

**FORT BEND COUNTY EMPLOYEE BENEFIT
MEDICAL PLAN DOCUMENT**

January 1, 2022

Fort Bend County, the Employer, hereby amends and restates effective August 11, 2020 the self-funded Fort Bend County Employee Benefit Medical Plan (“Medical Plan”) formed under Chapter 172 of the Local Government Code. The plan provides 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 January 1, 2022.

County Judge

County Commissioner, Precinct 1

County Commissioner, Precinct 2

County Commissioner, Precinct 3

County Commissioner, Precinct 4

Approved by Commissioners Court on
_____ day of _____ 20____

Attest:

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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

	DEDUCTIBLE	
	<u>INSIDE PPO</u>	<u>OUTSIDE PPO</u>
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	
	<u>INSIDE PPO</u>	<u>OUTSIDE PPO</u>
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 PROVISIONS: 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;

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.

2. 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.
3. The Plan reserves the right to allocate the deductible to any Eligible Expenses and to apportion the benefits to the Participant and any assignees.
4. 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	
	<u>INSIDE PPO</u>	<u>OUTSIDE PPO</u>
INPATIENT 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.		
(See Article II, section D, and Article VI)	80%	0%
<u>OTHER MEDICAL EXPENSES</u>		
1. Surgery* – Inpatient	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%
7. Chiropractic Charges – Calendar Year Maximum of eighteen (18) visits and additional visits require precertification* through PrimeDx for medical necessity	80%	50%

**COINSURANCE
PERCENTAGE PLAN PAYS**

INSIDE PPO OUTSIDE PPO

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%	Not Covered

***Mental Health** benefits may be used only at PPO providers with prior approval from PrimeDx as described under the Cost Containment Provisions under Article II. 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 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 **\$5000** 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 **\$5000** 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.

Participants 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 **\$5000** 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.

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.

- a) Mammograms at a **Preferred Provider**, including interpretation by radiologist at a **Preferred Provider**.
- b) Pap Smear including office visit, age nineteen (19) years and older, at a **Preferred Provider**.
- c) HPV vaccine, as recommended by CDC guidelines, at a **Preferred Provider**.
- d) Bone density testing including office visit at a **Preferred Provider**.
- e) 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**.
- f) Immunizations and vaccinations: the plan will pay for immunizations and vaccinations for all covered members if administered at a **Preferred Provider**, except for the purpose of international travel. In addition, these immunizations will not be subject to the calendar year benefit maximum for annual health screening benefit. Immunization charges incurred at a non-PPO Provider will be processed the same as any other non-PPO service.
- g) 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.**

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, except as otherwise provided herein.

EXAMPLE – Outpatient Non-Emergency PPO Office Visit

Medical Physician's charge	\$80.00
Minus PPO discount	<u>-\$20.00</u>
Balance of Physician's charge after discount	\$60.00
Minus Participant copay	<u>-\$30.00</u>
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 at 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	
	<u>INSIDE PPO</u>	<u>OUTSIDE PPO</u>
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. MEDICAL TOURISM BENEFIT

Covered Services	Plan Pays	Additional Information/Limitations
Surgical Services <i>Approved Medical Tourism Providers Only</i>	100% No Deductible	Covered Services include all medical costs incurred while receiving treatment or services at an Approved Surgery Center. Pre-certification is required. Refer to the Medical Tourism Benefit section for details and limitations.
Travel Benefit	Up to \$1,000* per surgery	Pre-approval of all Travel Benefits is required. Includes transportation (from home to surgery center), lodging and incidental expenses. Refer to Medical Tourism Benefit section for details and limitations. *Travel expenses that exceed \$1,000 must be pre-approved.
Incidental Expenses	\$45 per day reimbursement	Per diem meals and travel related (i.e.; parking, tolls, toiletries) incidentals for the Covered Person and one adult caregiver at the rate of \$45 per day per person. The Covered Person’s per diem will not be paid during any required inpatient stay.
High Tech Radiology performed at US Imaging	100% No Deductible	Pre-certification required
Virtual/Tele Physical Therapy	100% No Deductible	Pre-certification required

C. 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*

EXPRESS SCRIPTS HOME DELIVERY (for up to a 90-day supply)

Generic \$24.00*
 Preferred Brand Name \$60.00*
 Non-Preferred Brand Name \$100.00*

SPECIALTY MEDICATIONS (30 Days Supply or Less Only)**

Generic \$125.00*
 Preferred Brand Name \$125.00*
 Non-Preferred Brand Name \$125.00*

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

There is no copay required for syringes.

**Specialty Medications are those typically requiring special handling and/or additional patient monitoring used for disease states not considered common, is chronic in nature and has a cost higher than traditional medications. All specialty medications must be purchased from Express Scripts Specialty Pharmacy. For questions about this program, please call Express Scripts at 1-866-713-7354.

The Express Scripts formulary determines the pricing category of your Prescription Drug. Contact **Express Scripts at 1-866-713-7354** or visit www.express-scripts.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 Express Scripts 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. Express Scripts will be responsible for contracting with all pharmacies that will accept the ID card. They may be contacted at 1-866-713-7354. 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 the prescribing 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 regards 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.

STEP THERAPY REQUIREMENT:

This Plan requires "step therapy" for various types of medications. Step therapy is the requirement of using conservative therapeutic options before progressing to the other alternative. The primary step therapy requirements are as follows:

- **Generic Step Therapy: When there is a generic alternative to a medication within the same therapeutic class, the Plan will only cover the generic alternative as the first step (step 1) in therapy. Use of the generic medication must be used for a period of at least three (3) months before the Plan**

will consider covering the brand alternative (step 2). Some examples of these medications 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. Additionally, over the counter (OTC) medications will also be covered as step 1 for PPI and Nasal Steroid classes.

- **Specialty Step Therapy: Before the Plan will cover a specialty medication, the patient must try and fail the conservative therapy options before progressing to a specialty medication.**

Under any step therapy program, should a patient have a medical need to progress to the advanced alternative without trying the conservative therapy as the first step, the patient's provider may appeal the step therapy process by contacting Express Scripts at 1-866-713-7354.

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 or specialty 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 on the Express Scripts 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 Express Scripts Excluded Drugs list may be accessed at www.express-scripts.com or by calling 1-866-713-7354.
6. Medications requiring prior authorization without compliance with the Express Scripts prior authorization protocol.
The list of medications requiring prior authorizations (PA) list is available at www.express-scripts.com or by calling 1-866-713-7354, the list is subject to change.

7. 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.
8. The administration or injection of any drug including injectable insulin;
9. 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;
10. 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
11. Replacement of lost, stolen, or damage prescriptions;
12. Drugs or medications which are covered under Medical Benefits (Article VI);), including medical devices appliances, and supplies;
13. 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.fortbendcountytexas.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). 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 inpatient 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 inpatient 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 inpatient 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 (36th) 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 (36th) 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, Participants are provided access to eight (8) free visits through our Employee Assistance Program (E.A.P.) for care related to mental health/substance abuse. 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 can also coordinate Participant's benefits with referral to another provider; however, Participant may only use providers with the Aetna Signature Administrators PPO network.

In the event of an Emergency inpatient Hospital admission or a scheduled inpatient Hospital admission, Participant must utilize an in network provider or benefits will be disallowed. Hospital Providers for Emergency Hospital admissions may be obtained from **ONLY** the Aetna Signature Administrators PPO website.

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.

5. 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 inpatient 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 inpatient 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 inpatient 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 inpatient care unless a condition of physical health that (regardless of psychiatric or substance abuse diagnosis) would necessitate inpatient 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 inpatient care necessary to treat a condition of physical health that (regardless of a psychiatric or substance diagnosis) would necessitate inpatient care, in accordance with the Plan’s coverage of such physical condition.

6. Inpatient 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 inpatient 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.

7. Subacute (Residential) Inpatient Confinements (Precertification Required)

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

8. 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 inpatient care;
- c) Multiple sessions per week;
- d) Necessary when used to prevent Hospitalization or re-Hospitalization;
- e) For a severe multiple problem family situation; and

- f) To significantly shorten the length of standard (i.e., once per week) therapy to achieve the same therapeutic goals.

9. 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).

10. 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.

Inpatient 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:

11. Be performed by a Physician who is certified or board eligible by the American Board of Surgery or other specialty board; and
12. 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 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. 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. After the initial free visits, should Participants need to continue mental health/substance abuse services, the Participant should access the Aetna Signature Administrators PPO network of Physicians. **Your E.A.P. provider is Deer Oaks EAP Services and they can be reached toll free at 1-866-327-2400.**

M. ALTERNATIVE MEDICAL TOURISM BENEFIT

Medical tourism is an optional and alternative benefits that if approved allows you to obtain services outside of our traditional providers and travel for surgical care in order to save on healthcare costs and in return receive highly specialized and efficient care. If you are advised that you need a surgical procedure you are encouraged to contact the Nurse Advocate at 833-864-4316 or fbcadvocate@boonchapman.com to discuss the availability of this benefit at any other facility before receiving the treatment or services. Alternatively, the Plan may initiate notification and consultation communications concerning the option of Medical Tourism even without an inquiry from a Plan Participant.

Domestic Approved Surgery Centers

Participants have access to certain Out-of-Network Approved Surgery Centers offering transparent pricing to receive surgical treatments when a treating physician(s) recommends certain eligible, medically necessary

treatment or services covered by this Plan (Covered Services) and the participant elects to receive treatment or services at that facility. Participants are not required to access an Approved Surgery Center, however, the Plan encourages participants to consider all options available when planning for an upcoming surgical procedure.

The Covered Services performed at these Approved Surgery Centers will be paid according to the Medical Schedule of Benefits for Medical Tourism.

Covered Services include all medical costs incurred while receiving treatment or services at the Approved Surgery Centers as well as a travel benefit (See Medical Tourism Schedule of Benefits for details). Travel benefits are only covered by the Plan if the travel and lodging is reserved, scheduled and approved by the Plan in advance. If these conditions are met, the Plan covers expenses for travel and lodging for the participant and one adult companion for the following expenses:

- Transportation for the participant and one adult companion who is traveling on the same day(s) to and/or from the site of treatment for a surgical episode of care which typically includes a preoperative evaluation, the surgical procedure and necessary post-operative follow-up. Reasonable transportation expenses may include:
 - Parking expenses at or transportation to and from the member's airport of origin
 - Airfare
 - Ground transportation from airport to hotel, between hotel and doctor's office for consultation, between hotel and surgery center, and from hotel to airport.
 - Mileage reimbursement at the IRS rate for the most direct route between the participant's home and the Approved Surgery Center facility (in lieu of airfare and ground transportation)
- Lodging: One-room accommodation at a Plan-approved hotel. Room and taxes only. Incidentals (Wi-Fi, etc. not included)
- Meals and Incidentals Expense Benefit
 - Provides \$45 per day to cover expenses for the participant while not admitted to the hospital and \$45 per day for one adult companion. Expense benefits are limited to the surgical episode days, and will not be paid for the participant during any required inpatient stay.

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

The Approved Surgery Centers physician(s) will make the medical necessity determination based on receipt and review of all applicable medical records unless stated otherwise.

Pre-Notification Requirement:

Except in an urgent care situation, the participant must call the Nurse Advocate at 833-864-4316, at least three (3) business days in advance before any/all procedures scheduled. Such services include but not are limited to the following:

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

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 – 002949

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**

Express Scripts
320 S. Polk Street, Suite 200
Amarillo, TX 79101
Telephone: 1-800-687-0707
Web address: www.express-scripts.com

Express Scripts Hope Delivery
P. O. Box 32050
Amarillo, TX 79120-2050
Telephone: 1-800-687-8629

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. Elected Official 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 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: medical supplies, drugs, and medicines prescribed by a physician, laboratory services, and special meals prescribed by a physician, nutritionist or dietitian, but only to the extent that such charges would have been covered if the covered person had remained in the hospital. Covered expenses are limited to those for services listed herein that are furnished by a home health care agency to a covered person who is under the care of a physician. Home health care services must be furnished in accordance with a home health care plan that is established by the attending physician, and the orders must be renewed at least every 30 days. The attending physician must also certify that the proper treatment of the sickness or accidental injury would require confinement as a resident inpatient in a hospital or skilled nursing facility in the absence of the services and supplies provided as part of the home health care plan.

Covered expenses for home health care visits are limited to those made by:

1. a registered graduate nurse (R.N.), a licensed practical nurse (L.P.N.), or a licensed vocational nurse (L.V.N.);
2. home health aides under supervision of a R.N.;
3. physical, occupational, and speech therapists; or
4. a licensed midwife.

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

1. Leaving the home isn't recommended because of the patient's condition
2. The patient's condition keeps the patient from leaving home without help (such as needing special transportation, using a wheelchair or walker, or getting help from another person)
3. Leaving home takes a considerable and taxing effort.

The patient may leave home for medical treatment or short, infrequent absences for non-medical reasons, such as attending religious services. The patient can still get home health care if the patient attends adult day care, but y the home care services will be provided in the home.

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 inpatient facilities; and
5. Is licensed as a Hospital by the appropriate state agency.

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

Illness means a bodily disorder, disease, physical Sickness, mental infirmity, 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 at the discretion of Plan Administrator or its Contract Claims Administrator considering:

1. For in-network claims the negotiated preferred provider allowable.
2. For out-of-network claims the amount agreed to by the non-network provider and Plan Administrator or its delegate. If the amount has not been negotiated, then one of the following amounts will apply:
 - a) For out-of-network hospital claims the lesser of billed charges or 125% of the published rates allowed by Medicare for the same or similar service or supply.
 - b) For out-of-network professional claims and other providers the lesser of billed charges or 125% of the published rates allowed by Medicare for the same or similar service or supply.
 - c) For out-of-network claims submitted by providers that do not participate in Medicare, for care provided in non-standard settings and for services and supplies not covered by Medicare the Payer Compass equivalency tables, Payer Compass approximation tool, Payer Compass cross walks or the Optum360 Essential RBRVS Schedule will be considered at corresponding percentile listed above.
 - d) In determining the Maximum Eligible Charge for any out-of-network claim, the Plan Administrator or its delegate may consider any other relevant factor, including but not limited to the Average Wholesale Price, the invoice price, Medicare cost data, Medicare cost-to-charge ratios, the amount Medicaid would allow for the same or similar service and the Fair Health Data Base.
 - e) For out-of-network dental claims – the lesser of billed charges or the 90th percentile of what Fair Health’s Data Base shows for the same or similar service.

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.

In the event the Contract Claims Administrator determines that a service is not medically necessary, but the applicable network or network provider determines that a service is medically necessary, the Plan will defer to the Aetna provider network agreement to resolve the conflict.

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 inpatient 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 inpatient 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.

State Eligible Elected Official means an Elected Official who is eligible for Group Benefit Coverage with the State of Texas as a result of being elected to office. “State Eligible Elected Official” will be included in the reference to “Elected Official” within the Plan; exceptions will be noted with specific reference to “State Eligible Elected Official.”

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 (other than State Eligible 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. State Eligible Elected Officials that are eligible for medical benefit coverage, offered by the State of Texas, may also elect and participate in Fort Bend County medical plan; however the State plan shall be considered primary coverage. The Fort Bend County medical plan shall be Secondary coverage and will provide benefits based on Fort Bend County's schedule of benefits and will only pay for Eligible Expenses after the State plan has paid.

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 are eligible for coverage under this Plan subject to the provisions herein.

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; (5) and is not currently covered through an active employee or Fort Bend County Retiree. 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.

1. **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

3. 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.

4. 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.

5. 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.

6. 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

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**

A. 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 Hyperplasia 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 following contraceptives: oral, injectable, implant and transdermal patches, intravaginal rings, and emergency contraceptive (the early removal of implanted contraceptives is only covered subject to medical necessity) for the purposes of birth control and obtainable only on a Physician's written prescription. 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. Contraceptive devices, such as intrauterine device (IUD).
23. Eligible medical expenses incurred for treatment while confined to a Hospice for the physical and emotional needs of terminally ill patients;
24. Benefits for Eligible Medical Expenses incurred will be payable according to the Schedule of Benefits in effect on the day the expenses are incurred;
25. The Plan will pay for routine nursery care (Well-Baby Care) at the time of delivery.
26. Routine immunizations are covered, except when for the purpose of international travel.
27. 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;
28. 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;
29. Observation Room Services:
- a) Observation services are defined as the use of a bed and periodic monitoring and/or short term treatment by a hospital's nursing or other staff. These services are considered reasonable and necessary to evaluate a patient's condition to determine the need for possible inpatient admission. Observation care provides a method of evaluation and treatment as an alternative to inpatient hospitalization. The services may be considered eligible for coverage only when provided under a physician's order or under the order of another person who is authorized by state statute and the hospital's by laws to admit patients and order outpatient testing. The observation services must be patient specific and not part of a standard

- operating procedure or facility protocol for a given diagnosis or service.
- b) In order for an observation stay (a period not to exceed 48 hours) to be considered medically necessary, the following conditions must be met:
 - 1) The patient is clinically unstable for discharge; **AND**
 - 2) Clinical monitoring, and/or laboratory, radiologic, or other testing is necessary in order to assess the patient's need for hospitalization; **OR**
 - 3) The treatment plan is not established or based upon the patient's conditions, is anticipated to be completed within a period not to exceed 48 hours; **OR**
 - 4) Change in status or condition are anticipated and immediate medical intervention may be required.
 - c) Observation room services are not covered when the above criteria are not met. Observation services that extend beyond a 48 hour period are not covered. Providers must contact Boon Chapman and obtain approval for inpatient status for services beyond the initial 48 hour period.
 - d) The following is a list of services that are not considered appropriate for observation room services (this list is not all inclusive):
 - 1) Service are not reasonable or necessary for the diagnosis and treatment of the patient
 - 2) Outpatient blood or chemotherapy administration
 - 3) Lack of/delay in patient transportation
 - 4) When used as a substitute for inpatient admission or services would normally require inpatient stay
 - 5) When it is provided only as a convenience for the physician, patient or patient's family
 - 6) While waiting for transfer to another facility
 - 7) When inpatients discharged to observation status
30. 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.
31. 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.
32. 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.

B. 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, (except screening test for hearing loss from birth through the date that a child is 30 days of age or for necessary diagnostic follow up care related to the screening test from birth through the date a child is 24 months of age; testing and follow up deductible will be waived but coinsurance will still apply), 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 inpatient; 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, and fertility drugs
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 determined by the Contract Claims Administrator and the pre-certification company, the weight requirement for morbid obesity shall be defined as a minimum of 100 pounds over your normal body weight as determined by your physician. Surgical procedures and all associated costs will be limited to one procedure per covered participant under this medical plan.
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, unless this condition is incurred by a dependent child under the age of 18;
 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 under Section A. Annual Health Screening/Well Care/PPO Providers Only;
 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.

NOTE: This exception does not apply to **State Eligible Elected Officials**.

- b) **Rules** – This Plan determines its order of benefits using the first of the following rules which applies:
 - 1. For **State Eligible Elected Officials** and any eligible dependents, The Fort Bend County Plan will determine County benefits after the benefits of their state offered plan.
 - 2. **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.
 - 3. **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.
 - 4. **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.

5. **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.
6. **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 and 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 of 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. A Participant may not bring an action at law or equity until ninety (90) days after all claims appeal procedures have been exhausted.

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

Assignment of Benefits is defined as an arrangement whereby a Participant, at the discretion of the Plan Administrator, assigns its right to seek and receive payment of eligible Plan benefits, less deductible, copayments and coinsurance amounts, to a medical provider. If a provider accepts said arrangement, the provider's rights to receive Plan benefits are equal to those of the Participant, and are limited by the terms of this Plan Document. A provider that accepts this arrangement indicates acceptance of an assignment of benefits and deductibles, copayments and coinsurance amounts, as consideration in full for treatment rendered.

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

is submitted, or the Plan Administrator – at its discretion – revokes the assignment.

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

F. PROTECTION AGAINST CREDITORS

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

G. 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.

Notice of Non-Discrimination

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

Fort Bend County:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

- If you need these services, contact Director of Human Resources or their designee

If you believe that Fort Bend County has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Director of Human Resources or their designee, address: 301 Jackson Street, suite 243, Richmond, TX 77469, phone number: 281-341-8617, fax number: 281-341-8615, email: HumanResources@fortbendcountytexas.gov. You can file a grievance in person or by mail, fax, or email.

If you need help filing a grievance, Director of Human Resources or their designee is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human

Services 200 Independence Avenue, SW

Room 509F, HHH

Building Washington,

D.C. 20201

1-800-368-1019, 800-537-7697 (TDD)

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

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 281-341-8617.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 281-341-8617.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 281-341-8617。

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 281-341-8617 번으로 전화해 주십시오.

مقررہ اتصل . ناجملا پر فاونٹنٹا . تہو غللا دے عاسملا تامدخ ن ا ف ، تہو غللا تہو دختت رکذا تنک اذہ : طو حلمة 1-xxx-xxx-xxxx مقررہ

مکبلاو مصلا اہتف 281-341-8617

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں۔ کال کریں (TTY: 1-xxx-xxx-xxxx) 1-xxx-xxx-xxxx

281-341-8617

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 281-341-8617.

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 281-341-8617.

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-xxx-xxx-xxxx (TTY:

1-xxx-xxx-xxxx) पर कॉल करें।

281-341-8617

هجوٹ: رگا امش ییایناپسا تبص یم دنک، امش یم تامدخ کمک نابز
ناگیار رد سرتسد دنتسه . حساب 281-341-8617

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung.
Rufnummer: 281-341-8617.

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે.

ફોન કરો 1-xxx-xxx-xxxx (TTY: 1-xxx-xxx-xxxx).

281-341-8617

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 281-341-8617.

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。281-341-8617 まで、お電話にてご連絡ください。

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