

FORT BEND COUNTY FY 2009  
COMMISSIONERS COURT AGENDA REQUEST FORM

30

Return Completed Form by E-Mail to: Agenda Coordinator, County Judge's Office

Date Submitted: 6/30/2009 Submitted By: Risk Management Dept.  
 Court Agenda Date: 07/07/2009 Phone Number: 281 341 8630

**SUMMARY OF ITEM:** CONSENT AGENDA ITEM:  
 Consider and approve updated Fort Bend County Employee Benefit Plan document effective July 7, 2009.

RENEWAL AGREEMENT/APPOINTMENT YES  NO   
 REVIEWED BY COUNTY ATTORNEY'S OFFICE: YES  NO

**FINANCIAL SUMMARY:**

BUDGETED ITEM: YES  NO

FUNDNG SOURCE: Accounting Unit: \_\_\_\_\_ Account Number: \_\_\_\_\_  
 Activity (If Applicable): \_\_\_\_\_

DESCRIPTION OF LAWSOM ACCOUNT: \_\_\_\_\_

**Instructions to submit Agenda Request Form:**

- Completely fill out agenda form: incomplete forms will not be processed.
- Agenda Request Forms should be submitted by e-mail, fax, or inter-office mail, and all back-up information must be provided by Wednesday at 2:00 p.m. to all those listed below.
- All original back-up must be received in the County Judge's Office by 2:00 p.m. on Wednesday.

**DISTRIBUTION:**  
 Original Form Submitted with back up to County Judge's Office  (✓ when completed)  
 If by E-Mail to [ospindon@co.fort-bend.tx.us](mailto:ospindon@co.fort-bend.tx.us) If by Fax to (281) 341-8609

Distribute copies with back-up to all listed below. If by fax, send to numbers below:

<input type="checkbox"/> Auditor (281-341-3774)	<input type="checkbox"/> Comm. Pct. 1 (281-342-0587)
<input type="checkbox"/> Budget Officer (281-344-3954)	<input type="checkbox"/> Comm. Pct. 2 (281-403-8009)
<input type="checkbox"/> Facilities/Planning (281-633-7022)	<input type="checkbox"/> Comm. Pct. 3 (281-242-9060)
<input type="checkbox"/> Purchasing Agent (281-341-8642)	<input type="checkbox"/> Comm. Pct. 4 (281-980-9077)
<input type="checkbox"/> Information Technology (281-341-4526)	<input type="checkbox"/> County Clerk (281-341-8697)
<input type="checkbox"/> Other:	<input type="checkbox"/> County Atty (281-341-4557)

**RECOMMENDATION / ACTION REQUESTED:**

Special Handling Requested (specify): \_\_\_\_\_

COUNTY JUDGE  
RECEIVED  
JUN 29 2009

713-04 Orig. ret. to Sandy at Risk Man.

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

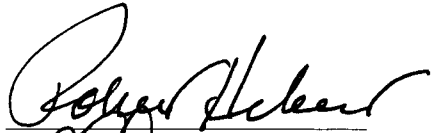
**July 7, 2009**


Fort Bend County, the Employer, hereby establishes a self-funded medical and dental coverage Plan for the benefit of the eligible employees of Fort Bend County and their eligible dependents. The Employer's current group medical and dental Plan will be replaced by this self-funded Plan entitled "Fort Bend County Employee Benefit Plan", effective July 7, 2009.

Retirees and their eligible dependents will also 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.

The purpose of this medical coverage and dental coverage Plan is to provide reimbursement for covered charges incurred as a result of medically necessary treatment for Illness or Injury or eligible dental expense of the Employer's eligible employees, retirees and their eligible dependents. In consideration of any required contributions by its employees or retirees, the Employer agrees to make payment as provided in this Plan document. The Employer has the right to periodically amend the Plan. All amendments previous to July 7, 2009 have been included in this document. The Plan document constitutes the entire Plan.

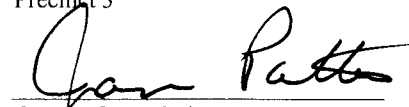
The employer has caused this instrument to be executed by its duly authorized officers with the effective date of the 7th day of July 2009.


  
\_\_\_\_\_  
County Judge

  
\_\_\_\_\_  
County Commissioner  
Precinct 1

  
\_\_\_\_\_  
County Commissioner  
Precinct 2

  
\_\_\_\_\_  
County Commissioner  
Precinct 3

  
\_\_\_\_\_  
County Commissioner  
Precinct 4

*Attest*  
  
\_\_\_\_\_  
DIANNE WILSON  
COUNTY CLERK  
7-7-09

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

**MAJOR MEDICAL BENEFITS  
SCHEDULE OF BENEFITS  
&  
SUMMARY PLAN DESCRIPTION  
PLAN A-250 / PLAN B-750**

**LIFE & ACCIDENTAL DEATH AND DISMEMBERMENT**

(See Certificate of Coverage)

	<b>OUTSIDE P.P.O.</b>	<b>INSIDE P.P.O.</b>
<b><u>PLAN A-250 DEDUCTIBLE</u></b>	<b>DEDUCTIBLE</b>	
Per person per calendar year, with a maximum of five (5) per family	<b>\$700.00</b>	<b>\$250.00</b>
With three (3) month carry-over provision (See Pg 47, N)		
Inside P.P.O. plan deductible can be used to satisfy Outside P.P.O. plan deductible		
Separate per hospital confinement deductible at Non P.P.O. Hospital	<b>\$500.00</b>	<b>N/A</b>

**PLAN A-250 / CO-INSURANCE PROVISION PER CALENDAR YEAR INSIDE P.P.O. vs. OUTSIDE P.P.O.**

**PLAN A-250 / Inside the P.P.O. Co-Insurance Provision:** If you utilize P.P.O. providers, all qualified and eligible medical expenses will be paid by the Plan at **80%** and the participant will pay at **20%** up to the first **\$15,000.00** of qualified and eligible medical expenses (unless otherwise stated in the Schedule of Benefits), after the appropriate deductibles have been satisfied. When qualified and eligible medical expenses reach **\$15,000.00 after the appropriate deductibles have been satisfied**, the Plan will pay **100%** of qualified and eligible medical expenses up to the **\$2,000,000.00 Lifetime Maximum** per participant. **The maximum co-insurance paid by participant at 20% is \$3,000.00 per plan participant with a family maximum of five (5) per family per plan year.**

**PLAN A-250 / Outside the P.P.O. Co-Insurance Provision:** If you utilize providers outside the P.P.O., all qualified and eligible medical expenses will be paid by the Plan at **50%** and the participant will pay at **50%** up to the first **\$20,000.00** of qualified and eligible medical expenses (unless otherwise stated in the Schedule of Benefits), after the appropriate deductibles have been satisfied. When qualified and eligible medical expenses reach **\$20,000.00**, the Plan will pay **100%** of qualified and eligible medical expenses up to the **\$2,000,000.00 Lifetime Maximum** per participant. **The maximum co-insurance paid by participant at 50% is \$10,000.00 per plan participant with a family maximum of five (5) per family per plan year.**

**Whether inside or outside the P.P.O.,** any expenses other than qualified and eligible expenses will be disallowed and cannot be used to satisfy deductibles or your medical co-insurance provisions. **Any expense related to mental health care, substance abuse, alcoholism and out-patient prescription drugs purchased with your prescription card will not be applied to your maximum medical co-insurance provision or calendar year deductibles. These provisions apply to each covered participant.**

**If you are a dependent or a retiree and reside outside the P.P.O. service area** (there are no P.P.O. providers within 100 miles) you will be subject to the calendar year deductible plus your percentage of co-insurance, 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 the P.P.O. All qualified and eligible medical expenses will be paid by the Plan at **70%** co-insurance and the participant will pay **30%** up to the first **\$20,000.00** of qualified and eligible medical expenses (unless otherwise stated in the Schedule of Benefits), after the appropriate deductibles have been satisfied. When qualified and eligible medical expenses reach **\$20,000.00**, the Plan will pay 100% of qualified and eligible medical expenses up to the **\$2,000,000.00 Lifetime Maximum** per participant. The maximum co-insurance paid by participant at 30% is **\$6,000.00** per plan participant with a family maximum of five (5) per family per plan year.

**OUTSIDE P.P.O.    INSIDE P.P.O.**

**PLAN B-750 DEDUCTIBLE**

	DEDUCTIBLE	
Per person per calendar year, with a maximum of three (3) per family With three (3) month carry-over provision (see Pg 47, N) Inside P.P.O. plan deductible can be used to satisfy Outside P.P.O. plan deductible	<b>\$1,000.00</b>	<b>\$750.00</b>
Separate per hospital confinement deductible @ Non P.P.O Hospital	<b>\$500.00</b>	<b>N/A</b>

**PLAN B-750/ CO-INSURANCE PROVISION PER CALENDAR YEAR INSIDE P.P.O. vs. OUTSIDE P.P.O.**

**PLAN B-750 / Inside the P.P.O. Co-Insurance Provision:** If you utilize P.P.O. providers, all qualified and eligible medical expenses will be paid by the Plan at the **80%** and the participant will pay at **20%** up to the first **\$10,000.00** of qualified and eligible medical expenses (unless otherwise stated in the Schedule of Benefits), after the appropriate deductibles have been satisfied. When qualified and eligible medical expenses reach **\$10,000.00 after the appropriate deductibles have been satisfied**, the Plan will pay **100%** of qualified and eligible medical expenses up to the **\$2,000,000.00 Lifetime Maximum** per participant. **The maximum co-insurance paid by participant at 20% is \$2,000.00 per plan participant with a family maximum of three (3) per family per plan year.**

**PLAN B-750 / Outside the P.P.O. Co-Insurance Provision:** If you utilize providers outside the P.P.O., all qualified and eligible medical expenses will be paid by the Plan at **50%** and the participant will pay at **50%** up to the first **\$15,000.00** of qualified and eligible medical expenses (unless otherwise stated in the Schedule of Benefits), after the appropriate deductibles have been satisfied. When qualified and eligible medical expenses reach **\$15,000.00**, the Plan will pay **100%** of qualified and eligible medical expenses up to the **\$2,000,000.00 Lifetime Maximum** per participant. **The maximum co-insurance paid by participant at 50% is \$7,500.00 per plan participant with a family maximum of three (3) per family per plan year.**

**Whether inside or outside the P.P.O.,** any expenses other than qualified and eligible expenses will be disallowed and cannot be used to satisfy deductibles or your maximum medical co-insurance provisions. **Any expense related to mental health care, substance abuse, alcoholism and out-patient prescription drugs purchased with your prescription card will not be applied to your maximum medical co-insurance provision or calendar year deductibles. These provisions apply to each covered participant.**

**If you are a dependent or a retiree and reside outside the P.P.O. service area** (there are no P.P.O. providers within 100 miles) you will be subject to a calendar year deductible plus co-insurance, subject to any additional benefit limitations of this Plan. There will be an additional **\$500.00** deductible if confined in a hospital outside the P.P.O. (per confinement). All qualified and eligible medical expenses will be paid by the Plan at **70%** and by the participant will pay at **30%** up to the first **\$15,000.00** of qualified and eligible medical expenses (unless otherwise stated in the Schedule of Benefits), after the appropriate deductibles have been satisfied. When qualified and eligible medical expenses reach **\$15,000.00**, the Plan will pay **100%** of qualified and eligible medical expenses up to the **\$2,000,000.00 Lifetime Maximum** per participant. The maximum co-insurance paid by participant at **30%** is **\$4,500.00** per plan participant with a family maximum of three (3) per family per plan year.

**AFTER THE DEDUCTIBLE HAS BEEN SATISFIED, OF THE PLAN THAT YOU PARTICIPATE IN, EITHER PLAN A-\$250.00 DEDUCTIBLE OR PLAN B-\$750.00 DEDUCTIBLE, THE FOLLOWING BENEFIT WILL BE PAID BY THIS PLAN AT THE STATED PERCENTAGE LEVELS BELOW:**

**\*PRE-CERTIFICATION IS REQUIRED FOR HOSPITAL ADMISSIONS OR A 50% REDUCTION IN BENEFITS WILL OCCUR**

	<b><u>OUTSIDE P.P.O.</u></b> <b>CO-INSURANCE</b> <b>PERCENTAGE</b> <b>PLAN PAYS</b>	<b><u>INSIDE P.P.O.</u></b> <b>CO-INSURANCE</b> <b>PERCENTAGE</b> <b>PLAN PAYS</b>
<b><u>*IN-PATIENT HOSPITAL EXPENSES</u></b>		
1. <b>Average semi-private room</b> All usual hospital services including blood, plasma and intensive care	50%	80%
2. <b>Anesthesiologist Charges</b>	50%	80%
3. <b>Mental Health Care, Alcohol &amp; Substance Abuse</b> - See cost containment section for any additional limitations. Must access E.A.P. before these benefits are eligible (See pages 14-16 & 35-37)	0%	80%
<b>Calendar year maximum benefits for:</b>		
<b>Mental Health Care, Alcohol &amp; Substance Abuse</b> (See page 9)	<b>\$0.00</b>	<b>\$10,000.00</b>
<b><u>OTHER MEDICAL EXPENSES</u></b>		
1.* <b>Surgery - In-patient</b>	50%	80%
2.* <b>Surgery - Out-patient</b> (See page 17-18)	70%	80%
3. <b>Pre-admission Testing, (Outpatient)</b> (See page 16)	70%	100%
4. <b>Out-patient testing</b> (See page 16)	50%	80%
5. <b>Second &amp; Third Surgical Opinions</b> (See page 17)	100%	100%
6. <b>All other eligible expenses except Outpatient Mental Health Care, Alcohol and Substance Abuse</b>	50%	80%
7. <b>Chiropractic Charges</b> With a calendar year maximum of	50% \$1,000.00	80% \$1,500.00
8. <b>Elective Sterilization (Vasectomy and Tubal Ligation)</b>	50%	80%
9. <b>Out-patient Mental Health Care,</b> <b>Office Co-Pay for a out-patient office visit</b>	0%	\$25.00 <b>Maximum Plan Payment per office visit of \$100.00</b>
<b><u>Payable by the plan at the following percentages:</u></b>		
Alcohol and Substance Abuse including psychiatrist charges and day treatments, with a maximum of 50 out-patient visits per calendar year	0%	80%
Calendar year maximum out-patient plan benefit of:	0%	\$5,000.00
<b><u>EAP Benefits must be accessed before out-patient mental health care benefits will be eligible by this plan (see pages 14-15 and 20). Benefits may be used only at P.P.O. providers with prior approval from HealthFirst T.P.A., Inc. Charges will not be eligible for payment if services are received at a non-P.P.O. provider.</u></b>		

Dependents that reside outside the service area (not within 100 miles of a P.P.O. provider) will have benefits paid by the Plan at the 70% co-insurance level. All other provisions and limitations remain the same. Benefits must be accessed by calling the Employee Assistance Program (see pages 14-15 and 20).

10. **Out-patient Prescription Drugs**

**Out-patient** prescription drugs must be filled with your Fort Bend County Employee Benefit Plan ID card. Reimbursement will not be allowed under this medical Plan. Co-pays and any additional R<sub>x</sub> charges cannot be used to satisfy deductibles or co-insurance maximums. See pages 9-11 for additional information and limitations.

11. **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% co-insurance subject to the applicable calendar year deductible and a \$25.00 office visit co-pay if a P.P.O. provider performs the exam. If this exam is performed by a non-P.P.O. provider, benefits will be payable at 50% co-insurance subject to the applicable per person calendar year deductible.

12. **Annual Health Screening Benefits/Well Care/ P.P.O. Providers Only**

All covered employees, and their dependents that participate in the Plan are eligible to receive the following benefits without a medical diagnosis as indicated below. The benefits listed below will not be subject to a \$25.00 office co-pay and will be paid by the plan at 100%, not to exceed \$750.00 per covered person per calendar year for any one benefit or a total of all benefits listed below. These benefits may be used only once during the calendar year. Any expenses over \$750.00 or expenses incurred at a provider outside the P.P.O. network will be the responsibility of the covered person. Any expenses incurred by the participant cannot be used to satisfy the calendar year deductible or maximum co-insurance provisions of either Plan A-250 or Plan B-750. **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.**

Retirees and dependents who reside outside the service area (not within 100 miles of a P.P.O. provider) will have this benefit provided by the Plan at the 70% co-insurance level, to a maximum Plan payment of \$750.00 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 co-insurance provisions.

- A) Mammograms at a Preferred Provider, including interpretation by radiologist (**at a Preferred Provider**).
- B) Pap smear-including office visit & HPV vaccine (age 19 and older) at a Preferred Provider.
- C) Bone density testing including office visit at a Preferred Provider.
- D) Colon rectal and prostate screenings-which include office visit, diagnostic proctoscopy, occult blood work and prostate specific antigen (P.S.A.) test at a Preferred Provider.
- E) Immunizations: Adult (age 19 years and older) immunization benefits are limited to annual flu shots tetanus booster shots and HPV vaccine, including office visit **at a Preferred Provider.**
- F) Annual physicals: Benefits will be limited to urinalysis, lab work, blood work, stress test, electrocardiogram and chest x-rays **at a Preferred Provider.**

13. **Outpatient, Non-emergency Office Visits (Medical) PREFERRED PROVIDERS ONLY**

The participant is required to pay \$25.00 per visit toward the medical physician's charge for an office visit, and if incurred prior to satisfying the calendar year deductible, the \$25.00 may be used to satisfy the calendar year deductibles of the plan option that you participate in. **The \$25.00 co-pay will be assessed every time you utilize a P.P.O. physician, regardless if you have satisfied your calendar year deductible.** The balance of physician's charges due after the \$25.00 per visit co-payment has been made will be paid by the Plan at 100%. This \$25.00 co-pay can be applied to satisfy any calendar year deductible requirements. **If your calendar year deductible has been satisfied, this co-pay will continue to be assessed each time you have a P.P.O. physician office visit.**

All eligible charges incurred during an office visit, other than physician's charges, shall be subject to the deductible and co-insurance provisions of the plan option that you participate in. **Children's immunizations will be an eligible expense at P.P.O. providers only. The only allowable immunizations are those immunizations that are required for attendance in school in the State of Texas as listed in Title 25 Health Services subsection 97.61-97.72 of the Texas Administrative Code. Immunization charges incurred at a non-P.P.O. provider will be excluded.**

**EXAMPLE**

**OUT PATIENT NON-EMERGENCY P.P.O.OFFICE VISIT**

Medical Physician's charge	<b>\$80.00</b>
Minus P.P.O. discount	<b><u>-\$20.00</u></b>
Balance of Physicians charge after discount	<b>\$60.00</b>
Minus Participant co-pay	<b><u>-\$25.00</u></b>
Plan pays 100% of balance	<b>\$35.00</b>

Other Eligible Charges incurred during office visit: Lab, X-Ray, injections, and any other eligible charges: **After patient Deductible is satisfied, the Plan Pays at the 80% co-insurance level Inside P.P.O or at the 50% co-insurance level Outside P.P.O.**

14. **Non-P.P.O. Out-patient Office Visits (Medical)**

The participant will be required to satisfy the Outside the P.P.O. calendar year deductible of the plan they participate in before expenses will be eligible for reimbursement. The Plan will pay for any eligible services performed by a non-P.P.O. provider at the 50% co-insurance level.

15. **Emergency Room - (Preferred Provider Only)**

All eligible charges 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 co-insurance provisions. If the patient is admitted to the hospital, then all additional eligible charges incurred during that confinement would be paid at 80% after the deductible is satisfied if billed by a P.P.O. provider or 50% if billed by a non-P.P.O. provider, after the applicable deductibles are satisfied.

16. **Accidental Injury or Emergency Illness at an Emergency Room or Hospital (Outside the P.P.O. Area)**

All eligible charges associated with an accidental injury or emergency illness incurred at a non-P.P.O. emergency room or hospital while outside the P.P.O. service area (not within 100 miles of a P.P.O. facility), will be paid at the 80% co-insurance level. The Non-P.P.O. calendar year deductible will not be waived for this accidental injury or emergency illness. **The \$500.00 Non-P.P.O. per confinement deductible will be waived if you are admitted to the hospital directly from the emergency room. Pre-certification will be required for any hospital confinement; otherwise benefits will be paid by the plan at the 50% co-insurance level.**

17. **Dependents and Retirees Residing Outside the P.P.O. Service Area**

**(Office Visits/Non-Emergency or Scheduled Hospital Admissions)**

If you reside outside the P.P.O. service area and there are no preferred providers within 100 miles, benefits will be paid at the 70% co-insurance level to the maximums of the plan you participate in, subject to the applicable calendar year. All other plan provisions will remain the same. **Pre-certification will be required for any hospital confinement, otherwise benefits will be paid by the plan at the 50% co-insurance level. The \$500.00 per hospital confinement deductible will not be waived.**

<u>OUTSIDE P.P.O.</u>	<u>INSIDE P.P.O.</u>
CO-INSURANCE	CO-INSURANCE
PERCENTAGE	PERCENTAGE

18. **EXTENDED CARE – PLAN A-250 / PLAN B-750**

1	Skilled nursing facility services (Maximum of 120 days or \$10,000.00 per calendar year, whichever occurs first)	50%	80%
2.	Home health care (Maximum of 120 visits or \$10,000.00 per calendar year, whichever occurs first)	50%	80%
3.	Hospice (Maximum of 180 facility days or \$7,500.00 per lifetime, whichever occurs first)	50%	80%

19. **MEDICAL PLAN LIFETIME MAXIMUM BENEFITS (PLAN A-250 / PLAN B-750)**

**Maximum lifetime benefits for all benefits available to each plan participant      \$2,000,000.00**

Contained within the Lifetime maximum benefit are the following benefits:

1.	Skilled Nursing.....	\$10,000.00/calendar year
2.	Home Health Care.....	\$10,000.00/calendar year
3.	Hospice Care.....	\$7,500.00 lifetime maximum
4.	Morbid obesity (non-surgical).....	\$1,500.00 lifetime maximum
5.	Chiropractic charges (see Schedule of Benefits page).....	\$1,000.00/1,500.00/calendar year
6.	Mental Health Care, Alcohol and Substance Abuse..... (in-patient/out-patient combined)	\$15,000.00/calendar year

20. **OUT-PATIENT PRESCRIPTION DRUG EXPENSE COVERAGE (PLAN A-250 / PLAN B-750)**

\*This coverage pays benefits for prescription drugs bought for the medical care of a Plan Participant’s sickness or injury. All out-patient prescription drugs must be filled with your benefit ID card. Reimbursement will not be allowed under the medical plan. Participants will be required to use their ID card for prescription drugs and pay the following amounts:

**RETAIL PHARMACY – 30-day supply or less ONLY**

**Maximum of two (2) months (60 days) for maintenance drugs**

<b>Generic</b>	<b>\$10.00** co-pay</b> per prescription per participant or the actual cost, if less
<b>Preferred Brand Name</b>	<b>\$25.00** co-pay</b> per prescription per participant or the actual cost, if less
<b>Non- Preferred Brand Name</b>	<b>\$40.00** co-pay</b> per prescription per participant or the actual cost, if less
<b>***Specialty (see below)</b>	<b>\$100.00**co-pay</b> per prescription per participant or the actual cost, if less

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

**\*\*Co-payments are required for refills.**

Contact Maxor @1-800-687-0707 to determine if your prescription drug is listed as a Generic, Preferred Brand Name, Non- Preferred Brand, Specialty or Maintenance drug. Maxor determines the category under which your prescription drug is listed, and it is the participant’s responsibility to verify the Maxor category of their prescription drug. Maxor periodically updates these categories.

**MAXOR MAILORDER PHARMACY–Greater than a 30 day supply. MANDATORY for maintenance drugs after retail maximum is reached**

Generic	\$20.00** co-pay per prescription per participant or the actual cost, if less
Preferred Brand Name	\$50.00** co-pay per prescription per participant or the actual cost, if less
Non- Preferred Brand Name	\$80.00** co-pay per prescription per participant or the actual cost, if less
***Specialty (see below)	\$200.00** co-pay per prescription per participant or the actual cost, if less

\*\*\*Specialty Medication requiring special handling and additional patient monitoring. Used for disease states not considered common, is chronic in nature and has a cost higher than traditional medications.  
\*\*Co-payments are required for refills

Contact Maxor @1-800-687-0707 to determine if your prescription drug is listed as a Generic, Preferred Brand Name, Non- Preferred Brand, Specialty or Maintenance drug. Maxor determines the category under which your prescription drug is listed, and it is the participant’s responsibility to verify the Maxor category of their prescription drug. Maxor periodically updates these categories.

Not all charges are eligible; see definition of Eligible Charges (page 10). A person’s eligibility under this coverage may be extended after the date that person ceases to be a Covered Person. See COBRA (pages 30-31) and continuation of health care benefits in event of total disability (page 27). The Plan is not liable for any prescription filled after the termination of coverage under this benefit. Any benefits paid after termination will be recovered from the former Plan Participant.

The Fort Bend County Employee Benefit Plan ID card will be honored by most local pharmacies. **MaxorPlus, Ltd. will be responsible for contracting with all pharmacies that will accept the ID card. They may be contacted at 800-687-0707.** The prescription must be filled with a generic unless there is a valid medical reason prescribed by your physician that requires a brand name. **If the Plan Participant requires a brand name and there is no valid medical reason, 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 co-pay.**

**Any amounts spent on prescriptions, whether actual costs or co-pays, do not apply toward deductibles or co-insurance provisions.**

**This Plan will not coordinate benefits with any other entity in regard to out-patient prescription drugs purchased with your drug card.**

A Prescription Drug means:

- (1) A medicinal substance that, by law, can be dispensed only by prescription;
- (2) A compound medication that includes a substance described in (1); or
- (3) Injectable insulin.  
**\*Note: A “generic drug” is a Prescription Drug identified by its official or chemical name rather than by a brand name.**

## **ELIGIBLE CHARGES**

A charge is an Eligible charge if it is made for a Prescription Drug that meets all of these conditions:

- (1) It is prescribed in writing by a licensed physician;
- (2) It is bought while the person is a Covered Person;
- (3) It is dispensed by a pharmacy or any other person or organization licensed to dispense drugs in the U.S.A.;
- (4) Prenatal vitamins if prescribed by your physician to be used during pregnancy.

## CHARGES NOT COVERED

**A charge is not an Eligible Charge if it is described under Charges Not Covered.**

- (1) Charges for a prescription or a refill of a prescription that are more than the charges for a 90-day supply;
- (2) A charge for a refill of a prescription that is:
  - (a) in excess of the number specified by the Doctor; or
  - (b) furnished more than one year after the date of the Doctor's original order of the Prescription Drug;
- (3) Drugs or medicines for which reimbursement is provided under any workers compensation law, or by any municipal, state, or federal program;
- (4) Medicines or drugs which are lawfully obtainable without a prescription written by a licensed physician ("over-the-counter" medications), except insulin, including vitamins (except prenatal vitamins), cosmetics, and dietary supplements, or drugs that have an over-the-counter equivalent;
- (5) Any charge for the administration or injection of any drug including injectable insulin;
- (6) Medicines or drugs prescribed for the treatment of infertility, nicotine addiction, hair loss, or to change skin pigmentation;
- (7) Replacement of lost, stolen, or damaged prescriptions;
- (8) Drugs or medications, which are covered under the Major Medical Insurance Coverage section;
- (9) Any Generally Excluded Charges shown in the Limitations and Exclusions (Article IV page 38-40);
- (10) For weight reduction beyond the limits in. Limitations and Exclusions (Article IV page 39, #26).

## **COST CONTAINMENT PROVISIONS**

### **Schedule of Benefits**

The Plan encourages all Covered Persons to seek the best and most efficient medical care available. The following cost containment features are designed with that goal in mind. These include provisions for:

**Preferred Provider Organizations** contain a list of participating providers. This plan participates with the following P.P.O.'s:

Texas True Choice provides Physician and Ancillary providers and can be accessed @ [www.texastruechoice.com](http://www.texastruechoice.com) (page 13).

Private Health Care Systems (PHCS) provides Hospitals Only and can be accessed @ [http://www.multiplan.com/search/facility\\_form.cfm?originator=84451](http://www.multiplan.com/search/facility_form.cfm?originator=84451) (page 13)

**Pre-certification (page 13)**

**Utilization Review (pages 13-16)**

- A. **General Overview**
- B. **Definitions**
- C. **Types of Review**
- D. **Compliance Guidelines**
- E. **Mental & Nervous, Alcohol & Substance Abuse Guidelines**
- F. **Who Controls Medical Care**

**Out-patient Testing (page 16)**

**Pre-Admission Testing (page 16)**

**Weekend Admissions (page 17)**

**Second & Third Surgical Opinions (page 17)**

**Out-patient Surgery (page 17-18)**

**Home Health Care Benefits (pages 18)**

- A. **Limitations (page 18-19)**

**Hospice Benefits (pages 19-20)**

**Employee Assistance Program (E.A.P.) (page 20)**

**PREFERRED PROVIDER ORGANIZATIONS (P.P.O.'s)**  
**TEXAS TRUE CHOICE INC. and P.H.C.S (HOSPITAL ONLY) P.P.O.'s**  
1-800-683-4856 Texas True Choice

**Texas True Choice Inc P.P.O. and Private Health Care Systems** are organizations of preferred health care providers (P.P.O.). Medical Practitioners 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 your present health care plan, maximum benefits can be obtained by utilizing the large selection of preferred providers and facilities listed in the **Texas True Choice Inc. P.P.O. for physicians and ancillary providers**. **You may access these physicians and ancillary providers by going on-line @ [www.texastruechoice.com](http://www.texastruechoice.com) or at the Fort Bend County's network link @ [http://www.co.fort-bend.tx.us/upload/images/risk\\_management\\_insurance/ppo\\_directory.pdf](http://www.co.fort-bend.tx.us/upload/images/risk_management_insurance/ppo_directory.pdf)**

You must use **Private Health Care Systems (P.H.C.S) for eligible Hospitals**. **P.H.C.S. Hospitals are listed @ [http://www.multiplan.com/search/facility\\_form.cfm?originator=84451](http://www.multiplan.com/search/facility_form.cfm?originator=84451) or at the Fort Bend County's network link @ [http://www.co.fort-bend.tx.us/upload/images/risk\\_management\\_insurance/ppo\\_directory.pdf](http://www.co.fort-bend.tx.us/upload/images/risk_management_insurance/ppo_directory.pdf)**

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

When you choose a provider, simply call for an appointment and identify yourself as a participant in the **Texas True Choice Inc. P.P.O. for physicians and ancillary providers**. Your identification card provided by your employer should be presented at the time of your appointment. If you are utilizing a hospital, please identify yourself as a participant in the **PHCS Hospital Only P.P.O.** During the year, **Texas True Choice Inc. and PHCS** will update their directories, please make sure you verify your provider before each physician's appointment or hospital admission. **It is the participant's responsibility to ensure if the provider is within the P.P.O.**

In summary, **Texas True Choice Inc. and Private Health Care Systems (PHCS)** offer easy access to quality health care, widespread geographic coverage and maximum benefits from your current health plan.

**PRE-CERTIFICATION**  
**HealthFirst T.P.A., Inc.**  
**Telephone: (866) 810-7614**

**Expenses incurred while confined to a hospital as an inpatient are subject to the Pre-Certification provisions, consisting of Pre-Admission Evaluation and Concurrent Review. This program must be utilized on all hospital admissions to receive maximum medical benefits. Pre-certification is required before being admitted to the hospital. Non-compliance will result in a reduction of benefits.**

Length of stay is determined by the attending physician and is evaluated by the pre-certification program. Admission to a hospital without prior determination of length of stay or an extended length of stay without review by the program will result in benefits being paid at the 50% coinsurance level for all charges incurred for that hospital stay. These additional expenses will not apply to your deductible or co-insurance provisions.

**Pre-certification authorizes medical necessity only and does not guarantee payment of benefits. The medical plan contract claims administrator will determine if the procedure is eligible under the medical plan. You or your medical provider may request a pre-determination of a claim prior to incurring medical treatment.**

**UTILIZATION REVIEW**  
**HealthFirst T.P.A., Inc.**  
**Telephone: (800) 498-5371**

**A. General Overview**

Utilization Review is the review of a hospital confinement by the Plan (through HealthFirst T.P.A., Inc.) 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. HealthFirst T.P.A., Inc. will review the hospital confinement with your physician; however, in all cases the necessity of hospital confinement and you and your doctor, not the Contract Administrator or the Plan determines the length of stay.

In order for HealthFirst T.P.A., Inc. to review a hospital confinement with your 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 covered person goes through the Utilization Review System. The Schedule of Benefits outlines the differences in payment between compliance with the Utilization Review System and non-compliance.

**B. Definitions**

1. **Compliance** is notifying HealthFirst T.P.A., Inc.: (a) ten (10) working days prior to a scheduled admission; (b) by the 36th week for pregnancy; (c) immediately prior to admission for an urgent admission; or (d) within 48 hours of an emergency admission (72 hours on weekends or holidays).
2. **Emergency Admission** is a hospital admission that may not be scheduled at the convenience of the physician and the patient without endangering the patient's bodily functions.
3. **Urgent Admission** is a hospital admission that is not an emergency admission, but is necessary within at least 72 hours from the time a physician recommends such hospital confinement.
4. **Scheduled Admission** is a hospital admission that a physician has recommended that is neither an Emergency nor Urgent Admission.
5. **Working Day** is any day Monday through Friday, excluding national legal holidays.

**C. Types of Review**

1. **Pre-admission Review** - Review is performed prior to admission for scheduled procedures.
2. **Concurrent Review** - Review is performed for scheduled and non-scheduled admissions during confinement.
3. **Discharge Planning** - Where appropriate arrangements are made to facilitate the earliest possible discharge.
4. **Medical Case Management** - Alternate treatment plans are developed which meet the medical needs of the covered person and are more cost-effective than standard treatment forms.

**D. 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.**

1. **Scheduled Hospital Admission Including Pregnancy**  
The participant or a personal representative must notify HealthFirst T.P.A., Inc. by telephone well before such scheduled admission so that the attending physician can submit the pre-admission certification form to HealthFirst T.P.A., Inc. at least ten (10) working days prior to scheduled admission. Pregnancies must have the pre-admission certification process completed by the 36th week of pregnancy.
2. **Urgent Admission**  
The participant, physician, or a personal representative must notify HealthFirst T.P.A., Inc. by telephone immediately prior to actual admission.
3. **Emergency Admission**  
The participant, physician, or a personal representative must notify HealthFirst T.P.A., Inc. within 48 hours of admission (72 hours on weekends or legal holidays).

Once the participant has complied with these provisions, HealthFirst T.P.A., Inc. will proceed to work with the physician and hospital in the participant's behalf for necessary medical care in compliance with the physician's recommendations.

**E. Mental and Nervous, Alcohol and Substance Abuse Guidelines**

Participants in the Fort Bend County Employee Benefit Plan, you will be required to contact the E.A.P. in order to access your mental health/substance abuse benefits before accessing benefits under the Fort-Bend County Employee Benefit Plan. The E.A.P. counselor will assess your needs and determine what steps need to be taken in order to help resolve your situation.

Your E.A.P. provider is United Behavioral Health and they can be reached toll-free at 866-828-6049 or 866-216-9926 (TDD/TTY). Should you need to access the Texas True Choice P.P.O. network of providers, the E.A.P. provider will coordinate your benefits with HealthFirst T.P.A., Inc. You must contact HealthFirst T.P.A., Inc. to discuss

your benefit options at 281-999-9600, extension 501 (see page 13-14). Out-patient benefits must begin with the E.A.P., but must seek treatment through the P.P.O. Network, and should you be referred to the Texas True Choice P.P.O. Network, you may only use providers within that network and have prior approval from HealthFirst T.P.A., Inc. **In the event of an in-patient emergency hospital admission or a scheduled in-patient hospital admission, you must utilize the providers approved by HealthFirst T.P.A., Inc. or benefits will be disallowed.** Hospital Providers for emergency hospital admissions may be obtained from the PHCS/Hospital ONLY website. Retirees and their dependents participating in the medical benefits of the Fort Bend County Employee Benefit Plans are not eligible for E.A.P. benefits, therefore, they are exempt from the E.A.P. referral requirement, however, they must access the P.P.O. network providers or benefits will be disallowed.

**Receiving evaluation and/or out-patient treatment for services from any non-Texas True Choice provider will result in a 0% benefit pay out from the medical plan. Services provided by any provider, unless specifically referred to that provider by the E.A.P. or HealthFirst T.P.A., Inc. will result in a 0% benefits pay out from the medical plan.**

**1. Acute Care Hospital Confinements (Pre-Certification Required)**

- a. Psychotic state or eminent danger - maximum of 5 days in-patient care unless condition necessitates locked-door treatment in seclusion and/or under 24-hour watch;
- b. Detoxification - reasonable and customary in-patient care necessary to provide the treatment to restore physiologic functions disturbed by overuse and withdrawal from alcohol or other addictive drugs through the use of medication, diet, fluids, and nursing care;
- c. Adolescent Substance Abuse, behavioral, or other diagnosis - maximum of 5 days of in-patient care for all diagnoses not listed in paragraph 1 or 2 above;
- d. Eating disorders or chronic pain disorders - maximum of 5 days in-patient care unless a condition of physical health that (regardless of psychiatric or substance abuse diagnosis) would necessitate in-patient care;
- e. Condition of physical health - reasonable and customary in-patient care necessary to treat a condition of physical health that (regardless of a psychiatric or substance diagnosis) would necessitate in-patient care.

**2. Treatment or Therapies Requiring Pre-Authorization as In-patient Care**

- a. Psychological testing;
- b. Aversion therapy;
- c. Multiple psychotherapy sessions per day. Without pre-authorization a maximum of one (1) session per day and benefits would be limited to the reasonable and customary maximum;
- 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;
  3. A non-experimental drug given in a dosage level contrary to standard medical practice in relationship to the diagnosis of the case;
- f. Other in-patient approaches not listed may be eligible expenses pending review through pre-certification of the therapy types delivered and the hours per week of therapy delivered by the facility.

**3. Sub-acute (Residential) In-patient Confinements (Pre-Certification Required)**

Necessary when out-patient treatment is not effective or programmatic in-patient treatment is needed without the need for an acute-care confinement. Sub-acute care shall also apply to treatment modalities listed as residential in-patient; social model in-patient; social psychiatric residential; light psychiatric; group home; halfway in-patient treatment and psychiatric health facility.

4. **Treatment or Therapies Requiring Pre-Authorization as Out-patient Care**

- a. Psychological testing;
- b. Day treatment - necessary when out-patient treatment is not effective or programmatic treatment is necessary without the need for in-patient care;
- c. Multiple sessions per week;
- d. Necessary when used to prevent hospitalization or re-hospitalization;
- e. For a severe multiple problem family situation;
- f. To significantly shorten the length of standard (i.e. once per week) therapy to achieve the same therapeutic goals.

5. **Treatment or Therapies Excluded**

- a. Rest cures;
- b. Custodial care;
- c. Health and well being enhancement programs (i.e. weight control programs; smoking cessation programs; stress reduction programs; marriage enrichment programs; any program significantly educational in nature and not giving special emphasis and treatment to a diagnosed illness).

F. **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 System, the physician's instructions should be followed. The Contract Administrator should be contacted in all cases to assure compliance under the Plan and the most favorable benefit schedule. Following your physician's instructions is not a guarantee of payment by the Plan.

**OUT-PATIENT TESTING**

Any eligible testing that is performed on an out-patient basis, the Plan will pay 50% co-insurance if a non-P.P.O. provider performs service and the Plan will pay 80% co-insurance if a P.P.O. provider performs the service.

**PRE-ADMISSION TESTING**

Under this provision Covered Persons may receive 100% payment of charges for out-patient x-rays and lab tests performed prior to surgery at a P.P.O provider or charges will be paid at 50% of usual and customary charges at a non P.P.O. provider. Charges for pre-admission testing will be covered under the Major Medical Benefits. **The Calendar Year Deductible Amount will not apply.** The Benefit Percent will be 100% for Eligible Charges for Pre-Admission Testing at a P.P.O provider or 70% of the usual and customary charges at a non P.P.O. provider. "Pre-Admission Testing" means X-ray and laboratory exams made in contemplation of and within four days of a scheduled surgery, which is performed within the 48 hours following the Covered Persons admission to the hospital. If for medical reasons, the scheduled hospitalization is canceled or postponed for more than two weeks, benefits will be payable for any similar diagnostic, X-ray and laboratory examinations again made in connection with and prior to the rescheduled hospitalization. Benefits will not be paid for any duplication of the same tests after hospital confinement.

**WEEKEND ADMISSIONS**

Non-emergency hospital admissions must be confined to weekdays. If a Covered Person 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 24 hours immediately following the Covered Person's admission to the hospital; or
2. The Covered Person is admitted for an acute illness not requiring surgery.
3. Pre-certification is required within 72 hours for an emergency hospital admission.

## 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 opinions if the second surgical opinion does not confirm the recommendations of the Physician who will perform the surgery.

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

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

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

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

## OUT-PATIENT SURGERY

Whenever possible, Covered Persons are encouraged to have necessary surgery performed on an out-patient basis. When incurred in connection with out-patient surgery, the following will be covered under Major Medical Benefits after the deductible is satisfied, at a benefit percentage of 70% outside P.P.O. or 80% inside the P.P.O. (including surgery centers), subject to applicable coinsurance provisions.

1. All related charges for out-patient services including lab fees, biopsies, and supplies by a surgery center or out-patient department of a hospital for charges incurred on the day surgery is performed on a Covered Person;
2. Anesthesiologist charges will be paid at 80% if charges were incurred at a surgery center or at a participating P.P.O. Hospital. They will be paid at 70% at all other facilities in connection with an out-patient surgery.
3. Fees by surgeons for surgery performed on an out-patient basis. **"Out-patient services and supplies"** means services and supplies furnished by the center or by a hospital on the day the procedure is performed.
4. Any eligible out-patient surgeries or related charges including anesthesiologist charges will be paid at 70% if performed at a non-P.P.O. hospital.

"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;
  11. Provides an ongoing quality assurance program with review Physicians who do not own or direct the facility;
  12. Keeps a medical record on each patient.

**HOME HEALTH CARE BENEFITS**  
**Pre-certification is Required**

Covered Persons are encouraged to receive care at home, when possible, rather than in a hospital. Home Health Care Benefits are a basic medical coverage benefit and are not part of the Major Medical Benefits. Benefits for Home Health Care will be payable for up to 120 visits in a calendar year. Each visit by a person providing services under a Home Health Care Plan or evaluating the need for or developing a Plan will be viewed as one Home Health Care visit. Up to 4 consecutive hours of home health aide service in a 24-hour period will be eligible for payment as one Home Health Care visit. The amount paid will be 50% outside P.P.O. or 80% inside P.P.O. of the eligible Home Health Care charges and subject to Plan deductible. The Maximum Eligible Charge will not be more than the usual and customary charge for such visit.

"Home health care" means the care of a Covered Person under a Plan of care established, approved in writing and reviewed at least every two months by the attending Physician, unless the attending Physician finds that a longer time between reviews is sufficient.

Home Health Care includes one or more of the following:

1. Part-time or intermittent home nursing care by or under the supervision of a registered nurse (R.N.);
2. Part-time or intermittent home health aide services which are medically necessary as part of the Home Health care Plan. Services must be rendered under the supervision of a registered nurse (R.N.) or medical social worker, and consist solely of caring for the Covered Person;
3. Physical, respiratory, occupational or restorative speech therapy, not to include speech development therapy in connection with learning disabilities;
4. Medical supplies, drugs and medications prescribed by a Physician or laboratory services by or on behalf of a hospital under the Home Health Care Plan. This is true to the extent such items would be covered under the Plan if the Covered Person had been hospitalized;
5. Nutritional counseling provided by, or under the supervision of, a registered dietician where such services are medically necessary as part of the Home Health Care Plan;
6. The evaluation of the need for, and development of, a Plan by a registered nurse (R.N.), Physician or medical social worker, for Home Health Care when approved or requested by the attending Physician.

**HOME HEALTH CARE LIMITATIONS**

- A. No Home Health Care Benefits will be paid unless the Covered Person's attending Physician certifies that:
  1. Confinement in a hospital or skilled nursing facility would be required if Home Health Care was not provided; and
  2. The Covered Person's immediate family or other Covered Person residing with him or her are not able to provide proper care without undue hardship; and
  3. Home Health Care services will be provided or coordinated by a Home Health Care agency which:
    - (a) is state licensed;
    - (b) is a Certified Rehabilitation Agency;
    - (c) qualifies under Medicare; or
    - (d) meets all of the following:
      - i) is mainly involved in home health care delivery, including skilled nursing care;

- ii) has a staff including at least one supervisor registered nurse (R.N.);
- iii) has an administrator; and
- iv) maintains daily health records for all patients.

B. The Home Health Care Plan must:

- 1. Be needed for care of a condition, which caused the Covered Persons to be hospital confined;
- 2. Begin within 14 days following that confinement; and
- 3. Initially is approved by the attending Physician while the Covered Person was hospital confined.

C. No Home Health Care Benefits are payable for Home Health Care:

- 1. Provided by any member of the Covered Person's immediate family or any person who resides with the Covered Person;
- 2. Which is custodial or housekeeping in nature; or
- 3. Which involves services or supplies not included in the Home Health Care Plan prescribed by a Physician.

**HOSPICE BENEFITS**  
**Pre-certification Is Required**

Terminally ill Covered Persons are provided coverage for necessary care without hospital confinement.

- 1. The Plan will pay Hospice Benefits if a Covered Person incurs Eligible Hospice Charges. Benefits are payable if the Covered Person is terminally ill, and the attending Physician expects him or her to live no more than six months after the date services are performed and has recommended a formal program of Hospice care. The amount paid will be 50% of Eligible Hospice Charges for Non-P.P.O. Providers or 80% of Eligible Hospice Charges for P.P.O. Providers. Some charges may be payable under other provisions of this Plan.
- 2. "Hospice" means a licensed or certified agency which:
  - a. Is primarily engaged in providing counseling, medical services or room and board to terminally ill persons and is licensed by the appropriate licensing authority;
  - b. Has professional service policies established by a group associated with it and the group includes one Physician, one registered nurse (R.N.) and one social service coordinator;
  - c. Has full-time supervision by a Physician;
  - d. Has a full-time administrator;
  - e. Provides services 24 hours a day, 7 days a weeks; and
  - f. Maintains a complete medical record of each patient.
- 3. Eligible Hospice Charges are charges made by a Hospice for:
  - a. Room and board;
  - b. Private duty nursing care provided by, or under the supervision of, a registered nurse (R.N.);
  - c. Part-time or intermittent home health aid services by employees of the Hospice;
  - d. Social work performed by a licensed social worker; and
  - e. Nutritional services, including special meals.
- 4. Exclusions
  - a. Services provided by volunteers or others who do not usually charge for their services;
  - b. Services by a person who lives in your home or is a close relative;

- c. Any period during which you are not under the care of a physician; and
- d. Bereavement counseling.

### **EMPLOYEE ASSISTANCE PROGRAM**

All Fort Bend County Employee Benefit Plan participants (except Retirees and their dependents) are offered assistance in a variety of areas such as debt management, budget planning, legal advice, supervisory consultations and referrals to E.A.P. counselors. This program will assist you in obtaining mental health and substance abuse counseling. **If you and your eligible dependents participate in the Fort Bend County Employee Benefit Plan, you will be required to contact the E.A.P. (United Behavioral Health) at 1-866-828-6049 or 1-866-216-9926 (TDD/TTY) in order to access your mental health/substance abuse benefits.** The E.A.P. counselor will assess your needs and determine what steps need to be taken in order to help resolve your situation. You are eligible to receive six (6) free visits at a provider referred through the E.A.P. Should Plan participants need to access the Texas True Choice P.P.O. network of physician providers, the E.A.P. provider will coordinate your benefits with HealthFirst T.P.A., Inc. **Your E.A.P. provider is United Behavioral Health and they can be reached toll-free at 1-866-828-6049 or 1-866-216-9926 (TDD/TTY).**

## PLAN INFORMATION

### EMPLOYER

Fort Bend County  
Fort Bend County Courthouse  
Richmond, Texas 77469 Telephone 281-341-8630

### PLAN ADMINISTRATOR/PLAN SPONSOR AND AGENT FOR SERVICES OF LEGAL PROCESS

Fort Bend County  
Attention: County Attorney's Office  
Fort Bend County Courthouse  
Richmond, Texas 77469 Telephone 281-341-4555

### PLAN NAME

Fort Bend County Employee Benefit Plan - This is a welfare benefit plan providing Comprehensive Medical Benefits, Dental Benefits, Prescription Drug Benefits, and Life Insurance & Accidental Death & Dismemberment Insurance.

### PLAN NUMBER/IDENTIFICATION - 949

**BENEFIT YEAR** - January 1 thru December 31.

**PLAN YEAR** - January 1 thru December 31.

### CONTRACT CLAIMS ADMINISTRATOR

Boon-Chapman Benefit Administrators Inc.  
12301 Research Boulevard Suite 400  
Austin, Texas 78759 Telephone: 512-454-2681 or 1-800-252-9653 Facsimile: 512-459-1552  
[www.boonchapman.com](http://www.boonchapman.com)

### PREFERRED PROVIDER ORGANIZATIONS

Texas True Choice: for Physicians and ancillary providers. Private Health Care Systems (PHCS): for Hospitals Only  
5000 Legacy Drive, # 190 PHCS is contracted through HealthFirst listed below.  
Plano, Texas 75024 Telephone: 1-800-683-4856 Web address to access the PHCS directory is listed below:

Texas True Choice web address: <http://www.texastruechoice.com/fortbend/fortbend.asp>  
Private Health Care Systems (PHCS): web address: [http://www.multiplan.com/search/facility\\_form.cfm?originator=84451](http://www.multiplan.com/search/facility_form.cfm?originator=84451)

### PRE-CERTIFICATION/UTILIZATION REVIEW

HealthFirst T.P.A. Inc.  
509 N. Sam Houston Parkway East #500  
Houston, Texas 77060-4001 Telephone: 1-866-810-7614 or 281-999-9600

### PRESCRIPTION DRUG CARD PROGRAM

**MaxorPlus, Ltd.**  
320 S. Polk Street, Suite #200  
Amarillo, TX 79101  
[www.maxor.com](http://www.maxor.com)  
Telephone 800-687-0707

**MAIL ORDER:**  
MaxorPlus, Ltd.  
Mail Service Pharmacy  
216 S. Polk Street  
Amarillo, TX 79101  
Telephone 800-687-8629

### EMPLOYEE ASSISTANCE PROGRAM

United Behavioral Health Telephone 866-828-6049 or 866-216-9926 (TDD/TTY)

### FINANCING OF THE BENEFITS PLANS

You and your employer contribute to this Plan, if you chose to participate. The amount of the contribution is determined by the claims experience of those who participate in this 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 plan participants at any time. The benefit year begins January 1 and runs through December 31.

## **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.

## **PRESENTING CLAIMS FOR BENEFITS**

If you think you are eligible for a benefit described in this Plan, you must file a claim. Forms required for filing proof of loss for claims are available at Risk Management or can be found at County Wide Website Risk Management link [http://cww.co.fort-bend.tx.us/departments/risk\\_management/RM\\_forms.htm](http://cww.co.fort-bend.tx.us/departments/risk_management/RM_forms.htm). Completed forms must be filed with the Contract Claims Administrator.

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

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

## **REQUESTING A REVIEW OF CLAIMS DENIED**

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

If you have not received a response from the contract claims administrator regarding your claim within 90-days of filing the claim or if your claim has been denied, you can send a written appeal to the Contract Claims Administrator for a review of the denied claims which under other circumstances could be covered under the plan. You have 61 days to appeal from the time you are notified of the denial or 61 days from the end of the processing period, if you have not received a response by that time.

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

**ARTICLE I**  
**DEFINITIONS**

**Active Service** means the Participant 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 at which that employment requires travel on a scheduled work day, or if he/she 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, which is not a scheduled workday only if he/she was performing in the customary manner all of the regular duties of employment on the last preceding scheduled workday.

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

**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** means the period of time from January 1 thru December 31.

**Close Relative** means the spouse, parent, brother, sister, child, or spouse's parent of the Covered Person.

**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 Covered Participant. Such reviews may occur at the time of admission to an acute-care hospital facility or during confinement at such facility.

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

**Custodial Care** means that type of care or service, wherever furnished and by whatever name called, which is designed primarily to assist a Covered Person, 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 which can normally be self administered.

**Dependent of an Employee** means any one or more of the following:

- 1) The lawful spouse of the Employee not legally separated from the Employee;
- 2) Unmarried natural children of the Employee under the age of 19, including legally adopted children and stepchildren principally dependent upon the Employee for support;
- 3) Unmarried natural children of the Employee, including legally adopted children and step-children who reside with the employee, who have not attained age 25 and who are full-time students in an accredited college, university, trade school or business school and principally dependent upon the Employee for support; and
- 4) Unmarried natural children of the Employee, including legally adopted children and step-children who reside with the employee, through the age of 19 or up to the age of 25, if a full-time student, and are principally dependent upon the Employee for support and maintenance, including eligible dependents who are incapable of self-sustaining employment due to mental or physical disability, provided such disability commenced prior to attainment of age 19 or up to the age of 25, whichever is applicable under 2 or 3 above, and such 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. See pg.34, Public Law 110-381, ("Michelle's Law") effective January 1, 2010.
- 5) Unmarried natural child not living with the employee provided the employee is subject to a current order of a court or Attorney General for the State of Texas to provide health benefits for such unmarried natural child.

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

**Employee Assistance Program (E.A.P.)** means an organization that assists employees and dependents in managing a variety of problems they may encounter, both on the job and off the job.

**Employee** means all persons who work the required hours indicated in the eligibility section of the Plan for the Employer and are entitled to compensation for such services.

**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 and to complete the necessary form(s). Verbal notification is unacceptable.

**Full-Time Student** means a Participant's dependent child who is enrolled in and regularly attends an accredited college, university, trade school or business school for the minimum number of credit hours required by that college, university, trade school or business school in order to maintain full-time student status.

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

**Home Health Agency** means a public or private agency that specializes in giving nursing and other therapeutic services in the covered Participant's home, provided that the agency is licensed as such (or if no license is required, approved as such) by a state department or agency having authority over home health agencies.

**Hospice** means an establishment or a program that provides for the physical and emotional needs of terminally-ill patients.

**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 24-hour a day nursing services by Registered Nurses (RNs) or other nursing services when assumed under the complete responsibility of the physician in charge;
4. Maintains in-patient facilities; and
5. Is licensed as a Hospital by the appropriate state agency.

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

**Illness** means a bodily disorder, disease, physical sickness, mental infirmity, or functional nervous disorder of a Covered Person. 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 Covered Person'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 P.P.O.** means receiving eligible services from providers who are participants in the Preferred Provider Organization that this plan has adopted as Preferred Providers.

**Lifetime** in reference to benefit maximums and limitations means only while covered under this plan. Under no circumstances does lifetime mean during the lifetime of the plan participant or previous participant.

**Medically Necessary** means a procedure or service that is:

1. Appropriate to the diagnosis;
2. Consistent with the location of services and the level of care provided;
3. Reasonably safe;
4. Widely accepted by the practicing peer group;
5. Based upon scientific criteria;
6. Not of an experimental, investigative or research nature; and
7. As determined by this Plan.

**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 P.P.O. Provider** means receiving eligible services from providers who do not participate in the Preferred Provider Organization that this plan as adopted as Preferred Providers.

**Outside Preferred Provider Organization Service Area** means not within 100 miles of a P.P.O. provider.

**Participant** means those Employees or Retirees and their eligible Dependents who are entitled to health care benefits under this Plan.

**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.

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

**Preferred Provider Organization (P.P.O.)** is a group of medical providers (doctors 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.

**Reasonable or Usual and Customary Charges** means charges that are not greater than the general level of charges made by other health care providers:

1. In the same locality;
2. When furnishing similar treatment for a person of the same sex and approximately the same age for a similar sickness or injury; and
3. As determined by this Plan.

**Retiree** means any person who meets the definition of retiree as defined by Article VI, Section Q of the Fort Bend County Employee Benefit Plan document.

**Sickness** means any physical or mental illness, including pregnancy.

**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.

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

**ARTICLE II**  
**PARTICIPATION IN HEALTH CARE BENEFITS**

**A. EMPLOYEE PARTICIPATION**

**1. Waiver of Participation in this Plan**

An employee has the right to waive their medical coverage under this plan. If employee coverage is not selected, dependent coverage will not be available. If an employee elects to waive participation and later decides to enroll in the medical plan, beyond 31 days of first becoming eligible to participate in this plan, the applicant will be considered a **“late entrant,”** as defined by the Fort Bend County Employee Benefit Plan and will be required to comply with any and all plan provisions for enrollment in the plan as a **“late entrant”**. If approved for coverage, the earliest time the employee’s or dependents medical coverage will be effective, will be the 1<sup>st</sup> day of the month, following 90-days. The employee will also be subject to a 12 month (beginning from their benefit effective date) pre-existing condition requirement. . Eligible dependents of the employee, who elected to waive coverage and then later request coverage under the plan, will be subject to **“late entrant”** requirements. If an employee terminates medical coverage, they must also terminate their dependent medical coverage.

**2. Eligibility for Health Care Benefits**

- a. All full-time regular Employees in a budgeted position, in Active Service at their customary place of employment on the day their health care benefits become effective, who work a minimum of 40 hours per week for the Employer and their eligible dependents shall be eligible for Health Care Benefits under this Plan. Eligible employees will be required to notify the Risk Management Department in writing, complete any necessary enrollment applications and supply all necessary documentation as required by the plan within the first 60-days of employment.
- b. All retirees eligible for retirement through the Texas County and District Retirement System (TCDRS) and under the age of 65 years.
- c. All retirees eligible for retirement through the Texas County and District Retirement System (TCDRS) and age 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 would make the determination to revert the retirees’ supplemental coverage back to the County Plan or to another Medicare Supplement Plan.
- d. All other persons are excluded.

**3. Waiting Period**

For all new Employees and Employees with a break in coverage, benefits will be effective the first of the month following ninety (90) days of continuous Active Service.

**4. Effective Date of Health Care Benefits**

Coverage will become effective for an Employee on the first (1st) day of the month following completion of any applicable waiting period, or if none, upon the date of eligibility (provided the Employee is in Active Service on that date, otherwise the Effective Date will be deferred until return to Active Service) subject to pre-existing clause. Employees with a change of status from part-time to full-time or from temporary to regular will be subject to the same waiting period beginning the date their status changes and subject to pre-existing clause. 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 1<sup>st</sup> the following year) and subject to pre-existing clause. Payment of any contribution toward the cost of Health Care Benefits, if required by the Employer, must be made prior to coverage becoming effective.

**5. Termination of Health Care Benefits**

Except as provided in the Continuation of Health Care Benefits (C.O.B.R.A.) provision and except as provided below, **Employee's** will retain benefit coverage through the same date of termination on the earliest of the following dates:

- a. If the Employee fails to remit required contributions for Health Care Benefits when due, benefits will terminate at the end of the period for which the last contribution is made;
- b. The day you terminate your employment or lost your eligibility status;

- c. Participation may be continued for an Employee on an employer-approved leave of absence. See Fort Bend County Employee Information Manual;
- d. On the termination date of the Plan.

Except as provided in the Continuation of Health Care Benefits (C.O.B.R.A.) provision and except as provided below, **Dependent's** coverage will terminate on the earliest of the following dates:

- a. The day 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 day you cease to be an eligible dependent as defined by the Plan;
- d. The day of the month in which the Employee ceases to be in a class eligible for coverage as long as contributions are paid for the month in which you are terminated;
- e. On the termination date of the Plan;
- f. An employee cannot terminate a spouse during legal separation until the divorce is final. A certified divorce decree must be submitted before any paperwork can be processed.

**6. Continuation of Health Care Benefits in the Event of Total Disability**

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

- a. The Employee must be totally disabled when Health Care Benefits terminate;
- b. The Employee must remain totally and continuously disabled through the date on which the medical expenses are incurred;
- c. Only expenses incurred for the treatment of the condition causing the total disability will be eligible for consideration under this benefit.

7. **Total Disability** means the complete inability of an Employee, because of sickness or accidental injury, to engage in or perform the duties of the Employee's regular occupation or employment, or in the case of a Dependent, unable to perform their normal, routine activities or confined to a hospital.

8. **Changes in Health Care Benefits** will be effective for all Employees in Active Service on the date the Plan is amended. For Employees on leave of absence or on disability leave the change will be delayed until the Employee returns to Active Service.

9. **Retirees who terminate coverage under this plan** will not be able to re-enroll in the terminated coverage.

**B. DEPENDENT PARTICIPATION**

**1. Required Documentation for Proof of Dependent (Documents must be submitted to Risk Management before eligibility is approved.)**

- a. **Spouse:** Certified Marriage License or Certified Informal Marriage Certificate, and Social Security Number.
- b. **Natural/Adopted Child:** Certified Birth Certificate, which shows name of mother and father (mother or father must be the employee); Certified, signed and filed, Adoption Decree (parent must be the employee), original Certified Birth Certificate and new Certified Birth Certificate with name change, etc., with certified, signed and filed, supporting documents for changes; Certified Divorce Decree stating responsibility for medical, dental, and vision coverage, court order (signed by a Judge or the Attorney General) or order for support by the Attorney General for the State of Texas, and Social Security Number.
- c. **Stepchild:** Certified, signed and filed Divorce Decree stating the individual responsible for dependent medical/dental coverage, Proof of Residency (certified school record), Certified Birth Certificate which shows name of mother and father, Certified Marriage License showing that employee is legally married to Stepchild's parent and Stepchild's Social Security Number.

## 2. Eligibility for Dependent's Health Care Benefits

A Dependent will be eligible to participate in the Health Care Benefits 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; or
- b. The date the Employee gains an Eligible Dependent, if on that date he is covered by the Plan, and has made any necessary contributions; and has notified the plan within 31 days of gaining that dependent.
- 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;
- d. In no event will the Dependent's coverage begin before the Employee's;
- e. Any approved medical related absence from secondary educational institution subject to qualifying under the provisions of Public Law 110-381, ("Michelle's Law") (Page 34).

All dependents, age 65 and older, of retirees will be covered under the Medicare Supplement Plan. These dependents of 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 would make the determination to revert the retirees' dependents' supplemental coverage back to the County Plan or to another Medicare Supplement Plan. In the event of the retiree's death, the dependent may elect to continue the Medicare Supplement Plan, and the Fort Bend County Employee Benefit 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 his/her 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 12 months preceding their termination of employment. The retiree will be eligible to cover all other eligible dependents; other than the remaining spouse, when they retire.

**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 children they might have. If the employee covering a dependent terminates his/her employment, the dependent may be added to the existing coverage of the remaining employee, provided that there is no lapse in coverage and they must be added immediately** (Article II, H). In the event that the dependent addition results in a change of benefit plan they shall be required to meet the deductible and co-insurance provisions of the new plan in which they will participate. Any deductible and co-insurance provisions previously met will be applied to the plan in which they will be participating. In the event that deductible credits or co-insurance credits do not satisfy the provisions of the new plan, the dependent will be required to meet the difference between their credits and the remaining amounts necessary to meet the new deductible and co-insurance amounts. If moving from a higher deductible and coinsurance plan to a lower deductible and coinsurance plan, should deductible and coinsurance credits exceed the requirements of the new plan, the credits will be considered to have satisfied the plan requirements and paid amounts exceeding new plan'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 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 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. Disability Extension

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

- a. The Dependent was totally disabled when Health Care Benefits terminated;
- b. The Dependent remains totally and continuously disabled through the date on which the medical expenses are incurred;

- c. Only expenses incurred for the treatment of the condition causing the total disability will be eligible for consideration under this benefit.

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

If prior to, or within thirty-one (31) days after the attainment of the specified age whereby participation would otherwise terminate for a Dependent Child, the Contract Administrator has received due proof such child is mentally retarded or physically handicapped and thereby incapable of earning his own living and is dependent upon the Employee for his support, his or her participation will continue so long as the incapacity continues and the Plan remains in full force and effect. The plan has the right to require that the employee show proof of the incapacity of the dependent from time to time, as determined by the plan administrator.

All Plan provisions apply during this extension.

#### C. **LATE ENTRANTS/FAMILY STATUS CHANGE/DEPENDENT DELETION**

A late entrant is: 1) any eligible employee or dependent who seeks to enroll in the Plan after the employee's waiting period at the time of full-time employment has passed, and 2) any eligible dependent who is not enrolled in the Plan within 31 days of the date the dependent becomes eligible, as defined below under "Family Status Change". 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.

*All late entrants are required* to satisfy the waiting period (90-days) and have a physical exam performed by a licensed physician. At the time of the physical exam, the late entrant application must be signed and dated by the physician. This form is available in Risk Management. The physical exam will be at your expense. 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 90-days after the late entrant's waiting period begins. The Plan reserves the right to approve or deny any late entrant applicant. If additional information is received by the Plan after the late entrant's acceptance that would disqualify the late entrant from coverage, the Plan will have the right to terminate coverage back to the original effective date and the employer will refund any contribution that was already made towards said coverage. The employee will be responsible for paying all claims paid by the Plan on behalf of the ineligible person.

##### **Mid-Year Late Entrants**

Participants who do not participate in the Section 125 Plan may add eligible dependents mid-year without a family status change. All new participants will be considered late entrants and must fulfill the requirements as stated above. The 90-day waiting period for the late entrant will begin on the date Risk Management receives all required documentation.

##### **Annual Enrollment Late Entrants**

An Employee may enroll eligible dependent(s) during the annual enrollment period without a family status change. All new participants will be considered late entrants and must fulfill the requirements as stated above. The 90 day waiting period for the late entrant will begin on January 1<sup>st</sup> of the following year. Required documents must be submitted by the deadline, which will be set for each annual enrollment period. Late entrant applications are due within two weeks of the deadline, which will be set for each annual enrollment period.

##### **Family Status Change**

An Employee who participates in the Section 125 Plan may add eligible dependent(s) mid-year only if there is a qualified family status change and the participant has all required documentation turned into Risk Management within 31 days of the family status change event. Qualified family status changes for adding an eligible dependent include but are not limited to: marriage, birth, adoption, or a change in a spouse or dependent's employment status as specified by section 125 of the Internal Revenue Code.

##### In the event of birth, adoption, or marriage:

Benefits for the eligible dependents will be effective on the date of the family status change. For example, when adding a spouse due to marriage, the effective date of coverage will be the date of marriage on the certified marriage license or informal marriage certificate.

##### In the event of a change in a spouse's or dependent's employment status:

All new participants will be considered late entrants and must fulfill the requirements as stated above. The 90-day waiting period for the late entrant will begin on the date Risk Management receives all required documentation.

##### **Dependent Deletion**

An employee must delete a dependent that is no longer eligible to remain on the Plan at the time they become ineligible. Dependents who are not eligible are those who are: 1) children 19 years of age or older and who are not full-time students in an accredited college, university, or trade school, 2) children 25 years of age or older, 3) children who are married, 4) ex-spouses and step-children, and 5) step-children who do not reside with the employee. In the case of divorce, a certified

divorce decree or legal separation is required before the Plan will terminate the dependents no longer eligible.

**It is the employee's responsibility to notify Risk Management of a dependent who is no longer eligible and complete the proper form(s).** Notification is subject to C.O.B.R.A notification requirements. Verbal notification is unacceptable. The Plan will not refund premiums paid prior to the submission of the proper forms. In addition, the employee will be responsible for paying all claims paid by the Plan on behalf of the ineligible person.

**D. AGE DISCRIMINATION IN EMPLOYMENT ACT**

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

**E. CONTINUATION OF COVERAGE IN COMPLIANCE WITH COBRA  
(Consolidated Omnibus Budget Reconciliation Act of 1985)**

**1. Continuation of Coverage**

Coverage that may be continued under this section includes medical coverage and dental, if provided under this Plan. Under this section, the following Covered Persons and dependents whose coverage would otherwise end may continue to be covered under the Plan:

- a. Covered dependents of a Covered Person (employee, or retiree) who dies.
- b. A Covered Person and his/her 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 spouse upon divorce or legal separation from the Covered Person (employee).
- d. A covered dependent child who marries or attains the maximum age at 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 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 or legally separated from a Covered Person (employee) or a dependent child's marriage or attainment of the maximum age for coverage under the Plan, the covered person or dependent must notify the Employer of that event within 60 days of the event.
- c. Within 30 days of receiving notice, the Employer will notify the COBRA administrator of the termination of coverage. Within 14 days of receiving the notice from the Employer, the COBRA administrator will mail the covered person information regarding his/her right to continued benefits.
- d. After receiving that notice, the Covered Person or dependent has 60 days in which to decide whether to elect continued benefits. These 60 days begins on the later of:
  - (i) the date coverage under the Plan would otherwise end; or
  - (ii) the date the person receives notice from the Employer of his/her rights under the law.

If the Covered Person or dependent chooses to have continued benefits, he or she must advise the Employer in writing of this decision. The Employer must receive this written notice before the end of 60 days.

- e. Within 45 days after the date the Covered Person or dependent notifies the Employer that he or she has chosen to continue medical insurance, the covered person 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 any coverage being continued.

3. **Length of Continuation**

For Covered Persons who are terminated or have their hours reduced, coverage may be continued for up to 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 36 months after the event, which makes the Covered Person eligible for continued benefits. Continuation will end on the earliest of:

- a. The end of the 18 or 36-month period noted above;
- b. The date the Employer's Plan terminates;
- c. Failure to make payment for coverage as required above;
- d. The date the person becomes covered under any other group health Plan as a result of employment, re-employment or re-marriage;
- e. The date the person becomes entitled to benefits under Medicare.

4. 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):

- a. 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
- b. Any benefits otherwise payable under this section will be reduced by any amounts for which the person is eligible under the Plan.

F. **HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT OF 1996 (H.I.P.A.A.)  
ELECTION UNDER 42 U.S.C. §300gg-21**

Federal law imposes upon group health plans certain limitations on (1) pre-existing condition exclusion periods, (2) special enrollment periods for individuals (and dependents) losing other coverage, (3) prohibitions against discriminating against individual participants and beneficiaries based on health status, (4) standards relating to mothers and newborns, (5) parity in the application of certain limits to mental health benefits, and (6) required coverage for reconstructive surgery following mastectomies.

Federal law allows a non-federal governmental self-funded plan (such as the Fort Bend County Employee Benefit Plan for employees of Fort Bend County, Texas) to exempt its Plan in whole or in part from these requirements: (1) Limitations on pre-existing condition exclusion periods, (2) special enrollment periods for individuals (and dependents) losing other coverage, (3) prohibitions against discriminating against individual participants and beneficiaries based on health status, (4) standards relating to mothers and newborns, (5) parity in the application of certain limits to mental health benefits, and (6) required coverage for reconstructive surgery following mastectomies. Fort Bend County has requested that the entire Fort Bend County Employee Benefit Plan be exempt under 42 U.S.C. §300gg-21.

Fort Bend County is required to provide certificates of coverage to those individuals covered by the Plan at the time they cease to be covered by the Plan and when they request a certificate within 24 months following cessation of coverage.

**H.I.P.A.A. 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 "H.I.P.A.A. Privacy RULE" and § 164.504(f) is referred to as "the "504" provisions") which establish the extent to which the Plan sponsor will receive, use and/or disclose Protected Health Information.

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

The Plan has determined that it is a group health plan within the meaning of the H.I.P.A.A. 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 H.I.P.A.A. Privacy Rule (e.g., entering into business associate contracts; accepting certification from the Plan sponsor).

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

Except as provided below with respect to the Plan's disclosure of summary health information, the Plan will (a) disclose

Protected Health Information to the Plan sponsor or (b) provide for or permit the disclosure of protected Health Information to the Plan sponsor by a health insurance issuer with respect to the Plan, only if the Plan has received a certification (signed on behalf of the Plan sponsor) that:

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

**Permitted disclosure of members’ Protected Health Information to the Plan sponsor**

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

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

The Plan may not, 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.

**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. § 164.528.

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

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

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

## **Disclosures of Summary Health Information and Enrollment and Disenrollment Information to the Plan sponsor**

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

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

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

## **Required separation between the Plan and the Plan sponsor**

In accordance with the "504" provisions, this section describes the employees or classes of employees or workforce members under the control of the Plan sponsor 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)

1. Director of Risk Management
2. Risk Management Personnel
3. Financial Accountants
4. Legal Advisors who represent the plan
5. Part-time/Temporary Clerical support
6. 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.

## **Security Standards**

### **Plan Sponsor Obligations**

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

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

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

- a) Plan sponsor shall report to the Plan any other Security Incident on an aggregate basis every month, or more frequently upon the Plan's request.

G. **COVERAGE OF DEPENDENT STUDENTS ON MEDICALLY NECESSARY LEAVE OF ABSENCE**  
**Public Law 110-381, ("Michelle's Law")**

1. **Continuation of Coverage**

Beginning January 1, 2010, continuation of coverage is allowable for medically necessary absences for:

- a) full-time dependent student plan participants;
- b) enrolled in a public or private secondary educational institution, accredited college, university, trade school or business school;
- c) immediately before the first day of a medically necessary leave of absence;
- d) subject to approval by the medical plan.

2. **Notice Requirements**

Written certification by the treating physician of the full-time dependent student participant is required and the certification must state:

- a) participant is suffering from a serious illness or injury;
- b) absence is medically necessary;
- c) such serious illness or injury caused participant to lose fulltime dependent student status for purposes of coverage under the terms of this plan.

3. **Length of Continuation**

The medically necessary leave of absence shall not exceed the date that is:

- a) one year after the first day of the medically necessary leave of absence or;
- b) the date on which such coverage would otherwise terminate under the terms of the plan.

H. **DUAL COVERAGE PRECLUDED**

No person will be covered under the Plan simultaneously:

- 1. As both an Employee and a Dependent, if eligible for County coverage;
- 2. As a Dependent of more than one Employee.

**ARTICLE III**  
**HEALTH CARE BENEFITS**  
**ELIGIBLE MEDICAL AND MENTAL HEALTH CARE EXPENSES**

The following are considered eligible for reimbursement under the Health Care Benefits Plan unless they are specifically excluded under the Schedule of Benefits. These eligible expenses are limited to the medically necessary, usual and customary 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 charged 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. Pre-admission 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:  
**(See limits shown in the Schedule of Benefits and Cost Containment Section).**
  - a. Affiliated with a hospital under a contractual agreement with an established system for patient referral; or
  - b. Accredited as such a facility by the Joint Commission on Accreditation of Hospitals; or
  - c. Licensed as an alcohol treatment program by the Texas Commission on Alcoholism; or
  - d. Licensed, certified, or approved as an alcohol dependency treatment program or center by any other state agency having legal authority to so license, certify or approve.
10. Fees charged by a Surgeon, Assistant Surgeon or Surgical Technician for surgical procedures. Assistant Surgeon's fees will be eligible if the procedure required an Assistant Surgeon or the facility where the surgery was performed requires an Assistant Surgeon. Assistant Surgeon fees will be limited to a maximum payment of twenty-five percent (25%) of the eligible and reasonable and necessary charges of the Surgeon as determined by the Plan or twenty-five (25%) of the negotiated discounted fee of a Preferred Provider Physician.
11. Services of an Out-patient Surgical Facility;
12. Professional Nursing Services - fees charged for professional services by a Registered Nurse (R.N.), 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 R.N. license, LVN license, or other license requiring a higher level of medical skill and training;
  - b. The level of skill of an RN or LVN is medically necessary;
  - c. The 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 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 within fourteen (14) consecutive days of termination of that confinement a Participant becomes confined in the Extended Care Facility; and
  - b. The attending physician certifies twenty-four hour nursing care is necessary for recuperation from the injury or sickness, which required the Hospital Confinement;
  - c. Is approved by and is a participating Extended Care Facility of Medicare; and
  - d. Has organized facilities for medical treatment and provides twenty-four hour nursing service under the full-time supervision of a physician or Registered Graduate Nurse; and
  - e. Maintains daily clinical records on each patient and has available the services of a physician under an established agreement; and
  - f. Provides appropriate methods of dispensing and administering drugs and medicine; and
  - g. Has transfer arrangements with one or more hospitals, a utilization review plan in effect and operational policies developed with the advice of, and reviewed by, a professional group including at least one physician; and
  - h. Not to exceed the Daily Room Rate for Extended Care shown in the Schedule of Benefits for each day of such confinement, in lieu of any other payment under this benefit. Payment will continue for a Maximum Period of Payment for Extended Care, as set forth in the Schedule of Benefits, but only so long as the attending physician certifies such confinement remains necessary for recuperation; and the facility is licensed pursuant to state and local laws and is operated primarily for the purpose of providing skilled nursing care and treatment for individuals convalescing from injury or sickness; and
  - i. Excluding any institution, 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;**

21. Legal drugs and medicine, including oral contraceptives, and injectable contraceptives (Depo-Provera injections, Norplant implants, but not the removal) for the purposes of birth control and obtainable only on a physician's written prescription. Out-patient prescription drugs must be purchased with your prescription drug card. No reimbursement will be made for out-patient prescription drugs submitted to this benefit Plan;
22. Eligible medical expenses incurred for treatment while confined to a hospice for the physical and emotional needs of terminally ill patients;
23. Benefits for Eligible Medical Expenses incurred will be payable according to the Schedule of Benefits in effect on the day the expenses are incurred;
24. The Plan will pay for routine nursery care (well-baby care) at the time of delivery including medical checkups until age 24 months. Routine well-baby checkups are not part of the annual wellness benefit. Routine immunizations will be covered for eligible dependent children age 0 to 18, as recommended by the Center for Disease Control and State of Texas Minimum State Vaccine for Students. HPV for children age 7 to 18 and Rotavirus for children age 0 to age 6 will be eligible;
25. The Plan will pay for the purchase of a nebulizer up to the maximum purchase price of \$100.00. The plan participant will be required to pay a co-pay of \$25.00 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;
26. Eligible conditions for mental illness under this Plan shall be defined by the International Classification of Diseases 9<sup>th</sup> Edition (ICD-9) Codes. Eligible mental illness conditions shall begin at 290.0 through and including 315.9 of the ICD-9 Code Book;
27. The treatment of temporomandibular joint dysfunction or TMJ syndrome will be limited to \$1,000.00 per lifetime per participant.

**ARTICLE IV**  
**LIMITATIONS AND EXCLUSIONS**

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

1. In excess of the Reasonable or Usual and Customary charge, 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;
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 refraction's or eye examinations for the correction of vision or fitting of glasses or contact lenses, furnishing or replacement of glasses or contact lenses;
8. For routine hearing examinations in which there is no medical diagnosis requiring the examination, or the furnishing of hearing aides beyond the limits in the Schedule of Benefits;
9. For dental treatment, except as cited in Article III, #20;
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 surgery, unless required because of an accidental injury which occurs while covered hereunder or because of a congenital malformation of a dependent child unless the child was born while covered under this Plan and has remained continuously covered under this Plan since birth;
12. For the diagnosis or treatment of mental, nervous, or emotional disorders, including drug and alcohol related disorders whether as an out-patient or as an in-patient; beyond the limits in the Schedule of Benefits subject to the definition of mental illness in Article III, #26;
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 a direct result of an accident that occurred when covered as an eligible participant under this Plan or because of a congenital malformation of a dependent child that was born while covered under the Plan and has remained continuously covered under the Plan since birth up to a maximum benefit of \$1,000.00 per lifetime of the participant (Article III, #27) for the treatment of temporomandibular joint dysfunction or TMJ syndrome.
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 will have a plan benefit limit of \$15,000.00 per lifetime per participant 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 smoking cessation or similar program;

20. Purchased or rented supplies of common use such as: exercise cycles, air purifiers, air conditioners, water purifiers, hypo-allergenic pillows or mattresses, or waterbeds or convenience items;
21. Purchase or rental of: motorized transportation equipment, escalators or elevators, saunas, steam baths, swimming pools, hot tubs, blood pressure kits, blood sugar test machines (except syringes, test strips, and lancets);
22. In vitro fertilization, artificial insemination, surgical reversal of elective sterilization, fertility drugs, contraceptives other than birth control pills or Depo-Provera injections for the purpose of birth control or Norplant implants for the purposes of birth control, but not the removal of Norplant implants;
23. Vitamins (except prenatal vitamins) or dietary supplements, minerals, any drugs that can be purchased without a written prescription;
24. Sex transformation, or the treatment of or for trans-sexual purposes;
25. Treatment for sexual dysfunctions of inadequacy, which includes implants, pumps and related hormones and/or drug therapy. Expenses for drug therapy may be considered eligible under this Plan when sexual dysfunction of inadequacy is not the primary diagnosis;
26. Treatment of obesity; but not morbid obesity. In addition to other medical requirements, the weight requirement for morbid obesity shall be defined as a minimum of 100 pounds over your normal body weight as determined by your physician. Payment for non-surgical treatment for morbid obesity shall be limited to a lifetime maximum of \$1,500.00. Surgical procedures and all associated costs will be limited to \$30,000.00 per lifetime of the covered plan participant. **NO SURGICAL PROCEDURES FOR MORBID OBESITY ARE ALLOWED OR CONSIDERED ELIGIBLE FOR COVERAGE DURING YOUR FIRST 12 MONTHS OF COVERAGE UNDER THIS 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;
31. Eligible expenses do not include any charges incurred by an individual with respect to any injury, illness, including pregnancy, which existed 12 months prior to being covered under this Plan. These injuries, illnesses, pregnancies or related conditions shall be considered a pre-existing condition. Any expenses associated with these conditions, excluding prescription drugs, will not be considered as eligible expenses until after the participant has been covered by the Plan for 12 months.
32. 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;
33. Charges 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;
34. Charges for services rendered by a physician, nurse, or licensed therapist if such physician, nurse, or licensed therapist is a Close Relative of the Covered Person;
35. Charges incurred outside the United States if the Covered Person traveled to such a location for the sole purpose of obtaining medical services, drugs or supplies;
36. Charges for physician fees for any treatment, which is not rendered by or in the physical presence of a physician;
37. Charges for experimental procedures, drugs, or research studies or for any services or supplies not considered legal in the United States;
38. Charges for replacement of a lost, missing, or stolen prosthetic device;
39. Treatment of eating disorders; beyond the limits in the Schedule of Benefits subject to the definition of mental illness in Article III, #26;

40. Charges incurred as a result of or in connection with diagnosis or treatment of a learning disability or learning impairment by any name called. This exclusion includes, but is not limited to, 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 III, # 26. Attention deficit disorder is considered a learning disorder and is not covered except for medication as covered under "Out-patient Prescription Drugs" or for medical examinations to measure appropriateness of medications;
41. For any charges in connection with growth hormone deficiencies, including diagnosis and treatment, unless this condition is incurred by a dependent child who was born while covered under this Plan and has remained continuously covered under this Plan before diagnosis;
42. For any procedures that have not been formally approved by the Federal Food and Drug Administration and/or the American Medical Association, and are experimental or for research purposes, or for procedures that require an Informed Consent Form;
43. Drugs labeled "Caution--limited by a federal law to investigational use" or experimental drugs even though a charge is made to the covered Individual; drugs that have no FDA-approved indications for use; FDA-approved drugs or dosage regimens used for indications or routes of administration outside of FDA approval;
44. Charges for the purchase, storage or transportation of organs that is being used for transplant purposes;
45. Charges or expenses incurred for massage therapy or acupuncture;
46. For any elective surgery that is not medically necessary, except for elective sterilization;
47. 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 III, #26;
48. Weight loss programs beyond the limits in the Article IV, Limitations and Exclusions, #26;
49. 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 out-patient basis will be considered eligible expense.
50. Adult immunizations other than what are listed in the Schedule of Benefits;
51. For wigs, unless hair loss is due to radiation or chemotherapy with a diagnosis of cancer;
52. 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 V**  
**COORDINATION OF BENEFITS/SUBROGATION**

**A. COORDINATION OF BENEFITS**

All of the Benefits provided under the Plan are subject to these provisions, with the exception of out-patient prescription drugs. No coordination of benefits will be allowed for out-patient prescription drugs.

**1. Applicability**

- a. This Coordination of Benefits ("COB") provision applies to This Plan when an Employee or the Employee's covered Dependent has health care coverage under more than one Plan. "Plan" and "This Plan" are defined below.
- b. If this COB provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of This Plan are determined before or after those of another Plan. The benefits of This Plan:
  - (i) shall not be reduced when, under the order of benefit determination rule, This Plan determines its benefits before another Plan; but
  - (ii) may be reduced when, under the order of benefit determination rules, another Plan determines its benefits first. The above reduction is described in Article V, #4, "Effect on Benefits" of This Plan.

**2. Definitions**

- a. Plan means any Plan providing benefits or services for or by reason of medical or dental care or treatment, which benefits or services are provided:
  - (i) group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.
  - (ii) coverage under a governmental Plan or required or provided by law, including Medicare (Title XVIII, Social Security Act of 1965, as amended). This does not include a state Plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act as 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.
  - (iii) 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 (i) or (ii) is a separate Plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate Plan.

- b. **This Plan** is the part of the group contract that provides benefits for health care expenses.
- c. **Primary Plan/Secondary Plan** the order of benefits determination rules state whether This Plan is a Primary Plan or Secondary Plan as to another Plan covering the person.

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

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

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

- d. **Allowable Expense** means any 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 a similar provision takes effect.

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

- a. **General.** When there is a basis for a claim under This Plan and another Plan, This Plan is a Secondary Plan, which has, its benefits determined after those of the other Plan, unless:
  - (i) The other Plan has rules coordinating its benefits with those of this Plan; and
  - (ii) Both those rules and This Plan's rules, subparagraph b) below, require that This Plan's benefits be determined before those of the other Plan.
- b. **Rules.** This Plan determines its order of benefits using the first of the following rules which applies:
  - (i) **Non-dependent/Dependent** the benefits of the Plan which covers the person as an Employee, member or subscriber (that is, other than as a Dependent) are determined before those of the Plan which covers the person as a Dependent.
  - (ii) **Dependent Child/Parents Not Separated or Divorced** except as stated in section (iii) below, when This Plan and another Plan cover the same child as a Dependent of different persons, called "parents":
    - (a) The benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in that year; but
    - (b) If both parents have the same birthday, the benefits of the Plan, which covered the parent longer, are determined before those of the Plan, which covered the other parent for a shorter period of time.
  - (iii) **Dependent Child/Separated or Divorced Parents** if two or more Plans cover a person as a Dependent child of divorced or separated parents, benefits for the child are determined in this order:
    - (a) First, the Plan of the parent with custody of the child;
    - (b) Then, the Plan of the spouse of the parent with custody of the child; and
    - (c) Finally, the Plan of the parent not having custody of the child.

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

- (iv) **Active/Inactive Employee** the benefits of a Plan, which covers a person as an Employee 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 (iv) is ignored.
- (v) **Longer/Shorter Length of Coverage** if none of the above rules determines the order of benefits, the benefits of the Plan which covered an Employee, member or subscriber longer are determined before those of the Plan which covered that person for the shorter period of time.

4. **Effect on Benefits**

- a. When This Section Applies. 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:
  - (i) The benefits that would be payable for the Allowable Expenses under this Plan in the absence of this COB provision; and
  - (ii) The benefits that would be payable for the Allowable Expenses under the other Plans, in the absence of a provision with a purpose like that of this COB provision, whether or not claim is made;
- c. **Medicare Coordination of Benefits**
  - (i) If you are age 65 or over and a full time employee of Fort Bend County, this Plan will be the primary payer. If your dependent spouse is 65 or over and covered under your Plan while you are a full time employee, this Plan will be the primary payer; and
  - (ii) For all other Covered Persons, the benefits payable by the Plan for Eligible Expenses will be reduced by the amount for which such persons are eligible for comparable benefits under Full Medicare Coverage. This Plan will assume that any person age 65 and over will have full Medicare coverage (Part A and Part B and any other optional coverage offered by Medicare). The benefits of this Plan would be reduced after both Part A and Part B of Medicare has paid. In the event you have not chosen the optional coverage offered by Medicare, this Plan would still assume and pay eligible benefits as if full Medicare coverage had already been applied.

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

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

5. **Right to Receive and Release Necessary Information**

Certain facts are needed to apply these COB rules. The Contract Administrator has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. 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**

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
- d. Other organizations.

The "amount of the payments made" includes the reasonable cash value of any benefit provided in the form of services.

8. **Exception**

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

B. **SUBROGATION AND REIMBURSEMENT**

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

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

arising under state, federal, or local law;

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

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

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

under worker’s compensation laws or regulations or pursuant to any group accident and health insurance policy or any pre-paid health or accident benefit plan; and or from any source whatsoever.

When the Plan receives notice of an injury claim, it shall be entitled to assert a priority subrogation lien to the extent it has become or may become obligated to provide injury-related benefits. Notice of the Plan’s right of subrogation, or of the priority lien that it claims, is sufficient to establish its subrogation rights with respect to insurers, third parties, attorneys, and other persons or entities against whom a covered person may have a right of recovery arising out of the injury. The Plan is not required to intervene in a personal injury or other action brought by a covered person in order to establish or maintain the Plan’s subrogation rights. The Plan is authorized, but not required, to initiate legal action in its name or in the name of the covered person in order to enforce the Plan’s subrogation rights.

The covered person and anyone acting on his/her behalf shall provide the Plan with information it deems necessary to protect its right of subrogation. The covered person is required to contact the Plan prior to the settlement of an injury claim in order to determine the then-current amount of the Plan’s subrogation claim. The covered person shall do nothing to prejudice the Plan’s subrogation rights and shall cooperate with the Plan in the enforcement of its rights. Neither a covered person nor his/her attorney is authorized to accept subrogation reimbursement payments on behalf of the Plan or to settle or otherwise compromise the Plan’s subrogation rights without the Plan’s written consent, and the Plan will not be responsible for any expenses or fees incurred in connection with a recovery unless it shall have agreed in writing to pay such expenses or fees. The amount of the Plan’s subrogation interest shall be deducted first from any recovery obtained by or on behalf of a covered person.

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

**ARTICLE VI**  
**MISCELLANEOUS PROVISIONS**

**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, Texas 78766**

**Additional Contact information:**  
**1-800-252-9653**  
**[www.boonchapman.com](http://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. 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.

**C. 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.

**D. 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.

E. **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.

F. **PROOF OF LOSS**

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

G. **TIME OF PAYMENT OF CLAIM**

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

H. **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 reasonably be 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.

I. **LEGAL ACTIONS**

No actions at law or in equity shall be brought to recover on the Plan prior to the expiration of sixty (60) days after proof of loss has been filed in accordance with the requirements of the Plan, nor shall such action be brought at all unless brought within three (3) years from the expiration of the time within which proof of loss is required by the Plan.

J. **THIRD PARTY LIABILITY**

If a Covered Person has medical charges:

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

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

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

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

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

K. **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.

L. **ASSIGNMENT OF BENEFITS**

Benefits for medical expenses (**except for out-patient prescription drugs**) covered under the Plan may be assigned by a plan participant to the person or institution rendering the services for which the expenses were incurred. No such assignment will bind the Plan unless it is in writing and unless it has been received by the Plan prior to the payment of the benefit assigned. The Plan will not be responsible for determining whether any such assignment is valid. Payment of benefits, which

have been assigned, will be made directly to the assignee unless a written request not to honor the assignment signed by the plan participant and the assignee has been received before the proof of loss is submitted. Any payment made in accordance with the provision of this Section shall fully discharge the liability of the Plan to the extent of such payment.

**M. PPO PHYSICIAN REFERRALS**

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

**N. DEDUCTIBLE AMOUNT AND CARRY-OVER PROVISIONS**

The Deductible Amount of **\$250.00 (P.P.O.) or \$700.00 (Non-P.P.O.)** in Plan A-250 or the deductible amount of **\$750.00 (P.P.O.) or \$1,000.00 (Non-P.P.O.)** in Plan B-750 will be deducted from the covered expenses before benefits are computed, unless the "SCHEDULE OF BENEFITS" indicates otherwise. In the event a plan participant is hospital confined on December 31, satisfaction of a deductible for the following year shall not be applied until after the date of discharge.

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

1. When two or more covered family members are injured in the same accident, only one Deductible will be applied in any calendar year to the expenses directly resulting from injuries sustained in that accident;
2. If you incur eligible claims or expenses in October, November and December that apply toward the calendar year deductible and you have not incurred any eligible claims or expenses or received any credit towards your deductible between January and the last day of September of the same year, then any eligible claims or expenses that will apply toward your deductible in October, November and December will be carried over to the next year's deductible in the form of a credit. Any expenses paid by this plan toward the **Annual Health Screening Benefits/Well Care** as defined on page 7, #12 will not apply to this carry-over provision.
1. When five covered family members on the Plan A-250 or three covered members on the Plan B-750 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 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 plans, then the deductible from the plan with the highest number of family member deductible maximums will apply.
4. The Plan reserves the right to allocate the Deductible to any Covered Medical Expenses and to apportion the benefits to the covered person and any assignees.
5. Any Deductible movement between Plan A-250 and Plan B-750 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 II, Section B.

**O. EMPLOYEE HOSPITAL AUDIT PROGRAM**

Any employee who participates in the Plan will be eligible for this benefit. You will be paid 50% of any amount that you can identify as an error on your hospital bill up to a maximum payment of \$1,000.00 per year.

**P. ORGAN TRANSPLANT BENEFIT**

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 breast cancer) and provided the procedure is not deemed as experimental or research in nature in the judgment of the Administrator, 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 covered 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-P.P.O. 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.

**Q. RETIREE COVERAGE/CONTINUATION OF COVERAGE/Chapter 175 of the Local Government Code**

Retirees 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.

**FORT BEND COUNTY  
EMPLOYEE BENEFIT PLAN**

**DENTAL BENEFITS  
SCHEDULE OF BENEFITS  
&  
SUMMARY PLAN DESCRIPTION**

Type of Expense	Deductible Amount*	Percent of Reimbursement
I	-0-	100%
II	\$100.00	80%
III	\$100.00	50%
IV	\$100.00	50%
V	\$100.00	80%

**Type I routine oral examinations and prophylaxis expenses must be used during the 180 days prior to incurring any Type II, III, IV or V benefits.**

\*The Deductible Amount can be satisfied by any combination of Type II, III, IV, and V Services. The **\$100.00** calendar year per person deductible has a maximum of **\$300.00** per family.

Maximum benefit payable for Type I, II, III, and V Services each Calendar Year - **\$1,500.00**.  
Maximum lifetime benefit for Type IV Services - **\$1,500.00**.

The Amount Payable will be the percent specified in the Schedule of Benefits, subject to the maximum Dental Benefit.

The Deductible Amount for a Calendar Year will be satisfied when Covered Dental Expenses equal to the Deductible Amount in the Schedule of Benefits have been incurred in connection with dental care during the "Deductible Period for a Calendar Year" as defined in the Plan. Covered Dental Expenses for which benefits were payable during the previous Calendar Year will not be used toward satisfaction of the Deductible Amount.

Expenses for Type IV Services will be payable at the percent and in excess of the Deductible Amount, if any, specified in the Schedule of Benefits, provided expenses are incurred while the eligible Dependent is covered under this Plan. In no event will the total amount payable for Type IV Services exceed the Maximum Lifetime Benefit for Type IV Services specified in the Schedule of Benefits.

**Maximum Dental Benefit**

The aggregate benefits payable under this Plan for all Type I, II, III and V Services in the list of Dental Services furnished for you or your Covered Dependent's dental care in any one Calendar Year will not exceed the Maximum Dental Benefit Each Calendar Year specified in the Schedule of Benefits.

The aggregate benefits payable under this Policy for all Type IV Services will not exceed the Maximum Orthodontic Benefit Specified in the Schedule of Benefits for all services and supplied furnished to you or your Covered Dependent during your entire lifetime.

**Limitations of Covered Dental Expenses**

**Dental conditions or procedures, which were started, diagnosed or existed before you became eligible to participate in this Plan, will be subject to a pre-existing limitation. A pre-existing condition shall be defined as any dental condition or procedure, which began, or was diagnosed or existed during the previous 12 months prior to your becoming eligible to participant in this program. No Type II, III, IV or V expenses will be eligible for benefits for those conditions or procedures until you have satisfied 12 continuous months of coverage. During this time you will be eligible for Type I Services only for those pre-existing conditions or procedures.**

## **TYPE I SERVICES:**

### **PREVENTATIVE AND EMERGENCY EXPENSES**

The following expenses will be payable at the percent shown in the Schedule of Benefits in excess of the Deductible Amount, if any:

- (1) Routine oral examinations and prophylaxis (scaling and cleaning of teeth, must be used not more than once each in any period of 180 consecutive days).
- (2) Topical application of fluoride (the direct application of fluoride to the exposed surfaces of the teeth to inhibit tooth decay), (not more than once in any period of 180 consecutive days).
- (3) Space maintainers (a fixed or removable appliance designed to prevent adjacent and opposing teeth from moving) that replace prematurely lost teeth for qualified Dependent children under 19 years of age.
- (4) Emergency treatment of temporary relief of pain, which does not provide a definite cure.
- (5) Bite Wing X-ray (no more than once in a period of 180 consecutive days).

#### **Limitation of Type I Service:**

Payment will be made based on the applicable percentage, toward the cost of procedures necessary to eliminate oral disease and the replacement of missing teeth.

## **TYPE II SERVICES:**

### **DIAGNOSTIC AND RESTORATIVE EXPENSES**

The following expenses will be payable at the percent shown in the Schedule of Benefits in excess of the Deductible Amount, if any:

- (1) X-rays:
  - (a) Full mouth ((panoramic) not more than once in any period of 36 consecutive months);
  - (b) Miscellaneous dental x-rays required in connection with diagnosis of a specific condition with orthodontic diagnostic procedures and treatment.
- (2) Extractions.
- (3) Oral surgery.
- (4) Amalgam, silicate, acrylic, synthetic porcelain, and composite filling restorations to restore diseased or accidentally broken teeth.
- (5) Endodontic treatment (those procedures usually employed for prevention and treatment of diseases of the dental pulp and the area surrounding the tip of the tooth root), including root canal therapy.
- (6) Treatment of periodontal and other diseases of the gums and other tissues of the mouth.
- (7) Inlays, onlays, gold fillings, or crown restoration to restore diseased or accidentally broken teeth, but only when the tooth, as a result of extensive caries or fracture, cannot be restored with an amalgam, silicate, acrylic, synthetic porcelain, or composite filling restoration.
- (8) Repair or recementing of crowns, inlays, bridgework or dentures.
- (9) Relining or rebasing of dentures more than six months after the installation of an initial or replacement denture, (not more than one relining or rebasing in any period of 36 consecutive months).
- (10) Injection of antibiotic drugs by the attending Dentist.
- (11) Administration of general anesthetics, including intravenous sedation, when medical necessary due to a concurrent, hazardous medical condition and administered in connection with oral or dental surgery.

- (12) Sealants to permanent teeth, but limited to children up to age 16 (replacement no less than 36 months consecutive months).
- (13) Appliances for bruxism are considered eligible under Type II Services.

**Limitation of Type II Service:**

If you or your covered Dependent should choose a more costly type of restoration, such as porcelain veneer, crowns or jackets, but the tooth can be restored with a material such as amalgam, the Plan will pay the applicable percentage of the charge for that procedure and the participant will be responsible for remaining expense.

**TYPE III SERVICES:**

**PROSTHODONTICS OR RECONSTRUCTIVE EXPENSES**

The following expenses will be payable at the percent shown in the Schedule of Benefits in excess of the Deductible Amount, if any:

- (1) Initial installation of fixed bridgework (including inlays and crowns as abutments) but only if required to replace one or more natural teeth extracted while the family member is a covered individual.
- (2) Initial installation of partial or full removable dentures to replace one or more natural teeth extracted while the family member is a covered individual (including precision attachments which can be justified as functionally necessary with study models and radiographs) and any adjustments during the six-month period following installation.
- (3) Replacement of an existing partial or full removable denture or bridgework by a new denture or by new bridgework, but only if satisfactory evidence is presented that:
  - (a) the replacement or addition of teeth is required to replace one or more teeth extracted after the existing denture or bridgework was installed and while the family member is a covered individual; or
  - (b) the existing denture or bridgework cannot be made serviceable and it was installed at least five years prior to its replacement; or
  - (c) the existing denture is an immediate temporary denture, which cannot be made permanent and replacement, by a permanent denture takes places within 12 months from the date of initial installation of the immediate temporary denture.

**Limitations of Type III Services:**

- (a) **Partial Dentures:**  
if a cast chrome or acrylic partial denture will restore the dental arch satisfactorily, payment of the applicable percentage of the cost of such procedure will be made toward the charge for a more elaborate or precision appliance selected by the covered individual and the Dentist. The balance of the cost remains the responsibility of the covered individual.
- (b) **Precision Attachments:**  
Benefits will not be provided for precision attachments when used for cosmetic purposes.
- (c) **Dentures:**  
If in the provision of denture services, the covered individual and the dentist decide on personalized restorations or specialized techniques as opposed to standard procedures, payment of the applicable percentage of the cost of the standard denture services will be made toward that treatment and the balance of the cost remains the responsibility of the covered individual.
- (d) **Replacement of existing Dentures or Fixed Bridgework:**  
Replacement of an existing denture will be a Covered Dental Expense only if the existing denture is unserviceable and cannot be made serviceable. Payment based on the applicable percentage will be made toward the cost of services, which are necessary to render such appliances serviceable. Replacement of the prosthodontic appliances will be a Covered Dental Expense only if at least five years have elapsed since the date of the initial installation of that appliance.

#### **TYPE IV SERVICES:**

The following expenses will be payable at the percent shown in the Schedule of Benefits in excess of the Deductible Amount, if any:

Orthodontic treatment consisting of appliance, surgical, functional myofunctional, and other related treatment (including incidental oral examinations) of dental irregularities which result from abnormal growth and development of teeth, gums, or jaws as a result of accidental injury which requires repositioning (except for preventive treatment) of teeth to establish normal occlusion. (Related oral examinations, surgery and extraction's included as Type I, II or III Services are not considered Orthodontic treatment). Benefits are payable for dependent children under 19 years of age only.

#### **Limitations of Type IV Services:**

- (a) If Orthodontic Treatment is terminated for any reason before completion, the obligation to pay benefits will cease with payment to the date of termination. If such services are resumed, benefits for the services will be resumed to the extent of the remaining lifetime benefit applicable to the covered individual being treated.
- (b) Payment of benefits for orthodontic services will be only for months in which a person is a covered individual.
- (c) No payment will be made for orthodontic treatment, which commenced prior to the covered individual's effective date.

#### **TYPE V SERVICES:**

The following expenses will be payable at the percent shown in the Schedule of Benefits in excess of the Deductible Amount, if any:

- (1) Surgical removal of impacted teeth if partially or completely covered by bone;
- (2) Extraction of seven or more natural teeth (within a period of 15 consecutive days);
- (3) Frenectomy;
- (4) Oссous surgery;
- (5) Gingivectomy; and
- (6) Alveolectomy.

## DEFINITIONS

A **Person** means any full-time employee, retiree or eligible dependent that becomes eligible for coverage under this Plan as specified in the Persons Eligible section of the General Information page.

A **Covered Person** means a Person who is covered under this Plan.

The term “**legally qualified physician or surgeon**” shall mean a practitioner of the healing arts who is operating pursuant to the authority of his/her respective license in connection with a service covered by the terms of the Plan and who is not a member of the Covered Person’s or Covered Dependent’s immediate family.

**Policy Month** means one month beginning on the effective date of this Policy or any subsequent month beginning on such day of the month.

**Necessary** means medically necessary.

**Actively at Work** means an eligible Person who is not absent from active full-time work from illness or personal injury.

**Reasonable and Customary Charges** - Charges made for services or supplies essential to the care of the individual will be considered Regular and Customary if they do not exceed the average charges made for those services or supplies in the locality where the services or supplies are received, with due consideration for the nature and severity of the condition being treated.

**Area** means the location where the service is actually provided.

**Treatment Plan** means a Dentist’s report on a form satisfactory to the Plan Administrator which, (1) itemizes the dental services recommended by the Dentist for the necessary dental care of a Person, (2) shows the charge for each dental service and (3) when requested by the Plan Administrator, is accompanied by supporting preoperative X-rays and any additional information requested by the Plan Administrator.

**Orthodontic Treatment** means prevention and correction of dental irregularities resulting from the abnormal growth and development of the teeth or as a result of accidental injury requiring repositioning (except for preventive treatment) of teeth to establish normal occlusion.

**Ordered** means, in the case of dentures, that impressions have been taken from which the denture will be prepared; and in the case of fixed bridgework, restorative crowns, inlays and onlays, that the teeth which will serve as abutments or support or which are being restored have been fully prepared to receive, and impressions have been taken from which will be prepared the bridgework, crowns, inlays or onlays.

**Calendar Year** means the January first of any year through the December thirty-first of that same year.

**Deductible Period for a Calendar Year** means a continuous period composed of the Calendar Year and the preceding three months (see deductible amount and carry-over provisions below).

**Deductible Carry-Over Provision** means if you incur eligible claims or expenses in October, November and December that apply toward the calendar year deductible and you have not incurred any eligible claims or expenses or received any credit towards your deductible between January and the last day of September of the same year, then any eligible claims or expenses that will apply toward your deductible in October, November and December will be carried over to the next year’s deductible in the form of a credit. Any expenses paid by this plan toward **TYPE I SERVICES as listed on pages 49 and 50** will not apply to this carry-over provision.

## EXCLUSIONS AND LIMITATIONS APPLICABLE TO DENTAL BENEFITS

No benefits shall be payable under this Plan with respect to expenses incurred for:

- (a) The portion of any charge for any service in excess of the Reasonable and Customary Charge;
- (b) Any services or supplies other than those specifically covered under the provisions of the Plan;
- (c) Veneers (the coating or covering of plastic or porcelain on the outside of an bonded to a crown or false tooth to cause it to blend with the color of surrounding teeth) or similar properties of crowns and pontics placed on or replacing teeth, other than the ten upper and lower anterior teeth;
- (d) Services or supplies that is cosmetic in nature, including charges for personalization or characterization of dentures;
- (e) Prosthetic devices (including bridges) and crowns for a Person, and the fitting thereof, which are Ordered while such Person is not covered under this Policy or which were Ordered while such Person was covered under this Policy but are finally installed or delivered to such Person more than 60 days following termination of coverage;
- (f) Treatment by other than a Dentist, except that scaling or cleaning of teeth and topical application of fluoride may be performed by a licensed dental hygienist if the treatment is rendered under the supervision and guidance of the Dentist;
- (g) The replacement of a lost, missing or stolen prosthetic device, or the replacement or repair of an orthodontic appliance;
- (h) Services charged for, but not received, because of an individual's failure to appear for a scheduled appointment;
- (i) Any duplicate prosthetic device or any other duplicate appliance;
- (j) Sealants (materials, other than fluoride, painted on the grooves of the teeth in an attempt to prevent future decay) except as listed under Type II services, implantology (an insert set firmly or deeply into or on to the part of the bone that surrounds and supports the teeth); periodontal splinting;
- (k) Charges for dentures and bridgework (including crowns and inlays forming the abutments) when such charges are incurred for the replacement of teeth which were lost or missing prior to the person's becoming a covered individual under this Plan;
- (l) A plaque control program (a series of instructions on the care of teeth) or oral hygiene or dietary instructions;
- (m) Services or supplies for which the individual is not required to make payment;
- (n) Services or supplies which are not necessary, according to accepted standards of dental practice or which are not recommended or approved by the attending Dentist;
- (o) Services or supplies which do not meet accepted standards of dental practice including charges for services or supplies which are experimental in nature;
- (p) Services or supplies received as a result of dental disease, defect or injury due to an act of war, declared or undeclared; or by participation in a riot;
- (q) Charges for services or supplies which are, or could be, furnished, paid for or otherwise provided for (1) by reason of the past or present service of any person in the armed forces of a government, or (2) under any law of a government (national or otherwise) except where the payments or benefits are provided under a plan specifically established by a government for its own civilian employees or their Dependents. The amount of any such charges will be deducted from the family member's expenses unless the family member is legally obligated to pay the charge;
- (r) Services or supplies furnished through a medical department, clinic or similar facility provided or maintained by the covered individual's employer, unless the individual is legally obligated to pay the charge;

- (s) any services or supplies received because of oral disease or injury arising out of or in the course of employment and entitling the covered individual to benefits under any Worker's Compensation, Jones' Act, Longshoremen and Harbor Worker's Compensation Act, or Occupational Disease Act or Law;
- (t) Services or supplies for which benefits are payable under any other plan of group benefits provided by an included employer.
- (u) Services or supplies furnished by an immediate family member.
- (v) Dental conditions or procedures, which were started, diagnosed or existed before you became eligible to participate in this Plan, will be subject to a pre-existing limitation. A pre-existing condition shall be defined as any dental condition or procedure, which began, or was diagnosed or existed during the previous 12 months prior to your becoming eligible to participant in this program. No Type II, III, IV or V expenses will be eligible for benefits for those conditions or procedures until you have satisfied 12 continuous months of coverage. During this time you will be eligible for Type I Services only for those pre-existing conditions or procedures.
- (w) Services that are not specifically listed under Type I, II, III, IV or V