Fort Bend County
Employee Benefit Medical Plan Document

Amendment #1

Effective January 1, 2025

IT IS HEREBY UNDERSTOOD AND AGREED THAT THE MEDICAL PLAN DOCUMENT IS AMENDED AS FOLLOWS:

1. On page 2, Article I – **Schedule of Benefits**, Section A – **Medical Schedule of Benefits,** the carry-over deductible provision is removed from **Option A – Low Deductible** as follows:

   REMOVE THE FOLLOWING:

OPTION A – LOW DEDUCTIBLE	**Inside PPO**	**Outside PPO**
Per person per calendar year, with a maximum of five (5) per family. With three (3) month carry-over provision (see "Deductible Amount and Carry-Over Provisions"). Inside PPO plan deductible can be used to satisfy Outside PPO Plan deductible.	$300	$700
Separate per Hospital confinement deductible at Non-PPO Hospital.	N/A	$500

   REPLACE WITH THE FOLLOWING:

OPTION A – LOW DEDUCTIBLE	**Inside PPO**	**Outside PPO**
Per person per calendar year, with a maximum of five (5) per family. Inside PPO plan deductible can be used to satisfy Outside PPO Plan deductible.	$300	$700
Separate per Hospital confinement deductible at Non-PPO Hospital.	N/A	$500

2. On page 3, Article I – **Schedule of Benefits**, Section A - **Medical Schedule of Benefits,** the carry-over deductible provision is removed from **Option B – High Deductible** as follows:

   REMOVE THE FOLLOWING:

OPTION B – HIGH DEDUCTIBLE	**Inside PPO**	**Outside PPO**
Per person per calendar year, with a maximum of five (5) per family. With three (3) month carry-over provision (see "Deductible Amount and Carry-Over Provisions"). Inside PPO plan deductible can be used to satisfy Outside PPO Plan deductible.	$850	$1,000
Separate per Hospital confinement deductible at Non-PPO Hospital.	N/A	$500

REPLACE WITH THE FOLLOWING:

OPTION B – HIGH DEDUCTIBLE	Inside PPO	Outside PPO
Per person per calendar year, with a maximum of five (5) per family. Inside PPO plan deductible can be used to satisfy Outside PPO Plan deductible.	$850	$1,000
Separate per Hospital confinement deductible at Non-PPO Hospital.	N/A	$500

3. On page 4, the carry-over deductible provision is removed from the **DEDUCTIBLE AMOUNT AND CARRY-OVER PROVISIONS** as follows:

REMOVE THE FOLLOWING:

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.

REPLACE WITH THE FOLLOWING:

DEDUCTIBLE AMOUNT: The applicable deductible for Plan Option A or Plan Option B will be deducted from the Eligible Expenses before benefits are computed, unless the "SCHEDULE OF BENEFITS" indicates otherwise. In the event a Participant is Hospital confined on December 31,

satisfaction of a deductible for the following year shall not be applied until after the date of discharge.

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

1. When two or more covered family members are injured in the same accident, only one deductible will be applied in any calendar year to the Eligible Expenses directly resulting from injuries sustained in that accident.
2. 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.

4. On page 6, under **11. Outpatient Dialysis Services**, the following changes are made:

REMOVE THE FOLLOWING:

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	Limitations/Requirements
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.	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.

REPLACE WITH THE FOLLOWING:

11. Outpatient Dialysis Services*

The Plan does not use a preferred provider organization for dialysis services. Precertification is required.

Reimbursement	Limitations/Requirements
100% of MEC; deductible waived 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.	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.

5. On page 8, following #**15. Outpatient, Non-Emergency Office Visit (Medical) PREFERRED PROVIDER ONLY**, the following is added:

16. **TELADOC®** Plan pays 100%; deductible waived

GENERAL MEDICAL: Teladoc® is a telehealth medicine program that gives participants access to quality medical care via phone or video access 24 hours a day, seven days a week, 365 days a year. The doctors in this program are U.S. Board Certified in Internal Medicine, Family Practice, and Pediatrics. They are licensed in your state and incorporate Teladoc® into their day-to-day practice to provide members with convenient access to quality medical care. Teladoc® physicians can treat many medical conditions such as cold and flu symptoms, allergies, bronchitis, skin problems, respiratory infections and sinus problems, and can prescribe medications* for short-term conditions.

Teladoc® is not meant to replace your primary care physician. Teladoc® should be used when you need immediate care for non-emergency medical issues. It is an inexpensive, convenient alternative to urgent care and ER visits. It is also helpful when you are on vacation, on a business trip, or away from home and cannot see your primary care physician for an urgent need.

MENTAL HEALTH: Teladoc® offers evidence-based therapy and counseling provided by licensed therapists, as well as medication evaluation and management by board-certified psychiatrists. You can schedule appointments 7 days a week at the time most convenient for you and connect with your therapist or psychiatrist by video or phone.

They offer different types of providers to best meet your needs for medications or therapy.

Medication management*: If you are looking for medication evaluation or help with ongoing medication management, you may schedule a visit with a psychiatrist (MD/DO). Psychiatrists are medical doctors who do not provide talk therapy through Teladoc®.

Their board-certified psychiatrists can prescribe specific medications for anxiety, depression, mood disorder, PTSD and a variety of other mental health diagnoses.

Therapy: If you are looking for talk therapy and counseling (such as anger management, cognitive behavioral therapy [CBT], dialectical behavioral therapy [DBT], etc.), please schedule a visit with a therapist. They offer different types of therapists, such as psychologists [PhD/PsyD], licensed clinical social workers [LCSW], licensed Marriage and family therapists [LMFT] and licensed professional counselors.

To access this program, either visit www.teladoc.com or call 1-800-Teladoc (835-2362).

*Please note that Teladoc® provider are unable to prescribe or provide refills for DEA-controlled substances such as stimulants (e.g., Adderall, Concerta), benzodiazepines (e.g., Xanax, Klonopin), pain medications (e.g., OxyContin) and medications used for treating substance use (e.g., Suboxone).

6. On pages 8-9, numbers 16-20 are renumbered 17-21 accordingly.

7. On page 28, under **Article IV, DEFINITIONS**, the following is REMOVED:

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.

8. On page 32, under **Article IV, DEFINITIONS**, the following is ADDED:

Telemedicine Medical Service means a health care service delivered by a Physician or Behavioral Health Practitioner licensed in Texas, or a health professional acting under the delegation and supervision of a Physician or Behavioral Health Practitioner licensed in Texas, and acting within the scope of the Physician's or health professional's license to a patient at a different physical location than the Physician or health professional using telecommunications or information technology.

9. On page 33, under **Article V, ELIGIBIILTY AND PARTICIPATION**, section A. EMPLOYEE PARTICIPATION, **#1. Waiver of Participation in this Plan** is replaced in its entirety removing reference to Late Entrants as follows:

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, they will not be allowed to enroll until Annual Enrollment, as a result of a Family Status Change or Special Enrollment Right as described herein.

10. On page 34, under **Article V, ELIGIBIILTY AND PARTICIPATION**, section **A. EMPLOYEE PARTICIPATION, #3. Effective Date of Coverage** is REPLACED in its entirety removing reference to Late Entrants as follows:

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. 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.

11. On page 38, under **Article V, ELIGIBIILTY AND PARTICIPATION**, section **D. ANNUAL ENROLLMENT** is REPLACED in its entirety removing reference to Late Entrants as follows:

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.

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 designated annually by the County.

If an Eligible Employee is on Leave of Absence at the time of the Annual Enrollment period and continues to pay their monthly Plan Participant contributions timely with no break in coverage, they may re-enroll during the Annual Enrollment period for the following Plan Year.

12. On page 39, under **Article V, ELIGIBIILTY AND PARTICIPATION**, section **F. LATE ENTRANTS/FAMILY STATUS CHANGE/ DEPENDENT DELETION**, is RENAMED and REPLACED in its entirety with the following:

F. FAMILY STATUS CHANGE/DEPENDENT DELETION

Annual Enrollment– An Employee may enroll or disenroll eligible Dependent(s) during the annual enrollment period without a Family Status Change. 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-stepchildren. 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 timeframes 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.

13. On page 48, under **Article VI, MEDICAL BENEFITS**, section **A. ELIGIBLE EXPENSES**, is REPLACED in its entirety with the following:

    6. Fees charges by a Physician or a Physician Assistant (including telehealth) for medical care or specified treatment of an accidental Injury or Sickness;

ALL OTHER SECTIONS OF THE PLAN DOCUMENT REMAIN UNCHANGED.

APPROVED AND ACCEPTED:

_____
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:

_____