

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

JANUARY 1, 2011

Fort Bend County, the Employer, hereby amends and restates effective January 1, 2011 the self-funded Fort Bend County Employee Benefit Dental Plan (the "Plan") formed under Chapter 172 of the Local Government Code. The plan provides dental benefits for the eligible Employees of the Employer and their eligible Dependents.

Eligible Retirees and Dependents may participate in the plan in accordance with the rules established and approved by Fort Bend County Commissioners Court.

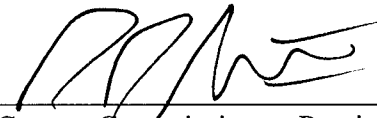
Eligible Survivors may participate in the plan in accordance with the rules established and approved by Fort Bend County Commissioners Court and Chapter 615 of the Local Government Code ("LGC 615 Survivor").

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

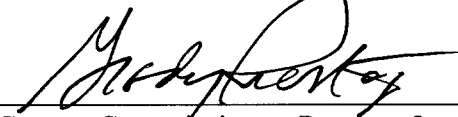
The Employer has caused this instrument to be executed by its duly authorized officers with the effective date of January 1, 2011.



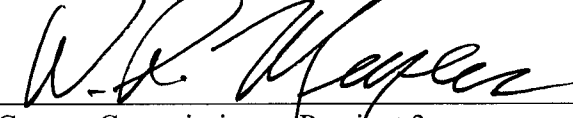
County Judge



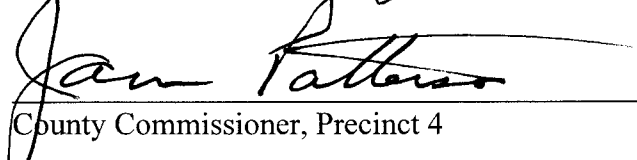
County Commissioner, Precinct 1



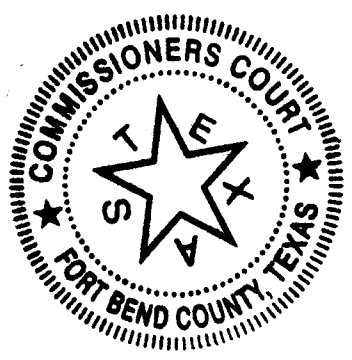
County Commissioner, Precinct 2



County Commissioner, Precinct 3



County Commissioner, Precinct 4



Approved by Commissioners Court on
September 27, 2011

Attest:


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PLAN ADMINISTRATOR'S DISCRETIONARY AUTHORITY

The benefits provided under the Dental Plan are for the exclusive benefit of eligible Employees/Dependents, eligible Retirees/Dependents, and Survivors as defined by LGC 615. These benefits are intended to be continued indefinitely, however, the Employer reserves the unilateral right and discretion to make any changes, without advance notice, to the Dental Plan which it deems to be necessary or appropriate, to comply with applicable law, regulation or other authority issued by a governmental entity. The Employer also reserves the unilateral right and discretion to amend, modify, or terminate, without advance notice, all or any part of the Dental Plan and to make any other changes that it deems necessary or appropriate. Changes in the Dental Plan may occur in any or all parts of the plan, including, but not limited to, benefit coverage, deductibles, maximums, co-payments, exclusions, limitations, definitions, eligibility and the like, under the plan. You should not, therefore, assume that the benefits that are provided under the plan will continue to be available and remain unchanged, and you should disregard any information or communication (written or oral) that would seem to limit the Employer's absolute right and discretion to terminate, suspend, discontinue or amend such benefits. Furthermore, the Plan Administrator reserves the absolute right, authority and discretion to interpret, construe, construct and administer the terms and provisions of the plan, including correcting any error or defect, supplying any omission, reconciling any inconsistency, and making all findings of fact including, without limitation, any factual determination that may impact eligibility or a claim for benefits. All decisions, interpretations and other determinations of the Plan Administrator will be final, binding and conclusive on all persons and entities subject only to the claims appeal provisions of the plan. Benefits under the plan will be paid only if the Plan Administrator determines, in its discretion, that the Participant is entitled to them.

**FORT BEND COUNTY
EMPLOYEE BENEFIT DENTAL PLAN
AND SUMMARY PLAN DESCRIPTION**

**ARTICLE I
SCHEDULE OF BENEFITS**

A. DENTAL SCHEDULE OF BENEFITS

	<u>DEDUCTIBLE</u>
Type I Services	-0-
Type II, III, IV and V Services*	\$100.00

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

<u>TYPE OF SERVICES</u>	<u>PLAN PAYS</u>
I	100%
II	80%
III	50%
IV	50%
V	80%

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

Maximum benefit payable for any combination of Type I, II, III, and V Services each Calendar Year is \$1,500.00.

Maximum lifetime benefit for Type IV Services is \$1,500.00.

The amount payable by the Plan will be the percent specified in the Schedule of Benefits, subject to the maximum Dental Benefit.

The deductible for a calendar year will be satisfied when Eligible Expenses equal to the deductible, in the schedule above, have been incurred in connection with dental care during the calendar year. If you incur eligible claims or expenses in October, November and December that apply toward the calendar year deductible and you have not incurred any eligible claims or expenses or received any credit towards your deductible between January and the last day of September of the same year, then any eligible claims or expenses that will apply toward your deductible in October, November and December will be carried over to the next year's deductible in the form of a credit. Any expenses paid by this Plan toward Type I Services will not apply to this carry-over provision.

The total benefits payable under this Plan for all Type I, II, III and V Services furnished for a Participant in any one calendar year will not exceed the amount specified in the schedule above.

In no event will the total benefits payable for Type IV Services incurred, while the individual is a Participant, exceed the maximum lifetime benefit for Type IV Services specified in the Schedule of Benefits for a participating eligible Dependent child.

B. ELIGIBLE EXPENSES

Benefits for Eligible Dental Expenses incurred will be payable according to the Schedule of Benefits, unless specifically excluded, in effect on the day the expenses are incurred.

Expense incurred on the date a dental service or treatment is performed, except for the following services or treatments:

- Dentures or bridgework on the date the impressions are taken;
- Crowns, inlays, onlays on the date the teeth are first prepared;
- Root canal therapy on the date the pulp chamber is opened; and
- Active orthodontic care on the date the appliances are inserted.

Administration of Anesthesia – fees charged by a Dentist and Dental Specialist for administration or anesthetics.

Fees charged by a Dentist, Dental Specialist, or Dental Hygienist (excluding Denturist) for dental care or specified treatment of an accidental Injury or dental disease.

Legal drugs and medicine are obtainable only on a Physician's written prescription. Out-patient Prescription Drugs must be purchased with your Fort Bend County Employee Benefit Plan ID card. No reimbursement will be made for out-patient Prescription Drugs submitted to this benefit Plan.

1. TYPE I SERVICES:

Preventative and Emergency Expenses

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

- a) Routine oral examinations and prophylaxis (scaling and cleaning of teeth) must be used not more than once each in any period of one hundred-eighty (180) consecutive days, with a window of one hundred-fifty (150) to two hundred-ten (210) days allowed;
- b) Topical application of fluoride (direct application of fluoride to the exposed surfaces of the teeth to inhibit tooth decay), not more than once in any period of one hundred-eighty (180) consecutive days;
- c) Space maintainers (a fixed or removable appliance designed to prevent adjacent and opposing teeth from moving) that replace prematurely lost deciduous teeth for qualified Dependent children under nineteen (19) years of age;
- d) Emergency treatment of temporary relief of pain, which does not provide a definite cure; and
- e) Bitewing x-ray, not more than once in a period of one hundred-eighty (180) consecutive days.

Limitation of Type I Services

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

2. TYPE II SERVICES:

Diagnostic and Restorative Expenses

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

- a) X-rays:
 - 1) Full mouth series or panoramic, not more than once in any period of thirty-six (36) consecutive months;
 - 2) Periapical x-rays, only when not performed on the same date as the complete series or panoramic x-rays; and
 - 3) Miscellaneous dental x-rays required in connection with diagnosis of a specific condition with orthodontic diagnostic procedures and Orthodontic Treatment;
- b) Extractions;
- c) Oral surgery;
- d) Amalgam, silicate, acrylic, synthetic porcelain, and composite filling restorations to restore diseased or accidentally broken teeth;
- e) Endodontic treatment (those procedures usually employed for prevention and treatment of diseases of the dental pulp and the area surrounding the tip of the tooth root), including root canal therapy;
- f) Treatment of periodontal and other diseases of the gums and other tissues of the mouth;
- g) Inlays, onlays, gold fillings, or crown restoration to restore diseased or accidentally broken teeth, but only when the tooth, as a result of extensive caries or fracture, cannot be restored with an amalgam, silicate, acrylic, synthetic porcelain, or composite filling restoration;
- h) Repair or recementing of crowns, inlays, bridgework or dentures;
- i) Relining or rebasing of dentures more than six months after the installation of an initial or replacement denture, not more than one relining or rebasing in any period of thirty-six (36) consecutive months;
- j) Injection of antibiotic drugs by the attending dentist;
- k) Administration of general anesthetics, including intravenous sedation, when Medically Necessary due to a concurrent, hazardous medical condition and administered in connection with oral or dental surgery;
- l) Sealants to permanent teeth, materials other than fluoride painted on the grooves of the teeth in an attempt to prevent future decay, but limited to children up to age sixteen (16), replacement no less than thirty-six (36) consecutive months; and
- m) Appliances for bruxism.

Limitation of Type II Services

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

3. TYPE III SERVICES:

Prosthodontics or Reconstructive Expenses

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

- a) Initial installation of fixed bridgework, including inlays and crowns as abutments, but only if required to replace one or more natural teeth extracted while the Participant is a covered individual;
- b) Initial installation of partial or full removable dentures to replace one or more natural teeth extracted while the Participant is a covered individual, including precision attachment which can be justified as functionally and Medically Necessary with study models and radiographs, and any adjustments during the six (6) month period following installation; and

- c) Replacement of an existing partial or full removable denture or bridgework by a new denture or by new bridgework, but only if satisfactory evidence is presented that:
 - 1) Replacement or addition of teeth is required to replace one or more teeth extracted after the existing denture or bridgework was installed and while the Participant is a covered individual;
 - 2) Existing denture or bridgework cannot be made serviceable and was installed at least five (5) years prior to its replacement; or
 - 3) Existing denture is an immediate temporary denture, which cannot be made permanent, and replacement by a permanent denture takes place within twelve (12) months from the date of initial installation of the immediate temporary denture.

Limitations of Type III Services

- a) Partial Dentures: If a cast chrome or acrylic partial denture will restore the dental arch satisfactorily, payment of the applicable percentage of the cost of such procedure will be made toward the charge for a more elaborate or precision appliance selected by the covered individual and the dentist. The balance of the cost remains the responsibility of the covered individual.
- b) Precision Attachments: Benefits will not be provided for precision attachments when used for cosmetic purposes.
- c) Dentures: If in the provision of denture services, the covered individual and the dentist decide on personalized restorations or specialized techniques as opposed to standard procedures, payment of the applicable percentage of the cost of the standard denture services will be made toward that treatment and the balance of the cost remains the responsibility of the covered individual.
- d) Replacement of existing Dentures or Fixed Bridgework: Replacement of an existing denture will be a Covered Dental Expense only if the existing denture is unserviceable and cannot be made serviceable. Payment based on the applicable percentage will be made toward the cost of services, which are Medically Necessary to render such appliances serviceable. Replacement of prosthodontic appliances will be a Covered Dental Expense only if at least five (5) years have elapsed since the date of the initial installation of that appliance.

4. TYPE IV SERVICES:

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

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

Limitations of Type IV Services

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

5. TYPE V SERVICES:

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

- a) Surgical removal of impacted teeth if partially or completely covered by bone;
- b) Extraction of seven or more natural teeth within a period of fifteen (15) consecutive days;
- c) Frenectomy;
- d) Osseous surgery;
- e) Gingivectomy; and
- f) Alveolectomy.

C. LIMITATIONS AND EXCLUSIONS

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

If a patient chooses a more expensive treatment than is needed to correct a dental problem according to accepted standards of dental practice, the benefit payment will be based on the cost of the treatment which provides professionally satisfactory results at the most cost effective level.

Unless otherwise specifically included, no benefits shall be payable under this Plan with respect to expenses incurred for:

1. The portion of any charge for any service in excess of the Reasonable and Customary Charge;
2. Any services or supplies other than those specifically covered under the provisions of the Plan;
3. Veneers (the coating or covering of plastic or porcelain on the outside of and bonded to a crown or false tooth to cause it to blend with the color of surrounding teeth), or similar properties of crowns and pontics placed on or replacing teeth, other than the ten (10) upper and lower anterior teeth;
4. Services or supplies that are cosmetic in nature, including charges for personalization or characterization of dentures;
5. Prosthetic devices, including bridges, and crowns for a Participant, and the fitting thereof, which are ordered while such Participant is not covered under this Plan or which were ordered while such Participant was covered under this Plan but are finally installed or delivered to such Participant more than sixty (60) days following termination of coverage.
6. Treatment by other than a dentist, except that scaling or cleaning of teeth and topical application of fluoride may be performed by a licensed dental hygienist if the treatment is rendered under the supervision and guidance of the dentist;
7. The replacement of a lost, missing or stolen prosthetic device, or the replacement or repair of an orthodontic appliance;
8. Services charged for, but not received, because of an individual's failure to appear for a scheduled appointment;
9. Any duplicate prosthetic device or any other duplicate appliance;
10. Implantology (an insert set firmly or deeply into or on to the part of the bone that surrounds and supports the teeth); and periodontal splinting;
11. Charges for dentures and bridgework, including crowns and inlays forming the abutments, when such charges are incurred for the replacement of teeth which were lost or missing prior to the Participant becoming a covered individual under the Plan;

12. A plaque control program (a series of instructions on the care of teeth) or oral hygiene or dietary instructions;
13. Services or supplies for which the individual is not required to make payment;
14. Services or supplies which are not Medically Necessary, according to accepted standards of dental practice or which are not recommended or approved by the attending dentist;
15. Services or supplies which do not meet accepted standards of dental practice including charges for services or supplies which are experimental in nature;
16. Resulting from care or treatment not reasonably necessary for the care and treatment of Dental Disease or accidental Injury;
17. Any services or supplies received because of oral disease or Injury arising out of or in the course of employment and entitling the covered individual to benefits under any Worker's Compensation, Jones' Act, Longshoremen and Harbor Worker's Compensation Act, or Occupation Disease Act or Law;
18. For any procedures that have not been formally approved by the Federal Food and Drug Administration and/or the American Dental Association, and are experimental or for research purposes, or for procedures that require an informed Consent Form;
19. Drugs labeled "Caution-limited by a federal law to investigational use" or experimental drugs even though a charge is made to the covered individual; drugs that have no FDA approved drugs or dosage regimens used for indication or routes of administration outside of FDA approval;
20. Services or supplies received as a result of dental disease, defect or Injury due to an act of war, declared or undeclared; or by participation in a riot;
21. Resulting from accidental Injury arising out of or in the course of employment for wages or profit;
22. Resulting from any intentionally self-inflicted Injury whether sane or insane;
23. Illness or Injury caused by, or contributed to, engagement in an illegal occupation or commissions or attempt to commit a felony;
24. Charges incurred outside the United States if the Participant traveled to such a location for the sole purpose of obtaining dental services, drugs or supplies;
25. Charges for experimental procedures, drugs, or research studies or for any services or supplies not considered legal in the United States;
26. Charges for services or supplies which are, or could be, furnished, paid for or otherwise provided for (i) by reason of the past or present service of any person in the armed forces of a government, or (ii) under any law of a government, national or otherwise, except where the payments or benefits are provided under a plan specifically established by a government for its own civilian Employees or their Dependents. The amount of any such charges will be deducted from the family member's expenses unless the family member is legally obligated to pay the charge;
27. Services or supplies furnished through a medical department, clinic or similar facility provided or maintained by the covered individual's Employer, unless the individual is legally obligated to pay the charge;
28. Services or supplies for which benefits are payable under any other group plan;
29. Services or supplies furnished by a Close Relative of the Participant; or
30. Services that are not specifically listed under Type I, II, III, IV or V.

ARTICLE II
PREDETERMINATION OF BENEFITS

The Plan encourages all Participants to seek the best and most efficient dental care available. The Participant or their dental provider may request a predetermination of a claim prior to incurring dental treatment. Predetermination of a claim does not guarantee payment of benefits. The Claims Administrator will determine if the procedure is eligible under the Plan.

Before starting a dental treatment for which the charge is expected to be \$200.00 or more, a predetermination of benefits form is recommended. A regular dental claim form is used for the predetermination of benefits. The Dentist must itemize all recommended services and costs and attach all supporting x-rays to the form. The Claims Administrator will notify the Dentist and the Participant of the benefits payable under the Plan. The Participant and the Dentist can then decide on the course of treatment, knowing in advance how much the Plan will pay.

If the description of the procedures to be performed, x-rays and an estimate of the Dentist's fees are not submitted in advance, the Plan reserves the right to make a determination of benefits payable taking into account alternative procedures, services or courses of treatment, based on accepted standards of dental practice. If verification of necessity of dental services cannot reasonably be made, the benefits may be for a lesser amount than would otherwise have been payable.

ARTICLE III
PLAN INFORMATION

EMPLOYER

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

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

Fort Bend County
Attention: County Attorney's Office
Fort Bend County Courthouse
Richmond, Texas 77469
Telephone 1-281-341-4555

PLAN NAME

Fort Bend County Employee Benefit Dental Plan – This is an employee benefit plan formed under Chapter 172 of the Local Government Code, providing Dental Benefits.

PLAN NUMBER/IDENTIFICATION – 949

BENEFIT YEAR – January 1 through December 31

PLAN YEAR – January 1 through December 31

CONTRACT CLAIMS ADMINISTRATOR

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

FINANCING OF THE BENEFITS PLAN

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

ARTICLE IV **DEFINITIONS**

Active Service means an Employee is performing in the customary manner all of the regular duties of employment on a full-time basis either at the customary place of employment or at some location to where that employment requires travel on a scheduled work day, or if the Employee is absent from work solely by reason of vacation and at the time coverage would otherwise become effective, has not been absent from work for a period of more than three (3) consecutive weeks. An Employee will be considered in Active Service on a day that is not a scheduled work day only if the Employee was performing in the customary manner all of the regular duties of employment on the last preceding scheduled work day. In no event will an Employee be considered in Active Service if he has effectively terminated employment with the Employer. An eligible Dependent will be considered in Active Service on any day if the Dependent is then engaging in all the normal activities of a person in good health of the same age and sex, and the Dependent is not confined in a medical facility. (This paragraph will not apply to a newborn child.) An Elected Official by virtue of office is deemed to be Active Service throughout their term once sworn into office and the officeholder is considered a full-time budgeted position regardless of hours worked.

Alternate Procedure is the most cost effective treatment of a dental condition which will provide a professionally acceptable result as determined by national standards of dental practice. Consideration is given to the current clinical oral condition based upon the diagnostic material submitted by the dentist.

Amendment means a formal document that changes the provisions of the Plan Document, duly signed by the authorized person or persons as designated by the Plan Administrator.

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

Benefit Maximums means total plan payments for each covered person are limited to certain maximum benefit amounts. A benefit maximum can apply to specific benefit categories or to all benefits. A benefit maximum also applies to a specific time period, such as annual or lifetime. When the word lifetime appears in this plan in reference to benefit maximums, it refers to the period of time you participate in this plan.

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

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

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

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

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

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

Deductible is the amount of covered expenses a Participant must pay during the year before the plan begins to consider expenses for reimbursement.

Dental Hygienist is a person who is licensed to practice dental hygiene, practicing within the scope of their license, and not a close relative.

Dentist is a person who is licensed to practice dentistry or oral surgery, practicing within the scope of their license and not a close relative.

Dependent means any one or more of the following:

1. The lawful Spouse of an Employee;
2. Unmarried natural children of the Employee under the age of nineteen (19), including legally adopted children and step-children who reside with the Employee, and are principally dependent on the Employee for support;
3. Unmarried natural children of the Employee, including legally adopted children and step-children who reside with the Employee, have attained the age of nineteen (19) and up to the age of twenty-five (25), and are full-time students in an accredited public or private secondary school, college, university, trade school or business school, and are principally dependent on the Employee for support (coverage will terminate on last day of full-time student status);
4. Unmarried natural children of the Employee, including legally adopted children and step-children, who have attained age nineteen (19), reside with the Employee, and are principally dependent upon the Employee for support and maintenance, are incapable of self-sustaining employment due to mental or physical disability, provided such disability commenced prior to attainment of age nineteen (19), and Dependent was covered prior to attainment of such age. Proof of dependency or mental or physical disability must be furnished by you when required by the Plan Administrator; or
5. Unmarried natural child of an Employee who is subject to a current order of a court or Attorney General for the State of Texas to provide dental benefits for such natural child.

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

Emergency Treatment refers to an urgent and unplanned visit in which dental services are provided for the temporary relief of acute pain.

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

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

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

Family Status Change events include marriage, birth, death, divorce, changes in a Spouse or Dependent's employment status, or a change from full-time to part-time status by the Employee or the Spouse. Other status changes include termination of employment; lay off, unpaid leave of absence, or retirement. It is the Employee's responsibility to notify Risk Management of the change in writing and to complete the necessary form(s). Verbal notification is unacceptable.

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

Injury means a condition caused by accidental means, which results in damage to the Participant's body from an external force.

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

Medically Necessary means a procedure or service that is:

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

Oral Surgery constitutes the necessary procedures for surgery in the oral cavity, including preoperative and postoperative care.

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

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

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

Pre-existing Condition means, as determined by the Plan Administrator, any Illness, Injury, or other condition of a Participant (whether physical or mental) including pregnancy, and including all complications that can reasonably be determined to be related to such conditions which existed at anytime during the twelve (12)

months prior to your effective date of coverage under this Plan. Genetic information on a Participant will not be considered a Pre-existing Condition.

Reasonable or Usual and Customary Charges means the plan provides benefits only for covered expenses that are equal to or less than the reasonable or usual and customary charge in the geographic area where services or supplies are provided. Any amount that exceeds the reasonable or usual and customary charge is not recognized by the plan for any purpose.

Retiree means any person who meets the definition of Retiree as defined by the Fort Bend County Commissioners Court.

Spouse means a person of the opposite sex to whom an Employee is lawfully married, which marriage was solemnized, authenticated and recorded as required by the state in which the marriage took place, to the extent such state law requirements are consistent with the federal Defense of Marriage Act, P.L. 104-199, but shall not include an individual separated from the Employee under a divorce decree. Under current Texas law, "spouse" shall also include a common law spouse provided that the requirements for common law marriage have been met. The Employee must provide proof of a common law marriage to include but is not limited to a declaration of informal marriage filed with the County Clerk.

Survivor(s) means an eligible surviving Spouse and/or Dependent of an Employee as defined in Chapter 615 of the Local Government Code.

Treatment Plan means a Dentist's report on a form satisfactory to the Plan Administrator which, (i) itemizes the dental services recommended by the Dentist for the necessary dental care of a person, (ii) shows the charge for each dental service and (iii) when requested by the Plan Administrator, is accompanied by supporting preoperative x-rays and any additional information requested by the Plan Administrator.

Waiting Period means for a regular enrollee, the first of the month after 90 days of continuous Active Service beginning on the first day of eligibility for coverage under the Plan (other than satisfaction of the Waiting Period requirement). For a Late Entrant, the term "Waiting Period" means the 90 day period of time between the date of enrollment in the Plan and the effective date of coverage under the Plan.

ARTICLE V
ELIGIBILITY AND PARTICIPATION

A. EMPLOYEE PARTICIPATION

1. Waiver of Participation in this Plan

An Employee has the right to waive their dental coverage under this Plan. Dependent coverage will not be available if Employee coverage is not selected. If an eligible Employee or Dependent elects to waive participation and later decides to enroll in the Plan beyond 31 days of first becoming eligible to participate in the Plan, the Employee and the Employee's Dependents will be Late Entrants and required to comply with any and all Plan provisions for enrollment in the Plan as Late Entrants. Coverage under the Plan for Late Entrants will be effective on the first (1st) day of the month following completion of the Waiting Period provided the employee is in active service (Elected Official is deemed to be "Active Service" once sworn into office) on that date, otherwise the effective date will be deferred until returned to Active Service. A Late Entrant will also be subject to the twelve (12) months (beginning from the effective date of coverage under the Plan) Pre-existing Condition exclusion.

2. Eligibility

All Employees in a full time budgeted position, who are in Active Service at their customary place of employment on the day their health care benefits become effective, and who complete the Waiting Period shall be eligible to participate in the Plan. Eligible Employees will be required to notify the Risk Management Department in writing, complete any necessary enrollment applications and supply all necessary documentation as required by the Plan within the first sixty (60) days of employment or eligibility to participate in the Plan.

Elected Officials who complete the required Waiting Period shall be eligible to participate in the Plan. Eligible Elected Officials will be required to notify the Risk Management Department in writing, complete any necessary enrollment applications and supply all necessary documentation as required by the Plan within the first sixty (60) days of employment or eligibility to participate in the Plan.

All other persons are excluded.

3. Effective Date of Coverage

Coverage will become effective for an eligible Employee on the first (1st) day of the month following completion of the Waiting Period, or if none, upon the date of eligibility (provided the Employee is in Active Service on that date, otherwise the Effective Date will be deferred until return to Active Service) subject to the Pre-existing Conditions exclusion. Employees with a change of status from part-time to full-time or from temporary to regular will be subject to the same Waiting Period beginning the date their status changes and subject to the exclusion of Pre-existing Conditions. Employees who previously waived their benefit participation and decide to participate at a later date may only enroll during the annual enrollment period as a Late Entrant and will be subject to the Waiting Period (which will start as of January 1st the following year) and subject to the exclusion of Pre-existing Conditions. Payment of any contribution toward the cost of coverage under the Plan, if required by the Employer, must be made prior to coverage becoming effective.

4. Termination of Coverage

Except as provided in the Continuation of Coverage in compliance with COBRA section, an Employee's coverage under the Plan will terminate at 11:59 p.m. on the earliest of the following dates:

- a) The date at the end of the period for which the Employee made the last required contribution for coverage under the Plan;
- b) The last day of the month in which the Employee terminates employment or retires;
- c) The date on which the Employee no longer satisfies the eligibility requirements under the Plan;
- d) The date on which the Plan is terminated or amended, resulting in the Employee's loss of coverage;
- e) The date of the Employee's death; or
- f) The date on which the Employee falsifies information provided to the Plan, fraudulently or deceptively uses Plan services, or knowingly permits such fraud or deception by another person.

Notwithstanding the foregoing, a termination of coverage may only be effective retroactively if the Employee (i) performs an act, practice or omission that constitutes fraud, (ii) makes an intentional misrepresentation of material fact, or (iii) fails to make a required contribution when due.

Participation may be continued for an Employee on an Employer approved leave of absence. See the Fort Bend County Employee Information Manual.

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

B. DEPENDENT PARTICIPATION

1. Required Documentation for Proof of Dependent

Documents must be submitted to Risk Management before eligibility is approved.

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

2. Eligibility

A Dependent will be eligible to participate in the Plan during or on:

- a) The date the Employee is eligible for benefits under the Plan, if on that date the Employee has such Eligible Dependents; or
- b) The date the Employee gains an Eligible Dependent, if on that date the Employee is covered by the Plan, and has made any necessary contributions; and has notified the Plan within thirty-one (31) days of gaining that Dependent.
- c) If a Dependent, other than a Newborn child, is Hospitalized on the date participation would normally commence, participation of that Dependent will not be effective until the day after the Dependent is discharged from the Hospital; and
- d) In no event will the Dependent's coverage begin before the Employee's coverage.

LGC 615 Survivor(s) are eligible to continue dental coverage under this Plan at the time of the Employee's death, but not enroll as a new Participant.

The Risk Management Department must be notified in writing of Eligible Dependents, complete any necessary enrollment applications and supply all necessary documentation as required by the Plan within the first sixty (60) days of employment or eligibility to participate in the Plan.

In the event a husband and wife are both eligible to participate in the Plan as Employees, only one Employee will be eligible to cover any eligible Dependent child(ren) they might have. If the Employee covering a Dependent terminates their employment, the terminated Employee and Dependent(s) may be added to the existing coverage of the remaining Employee, provided that there is no lapse in coverage and they are added immediately (Article V, G).

3. Changes in Dependent Health Care Benefits

Changes in the Health Care Benefits will be effective for Dependents only if the Employee is still eligible and the Dependent is not confined in a Hospital, or other institution. Employee and Dependent must be covered under the same benefit package.

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

4. Termination of Coverage

Except as provided in the Continuation of Coverage in Compliance with COBRA section, a Dependent's coverage will terminate at 11:59 p.m. on the earliest of the following dates:

- a) The date the Employee's coverage terminates;
- b) The Employee fails to remit required contributions for Dependent Health Care Benefits when due, Dependent's benefits will terminate at the end of the period for which contribution is made;
- c) The date on which the Dependent ceases to be an eligible Dependent as defined by the Plan;
- d) The date on which the Plan is terminated or amended, resulting in the Dependent's loss of coverage;
- e) The date of the Dependent's death; or
- f) The date on which the Employee or Dependent falsifies information provided to the Plan, fraudulently or deceptively uses Plan services, or knowingly permits such fraud or deception by another person.

LGC 615 Survivor(s) who terminate coverage under this Plan will not be able to re-enroll in the terminated coverage.

An Employee cannot terminate a Spouse during legal separation until the divorce is final. A certified divorce decree must be submitted before any paperwork can be processed. The termination date will be the effective date of the certified divorce decree.

Notwithstanding the foregoing, a termination of coverage may only be effective retroactively if the Employee or Dependent (i) performs an act, practice or omission that constitutes fraud, (ii) makes an intentional misrepresentation of material fact, or (iii) fails to make a required contribution for coverage under the Plan when due.

C. RETIREE PARTICIPATION

Elected Officials and employees in a full time budgeted position eligible for retirement through the Texas County and District Retirement System (TCDRS) and in accordance with the rules established and approved by Fort Bend County Commissioners Court.

Eligible Retirees and their eligible Dependents (except for deceased Retiree's survivors) will be eligible to participate in this Plan subject to the rules established by and approved by Fort Bend County Commissioners Court (i.e. Employee Information Manual Section 511).

Eligible Employees who retire before the end of a month, once retired will continue to participate in the employee dental plan through the end of that month as an active employee. On the first day of the month following retirement, the Retiree and their eligible Dependents may continue coverage in the FBC Dental plan in a Retiree status.

Effective September 11, 2001, Retirees who are married to a County Employee when they retire will be allowed to add the remaining Spouse/Employee and any covered Dependents to their coverage when the Spouse terminates their employment. The remaining Employee and eligible Dependents will be required to have the same dental benefits as the Retiree for at least the twelve (12) months preceding their termination of employment. The Retiree will be eligible to cover all other eligible Dependents; other than the remaining Spouse, when they retire.

Employee/Dependent Termination of Coverage rules apply to Retiree/Dependent.

Retirees who terminate coverage on themselves or Dependent(s) under this Plan will not be able to re-enroll in the terminated coverage.

D. LATE ENTRANTS / FAMILY STATUS CHANGE / DEPENDENT DELETION

All Late Entrants are required to satisfy the waiting period (ninety (90) days). The waiting period begins upon receipt of required enrollment and documentation by Risk Management. Original form(s) must be submitted to Risk Management, a fax or scanned email will not be accepted. Forms are available on the County Wide Web (CWW) site under Risk Management. If approved as a new Participant in the Plan, the earliest date that a Late Entrant's coverage may take effect will be the first day of the month following ninety (90) days after the Late Entrant's waiting period begins. The Plan reserves the right to approve or deny any Late Entrant applicant. If additional information is received by the Plan after the Late Entrant's acceptance that would disqualify the Late Entrant from coverage, the Plan will have the right to terminate coverage back to the original effective date and the Employer will refund any contribution that was already made towards said coverage. The Employee will be responsible for paying all claims paid by the Plan on behalf of the ineligible person.

Mid-Year Late Entrants – Participants who do not participate in the Section 125 Plan may add eligible Dependents mid-year with a Family Status Change. All new Participants will be considered Late Entrants and must fulfill the requirements as stated above. The ninety (90) day waiting period for the Late Entrant will begin on the date Risk Management receives all required documentation.

Annual Enrollment Late Entrants – An Employee may enroll eligible Dependent(s) during the annual enrollment period without a Family Status Change. All new Participants will be considered Late Entrants and must fulfill the requirements as stated above. The ninety (90) day waiting period for the Late Entrant will begin on January 1st of the following year. Required documents must be submitted by the deadline, which will be set for each annual enrollment period. Late Entrant applications are due within two (2) weeks of the deadline, which will be set for each annual enrollment period.

Family Status Change – An Employee who participates in the Section 125 Plan may add eligible Dependent(s) mid-year only if there is a qualified Family Status Change and the Participant has all required documentation

turned into Risk Management within thirty (31) days of the Family Status Change event. Qualified Family Status Changes for adding an eligible Dependent include, but are not limited to, marriage, birth, adoption, or a change in a Spouse or Dependent's employment status as specified by Section 125 of the Internal Revenue Code.

In the event of birth, adoption, or marriage, benefits for the eligible Dependents will be effective on the date of the Family Status Change. For example, when adding a Spouse due to marriage, the effective date of coverage will be the date of marriage on the certified marriage license or informal marriage certificate and premiums will be due beginning on that date.

In the event of a change in a Spouse's or Dependent's employment, all new Participants will be considered Late Entrants and must fulfill the requirements as stated above. The ninety (90) day waiting period for the Late Entrant will begin on the date Risk Management receives all required documentation.

Dependent Deletion – An Employee must delete a Dependent that is no longer eligible to remain on the Plan at the time they become ineligible. Dependents who are not eligible are those who are (i) children nineteen (19) years of age or older and who are not full-time students in an accredited public or private secondary school, college, university, trade school or business school, and are principally dependent on the Employee for support, (ii) children twenty-five (25) years of age or older and who are not eligible for coverage due to a mental or physical disability, (iii) children who are married, (iv) ex-Spouses and ex-step-children, and (v) step-children who do not reside with the employee. In the case of divorce, a certified divorce decree is required before the Plan will terminate the Dependents no longer eligible.

It is the Employee's responsibility to notify Risk Management of a Dependent who is no longer eligible and complete the proper form(s). Notification is subject to COBRA notification requirements. Verbal notification is unacceptable. The Plan will 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 Dependent during the ineligible period.

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

1. Continuation of Coverage

Coverage that may be continued under this section includes dental coverage provided under this Plan. For purposes of this section, a "Covered Person" is a Participant who is covered under the Plan due to his status as an Employee or Retiree and a "Covered Dependent" is a Dependent who is a Participant. Under this section, the following Participants whose coverage would otherwise end may continue to be covered under the Plan:

- a) Covered Dependents of a Covered Person who dies.
- b) A covered Person and their Covered Dependents upon the Covered Person's termination of employment (other than termination for gross misconduct), or whose work hours have been reduced to less than the minimum required for coverage under the Plan.
- c) A Covered Dependent Spouse upon divorce from the Covered Person.
- d) A Covered Dependent child loses coverage due to attainment of the maximum age to which Dependents may be covered under this Plan.

2. Notice Requirements – Employer/Employee

- a) When eligibility for continuation results from a Covered Person's death, termination, reduction in working hours, or entitlement to Medicare, the Covered Person or Dependent will notify the Employer

of that event. Notice must be given to Risk Management within thirty (30) days of the Covered Person's death, termination, reduction of working hours, or entitlement to Medicare.

- b) When eligibility for continuation results from a covered Spouse being divorced from a Covered Person (Employee) or a Dependent child's marriage or attainment of the maximum age for coverage under the Plan, the covered person or Dependent must notify the Employer of that event within sixty (60) days of the event.
- c) Within thirty (30) days of receiving notice, the Employer will notify the COBRA administrator of the termination of coverage. Within fourteen (14) days of receiving the notice from the Employer, the COBRA administrator will mail the covered person information regarding their right to continue benefits.
- d) After receiving that notice, the Covered Person or Dependent has sixty (60) days in which to decide whether to elect continued benefits. These sixty (60) days begins on the later of:
 - 1) The date coverage under the Plan would otherwise end; or
 - 2) The date the person receives notice from the Employer of their rights under the law.If the Covered Person or Dependent chooses to have continued benefits, they must advise the Employer in writing of this decision. The Employer must receive this written notice before the end of sixty (60) days.
- e) Within forty-five (45) days after the date of the Covered Person or Dependent notifies the Employer that they have chosen to continue dental insurance, the first premium must be paid. The first payment will be the amount needed to provide coverage from the date continued benefits begin to the date that the first payment is made. Thereafter, premiums for the continued benefits are to be paid monthly on the day of each month stated by the Employer.
- f) A Covered Person's Dependent must pay the premium for a coverage being continued.

3. Length of Continuation

- a) For Covered Persons who are terminated or have their hours reduced, coverage may be continued for up to eighteen (18) months after the termination or reduction in hours. For all others who qualify for continuation of benefits, coverage may be continued for up to thirty-six (36) months after the event, which makes the Covered Person eligible for continued benefits. Continuation will end on the earliest of:
 - 1) The end of the eighteen (18) or thirty-six (36) month period noted above;
 - 2) The date the Employer's Plan terminates;
 - 3) Failure to make payment for coverage as required above;
 - 4) The date the person becomes covered under any other group health Plan as a result of employment, re-employment or re-marriage;
 - 5) The date the person becomes entitled to benefits under Medicare.
- b) The following applies when this Plan replaces another Plan of group dental coverage. If, on the day before the effective date of the Employer's coverage under this Plan, eligible Employee or Dependent coverage is being continued under that prior Plan under COBRA (the Consolidated Omnibus Budget Reconciliation Act of 1985):
 - 1) That person will have the right to become covered under this Plan. Coverage may be provided until the end of the period for which the person could have been covered under the prior Plan if it had not been replaced; and
 - 2) Any benefits otherwise payable under this section will be reduced by any amounts for which the person is eligible under the Plan.

F. HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT OF 1996 (HIPAA) ELECTION UNDER 42 U.S.C. §300 GG-21

Federal law imposes upon group health plans (including Dental plans) certain limitations of (1) Pre-existing Condition exclusion periods, (2) special enrollment periods for individuals (and Dependents) losing other

coverage, (3) prohibitions against discriminating against individual Participants and beneficiaries based on health status, (4) standards relating to mothers and Newborns, (5) parity in the application of certain limits to mental health benefits, and (6) required coverage for reconstructive surgery following mastectomies.

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

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

1. HIPAA Privacy Rule

This Plan complies with the requirements of §164.504(f) of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations, 45 C.F.R. parts 160 through 164 (the regulations are referred to herein as the “HIPAA Privacy Rule” and §164.504(f) is referred to as “the “504” provisions”) which establish the extent to which the Plan Sponsor will receive, use and/or disclose Protected Health Information. “Protected Health Information” means information, including genetic information, that is created or received by the Plan which (a) relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual, (b) identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual, and (c) is transmitted or maintained in any form or medium.

2. The Plan’s Designation of Person/Entity to Act on its Behalf

The Plan has determined that it is a group health plan within the meaning of the HIPAA Privacy Rule, and the Plan designates Director of Risk Management as Privacy Officer to take all actions required by the Plan in connection with the HIPAA Privacy Rule (e.g., entering into business associate contracts; accepting certification from the Plan Sponsor).

3. The Plan’s disclosure of Protected Health Information to the Plan Sponsor – Required Certification of Compliance by Plan Sponsor

Except as provided below with respect to the Plan’s disclosure of summary health information, the Plan will (a) disclose Protected Health Information to the Plan Sponsor or (b) provide for or permit the disclosure of protected Health Information to the Plan Sponsor by a health insurance issuer with respect to the Plan, only if the Plan has received a certification (signed on behalf of the Plan Sponsor) that:

- a) The Plan Document has been amended to establish the permitted and required uses and disclosures of such information by the Plan Sponsor, consistent with the “504” provisions;
- b) The Plan Document has been amended to incorporate the Plan provisions set forth in this section; and
- c) The Plan Sponsor agrees to comply with the Plan provisions as described by this section.

4. Permitted disclosure of members’ Protected Health Information to the Plan Sponsor

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

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

The Plan may not, and may not permit a health insurance issuer, to disclose members' Protected Health Information to the Plan Sponsor for employment related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

The Plan Sponsor will not use or further disclose members' Protected Health Information other than as described in the Plan Documents and permitted by the "504" provisions.

The Plan Sponsor will ensure that any agent(s), including a subcontractor, to whom it provides members' Protected Health Information received from the Plan (or from the Plan's health insurance issuer), agrees to the same restrictions and conditions that apply to the Plan Sponsor with respect to such Protected Health Information.

The Plan Sponsor will not use or disclose members' Protected Health Information for employment related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

The Plan Sponsor will report to the Plan any use or disclosure of Protected Health Information that is inconsistent with the uses or disclosures provided for in the Plan Document (as amended) and in the "504" provisions, of which the Plan Sponsor becomes aware.

5. Disclosure of members' Protected Health Information – Disclosure by the Plan Sponsor

The Plan Sponsor will make the Protected Health Information of the member who is the subject of the Protected Health Information available to such member in accordance with 45 C.F.R. §164.524.

The Plan Sponsor will make members' Protected Health Information available for amendment and incorporate any amendments to members' Protected Health Information in accordance with 45 C.F.R. §164.526.

The Plan Sponsor will make and maintain an accounting so that it can make available those disclosures of members' Protected Health Information that it must account for in accordance with 45 C.F.R. §164.524.

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

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

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

6. Disclosures of Summary Health Information and Enrollment and Disenrollment Information to the Plan Sponsor

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

- a) Obtaining premium bids from health plans for providing health insurance coverage under the Plan; or
- b) Modifying, amending, or terminating the Plan.

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

7. Required separation between the Plan and the Plan Sponsor

In accordance with the “504” provisions, this section describes the Employees or classes of Employees or workforce members under the control of the Plan sponsor who may be given access by the Director of Risk Management as the Plan’s HIPAA Privacy Officer to members’ Protected Health Information received from the Plan or from a health insurance issuer. (Classes may include, for example: Analyst/Administrators; Service Personnel; Information Technology Personnel; Clerical Personnel; Supervisors/Managers; Quality Assurance Unit.)

- a) Director of Risk Management
- b) Risk Management Personnel
- c) Financial Accountants
- d) Legal Advisors who represent the Plan
- e) Part-time/Temporary Clerical support
- f) Information Technology Personnel

This list reflects the Employees, classes of Employees, or other workforce members of the Plan Sponsor who receive members’ Protected Health Information relating to payment under, health care operations of, or other matters pertaining to Plan administration functions that the Plan Sponsor provides for the Plan. These individuals will have access to members’ Protected Health Information solely to perform these identified functions, and they will be subject to disciplinary action and/or sanctions (including termination of employment or affiliation with the Plan Sponsor) for any use or disclosure of members’ Protected Health Information in violation of, or noncompliance with, the provisions of this section.

The Plan Sponsor will promptly report any such breach, violation, or noncompliance to the Plan and will cooperate with the Plan to correct the violation or noncompliance; to impose appropriate disciplinary action and/or sanctions, and to mitigate any deleterious effect of the violation or noncompliance.

8. Security Standards

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

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

- e) Plan Sponsor shall report to the Plan within a reasonable time after Plan Sponsor becomes aware, any Security Incident that results in unauthorized access, use, disclosure, modification, or destruction of the Plan's Electronic Protected Health Information; and
- f) Plan Sponsor shall report to the Plan any other Security Incident on an aggregate basis every month, or more frequently upon the Plan's request.

G. DUAL COVERAGE PRECLUDED

No person will be covered under the Plan simultaneously:

- a) As both an Employee and a Dependent, if eligible for County coverage;
- b) As a Dependent of more than one Employee/Retiree.

H. UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT

The Plan will comply with the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") with regard to continuation rights during an approved military leave of absence and reenrollment rights on return from such military leave of absence.

1. An Employee who is not at work because of a period of duty in the Uniformed Services (as defined in USERRA), may, at the Employee's election, continue coverage under the Plan during the period of absence, so long as the Employee satisfies the necessary provisions and makes any required Participant contribution as provided under USERRA.
2. The maximum period of coverage for an Employee, an Employee's Spouse and/or Dependent(s), if any, under the Plan during a period of duty in the Uniformed Services will be governed by the applicable limitation and provisions contained in USERRA unless more generous limitations are provided under the Employer's leave of absence policy.
3. An Employee who elects to continue coverage under the Plan will pay:
 - a) The Employee's share, if any, for coverage under the Plan if the Employee performs service in the Uniformed Services for up to thirty-one (31) days; or
 - b) One hundred-two percent (102%) of the full premium or cost under the Plan (determined in the same manner as the applicable COBRA continuation coverage premium under Section 4980B(f)(4) of the Code) if the employee performs service in the Uniformed Services for thirty-one (31) days or more.
4. During the period of service in the Uniformed Services, the Employee may pay the necessary costs associated with coverage under the Plan, if any, by:
 - a) Remitting payment to the Employer, due the first day of each month for which the Participant contributions would have been deducted from the Employee's paycheck had the Employee not been absent serving in the Uniformed Services, provided that any delinquent payments must be made within thirty (30) days after their due date;
 - b) At the Employee's request, prepaying the amounts that will become due during the period of service in the Uniformed Services out of one or more of the Employee's paychecks preceding such period of service in the Uniformed Services; or
 - c) Pre-approved arrangement with the Plan Administrator and in accordance with administrative policies adopted by the Plan Administrator wherein the Employer pays the Employee's Participant contributions during the Employee's period of service in the Uniformed Services. Upon return from such service, the Employee will reimburse the Employer for such previous payments.

Any Employee who is a Participant, who is not at work because of service in the Uniformed Services and who returns to active employment within the relevant time period determined under USERRA, will be eligible to return to work and immediately participate in the same benefit options and coverage level (i.e., same dependents if currently eligible) under the Plan which the Participant had elected to participate in prior to serving in the Uniformed Services, subject to any changes in the Plan that affect the workforce as a whole, provided that the Participant returns to employment with the same benefit eligibility status that he held prior to serving in the Uniformed Services, and provided further, that the Participant makes all required elections to participate in the Plan on a timely basis. Except to the extent provided in administrative policies adopted by the Plan Administrator (or the Employer, if applicable), the maximum period of health care coverage available to a Participant (and their Dependents) while on a USERRA leave of absence will end on the earlier of (i) the last day of the maximum coverage period prescribed under USERRA (or if required by USERRA's discrimination rules, the last day of the longest period that the Employer's leave of absence policy permits Plan coverage to continue) or (ii) the day after the date upon which the person fails to apply for a return to a position of employment within the time required under Section 4312(a) of USERRA. For purposes of determining eligibility for health benefits (and only if the Participant pays the full amount which the Employer is permitted to charge the Participant for health coverage under USERRA), a Participant who experiences a reduction in hours or termination of employment solely due to a USERRA leave will continue to be considered qualified as a Participant under the Plan until the earliest date that the termination of their health benefits is permitted under USERRA.

ARTICLE VI
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 area determined before or after those of another Plan. The benefits of This Plan:
 - 1) Shall not be reduced when, under the order of benefit determination rule, This Plan determines its benefits before another plan; but
 - 2) May be reduced when under the order of benefit determination rules, another Plan determines its benefits first. The above reduction is described in Article V, #4, “Effect on Benefits” of This Plan.

2. Definitions

- a) Plan means any Plan providing benefits or services for or by reason of dental care or treatment, which benefits or services are provided:
 - 1) Group insurance or group type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident type coverage.
 - 2) Coverage under a governmental Plan or required or provided by law, including Medicare (Title XVIII, Social Security Act of 1965, as amended). This does not include a state Plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act as periodically amended). It also does not include any Plan when, by law, its benefits are excess to those of any private insurance program or other non-governmental program.
 - 3) This Plan will assume that any person who attains the age of 65 will receive full Medicare coverage. Full Medicare coverage will be defined as both Part A and optional Part B and any other optional benefits available through Medicare.

Each contract or other arrangement for coverage under (1) or (2) is a separate Plan. Also, if an arrangement has two parts and COB rules apply only to the one of the two, each of the parts is a separate Plan.

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

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

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

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

- d) Allowable Expense means any necessary, reasonable and customary item of expense for health care, when the item of expense is covered at least in part by one or more Plans covering the person for whom the claim is made. The difference between the cost of a private Hospital room and the cost of a semi-private Hospital room is not considered an Allowable Expense under the above definition unless, the patient's stay in a private Hospital room is Medically Necessary either in terms of generally accepted medical practice, or as specifically defined in the Plan.

When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

- e) Claim Determination Period means a calendar year. However, it does not include any part of a year during which a person has no coverage under This Plan, or any part of a year before the date this COB provision or similar provision takes effect.

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

- a) General - When there is a basis for a claim under This Plan and another Plan, This Plan is a Secondary Plan, which has, its benefits determined after those of the other Plan, unless:
 - 1. The other Plan has rules coordinating its benefits with those of this Plan; and
 - 2. Both those rules and This Plan's rules, subparagraph b) below, require that This Plan's benefits be determined before those of the other Plan.
- b) Rules – This Plan determines its order of benefits using the first of the following rules which applies:
 - 1. Non-Dependent/Dependent the benefits of the Plan which covers the person as an Employee, member or subscriber (that is, other than as a Dependent) are determined before those of the Plan which covers the person as a Dependent.
 - 2. Dependent Child/Parents Not Separated or Divorced except as stated in section (3) below, when This Plan and another Plan cover the same child as a Dependent of different persons, called "parents":
 - a) The benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in that year; but
 - b) If both parents have the same birthday, the benefits of the Plan, which covered the parent longer, are determined before those of the Plan, which covered the other parent for a shorter period of time.
 - 3. Dependent Child/Separated or Divorced Parents if two or more Plans cover a person as a Dependent child of divorced or separated parents, benefits for the child are determined in this order:
 - a) First, the Plan of the parent with custody of the child;
 - b) Then, the Plan of the Spouse of the parent with custody of the child; and
 - c) Finally, the Plan of the parent not having custody of the child.
 - d) Active/Inactive Employee-The benefits of a Plan, which covers a person as an Employee who is neither laid off nor retired (or as that Employee's Dependent) are determined before those of a Plan, which covers that person as a laid off or retired Employee (or as that Employee's Dependent). If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule "d)" is ignored.
 - e) Longer/Shorter Length of Coverage if none of the above rules determines the order of benefits, the benefits of the Plan which covered an Employee, member or subscriber longer are determined before those of the Plan which covered that person for the shorter period of time.

4. Effect on Benefits

- a) When This Section Applies - This Section 4 applies when, in accordance with Section 3, “Order of Benefit Determination Rules”, this Plan is a Secondary Plan as to one or more other Plans. In that event, the benefits of This Plan may be reduced under this section. Such other Plan or Plans are referred to as “the other Plans” in b) immediately below.
- b) Reduction in This Plan’s Benefits - The benefits of this Plan will be reduced when the sum of:
 1. The benefits that would be payable for the Allowable Expenses under this Plan in the absence of this COB provision; and
 2. The benefits that would be payable for the Allowable Expenses under the other Plans, in absence of a provision with a purpose like that of this COB provision, whether or not claim is made;

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

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

5. Right to Receive and Release Necessary Information

Certain facts are needed to apply these COB rules. The Contract Administrator has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. The Contract Administrator needs to tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give the Contract Administrator any facts it needs to pay the claim.

6. Facility of Payment

A payment made under another plan may include an amount, which should have been paid under This Plan. If it does, the Contract Administrator may pay that amount to the organization, which made that payment. That amount will then be treated as though it was a benefit paid under This Plan. The Contract Administrator will not have to pay that amount again. The term “payment made” includes providing benefits in the form of services, in which case “payment made” means reasonable cash value of the benefits provided in the form of services.

7. Right of Recovery

Whenever any benefit payments have been made by the Plan in excess of the maximum amount required under the terms of this Plan Document, the Plan Administrator shall have the right to recover all such excess amounts from any persons, insurance companies, or other payees, and the Participant shall make a good-faith attempt to assist in such recovery. Further, the Plan Administrator shall have the right to recover any excess payments from any future benefits payable to the Employee or their Dependent(s).

The Plan Administrator may, in its’ sole discretion, pay benefits for care or services pending a determination of whether or not such care or services are covered hereunder. Such payment will not affect or waive any exclusion, and to the extent such care or services have been provided, the Plan shall be entitled to recoup and recover the amount paid from the Covered Person or the provider of service in the event it is determined that such care or services are not covered hereunder. The Covered Person or his parent or guardian shall execute and deliver to the Plan all assignments and other documents necessary or useful to the Plan Administrator for the purpose of enforcing its’ rights under this provision.

If the amount of the payments made by the Contract Administrator is more than should have been paid under this COB provision, it may recover the excess from one or more of:

- a) The person or persons it has paid or for whom it has paid;
- b) Insurance companies; or
- c) Other organizations.

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

B. SUBROGATION AND REIMBURSEMENT

The Plan reserves all its subrogation and reimbursement rights, at law and in equity, to the full extent not contrary to applicable law, as determined by the Plan Administrator. At its’ discretion, the Plan Administrator may designate a third party provider or other person or entity to exercise the rights described in this section on behalf of the Plan. In addition, the Plan Administrator may, in its discretion and on a case-by-case basis, waive or limit any of the subrogation and reimbursement rights set forth in this section on behalf of the Plan to the extent deemed appropriate. Any such waiver or limitation in a particular case will not limit or diminish in any way the Plan’s rights in any other instance or at any other time.

1. Benefits Subject to this Provision

This Section B will apply to all benefits provided under the Plan. For purposes of this section, terms are defined as follows:

- a) “Recovery” means any and all monies and property paid by a Third Party to (i) the Participant, (ii) the Participant’s attorney, assign, legal representative, or Beneficiary, (iii) a trust of which the Participant is a beneficiary, or (iv) any other person or entity on behalf of the Participant, by way of judgment, settlement, compromise or otherwise (no matter how those monies or property may be characterized, designated or allocated and irrespective of whether a finding of fault is made as to the Third Party) to compensate for any losses or damages caused by, resulting from, or in connection with, the injury or illness.
- b) “Reimbursement” means repayment to the Plan for medical or other benefits that it has paid to or on behalf of the Participant toward care and treatment of the injury or illness and for the expenses incurred by the Plan in collecting this amount, including the Plan’s equitable rights to recovery.
- c) “Subrogation” means the Plan’s right to pursue the Participant’s claims against a Third Party for any or all medical or other benefits or charges paid by the Plan.
- d) “Third Party” will include the party or parties who caused the injury or illness; the insurer, guarantor or other indemnifier or indemnitor of the party or parties who caused the injury or illness; a Participant’s own insurer, such as an uninsured, underinsured, medical payments, no fault, homeowner’s, renter’s or any other liability insurer; a workers’ compensation insurer; and any other individual or entity that is or may be liable or legally or equitably responsible for Reimbursement or payment in connection with the injury or illness.

2. When this Provision Applies

A Participant may incur medical or other charges related to any injury or illness caused by the act or omission of a Third Party. Consequently, such Third Party May be liable or legally or equitably responsible, for payment of charges incurred in connection with the injury or illness. If so, the Participant may have a claim against that Third Party for payment of the medical or other charges. In that event, the Plan will be secondary payer, not primary, and the Plan will be Subrogated to all rights the Participant may have against that Third Party.

Furthermore, the Plan will have a right of first and primary Reimbursement enforceable by an equitable lien against any Recovery paid by the Third Party. The equitable lien will be equal to one hundred percent (100%) of the amount of benefits paid by the plan for the Participant’s injury or illness and expenses

incurred by the Plan in enforcing the provisions of this Section B (including, without limitation, attorneys' fees and costs of suit, and without regard to the outcome of such an action), regardless of whether or not the participant has been made whole by the Third Party. This equitable lien will attach to the Recovery regardless of whether (a) the Participant receives the Recovery or (b) the Participant's attorney, a trust of which the Participant is a beneficiary, or other person or entity receives the Recovery on behalf of the Participant.

As a condition to receiving benefits under the Plan, the Participant hereby agrees to immediately notify the Plan Administrator, in writing, of whatever benefits are payable under the Plan that arise out of any injury or illness that provides, or may provide, the Plan with Subrogation and/or Reimbursement rights under this Section B.

The Plan's equitable lien supersedes any right that the Participant may have to be "made whole." In other words, the Plan is entitled to the right of first Reimbursement out of any Recovery the Participant procures, or may be entitled to procure, regardless of whether the Participant has received compensation for any or all of his damages or expenses, including any of his attorneys' fees or costs. Additionally, the Plan's right of first and primary Reimbursement will not be reduced for any reason, including attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise. The Plan is not responsible for a Participant's legal fees and costs, is not required to share in any way for any payment of such fees and costs, and its equitable lien will not be reduced by any such fees and costs. As a condition to coverage and receiving benefits under the Plan, the Participant agrees that acceptance of benefits, as well as participation in the Plan, is constructive notice of the provisions of this Section B, and Participant hereby automatically grants an equitable lien to the Plan to be imposed upon and against all rights of Recovery with respect to Third Parties, as described above.

In addition to the foregoing, the Participant:

- a) Authorizes the Plan to sue, compromise and settle in the Participant's name to the extent of the amount of medical or other benefits paid for the injury or illness under the Plan, and the expenses incurred by the Plan in collecting this amount, and assigns to the Plan the Participant's rights to Recovery when the provisions of this Section B, apply;
- b) Must notify the Plan in writing of any proposed settlement and obtain the Plan's written consent before signing any release or agreeing to any settlement; and
- c) Must cooperate fully with the Plan in its exercise of its rights under this Section B, do nothing that would interfere with or diminish those rights, and furnish any information as required by the Plan to exercise or enforce its rights hereunder.

Furthermore, the Plan Administrator reserves the absolute right and discretion to require a Participant who may have a claim against a Third Party for payment of medical or other charges that were paid, or are payable, by the Plan to execute and deliver a Subrogation and Reimbursement agreement acceptable to the Plan Administrator (including execution and delivery of a Subrogation and Reimbursement agreement by any parent or guardian on behalf of a covered Dependent, even if such Dependent is of majority age) and, subject to Section B, 5, that acknowledges and affirms: (i) the conditional nature of medical or other benefits payments which are subject to Reimbursement and (ii) the Plan's right of full Subrogation and Reimbursement, as provided in this Section B ("S&R Agreement").

When a right of Recovery exists, and as a condition to any payment by the Plan (including payment of future benefits for the same or other illnesses or injuries), the Participant will execute and deliver all required instruments and papers, including any S&R Agreement provided by the Plan, as well as doing and providing whatever else is needed, to secure the Plan's rights of Subrogation and Reimbursement, before any medical or other benefits will be paid by the Plan for the injury or illness. The Plan may file a copy of an S&R Agreement signed by the Participant and his attorney (and if applicable, signed by the parent or guardian on

behalf of the covered Dependent) with such other entities, or the Plan may notify any other parties of the existence of Plan's equitable lien; provided, the Plan's rights will not be diminished if it fails to do so.

To the extent the Plan requires execution of an S&R Agreement by a Participant (and his attorney, as applicable), a Participant's claim for any medical or other benefits for any injury or illness will be incomplete until an executed S&R Agreement is submitted to the Plan Administrator. Such S&R Agreement must be submitted to the Plan Administrator within the timeframe applicable to the particular type of benefits claimed by the Participant, as specified in the Plan's claims procedures. Any failure to timely submit the required S&R Agreement in accordance with the Plan's claims procedures will constitute the basis for denial of the Participant's claim for benefits for the injury or illness, and will be subject to the Plan's claims appeal procedures.

The Plan Administrator may determine, in its sole discretion, that it is in the Plan's best interests to pay medical or other benefits for the injury or illness before an S&R Agreement and other papers are signed and actions taken (for example, to obtain a prompt payment discount); however, in that event, any payment by the Plan of such benefits prior to or without obtaining a signed S&R Agreement or other papers will not operate as a waiver of any of the Plan's Subrogation and Reimbursement rights and the Plan still will be entitled to Subrogation and Reimbursement. In addition, the Participant will do nothing to prejudice the Plan's right to Subrogation and Reimbursement, and hereby acknowledges that participation in the Plan precludes operation of the "made whole" and "common fund" doctrines. A Participant who receives any Recovery as an absolute obligation to immediately tender the Recovery (to the extent of 100% of the amount of benefits paid by the Plan for the Participant's injury or illness and expenses incurred by the Plan in enforcing the provisions of this Section B, including attorneys' fees and costs of suit, regardless of an action's outcome) to the Plan under the terms of this Section B. A Participant who receives any such Recovery and does not immediately tender the Recovery to the plan will be deemed to hold such Recovery in constructive trust for the Plan because the Participant is not the rightful owner of such Recovery to the extent the Plan has not been fully reimbursed. By participating in the Plan, or receiving benefits under the Plan, the Participant automatically agrees, without further notice, to all the terms and conditions of this Section B, and any S&R Agreement.

The Plan Administrator has maximum discretion to interpret the terms of the Section B, and to make changes in its interpretation as it deems necessary or appropriate.

3. Amount Subject to Subrogation or Reimbursement

Any amounts Recovered will be subject to Subrogation or Reimbursement, even if the payment the Participant receives is for, or is described as being for, damages other than medical expenses or other benefits paid, provided or covered by the Plan. This means that any Recovery will be automatically deemed to first cover the Reimbursement, and will not be allocated to or designated as reimbursement for any other costs or damages the Participant may have incurred, until the Plan is reimbursed in full and otherwise made whole. In no case will the amount subject to Subrogation or Reimbursement exceed the amount of medical or other benefits paid for the injury or illness under the Plan and the amount of medical or other benefits paid for the injury or illness under the Plan and the expenses incurred by the Plan in collecting this amount. The Plan has a right to recover in full, without reduction for attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise, even if the Participant does not receive full compensation for all of his charges and expenses.

4. When Recovery Includes the Cost of Past or Future Expenses

In certain circumstances, a Participant may receive a Recovery that includes amounts intended to be compensation for past and/or future expenses for treatment of the illness or injury that is the subject of the Recovery. The Plan will not cover any expenses for which compensation was provided through a previous Recovery. This exclusion will apply to the full extent of such Recovery or the amount of the expenses

submitted to the Plan for payment, whichever is less. Participation in the Plan also precludes operation of the “made whole” and “common fund” doctrines in applying the provisions of this Section B.

It is the responsibility of the Participant to inform the Plan Administrator when expenses incurred are related to an illness or injury for which a Recovery has been made. Acceptance of benefits under this Plan for which the Participant has already received a Recovery will be considered fraud, and the Participant will be subject to any sanctions determined by the Plan Administrator, in its discretion, to be appropriate. The Participant is required to submit full and complete documentation of any such Recovery in order for the Plan to consider eligible expenses that exceed the Recovery.

5. When a Participant Retains an Attorney

If the Participant retains an attorney, the Plan will not pay any portion of the Participant’s attorneys’ fees and costs associated with the Recovery, nor will it reduce its Reimbursement pro-rata for the payment of the Participant’s attorneys’ fees and costs. Attorneys’ fees will be payable from the Recovery only after the Plan has received full Reimbursement.

The Plan Administrator reserves the absolute right and discretion to require the Participant’s attorney to sign an S&R Agreement as a condition to any payment of benefits under the Plan and as a condition to any payment of future Plan benefits for the same or other illnesses or injuries. Additionally, pursuant to such S&R Agreement, the Participant’s attorney must acknowledge and consent to the fact that the “made whole” and “common Fund” doctrines are inoperable under the Plan, and the attorney must agree not to assert either doctrine in his pursuit of Recovery.

Any Recovery paid to the Participant’s attorney will be subject to the Plan’s equitable lien, and thus an attorney who receives any Recovery has an absolute obligation to immediately tender the Recovery (to the extent of 100% of the amount paid by the Plan for the Participant’s injury or illness and expenses incurred by the Plan in enforcing the provisions of this Section B, including attorneys’ fees and costs of suit regardless of an action’s outcome) to the Plan under the terms of this Section B. A Participant’s attorney who receives any such Recovery and does not immediately tender the recovery to the Plan will be deemed to hold the Recovery in constructive trust for the Plan because neither the Participant nor his attorney is the rightful owner of the Recovery to the extent the Plan has not received full Reimbursement.

6. When a Participant Does Not Comply

When a Participant does not comply with the provisions of this Section B, the Plan Administrator will have the power and authority, in its sole discretion, to (i) deny payment of any claims for benefits by or on behalf of the Participant and (ii) deny or reduce future benefits payable (including payment of future benefits for the same or other injuries or illnesses) under the Plan by the amount due as Reimbursement to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for the same or other injuries or illnesses) under any other group benefits plan maintained by the Plan Sponsor. The reductions will equal the amount of the required Reimbursement. If the Plan must bring an action against a Participant to enforce the provisions of this Section B, the Participant will be obligated to pay the Plan’s attorneys’ fees and costs regardless of the action’s outcome.

ARTICLE VII

CLAIMS PROCEDURES

A. HOW TO FILE A CLAIM

The covered Employee should submit a completed claim form directly to Boon-Chapman, Inc., and maintain a copy of all material submitted.

1. Send in expense or expenses as soon as possible. We do recommend holding small expenses until a minimum of \$50.00 is accumulated.
2. Attach all expenses to a fully completed Claim Form. These statements should be “itemized”, that is, they should at least show the minimum information:
 - a) Name of the provider of service;
 - b) The date and type of service;
 - c) The cost of service; and
 - d) The name of the person who received the service.
3. Complete the “other insurance” portion of the claim form. Failure to do this can result in a delay in processing the claim.
4. Claim forms and itemized statement of expenses should be forwarded by the Employee directly to:

Boon-Chapman Benefit Administrators, Inc.
Attn: Claims Department
P. O. Box 9201
Austin, TX 78766

Additional Contact Information: 1-800-252-9653; www.boonchapman.com

Request for additional information or denial action will be sent directly to the covered Employee. Payment will be sent directly to the covered Employee or provider of service, whichever is applicable.

An Explanation of Benefits (EOB) will be sent to the Employee as a result of each claim submission. The EOB will outline covered services and how the benefit calculation was accomplished.

B. PAYMENT OF BENEFITS

All benefits for expenses incurred will be paid to the Employee except that the Employee may authorize benefits to be paid to the facility or person furnishing services. All benefits are payable to the Employee if living, otherwise to the surviving wife, husband, mother, father, child or children, or estate.

C. NOTICE OF CLAIM

Notice given by or on behalf of the claimant to the Plan, or to any other authorized agent of the Employer, with information sufficient to identify the participating Employee, shall be deemed notice to the Plan.

D. CLAIM FORMS

The Plan upon receipt of such notice will furnish to the Employee such forms as are usually furnished by it for filing proofs of loss. If such forms are not so furnished within thirty (30) days after the receipt of such notice, the Employee shall be deemed to have complied with the requirements of the Plan as to proof of loss, upon

submitting, within the time fixed in the Plan for filing proofs of loss, written proof covering the occurrence, character and extent of the loss of which claim is made.

E. PROOF OF LOSS

Written proof of loss must be furnished to the Contract Administrator within ninety (90) days after the date of such loss. Failure to furnish said proof within such time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished.

F. TIME OF PAYMENT OF CLAIM

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

G. PRESENTING CLAIMS FOR BENEFITS

If Participant thinks they are eligible for a benefit described in this Plan, Participant must file a claim. Forms required for filing proof of loss for claims are available at Risk Management or can be found at County Wide Website Risk Management link http://cww.co.fortbend.tx.us/departments/risk_management/RM_forms.htm. Complete forms must be filed with the Contract Claims Administrator at least annually.

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

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

H. REQUESTING A REVIEW OF CLAIMS DENIED

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

If Participant has not received a response from the Contract Claims Administrator regarding the claim within ninety (90) days of filing the claim or if the claim has been denied, Participant can send a written appeal to the Contract Claims Administrator for a review of the denied claim(s) which under other circumstances could be covered under the Plan. Participant has sixty-one (61) days from the end of the processing period, if Participant has not received a response by that time.

Those reviewing the Participant's claim have to act within sixty (60) days of receiving Participant's request. However, in special cases, they may be allowed one hundred-twenty (120) days. The final decision will be sent to the Participant in writing, together with an explanation of how the decision was made. If the Participant is not satisfied with the result of the Participant's appeal, Participant may file a suit and serve process on The Fort Bend County Employee Benefit Dental Plan.

I. LEGAL ACTIONS

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

J. THIRD PARTY LIABILITY

If a Participant has medical charges:

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

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

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

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

The repayment agreement is equally binding upon the Participant regardless of whether or not the third party or its insurer had admitted liability or the dental charges are itemized in the third party payment.

ARTICLE VIII

GENERAL PROVISIONS

A. INTERPRETATION OF THE PLAN

In the event any benefit summary contained herein differs from the official text of the Plan, the official text shall prevail. Some differences from the official text may occur due to the need to restate the Plan briefly in the summaries, compared to a lengthier and detailed official text, and due to normal time lapse between amendment of the Plan and updating of the appropriate summary. The Plan Administrator has the responsibility for interpretation of the Plan and the interpretation shall be final.

B. AMENDMENT AND TERMINATION OF THE PLAN

The Commissioners Court shall each have the right, authority and power to make, at any time, and from time to time, any amendment to the Plan; provided, however, no amendment shall prejudice any claim under the Plan that was incurred but not paid prior to the amendment date, unless the person or entity as responsible above for the amendment, as applicable, determines such amendment is necessary to comply with applicable law.

The Commissioners Court shall have the right, authority and power to terminate the Plan at any time, in whole or in part, without prior notice, to the extent deemed advisable in its discretion; provided, however, such termination shall not prejudice any claim under the Plan that was incurred but not paid prior to the termination date unless the Commissioners Court determines it is necessary to comply with applicable law.

C. CHOICE OF PHYSICIANS

An Employee or covered Dependent will have the choice of any Dentist licensed to practice in the United States. The Dentist-patient relationship will not be disturbed in any way.

D. LEAVE OF ABSENCE

Leave of Absence means the Employee has obtained an approved leave of absence from the Employer as provided for in the Employer's rules, policies, procedures, and/or practices. This Plan will follow the Employer's rules, policies, procedures and/or practices.

E. ASSIGNMENT OF BENEFITS

Benefits for dental expenses covered under the Plan may be assigned by a Participant to the person or institution rendering the services for which the expenses were incurred. No such assignment will bind the Plan unless it is in writing and unless it has been received by the Plan prior to the payment of the benefit assigned. The Plan will not be responsible for determining whether any such assignment is valid. Payment of benefits, which have been assigned, will be made directly to the assignee unless a written request not to honor the assignment signed by the Participant and the assignee has been received before the proof of loss is submitted. Any payment made in accordance with the provision of this Section shall fully discharge the liability of the Plan to the extent of such payment.