and relates to a past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual or the past, present or future payment for health care, and which identifies the individual and with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

G. **Privacy Rule"** shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR part 160 and part 164, subparts A and E.

H. **"Protected Health Information" or "PHI"** means information that is or has been electronically transmitted by or maintained in electronic media or any other form or medium, including demographic information collected from an individual, that (a) relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual; (b) individually identifies the individual or, with respect to which, there is a reasonable basis for believing that the information can be used to identify the individual; and (c) is received by Business Associate from or on behalf of Covered Entity, or is created by Business Associate, or is made accessible to Business Associate by Covered Entity. PHI shall have the same meaning as the term "protected health information" in 45 CFR 160.103, limited to the information created or received by Business Associate from or on behalf of Covered Entity.

I. **"EPHI"** means electronic Protected Health Information.

J. **"Required by Law"** shall have the same meaning as the term "required by law" in 45 CFR 164.501.

K. **"Secretary"** shall mean the Secretary of the Department of Health and Human Services or any other officer or employee of the Department of Health and Human Services to whom the authority involved has been delegated.

L. **"Security Rule"** shall mean the standards for the security of electronic protected health information at 45 CFR Parts 160,162, and 164.

M. **"Services"** has the same meaning as in the Underlying Agreement.

N. **"Use"** (whether capitalized or not and including the other forms of the word) means, with respect to Protected Health Information, the sharing, employment, application, utilization, transmission, examination, or analysis of such information to, from or within Business Associate's organization.

III. CONFIDENTIALITY OBLIGATIONS OF BUSINESS ASSOCIATE

A. **Privacy, Security, and Confidentiality.** Business Associate shall maintain the privacy, security, and confidentiality of all PHI or EPHI, in accordance with HIPAA and this Agreement.

B. **Use of PHI or EPHI.** Business Associate is authorized to use and disclose PHI or EPHI only in accordance with the provisions of this Agreement, and only to the extent reasonably necessary (a) to provide the Services; (b) for the proper management and administration of Business Associate; and (c) to carry out the legal responsibilities of Business Associates.

C. **Notice of Breach or Violation.** Business Associate acknowledges that, under HIPAA, Covered Entity could be deemed to be in violation of HIPAA if Covered Entity knows of a pattern of activity or practice of Business Associate that constitutes a material breach or violation of Business Associate's obligations under this Agreement to maintain privacy, security, and confidentiality of PHI or EPHI, unless Covered Entity takes reasonable steps to cure the breach or end the violation; and, if such steps are unsuccessful, terminates the Underlying Agreement or reports the problem to the Secretary. Accordingly, Business Associate shall promptly notify Covered Entity of any pattern of activity or practice of Business Associate that constitutes any such material breach or violation.

D. **Additional Obligations.** Business Associate shall:

1. Review and understand the HIPAA Rules as it applies to Business Associate, and to comply with the applicable requirements of the HIPAA Rules, as well as any applicable amendments.
2. Not use or disclose PHI or EPHI other than as permitted or required by the Underlying Agreement, this Agreement or as required by law.
3. Implement industry best practices in administrative, physical, and technical safeguards that protect the confidentiality, integrity, and availability of EPHI that it creates, receives, maintains or transmits on behalf of the Covered Entity in accordance with 45 C.F.R. section 164.314(a)(2)(i)(A).

4. Report to Covered Entity any Security Incident without unreasonable delay, and in no event later than ten (10) calendar days, after becoming aware that such Security Incident affects Covered Entity's information, as such term is defined in the HIPAA Security Rule.
5. Business Associate agrees to report to Covered Entity any breach of unsecured Protected Health Information, as identified in 45 C.F.R. section 164.314(a)(2)(i)(C), without unreasonable delay and in no case later than ten (10) calendar days after becoming aware that such Breach affects Covered Entity's Protected Health Information. Such notice shall include the date of the security incident, the scope of the security incident, the Business Associate's response to the security incident and the identification of the party responsible for causing the security incident, if known. Thereafter, Business Associate shall provide periodic updates regarding the security incident, at Covered Entity's written request.
6. Perform breach notification to individuals as directed by Covered Entity. Business Associate's duty to notify Covered Entity of any breach does not permit Business Associate to notify those individuals whose PHI or EPHI has been breached by Business Associate without the express written permission of Covered Entity to do so. Any and all notification to those individuals whose PHI has been breached shall be made under the direction, review and control of Covered Entity. The Business Associate will notify the County Risk Management Director via telephone with follow-up in writing to include; name of individuals whose PHI or EPHI was breached, information breached, date of breach, form of breach, etc. All cost of the notification will be paid by the Business Associate regardless of which party performs the notification, if the breach is caused by Business Associate.
7. Ensure that any agent, including a subcontractor, to whom it provides PHI or EPHI agrees in writing to implement reasonable and appropriate safeguards to protect EPHI. 45 C.F.R. section 164.314(a)(2)(i)(B).
8. Mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI or EPHI by Business Associate in violation of the Underlying Agreement or this Agreement.
9. Promptly report to Covered Entity any use or disclosure of PHI or EPHI not provided for by the Underlying Agreement or this Agreement of which Business Associate becomes aware.
10. Ensure that any agent or subcontractor, to whom it provides PHI or EPHI received from, or created or received by Business Associate on behalf of Covered Entity agrees to the same restrictions and conditions, in writing, that apply through the Underlying Agreement or this Agreement to Business Associate with respect to such information.
11. Provide access, at the request of Covered Entity, and in reasonable time and manner, to PHI or EPHI in a Designated Record Set to an Individual to whom the particular PHI or EPHI pertains for the purposes of inspecting and obtaining a

copy of such PHI or EPHI, In accordance with the Privacy Rule, specifically 45 CFR §164.524.

12. Make any amendment(s) to PHI or EPHI in a Designated Record Set as instructed by Individual or Covered Entity, in accordance with the Privacy Rule, specifically 45 CFR §164.526.
13. Make its internal practices, books, records (including policies and procedures, PHI or EPHI and the pertinent provisions of this Agreement and the Underlying Agreement), relating to the use and disclosure of PHI or EPHI received from, or created or received by Business Associate on behalf of, Covered Entity available to the Covered Entity or the Secretary, in a time and manner designated by the Secretary, for the purposes of the Secretary determining Covered Entity's compliance with the Privacy Rule (in all events, Business Associate shall immediately notify Covered Entity upon receipt by Business Associate of any such request, and shall provide Covered Entity with copies of any such materials).
14. Document such disclosures of PHI or EPHI and information related to such disclosures as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI or EPHI, in accordance with the Privacy Rule, specifically 45 CFR §164.528.
15. Provide to an Individual as directed by Covered Entity, in a reasonable time and manner, information collected in accordance with the Underlying Agreement, to permit Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI or EPHI, in accordance with the Privacy Rule, specifically 45 CFR §164.528.
16. Return or destroy all PHI or EPHI received from Covered Entity that Business Associate still maintains in any form and Business Associate agrees to retain no copies of such information upon termination of the Underlying Agreement. In the event that Business Associate determines that returning or destroying the PHI or EPHI is infeasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction infeasible. Business Associate shall extend the protections of this Agreement to such PHI or EPHI to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such PHI or EPHI

IV. PERMITTED USES AND DISCLOSURES BY BUSINESS ASSOCIATE

A. Except as otherwise limited in this Agreement, Business Associate may use or disclose PHI or EPHI to perform functions, activities, or services for, or on behalf of, Covered Entity as specified in the Underlying Agreement, provided that such use or disclosure would not violate the Privacy Rule if done by Covered Entity or the minimum necessary policies and procedures of the Covered Entity.

B. Business Associate may use Protected Health Information to report violations of law to appropriate Federal and State authorities, consistent with Sec. 164.502 (j) (1).

V. OBLIGATIONS OF COVERED ENTITY

A. Covered Entity shall notify Business Associate of any limitation(s) in its notice of privacy practices of Covered Entity in accordance with 45 CFR 164.520, to the extent that such limitation may affect Business Associate's use or disclosure of PHI or EPHI.

B. Covered Entity shall notify Business Associate of any changes in, or revocation of, permission by Individual to use or disclose PHI or EPHI, to the extent that such changes may affect Business Associate's use or disclosure of PHI or EPHI.

C. Covered Entity shall notify Business Associate of any restriction to the use or disclosure of PHI or EPHI that Covered Entity has agreed to in accordance with 45 CFR 164.522 to the extent that such restriction may affect Business Associate's use or disclosure of PHI or EPHI.

VI. PERMISSIBLE REQUESTS BY COVERED ENTITY

Covered Entity shall not request Business Associate to use or disclose PHI or EPHI in any manner that would not be permissible under the Privacy Rule if done by Covered Entity.

VII. TERM AND TERMINATION

A. **Term.** The Term of this Agreement shall be effective as of January 1, 2017 and shall terminate when all of the PHI or EPHI provided by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity, is destroyed or returned to Covered Entity, or, it is infeasible to return or destroy PHI or EPHI, protections are extended to such information, in accordance with the termination provisions of this section.

B. **Termination for Cause**. Without limiting the rights and remedies of Covered Entity elsewhere set forth in this Agreement or available under applicable law, Covered Entity may terminate this Agreement without penalty or recourse to Business Associate if Covered Entity determines that Business Associate has violated a material term of the provisions of this Agreement or Underlying Agreement, or such violation is imminent and material. Upon Covered Entity's knowledge of a material breach by Business Associate, Covered Entity shall either:

1. Provide an opportunity for Business Associate to cure the breach or end the violation and terminate this Agreement if Business Associate does not cure the breach or end the violation with the time specified by Covered Entity.
2. Immediately terminate this Agreement if Business Associate has breached a material term of this Agreement and cure is not possible; or
3. If neither termination nor cure is feasible, Covered Entity shall report the violation to the Secretary.

VIII. **DEFAULT.**

A breach under this Agreement shall be deemed to be a material default under the Underlying Agreement.

IX. **EFFECT OF TERMINATION.**

A. Except as provided in paragraph (7.B.1) of this section, upon termination of the Agreement, for any reason, Business Associate shall return or destroy all PHI OR EPHI received from Covered Entity. This provision shall apply to PHI or EPHI that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the PHI or EPHI.

B. In the event that Business Associate determines that returning or destroying the PHI or EPHI is infeasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction infeasible. Business Associate shall extend the protections of this Agreement to such PHI or EPHI to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such PHI or EPHI.

X. **MISCELLANEOUS**

A. **Regulatory References.** A reference in this Agreement to a section in the Privacy Rule means the section as in effect or as amended.

B. **Amendment.** The Parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for Covered Entity to comply with the requirements of the Privacy Rule and the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191.

C. **Survival.** The respective rights and obligations of Business Associate under Section 4 of this Agreement shall survive the termination of this Agreement.

D. **Interpretation.** Any ambiguity in this Agreement shall be resolved to permit Covered Entity to comply with the Privacy Rule.

E. **Inconsistencies.** To the extent there are any inconsistencies between this Agreement, and the terms of the Underlying Agreement, the terms of this Agreement shall prevail.

F. **Mitigation.** If Business Associate violates this Agreement or the HIPAA Rules, Business Associate agrees to mitigate any damage caused by such breach.

G. **Indemnification.** Business Associate agrees to indemnify and hold harmless Covered Entity from and against all claims, demands, liabilities, judgments or causes of action of any nature for any relief, elements of recovery or damages recognized by law (including, without limitation, attorney's fees, defense costs, and equitable relief), for any damage or loss incurred by Covered Entity arising out of, resulting from, or attributable to any acts or omissions or other conduct of Business Associate or its agents in connection with the performance of Business Associate's or its agents' duties under this Agreement.

IN WITNESS WHEREOF, the parties have hereunto set their hands.

FORT BEND COUNTY

Robert E. Hebert, County Judge

COMMISSIONERS COURT TEXAS FORT BEND COUNTY, TEXAS

ATTEST:

Laura Richard, County Clerk

BOON-CHAPMAN
BENEFIT ADMINISTRATORS, INC.,

Authorized Agent- Signature

Kevin S. Chapman

Authorized Agent- Printed Name

President

Title

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Exhibit E:

Security Policies

F.7 Security Policies

BOON-CHAPMAN

F.7 Security Policies

a. Building Access Policy

BOON-CHAPMAN

BOON-CHAPMAN

Building Access Policy

Revision History

REVISION	DATE	NAME	DESCRIPTION
Original 1.0	September 16, 2014	Daniel Chapman, Dayne Miller	Technical Writer, Help Desk Lead
Revised 1.1	April 15, 2015	Daniel Chapman, Jill Monsees	Compliance Officer, HR Manager
Updated 2.0	April 21, 2015	Daniel Chapman	Compliance Officer

BOON-CHAPMAN

Building Access Policy

1.0 Purpose

This document provides guidance for employees, visitors, authorized and unauthorized vendors to the Boon-Chapman premises.

2.0 Scope

This policy applies to all employees, visitors, and vendors of Boon-Chapman.

3.0 Policy

3.1 Employees/Contractors

All employees must have their assigned company badges clearly visible on their clothing at all times at Boon-Chapman. Employees include full-time workforce, part-time workforce, temporary employees, and company contractors.

Employees wanting to enter their building must:

1. Have their company-issued ID badges on their person and clearly visible on their clothing at all times in the main building.
2. Scan their card at the back entrance or front entrance of the building.
    * *Any employee entering the building without scanning their badge or without a badge on their person will be reported to their manager.*
    * *Any employee allowing entry through the employee entrance without that person scanning their badge, regardless whether they recognize that individual, will be reported to their manager.*
    * *Employee(s) caught violating these clauses may face disciplinary action, up to or including termination.*

Employees without their company badges must enter Boon-Chapman through the front entrance, provide identification, and fill out the *Visitor Sign-In Sheet*.

1. Upon arrival the employee must inform the head receptionist that they are an employee without their employee badge.
2. The head receptionist will verify the employee's employment through:
    a. A current employee list check.
3. Once confirmed, the employee will follow the following steps:
    a. Sign the *Visitor Sign-In Sheet.*
    b. Show the head receptionist a government-issued ID.
    c. Wear a No Escort Badge.
4. Before the employee leaves, the employee must:
    a. Return the No Escort Badge to the front desk.
    b. Leave through the front entrance.
5. If the employee enters the office without a badge, the employee must be reported to the head receptionist. Once reported, the employee may face disciplinary action from their manager, up to or including termination.
6. If the identity and employment of the person cannot be verified, and they enter the premises and refuse to leave, the head receptionist may call the police.

Former employees are not authorized to enter the building except as a visitor. See ***Section 3.2 Visitors.***

3.2 Visitors

All visitors must enter Boon-Chapman through the front entrance, receive Manager Approval for their visit, provide identification, and fill out the Visitors' Log:

1. Upon arrival, the head receptionist must ask the visitor who they're here to see and why.
2. The head receptionist will contact the employee's manager or department director for approval for the visit. If the employee's manager is unavailable, request approval from the first available:
    a. The Human Resources Manager
    b. Vice President of Operations
    c. Boon-Chapman President
    d. Compliance Officer
        * *A manager may approve a visit in advance by contacting the head receptionist prior to a scheduled visit.*
3. The manager approving the visit is responsible for sending a visitor escort to the front desk.
4. Once approved, the visitor will follow the following steps. If visitors are a group or a tour, each member must follow the same step:
    a. Sign the *Visitor Sign-In Sheet.*
    b. Provide the head receptionist with a company or government-issued ID, which will be held for the duration of the visit.
    c. Wear an Escort Required Badge.
    d. Follow an Escort for the duration of the visit.
        * *Minors may enter the building without a government-issued ID if their guardian is present, whom has signed in as a visitor and offered a company or government-issued ID.*
5. At the end of the visit, the visitor must:
    a. Return their Escort Required Badge to the front desk.
    b. Have their company or government-issued ID returned to them.
    c. Be escorted off the premises.
6. If the visitor refuses to leave or enters the office without authorization, the head receptionist must:
    a. Call the police.
    b. Alert the office of a building invasion through the phone system.
    c. Alert building management (CBRE) of a building invasion.

If visitors are seen roaming the hallways or in unauthorized rooms without their escorts, they must be reported to the front desk immediately. Visitors found without a badge must be reported to the reception desk immediately. Visitors may be without an escort if they are in the restroom with an escort waiting outside.

It is the escort's responsibility to look after their visitor. If an escort is caught leaving their visitor unattended, they may face disciplinary action, up to or including termination.

3.3 Unauthorized Vendors

Unauthorized vendors must enter Boon-Chapman through the front entrance, provide company or government-issued ID, and fill out the Visitors' Log. Unauthorized vendors are irregular vendors to the Company whom have not signed our Vendor Agreement guaranteeing background checks of their employees.

1. Upon arrival, the head receptionist must ask the vendor who they are, whom they work for, and what their business is at the main office.
2. The head receptionist will contact who they're here to see.
3. A visitor escort must be assigned to the vendor at the front desk.
4. Once approved, the vendor will follow the following steps:
    a. Sign the *Visitor Sign-In Sheet.*
    b. Provide the head receptionist with a company or government-issued ID, which will be held at the front desk for the duration of the visit.
    c. Wear an Escort Required Badge.
    d. Follow an Escort for the duration of the visit.
5. At the end of the visit, the vendor must:
    a. Return their Escort Required Badge to the front desk.
    b. Have their company or government-issued ID returned to them.
    c. Be escorted off the premises.
6. If the vendor enters the office without authorization and refuses to leave, the head receptionist may call the police.

If vendors are seen roaming the hallways or in unauthorized rooms without their escorts, they must be reported to the front desk immediately. Vendors found without a badge must be reported to the reception desk immediately. Vendors may be without an escort if they are in the restroom with an escort waiting outside.

It is the escort's responsibility to look after their vendor. If an escort is caught leaving their vendor unattended, they may face disciplinary action, up to or including termination.

3.4 Authorized Vendors

To become an authorized vendor, vendors must sign the *Boon-Chapman Vendor Agreement,* which guarantees the representatives of the vendors have cleared background checks. After background checks are confirmed, the vendor's employees will be approved for a No Escort Required Badge that will allow them to move freely within unrestricted areas of the building.

There are two entrances to the building that vendors will be allowed to enter:

- Back Entry – This entrance, at the back of the building, will require a check-in through the Mail Room. Deliveries and supplies will be allowed to enter through here. Vendors will have to sign a Vendors' Log and show Company ID to receive the No Escort Required Badge. After their work is complete, they must return the badge where they received it.

- Front Entry – Building maintenance and other vendors will be allowed through the front entrance of the building. Vendors will need to fill out the *Visitor Sign-In Sheet* and show a company ID to receive the No Escort Required Badge. After their work is complete, they must return the badge where they received it.

The only vendor that will not have to fill out a log upon entry to the building will be the cleaning crew, they will be issued special badges that allow them to enter and exit the building, along with certain secure areas, such as the IT Room and Mail Room. Access will not be granted to the Wiring Room or Server Room.

3.5 After-Hours Authorized Vendors

Authorized vendors whom enter the building after-hours (ex. CBRE) will be treated like vendors and will be in charge of running background checks on their employees before their arrival. After-Hours Vendors must sign the *Boon-Chapman Vendor Agreement* to insure background checks have been run. Afterwards, special after-hours access badges will be assigned to these vendors.

If/when the business relationship between the vendor and Boon-Chapman ends, their after-hours access badges must be returned to Boon-Chapman.

3.6 Photographs and Cameras

Visitors are not permitted to take photographs inside of the Boon-Chapman premises, unless discussed specifically with Boon-Chapman Management. For instance, photographs are sometimes required for documentation purposes. If employees have any questions about the suitability of photographs, they should consult the Human Resources Manager or the Compliance Officer.

Dedicated cameras are not permitted on-site. Cell phones and laptops equipped with cameras are permitted, but photographs may not be taken without permission from Boon-Chapman Management.

3.8 Information Disclosure

Visitors should not request information that does not pertain to their visit or the work being performed. Confidential and otherwise inappropriate requests for corporate documents, customer information, financial projections, comments on any matter currently under litigation, future products or future corporate direction, or requests for information or statements in the name of the company will be reported to Boon-Chapman Management, and may lead to the Visitor being asked to leave.

3.9 Exit Inspection

Visitors may be subject to a brief search of their bags or other luggage as they enter and exit the Boon-Chapman premise. Permission for this search is granted by signature on the Visitors' Log as well as the Vendors' Log.

3.10 Emergency Evacuation

In the event of an emergency, Visitors and Vendors must evacuate the building with Employees. The Emergency Response Team will then notify the Employees, Vendors, and Visitors when the evacuation is complete.

Visitors shouldn't leave the evacuation area until they have returned their badges to the head receptionist.

3.11 Visitor System Access

Visitors that require internet or network access must follow proper procedure. Visitors will need an employee sponsor, who will arrange temporary credentials with the Helpdesk. Visitor use of employee credentials is not permitted under any circumstances.

3.11.1 Unacceptable Use

When accessing the Boon-Chapman Network or Boon-Chapman's Internet/Intranet and when using company owned resources, visitors may not engage in the following activities:

- Activities deemed illegal under local, state, and/or federal law.
- Accessing data, a server or an account for any other purpose than conducting Boon-Chapman business.
- Introduction of malicious programs into the network or server (ex. Viruses, worms, Trojan horses, e-mail bombs).
- Revealing your account password to others or allowing use of the account by others.
- Using a Boon-Chapman computer asset to engage in procuring or transmitting material that is in violation of sexual harassment or hostile workplace rules.
- Effecting security breaches or disruptions of network communication.
- Executing any form of network monitoring which will intercept data not intended for the employee's host.
- Circumventing user authentication or security of any host, network or account.
- Introducing honeypots, honeynets, or similar technology on the Boon-Chapman network.
- Using any program/script/command, or sending messages of any kind, with the intent to interfere with, or disable, a user's terminal session, via any means, locally or via the Internet/Intranet/Extranet.
- Providing information unauthorized for release about, or lists of, Boon-Chapman employees to parties outside of Boon-Chapman.

3.11.2 Remote Access

Remote Access to the Boon-Chapman network is governed by the Remote Access Policy.

Building Access Policy

4.0 Badges

4.1 "No Escort Required"

- This badge will allow access to the Back and Front Entry of the building from 8:00 AM to 5:00 PM Monday to Friday.
- Only issued to:
    - Representatives of authorized vendors who have signed the *Boon-Chapman Vendor Agreement*, have shown a company ID and signed the Vendors' Log.
    - Employees whom have misplaced their company issued ID and need temporary credentials for the day
- Will not allow entry into any secure areas. Entry to those areas must be granted and an escort must be present.

4.2 "Escort Required"

- This badge is for visitors and unauthorized vendors whom will be required to have a personal escort for the entirety of their visit.
- Will be handed out to all visitors including potential vendors, potential employees here for interviews, and unauthorized vendors whom have not signed the *Boon-Chapman Vendor Agreement* guaranteeing representatives have cleared background checks.
- If a visitor or vendor is inside the restroom, or has been assigned to a room by a manager, they will not be required to have an escort so long as they remain in that room. Movement from room-to-room will require an escort.

4.3 Cleaning/Maintenance Crew

- Access includes certain secure areas, such as the IT Room and Mail Room.
- Access will not be granted to the Wiring Room or Server Room.

5.0 Responsibility

This document is maintained by the Compliance Officer. Enforcement falls to the Human Resources Department and Boon-Chapman Management.

Administering the check-in and check-out of employees without their badges, visitors, and unauthorized vendors is the responsibility of the head receptionist. Administering the check-in and check-out of authorized vendors is the responsibility of the Mail Room or the head receptionist.

6.0 Penalties

Violation of any of the requirements in this policy by an employee may result in disciplinary action, up to and including termination or prosecution. Violation of this policy by a vendor or visitor can result in removal from the building or contacting authorities.

F.7 Security Policies

b. Security Policy

BOON-CHAPMAN

BOON-CHAPMAN

Security Policy

Revision History

REVISION	DATE	NAME	DESCRIPTION
Original 1.0	July 8, 2014	Daniel Chapman	Technical Writer
Revised 1.1	July 25, 2014	Daniel Chapman	Technical Writer
Revised 1.2-1.4	October 10, 2014 - May 20, 2015	Daniel Chapman	Compliance Officer
Update 2.0	August 7, 2015	Daniel Chapman	Compliance Officer

Table of Contents

I. Policy

This Security Policy of Boon-Chapman Benefit Administrators, Inc. ("Boon-Chapman") exists to guarantee:

- Company information, as defined hereinafter, in all its forms (written, spoken, recorded electronically or printed) will be protected from unauthorized modification, destruction or disclosure. This protection includes an appropriate level of security over the equipment and software used to process, store, and transmit that information.
- All policies and procedures must be documented and made available to individuals responsible for their implementation and compliance.
- All documentation must be annually reviewed by the Compliance Officer for appropriateness and currency.
- Additional policies, standards and procedures may be developed to detail the implementation of this policy and set of standards, and addressing any additional information systems functionality. All policies and policies must be consistent with this policy.
- This policy assumes that any "outside" entity/organization that utilizes Boon-Chapman applications maintain and update its own policies and procedures in accordance with HIPAA and approved industry standards.

II. Scope

The scope of this policy applies to all workforce members and visitors of Boon-Chapman, including but not limited to those who work with or use company systems and applications developed or licensed by Boon-Chapman.

The scope of information security includes the protection of the confidentiality, integrity, and availability of company information, which includes internal, confidential, and protected health information in any form.

III. Security Definitions

- **Agent Console:** A tool developed by Boon-Chapman for data consumption used to see work status, commission information, graphical breakdowns of business to date, and companywide communications.
- **Availability:** Data or information is accessible and usable upon demand by an authorized person.
- **Clean Desk Policy:** Rule that ensures that all confidential materials are removed from an end user workspace and locked away when the items are not in use or an employee leaves his/her workstation.
- **Company Systems:** All Boon-Chapman owned computer equipment and network systems that are operated within the Agent Console, EMR, or company network environment. This includes all platforms (operating systems), all computer sizes (personal digital assistants, desktops, servers, mainframes, etc.), and all

applications and data (whether developed in-house or licensed from third parties) contained on those systems.

- **Confidential Information:** See Section *V. Data Classification.*
- **Confidentiality:** Data or information is not made available or disclosed to unauthorized persons or processes.
- **Electronic Medical Record (EMR):** A digital tool developed by Boon-Chapman to digitally contain and chart medical and treatment history of patients of a practice.
- **Encryption:** The conversion of electronic data into another form, called ciphertext, which cannot be easily understood by anyone except authorized parties. All confidential information sent electronically outside the Boon-Chapman network must be transported securely in this form.
- **Helpdesk:** Internal resource for company workforce to get help with user problems. Responsible for maintaining Helpdesk Ticketing System and User devices. Run by System Administrator.
- **HIPAA:** The Health Insurance Portability and Accountability Act, a federal law passed in 1996 that affects the healthcare and insurance industries. It has since been amended several times, by the HITECH Act of 2009 and the Omnibus Rule in 2013. A key goal of HIPAA regulations is to protect the privacy and confidentiality of protected health information by setting and enforcing standards.
- **Integrity:** Data or information has not been altered or destroyed in an unauthorized manner.
- **Internal Information:** See Section *V. Data Classification.*
- **Limited Data Set:** A limited set of identifiable patient information with all "facial" identifiers removed. A limited data set may be disclosed to an outside party without a patient's authorization if certain conditions are met. The purpose of the disclosure may only be for research, public health or health care operations. In a limited data set, the following identifiers are usually removed.
    - Names;
    - Street addresses (other than town, city, state);
    - Telephone numbers;
    - Fax numbers;
    - E-mail addresses;
    - Social security numbers;
    - Medical records numbers;
    - Health plan beneficiary numbers;
    - Account numbers;
    - Vehicle identifiers and serial numbers, including license plates;
    - Device identifiers and serial numbers;
    - URLs;
    - IP address numbers;

- Biometric identifiers (including finger and voice prints); and
- Full face photos (or comparable images)

The health information that may remain in the information disclosures include:

- Dates (admission, discharge, service, DOB, DOD, etc.)
- City, state; and
- Ages in years, months, or days

It is important to note that this information is still protected health information ("PHI") under HIPAA. It does not de-identify the patient and is still subject to the requirements of the Privacy Regulations.

- **Minimum Necessary:** The minimum necessary to complete a job.
- **Practice:** The place of business of the clinic and clinical staff including the physician(s), nurse practitioner(s), medical assistant(s) and other clinical positions as defined by the Clinical Manager.
- **Producer Management Console (PMC):** A tool developed by Boon-Chapman to generate and update information to be displayed in the Agent Console.
- **Protected Health Information (PHI):** Healthcare information, including demographic information, created or received by Boon-Chapman entities which relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual and that identifies or can be used to identify the individual.
- **Public Information:** See *Section V. Data Classification*.
- **Restricted Confidential:** See *Section V. Data Classification*.
- **Risk:** The probability of a loss of confidentiality, integrity, or availability of information.
- **Security Incident:** A violation or imminent threat of violation of computer security policies, acceptable use policies, or standard security practices. This includes:
  - **Loss of confidentiality of information** (ex. Unauthorized access to and theft of systems, intrusion, intentional and unintentional exposure, etc.)
  - **Compromise of integrity of information** (ex. Misuse and damage to systems and information, virus attacks, etc.)
  - **Prevention of availability of information** (ex. Denial of service, loss of access, missing correspondence, etc.)

  See *Section IX. Security Incident Reporting*.
- **Visitors:** Non-workforce persons whom don't have authorization to enter Boon-Chapman without signing in through the Visitor Sign-In process. This includes business partners, job applicants, family and friends of workforce members, etc.

- **Workforce Members:** Every worker at Boon-Chapman, no matter what their status is. This includes full-time employees, part-time employees, temporary employees, contractors, consultants, volunteers and interns.

IV. Security Responsibilities

1. **President:** Responsible for designating company responsibilities and making final management decisions.
2. **Vice-President of Operations:** Oversees day-to-day company & security operations. Supervises the Compliance Officer.
3. **Compliance Officer:** Works as Privacy/Security Officer of the company. Oversees the company's compliance program, reviews and evaluates compliance issues, writes compliance documentation. Answers to Vice-President of Operations.
4. **IT Director:** Oversees the information technology strategy of the company, developing and implementing goals for the IT Department. Supervises the System Administrator and System Architect.
5. **System Administrator:** Responsible for managing Boon-Chapman's network and multi-user computing environment. Responsible for installing and configuring system hardware and software, establishing and maintaining user accounts, upgrading software and backup and recovery tasks. Answers to IT Director.
6. **System Architect:** Manages the IT architecture and its overall effectiveness, understands changing business requirements and defines detailed technical solutions. Answers to IT Director.
7. **User:** Workforce member who uses or operates Boon-Chapman equipment and the Boon-Chapman network, responsible for abiding by company rules on that equipment.

V. Data Classification

Data Classification is designed to support the need to know basis so company information will be protected from unauthorized disclosure, use, modification, and deletion. This classification is applicable to all information in company use and/or possession, and must be protected throughout its life cycle, from its origination to its destruction. All workers who may come in contact with confidential information are expected to familiarize themselves with Boon-Chapman's Data Classification.

- **Public:** Applies to information available to the general public and intended for distribution outside of Boon-Chapman. This information may be freely disseminated without potential harm.
    - *Examples include product and service brochures, advertisements, and job opening announcements.*

- **Internal:** Also known as "For Internal Use Only." Applies to information meant for use inside Boon-Chapman, but the unauthorized disclosure, modification, or destruction of it is not expected to seriously or adversely impact Boon-Chapman, its clients, its employees, or its business partners.
    - *Examples include telephone directory, new employee training manuals and internal policy manuals.*
- **Confidential:** Information that is intended for use within Boon-Chapman. Its unauthorized disclosure could adversely impact the company's clients, employees and business partners. Information that some people would consider private is included in this classification.
    - *Examples include appointment schedules, department financial data, contracts and agreements.*
- **Restricted Confidential:** This classification applies to the most sensitive medical and business information that is intended strictly for use within the organization. Its unauthorized disclosure could seriously and adversely impact the organization, its patients, employees and business partners.
    - *For example, protected health information (PHI), corporate level strategic plans, and software code.*

For more information please see the company's *Data Classification Policy.*

VI. Data Retention and Disposal

See *Data Retention and Disposal Policy.*

VII. Risk Assessment and Management

A Risk Analysis, or a "Risk Assessment," is required of every company maintaining PHI under HIPAA. A thorough Risk Assessment of all Boon-Chapman information networks and systems is conducted on an annual basis by the Compliance Officer to document the threats and vulnerabilities to stored and transmitted company information.

The Risk Assessment will:

- Examine the types of threats – internal or external, natural or manmade, electronic or non-electronic – that affect the ability to manage the information resource.
- Document the existing vulnerabilities within each entity which could potentially expose the information resource to the threats.
- Evaluate of the information assets and the technology associated with its collection, storage, dissemination and protection.

From the combination of threats, vulnerabilities and asset values, an estimate of the risks to the confidentiality, integrity and availability of company information will be determined and presented to Boon-Chapman management by the Compliance Officer.

Plans for mitigation of risk will be determined by Boon-Chapman management, and assigned by the Vice-President of Operations to the Compliance Officer to complete.

For more information, please see the company's *Risk Assessment.*

VIII. Compliance Assessment

A Non-Technical Security Evaluation, or a "Compliance Assessment," is required of every company maintaining PHI under HIPAA. A thorough Compliance Assessment of the company is conducted on an annual basis by the Compliance Officer to determine the status and progress of Boon-Chapman's goal to achieving compliance.

The Compliance Assessment will determine if:

- Policies, procedures and documentation needed to achieve compliance exist.
- Policies and procedures are in use and are being enforced.
- Rules set by the company are reasonable and appropriate.

The Compliance Officer will perform this self-audit by first completing a questionnaire with company leaders. The CO will conduct interviews with the Vice-President of Operations, the System Administrator, the System Architect and members of Boon-Chapman executive management. When complete, the CO will take the results of the questionnaire and determine to the best of his ability the company's compliance status, and present those results to Boon-Chapman management.

Plans for mitigation of risk will be determined by Boon-Chapman management, and assigned by the Vice-President of Operations to the Compliance Officer to complete.

For more information, please see the company's *Compliance Assessment Questionnaire.*

IX. Technical Assessment

A Technical Security Evaluation, or a "Technical Assessment," is required of every company maintaining PHI under HIPAA. The Technical Assessment is responsible for monitoring, validating, and assuring technical security of the Boon-Chapman network by testing the network. Technical Assessment operations of the company are conducted by the System Administrator and System Architect, then reviewed with the Compliance Officer to determine vulnerabilities in the network.

The Technical Assessment will consist of:

- External vulnerability scans of the Boon-Chapman network, identifying any security vulnerabilities in the network that are accessible from the internet, such as externally visible servers or devices including email, SFTP, and firewalls.
- Internal vulnerability scans of the Boon-Chapman network, identifying security vulnerabilities that are accessible from inside the network, such as potential security issues on servers and systems accessible within the network.
- Web application scans that identify security vulnerabilities on Boon-Chapman's web-based applications, such as security flaws in application design, misconfiguration, and insecure coding practices.

The Compliance Officer will be responsible for periodically performing audits of assessments of the system and reporting results to the Vice-President of Operations. See *Section X. Audits* for more information.

Plans for mitigation of risk will be determined by Boon-Chapman management, and assigned by the Vice-President of Operations and IT Director to the Compliance Officer, System Administrator, and System Architect to complete.

X. Audits

Periodic audits of the technical assets of a company handling PHI are required by HIPAA, and part of the Technical Assessment. Boon-Chapman's network utilizes several technical assets that grant access to company information and are in need of periodic review for undisclosed access, removed access, and security logs in need of review.

The Compliance Officer is responsible for annually auditing the following technical assets owned by the company:

- Active Directory
- Company Email Exchange
- MaxxVault
- ID Badge Access to main building
- Eldorado
- CCMS
- S:/ Drive Access
- Oaisys
- Building Alarm Codes

When complete, the Compliance Officer will present audit results to the Vice-President of Operations. Plans for mitigation of risk will be determined by Boon-Chapman management, and assigned by the Vice-President of Operations and IT Director to the Compliance Officer, System Administrator, and System Architect to complete.

XI. Security Incident Reporting

Security Incident Reporting is required of every company maintaining PHI under HIPAA. Boon-Chapman has a clear incident reporting system in place which allows the company to identify, report and record security incidents that threaten the security of the company, or the confidentiality, integrity and availability of company information and PHI. Security incident reporting is conducted circumstantially by the Compliance Officer, System Administrator and System Architect. The security incident reporting system is tested on an annual basis by the Compliance Officer.

All Boon-Chapman employees and contractors have a responsibility to report breaches in policy through an incident report, available on the company's eTicket System. An employee filing an incident report must:

Fill out the Incident Report Form on the E-Ticketing System

1) Go to the Boon-Chapman Helpdesk eTicket System. Create an e-ticket.
2) Change Category section to **Incident Report** under **Systems** tab.
3) Enter the subject of your Incident Report, fill out a brief description of the Incident in question. Also select best assessment of the priority of the incident being reported.
4) Assign to the Compliance Officer, System Architect, or System Administrator.
5) Submit Ticket.

Or, fill out the Incident Report Form on paper

1) Fill out *Boon-Chapman Incident Report*. Find in S:\ Drive, Policies and Procedures Folder. Open Boon-Chapman Incident Report Policy Procedure Form. See Attachment 1.
    - Give to Help Desk in person, or proceed to Step 2.
2) Go to Boon-Chapman intranet and select Help Desk under Links or compose an email to incidents@boonchapman.com
    - Include details, specifically what the incident is, when and where the incident occurred, and who is involved.
3) Attach completed *Boon-Chapman Incident Report* to "ticket," and send.
4) Once received, the System Administrator, System Architect, or Compliance Officer will open the ticket.

Failure to report incidents could result in disciplinary action. Types of incidents which should be reported include but are not limited to:

- Company computers left unlocked when unattended
- Password disclosures
- Computer virus detection
- Data Loss/Unauthorized disclosure or abuse
- Physical security or electronic access control flaws
- Unauthorized access to company building or data

If an event meets the criteria of a security incident, the Compliance Officer will meet with parties concerned with the incident, write a report of the incident, and report findings to the Vice-President of Operations. The Compliance Officer will be responsible for executing remedial actions decided by Boon-Chapman management.

For more information, please see the company's *Incident Reporting Policy and Procedures*.

XII. Disaster Recovery Plan

A Disaster Recovery Plan is required of every company maintaining PHI under HIPAA. Boon-Chapman has a disaster recovery plan in place which allows the company to respond to a disaster that prevents the company's ability to function normally and threaten the confidentiality, integrity and availability of company information and PHI.

An event triggers the activation of the DRP, such as:

- Total loss of communications
- Total loss of power
- Flooding of the premises
- Loss of main office or colocation site
- Fire
- Tornado, etc.

When an incident occurs the Emergency Response Team (ERT) must be activated. The ERT will then decide the extent to which the Boon-Chapman DRP must be invoked.

Responsibilities of the ERT are to:

- Respond immediately to a potential disaster and call emergency services;
- Assess the extent of the disaster and its impact on Hosted applications downtime, data security, etc.;
- Decide which elements of the Hosted applications Disaster Recovery Plan should be activated;
- Establish and manage disaster recovery team to maintain vital services and return to normal operation;
- Ensure employees are notified and allocate responsibilities and activities as required.
- Keep needed documentation.

After the extent of damage is assessed, the ERT will be responsible for:

- Establishing facilities for an emergency level of service within 24 business hours;
- Restoring key services within 48 business hours of the incident;
- Recover to business as usual within 24 to 120 hours after the incident;
- Coordinate activities with Boon-Chapman management, first responders, etc.
- Complete necessary documentation.

The Disaster Recovery Plan is activated circumstantially by the Vice-President of Operations, and tested on an annual basis by the Compliance Officer. For more information, please see the company's *Disaster Recovery Plan.*

XIII. Business Continuity / Emergency Mode Plan

Boon-Chapman's Business Continuity Plan is a plan for continuing operations of the company if the place of business is affected by a disaster that ceases the company's ability to function normally for a long period of time.

The plan will explain how the business would recover its operations or move operations to another location after damage by events like natural disasters, theft, or flooding, which cannot be handled under the normal operations of the Disaster Recovery Plan.

The Business Continuity Plan is activated circumstantially by the Vice-President of Operations, and updated on an annual basis by the Compliance Officer. For more information, please see the company's *Business Continuity Plan.*

XIV. Security Training

Security training of workforce is required of all companies handling PHI under HIPAA. Boon-Chapman provides an extensive training workshop every year which includes orientation training, security exams, and period e-mail reminders.

When a new employee is brought on to the company, the employee must undergo multiple day orientation training, provided by the Human Resources Department. The training includes:

- Training with company equipment
- Mandatory reading of this Security Policy and the Company Rules Handbook
- Signing of company authorization form, guaranteeing the employee has read the Security Policy and Handbook and adheres to their rules
- Passing grade of 70% on the company's HIPAA security/privacy exam

The employee has a responsibility to maintain his/her knowledge of company rules. Annually, the employee is tested on this knowledge by retaking the company's HIPAA security/privacy exam. The employee must maintain a passing grade of at least 70% to remain an employee at Boon-Chapman.

Periodically, every employee will receive scheduled security and privacy rule reminders via email from the Compliance Officer approved by the Vice-President of Operations. The Compliance Officer and Human Resources Lead is responsible for fulfilling company training, and will answer to the Vice-President of Operations.

XV. Law Enforcement, Judicial Proceedings

Boon-Chapman has a very simple procedure when dealing with law enforcement and other legal issues. The company's actions and policies are determined by the company's executive management, which include the President/CEO, the Vice-President/Treasurer, and Vice-President of Operations.

When a legal issue, such as a lawsuit, subpoena, or other legal matter presents itself, executive management will follow the following guidelines, the President holds the final decision on how to handle each issue and when to deviate from the guidelines.

- **Subpoenas**
    1. Boon-Chapman receives subpoena, subpoena is to be forwarded to the Compliance Officer, acting as the custodian of records.
    2. Compliance Officer reviews the subpoena's legality, the records requested, shipping costs, etc.
    3. In the event of an issue or question about the subpoena, the Compliance Officer may call a meeting of Executive Management to review or challenge the subpoena in question. If required, the President may choose to seek legal advice from an outside attorney on how the Compliance Officer should proceed.

4. If the Compliance Officer and Executive Management wish to object to subpoena, it is the Compliance Officer's responsibility to file proper order to quash or modify the subpoena to the judge whom filed the subpoena.
5. If the subpoena is approved, the Compliance Officer will forward the subpoena to the Records Supervisor, whom will extract records required to complete subpoena.
6. Subpoena with records will be sent to Compliance Officer to review, get notarized, and send. Any responses to subpoena will be completed with the same format.
7. While it is the Compliance Officer's responsibility to complete subpoenas, the President will have the final say on how to proceed.

- **Lawsuit**
  1. Filing suit is sent to Boon-Chapman, receiver's responsibility to forward to Compliance Officer and Executive Management.
  2. Compliance Officer and President will call a meeting of Executive Management to review the suit. If required, the President may choose to seek legal advice from an outside attorney on how the company should proceed.
  3. The President will have final say on how to proceed.
- **Other Law Enforcement/Legal Issues**
  1. In the event of incident reporting, disaster recovery, or emergency mode operations involving law enforcement or legal issues, the Compliance Officer and/or Emergency Response Team will follow company procedures, and send to Executive Management.
  2. While following normal policies and procedures, it will be the Compliance Officer's responsibility to reach out to Executive Management and call a meeting of Executive Management on how to proceed in a legal matter. If required, the President may choose to seek legal advice from an outside attorney on how the company should proceed.
  3. Vice-President of Operations and/or Compliance Officer will carry out.
  4. The President will have final say on how to proceed.

XVI. Access Controls

Physical and electronic access to company information, PHI, computing resources, and company equipment is controlled by Boon-Chapman. To ensure appropriate levels of access by internal workers, a variety of security measures will be instituted as recommended by the Compliance Officer, and approved by Boon-Chapman.

Mechanisms to control access to company information and PHI include the following methods:

1. Authorization

Access will be granted on a minimum necessary basis and must be authorized by the System Administrator. Any of the following methods are acceptable for providing access under this policy:

- **Active Directory:** Controls user profiles and security policies that dictate or control those user profiles. System Administrator and Executive Management have access. Compliance Officer responsible for periodic audits.
- **Domain Directory:** Dictates what physical devices have access to the Boon-Chapman Network. System Administrator and Executive Management have access. Compliance Officer responsible for periodic audits.
- **Role-based access:** Predefining roles, each of which has been assigned the various privileges needed to perform that role. Assignment of these roles are made by the employee's company director. Access is granted by System Administrator and Executive Management.
- **User-based access:** Security measure used to grant users of a system access based upon the identity of the user. Permission for access sent by employee's company director. Access granted by System Administrator and Executive Management.

2. Identification/Authentication

Boon-Chapman requires workforce members to have unique user identification and authentication for all access to systems that maintain or access company information and PHI. Users will be provided personal credentials by the System Administrator.

Personal credentials will include:

a) **Building Access Badge:** Used to gain access to the main building and rooms where employee has been granted access.
b) **User Name and Password:** Used to gain access to computer systems, the Boon-Chapman Network, and systems where employee has been granted access.

When accessing the main building, the building access badge acts as identification and authorization for the user, which include:

- A name and Photo ID of the workforce member
- Swipe card access to the building
- Users not allowed to let other people in using their building access badge

When accessing computer systems, the user name and password act as identification and authorization for the user, which include:

- Strictly controlled passwords implemented by System Administrator for proper user authentication. See the *Password Control Standards.*
- Automatic timeout re-authentication after fifteen minutes of no activity.
- Users not allowed to leave their computer or workstation without locking their computer.

Users are held accountable for all actions performed on the system with their User ID. Unauthorized usage of the building access badge and of the user name and password may lead to disciplinary action.

3. Data Integrity

Boon-Chapman has retained the ability to provide assurance that company information and PHI isn't altered or destroyed in an unauthorized manner using the following:

- **Internal audits:** Performed periodically by the Compliance Officer.
- **Disk redundancy (RAID)**
- **System Backups (Daily, Weekly, Monthly, Quarterly)**

4. Transmission Security

Boon-Chapman has technical security mechanisms in place to guard against unauthorized access to data that is transmitted in the company network and outside of the network, using the following integrity controls:

- **Data Encryption**
  - **Firewalls**
  - **Encrypted E-mail**
- **Secure File Transfer Protocol (SFTP)**
- **SSL, HTTPS**

These systems are maintained by the System Administrator and System Architect under the supervision of the IT Director.

5. Remote Access

Boon-Chapman allows approved off-site access into the Boon-Chapman Network. The System Administrator grants access to Boon-Chapman approved devices and pathways on a user and application basis. Users may check out a computer from the Helpdesk on a first come first serve basis if deemed appropriate by the System Administrator.

Remote access will always consist of multifactor authentication:

- Outside access available through Boon-Chapman-issued hardware or software.
- Login authentication required to connect to Boon-Chapman network.
- Issued hardware verified with certificate credentials installed on each device.

Access to remote devices is a privilege, any misuse of this privilege may lead to devices being taken away and disciplinary action, up to and including termination. Lost devices may constitute a potential PHI breach, which could lead to criminal charges.

6. Physical Access

Boon-Chapman limits physical access to the building to protect company information and PHI. Access to areas with confidential information are restricted only to appropriately authorized individuals, who can access areas with their building access badge. The physical controls include:

- **Restricted Areas (Wiring Room and Server Room):** Network servers, which contain company information and PHI, are installed in the Server Room and Wiring Room. Only the System Administrator, System Architect, and Executive Management have access to these restricted areas through key card access to prevent theft, destruction, and unauthorized access.
- **Fire, Water, Environmental Protection:** The building, the Server Room, and Wiring Room contain protection against fire, water damage, and other environmental hazards such as power outages and extreme temperature situations.
- **Work Stations:** Secured against unauthorized access. Appropriate workstations will:
    - Position out of sight to prevent unauthorized viewing.
    - Grant minimum necessary access to employees.
    - Employ physical safeguards in controlled access areas.
    - Use automatic screen lock with passwords to protect unattended machines after 15 minutes of inactivity.
    - A Clean Desk Policy, requiring employees to place company information and PHI out of sight when leaving their desk.

7. Facility Access

Boon-Chapman's facility access controls limit physical access to electronic information systems and the facilities in which they are housed, while ensuring that properly authorized access is allowed. Policies and procedures concerning facility access are written by the Compliance Officer and approved by Executive Management.

- **Contingency Plans:** Documented policies and procedures that allow facility access in support of restoration of lost data in the event of an emergency. See the *Disaster Recovery Plan* and *Business Continuity Plan.*
- **Building Access Control and Validation:** Documented procedure to control and validate a person's access to the main building based on their role or function, including workforce members, visitors and vendors, and control of access to software programs for testing and revision. See the *Building Access Policy.*

8. Wireless Access

The Boon-Chapman Wireless Network is maintained outside of the Boon-Chapman firewall and disconnected from the Boon-Chapman Network. The wireless network exists as a courtesy to employees and guests, not as a work tool. The wireless network is secured through acceptance of rules. Guests must create a username and accept the Boon-Chapman Wireless Terms of Use to use the wireless network.

9. Mobile Device Access

Boon-Chapman keeps a strict policy regarding mobile devices. Company information and PHI must never be stored on mobile computing devices (laptops, personal digital assistants [PDAs], smart phones, tablet PCs, etc.). Before being issued mobile devices, users must sign the *Off-Site Equipment Agreement.*

After being issued by the System Administrator, Boon-Chapman mobile devices must have the following minimum security requirements implemented:

a) Power-on passwords
b) Auto log-off or screen saver lock with password
c) Encryption of device or other acceptable safeguards approved by the System Administrator
d) Must never be left unattended in unsecured areas.

If confidential information or PHI is stored on external medium or mobile computing devices and there is a potential breach of confidentiality as a result, the person with the device will be held personally accountable and may be subject to disciplinary action, up to and including termination.

10. Emergency Access

In the event of an emergency in which the System Administrator and System Architect are unavailable, Boon-Chapman Executive Management have access to enter and secure areas where company information and PHI are stored, including the Server Room and Wiring Room.

Compliance [§ 164.308(a)(1)(ii)(C)]

The Boon-Chapman Security Policy applies to all users of Boon-Chapman information including: physicians, employees, contractors, consultants, temporaries, volunteers, interns, etc. Failure to comply with Information Security Policies and Standards may result in disciplinary action up to and including termination in accordance with applicable Boon-Chapman procedures, or, in the case of outside affiliates, termination of the affiliation. Further, penalties associated with state and federal laws may apply.

Possible disciplinary/corrective action may be instituted for, but is not limited to, the following:

1. Unauthorized disclosure of PHI or Confidential information as specified in Confidentiality Statement.
2. Unauthorized disclosure of a sign-on code (User ID) or password.
3. Attempting to obtain a sign-on code or password that belongs to another person.
4. Using or attempting to use another person's sign-on code or password.
5. Unauthorized use of an authorized password to invade patient privacy by examining records or information for which there has been no request for review.
6. Installing or using unlicensed software on Boon-Chapman computers.
7. The intentional unauthorized destruction of Boon-Chapman information.
8. Attempting to get access to sign-on codes for purposes other than official business, including completing fraudulent documentation to gain access.

ATTACHMENT 1 - Password Control Standards

The Boon-Chapman Security Policy requires the use of **strictly** controlled passwords for accessing Protected Health Information (PHI), confidential information (CI) and Internal Information (II) on the Boon-Chapman applications. (See Boon-Chapman Security Policy for definition of these protected classes of information.)

Listed below are the minimum standards that must be implemented in order to ensure the effectiveness of password controls.

Standards for accessing PHI, CI, II:
Users are responsible for complying with the following password standards:

1. Passwords must never be shared with another person, unless the person is a designated security manager.
2. Every password must, where possible, be changed every 90 days.
3. Passwords must, where possible, have a minimum length of eight characters, with one capitol letter, and one digit or special symbol.
4. When creating a password, it is important not to use words that can be found in dictionaries or words that are easily guessed due to their association with the user (i.e. children's names, pets' names, birthdays, etc...). A combination of alpha and numeric characters are more difficult to guess.

Where possible, system software must enforce the following password standards:

1. Passwords routed over a network must be encrypted.
2. Passwords must be entered in a non-display field.
3. System software must disable the user identification code when more than five consecutive invalid passwords are given within a 15-minute timeframe. A lockout is then put in place unless removed by Boon-Chapman's Compliance Officer, System Administrator, or Junior Administrator.
4. System software must maintain a history of previous passwords and prevent their reuse.

F.10 HIPAA Policies

BOON-CHAPMAN

F.10 HIPAA Policies

a. Breach Notification Policy

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Breach Notification Policy

Revision History

REVISION	DATE	NAME	DESCRIPTION
Original 1.0	July 8, 2014	Daniel Chapman	Technical Writer
2016 Revision	March 10, 2016	Daniel Chapman	Compliance Officer

BOON-CHAPMAN

BREACH NOTIFICATION POLICY

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BOON-CHAPMAN

BREACH NOTIFICATION POLICY

I. PURPOSE

The purpose of this policy is to provide guidance to staff of Boon-Chapman Benefit Administrators ("Boon-Chapman") in the event of an unauthorized breach of protected health information ("PHI"). PHI is protected by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") from unauthorized disclosure.

In the event an unauthorized disclosure occurs, Boon-Chapman must notify individuals whose unsecured PHI has been compromised by a breach, must secure the breach, and take steps to prevent the breach from occurring again. In certain circumstances, when a breach is deemed more severe, Boon-Chapman may have to report breaches to the press and to the Secretary of Health and Human Services ("The Secretary"). Boon-Chapman's breach notification process will be carried out in compliance with HIPAA and all future amendments.

II. DEFINITIONS

- **Breach:** The acquisition, access, use, or disclosure of PHI in a manner not permitted under HIPAA, which compromises the security or privacy of PHI. Breach excludes:
  - Any unintentional acquisition, access, or use of PHI by a Boon-Chapman workforce member or person acting under the authority of Boon-Chapman if such acquisition, access, or use was made in good faith and within the scope of authority and does not result in further use or disclosure in a manner not permitted under HIPAA.
  - Any inadvertent disclosure by a person who is authorized to access PHI at Boon-Chapman to another person authorized to access PHI at Boon-Chapman, or organized health care arrangement in which Boon-Chapman participates, and the information received as a result of such disclosure is not further used or disclosed in a manner not permitted under HIPAA.
  - A disclosure of PHI where a covered entity or business associate has a good faith belief that an unauthorized person to whom the disclosure was made would not reasonably have been able to retain such information.
- **Protected Health Information (PHI):** Individually identifiable information that includes any part of a person's past, current, or future medical condition (ex. medical record, billing history). PHI can be transmitted by electronic media, maintained in electronic media, or transmitted and maintained in a hard copy form.
- **"Safe Harbor":** This is a phrase used to describe **de-identified PHI.** Health information is safe to transmit without reporting a breach when these identifiable variables are removed:
  1. Names
  2. Geographical data
  3. All elements of dates
  4. Telephone numbers
  5. FAX numbers
  6. Email addresses

7. Social Security numbers
8. Medical record numbers
9. Health plan beneficiary numbers
10. Account numbers
11. Certificate/license numbers
12. Vehicle identifiers and serial numbers including license plates
13. Device identifiers and serial numbers
14. Web URLs
15. Internet protocol addresses
16. Biometric identifiers
17. Full face photos and comparable images
18. Any unique identifying number, characteristic or code

- **Unsecured Protected Health Information (Unsecured PHI)**: Any PHI which is not unusable, unreadable, or indecipherable to unauthorized persons through the use of technology or methodology, such as encryption or destruction.
- **Workforce**. Workforce means employees, contractors, volunteers, trainees, and other persons under the direct control of Boon-Chapman, whether or not they are paid by Boon-Chapman.

III. POLICY AND PROCEDURES

Boon-Chapman is required by HIPAA to notify individuals whose unsecured PHI has been impermissibly accessed, acquired, used, or disclosed, compromising the security or privacy of the PHI.

1) Discovery of Breach

A breach is "discovered" the day Boon-Chapman staff are aware of it, or by exercising reasonable diligence, would have become aware of it. Workforce members who believe that PHI has been breached must report the breach to the Compliance Officer.

Following the discovery of a potential breach, the breach discoverer will report the breach to the Compliance Officer via the eTicket system. The **HIPAA Breach eTicket** includes these fields:

- Description of breach
- Reporter's name
- Breach discovery date
- Actual breach occurrence date
- Type of medium breached (electronic, oral, paper)
- Type of breach (Loss, misuse, theft)
- Individuals Involved/Affected by breach
- Estimated cost of breach
- Impact of Breach

2) Breach Investigation

After reporting, the Compliance Officer begins a breach investigation, which determines whether or not PHI has been breached. Boon-Chapman's Compliance Officer shall be responsible for the management of the breach investigation.

The breach investigation involves coordinating with Boon-Chapman management, human resources, public relations, and legal counsel as appropriate. Boon-Chapman's entire workforce is expected to assist management in this investigation as requested. The Compliance Officer shall be the key facilitator for all breach notification processes.

3) Notification: Individuals Affected.

If the suspected breach is verified as an actual breach, the notification process begins by notifying victims of the breach who's PHI has been, or is reasonably believed by Boon-Chapman to have been, accessed, acquired, used, or disclosed as a result of the breach.

The first step is for the Compliance Officer to send out a *Breach Notification Letter* to all victims of the breach. The *Breach Notification Letter* is written in plain language and contains the following information:

1. A brief description of what happened, including the date of the breach and the date of the discovery of the breach, if known.
2. A description of the types of unsecured PHI that were involved in the breach (such as whether full name, social security number, date of birth, home address, account number, diagnosis, disability code, or other types of information were involved).
3. Any steps the individuals should take to protect themselves from potential harm resulting from the breach.
4. A brief description of what Boon-Chapman is doing to investigate the breach, to mitigate harm to individuals, and to protect against further breaches.
5. Contact information for individuals to ask questions or learn additional information, which includes a toll-free telephone number, email address, website, or postal address.

Notice to affected individuals shall be made without unreasonable delay and in no case later than 60 calendar days after the discovery of the breach. It is the responsibility of Boon-Chapman to demonstrate that all notifications were made as required, including evidence demonstrating the necessity of any delay.

The *Breach Notification Letter* will be sent by first-class mail to the individual's last known address of the individual or by email. If the individual is deceased, the letter will be sent to the next of kin or personal representative of the individual, written notification by first-class mail to the next of kin or person representative shall be carried out.

If there is insufficient or out-of-date contact information for 10 or more individuals, then a notice will be posted on the home page of Boon-Chapman's website for a period of 90 days. The notice shall include a toll-free number that remains active for at least 90 days where an individual can learn whether his or her PHI may be included in the breach.

4) Notification: HHS

After notifying the individuals, the Compliance Officer shall begin the process of determining what notifications are required or should be made to the Secretary of Health and Human Services.

In the event a breach of unsecured PHI affects 500 or more of Boon-Chapman's clients, the Compliance Officer must notify HHS at the same time notice is made to the affected individuals. If fewer than 500 of Boon-Chapman's patients are affected, the Compliance Officer will maintain a log of the breaches to be submitted annually to the Secretary of HHS no later than 60 days after the end of each calendar year. The submission shall include all breaches discovered during the preceding calendar year.

5) Notification: Press

After notifying HHS, the Compliance Officer shall begin the process of determining what notifications are required or should be made, if any, to the press.

In the event the breach affects more than 500 residents of a state, prominent media outlets serving the state and regional area will be notified without unreasonable delay and in no case later than 60 calendar days after the discovery of the breach. The notice shall be provided in the form of a press release written by the Compliance Officer and approved by Boon-Chapman Management.

6) Delay of Notification Authorized for Law Enforcement Purposes.

Boon-Chapman will cooperate with law enforcement if officials state that a notification, notice, or posting would impede a criminal investigation.

7) Risk Assessment

If it is deemed necessary to prevent future breaches, the Compliance Officer may perform a Risk Assessment of Boon-Chapman. A Risk Assessment looks for potential vulnerabilities and threats to company PHI, and leads to mitigation of those risks to prevent future breaches. These results will be made available in a report.

8) Exceptions

There are three exceptions to the definition of "breach."

The first exception applies to the unintentional acquisition, access, or use of PHI by a workforce member or person acting under the authority of a covered entity or business associate, if such acquisition, access, or use was made in good faith and within the scope of authority.

The second exception applies to the inadvertent disclosure of PHI by a person authorized to access PHI at a covered entity or business associate to another person authorized to access PHI at the covered entity or business associate, or organized health care arrangement in which the covered entity participates. In both cases, the information cannot be further used or disclosed in a manner not permitted by the Privacy Rule.

The final exception applies if the covered entity or business associate has a good faith belief that the unauthorized person to whom the impermissible disclosure was made, would not have been able to retain the information.

9) Maintenance of Breach Information

The Compliance Officer shall maintain records of breach notification information, regardless of the number of patients affected.

10) Workforce Training

Boon-Chapman shall train all members of its workforce on Boon-Chapman's policies and procedures with respect to PHI as necessary for members to carry out their job responsibilities. Workforce members shall also be trained as to how to identify and report breaches to the Compliance Officer using the Boon-Chapman eTicketing tool.

11) Sanctions

Members of Boon-Chapman's workforce who fail to comply with this policy shall be subject to disciplinary action, up to and including termination. Those sanctions are determined by company managers and supervisors.

12) Retaliation/Waiver

Boon-Chapman provides individuals the ability to make complaints concerning Boon-Chapman's privacy policies and procedures (including the *Breach Notification Policy*) without fear of retaliation.

Also, Boon-Chapman may not intimidate, threaten, coerce, discriminate against, or take other retaliatory action against any individual for exercising his or her privacy rights. Individuals shall not be required to waive their privacy rights as a condition of the provision of treatment, payment, enrollment in a health plan, or eligibility for benefits.

13) Burden of Proof

Boon-Chapman has the burden of proof for demonstrating that all notifications were made as required or that the use or disclosure did not constitute a breach.

F.10 HIPAA Policies

b. Data Classification Policy

BOON-CHAPMAN

BOON-CHAPMAN

Data Classification Policy

Revision History

REVISION	DATE	NAME	DESCRIPTION
Original 1.0	April 24, 2015	Daniel Chapman, Josh Rynearson	Compliance Officer, IT Director
Revised 2.0	April 11, 2016	Daniel Chapman, Betsy D'Acierno	Compliance Officer, Executive Director of Clinic Operations

Boon-Chapman Data Classification Policy

I. PURPOSE

The purpose of this Data Classification Policy is to provide a system for protecting company information that is critical to Boon-Chapman Benefit Administrators, Inc. ("Boon-Chapman") from its creation to its disposal.

II. SCOPE

This policy applies to all Boon-Chapman employees, volunteers and contractors. All workers who may come into contact with confidential information are expected to familiarize themselves with this data classification policy and to consistently use it.

III. POLICY

This policy has been designed for a need to know basis. This is so company information will be protected from unauthorized disclosure, use, modification, and deletion. Consistent use of this system will facilitate business activities and help keep the costs for information security to a minimum. Without the consistent use of this data classification system, Boon-Chapman unduly risks loss of customer relationships, internal operational disruption, excessive costs, and competitive disadvantage.

Information must be consistently protected throughout its life cycle, from its origination to its destruction. Information must be protected in a manner commensurate with its sensitivity, regardless of where it resides, what form it takes, what technology was used to handle it, or what purpose(s) it serves.

IV. CLASSIFICATION LABELS

Public: Applies to information available to the general public and intended for distribution outside Boon-Chapman. This information may be freely disseminated without potential harm. (Ex: product and service brochures, advertisements, job opening announcements)

For Internal Use Only: Applies to information meant for use inside Boon-Chapman, but the unauthorized disclosure, modification or destruction of it is not expected to seriously or adversely impact Boon-Chapman, its client, its employees, or its business partners. (Ex: telephone directory, new employee training materials, and internal policy manuals)

Confidential: Information that is intended for use within Boon-Chapman. Its unauthorized disclosure could adversely impact the company's clients, employees and business partners. Information that some people would consider private is included in this classification. (Ex: appointment schedules, department financial data, contracts and agreements)

Restricted Confidential: This classification applies to the most sensitive medical and business information that is intended strictly for use within the organization. Its unauthorized disclosure could seriously and adversely impact the organization, its patients, its employees and its business partners. (Ex: protected health information, corporate level strategic plans, software code)

V. DATA RETENTION.

See *Record Retention Policy.*

F.10 HIPAA Policies

c. Incident Report Policy

BOON-CHAPMAN

BOON-CHAPMAN

Incident Report Policy, Procedure, Form

Revision History

REVISION	DATE	NAME	DESCRIPTION
Original 1.0	March 27, 2015	Daniel Chapman	Compliance Officer
Revised 2.0	April 15, 2016	Daniel Chapman	Compliance Officer

1. Overview

Boon-Chapman Benefit Administrators, Inc. ("Boon-Chapman") is responsible for the security and integrity of its employees and company data. Boon-Chapman must protect both using all means necessary by ensuring at all times that any incident which could cause damage to Boon-Chapman can be easily reported. This way, damage can be minimized with a quick response.

2. Purpose

The purpose of this policy is to outline the types of security incidents, detail how incidents can and will be dealt with, identify responsibilities for reporting and dealing with incidents, and detail procedures in place for reporting and processing of incidents

Fostering a culture of proactive incident reporting and logging will help reduce the number of security incidents and reduce the damage of incidents that do occur.

3. Scope

All employees, contractors, temporary workers, and those employed by others to perform work on Boon-Chapman premises or who have been granted access to Boon-Chapman information or systems, are covered by the policy and must comply with it.

4. Policy

A security incident is any event that inconveniences Boon-Chapman by putting data and/or employees at risk of disclosure, theft or exploitation. Boon-Chapman employees are required to report suspected incidents that threaten the Boon-Chapman network as soon as possible to the Compliance Officer, who will write a report of the incident and report findings to the Vice President of Operations.

The types of Incidents which this policy addresses include but is not limited to:

4.1 Password Disclosures

Unique user account passwords are to be used when allowing a Boon-Chapman employee access to Boon-Chapman hardware and network. It is imperative that passwords are not disclosed to anyone. The only exception to this rule is in the event that the IT Department require the password to resolve a problem.

If anyone suspects that their password has been disclosed, an incident report should immediately be reported to the Compliance Officer or the Help Desk.

4.2 Computer Viruses/Antivirus

All Boon-Chapman computers have antivirus capabilities. If an employee has an issue with their computer they believe may be caused by a virus, notify the Help Desk. If a virus is confirmed to have infected the computer and potentially other systems, an incident report should be reported.

4.3 ID Badges

ID cards are essential to helping Boon-Chapman employees and systems stay safe and secure. If lost or stolen, they could potentially give access to Boon-Chapman systems to unauthorized users. Any Boon-Chapman employee who suspects their ID stolen must file an incident report.

4.4 Theft

Information which cannot be found or is suspected of being stolen must be reported in an incident report.

4.5 Data Loss/Disclosure

The potential for data loss, disclosure or theft could apply to data which is:

- Transmitted over a network and reaching an unintended, unauthorized recipient
- Intercepted over the internet through non secure channels
- Posted on the internet whether accidental or intentional
- Conversationally – information disclosed during conversation
- Disclosed to the press
- Hard copies of information and data accessible from desks and unattended areas

All Boon-Chapman employees must act responsibly and be mindful of the importance of maintaining the security and integrity of company data at all times. If there is a loss of data and/or disclosure made without proper authorization, an incident report must be reported.

4.6 Personal Information Abuse

Individually identifiable information, such as an employee's home address, bank accounts, SSN, etc. must be kept confidential. Only a person with written consent and a specific information request may access identifiable information. Any abuse/misuse of such information requires an incident report.

4.7 Physical Security

Maintaining the physical security of company data is extremely important. Rooms or offices where confidential information is located or stored must have access controls in place. Rooms which have not been secured should not be used to store confidential information – concerns about any rooms/office should be reported with an incident report.

4.8 Electronic Security

It is equally important to secure digital data with encryption, firewalls, and access controls. If an employee notices they can gain access to files and confidential information they aren't allowed to see due to an error in access controls, an incident report should be reported.

Responsibilities

It is every Boon-Chapman employee's responsibility to be proactive in the reporting of Boon-Chapman security incidents at or away from the workplace. Boon-Chapman Information Security Incident Policy and Procedures are in place to prevent and minimize the risk of damage to Boon-Chapman information.

It is the responsibility of employees to notify the Compliance Officer or the Help Desk of incidents requiring a report. The Compliance Officer is responsible with completing and filing the report form to the Vice President of Operations.

5. Breaches of Policy

Breaches of this policy and/or security incidents are incidents which could or have resulted in the loss or damage of Boon-Chapman assets.

All Boon-Chapman employees and contractors have a responsibility to report breaches in policy as quickly as possible. Failure to do so could result in the immediate removal of access to the Boon-Chapman Network, termination, and/or legal action.

6. Procedures

Below are the procedure for reporting an incident using the Boon-Chapman Ticketing System. All incidents forms are archived in an electronic database:

A. Fill out the Incident Report Form on the E-Ticketing System

1) Go to the Boon-Chapman Helpdesk. Create an e-ticket.
2) Change Category section to **Incident Report** under **Systems** tab.
3) Enter the subject of your Incident Report, fill out a brief description of the Incident in question. Also select best assessment of the priority of the incident being reported.
4) Assign to the Compliance Officer, System Architect, or System Administrator.
5) Submit Ticket.
6) When System Administrator, System Architect, and Compliance Officer are finished with the ticket, Compliance Officer will assign ticket to the Vice-President of Operations.
7) Incident Report Form ticket will close when the Vice-President of Operations will mark the Incident complete.

B. If the eTicketing System isn't available, fill out the Incident Report Form on paper

1) Fill out *Boon-Chapman Incident Report*. Find in S:\ Drive, Policies and Procedures Folder. Open Boon-Chapman Incident Report Policy Procedure Form. See Attachment 1.
    - Give to Help Desk in person, or proceed to Step 2.
2) Go to Boon-Chapman intranet and select Help Desk under Links or compose an email to incidents@boonchapman.com
    - Include details, specifically what the incident is, when and where the incident occurred, and who is involved.
3) Attach completed *Boon-Chapman Incident Report* to "ticket," and send.
4) Once received, the System Administrator, System Architect, or Compliance Officer will open the ticket.
5) When complete, the report will be sent to the Compliance Officer for documentation. The Compliance Officer will send incident report to Vice President of Operations.
6) The Incident Report Form will be filed after the Vice-President of Operations signs the Incident Report Form, completing it.

7. Incidents vs Disasters

In the event an Incident is so disastrous that it prevents the company from being able to function normally, the Compliance Officer and Vice-President of Operations may instead elect to respond by activating the *Disaster Recovery Plan*.

The Disaster Recovery Plan is a plan required by federal and state law to help Boon-Chapman recover from an unforeseen disaster or emergency which interrupts business operations including flood, fire, tornado, power failure, acts of terrorism and sabotage, and earthquake. All disasters, like incidents, must be thoroughly documented by the Compliance Officer.

For more information, please read Boon-Chapman's *Disaster Recovery Plan*.

BOON-CHAPMAN

INCIDENT RESPONSE REPORT FORM

General Information

Incident Detector's Information:

Name: _____ | Signature:
Title: _____ | X _____
Email: _____ | Date Signed: _____

Brief Description of Incident: _____

Incident Summary

Incident Detector's Information:

◊ Denial of Service ◊ Unauthorized Use ◊ Espionage ◊ Hardware Failure ◊ Software Failure

◊ Malicious Code ◊ Vulnerability ◊ Annual Test ◊ Other: _____

Incident Priority:

☐ Low ☐ Medium ☐ High

Incident Location:

Address: _____ | Describe affected system(s): _____

Location Name: _____

Date and Time Detected: _____

Describe how incident was detected: _____

Date and time response team arrived: _____

Describe affected information system(s):
Hardware Manufacturer: _____
Serial Number: _____
Corporate Property Number (if applicable): _____
Is affected system connected to a network? ◊ **YES** ◊ **NO**
System Name: _____
System Network Address: _____
MAC Address: _____

Describe the physical security of the location of affected information systems (locks, security alarms, building access, etc.):

_____

_____

_____

Was the system removed from network? ◊ YES ◊ NO ◊ N/A
If YES, date and time systems were removed: _____
If NO, state the reason: _____

_____

If N/A, state the reason: _____

_____

Is there a backup of the system? ◊ YES ◊ NO ◊ N/A
If YES, date and time of backup: _____
If NO, state the reason: _____

_____

If N/A, explain: _____
Were backups used? ◊ YES ◊ NO
If YES, which backup was used: _____
If NO, state the reason: _____
Name of persons performing forensics on systems: _____

_____

_____

Was vulnerability identified? ◊ YES ◊ NO

What was the validation procedure used to ensure problem is eradicated: _____

_____

_____

_____

_____

_____

_____

_____

Who approved this validation procedure: _____

Total Down Time: _____

Compliance Officer Signature:

X_____

Date: _____

Vice President of Operations Signature:

X _____

Date: _____

BOON-CHAPMAN

INCIDENT CONTACT LIST

Name, Title	Contact Option	Contact Address
Kevin Chapman, President	Phone Number	(512) 233-7118
	Email Address	kevinc@boonchapman.com
Nyle Leftwich, Vice President	Phone Number	(512) 619-7613
	Email Address	nleftwich@boonchapman.com
Carrie Mabrito, Vice President of Operations	Phone Number	(210) 316-6141
	Email Address	cmabrito@boonchapman.com
Josh Rynearson, Director of Information Technology	Phone Number	(512) 454-2681 x 7203
	Email Address	Joshr@boonchapman.com
Jason Gomes, System Architect	Phone Number	(512) 796-2552
	Email Address	jasong@boonchapman.com
Dayne Miller, System Administrator	Phone Number	(972) 832-6817
	Email Address	daynem@boonchapman.com
Trey Wilkins, Help Desk Lead	Phone Number	(512) 233-7191
	Email Address	danielw@boonchapman.com
Matt Durham, Controller	Phone Number	(512) 233-7212
	Email Address	mdurham@boonchapman.com
Jill Monsees, HR and Support Manager	Phone Number	(512) 233-7136
	Email Address	jillm@boonchapman.com
Daniel Chapman, Compliance Officer	Phone Number	(512) 233-7253
	Alt. Phone Number	(512) 680-3452
	Email Address	dchapman@boonchapman.com

EMERGENCY CONTACT LIST

Name, Title	Contact Option	Contact Address
Emergency	Phone Number	911
Fire Department	Phone Number	(512) 258-1038
Sheriff Department	Phone Number	(512) 352-4123
CBRE (Building Management) Office	Phone Number	(512) 331-5040
CBRE After-Hours Emergency	Phone Number	(512) 331-5040

Exhibit F:

Boon Chapman Original Response dated May 16, 2016

Optional Services

Section E
Optional Services

BOON-CHAPMAN

Optional Services

KelseyCare powered by Boon-Chapman

The KelseyCare health benefits plan, administered by Boon-Chapman, provides high quality healthcare for self-funded companies with more than 50 covered employees in the Greater Houston area. Members have access to the Kelsey-Seybold provider network, which includes 370 Kelsey-Seybold physicians and more than 1,800 KelseyCare Affiliate Specialists selected by Kelsey-Seybold physician leadership for quality care.

The plan integrates person-to-person care delivery in 50 specialties, care coordination, disease and case management, hospitalist physicians and hospital partners all into one plan offering. But more than that, the plan delivers superior clinical, financial and satisfaction outcomes compared to the performance of other networks and PPO plans. We would need additional information to determine the cost.

Quarterly one-on-one employee meetings

Boon-Chapman claims personnel will be in Fort Bend County for 2 days each quarter of the year to meet with participants who have questions about EOBs, benefits, precertification issues, etc. There is no charge for this service.

Employee communications

Boon-Chapman will assist in the design and content of employee communications to be used at enrollment and/or other educational meetings. There is no charge for this service, unless Boon-Chapman prints and/or mails communication pieces. In that case, all printing, supplies, postage, and labor will be passed through at cost.

Enrollment meetings

Boon-Chapman will assist the Risk Management department in conducting annual enrollment meetings. The charge is outlined in the current Administrative Services Agreement.

Legal notices

Boon-Chapman will provide the following annual notices as required by the federal law:

1. Women's Health and Cancer Rights Act "WHCRA"
2. Medicare Part D Creditable Coverage
3. Children's Health Insurance Program Reauthorization Act "CHIPRA"

The fee for this service is $1.00 per employee per month.

Reinsurance/stop loss marketing and placement

Boon-Chapman will market and secure reinsurance annually at renewal. There is no charge for this service.

Plan Analysis, Review, and Management Services

Boon-Chapman will prepare a financial status report as to the financial history of the Plan, current financial status with options available, and prepare periodic and annual reports as they relate to Plan performance and the financial status. We will also assist in the development of, and continued review of, Plan design of existing and new plan options, and recommend employer contributions consistent with current budget. We will also analyze the current Medical Plan in terms of participation and the most effective use of employer contributions. The charge for this service is $2.00 per employee per month.

Transitional Reinsurance Fee

Boon-Chapman will report membership counts to the Department of Health and Human Services. Upon receipt of Fort Bend County's HHS invoice, we will submit notice to the Plan of the full Fee. Upon this notification, the County will authorize Boon-Chapman to make payment directly from their account to HHS. The fee for this service is $1000 annually.

Patient-Centered Outcomes Research Institute Fee

Boon-Chapman will provide necessary census reporting to the County so that they can complete the application IRS Form. There is no charge for this service.

Medicare Part D reporting

Annual notices to participants – See "Legal Notices" section above

Creditable coverage disclosure to Centers for Medicare and Medicaid "CMS" –Boon-Chapman will assist the County in the online annual reporting to CMS. There is no charge for this service.

Medicare Part D retiree drug subsidy recovery assistance – Boon-Chapman will assist the County in subsidy recoupment. The fee for this service is $2.00 per retiree per month, plus the cost of the actuarial attestation.

Prescription Benefit Management Services

We can offer the County several prescription benefit management companies to choose from. We can also introduce the county to the PBM consultant we use who can assist in evaluating the options. We would need additional information to determine the cost.

Medical Tourism

Domestic – Boon-Chapman will assist participants in obtaining applicable outpatient surgical care at Surgery Center of Oklahoma or other facilities that use "transparent pricing". We will work with the County to implement and communicate Plan language to incent participants to use this facility. There is no charge for Boon-Chapman to facilitate this arrangement or to provide Plan language. Applicable Plan benefits apply to services rendered.

International – Boon-Chapman will assist participants in obtaining applicable care Health City Cayman Islands or other like facilities. We will work with the County to implement and communicate Plan language to incent participants to use this facility. There is no charge for Boon-Chapman to facilitate this arrangement or to provide Plan language. Applicable Plan benefits apply to services rendered.

Hospital Bill Audit

Boon-Chapman will assist the County in the evaluation, procurement, contracting, and implementation of the services of a hospital bill audit company to scrub bills to find billing code errors, gross overcharges, and other types of common billing errors. The fee for this service varies according to which audit company is used.

Provider Negotiations

At the direction of the County, our Cost Containment unit will attempt to obtain discounts from out-of-network providers in order to decrease both Plan costs and balance billing to the member. Negotiated claims will be processed at the out of network coinsurance level, and all negotiations will be signed off on by the provider. The fee for this service is 25% of savings.

Plan Document services

Development and maintenance of plan document (using the Boon-Chapman template document), including regulatory language updates as applicable. There is no charge for this service.

Employee Assistance Programs

Boon-Chapman will assist the County in the evaluation, procurement, contracting, and implementation of Employee Assistance Programs to best meet the needs of your members. There is no charge for this service.

Debit card for Section 125 Plan

The Benny Prepaid Benefits Card is a special-purpose MasterCard® Card or Visa® Card that gives participants an easy, automatic way to pay for eligible health care or benefit expenses. The Card lets participants electronically access the pre-tax amounts set aside in their respective employee benefits accounts such as Flexible Spending Accounts (FSAs), Health Reimbursement Accounts (HRAs), and Health Savings Accounts (HSAs). There is no fee for the additional card. There is a $5.00 fee to replace lost or stolen cards, this fee is typically billed directly to the cardholder's account.

Benefit administration outsourcing

Boon-Chapman can offer combined billing and online enrollment services. We would need additional information to determine the fee.

Dental Preferred Provider Organization ("PPO")

Boon-Chapman will assist the County in the evaluation, procurement, contracting, and implementation of a dental PPO. Working with Aetna, Guardian, Cigna, or Connection Dental, can enhance the current self-funded dental offering. The fees vary by PPO.

Real-time diabetes testing and monitoring

Boon-Chapman will assist the County in the evaluation, procurement, contracting, and implementation of the services of ActiveCare, or other similar diabetes testing and monitoring vendors, to provide accurate and actionable blood glucose monitoring via remote device. Additional information is required for a charge/fee quote.

Mobile healthcare application

Boon-Chapman will assist the County in the evaluation, procurement, contracting, and implementation of the services of Zest Health, or other similar vendors, to deliver convenient access to concierge support and benefits information. Participants will save time and money through easy in-network appointment scheduling and 24/7 access to health professionals. Benefit information, including ID cards, claims information, deductibles, and out of pocket amounts, are also accessible. Additional information is required for a charge/fee quote.

Transparency tool

Boon-Chapman will offer the services of Healthcare Bluebook, or other similar vendors. Using this service, participants can find the best prices within the existing provider network, ensuring they get the most value for every dollar spent. They can also view quality metrics, allowing the participants to get the highest quality care at the lowest price. Additional information is required for a charge/fee quote.

Pre-diabetes detection and treatment program

Boon-Chapman can offer a pre-diabetes management program. The treatment would be based on physician-directed care and lifestyle intervention. The company offers a complimentary biomarker blood test that can detect prediabetes, and also continuing biomarker tests throughout the personalized program to monitor specific processes in the body associated with prediabetic conditions. Additional information is required for a charge/fee quote.

Telemedicine

Boon-Chapman will assist the County in the evaluation, procurement, contracting, and implementation of TelaDoc, or other similar telemedicine vendors. Participants may request a visit with a doctor 24 hours a day, 365 days a year, by web, phone, or mobile app. Additional information is required for a charge/fee quote.

Dialysis Program

The objective of the dialysis program is to limit the financial exposure to self-funded employer groups produced by long-term dialysis care. PPO contracts do not sufficiently control the exorbitant costs associated with this care. Our dialysis program leverages existing Medicare regulations to provide a solution that addresses both the direct impact to claim costs, as well as stoploss insurance rates. This program can generate hundreds of thousands of dollars in savings on even one dialysis case. We can provide this service for $100 per dialysis claim.

Non-network Hospital Claims

There is no accepted usual and customary pricing data available for hospital claims. Consequently, health plans are at risk of paying too much to non-network hospitals with inflated charges. We are one of the few third party administrators that license sophisticated software to determine the Medicare allowable for charges at every hospital in the United States. This gives our health plans the option of setting a non-network allowable at a percentage of Medicare to avoid this risk. The fee for this service is 10% of savings.

High Touch Customer Service

Traditionally, health insurance companies have received claims and in response mailed EOBs and letters requesting additional information to members and providers. Providers generally understand this correspondence and know what to do. Members, however, are sometimes confused by them and are often too busy to deal with them. This confusion can create frustration. If the correspondence requires member action and none is forthcoming, it can lead to more correspondence, claim denials, or other frustration. If someone could just talk to the member first and explain what is happening, why it is happening, or what is needed much of this heart ache could be avoided. That is what the Boon-Chapman Fort Bend County Member Champion could provide. The Member Champion would proactively contact members when we need additional information and before certain claim denials. It is more labor intensive on our end, but your plan participants are worth it. We would charge $1.00 pepm.

Employer sponsored clinic services

Through our sister company Soluta, Inc. we can offer the County the Elevate application as described in the Executive Summary or offer full clinic management services. We would need additional information to determine the fee for these services.

Insured Transplant Carve out plan

Boon-Chapman will assist the County in the evaluation, procurement, contracting, and implementation of an insured transplant carve out plan. Additional information is required for a charge/fee quote.

Vision benefits

Boon-Chapman can assist in the evaluation, procurement, contracting, and implementation of fully insured vision coverage. Additional information is required for a charge/fee quote.

If the County chooses to self-fund the vision benefit, we can assist with plan design and contribution recommendations. There is no fee for this service.

Ancillary Products

Boon-Chapman will assist the County in the evaluation, procurement, contracting, and implementation of insured ancillary products, including but not limited to, short term disability, long term disability, life, accidental death and dismemberment, and long term care coverage. Additional information is required for a charge/fee quote.

Section 6055/6056 reporting

Boon-Chapman will assist the County in the evaluation, procurement, contracting, and implementation of a vendor to track and/or provide appropriate tax forms.

Bank reconciliation

Boon-Chapman will reconcile the FBC medical claims account and provide the cash journal at the end of each month, or upon request. The fee for this service is $1.50 per employee per month.

Jail clinic consulting

EXHIBIT TWO:

SECOND AMENDMENT TO AGREEMENT FOR THIRD PARTY CLAIMS ADMINISTRATION SERVICES
PURSUANT TO RFP 16-086

EXHIBIT G:

PBM SCOPE OF WORK

PBM SCOPE OF WORK

STATEMENT OF WORK. Boon-Chapman Benefit Administrators, Inc. ("Boon-Chapman") will provide the following pharmacy benefit management services to Fort Bend County through Boon-Chapman's Prescription Drug Program Agreement with Express Scripts, Inc. ("ESI"): implementation of Fort Bend County's pharmacy benefit plan design; pharmacy network contracting for retail pharmacy services; pharmacy claims processing; mail and specialty drug pharmacy services; cost containment, clinical, safety, adherence and other clinical programs; formulary and rebate administration. Boon-Chapman will pass-through any rebates it receives from ESI for Fort Bend County's brand drug utilization at retail, mail, and specialty. Boon-Chapman will pay any rebates it receives from ESI within ten (10) days of receipt. However, if Fort Bend County is in arrears on any payments for prescription drug claims, Boon-Chapman will be entitled to offset any amounts owed to Boon-Chapman for Fort Bend County's prescription drug claims from the rebates that Boon-Chapman receives from ESI for Fort Bend County's brand drug utilization."

EXHIBIT H:

STOP LOSS SCOPE OF WORK

EXHIBIT H:
STOP LOSS SCOPE OF WORK

Effective January 1, 2018, Boon Chapman will provide Stop-Loss coverage services to include: securing coverage with a vendor acceptable to the County's Risk Management director, billing for the stop-loss premiums in the monthly billing cycle, and remitting the premium to the stop-loss vendor. Additionally, Boon Chapman will file the specific and aggregate stop-loss claims as they occur, and provide monthly reports to the stop-loss vendor on County's behalf and provide copies of same to County. The fee for this service shall not exceed $10,200.00 which shall be payable in one sum in accordance with Section 4.2 of the AGREEMENT FOR THIRD PARTY CLAIMS ADMINISTRATION SERVICES PURSUANT TO RFP 16-086.