

STATE OF TEXAS §
 §
 COUNTY OF FORT BEND §

**AGREEMENT FOR THIRD PARTY CLAIMS ADMINISTRATION SERVICES
 PURSUANT TO RFP 24-004**

THIS AGREEMENT is made and entered into by and between Fort Bend County, (hereinafter “County”), a body corporate and politic under the laws of the State of Texas, and Boon-Chapman Benefit Administrators, Inc., (hereinafter “Boon-Chapman”), a company authorized to conduct business in the State of Texas. County and Boon-Chapman may be referred to individually as a “Party” or collectively as the “Parties.”

WITNESSETH

WHEREAS, County desires that Boon-Chapman provide Third Party Claims Administration Services for the Fort Bend County Medical, Dental and Cafeteria plans pursuant to RFP 24-004; and

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

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

AGREEMENT

Section 1. Services to be Provided by Boon-Chapman

- 1.1 Boon-Chapman shall perform Third Party Claims Administration Services (hereinafter “Services”) for the Fort Bend County Medical, Dental and Cafeteria plans (hereinafter “Benefit Plans”) (that meet or exceed the minimum requirements of RFP 24-004 with the exception of Section 21.0 and Section 22.0) (attached and incorporated as Exhibit A) and as described in the Scope of Work (attached and incorporated as Exhibit B). Boon-Chapman shall perform Pharmacy Benefit Management (“PBM”) services as described in the PBM Scope of Work (attached and incorporated as Exhibit G). Boon-Chapman shall perform Stop-Loss coverage services as described in the Stop Loss Scope of Work (attached and incorporated as Exhibit H).
- 1.2 The Parties reserve the right to add any service that was offered as an optional service by Boon-Chapman in Boon-Chapman’s Original Response to RFP 24-004, but not included as part of this Original Agreement, during the course of the Agreement or any renewal period. A copy of the Boon-Chapman Original Response dated September 8, 2023, Optional Services is attached as Exhibit F for reference only to document those services

and prices that were offered by Boon-Chapman for future consideration. Additional services may only be added by a written amendment to this Agreement, signed by both Parties.

- 1.3 For the avoidance of doubt and as a supplement to the statements of authority within the RFP, Scope of Work 24-004, the Parties agree and wish to acknowledge that Boon-Chapman shall have only the authority and obligations as specifically enumerated in this Agreement and all other authority, functions and obligations not expressly delegated to Boon-Chapman are to be retained by County. County agrees, Boon-Chapman is not, and County will not name Boon-Chapman in the Plan as, a “plan sponsor,” “named fiduciary,” “Plan Administrator” or “fiduciary,” (as those terms are interpreted in the context of the Employee Retirement Income Security Act of 1974, and/or other applicable law. County will not hold out to any person or entity, including covered individuals eligible for the payment of health and welfare benefits under the plan that Boon-Chapman serves in any aforementioned capacity. It is understood that all services delivered hereunder are intended to and will consist only of ministerial functions and will be performed within the framework of policies, instructions and interpretations established by County. Exceptions to this paragraph (if any), shall be limited, and narrowly construed, to only those exceptions that are in writing. Should Boon-Chapman be deemed a fiduciary by way of its actions in contravention of this paragraph, County and each Plan accessing services hereunder will fully and forever release Boon-Chapman from any and all resulting fiduciary responsibilities that may result from such designation.

Section 2. Personnel

- 2.1 Boon-Chapman will use commercially reasonable efforts to obtain and/or maintain, adequate qualified personnel in its employment for the timely performance of the Services required under this Agreement and that Boon-Chapman shall furnish and maintain, at its own expense, adequate and sufficient personnel, in the opinion of County, to perform the Services when and as required and without delays.
- 2.2 All employees of Boon-Chapman shall have such knowledge and experience as will enable them to perform the duties assigned to them. Any employee of Boon-Chapman who, in the opinion of County, is incompetent or by his conduct becomes detrimental to the project shall, upon request of County, immediately be removed from association with the project.

Section 3. County Responsibilities

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

- 3.2 If County fails to furnish any required information promptly, Boon-Chapman shall not be responsible for any delay in the performance of the actuarial, claim, and underwriting services caused by this failure, if the delay is due to County's negligent failure to provide the information.
- 3.3 County will establish an account for the Services at a bank of County's choice. The amounts needed for this account shall be determined upon Boon-Chapman providing County with a list of all Benefit Plans costs at the inception of the Benefit Plans, monthly thereafter and as requested. This will include the cost for coverage of each covered person. The list will be maintained by Boon-Chapman and adjusted regularly, based on additions, deletions, and changes provided to Boon-Chapman by County.
- A. Claims will be paid from this account.
 - B. County will deposit funds to the account sufficient to cover claims as they are adjudicated and processed by Boon-Chapman. County, by execution of this Agreement, expressly authorizes Boon-Chapman to issue drafts on the account for payment of benefits. Boon-Chapman will not release such drafts until sufficient funds are deposited to cover them.
 - C. County may deposit funds into the account for payments of insurance and or reinsurance premiums, administrative expenses, and other charges related to the Benefit Plans that may be authorized by County.
 - D. County may authorize and instruct Boon-Chapman to issue drafts on the account for payment of such expenses that shall have been authorized by County.
- 3.4 County will remit funds for payments of insurance and or reinsurance premiums, on behalf of the Services, County or covered persons, administrative services, and other expenses that have been authorized by County and that Boon-Chapman has agreed to disburse to the appropriate parties. The funds shall be provided to Boon-Chapman not later than the tenth day after the first day of the month in which they are due. The funds may be remitted directly to Boon-Chapman or deposited into the bank account referenced in this Section of the Agreement.
- 3.5 County shall give written notice to all Covered Persons of the identity of Boon-Chapman and the relationship of Boon-Chapman to County.
- 3.6 County shall resolve all ambiguities and disputes relating to the Benefit Plan eligibility, coverage, denial of claims and decisions regarding appeals of denials of claims, as well as other plan interpretation questions.

- 3.7 County shall maintain and operate the Benefit Plan(s) in accordance with applicable law and regulations. County shall timely distribute all notices, information and materials and documents to individuals participating in a Benefit Plan, required to be given to such individuals under applicable law. Additionally, County shall timely prepare or cause to be prepared, and timely execute any documents, forms or contracts concerning the Benefit Plan that is required by applicable law.

Section 4. Compensation and Payment

- 4.1 Boon-Chapman shall be compensated in accordance with the Service and Fee schedule attached and incorporated as Exhibit C. The Parties acknowledge and agree that County is exempt from taxes.
- 4.2 County will pay Boon-Chapman based on the following procedures: Monthly, Boon-Chapman will send the County invoice for the fees described in Exhibit C showing the amounts due for services performed in a form acceptable to County. County shall review such invoices and approve them within 30 calendar days with such modifications as are consistent with this Agreement and forward same to the Auditor for processing. County shall pay each such approved invoice within thirty (30) calendar days. County reserves the right to withhold payment pending verification of satisfactory work performed.
- 4.3 Boon-Chapman will conduct (or make arrangements for) an annual pricing audit/reconciliation of Fort Bend County's prescription drug claims for the prior Contract Year to validate that CaremarkPCS Health, L.L.C. ("Caremark" or "CVS/caremark") has met the pricing guarantees identified in "Prescription Drug Program Agreement between CaremarkPCS Health, L.L.C. ("Caremark" or "CVS/caremark"), a Delaware limited liability company, and Boon-Chapman Benefit Administrators, Inc. ("Boon-Chapman"), a Texas corporation organized under the laws of the state of Texas ("TPA")" with an effective date of January 1, 2024 (hereinafter "Caremark Agreement"). Boon-Chapman will keep accurate and complete accounting records. Upon no less than thirty days written notice and County may audit or use a reputable accounting firm to audit Boon-Chapman's records relating to its performance under this Agreement generally and with regard to the pricing guarantees secured by Caremark and made available to Fort Bend County by Boon-Chapman. Any under-performance amounts owed by Caremark to Boon-Chapman for missing the guarantees for Fort Bend County under the Caremark Agreement will be paid by Boon-Chapman to Fort Bend County within forty-five (45) days of receipt of rebates and a full accounting by client by Boon-Chapman.

Section 5. Limit of Appropriation and Non-Appropriation

- 5.1 **Limit of Appropriation.** Boon-Chapman understands and agrees, such understanding and agreement being of the absolute essence of this Agreement, that County shall have available the total maximum sum of Five Million Three Hundred Thousand and 00/100 Dollars (\$5,300,000.00) specifically allocated to fully discharge any and all liabilities

County may incur under this Agreement. Boon-Chapman does further understand and agree, said understanding and agreement also being of the absolute essence of this Agreement, that the total Maximum Annual Compensation that Boon-Chapman may become entitled to for capitated fees, unless there is an increase in enrollment, and the total maximum sum that County may become liable to pay to Boon-Chapman under this Agreement shall not under any conditions, circumstances, or interpretations thereof exceed Five Million Three Hundred Thousand and 00/100 Dollars (\$5,300,000.00

- 5.2 **Non-appropriation.** Boon-Chapman understands and agrees that in the event no funds or insufficient funds are appropriated by the County under this Agreement, County shall immediately notify Boon-Chapman in writing of such occurrence and the Agreement shall thereafter terminate and be null and void on the last day of the month for which appropriations were received or made without penalty, liability or expense to the County, except as to portions of fees or expenses which have been incurred and for which funds have been appropriated or budgeted from prior fiscal year or are otherwise available. In no event shall said termination of this Agreement or County's failure to appropriate said funds be deemed a breach or default of this Agreement or create a debt by County in any amount(s) in excess of those previously funded.

Section 6. Modifications and Waivers

- 6.1 The parties may not amend or waive this Agreement, except by a written agreement executed by both parties.
- 6.2 No failure or delay in exercising any right or remedy or requiring the satisfaction of any condition under this Agreement, and no course of dealing between the parties, operates as a waiver or estoppel of any right, remedy, or condition.
- 6.3 The rights and remedies of the parties set forth in this Agreement are not exclusive of, but are cumulative to, any rights or remedies now or subsequently existing at law, in equity, or by statute.

Section 7. Term and Termination

- 7.1 The term of this Agreement shall be for a period of twenty-four months, commencing on January 1, 2024, and ending at the close of business on December 31, 2025, with five additional one-year renewal options at County's sole discretion. Renewals shall be under on the same terms and conditions, except that pricing may be negotiated in accordance with Exhibit C. Either party shall have the right to terminate this Agreement as provided herein.
- 7.2 Termination for Convenience: County may terminate this Agreement at any time upon thirty (30) days written notice issued by County.

7.3 Termination for Default

- A. County may terminate the whole or any part of this Agreement for cause if Boon Chapman materially breaches any of the covenants or terms and conditions set forth in this Agreement or fails to perform any of the other provisions of this Agreement or so fails to make progress as to endanger performance of this Agreement in accordance with its terms, and in any of these circumstances does not cure such breach or failure to County's reasonable satisfaction within a period of ten (10) calendar days after receipt of notice from County specifying such breach or failure.
 - B. If, after termination, it is determined by County that for any reason whatsoever that Boon-Chapman was not in default, or that the default was excusable, services may continue in accordance with the terms and conditions of this Agreement or the rights and obligations of the parties shall be the same as if the termination had been issued for the convenience of the County in accordance with this Section.
- 7.4 Upon termination of this Agreement, County shall compensate Boon-Chapman for those services which were provided under this Agreement prior to its termination and which have not been previously invoiced to County. Boon-Chapman's final invoice for said services will be presented to and paid by County in the same manner set forth in the Compensation Section above.
- 7.5 If County terminates this Agreement as provided in this Section, no fees of any type, other than fees due and payable at the Termination Date, shall thereafter be paid to Boon-Chapman.

Section 8. Ownership and Reuse of Documents

- 8.1 All documents, data, reports, graphic presentation materials, etc., developed for County by Boon-Chapman as a part of its work under this Agreement shall be co-owned by Boon-Chapman and the County, and upon completion of this Agreement County will (upon its reasonable request) be entitled to a copy of any such materials in Boon-Chapman's immediate possession.
- 8.2 County's right of ownership under this Section shall not include Boon-Chapman's proprietary underlying research or data used for compilation of the materials for County.
- 8.3 At all times during the Agreement and upon termination, Boon-Chapman shall promptly furnish copies of all such data and material to County on request but no later than 45 days after the request was received. Boon-Chapman shall mark any materials believed to be proprietary prior to delivery of same. Nothing herein will be construed as Boon-Chapman's duty to divest itself of information of materials in its possession, as all such

materials will be subject to Boon-Chapman's corporation document retention policy and management in accordance thereto.

Section 9. Inspection of Books and Records

During normal business hours, Boon-Chapman will provide to County at Boon-Chapman's designated place of business access to those records in its immediate custody, relating to Boon-Chapman's performance under the Agreement, and not permissibly restricted from disclosure. Any such inspection and audit shall occur no more than once every twelve (12) months, and in no greater duration than five (5) consecutive business days, and all reviews hereunder shall be commenced within two years following the period being audited. County shall give Boon-Chapman not less than two weeks advanced written notice of its intent to inspect or audit records, with a description of the types of information within the scope of the audit, including dates, a complete listing of transactions and records to be reviewed for the audit and the identity of the proposed auditor's name, title and professional qualifications, as well as a statement concerning the purpose for the audit. The auditor shall be subject to Boon-Chapman's approval, which shall not be unreasonably withheld. In the event County and Boon-Chapman cannot agree upon an auditor, BDO USA, an audit company located in Austin, Texas, shall be considered a mutually acceptable auditor by both Parties. The Parties shall agree upon the date for the audit, and audits shall occur in a manner that does not unreasonably interfere with Boon-Chapman's ability to conduct its normal business and shall occur at County's sole expense. County shall reimburse Boon-Chapman for its cost for an audit that cannot be completed in five business days or that exceeds a sample size greater than twenty-five (25) files and/or transactions, or otherwise amounts to exceptional administrative demands. No portion of the audit shall be conducted by an auditor retained on a contingency basis without Boon-Chapman's prior written approval. The auditor or inspector shall provide Boon-Chapman with copies of all reports and summaries compiled as a result of the audit, including any draft report. The auditors shall meet with Boon-Chapman to discuss finding results contained in a draft report. Boon-Chapman may at its option include a supplementary statement in any final report and shall have the right to require any changes in or conditions in the audit findings that may be necessary to protect Boon-Chapman's legal and business interests. The auditor shall use the information audited solely for purposes of the audit, and shall ensure that the information accessed will be kept confidential in accordance with all applicable laws and professional standards, and shall not make photocopies or remove any of the records or information without the express written consent of Boon-Chapman.

Section 10. Insurance

10.1 Prior to commencement of the Services, Boon-Chapman shall furnish County with properly executed certificates of insurance which shall evidence all insurance required and provide that such insurance shall not be canceled, except on 60 days' prior written notice to County. Boon-Chapman shall provide certified copies of insurance endorsements and/or policies if requested by County. Boon-Chapman shall maintain such insurance coverage from the time Services commence until Services are completed and provide replacement certificates, policies and/or endorsements for any such insurance

expiring prior to completion of Services. Boon-Chapman shall obtain such insurance written on an Occurrence form from such companies having Bests rating of A/VII or better, licensed or approved to transact business in the State of Texas, and shall obtain such insurance of the following types and minimum limits:

- A. Workers Compensation in accordance with the laws of the State of Texas. Substitutes to genuine Workers' Compensation Insurance will not be allowed.
 - B. Employers' Liability insurance with limits of not less than \$500,000 per injury by accident, \$500,000 per injury by disease, and \$500,000 per bodily injury by disease.
 - C. Commercial general liability insurance with a limit of not less than \$1,000,000 each occurrence and \$2,000,000 in the annual aggregate. Policy shall cover liability for and property damage and products/completed operations arising out of the business operations of the policyholder.
 - D. Third Party Claims Administration Professional Liability insurance with limits not less than \$2,000,000 each claim/annual aggregate.
 - E. Crime coverage with limits of \$500,000 per occurrence/\$1,000,000 in aggregate.
- 10.2 County and the members of Commissioners Court shall be named as additional insured to all required coverage except for Workers' Compensation and Professional Liability (if required). Workers' Compensation shall contain a waiver of subrogation in favor of County and members of Commissioners Court.
- 10.3 If required coverage is written on a claims-made basis, Boon-Chapman warrants that any retroactive date applicable to coverage under the policy precedes the effective date of the Agreement and that continuous coverage will be maintained or an extended discovery period will be exercised for a period of 2 years beginning from the time the work under this Agreement is completed.
- 10.4 Boon-Chapman shall not commence any portion of the work under this Agreement until it has obtained the insurance required herein and certificates of such insurance have been filed with and approved by Fort Bend County.
- 10.5 No cancellation of the policies, may be made without thirty (30) days prior, written notification to Fort Bend County.
- 10.6 Approval of the insurance by Fort Bend County shall not relieve or decrease the liability of Boon-Chapman.

Section 11. Indemnity

- 11.1 **BOON-CHAPMAN SHALL SAVE HARMLESS COUNTY FROM AND AGAINST ALL CLAIMS, LIABILITY, AND EXPENSES, INCLUDING REASONABLE ATTORNEY'S FEES, ARISING FROM ACTIVITIES OF BOON-CHAPMAN, ITS AGENTS, SERVANTS OR EMPLOYEES, PERFORMED UNDER THIS AGREEMENT THAT RESULT FROM THE GROSSLY NEGLIGENT: (I) ACT, (II) ERROR, OR (III) OMISSION OF BOON-CHAPMAN OR ANY OF BOON-CHAPMAN'S AGENTS, SERVANTS OR EMPLOYEES.**
- 11.2 Boon-Chapman shall timely report all such matters to Fort Bend County and shall, upon the receipt of any such claim, demand, suit, action, proceeding, lien or judgment, not later than the fifteenth day of each month; provide Fort Bend County with a written report on each such matter, setting forth the status of each matter, the schedule or planned proceedings with respect to each matter and the cooperation or assistance, if any, of Fort Bend County required by Boon-Chapman in the defense of each matter.
- 11.3 Boon-Chapman's duty to defend, indemnify, and hold Fort Bend County harmless shall not abate or end by reason of the expiration or termination of any agreement unless otherwise agreed by Fort Bend County in writing. The provisions of this Section shall survive the termination of the Agreement and shall remain in full force and effect with respect to all such matters no matter when they arise.
- 11.4 The provision by Boon-Chapman of insurance shall not limit the liability of Boon-Chapman under an agreement.
- 11.5 Loss Deduction Clause - Fort Bend County shall be exempt from, and in no way liable for, any sums of money which may represent a deductible in any insurance policy. The payment of deductibles shall be the sole responsibility of Boon-Chapman and/or trade Boon-Chapman providing such insurance.

Section 12. Confidential and Proprietary Information

- 12.1 Boon-Chapman acknowledges that it and its employees or agents may, in the course of performing their responsibilities under this Agreement, be exposed to or acquire information that is confidential to County. Any and all information of any form obtained by Boon-Chapman or its employees or agents from County in the performance of this Agreement that the County has informed Boon-Chapman is confidential shall be deemed to be confidential information of County ("Confidential Information"). Any reports or other documents or items (including software) that result from the use of the Confidential Information by Boon-Chapman shall be treated with respect to confidentiality in the same manner as the Confidential Information. Confidential Information shall be deemed not to include information that (a) is or becomes (other than by disclosure by Boon-Chapman) publicly known or is contained in a publicly available document; (b) is rightfully in Boon-Chapman's possession without the obligation of nondisclosure prior to the time of its

disclosure under this Agreement; or (c) is independently developed by employees or agents of Boon Chapman who can be shown to have had no access to the Confidential Information.

- 12.2 Boon-Chapman agrees to hold Confidential Information in strict confidence, using at least the same degree of care that Boon-Chapman uses in maintaining the confidentiality of its own confidential information, and not to copy, reproduce, sell, assign, license, market, transfer or otherwise dispose of, give, or disclose Confidential Information to third parties or use Confidential Information for any purposes whatsoever other than the provision of Services to County hereunder, and to advise each of its employees and agents of their obligations to keep Confidential Information confidential. Boon-Chapman shall use its best efforts to assist County in identifying and preventing any unauthorized use or disclosure of any Confidential Information. Without limitation of the foregoing, Boon-Chapman shall advise County immediately in the event Boon-Chapman learns or has reason to believe that any person who has had access to Confidential Information has violated or intends to violate the terms of this Agreement and Boon-Chapman will at its expense cooperate with County in seeking injunctive or other equitable relief in the name of County or Boon-Chapman against any such person. Boon-Chapman agrees that, except as directed by County, Boon-Chapman will not at any time during or after the term of this Agreement disclose, directly or indirectly, any Confidential Information to any person, and that upon termination of this Agreement or at County's request, Boon-Chapman will promptly turn over to County all documents, papers, and other matter in Boon-Chapman's possession which embody Confidential Information.
- 12.3 Boon-Chapman acknowledges that a breach of this Section, including disclosure of any Confidential Information, or disclosure of other information that, at law or in equity, ought to remain confidential, will give rise to irreparable injury to County that is inadequately compensable in damages. Accordingly, County may seek and obtain injunctive relief against the breach or threatened breach of the foregoing undertakings, in addition to any other legal remedies that may be available. Boon-Chapman acknowledges and agrees that the covenants contained herein are necessary for the protection of the legitimate business interest of County and are reasonable in scope and content.
- 12.4 Boon-Chapman in providing all services hereunder agrees to abide by the provisions of any applicable Federal or State Data Privacy Act.
- 12.5 Boon-Chapman expressly acknowledges that County is subject to the Texas Public Information Act, TEX. GOV'T CODE ANN. §§ 552.001 et seq., as amended, and notwithstanding any provision in the Agreement to the contrary, County will make any information related to the Agreement, or otherwise, available to third parties in accordance with the Texas Public Information Act. Any proprietary or confidential information marked as such provided to County by Boon-Chapman shall not be disclosed to any third party, except as directed by the Texas Attorney General in response to a

request for such under the Texas Public Information Act, which provides for notice to the owner of such marked information and the opportunity for the owner of such information to notify the Attorney General of the reasons why such information should not be disclosed. The terms and conditions of the Agreement are not proprietary or confidential information.

- 12.6 In accordance with the services being provided under the Services Agreement, Boon-Chapman will have access to, create and/or receive certain Protected Health Information thus necessitating a written agreement that meets the applicable requirements of the privacy and security rules promulgated by the Federal Department of Health and Human Services. County and Boon-Chapman mutually agree to satisfy the foregoing regulatory requirements through execution of the Business Associate Agreement incorporated and attached as Exhibit D to the Services Agreement. As of the effective dates set forth therein, the provisions of Business Associate Agreement supersede any other provision of the Services Agreement, which may be in conflict with such Business Associate Agreement on or after the applicable effective date.
- 12.7 Boon-Chapman has represented that Boon-Chapman has implemented the attached Security Policies and has further represented that they meet or exceed industry standards in Data Privacy and Security. A copy of the current policies is attached as Exhibit E for reference only to document the policies that Boon-Chapman represents meet or exceed industry standards and upon which County has relied in selecting Contractor. Boon-Chapman shall ensure that these policies are updated if law or industry standards mandate stricter requirements. Upon request, copy of any updated policies will be provided to County without delay. Boon-Chapman shall also ensure all employees are trained to adhere to the requirements of their current policies and as may be updated during the course of the Agreement.
- 12.8 Upon termination of this Service Agreement, Boon-Chapman shall provide notice to all affected individuals and facilitate the transfer of any needed records to any subsequent Service Provider as directed by County. Copies of records shall be made available in accordance with law and this Agreement. Boon-Chapman may charge reasonable copy fees for copies provided that the charges do not exceed the amounts set by the Texas Public Information Act.

Section 13. Independent Contractor

- 13.1 In the performance of work or services hereunder, Boon-Chapman shall be deemed an independent contractor, and any of its agents, employees, officers, or volunteers performing work required hereunder shall be deemed solely as employees of Boon-Chapman or, where permitted, of its subcontractors.
- 13.2 Boon-Chapman and its agents, employees, officers, or volunteers shall not, by performing work pursuant to this Agreement, be deemed to be employees, agents, or servants of

County and shall not be entitled to any of the privileges or benefits of County employment.

Section 14. Notices

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

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

County: Fort Bend County
Attn: County Judge
401 Jackson Street
Richmond, Texas 77469

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

Boon-Chapman: Boon-Chapman Benefit Administrators, Inc.
Attn: Nyle Leftwich, CEO
9401 Amberglen Blvd.
Building I, Suite 100
Austin, Texas 78729

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

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

Section 15. Compliance with Laws

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

Section 16. Performance Standard

Boon-Chapman will discharge its obligation under this Agreement with that level of reasonable care which a similarly situated supplier of the same or similar services would exercise under similar circumstances, using appropriately qualified and trained personnel.

Section 17. Assignment and Delegation

17.1 Except as otherwise specified in this Agreement:

A. Neither party may assign any of its rights under this Agreement, except with the prior written consent of the other party. That party shall not unreasonably withhold its consent. Notwithstanding the foregoing, either Party may assign its rights, interest and obligations under this Agreement following a merger, acquisition, sale, reorganization or other corporate transaction without the written approval of the other Party. All assignments of rights by Boon-Chapman are prohibited under this subsection, whether they are voluntarily or involuntarily, without first obtaining written consent from County.

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

Section 18. Applicable Law

The laws of the State of Texas govern all disputes arising out of or relating to this Agreement. Any controversy or claim arising out of or relating to this Agreement, including by way of example only, the breach, termination or validity thereof, except for temporary, preliminary, or permanent injunctive relief or any other form of equitable relief, shall be subject to informal dispute resolution whereby the Parties hereto shall meet and confer in-person and in good faith to resolve any disputes arising during the Term. If the Parties are unable to resolve a dispute through such discussions, the aggrieved party shall propose, in writing, a reasonable manner of resolving the dispute. The other Party shall respond by accepting, rejecting, or modifying the proposal, in writing, within thirty (30) days of the date it receives the proposed resolution. Discussions, negotiations, and documents shared throughout the informal dispute resolution period shall be treated as inadmissible, compromise, and settlement negotiations. In the event the Parties are unable to resolve the dispute within sixty (60) days through such informal dispute resolution, the Parties agree all remaining disputes and claims may be brought in the courts located in Fort Bend

County, Texas. Nothing in the Agreement shall be construed to waive the County's sovereign immunity.

Section 19. Successors and Assigns

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

Section 20. Third Party Beneficiaries

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

Section 21. Severability

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

Section 22. Publicity

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

Section 23. Captions

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

Section 24. Entire Agreement

This Agreement contains the entire Agreement among the parties and supercedes all other negotiations and agreements, whether written or oral.

Section 25. Conflict

In the event there is a conflict among the documents that make up the Agreement, the following shall have priority in the numbered order with regard to the conflict:

1. This document entitled "Agreement for Third Party Claims Administration Services Pursuant to RFP 24-004"
2. Exhibit "D" – Business Associate Agreement

3. RFP 24-004
4. Exhibit "C" – Service and Fee Schedule
5. Exhibit "G" – PBM Scope of Work
6. Exhibit "E" – Security Policies
7. Exhibit "F" – Boon-Chapman Original Response dated September 8, 2023

Optional Services will have no priority with regard to any conflict because they are included only for reference.

Section 26. Certain State Law Requirements for Contracts. The contents of this Section are required by Texas law and are included by County regardless of content. For purposes of Sections 2252.152, 2271.002, and 2274.002, Texas Government Code, as amended, Boon-Chapman hereby verifies that Boon-Chapman and any parent company, wholly owned subsidiary, majority-owned subsidiary, and affiliate:

- 26.1 Unless affirmatively declared by the United States government to be excluded from its federal sanctions regime relating to Sudan or Iran or any federal sanctions regime relating to a foreign terrorist organization, is not identified on a list prepared and maintained by the Texas Comptroller of Public Accounts under Section 806.051, 807.051, or 2252.153 of the Texas Government Code.
- 26.2 If employing ten (10) or more full-time employees and this Agreement has a value of \$100,000.00 or more, Boon Chapman does not boycott Israel and is authorized to agree in such contracts not to boycott Israel during the term of such contracts. "Boycott Israel" has the meaning provided in § 808.001 of the Texas Government Code.
- 26.3 If employing ten (10) or more full-time employees and this Agreement has a value of \$100,000.00 or more, Boon Chapman does not boycott energy companies and is authorized to agree in such contracts not to boycott energy companies during the term of such contracts. "Boycott energy company" has the meaning provided in § 809.001 of the Texas Government Code.
- 26.4 If employing ten (10) or more full-time employees and this Agreement has a value of \$100,000.00 or more, Boon Chapman does not have a practice, policy, guidance, or directive that discriminates against a firearm entity or firearm trade association and is authorized to agree in such contracts not to discriminate against a firearm entity or firearm trade association during the term of such contracts. "Discriminate against a firearm entity or firearm trade association" has the meaning provided in § 2274.001(3) of the Texas Government Code. "Firearm entity" and "firearm trade association" have the meanings provided in § 2274.001(6) and (7) of the Texas Government Code.

Section 27. Human Trafficking

BY ACCEPTANCE OF THIS AGREEMENT, BOON CHAPMAN ACKNOWLEDGES THAT FORT BEND COUNTY IS OPPOSED TO HUMAN TRAFFICKING AND THAT NO COUNTY FUNDS WILL BE USED IN SUPPORT OF SERVICES OR ACTIVITIES THAT VIOLATE HUMAN TRAFFICKING LAWS.

Section 28. Electronic and Digital Signatures.

The Parties to this Agreement agree that any electronic and/or digital signatures of the Parties included in this Agreement are intended to authenticate this writing and shall have the same force and effect as the use of manual signatures.

Section 29. Certification.

By his or her signature below, each signatory individual certifies that he or she is the properly authorized person or officer of the applicable Party hereto and has the requisite authority necessary to execute this Agreement on behalf of such Party, and each Party hereby certifies to the other that it has obtained the appropriate approvals or authorizations from its governing body as required by law.

REMAINDER OF PAGE INTENTIONALLY LEFT BLANK

EXECUTION TO FOLLOW

IN WITNESS WHEREOF, and intending to be legally bound, County and Boon Chapman hereto have executed this Agreement to be effective as of January 1, 2024.

FORT BEND COUNTY

**BOON-CHAPMAN
BENEFIT ADMINISTRATORS, INC.**

KP George 12.19.2023
KP George, County Judge

Nyle Leftwich
Authorized Agent- Signature

Nyle Leftwich
Authorized Agent- Printed Name

CEO
Title

12/18/2023
Date



ATTEST:

Laura Richard
Laura Richard, County Clerk

APPROVED:

Wyatt Scott
Wyatt Scott
Risk Management Director

EXHIBITS:

- Exhibit A: RFP 24-004
- Exhibit B: Scope of Work
- Exhibit C: Service and Fee Schedule
- Exhibit D: Business Associate Agreement
- Exhibit E: Security Policies
- Exhibit F: Boon Chapman Original Response dated September 8, 2023, Optional Services

AUDITOR'S CERTIFICATE

I hereby certify that funds in the amount of \$ 5,300,000.00 are available to pay the obligation of Fort Bend County, Texas within the foregoing Agreement.

Robert Ed Sturdivant
Robert Ed Sturdivant, County Auditor

i:\agreements\2024 agreements\purchasing\risk management\boon-chapman benefit (24-risk-100276)\agreement for third party claims administration services.rfp 24-004 (kcj - 12.11.2023) v512.18.2023

EXHIBIT A
RFP 24-004

*Fort Bend County, Texas
Request for Proposals*



*Medical, Dental and Cafeteria Plans Third Party Claims Administration Services
RFP 24-004*

SUBMIT SEALED PROPOSALS TO:

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

Note: All correspondence must include the term
“Purchasing Department” in address to assist in
proper delivery

SUBMIT NO LATER THAN:

Tuesday, September 12, 2023
2:00 PM (Central)

LABEL SEALED ENVELOPE/BOX:

RFP 24-004
Medical Third Party Admin Svcs (TPA)

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

RFPs RECEIVED AS REQUIRED WILL THEN BE OPENED AND NAMES PUBLICLY READ.

RFPs RECEIVED AFTER THE SPECIFIED TIME, WILL BE RETURNED UNOPENED.

Result will be provide, upon request,
after final agreement is approved by
Commissioners Court.

Requests for information must be in
writing and directed to:
Cheryl Krejci, CPPB
Assistant County Purchasing Agent
Cheryl.Krejci@fortbendcountytexas.gov

Vendor Responsibilities:

- Download and complete any addendums. (Addendums will be posted on the Fort Bend County website no
Later than 48 hours prior to bid opening)
- Submit response in accordance with requirements stated on the cover of this document.
- DO NOT submit responses via email or fax.



COUNTY PURCHASING AGENT

Fort Bend County, Texas

Vendor Information

Jaime Kovar
Purchasing Agent

Office (281-341-8640)

Legal Company Name (top line of W9)				
Business Name (if different from legal name)				
Federal ID # or S.S. #		DUNS #		
Type of Business	<input type="checkbox"/> Corporation/LLC <input type="checkbox"/> Partnership <input type="checkbox"/> Sole Proprietor/Individual <input type="checkbox"/> Tax Exempt Organization	Age in Business?		
Publicly Traded Business	<input type="checkbox"/> No <input type="checkbox"/> Yes Ticker Symbol _____			
Remittance Address				
City/State/Zip				
Physical Address				
City/State/Zip				
Phone/Fax Number	Phone: _____ Fax: _____			
Contact Person				
E-mail				
Check all that apply to the company listed above and provide certification number.	DBE-Disadvantaged Business Enterprise <input type="checkbox"/>	Certification # _____ Certification # _____ Certification # _____ Certification # _____	<u>Cert Date</u>	<u>Exp Date</u>
	SBE-Small Business Enterprise <input type="checkbox"/>		_____	_____
	HUB-Texas Historically Underutilized Business <input type="checkbox"/>		_____	_____
	WBE-Women's Business Enterprise <input type="checkbox"/>		_____	_____
			_____	_____
Company's gross annual receipts	<\$500,000 _____	\$500,000-\$4,999,999 _____		
	\$5,000,000-\$16,999,999 _____	\$17,000,000-\$22,399,999 _____		
	>\$22,400,000 _____			
NAICs codes (Please enter all that apply)				
Signature of Authorized Representative				
Printed Name				
Title				
Date				

THIS FORM MUST BE SUBMITTED WITH THE SOLICITATION RESPONSE

1.0 INTRODUCTION:

Fort Bend County, Texas (hereafter referred to as the (“County”)) seeks sealed Proposals (“Proposals” or “RFP”) for selection of firm (“Respondent”) to provide Third Party Administration Services for the Fort Bend County Medical, Dental and Cafeteria Plan (“Project”) and Pharmacy Benefit Management (“PBM”) services which include a full pass through of any and all (100%) rebates back to Fort Bend County which should not be used to offset fees in accordance with the terms, conditions and requirements set forth in this RFP. Additionally, the County will accept proposals for an optional fully insured group health plan.

2.0 GUIDELINES:

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

- 2.1 The County reserves the right to reject any or all proposals if it determines that select proposals are not responsive to the RFP. The County reserves the right to reconsider any proposal submitted at any phase of the procurement. It also reserves the right to meet with select Respondents at any time to gather additional information. Furthermore, the County reserves the right to delete or add scope up until the final contract signing.
- 2.2 All Respondents submitting proposals agree that their pricing is valid for a minimum of ninety (90) days after proposal submission to the County. Furthermore, the County is by statute exempt from the State Sales Tax and Federal Excise Tax; therefore, proposal prices shall not include taxes.
- 2.3 This Proposal does not commit the County to award nor does it constitute an offer of employment or a contract for services. Costs incurred in the submission of this proposal, or in making necessary studies or designs for the preparation thereof, are the sole responsibility of the Respondents. Further, no reimbursable cost may be incurred in the anticipation of award. Proposals containing elaborate artwork, expensive paper and binding and expensive visual or other presentations are neither necessary nor desired.
- 2.4 In an effort to maintain fairness in the process, all inquiries concerning this procurement are to be directed only to the County’s Purchasing Agent in writing. Attempts to contact any members of the County’s Commissioners’ Court or any other County employee to influence the procurement decision may lead to immediate elimination from further consideration.
- 2.5 When responding to this Proposal, follow all instructions carefully. Submit proposal contents according to the outline specified and submit all hard copy and electronic documents according to the instructions. Failure to follow these instructions may be considered a non-responsive proposal and may result in immediate elimination from further consideration.

3.0 PROPOSAL CONTACT:

This Proposal is being issued by the County Purchasing Agent on behalf of Fort Bend County, Texas. Thus, responses should be directed to the Assistant Purchasing Agent, as outlined below. **Respondents are specifically directed NOT to contact any County personnel for meetings, conferences or technical discussions that are related to this Proposal other than specified herein. Unauthorized contact of any County personnel will likely be cause for rejection of the Respondent's proposal. All communications regarding the Proposal shall be directed to the County's Proposal Contact.** Communication with the Proposal Contact is permitted via email, facsimile, or written correspondence.

PROPOSAL CONTACT:

Cheryl Krejci, CPPB
Assistant County Purchasing Agent
Fort Bend County Travis Annex
301 Jackson, Suite 201
Richmond, Texas 77469
Cheryl.Krejci@fortbendcountytexas.gov

4.0 SUBMISSION REQUIREMENTS:

- 4.1 Submission requirements: one (1) original proposal, eight (8) paper copies, and one (1) electronic response on a labeled flash drive are required by RFP opening time of **2:00 PM on Tuesday, September 12, 2023**. Flash drive must contain only one (1) file in PDF format and must match written/original/paper response identically. Failure to provide proper flash drive is cause for disqualification. Proposal shall be submitted to the address shown below. Proposal shall be signed by a person having the authority to bind the firm in a contract.

Fort Bend County
Purchasing Department
301 Jackson, Suite 201
Richmond, Texas 77469

Proposal Number: R24-004
Due Date: Tuesday, September 12, 2023
Time: 2:00 PM (CST)
For: Medical, Dental and Cafeteria Plans Third
Party Claims Administration Services

- 4.2 Respondents may submit their proposal any time prior to the Opening Date and time. The Respondent's name and address as well as a distinct reference to the Proposal number above shall be marked clearly on the submission. All proposals are time-stamped upon receipt and are securely kept, unopened, until the Opening Date. No responsibility will attach to the County, or any official or employee thereof, for the pre-opening of, post-opening of, or the failure to open a proposal not properly addressed and identified. No oral, telegraphic, telephonic, or facsimile proposals will be considered.

- 4.3 Proposals may be modified or withdrawn prior to the established opening date by delivering written notice to the proposal contact. Any alteration made prior to opening date and time shall be initialed by the signer of the proposal, guaranteeing authenticity.
- 4.4 Proposals time-stamped after the due date and time will not be considered and will be returned to the Respondent unopened. Regardless of the method used for delivery, respondents shall be wholly responsible for the timely delivery of submitted proposals.
- 4.5 The Respondent's name and address shall be clearly marked on all copies of the proposal.

5.0 INCURRED COSTS:

Those submitting proposals do so entirely at their expense. There is no expressed or implied obligation by the County to reimburse any individual or firm for any costs incurred in preparing or submitting proposals, for providing additional information when requested by the County or for participating in any selection interviews, including discovery (pre-contract negotiations) and contract negotiations.

6.0 ACCEPTANCE:

- 6.1 Submission of any proposal indicates a Respondent's acceptance of the conditions contained in this Proposal unless clearly and specifically noted otherwise in their proposal.
- 6.2 Furthermore, the County is not bound to accept a proposal on the basis of lowest price, and further, the County has the sole discretion and reserves the right to cancel this Proposal, to reject any and all proposals, to waive any and all informalities and or irregularities, or to re-advertise with either the identical or revised specifications, if it is deemed to be in the County's best interests. The County reserves the right to accept or reject any or all of the items in the proposal, and to award the contract in whole or in part and/or negotiate any or all items with individual Respondents if it is deemed in the County's best interest.
- 6.3 Although Fort Bend County desires to negotiate toward a contract with a selected Respondent, the Commissioners' Court may award the contract on the basis of the initial proposals received, without discussions. Therefore, each initial proposal should contain the Respondent's best terms.

7.0 INTERPRETATIONS, DISCREPANCIES, AND OMISSIONS:

- 7.1 It is incumbent upon each potential Respondent to carefully examine these specifications, terms, and conditions. Should any potential Respondent find discrepancies, omissions or ambiguities in this Proposal, the Respondent shall at

once request in writing an interpretation from the County's Proposal Contact. Any inquiries, suggestions, or requests concerning interpretation, clarification or additional information shall be made in writing via e-mail only to the County's Proposal Contact, as specified in Section 3.0. Deadline for submission of questions and/or clarification is no later than **Wednesday, August 30, 2023 at 9:00 AM. (central)**. Requests received after the deadline will not be responded to due to the time constraints of this Proposal process.

- 7.2 The issuance of a written addendum is the only official method by which interpretation, clarification or additional information will be given by the County. Only questions answered by formal written addenda will be binding. Oral and other interpretations or clarification will be without legal effect. If it becomes necessary to revise or amend any part of this Proposal, notice will be given by the County Purchasing Agent to all prospective Respondents who were sent a Proposal. The Respondent in their proposal shall acknowledge receipts of amendments. Each Respondent shall ensure that they have received all addenda and amendments to this Proposal before submitting their proposals.

8.0 CONTRACTUAL OBLIGATIONS:

This Request for Proposal, response and associated documentation, any negotiations and final contract, when properly accepted by Fort Bend County, shall constitute a contract equally binding between the contractor and Fort Bend County.

9.0 RETENTION OF RESPONDENT'S MATERIAL:

The County reserves the right to retain all proposals regardless of which response is selected. All proposals and accompanying documents become the property of the County.

10.0 ASSIGNMENT:

The Respondent may not sell, assign, transfer or convey the contract resulting from this Proposal, in whole or in part, without the prior written approval from Fort Bend County Commissioners' Court.

11.0 CERTIFICATE OF INDEPENDENT PRICE DETERMINATION:

By submission of a proposal, each Respondent certifies, that in connection with this procurement:

- 11.1 The prices in this proposal have been arrived at independently, without consultation, communication, or agreement with any other Respondent; with any competitor; or with any County employee(s) or consultant(s) for the purpose of restricting competition on any matter relating to this Proposal.
- 11.2 Unless otherwise required by law, the prices which have been quoted in this proposal have not been knowingly disclosed by the Respondent and will not

knowingly be disclosed by the Respondent prior to award directly or indirectly to any other Respondent or to any competitor; and;

- 11.3 No attempt has been made or will be made by the Respondent to induce any other person or firm to submit or not to submit a proposal for the purpose of restricting competition.

12.0 CONFIDENTIAL MATTERS:

- 12.1 All data and information gathered by the Respondent and its agents, including this Proposal and all reports, recommendations, specifications, and data shall be treated by the Respondent and its agents as confidential. The Respondent and its agents shall not disclose or communicate the aforesaid matters to a third party or use them in advertising, publicity, propaganda, and/or in another job or jobs, unless written consent is obtained from the County.
- 12.2 Proposals will only be publicly received and acknowledged only so as to avoid disclosure of the contents to competing Respondents and kept secret during negotiation. However, all proposals shall be open for public inspection after the contract is awarded. Trade secrets and any material that is considered to be confidential information contained in the proposal and identified by Respondent as such will be treated as confidential to the extent allowable in the Open Records Act.

13.0 LIMITS OF SUBCONTRACTORS:

- 13.1 The County has approval rights over the use and/or removal of all subcontractors and/or vendor(s). Subcontractors shall conform to all County policies.
- 13.2 Any dispute between the Respondent and subcontractors, including any payment dispute, will be promptly remedied by the Respondent. Failure to promptly remedy or to make prompt payment to subcontractor may result in the withholding of funds from the Respondent by the County for any payments owed to the subcontractor.

14.0 JURISDICTION, VENUE, CHOICE OF LAW:

This Proposal and any contract resulting there from shall be governed by and construed according to the laws of the State of Texas. Should any portion of any contract be in conflict with the laws of the State of Texas, the State laws shall invalidate only that portion. The remaining portion of the contract(s) shall remain in effect. Any lawsuit shall be governed by Texas law and Fort Bend County, Texas shall be the venue for any action or proceeding that may be brought or arise out of, in connection with or by reason of this Proposal process and resulting Agreements.

15.0 INDEPENDENT CONTRACTOR:

The Respondent is an independent contractor and no employee or agent of the Respondent shall be deemed for any reason to be an employee or agent of the County.

16.0 AMERICANS WITH DISABILITIES ACT (ADA)

Proposals shall comply with all federal, state, county, and local laws concerning this type of products/service/equipment/project and the fulfillment of all ADA requirements.

17.0 DRUG-FREE WORKPLACE:

All Respondents shall provide any and all notices as may be required under the Drug-Free Workplace Act of 1988, 28 CFR Part 67, Subpart F, to their employees and all sub-contractors to insure that the County maintains a drug-free workplace.

18.0 PERFORMANCE AND PAYMENT BOND:

No performance nor payment bond is required for this project.

19.0 POWER OF ATTORNEY:

An attorney-in-fact who signs a bid bond, performance bond or payment bond must file with each bond a certified and effectively dated copy of his or her power of attorney.

20.0 TEXAS ETHICS COMMISSION FORM 1295:

20.1 Effective January 1, 2016 all contracts executed by Commissioners Court, regardless of the dollar amount, will require completion of Form 1295 “Certificate of Interested Parties”, per the new Government Code Statute §2252.908. All firms submitting a response to a formal Bid, RFP, SOQ or any contracts, contract amendments, renewals or change orders are required to complete the Form 1295 online through the State of Texas Ethics Commission website. Please visit:

<https://www.ethics.state.tx.us/File/>

20.2 On-line instructions:

20.2.1 Name of governmental entity is to read: Fort Bend County.

20.2.2 Identification number use: RFP 24-004.

20.2.3 Description is: Medical, Dental and Cafeteria Plans Third Party Claims Administration Services.

20.3 Highest evaluated vendor will be required to provide the Form 1295 within three (3) calendar days from notification; however, if your company is publicly traded you are not required to complete this form.

21.0 INSURANCE:

- 21.1 All respondents shall submit, with RFP, a current certificate of insurance indicating coverage in the amounts stated below. In lieu of submitting a certificate of insurance, respondents may submit, with RFP, a notarized statement from an Insurance company, authorized to conduct business in the State of Texas, and acceptable to Fort Bend County, guaranteeing the issuance of an insurance policy, with the coverage stated below, to the firm named therein, if successful, upon award of this Contract.
- 21.2 At contract execution, contractor shall furnish County with properly executed certificates of insurance, which shall evidence all insurance required and provide that such insurance shall not be canceled, except on 30 days prior written notice to County. Contractor shall provide certified copies of insurance endorsements and/or policies if requested by County. Contractor shall maintain such insurance coverage from the time Services commence until Services are completed and provide replacement certificates, policies and/or endorsements for any such insurance expiring prior to completion of Services. Contractor shall obtain such insurance written on an Occurrence form (or a Claims Made form for Professional Liability insurance) from such companies having Best's rating of A/VII or better, licensed or approved to transact business in the State of Texas, and shall obtain such insurance of the following types and minimum limits:
- 21.2.1 Workers' Compensation insurance. Substitutes to genuine Workers' Compensation Insurance will not be allowed.
- 21.2.2 Employers' Liability insurance with limits of not less than \$1,000,000 per injury by accident, \$1,000,000 per injury by disease, and \$1,000,000 per bodily injury by disease.
- 21.2.3 Commercial general liability insurance with a limit of not less than \$1,000,000 each occurrence and \$2,000,000 in the annual aggregate. Policy shall cover liability for bodily injury, personal injury, and property damage and products/completed operations arising out of the business operations of the policyholder.
- 21.2.4 Professional Liability (Errors & Omissions) Insurance with limits of not less than \$1,000,000 each occurrence, \$2,000,000 aggregate. Such insurance will cover all Work performed by or on behalf of Contractor and its subcontractors under this Agreement. No Professional Liability policy written on an occurrence form will include a sunset or similar clause that limits coverage unless such clause provides coverage for at least twenty-four (24) months after the expiration or termination of this Agreement for any reason.

- 21.3 County and the members of Commissioners Court shall be named as additional insured on a Primary and Non-Contributory basis to all required coverage except for Workers' Compensation and Professional Liability Insurance. All Liability policies including Workers' Compensation written on behalf of contractor, shall contain a waiver of subrogation in favor of County and members of Commissioners Court.
- 21.4 If required coverage is written on a claims-made basis, contractor warrants that any retroactive date applicable to coverage under the policy precedes the effective date of the contract; and that continuous coverage will be maintained or an extended discovery period will be exercised for a period of two (2) years beginning from the time that work under the agreement is completed.

22.0 INDEMNIFICATION:

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

- 22.1 Respondent shall timely report all such matters to Fort Bend County and shall, upon the receipt of any such claim, demand, suit, action, proceeding, lien or judgment, not later than the fifteenth day of each month; provide Fort Bend County with a written report on each such matter, setting forth the status of each matter, the schedule or planned proceedings with respect to each matter and the cooperation or assistance, if any, of Fort Bend County required by Respondent in the defense of each matter.
- 22.2 Respondent's duty to defend, indemnify and hold Fort Bend County harmless shall be absolute. It shall not abate or end by reason of the expiration or termination of any contract unless otherwise agreed by Fort Bend County in writing. The provisions of this section shall survive the termination of the contract and shall remain in full force and effect with respect to all such matters no matter when they arise.
- 22.3 In the event of any dispute between the parties as to whether a claim, demand, suit, action, proceeding, lien or judgment appears to have been caused by or appears to have arisen out of or in connection with acts or omissions of Respondent, Respondent shall never-the-less fully defend such claim, demand, suit, action, proceeding, lien or judgment until and unless there is a determination by a court of competent jurisdiction that the acts and omissions of Respondent are not at issue in the matter.
- 22.4 Respondent's indemnification shall cover, and Respondent agrees to indemnify Fort Bend County, in the event Fort Bend County is found to have been negligent for having selected Respondent to perform the work described in this request.

- 22.5 The provision by Respondent of insurance shall not limit the liability of Respondent under an agreement.
- 22.6 Respondent shall cause all trade contractors and any other contractor who may have a contract to perform construction or installation work in the area where work will be performed under this request, to agree to indemnify Fort Bend County and to hold it harmless from all claims for bodily injury and property damage that arise may from said Respondent's operations. Such provisions shall be in form satisfactory to Fort Bend County.
- 22.7 Loss Deduction Clause - Fort Bend County shall be exempt from, and in no way liable for, any sums of money which may represent a deductible in any insurance policy. The payment of deductibles shall be the sole responsibility of Respondent and/or trade contractor providing such insurance.

23.0 STATE LAW REQUIREMENTS FOR CONTRACTS:

The contents of this section are required by Texas Law and are included by County regardless of content.

- 23.1 Agreement to Not Boycott Israel Chapter 2271 Texas Government Code: Contractor verifies that if Contractor employs ten (10) or more full-time employees and this Agreement has a value of \$100,000 or more, Contractor does not boycott Israel and will not boycott Israel during the term of this Agreement.
- 23.2 Texas Government Code Section 2251.152 Acknowledgment: By signature on vendor form, Contractor represents pursuant to Section 2252.152 of the Texas Government Code, that Contractor is not listed on the website of the Comptroller of the State of Texas concerning the listing of companies that are identified under Section 806.051, Section 807.051 or Section 2253.153.

24.0 HUMAN TRAFFICKING:

By acceptance of this contract, Contractor acknowledges that Fort Bend County is opposed to human trafficking and that no County funds will be used in support of services or activities that violate human trafficking laws.

25.0 TENTATIVE SCHEDULE:

Release of RFP:	August 20, 2023
Deadline for Questions:	August 30, 2023
Submission Due Date:	September 12, 2023
Evaluation of Submissions:	Week of September 18 th , 2023
Commissioners Court Permission to Negotiate:	September 26, 2023
Negotiations:	Begin September 27, 2023
Final Contract Approval Commissioners Court:	November 14, 2023

26.0 PRE-RFP CONFERENCE:

There is no Pre-RFP meeting for this solicitation.

27.0 EVALUATION CRITERIA:

In order to facilitate the analysis of responses to this Proposal, Respondents are required to prepare their proposals in accordance with the instructions outlined in this part. Proposals should be prepared as simply as possible and provide a straightforward, concise description of the Respondent's capabilities to satisfy the requirements of the Proposal. Emphasis should be concentrated on accuracy, completeness, and clarity of content. All parts, pages, figures, and tables are to be numbered and clearly labeled.

27.1 Respondents are required to follow the outline below when preparing their proposals:

Tab	Title
	Title Page
	Table of Contents
	Executive Summary

1 Response to Questions:

- a. Medical Administration
- b. Dental Administration
- c. Cafeteria Plan Administration

2 Reference Letters and References from current and past clients. Include all contact information, date of contract start and end, and number of employees covered.

3 Optional Fully Insured Group Health Plan

4 Other Options which may be of interest to the County (i.e. Dental, Vision).

5 Price

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

27.3 Executive Summary - This section should be limited to a brief narrative highlighting the company's background and experience. Narrative should clearly demonstrate compliance with Respondent qualifications listed in the RFP specifications. Include length of time the company has been in business and provide examples of past and pending projects/contracts.

28.0 EVALUATION FACTORS:

Contract award will be made to the Respondent whose proposal is determined to be the best evaluated offer resulting from negotiations, taking into consideration the relative importance of service, price and other evaluation factors set forth in this RFP and in accordance with The County Purchasing Act of the TEXAS LOCAL GOVERNMENT CODE.

- 28.1 **Basic Requirements:** Initially, the proposal will be examined to determine if it “qualifies” in that it meets the basic requirement for consideration. This review will pertain to such matters as adequate responsiveness to the RFP, necessary signatures, completeness, and clarity with respect to such essential factors as price. Failure of the proposal to meet the basic requirements of a proposal may disqualify it from further consideration.
- 28.2 **Evaluation of Qualifying Proposals:** Having determined that a proposal meets the basic requirements, the Evaluation Committee will then evaluate it with respect to each of the following elements:

28.2.1 Proposal Submission and Completeness (Maximum 20 points):

The Evaluation Committee will review the proposal for its completeness, review how the respondent will approach the task of initiating and then fully implementing its program, review the proposed health care delivery system in all its facets including how desired results will be attained. In all, proposal's clarity, understanding of issues, completeness of program, and demonstration of assurance of performance as to quality and efficiency will be weighted when scoring this category.

28.2.2 Qualifications/Experience/References (Maximum 35 points):

Included in this criterion of the evaluation will be: Length of time respondent has been in the business of Employee Benefits Administration; current and recent history of past performance by the Respondent of a similar nature to the performance offered in response to the RFP; any evidence submitted (letters of reference) or readily attainable regarding the quality of past performance and the reliability of responsiveness of the Respondent; the apparent capabilities of the Respondent to perform well in the execution of its obligations under a contract with the County as evidenced by its leadership and management personnel, size of organization, length of time in business, past performance, and other current contractual obligations defining the Respondents capability to undertake and successfully fulfill the obligations proposed to be undertaken by its submission of a proposal in response to this RFP. Respondent should outline experience with clients of the same size and/or same vicinity/state as this County.

28.2.3 Price (Maximum 45 points):

Price per employee per month to provide medical, dental and cafeteria plan administration services.

29.0 EVALUATION PROCESS:

- 29.1 After the Proposals are received, the evaluation team shall evaluate each Proposal that was submitted on time, and the evaluation shall be based on the criteria stated in the proposal. Selection committee members will conduct a quantitative evaluation according to a numerical ranking system and a qualitative evaluation for overall proposal content and its conformance to requirements. The entire evaluation committee will then meet to discuss the strong and weak points of each proposal to assure that it has been evaluated fairly, impartially, and comprehensively. Following this initial evaluation, the evaluation team may recommend entering into contract negotiations without further discussion with Respondents, or the firms submitting the top rated proposals may be asked to make an oral presentation to the evaluation team for the propose of further clarification and evaluation of the proposals.
- 29.2 If site visits/interviews/oral presentations are scheduled, the representatives of the firm who will be directly assigned to the account must be present at the interview.
- 29.3 The evaluation team shall not disclose any information included in a firm's proposal to another firm during the RFP process and shall not disclose any information for the purpose of bringing one firm's proposal up to that of a competitor's proposal.
- 29.4 After final offers are received, the evaluation team shall reevaluate each of the final offers, including those deemed final at the interview. The final offers shall be evaluated on the same criteria used in the first evaluation.
- 29.5 Fort Bend County reserves the right to reject any and all proposals received for any reason that would be to the benefit of Fort Bend County.
- 29.6 All Proposals submitted are to be valid for a period of one-hundred twenty (120) days.

30.0 AWARD:

Proposals will be opened on the date specified on the cover page and kept confidential until the Fort Bend County Commissioners Court awards a final negotiated contract. Only the names of the Respondents will be read aloud during the opening. All proposals that have been submitted shall be open to public inspection after the contract award.

Firms shall not contact any members or employees of Fort Bend County regarding this RFP, evaluation, or selection process from the time the RFP is issued until the time a notification of intent to award is announced, except if such contact is in writing, with a copy of any written communication being forwarded to the Office of the Purchasing Agent. Contact discovered in any such manner, other than in writing and copied to the Office of the Purchasing Agent, would be considered as grounds for elimination.

31.0 TERM OF CONTRACT:

The term of this contract is for a period of twenty-four (24) months, commencing on January 1, 2024, and ending at the close of business on December 31, 2025, with three (3) additional one-year renewal options under the same terms and conditions if mutually agreeable to both parties. Either party for any reason may terminate this contract by giving thirty (30) days written notice of the intent to terminate.

32.0 REQUIRED FORMS:

All respondents submitting are required to complete the attached/included and return with submission:

- 32.1 Vendor Form
- 32.2 W9 Form
- 32.3 Tax Form/Debt/Residence Certification
- 32.4 Proof of Insurance

33.0 ATTACHMENTS:

- 33.1 Attachment 1: General Questionnaire
- 33.2 Attachment 2: Medical/Dental/Cafeteria Plan Administration Questionnaire

34.0 EXHIBITS:

- 34.1 Exhibit A: FBC Medical, Dental and Cafeteria Plan Statistical Data
- 34.2 Exhibit B: Current FBC Medical Plan Document
- 34.3 Exhibit C: Current FBC Dental Plan Document
- 34.4 Exhibit D: Current FBC Cafeteria Plan Document

ATTACHMENT 1

GENERAL QUESTIONNAIRE FOR THIRD PARTY ADMINISTRATORS

1. Please give a history of your firm, including ownership, length of time in the contract claims administration business, physical location and satellite operation locations
2. Please provide a list of all companies/organizations that you have a financial interest in and a description of that financial interest.
3. Successful vendor must have a completed 1295 form from The Texas Ethics Commission on file with Fort Bend County prior to award by Commissioners Court
4. Please include a copy of your most recent audited financial statement (including P&L and balance sheet) (Please mark as Confidential) and SAS70 report for the previous 3 years.
5. Please send a copy of your Third Party Administrators Errors and Omission Policy and disclose if you currently have, or have had in the past, any litigation involving your claims service and the disposition of that litigation.
6. Please list the number of employees you employ by department and job function.
7. Please list all employee benefit related organizations that your firm belongs to and the length of time.
8. Please give the total number of employee lives that you currently administer, month-by-month for the past twelve (12) months.
9. Please list all states where you are currently a licensed T.P.A.
10. Please list all states where you currently have clients.
11. Please list all fully insured carriers with which you have draft book authority.
12. Please list all Stop loss carriers with which you are approved.
13. Please list all PPO's with which you currently work.
14. Please list all Pre-Certification/Utilization Review/Case Management companies that you currently administer claims in conjunction with your clients benefit plans.
15. Please list all Prescription Benefit Management companies with which you currently work.
16. Please list all E.A.P organizations with which you work.

17. Please list all political subdivisions in Texas for which you currently administer medical, dental and cafeteria plans with including years doing business, the name of a contact and telephone number; i.e., state, county, city, school district, etc.
18. Please provide a list of all clients that have terminated the last three (3) years, give reason for termination and a contact person.
19. Please complete the Medical, Dental and Cafeteria Plan Administration Questionnaire. Please add a section in your response to this RFP and title it Optional Services if you wish to offer additional services. Any Optional Services you offer must be listed here with the name of the service and a complete description of the service. If there is a charge for the optional service, it must be disclosed in this section. If a charge/fee for an Optional Service cannot be quoted at this time due to a lack of information, please state in your proposal:” Additional information is required for a charge/fee quote”

ATTACHMENT 2

MEDICAL, DENTAL, CAFETERIA PLAN CLAIMS ADMINISTRATION QUESTIONNAIRE

MEDICAL ADMINISTRATION

1. Where is your claims payment office located that would serve the Plan? Would benefit checks and explanation of benefits forms be mailed from the claims office or elsewhere? Please provide a sample EOB
2. How many employees would you assign to our account? Which of them would be dedicated to our account only? State titles and explain function with brief biographies on each.
3. What is the minimum experience for hiring a claims processor at your firm? How much experience (minimum and average) would the personnel assigned to our account have?
4. Have you developed your own claims payment software, or do you use vendor software? Describe your system; identify the vendor if a vendor is used. Do you own or lease your claim software? Explain any special features of the system you use.
5. If any of your claim adjudication is manual, please explain.
6. Is your claim system and firm compliant with HIPAA Privacy requirements?
7. Is your claims system capable of handling a group with different plan designs?
8. Describe procedure used to screen for duplicate charges
9. Explain your coordination of benefits procedures and state your average percentage of recovery on all health benefit accounts now handled, in relation to claims paid. If possible, estimate your anticipated dollar amount of recovery on this account.
10. What is your average claims turnaround time? Specify in calendar days for both average and maximum allowed turnaround. Define all terminology used. If a claim is not “clean” when first received, explain the procedures used and the time required to correspond for additional information.
11. Do you furnish your explanation of benefits with the payment check or separately? Explain procedures and who receives copies.
12. Do you furnish your explanation of benefits with the payment check or separately? Explain procedures and who receives copies.

13. Do you generate your own usual and customary fee date, or do you use vendor data? If so, who? How often is it updated? Can you pay at differing percentiles if requested by the client?
14. Do you have the capability to process medical claims with Medicare pricing?
15. Describe the standard procedures used for subrogation investigation.
16. What services does your firm usually offer for claims on which subrogation may be possible? If options are available, explain and indicate fees
17. Do you batch claim payments?
18. Please explain what type of claims filing system you use.
19. Will you reimburse the County for all payments due to overpayment of a claim if refund cannot be received from provider within 6 months?
20. Describe your clinical editing capabilities to detect unbundling, up coding, duplicate claims payment and other erroneous claims filing practices, including fraud and other abuses
21. Please explain your internal audit procedures and at what level these audits begin. Please explain if you have external audits performed and will you provide copies of those audits?
22. Do you have a catastrophic backup plan? Please explain
23. Please explain all claim/eligibility system security and your company's security
24. Do you have a service by which providers may verify participant coverage? If so, what hours and days does it operate? Do you have a toll free number? If the service is not operated 24 hours/7 days a week, would you be willing to expand it?
25. Provide any third party actuarial studies or any other objective outside data available that assess the effectiveness of your TPA service for other clients with similar plans in obtaining accurate payment of claims.
26. Is postage included in your monthly fee per participant?
27. Please include samples with a description of the standard types of management reports and frequency you provide for your clients, and any fees that are charged for reports. Please explain what ad hoc report capabilities you have and any associated fees.
28. Please explain all Internet/Webpage capabilities your firm offers to employees and the County including security for these capabilities

29. What is the banking arrangement for transfer of funds that you would use for this account?
30. Include a description of your preferred banking arrangement. Be certain to address the following:
 - Who sets up the bank account and pays the banking charges?
 - How is the Client assessed banking charges if its own bank is not used to write checks?
 - How are funds to be remitted?
 - Minimum balance requirement?
 - Frequency of bank account funding?
 - Timing on claims funding?
 - Funding to claims through any bulk payment arrangement?
 - Reconciliation procedures
31. Are any alternative banking arrangements available? If so, describe briefly.
32. Are you able to use drafts and print on Client's stock?
33. Assuming direct claims submission, describe your procedures for handling eligibility?
34. How often do you require updated eligibility from your Clients?
35. How long do you anticipate it taking to set up eligibility for this Client?
36. What online eligibility capabilities are available to the Client?
37. Can you receive eligibility files electronically? If the County provides a full eligibility feed to the new administrator, how long before the effective date does your firm need to receive this data?
38. Can your system track each dependent by the dependent's name and the dependent's social security number?
39. Specify how you would prefer to receive the data (i.e. tape, disk electronically)
40. Please provide the specifications of your preferred method
41. If any costs are associated with your preferred method, would you be willing to assume that cost?
42. Estimate your minimum start-up time from date of contract award to date you could commence processing claims. Do you presently have the needed personnel, equipment and facilities? If not, how do you propose to obtain them?
43. Do you provide COBRA administration in your basic fee? If not, please state additional fee.

44. Please include a copy of your company's HIPAA policy including a copy of the training your employees receive.
45. Will you provide an administrative manual for the Risk Management Department?
46. Will you produce I.D. cards, benefit booklets and is there a cost? If yes, please explain any costs associated with this item.
47. Will you produce and timely file IRS form 1099 for providers?
48. Please include a sample monthly invoice for your services
49. May additional vendors be added to your monthly invoice in order to consolidate billing?
50. Can you invoice monthly for COBRA participants Retiree participants and Survivor participants? Please explain in detail what you would do if a COBRA, Retiree participant and Survivor participant does not pay their monthly premium in a timely fashion.
51. Will you provide a contact person to answer legal questions and explain changes in benefits required by the federal government?
52. Does your firm have personnel available to assist in annual enrollments? Please explain any costs associated with this.
53. Please describe the PPACA - Health Reform Services you will provide to self-insured clients and the associated costs as applicable
54. Furnish your proposed fee structure, and explain the details and costs of any services or options offered. Explain if additional fees will be imposed for processing runoff claims in the event of termination. Unless you state otherwise, it will be assumed that all TPA services discussed in your proposal are included in the basic fee quoted. The County would prefer a composite basic fee (PEPM) for medical claim administration. If you have a separate fee for COBRA participants or any other category of participation in the medical program, please include the fee or it will be assumed all participants in the medical program will have the same fee as the composite basic fee (PEPM)
55. Include a sample of your administrative service contract for medical claim administration.

DENTAL ADMINISTRATION

1. Is your dental claims payment system a component of your medical claim system or is it a separate system?
2. Is any part of your dental claims payment system manual? If so, please explain.
3. Do you generate your own dental usual and customary fee data, or do you use vendor data? If so, who? How often is it updated? Can you pay at differing percentiles if requested by the client?
4. What percentile do you use for payment of dental claims and can clients pick alternate percentiles?
5. Will the system automatically deny any (all) non-covered items based on the procedure codes entered by the processor?
6. Are claims routinely coded using standard ADA codes? What other coding protocols are used?
7. How long has your firm been processing dental claims?
8. Are the same internal and external audit processes the same as medical claims? If not, please explain
9. Please include resumes on the dental claims team personnel
10. Please provide a sample EOB for a dental claim
11. Can you receive eligibility in the same electronic method as the medical plan?
12. The County would prefer a composite basic fee (PEPM) for dental claim administration.
13. Include a sample of your administrative service contract for dental.

CAFETERIA PLAN ADMINISTRATION

1. Is your cafeteria plan administration component integrated within your medical/dental claims/administration system?
2. Include with this proposal any forms, documents and brochures that you will provide Fort Bend County.
3. Include costs for any services, brochures, forms and audio-visual material, which you will provide assistance in developing.
4. What experience does your organization have with Section 125 Plans and for what period of time have you administered such plans?
5. If there are any questions from Fort Bend County or its employees relating to this program, will you provide easy access to the answers? This includes staff support and toll free access to the staff? Describe your consumer service program in detail.
6. Can you provide a printed copy of any employee's contribution and expense status if requested, on demand?
7. In order to provide the services at the level of fees indicated in your proposal, will you require any minimum amount of participants in the Section 125 Plan?
8. Describe a typical medical expense reimbursement claim. How would you expect it to be reported, what documentation would you require, to whom would a claim be submitted and where, how long thereafter on the average would a check be issued and to whom would it be issued? How frequently are reimbursement claims processed? Would you issue checks directly to a provider?
9. Describe a typical dependent care expense reimbursement claim; how would you expect it be reported, what documentation would you require, to whom would the claim be submitted and where, how long thereafter on the average would a check be issued and to whom would it be issued?
10. Is your company's primary business a plan administrator, or selling products? If you sell products would you require that Fort Bend County allow you the opportunity to sell your products? Is your administrative cost affected if you do not sell your products? If allowed the opportunity, what type marketing opportunity would you require of employees or Fort Bend County? What type products would you require be offered?
11. What assistance would you require of Fort Bend County's payroll and accounting department in implementing and administering the Plan?
12. What kind of frequency of reporting would you provide to participants regarding their

accounts, deposits, claims, etc.?

13. What kind of reporting would you provide the County and what frequency?
14. What happens to unused balances in the participant's account at the end of the year?
15. Do you provide all enrollment forms, claim forms, etc.?
16. Do you have a minimum monthly participation amount? Maximum monthly contribution amounts?
17. Do you maintain separate bookkeeping accounts by participant for each plan option?
18. Do you allow claims to be submitted as incurred, or in increments, or both?
19. Can you receive eligibility electronically?
20. The County would prefer a composite basic fee (PEPM) for Cafeteria Plan administration by category. Please state your fee for participation in the premium reduction account. Please state your fee for participation in the child care account. Please state your fee for participation in the medical reimbursement account.
21. Include a sample of your administrative service contract for Cafeteria Plan administration.

PHARMACY BENEFIT MANAGEMENT

Do you provide Pharmacy Benefit Management (PBM) services including conducting annual pricing audit/reconciliation of prescription drug claims to validate PBM has met PBM pricing guarantees including a full pass through of any and all (100%) rebates back to the Fort Bend County which should not be used to offset fees.

OPTIONAL SERVICES

Please explain all optional services your firm can offer by name, with a full description of the service and any additional charges involved. If a charge/fee for an Optional Service cannot be quoted at this time due to a lack of information, please state in your proposal "Additional Information is required for a charge/fee quote".

EXHIBIT A

Fort Bend County- Medical and Dental Plan Participant Count													
2022	January	February	March	April	May	June	July	August	September	October	November	December	
Medical	2759	2755	2767	2773	2768	2775	2780	2782	2789	2816	2800	2887	
Fort Bend County Dental	2093	2033	2101	2087	2118	2117	2102	2104	2103	2095	2094	2109	
Humana Dental	396	392	401	411	416	424	425	437	438	438	440	451	
2023	January	February	March	April	May	June	July	August	September	October	November	December	
Medical	2541	2559	2573	2595	2626	2665	2695						
Fort Bend County Dental	2125	2143	2156	2170	2191	2195	2201						
Humana Dental	400	410	420	432	432	439	444						
Fort Bend County- Cafeteria Plan Participant Count by Category													
2022	January	February	March	April	May	June	July	August	September	October	November	December	
Pre-Tax Premiums	1667	1714	1709	1725	1743	1754	1780	1816	1836	1841	1877	1894	
Dependent Care Reimbursement	22	21	26	26	26	28	26	27	27	28	27	27	
Medical Reimbursement	547	551	539	539	541	539	541	544	545	545	538	540	
2023	January	February	March	April	May	June	July	August	September	October	November	December	
Pre-Tax Premiums	1897	1925	1956	1975	2000	2022	2043						
Dependent Care Reimbursement	25	25	29	32	31	31	32						
Medical Reimbursement	541	540	563	573	571	573	579						

Fort Bend County- Active Medical/Dental/PBM Participant Count

2022	January	February	March	April	May	June	July	August	September	October	November	December
Medical- EE Only	1375	1374	1360	1366	1358	1363	1364	1383	1389	1405	1394	1459
Medical- EE+Spouse	262	260	267	264	270	271	272	266	269	270	268	274
Medical- EE+Children	743	747	755	753	758	757	756	743	739	747	744	754
Medical- EE+Family	379	374	385	390	382	384	388	390	392	394	394	400
Dental- EE Only	1063	1017	1016	1009	1029	1019	1016	1028	1028	1020	1017	1025
Dental- EE+Spouse	229	223	233	234	236	237	236	234	237	236	238	239
Dental- EE+Children	457	447	474	469	478	482	473	467	470	468	464	468
Dental- EE+Family	344	346	378	375	375	379	377	375	368	371	375	377
PBM	2524	2512	2520	2518	2517	2522	2524	2528	2532	2561	2577	2631
2023	January	February	March	April	May	June	July	August	September	October	November	December
Medical- EE Only	1317	1331	1317	1329	1346	1372	1390					
Medical- EE+Spouse	190	186	197	199	205	206	208					
Medical- EE+Children	689	697	701	709	722	727	732					
Medical- EE+Family	344	344	357	358	354	360	365					
Dental- EE Only	1072	1086	1062	1072	1086	1087	1088					
Dental- EE+Spouse	220	222	231	228	232	231	234					
Dental- EE+Children	472	478	495	499	506	508	509					
Dental- EE+Family	361	357	368	371	367	369	370					
PBM	2651	2681	2713	2608	2651	2650	2680					

Fort Bend County- *Retiree* Medical/Dental/PBM Participant Count

2022	January	February	March	April	May	June	July	August	September	October	November	December
Medical- Ret Only	130	135	136	137	138	137	137	136	138	138	140	139
Medical- Ret+Spouse	57	57	55	55	58	59	60	60	60	61	62	60
Medical- Ret+Children	31	32	32	33	34	33	33	34	33	32	32	34
Medical- Ret+Family	27	27	27	27	25	25	26	26	28	27	27	26
Dental- Ret Only	350	352	354	357	359	360	364	365	366	366	369	369
Dental- Ret+Spouse	332	302	304	306	306	307	307	308	310	311	313	313
Dental- Ret+Children	25	24	24	24	24	24	25	25	10	25	26	26
Dental- Ret+Family	73	74	72	69	67	67	68	67	70	70	68	67
PBM	729	732	734	738	741	743	749	752	756	758	762	764

2023	January	February	March	April	May	June	July	August	September	October	November	December
Medical- Ret Only	664	665	666	669	670	672	676					
Medical- Ret+Spouse	66	67	67	66	64	63	61					
Medical- Ret+Children	29	28	29	29	29	29	29					
Medical- Ret+Family	26	24	23	23	24	24	24					
Dental- Ret Only	374	375	374	377	377	380	380					
Dental- Ret+Spouse	323	321	321	322	322	321	321					
Dental- Ret+Children	20	22	22	21	19	19	19					
Dental- Ret+Family	60	60	58	60	62	63	63					
PBM	781	782	784	781	783	784	786					

EXHIBIT B

FORT BEND COUNTY EMPLOYEE BENEFIT MEDICAL PLAN DOCUMENT

January 1, 2022

Fort Bend County, the Employer, hereby amends and restates effective August 11, 2020 the self-funded Fort Bend County Employee Benefit Medical Plan ("Medical Plan") formed under Chapter 172 of the Local Government Code. The plan provides medical and prescription drug benefits for the eligible Employees of the Employer, including Elected Officials, and their eligible Dependents.

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


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

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

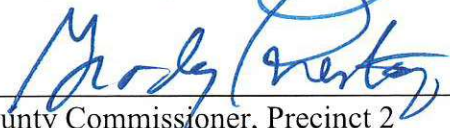
The Employer has caused this instrument to be executed by its duly authorized officers with the effective date of January 1, 2022.



County Judge




County Commissioner, Precinct 1



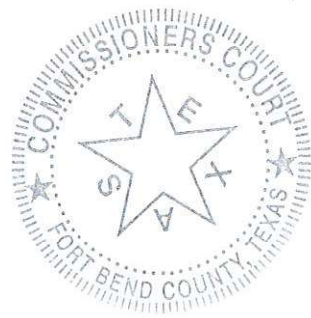
County Commissioner, Precinct 2



County Commissioner, Precinct 3



County Commissioner, Precinct 4



Approved by Commissioners Court on
14 day of December 2021

Attest:



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PLAN ADMINISTRATOR'S DISCRETIONARY AUTHORITY

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

THE MEDICAL PLAN IS A "GRANDFATHERED" PLAN

The Medical Plan believes it is a "grandfathered health plan" under the Patient Protection and Affordable Care Act ("Affordable Care Act"). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that the Medical Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator at 281-341-8630. You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

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

**ARTICLE I
SCHEDULE OF BENEFITS**

A. MEDICAL SCHEDULE OF BENEFITS

OPTION A – LOW DEDUCTIBLE / OPTION B – HIGH DEDUCTIBLE

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

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

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

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

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

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

OPTION B – HIGH DEDUCTIBLE

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

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

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

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

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

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

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

DEDUCTIBLE AMOUNT AND CARRY-OVER PROVISIONS: The applicable deductible for Plan Option A or Plan Option B will be deducted from the Eligible Expenses before benefits are computed, unless the "SCHEDULE OF BENEFITS" indicates otherwise. In the event a Participant is Hospital confined on December 31, satisfaction of a deductible for the following year shall not be applied until after the date of discharge.

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

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

If Participant incurs Eligible Expenses in October, November and December that apply toward the calendar year deductible and Participant has not incurred any Eligible Expenses or received any credit towards Participant's deductible between January and the last day of September of the same year, then any Eligible Expenses that will apply toward Participant's deductible in October, November and December will be carried over to the next year's deductible in the form of a credit. Any expenses paid by this Plan toward "Annual Health Screening Benefits / Well Care" as described in the Plan will not apply to this carry-over provision.

2. When five (5) covered family members on the Plan Option A or three (3) covered family members on the Plan Option B satisfy their individual deductibles, the deductible will be considered satisfied for all covered family members. Satisfaction of the family deductible is based on the date Eligible Expenses are incurred. The family deductible also applies when both Spouses are Fort Bend County Employees and covered by this Plan; if both Spouses are covered by different County health plan options, then the deductible from the plan with the highest number of family member deductible maximums will apply.
3. The Plan reserves the right to allocate the deductible to any Eligible Expenses and to apportion the benefits to the Participant and any assignees.
4. Any deductible movement between Plan Option A and Plan Option B after a separation of service from the County and when one Spouse continues County employment and is participating in this Plan is referenced in Article V.

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

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

	COINSURANCE PERCENTAGE PLAN PAYS	
	<u>INSIDE PPO</u>	<u>OUTSIDE PPO</u>
INPATIENT HOSPITAL EXPENSES*		
1. Average Semi-Private Room – All usual Hospital Services including blood, plasma and intensive care	80%	50%
2. Anesthesiologist Charges	80%	50%
3. Mental Health Care, Alcohol & Substance Abuse – See cost containment section for any additional limitations.		
(See Article II, section D, and Article VI)	80%	0%
<u>OTHER MEDICAL EXPENSES</u>		
1. Surgery* – Inpatient	80%	50%
2. Surgery – Outpatient* (See Article II)	80%	70%
3. Preadmission Testing – Outpatient (See Article II)	100%	70%
4. Outpatient Testing (See Article II)	80%	50%
5. Second & Third Surgical Opinions (See Article II)	100%	100%
6. All other Eligible Expenses except Outpatient Mental Health Care, Alcohol & Substance Abuse	80%	50%
7. Chiropractic Charges – Calendar Year Maximum of eighteen (18) visits and additional visits require precertification* through PrimeDx for medical necessity	80%	50%

**COINSURANCE
PERCENTAGE PLAN PAYS**

INSIDE PPO OUTSIDE PPO

8. Physical Therapy / Rehabilitation – Calendar Year Maximum of eighteen (18) visits and additional visits require precertification* for medical necessity	80%	50%
9. Elective Sterilization (Vasectomy & Tubal Ligation)	80%	50%
10. Outpatient Mental Health Care –*	80%	0%
Participant’s Copay per Office Visit	\$30.00	
Alcohol & Substance Abuse including Psychiatrist Charges and Day Treatments	80%	Not Covered

***Mental Health** benefits may be used only at PPO providers with prior approval from PrimeDx as described under the Cost Containment Provisions under Article II. Charges will not be eligible for payment if services are received at a provider Outside PPO, except as noted below for Dependents residing Outside the PPO Service Area.

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

11. Outpatient Dialysis Services*

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

Reimbursement

100% of MEC

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

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

Limitations/Requirements

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

12. Outpatient Prescription Drugs

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

13. Vision Benefit

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

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

Participants who reside within the PPO Service Area are eligible to receive the following benefits without a **medical** diagnosis as indicated below. The benefits listed below will not be subject to the **\$30.00** office copay and will be paid by the Plan at **100%**, not to exceed **\$5000** per covered person per calendar year for any one benefit or a total of all benefits listed below. These benefits may be used only once during the calendar year. Any expenses up to the **\$5000** limit cannot be used to satisfy the calendar year deductible or maximum coinsurance provisions of the Plan. Any expenses incurred at a provider Outside PPO will be the responsibility of the Participant.

Participants who reside Outside PPO Service Area (there are no PPO providers within 100 miles of your residence) will have this benefit provided by the Plan at the **70%** coinsurance level, to a maximum Plan payment of **\$5000** per person per year and will not be subject to any deductibles. Any out-of-pocket expense that you incur for this benefit cannot be used to satisfy your deductible or coinsurance provisions.

Any service listed below that is billed with a diagnosis will not be considered as an eligible benefit under the “Annual Health Screening Benefit / Well Care” benefit.

- a) Mammograms at a **Preferred Provider**, including interpretation by radiologist at a **Preferred Provider**.
- b) Pap Smear including office visit, age nineteen (19) years and older, at a **Preferred Provider**.
- c) HPV vaccine, as recommended by CDC guidelines, at a **Preferred Provider**.
- d) Bone density testing including office visit at a **Preferred Provider**.
- e) Colon Rectal and prostate screenings which include office visit, diagnostic proctoscopy, occult blood work and prostate specific antigen (P.S.A.) test at a **Preferred Provider**.
- f) Immunizations and vaccinations: the plan will pay for immunizations and vaccinations for all covered members if administered at a **Preferred Provider**, except for the purpose of international travel. In addition, these immunizations will not be subject to the calendar year benefit maximum for annual health screening benefit. Immunization charges incurred at a non-PPO Provider will be processed the same as any other non-PPO service.
- g) Annual physicals: Benefits will be limited to urinalysis, lab work, blood work, stress test, electrocardiogram and chest x-rays at a **Preferred Provider**.

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

The Participant is required to pay \$30.00 per visit toward the medical Physician's charge for an office visit,

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

All eligible Expenses incurred during an office visit, other than Physician's charges, shall be subject to the deductible and coinsurance provisions of the Plan option that you participate in, except as otherwise provided herein.

EXAMPLE – Outpatient Non-Emergency PPO Office Visit

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

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

16. Non-PPO Outpatient Office Visits (Medical)

The Participant will be required to satisfy the Outside PPO calendar year deductible of the Plan Option they participate in before expenses will be eligible for reimbursement. The Plan will pay for any eligible services performed by a non-PPO Provider at the **50%** coinsurance level.

17. Emergency Room – Preferred Provider Only

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

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

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

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

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

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

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

B. MEDICAL TOURISM BENEFIT

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

C. OUTPATIENT PRESCRIPTION DRUG SCHEDULE OF BENEFITS

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

RETAIL PHARMACY (30 Days Supply or Less Only)

Generic \$12.00*
 Preferred Brand Name \$30.00*
 Non-Preferred Brand Name \$50.00*

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

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

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

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

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

There is no copay required for syringes.

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

The Express Scripts formulary determines the pricing category of your Prescription Drug. Contact **Express Scripts at 1-866-713-7354** or visit www.express-scripts.com to determine if your Prescription Drug is listed as a Generic, Preferred Brand Name, Non-Preferred Brand or Specialty copay tier. The formularies are subject to change and it is the Participant's responsibility to verify the current Express Scripts category of their Prescription Drug.

Not all charges are eligible; see Eligible Expenses below. A person's eligibility under this coverage may be extended after the date that person ceases to be a Participant. See Retiree Participation or COBRA (Article V). The Plan is not liable for any Prescription filled after the termination of coverage under this benefit. Any benefits paid after termination will be recovered from the former Plan Participant.

The Fort Bend County Employee Benefit Plan ID card will be honored by most local pharmacies. Express Scripts will be responsible for contracting with all pharmacies that will accept the ID card. They may be contacted at 1-866-713-7354. Except as provided by the "step therapy" provisions of this Plan, Prescriptions must be filled with a generic medication *in order to be covered unless the prescribing doctor has specified "brand necessary" or "brand medically necessary." The Participant will be required to pay the difference in the price of the generic versus the brand name Prescription Drug in addition to the copay, when a brand name medication is requested due to patient preference.

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

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

A prescription drug means:

1. A medical substance that, by law, can be dispensed only by prescription;
2. A compound medication that includes a substance described in 1; or
3. Injectable insulin.

*Note: A "generic drug" is a Prescription Drug identified by its official or chemical name rather than by a brand name.

STEP THERAPY REQUIREMENT:

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

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

will consider covering the brand alternative (step 2). Some examples of these medications include, but are not limited to, Proton Pump Inhibitors (PPI), Nasal Steroids, Statin Medications, Angiotensin Receptor Blockers, Acne Oral Antibiotics, Topical Antifungals, Topical Acne Products, and Sleeping Medications. Additionally, over the counter (OTC) medications will also be covered as step 1 for PPI and Nasal Steroid classes.

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

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

ELIGIBLE PRESCRIPTION DRUG EXPENSES

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

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

PRESCRIPTION DRUG LIMITATIONS AND EXCLUSIONS

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

1. A prescription or a refill of a prescription that is more than a limit of a 30-day supply at a retail or specialty pharmacy or more than a 90-day supply through mail order;
2. A refill of a prescription that is:
 - a) In excess of the number specified by the Physician); or
 - b) Exceeds the quantity limits allowed by this Plan; (see for example: sexual dysfunction medications and contraceptives) or
 - c) Furnished more than one year after the date of the Physician's original order of the Prescription Drug;
3. Drugs for sexual dysfunction of inadequacy unless not primary diagnosis;
4. Drugs or medicines for which reimbursement is provided under any Workers Compensation law, or by any municipal, state, or federal program;
5. Medications on the Express Scripts Excluded Drug List. The list, which is subject to change, contains certain high cost medications that have older generic versions available as lower-cost alternatives and therefore are not a covered expense under the Plan. The Express Scripts Excluded Drugs list may be accessed at www.express-scripts.com or by calling 1-866-713-7354.
6. Medications requiring prior authorization without compliance with the Express Scripts prior authorization protocol.
The list of medications requiring prior authorizations (PA) list is available at www.express-scripts.com or by calling 1-866-713-7354, the list is subject to change.

7. Medicines or drugs which are lawfully obtainable without a prescription written by a licensed Physician (“over the counter” medications), including vitamins cosmetics, and dietary supplements, or drugs that have an over the counter equivalent; however insulin and prescribed prenatal vitamins are covered.
8. The administration or injection of any drug including injectable insulin;
9. Medicines or drugs prescribed for the treatment of infertility, nicotine addiction (except while participating in one of the nicotine cessation program(s) that has been approved in advance by the Plan Administrator), hair loss, or to change skin pigmentation;
10. Weight loss medications for the treatment of obesity; but not morbid obesity. The weight requirement for morbid obesity shall be defined as a minimum of 100 pounds over the normal body weight for your height, as determined by your Physician
11. Replacement of lost, stolen, or damage prescriptions;
12. Drugs or medications which are covered under Medical Benefits (Article VI);), including medical devices appliances, and supplies;
13. Any generally excluded charges shown in the Limitations and Exclusions (Article VI), even if not specifically identified above.

ARTICLE II

COST CONTAINMENT PROVISIONS

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

A. PREFERRED PROVIDER ORGANIZATIONS (PPO)

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

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

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

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

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

B. PRECERTIFICATION

Participant should call **PrimeDx** at **1-800-477-4625** to comply with the precertification provisions below. Expenses incurred while confined to a Hospital as an inpatient are subject to the precertification provisions, consisting of Preadmission Evaluation and Concurrent Review. This precertification program must be utilized on all Hospital admissions to receive maximum medical benefits. Precertification is required before being admitted to the Hospital. Non-compliance will result in a reduction of benefits.

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

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

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

C. UTILIZATION REVIEW

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

1. General Overview

“**Utilization Review**” is the review of a Hospital confinement by the Plan (through PrimeDx) prior to the date of such confinement and/or during such confinement. The purpose is to possibly avoid unnecessary Hospital confinements and/or reduce the length of some confinements without affecting the quality of treatment. PrimeDx will review the Hospital confinement with your Physician; however, in all cases the necessity of Hospital confinement and length of stay is determined by Participant and their Physician, not the Contract Administrator or the Plan. In order for PrimeDx to review a Hospital confinement with the Participant’s Physician, they must be advised of such confinement. Notification of such confinement is considered “Compliance” and will vary based on different types of confinements as described later.

Benefits under the Plan (as to percentages payable) will be more favorable if a Participant goes through the Utilization Review. If a Participant does not go through Utilization Review, benefits will be paid at the 50% coinsurance level for all Eligible Expenses incurred for that Hospital stay.

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

- a) Compliance is notifying PrimeDx: (1) ten (10) Working Days prior to a Scheduled Admission; (2) by the thirty-sixth (36th) week for pregnancy; (3) immediately prior to admission for an Urgent Admission; or (4) within forty-eight (48) hours of an Emergency Admission (seventy-two (72) hours on weekends or holidays); (5) when receiving initial dialysis treatment; (6) when receiving initial treatment for End Stage Renal Disease, (7) when receiving chemotherapy.
- b) Emergency Admission is a Hospital admission that may not be scheduled at the convenience of the Physician and the patient without endangering the patient’s bodily functions.
- c) Urgent Admission is a Hospital admission that is not an Emergency Admission, but is necessary within at least seventy-two (72) hours from the time a Physician recommends such Hospital confinement.
- d) Scheduled Admission is a Hospital admission that a Physician has recommended that is neither an Emergency nor Urgent Admission.
- e) Working Day is any day Monday through Friday, excluding national legal holidays.

3. Types of Review

- a) Preadmission Certification – Review is performed prior to a Scheduled Admission.
- b) Concurrent Review – Review is performed for Scheduled and non-Scheduled Admissions during confinement.
- c) Discharge Planning – Where Appropriate arrangements are made to facilitate the earliest possible discharge.
- d) Medical Case Management – Alternate treatment plans are developed that meet the medical needs of the

Participant and are more cost-effective than standard treatment forms.

4. Compliance Guidelines

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

- a) Scheduled Hospital Admission Including Pregnancy – The Participant or a personal representative must notify PrimeDx by telephone well before such Scheduled Admission so that the attending Physician can submit the Preadmission Certification form to PrimeDx at least ten (10) Working Days prior to Scheduled Admission. Pregnancies must have the Preadmission Certification process complete by the thirty-sixth (36th) week of pregnancy.
- b) Urgent Admission – The Participant, Physician, or a personal representative must notify PrimeDx by telephone immediately prior to actual admission.
- c) Emergency Admission – The Participant, Physician, or a personal representative must notify PrimeDx within forty-eight (48) hours of admission (seventy-two (72) hours on weekends or legal holidays).

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

D. MENTAL AND NERVOUS, ALCOHOL AND SUBSTANCE ABUSE GUIDELINES

As a Participant in the Plan, Participants are provided access to eight (8) free visits through our Employee Assistance Program (E.A.P.) for care related to mental health/substance abuse. The E.A.P. counselor will assess your needs and determine what steps need to be taken in order to help resolve your situation. Your E.A.P. provider is Deer Oaks EAP Services and they can be reached toll free at 1-866-327-2400.

Should Participant need to access the Aetna Signature Administrators PPO network of providers, the E.A.P. provider can also coordinate Participant's benefits with referral to another provider; however, Participant may only use providers with the Aetna Signature Administrators PPO network.

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

Receiving evaluation and/or outpatient treatment for services from any non-Aetna Signature Administrators PPO provider will result in a 0% benefit pay out from the Plan.

5. Acute Care Hospital Confinements (Preadmission Certification Required)

- a) Psychotic state or eminent danger – The Plan will cover Maximum Eligible Charges for a maximum of five (5) days inpatient care unless condition necessitates locked-door treatment in seclusion and/or under twenty-four (24) hour watch, in which case coverage will continue until such locked-door treatment or twenty-four (24) hour watch is no longer necessary;
- b) Detoxification – The Plan will cover Maximum Eligible Charges for inpatient care necessary to provide the treatment to restore physiologic functions disturbed by overuse and withdrawal from alcohol or other addictive drugs through the use of medication, diet, fluids, and nursing care;
- c) Adolescent Substance Abuse, behavioral, or other diagnosis – The Plan will cover Maximum Eligible Charges for a maximum of five (5) days of inpatient care for all diagnoses not listed in paragraph 1 or 2

above;

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

6. Inpatient Treatment or Therapies Requiring Precertification

- a) Psychological testing;
- b) Aversion therapy;
- c) Multiple psychotherapy sessions per day. Without precertification, the Maximum Eligible Charges for a maximum of one (1) session per day will be covered;
- d) Home therapy passes;
- e) Experimental use of medication (non-traditional) – the term experimental includes the following:
 - 1) Any drug classified as experimental;
 - 2) A non-experimental drug being used in a fashion contrary to standard medical practice in relationship to the diagnosis of the case; and
 - 3) A non-experimental drug given in a dosage level contrary to standard medical practice in relationship to the diagnosis of the case.
- f) Other inpatient approaches not listed may be Eligible Expenses pending review through precertification of the therapy types delivered and the hours per week of therapy delivered by the facility.

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

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

8. Treatment or Therapies Requiring Precertification as Outpatient Care

- a) Psychological testing;
- b) Day treatment considered Medically Necessary when outpatient treatment is not effective or programmatic treatment is necessary without the need for inpatient care;
- c) Multiple sessions per week;
- d) Necessary when used to prevent Hospitalization or re-Hospitalization;
- e) For a severe multiple problem family situation; and

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

9. Treatment or Therapies Excluded

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

10. The Attending Physician Retains Full Control Over The Medical Treatment Provided

If there is a potential conflict with the Contract Administrator of the Utilization Review, the Physician's instructions should be followed. The Contract Administrator should be contacted in all cases to ensure compliance under the Plan and the most favorable benefit schedule. Following your Physician's instructions is not a guarantee of payment by the Plan.

E. OUTPATIENT DIAGNOSTIC TESTING

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

F. PREADMISSION TESTING

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

Inpatient Surgery – The Plan will pay 100% of Eligible Expenses for Preadmission Testing by a PPO Provider or 70% of the Maximum Eligible Charges for Preadmission Testing by a non-PPO Provider. “Preadmission Testing” means diagnostic, X-ray and laboratory exams made in contemplation of and within four (4) days of a scheduled surgery, which is performed within the 48 hours following the Participant's admission to the Hospital. If for medical reasons, the scheduled Hospitalization is canceled or postponed for more than two (2) weeks, benefits would be payable for any similar diagnostic, X-ray and laboratory examinations again made in connection with and prior to the rescheduled Hospitalization. Benefits will not be paid for any duplication of the same tests after Hospital confinement.

G. WEEKEND ADMISSIONS

Non-Emergency Hospital admissions must be confined to weekdays. If a Participant is admitted to a Hospital between 12:00 noon on Friday and 12:00 noon on Sunday, no benefits will be paid for any Hospital charges incurred on these days. **This provision will NOT apply if:**

1. Surgery is performed within twenty-four (24) hours immediately following the Participant's admission to the Hospital; or
2. The Participant is admitted for an Acute Illness Not Requiring Surgery.

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

H. SECOND AND THIRD SURGICAL OPINIONS

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

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

The surgical opinion must:

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

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

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

I. OUTPATIENT SURGERY

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

1. All related Eligible Expenses for outpatient services, including lab fees, biopsies, and supplies by a Surgery Center or outpatient department of a Hospital for Eligible Expenses incurred on the day surgery is performed on a Participant;
2. Eligible Expenses related to the outpatient surgery, including anesthesiologist charges incurred at a Surgery Center, participating PPO Hospital, or other facilities in connection with an outpatient surgery; and
3. Fees by surgeons for surgery performed on an outpatient basis.

J. HOME HEALTH CARE BENEFITS

Precertification is Required – Participants are encouraged to receive care at home, when possible, rather than in a Hospital. Benefits for Home Health Care will be payable for up to **120** visits in a calendar year. Each visit by a person providing services under a Home Health Care Plan or evaluating the need for or developing a Home Health Care Plan will be viewed as one Home Health Care visit. Up to four (4) consecutive hours of home health aide service in a twenty-four (24) hour period will be eligible for payment as one Home Health Care visit. The amount paid will be **80%** Inside PPO or **50%** Outside PPO of the Maximum Eligible Charges for Home Health Care. Home Health Care must be provided in accordance with a Home Health Care Plan, once established.

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

1. Confinement in a Hospital or skilled nursing facility would be required if Home Health Care was not provided;
2. The Participant's immediate family or other Participant residing with him or her are not able to provide proper care of the Participant without undue hardship; and
3. Home Health Care will be provided or coordinated by a Home Health Care Agency.

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

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

K. HOSPICE BENEFITS

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

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

All Participants are offered assistance in a variety of areas and referrals to E.A.P. counselors. This program will assist you in obtaining mental health and substance abuse counseling. The E.A.P. counselor will assess your needs and determine what steps need to be taken in order to help resolve your situation. You are eligible to receive eight (8) free visits at a provider referred through the E.A.P. After the initial free visits, should Participants need to continue mental health/substance abuse services, the Participant should access the Aetna Signature Administrators PPO network of Physicians. **Your E.A.P. provider is Deer Oaks EAP Services and they can be reached toll free at 1-866-327-2400.**

M. ALTERNATIVE MEDICAL TOURISM BENEFIT

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

Domestic Approved Surgery Centers

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

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

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

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

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

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

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

Pre-Notification Requirement:

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

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

ARTICLE III
PLAN INFORMATION

EMPLOYER

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

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

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

PLAN NAME

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

PLAN NUMBER/IDENTIFICATION – 002949

BENEFIT YEAR – January 1 through December 31

PLAN YEAR – January 1 through December 31

CONTRACT CLAIMS ADMINISTRATOR

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

PREFERRED PROVIDER ORGANIZATIONS

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

PRECERTIFICATION/UTILIZATION REVIEW

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

**PRESCRIPTION DRUG CARD PROGRAM/
PHARMACY BENEFIT MANAGER**

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

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

EMPLOYEE ASSISTANCE PROGRAM

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

FINANCING OF THE BENEFITS PLAN

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

ARTICLE IV

DEFINITIONS

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

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

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

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

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

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

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

Concurrent Review means a process that utilizes physician-developed criteria and standards for determining the appropriateness or reimbursement for continued hospital treatment or confinement.

Continued Stay Review refers to the process whereby Health Care Review implements a study to evaluate the appropriateness of and the necessity of medical services that are rendered to a Participant. Such reviews may occur at the time of admission to an acute-care hospital facility or during confinement at such facility.

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

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

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

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

Creditable Coverage means the medical coverage that an individual had/has from any of the following sources: a group health plan, health insurance coverage, Medicare, Medicaid, medical for members and former members of the uniformed services and their dependents, a medical care program of the Indian Health Service or tribal organization, a state health benefits risk pool, certain other state-sponsored arrangements established

primarily to provide medical benefits to persons who have difficulty in obtaining affordable coverage because of a medical condition, a health plan offered under the Federal Employees Health Benefits Program, a public health plan, or a health benefit plan under the Peace Corps Act, provided the coverage did not consist solely of excepted benefits under federal law. (Shown by providing a written Certificate of Coverage from the source or entity that provided the coverage.)

Custodial Care means that type of care or service, wherever furnished and by whatever name called, which is designed primarily to assist a Participant, whether or not totally disabled, in the activities of daily living. Such activities include, but are not limited to, bathing, feeding, preparation of special diets, assistance in walking or in getting in and out of bed, and supervision over medication that can normally be self-administered.

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

Dependent means any one or more of the following:

1. The lawful Spouse of an Employee;
2. Natural children of the Employee, including legally adopted children and step-children, who have not attained age twenty-six (26);
3. Unmarried natural children of the Employee, including legally adopted children and step-children, who have attained age twenty-six (26), reside with the Employee, are principally dependent upon the Employee for support and maintenance, are incapable of self-sustaining employment due to mental or physical disability, provided such disability commenced prior to attainment of age twenty-six (26), and Dependent was covered prior to attainment of such age. Proof of dependency or mental or physical disability must be furnished by you when required by the Plan Administrator;
4. Natural child of an Employee who is subject to a current order of a court or Office of the Attorney General (OAG) to provide health benefits for such natural child, who have not attained age twenty-six (26);
5. Grandchild of the Plan Participant who is a dependent of the Plan Participant for federal income tax purposes at the time application for coverage of the child is made; who has not attained age twenty-six (26);
6. Grandchild of a Plan Participant who is a dependent of the Plan Participant for federal income tax purposes at the time application for coverage of the child is made; and who have attained age twenty-six (26), reside with the Employee, are principally dependent upon the Employee for support and maintenance, are incapable of self-sustaining employment due to mental or physical disability, provided such disability commenced prior to attainment of age twenty-six (26), and child was covered prior to attainment of such age (proof of dependency or mental or physical disability must be furnished by you when required by the Plan Administrator); or
7. Child for whom the Plan Participant must provide medical support under a court order issued under Chapter 154, Family Code, or enforceable by a court in the State of Texas, stating Employee must provide medical support for child, and child has not attained age eighteen (18) or graduated from high school, whichever occurs later.

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

Elected Official means a person who is elected to serve Fort Bend County and who by virtue of their office is entitled to participate in the County's Medical Plan. Elected Official will be included in the reference to

“Employee” within the Plan; exceptions will be noted with specific reference to Elected Official.

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

Emergency refers to a situation in which Medically Necessary health services are provided for the repair of accidental Injury, relief of acute pain, elimination of acute infection, or relief of Illness, which if not immediately diagnosed and treated, could reasonably be expected to result in physical impairment or loss of life.

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

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

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

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

Essential Health Benefits includes:

1. Ambulatory services;
2. Emergency services;
3. Hospitalization;
4. Maternity and newborn care;
5. Mental health and substance use disorder services, including behavioral treatment;
6. Prescription drugs;
7. Rehabilitative and habilitative services and devices;
8. Laboratory services;
9. Preventative and wellness services and chronic disease management; and
10. Pediatric services, including oral and vision care, as determined by the Plan Administrator in accordance with the Affordable Care Act.

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

Health Breach Notification Rule shall mean 16 CFR Part 318.

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

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

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

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

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

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

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

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

Home Health Care Agency means an entity that:

1. Is state licensed;
2. Is a Certified Rehabilitation Agency;
3. Qualifies under Medicare; and
4. Meets all of the follow:
 - a) Is mainly involved in Home Health Care delivery, including skilled nursing care;
 - b) Has a staff including at least one supervisor registered nurse (RN);
 - c) Has an administrator; and
 - d) Maintains daily health records for all patients.

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

Hospice means a licensed or certified agency that:

1. Is primarily engaged in providing counseling, medical services or room and board to terminally ill

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

Hospice Benefits include the following services provided by a Hospice:

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

“Hospice Benefits” do not include the following:

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

Hospital means a legally constituted institution which:

1. Is primarily engaged in providing diagnostic, medical and surgical facilities for the care and treatment of injured or sick persons and is compensated for such treatment;
2. Has a staff of one or more Physicians available at all times;
3. Has twenty-four (24) hour a day nursing services by Registered Nurses (RNs) or other nursing services when assumed under the complete responsibility of the Physician in charge;
4. Maintains inpatient facilities; and
5. Is licensed as a Hospital by the appropriate state agency.

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

Illness means a bodily disorder, disease, physical Sickness, mental infirmity, or functional nervous disorder of a Participant. A recurrent Illness will be considered one Illness. Concurrent Illnesses will be considered one Illness unless the concurrent Illnesses are totally unrelated. All such disorders existing simultaneously which are due to the same or related causes shall be considered one Illness.

Injury means a condition caused by accidental means, which results in damage to the Participant’s body from an external force. Any loss, which is caused by or contributed to by a hernia of any kind, will be considered a loss under the definition of Illness, and not as a loss resulting from accidental Injury.

Inside PPO means receiving eligible services from Preferred Providers.

Late Entrant means an Employee who elects to waive participation and later decides to enroll in the Plan more than thirty-one (31) days after first becoming eligible to participate in the Plan. “Late Entrant” will also include the Dependent of an Employee who is a Late Entrant and a Dependent who does not enroll in the Plan within

the first thirty-one (31) days after such Dependent is eligible to enroll. If you and/or your Dependent(s) do not enroll for benefits at the initial time you are eligible for benefits, then you and/or your Dependent(s) will be considered Late Entrants.

Maximum Eligible Charge is an amount determined at the discretion of Plan Administrator or its Contract Claims Administrator considering:

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

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

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

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

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

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

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

Medically Necessary or Medical Necessity means when a service, treatment, device, drug, or supply is necessary and appropriate for the diagnosis or active treatment of an Illness or Injury based on generally accepted medical practice.

To be Medically Necessary, Covered Expenses must:

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

To be Medically Necessary, Covered Expenses must also be provided at the most appropriate level of care or in the most appropriate type of health care facility. Only your medical condition (not the financial status or family situation, the distance from a facility or any other non-medical factor) is considered in determining which level of care or type of health care is appropriate. Medically Necessary is the criteria by which the Plan Administrator determines the necessity of medical service and treatment under this Plan.

A service, treatment, device, drug, or supply will not be considered Medically Necessary if:

1. It is provided only as a convenience to the Covered Person or provider;
2. It is not appropriate treatment for the Covered Person's diagnosis or symptoms;
3. It exceeds (in scope, duration or intensity) that level of care that is needed to provide safe, adequate and appropriate diagnosis or treatment;
4. It is part of a plan of treatment that is considered to be Investigative, Experimental or for Research Purposes in the diagnosis or treatment of an Illness or Injury. "Investigative, Experimental or for Research Purposes: means services or supplies not recognized or proven to be effective treatment of an Illness or Injury in accordance with generally accepted medical practice, based on consultation with an appropriate source; or
5. It involves the use of a drug or substance not formally approved by the United States Food & Drug Administration, even if approval is not required, or if it involves the use of a drug or substance that cannot be lawfully marketed without the approval of the Food and Drug Administration or other appropriate governmental agency, such approval not having been granted at the time of use or proposed use;
6. Is generally, commonly, and customarily regarded by experts who regularly practice in the area of treatment of the particular disease or condition in question as a drug, treatment, device, procedure, or other service whose usage should be substantially confined to research settings, as set forth in peer-reviewed scientific literature generally recognized by the relevant medical community; or
7. Is being provided pursuant to a Food and Drug Administration Phase I or Phase II clinical trial or as the experimental or research arm of a Phase III clinical trial.

The fact that any particular Physician may prescribe, order, recommend or approve a service, treatment, device, drug or supply does not, of itself, make it Medically Necessary.

The sources of information to be relied upon are:

1. The published authoritative medical or scientific literature regarding the drug, treatment, device, procedure, or other service at issue as it is applied to the particular Injury or Sickness at issue (contact the Plan Administrator for the authoritative literature used);
2. A Covered Person's medical records;
3. Protocol pursuant to which the treatments is to be delivered; or
4. Any regulations and publications set forth by any United State Federal or State governmental agency.

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

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

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

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

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

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

Physician means any professional practitioner who holds a lawful license authorizing the person to practice medicine or surgery in the locale in which the service is rendered, provided the service rendered is within the scope of that license, limited to the practitioners listed in the Texas Insurance Code, Article 3.70-2.

Physician Assistant means a health professional licensed to practice medicine in collaboration with Physicians and must graduate from an accredited Physician Assistant educational program. Physician Assistant practice is centered on patient care, but may also include educational, research, and administration activities.

Plan Administrator means Fort Bend County, who has contracted with a third party vendor for the administration of claims under this medical plan document.

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

Preexisting Condition means, as determined by the Plan Administrator, any Illness, Injury, or other condition of a Participant (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received, excluding pregnancy, and including all complications that can reasonably be determined to be related to such conditions which existed at any time during the twelve (12) months prior to your effective date of coverage under this Plan. Genetic information on a Participant will not be considered a Preexisting Condition. For services received prior to January 1, 2014, the Preexisting Condition Exclusion period may be reduced or eliminated for any enrollee nineteen (19) years old and over who has Creditable Coverage without a Significant Break in Coverage. For any enrollee further effective January 1, 2014, a Preexisting Condition will not be applied.

Preferred Provider is a health care provider who participates in the Preferred Provider Organization (PPO) adopted by this Plan.

Preferred Provider Organization (PPO) is a group of health care providers (Physicians and/or Hospitals) who, as a group or individually, agree to specified fee schedules and cost containment procedures in the delivery of health care and are named by the Plan as participating in the Plan.

Prescription Drug means:

1. A medicinal substance that, by law, can be dispensed only by prescription;
2. A compound medication that includes a substance described in (1); or
3. Injectable insulin.

*Note: A “generic drug” is a Prescription Drug identified by its official or chemical name rather than by a brand name.

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

Sickness means any physical or mental Illness, including pregnancy.

Significant Break in Coverage means, a period of sixty-three (63) consecutive days or more, during all of which an individual did not have any Creditable Coverage.

Spouse means a person to whom an Employee is lawfully married, but shall not include an individual separated from the Employee under a divorce decree. To the extent recognized by Texas law, “spouse” shall also include a common law spouse provided that the requirements for common law marriage have been met. The Employee must provide proof of a common law marriage to include but is not limited to a declaration of informal marriage filed with the County Clerk.

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

Surgery Center means a free-standing surgical facility that:

1. Meets licensing standards;
2. Is equipped and operated for general surgery;
3. Makes charges on its behalf;
4. Is directed by a staff of Physicians. A Physician must be present when surgery is performed and during the recovery period;
5. Has at least one certified anesthesiologist present when surgery which requires general or spinal anesthesia is performed and during the recovery period;
6. Extends surgical staff privileges to Physicians who practice surgery in an area Hospital and dentists who perform oral surgery;
7. Has at least two operating rooms and one recovery room;
8. Provides or arranges with a medical facility in the area for diagnostic x-ray and lab services necessary for surgery;
9. Is equipped and has a staff trained for medical emergencies, which requires:
 - a) A physician trained in cardiopulmonary resuscitation;
 - b) A defibrillator;
 - c) A tracheotomy set; and
 - d) A blood volume expander;
10. Has a written agreement with a Hospital in the area for immediate Emergency transfer of patients:
 - a) Provides an ongoing quality assurance program with review Physicians who do not own or direct the facility;
 - b) Keeps a medical record on each patient.

Surgical Technician means a technician assisting surgeons and anesthesiologists before, during, and after surgery, while working under the supervision of a registered nurse, operating room technician supervisor or Physician and must complete a one-year surgical training program.

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

Waiting Period means the first of the month following fifty-eight (58) days, which begins on the date the enrollee meets the eligibility requirements.

Well-Baby Care means medical treatment, services or supplies rendered to a Newborn or a child up to two (2) years old solely for the purpose of health maintenance and not for the treatment of an Illness or Injury.

ARTICLE V
ELIGIBILITY AND PARTICIPATION

A. EMPLOYEE PARTICIPATION

1. Waiver of Participation in this Plan

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

2. Eligibility

All Employees in a full time budgeted position, who are in Active Service at their customary place of employment on the day their health care benefits become effective, and who complete the Waiting Period, shall be eligible to participate in the Plan. Eligible Employees will be required to notify the Risk Management Department in writing or by online enrollment, complete any necessary enrollment elections within the first thirty (30) days of employment or eligibility to participate in the Plan and supply all necessary documentation as required by the Plan within the first thirty (30) days of employment or eligibility to participate in the Plan. Also, see Special Enrollment guidelines. If the requirements are not met within the time frame allowed, enrollment will be denied.

Elected Officials (other than State Eligible Elected Officials), who complete the required Waiting Period, shall be eligible to participate in the Plan. Eligible Elected Officials will be required to notify the Risk Management Department in writing, complete any necessary enrollment applications and supply all necessary documentation as required by the Plan within the first thirty (30) days of employment or eligibility to participate in the Plan. State Eligible Elected Officials that are eligible for medical benefit coverage, offered by the State of Texas, may also elect and participate in Fort Bend County medical plan; however the State plan shall be considered primary coverage. The Fort Bend County medical plan shall be Secondary coverage and will provide benefits based on Fort Bend County's schedule of benefits and will only pay for Eligible Expenses after the State plan has paid.

Elected Officials and employees in a full time budgeted position eligible for retirement through the Texas County and District Retirement System (TCDRS) and under the age of sixty-five (65) years are eligible for coverage under this Plan subject to the provisions herein.

Elected Officials and employees in a full time budgeted position eligible for retirement through the Texas County and District Retirement System (TCDRS) and age sixty-five (65) and older will be covered under the Medicare Supplement Plan (Chapter 175 of the Local Government Code). These retirees will retain, through the Fort Bend County Employee Benefit Plan, only prescription drug benefits. In the event the Medicare Supplement Plan ceases to provide medical coverage, Fort Bend County Commissioners Court will make the determination to revert the retirees' supplemental coverage back to the County Plan or to another Medicare Supplement Plan.

All other persons are excluded.

3. **Effective Date of Coverage**

Coverage will become effective for an eligible Employee on the first (1st) day of the month following completion of the Waiting Period, or if none, upon the date of eligibility (provided the Employee is in Active Service on that date, otherwise the Effective Date will be deferred until return to Active Service).

Employees with a change of status from part-time to full-time or from temporary to regular will be subject to the same Waiting Period beginning the date their status changes. Employees who previously waived their benefit participation and decide to participate at a later date may only enroll during the annual enrollment period as a Late Entrant and will be subject to the Waiting Period (which will start as of January 1st the following year). Payment of any contribution toward the cost of coverage under the Plan, if required by the Employer, must be made prior to coverage becoming effective.

Any person who is currently covered under this Plan shall not be required to satisfy a new waiting period for medical coverage if all of the following conditions are met: (1) satisfied any required waiting period; (2) has not had a lapse of coverage; (3) who assumes a full-time position (hired, appointed or elected); and (4) becomes eligible for benefits under this Plan; (5) and is not currently covered through an active employee or Fort Bend County Retiree. If the person is a spouse covered as a dependent of a deceased Employee who has a dependent child currently covered under this Plan, the eligible dependent shall not be required to satisfy a new waiting period for medical coverage if conditions (1) and (2) above are met.

4. **Termination of Coverage**

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

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

Notwithstanding the foregoing, a termination of coverage may be effective retroactively if the Employee (1) performs an act, practice or omission that constitutes fraud, (2) makes an intentional misrepresentation of material fact, or (3) fails to make a required contribution when due.

Participation may be continued for an Employee on an Employer approved leave of absence. See Article V, section H, Article IX, section D, and the Fort Bend County Employee Information Manual.

5. **Changes in Health Care Benefits** will be effective on the date the Plan is amended.

B. DEPENDENT PARTICIPATION

An Employee participating in the Plan may cover their Dependent who meets the definition of Dependent (see Article IV) and the following requirements.

1. **Required Documentation**

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

- a) **Spouse:** Certified Marriage License or Certified Informal Marriage Certificate, Social Security Number, and Spousal Eligibility Verification form including Certificate of Coverage (if applicable) for proof of enrollment in primary plan.
- b) **Natural/Adopted Child:** Certified Birth Certificate, which shows name of mother and father (mother or father must be the Employee); Certified, signed and filed, Adoption Decree or Placement for Adoption Order (parent must be the Employee), original Certified Birth Certificate and new Certified Birth Certificate with the name change, etc., with certified, signed and filed, supporting documents for changes; court order (signed by a Judge or the Attorney General) or order for support by the Attorney General, and Social Security Number.
- c) **Stepchild:** Certified Birth Certificate which shows name of mother and father, Certified Marriage License showing that Employee is legally married to Stepchild's parent and Stepchild's Social Security Number.
- d) **Grandchild:** Certified Birth Certificate; Social Security Number; and proof that the child is a dependent of the Plan Participant for federal income tax purposes at the time application for coverage of the child is made.
- e) **Court Ordered Child:** Certified Birth Certificate; Social Security Number; and Certified, signed and filed court order issued under Chapter 154, Family Code, or enforceable by a court in the State of Texas, stating Plan Participant must provide medical support for child.

2. Eligibility

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

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

Primary coverage under the Plan is not available to an Employee's Spouse who is eligible at any time for medical coverage through the Spouse's employer. However, an Employee's Spouse is eligible for secondary coverage under this Plan provided that the Employee's Spouse is enrolled in their employer's medical plan, required documents (Spousal Eligibility Verification form and Certificate of Insurance) are submitted in accordance with this Plan, and the Spouse meets all other Plan provisions.

As defined in Chapter 615 of the Local Government Code (LGC), LGC 615 Survivor(s) are eligible to continue medical coverage under this Plan at the time of the Employee's death, but not enroll as a new Participant.

Primary coverage under the Plan is not available to a Surviving Spouse of an Employee who is eligible at any time for medical coverage through the surviving Spouse's employer. However, a Surviving Spouse is eligible for secondary coverage under this Plan provided that the Surviving Spouse is enrolled in their employer's medical plan, required documents (Spousal Eligibility Verification form and Certificate of Insurance) are submitted in accordance with this Plan, and the Spouse meets all other Plan provisions.

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

the deductible and coinsurance provisions of the benefit plan option in which they will participate. Any deductible and coinsurance provisions previously met will be applied to the benefit plan option in which they will be participating. In the event that deductible credits or coinsurance credits do not satisfy the provisions of the new benefit plan option, the Dependent will be required to meet the difference between their credits and the remaining amounts necessary to meet the new deductible and coinsurance amounts. If moving from a higher deductible and coinsurance benefit plan option to a lower deductible and coinsurance benefit plan option, should deductible and coinsurance credits exceed the requirements of the new benefit plan option, the credits will be considered to have satisfied the benefit plan option requirements and paid amounts exceeding new benefit plan option's deductible and coinsurance requirements will not be considered reimbursable.

3. Changes in Dependent Health Care Benefits

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

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

4. Termination of Coverage

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

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

An Employee cannot terminate a Spouse during a separation until a divorce is final. A certified divorce decree must be submitted before any paperwork can be processed. The termination date will be the effective date the certified divorce decree was signed and dated by the Judge.

Notwithstanding the foregoing, a termination of coverage may only be effective retroactively if the Employee or Dependent (1) performs an act, practice or omission that constitutes fraud, (2) makes an intentional misrepresentation of material fact, or (3) fails to make a required contribution for coverage under the Plan when due.

C. RETIREE PARTICIPATION

3. Eligibility

Retirees eligible for retirement through the Texas County and District Retirement System (TCDRS), and their eligible Dependents, will be eligible to participate in this Plan subject to the rules established by and approved by

Fort Bend County Commissioners Court and Chapter 175 of the Local Government Code.

All eligible Retirees under the age of sixty-five (65) years will be covered under the Fort Bend County Employee Benefit Medical Plan (“Medical Plan”). Coverage under the “Medical Plan” for Employees retiring who are sixty-five (65) years or older will terminate at 11:59 p.m. on the last day of the month in which the Employee retires.

All eligible Retirees age sixty-five (65) years or older will be covered under the Medicare Supplement Plan (Chapter 175 of the Local Government Code). These Retirees will retain, through the Fort Bend County Employee Benefit Medical Plan, only prescription drug benefits. In the event the Medicare Supplement Plan ceases to provide medical coverage, Fort Bend County Commissioner Court would make the determination to revert the Retirees’ supplemental coverage back to the “Medical Plan” or to another Medicare Supplement Plan.

Rehired Retirees employed with Fort Bend County in a full-time budgeted position who are age sixty-five (65) years or older, who chose to retain retiree benefits upon becoming eligible for active benefits, and who cease to be eligible for benefits under the Medicare Supplement Plan may participate until termination of full-time employment with Fort Bend County. At that time retiree coverage will revert back to the Medicare Supplement Plan.

4. Retiree’s Dependent(s)

All Dependent Spouses, age sixty-five (65) or older, of Retirees will be covered under the Medicare Supplement Plan. These Dependent Spouses of Retirees will retain, through Fort Bend County Employee Benefit Medical Plan only Prescription Drug benefits. In the event the Medicare Supplement Plan ceases to provide medical coverage, Fort Bend County Commissioners Court would make the determination to revert the Retirees’ Dependent Spouse’s supplemental coverage back to the County Plan or to another Medicare Supplement Plan. In the event of the Retiree’s death, the Dependent Spouse may elect to continue the Medicare Supplement Plan, and the Fort Bend County Employee Benefit Medical Plan Prescription Drug benefits will terminate.

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

Primary coverage under the Plan is not available to a Retiree’s Spouse who is eligible at any time for medical coverage through the Spouse’s employer. However, a Retiree’s Spouse is eligible for secondary coverage under this Plan provided that the Retiree’s Spouse is enrolled in their employer’s medical plan, required documents (Spousal Eligibility Verification form and Certificate of Insurance) are submitted in accordance with this Plan, and the Spouse meets all other Plan provisions.

5. Changes in Retiree’s Dependent Health Care Benefits

Retiree and Dependent(s), under the age of sixty-five (65) years, must be covered under the same benefit plan option.

All Dependents other than a Dependent Spouse, age sixty-five (65) or older, of a Retiree are ineligible to participate in the Medicare Supplement Plan or Fort Bend County Employee Benefit Medical Plan.

If prior to, or within thirty-one (31) days after the attainment of the specified age whereby participation would otherwise terminate for a Dependent Child and the Contract Administrator has received due proof such child is mentally or physically incapacitated such that they are incapable of earning their own living and is dependent upon the Retiree for their support, participation up to the age of sixty-five (65) years will continue so long as the incapacity continues and the Plan remains in full force and effect. The Plan has the right to periodically require that the Retiree show proof of the incapacity of the Dependent as determined by the Plan Administrator.

6. Termination of Coverage

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

- a) The date the Retiree's coverage terminates;
- b) The Retiree fails to remit required contributions for Dependent Health Care Benefits when due, Dependent's benefits will terminate at the end of the period for which contribution is made;
- c) The date on which the Dependent ceases to be an eligible Dependent as defined by the Plan;
- d) The date on which the Dependent Spouse satisfies the benefit Waiting Period, after Dependent Spouse is hired or status changes to a benefit eligible position as an Employee of Fort Bend County;
- e) The last day of the month in which the Dependent Child, who is no longer eligible due to age, attains the age of twenty-six (26);
- f) The date on which the Plan is terminated or amended, resulting in the Dependent's loss of coverage;
- g) The date of the Dependent's death; or
- h) The date on which the Retiree or Dependent falsifies information provided to the Plan, fraudulently or deceptively uses Plan services, or knowingly permits such fraud or deception by another person.

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

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

Notwithstanding the foregoing, a termination of coverage may only be effective retroactively if the Retiree or Dependent (1) performs an act, practice or omission that constitutes fraud, (2) makes an intentional misrepresentation of material fact, or (3) fails to make a required contribution for coverage under the Plan when due.

D. ANNUAL ENROLLMENT

Eligible Employees and their Eligible Dependent(s) may enroll for coverage during an Annual Enrollment period. Coverage for Eligible Employees and their Eligible Dependent(s) enrolling during an Annual Enrollment period will become effective January 1 of the following Plan Year, unless the Employee and/or Dependent(s) had a break in coverage or after declining an earlier opportunity to enroll and subsequently are enrolling for the first time, in which event the Employee and/or Dependent(s) will be subject to the enrollment requirements during Annual Enrollment and must also satisfy the Waiting Period, which begins January 1 of the following Plan Year and benefits will be effective April 1 (the first of the month following the waiting period) of the following Plan Year. If an Eligible Employee has not yet begun work for the Employer, the Employee and their Eligible Dependent(s) are subject to the enrollment requirements and the Waiting Period, in which event coverage will become effective on the first of the month following completion of the Waiting Period if actively at work on that date, or on the first of the month following the day the Employee actually begins work. "Annual Enrollment period" shall mean a specific period during the month of October in each Plan Year. If an Eligible Employee is on Leave of Absence at the time of the Annual Enrollment period and continuously continues to monthly pay Plan Participant contributions timely with no break in coverage, they may re-enroll during the Annual Enrollment period for the following Plan Year. If an Employee on Leave of Absence has a break in coverage, they may not re-enroll during the Annual Enrollment period, but may re-enroll as a Late Entrant within thirty (30) days from the date the Employee actually returns to work, in which event coverage will become effective on the first of the month following completion of the Waiting Period if actively at work on that date and enrollment requirements were met, or on the first of the month following the day the Employee actually begins

work.

E. SPECIAL ENROLLMENT (Eligible Employee not currently enrolled in the Plan.)

Except as otherwise required by law, if an Eligible Employee does not enroll for coverage for the Employee and/or the Employee's Eligible Dependents within thirty (30) days of becoming eligible for coverage and subsequently wishes to elect such coverage, in appropriate circumstances the Employee may do so under the Plan's special enrollment rules.

An Eligible Employee may enroll for coverage for the Employee and all Eligible Dependents at any time provided that:

1. The Employee is eligible for coverage under the Plan, but is not currently enrolled; and
2. The Employee declined coverage under the Plan when it was offered previously and gave the existence of alternative health coverage as the reason for not enrolling on the Employee's enrollment form; and
3. The alternative coverage has terminated.

A completed enrollment form must be submitted by the Employee within thirty (30) days after the loss of the alternative health coverage for the following:

1. COBRA continuation coverage has been exhausted; or
2. Loss of eligibility for the alternative coverage (for reasons other than the individual's failure to pay premiums or for cause); or
3. The termination of employer contributions toward the cost of coverage.

A completed enrollment form must be submitted by the Employee within the sixty (60) days after the loss of the alternative health coverage for the following:

1. Termination of Medicaid or Children's Health Insurance Coverage (CHIP) due to loss of eligibility; or
2. Employee or dependents become eligible for a premium assistance subsidy under Medicaid or CHIP and the employee requests coverage under the Plan

Enrollment in the Plan will be effective the first day of the first calendar month beginning after the date on which the Plan receives the completed enrollment form.

In addition, an Eligible Employee may enroll for coverage for the Employee and all Eligible Dependents at any time provided that:

1. The Employee is eligible for coverage under the Plan, but is not currently enrolled; and
2. The Employee declined coverage under the Plan when it was offered previously; and
3. Another individual (a spouse or child) has become an Eligible Dependent of the Employee through marriage, birth, adoption, or placement for adoption. In this case, the Employee must submit a completed enrollment form and required documentation within thirty-one (31) days of the marriage, birth, adoption or placement for adoption. Enrollment in the Plan will be effective on the date (1) of the Employee's marriage; (2) of the new Dependent's birth; or (3) of the new Dependent's adoption or placement for adoption with the Employee.

F. LATE ENTRANTS / FAMILY STATUS CHANGE / DEPENDENT DELETION

All Late Entrants are required to satisfy the waiting period (fifty-eight (58) days). If approved as a new Participant in the Plan, the earliest date that a Late Entrant's coverage may take effect will be the first day of the month following fifty-eight (58) days after the Late Entrant's waiting period begins. The Plan reserves the right to approve or deny any Late Entrant applicant. If additional information is received by the Plan after the Late Entrant's acceptance that would disqualify the Late Entrant from coverage, the Plan will have the right to

terminate coverage back to the original effective date and the Employer will refund any contribution that was already made towards said coverage. The Employee will be responsible for paying all claims paid by the Plan on behalf of the ineligible person.

Mid-Year Late Entrants – Participants who do not participate in the Section 125 Plan may add eligible Dependents mid-year with a Family Status Change. All new Participants will be considered Late Entrants and must fulfill the requirements as stated above. The fifty-eight (58) days waiting period for the Late Entrant will begin on the date Risk Management receives all required documentation.

Annual Enrollment Late Entrants – An Employee may enroll eligible Dependent(s) during the annual enrollment period without a Family Status Change. All new Participants will be considered Late Entrants and must fulfill the requirements as stated above. The fifty-eight (58) days waiting period for the Late Entrant will begin on January 1st of the following year. Required documents must be submitted by the deadline, which will be set for each annual enrollment period.

Family Status Change – An Employee who participates in the Section 125 Plan may add eligible Dependent(s) mid-year only if there is a qualified Family Status Change and the Participant has all required documentation turned into Risk Management within thirty-one (31) days of the Family Status Change event. Qualified Family Status Changes for adding an eligible Dependent include, but are not limited to, marriage, birth, adoption, or placement for adoption as specified by Section 125 of the Internal Revenue Code. In the event of birth, adoption, placement for adoption, court ordered child or Office of the Attorney General (OAG) order, benefits for the eligible Dependents will be effective on the date of the Family Status Change (date of birth; date court order is signed for adoption, placement for adoption, or court ordered child; date ordered by OAG) and Plan Participant contributions will be due beginning on that date, which may be retroactive. In the event of a dependent's loss of medical coverage at their place of employment, Employee may submit a completed enrollment form and required documents prior to the dependent's loss of medical coverage, making the coverage effective the date following the other coverage termination date. If the Employee submits the enrollment form and required documents after the loss of coverage but before the end of the thirty-one (31) day notification requirement, the coverage effective date would be the first of the month after receipt of the documentation. All Family Status Changes, with the exception of birth, adoption, placement for adoption, court ordered child or OAG order, are effective the first day of the following month after meeting all Plan provisions and contributions may not be collected retroactive.

Dependent Deletion – An Employee must delete a Dependent that is no longer eligible to remain on the Plan at the time they become ineligible. Dependents who are not eligible are those who are (1) children twenty-six (26) years of age or older and who are not eligible for coverage due to a mental or physical disability and (2) ex- Spouses and ex-step-children. In the case of divorce, a certified divorce decree is required before the Plan will terminate the Dependents no longer eligible. If a spouse is eligible at any time for their employer's medical plan, but does not enroll, the spouse will no longer be eligible to participate in this Plan and coverage will be terminated. If additional information is received by the Plan that would disqualify the dependent from coverage, the Plan will have the right to terminate coverage back to the original effective date and the Employer will refund any contribution that was already made towards said coverage. The Employee/Retiree/LGC 615 Survivor will be responsible for paying all claims paid by the Plan on behalf of the ineligible person.

It is the Employee's responsibility to notify Risk Management of a Dependent who is no longer eligible and complete the proper form(s). Notification is subject to COBRA notification requirements. Verbal notification is unacceptable. The Plan will refund Plan Participant contributions paid after effective date and prior to the submission and receipt in Risk Management of the proper forms within required time frames of the life event. In addition, the Employee will be responsible for paying all claims paid by the plan on behalf of the ineligible person.

Special Enrollment Periods in Compliance with the Patient Protection and Affordable Care Act ("PPACA")

Notwithstanding any provision of the Plan to the contrary, the Plan will permit an eligible Employee or eligible Dependent to elect to enroll in the Plan if the following conditions is met:

1. A Dependent child terminated coverage, was denied coverage or was not eligible for coverage under the Plan because, under the terms of the Plan, the availability of Dependent coverage of children ended before the attainment of age twenty-six (26) and the Dependent child is now eligible for coverage under the Plan effective as of January 1, 2011.

If an eligible Employee or eligible Dependent satisfies either (1) or (2), as applicable, the eligible Employee or eligible Dependent will be given an opportunity to enroll in the Plan that starts on the later of (a) the date the eligible Employee or eligible Dependent satisfies (1) or (2) above or (b) the first day of the annual enrollment period for the 2011 Plan Year and, in either case, continues for thirty (30) days after such start date. This opportunity will be provided beginning not later than January 1, 2011 and coverage will be effective not later than January 1, 2011.

Any eligible Employee or eligible Dependent enrolling in the Plan in accordance with PPACA must be treated as if the eligible Employee or eligible Dependent were a special enrollee, as provided under HIPAA's portability provisions. Accordingly, the eligible Employee or eligible Dependent (and the eligible Employee through whom the eligible Dependent is otherwise eligible for coverage under the Plan) must be offered all the benefit plan options available to similarly situated individuals who did not lose coverage as described in (1) or (2) above. The eligible Employee or eligible Dependent also cannot be required to pay more for coverage than similarly situated individuals who did not lose coverage as described in (1) or (2) above.

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

1. Continuation of Coverage

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

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

2. Notice Requirements – Employer/Employee

- a) When eligibility for continuation results from a Covered Person's death, termination, reduction in working hours, or entitlement to Medicare, the Covered Person or Dependent will notify the Employer of that event. Notice must be given to Risk Management within thirty (30) days of the Covered Person's death, termination, reduction of working hours, or entitlement to Medicare.
- b) When eligibility for continuation results from a covered Spouse being divorced from a Covered Person (Employee) or a Dependent child's attainment of the maximum age for coverage under the Plan, the covered person or Dependent must notify the Employer of that event within sixty (60) days of the event.
- c) Within thirty (30) days of receiving notice, the Employer will notify the COBRA administrator of

the termination of coverage. Within fourteen (14) days of receiving the notice from the Employer, the COBRA administrator will mail the covered person information regarding their right to continue benefits.

- d) After receiving that notice, the Covered Person or Dependent has sixty (60) days in which to decide whether to elect continued benefits. These sixty (60) days begins on the later of:
 - 1. The date coverage under the Plan would otherwise end; or
 - 2. The date the person receives notice from the Employer of their rights under the law.If the Covered Person or Dependent chooses to have continued benefits, they must advise the Employer in writing of this decision. The Employer must receive this written notice before the end of sixty (60) days.
- e) Within forty-five (45) days after the date of the Covered Person or Dependent notifies the Employer that they have chosen to continue medical insurance, the Participant must pay the first premium. The first payment will be the amount needed to provide coverage from the date continued benefits begin to the date that the first payment is made. Thereafter, premiums for the continued benefits are to be paid monthly on the day of each month stated by the Employer.
- f) A Covered Person's Dependent must pay the premium for a coverage being continued.

3. Length of Continuation

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

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

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

Federal law allows a non-federal governmental self-funded plan (such as the Fort Bend County Employee Benefit Medical Plan for Employees of Fort Bend County, Texas) to exempt its Plan in whole or in part from these requirements: (1) Standards relating to mothers and Newborns, (2) parity in the application of certain limits to mental health benefits, and (3) required coverage for reconstructive surgery following mastectomies.

Fort Bend County has requested that the entire Fort Bend County Employee Benefit Plan be exempt under 42 U.S.C. §300gg-21.

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

1. HIPAA Privacy Rule

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

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

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

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

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

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

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

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

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

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

The Plan Sponsor will not use or further disclose members’ Protected Health Information other than as

described in the Plan Documents and permitted by the “504” provisions.

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

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

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

Notify participants of any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor, or any Business Associate of the Plan Sponsor becomes aware, in accordance with the Health Breach Notification Rule (16 CFR Part 318).

Notify the Federal Trade Commission of any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor, or any Business Associate of the Plan Sponsor becomes aware, in accordance with the Health Breach Notification Rule (16 CFR Part 318).

Obtain authorization prior to the sale of any PHI.

“Plan Administration” activities are limited to activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend or terminate the Plan or solicit bids from prospective issuers. “Plan Administration” functions include quality assurance, claims processing, auditing, monitoring and management of care-out plans, such as vision and dental. It does not include any employment-related functions or functions in connection with any other benefit or benefit plans.

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

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

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

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

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

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

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

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

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

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

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

7. Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage

The Plan Sponsor hereby authorizes and directs the Plan, through the Plan Administrator or the third party administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters (“MGUs”) for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the privacy standards.

8. Required separation between the Plan and the Plan Sponsor

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

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

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

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

9. Security Standards

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

Electronic Protected Health Information as follows:

- a) Plan Sponsor shall implement administrative, physical, and technical safeguards that reasonable and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information that Plan Sponsor creates, received, maintains, or transmits on behalf of the Plan;
- b) Plan Sponsor shall ensure that the adequate separation that is required by 45 C.F.R. §164.504(f)(2)(iii) of the HIPAA Privacy Rule is supported by reasonable and appropriate security measures;
- c) Plan Sponsor shall ensure that any agent, including a subcontractor, to whom it provides Electronic Protected Health Information agrees to implement reasonable and appropriate security measures to protect such information; and
- d) Plan Sponsor shall report to the Plan any Security Incidents of which it becomes aware as described below:
 - 1) Plan Sponsor shall report to the Plan within a reasonable time after Plan Sponsor becomes aware, any Security Incident that results in unauthorized access, use, disclosure, modification, or destruction of the Plan's Electronic Protected Health Information; and
 - 2) Plan Sponsor shall report to the Plan any other Security Incident on an aggregate basis every month, or more frequently upon the Plan's request.
 - 3) Notify participants of any PHI Security Incident of which the Plan Sponsor, or any Business Associate of the Plan Sponsor becomes aware, in accordance with the Health Breach Notification Rule (16 CFR Part 318); and
 - 4) Notify the Federal Trade Commission of any PHI Security Incident of which the Plan Sponsor or any Business Associate of the Plan Sponsor becomes aware, in accordance with the Health Breach Notification Rule (16DFR Part 318).

I. DUAL COVERAGE PRECLUDED

No person will be covered under the Plan simultaneously:

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

J. UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT

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

1. An Employee who is not at work because of a period of duty in the Uniformed Services (as defined in USERRA), may, at the Employee's election, continue coverage under the Plan during the period of absence, so long as the Employee satisfies the necessary provisions and makes any required Participant contribution as provided under USERRA.
2. The maximum period of coverage for an Employee, an Employee's Spouse and/or Dependent(s), if any, under the Plan during a period of duty in the Uniformed Services will be governed by the applicable limitation and provisions contained in USERRA unless more generous limitations are provided under the Employer's leave of absence policy.
3. An Employee who elects to continue coverage under the Plan will pay:
 - a) The Employee's share, if any, for coverage under the Plan if the Employee performs service in the Uniformed Services for up to thirty-one (31) days; or
 - b) One hundred-two percent (102%) of the full premium or cost under the Plan (determined in the same manner as the applicable COBRA continuation coverage premium under Section 4980B (f)(4) of the

Code) if the employee performs service in the Uniformed Services for thirty-one (31) days or more.

4. During the period of service in the Uniformed Services, the Employee may pay the necessary costs associated with coverage under the Plan, if any, by:
 - a) Remitting payment to the Employer monthly for which the Participant contributions would have been deducted from the Employee's paycheck had the Employee not been absent serving in the Uniformed Services, provided that any delinquent payments must be made within thirty (30) days after their due date (premiums are due on the first day of the month);
 - b) At the Employee's request, prepaying the amounts that will become due during the period of service in the Uniformed Services out of one or more of the Employee's paychecks preceding such period of service in the Uniformed Services; or
 - c) Pre-approved arrangement with the Plan Administrator and in accordance with administrative policies adopted by the Plan Administrator wherein the Employer pays the Employee's Participant contributions during the Employee's period of service in the Uniformed Services. Upon return from such service, the Employee will reimburse the Employer for such previous payments.

Any Employee who is a Participant, who is not at work because of service in the Uniformed Services and who returns to active employment within the relevant time period determined under USERRA, will be eligible to return to work and immediately participate in the same benefit options and coverage level for dependents under the Plan which the Participant had elected to participate in prior to serving in the Uniformed Services, subject to any changes in the Plan that affect the workforce as a whole, provided that the Participant returns to employment with the same benefit eligibility status that he held prior to serving in the Uniformed Services, and provided further, that the Participant makes all required elections to participate in the Plan on a timely basis. Except to the extent provided in administrative policies adopted by the Plan Administrator (or the Employer, if applicable), the maximum period of health care coverage available to a Participant (and his Dependents) while on a USERRA leave of absence will end on the earlier of (1) the last day of the maximum coverage period prescribed under USERRA (or if required by USERRA's discrimination rules, the last day of the longest period that the Employer's leave of absence policy permits Plan coverage to continue) or (2) the day after the date upon which the person fails to apply for a return to a position of employment within the time required under Section 4312(a) of USERRA. For purposes of determining eligibility for health benefits (and only if the Participant pays the full amount which the Employer is permitted to charge the Participant for health coverage under USERRA), a Participant who experiences a reduction in hours or termination of employment solely due to a USERRA leave will continue to be considered qualified as a Participant under the Plan until the earliest date that the termination of their health benefits is permitted under USERRA.

ARTICLE VI MEDICAL BENEFITS

A. ELIGIBLE EXPENSES

The following are considered eligible for reimbursement under the Health Care Benefits Plan unless they are specifically excluded under the Schedule of Benefits. These Eligible Expenses are limited to the Medically Necessary and Maximum Eligible Charges incurred as a result of accidental Injury or Sickness. An expense will be considered to be incurred at the time the service or the supply is provided. All Eligible Expenses must be incurred for the treatment of an accidental Injury or Sickness. The following are considered Eligible Expenses.

1. The Hospital's charge for an average semi-private room;
2. Intensive Care Unit or Coronary Care Unit charges when deemed Medically Necessary and recommended by a Physician;
3. Miscellaneous Hospital services and supplies directly related to the Sickness or Injury causing the Hospital confinement;
4. Administration of Anesthesia – fees charged by a Physician or Certified Registered Nurse Anesthetist (C.R.N.A.) for administration or anesthetics;
5. Local Ambulance service, including air ambulance to and from the Hospital provided that it is Medically Necessary;
6. Fees charges by a Physician or a Physician Assistant for medical care or specified treatment of an accidental Injury or Sickness;
7. Charges for a birthing center and the Medically Necessary supplies used there during a patient's stay;
8. Preadmission diagnostic testing performed within four (4) days of Hospital confinement for use during Hospitalization;
9. Charges by a PPO Hospital or PPO alcohol dependency treatment center which provides a program for the treatment of alcohol dependency pursuant to a written treatment plan approved and monitored by a Physician and which facility is also:
 - a) Affiliated with a Hospital under a contractual agreement with an established system for patient referral; or
 - b) Accredited as such a facility by the Joint Commission on Accreditation of Hospitals; or
 - c) Licensed as an alcohol treatment program by the Texas Commission on Alcoholism; or
 - d) Licensed, certified, or approved as an alcohol dependency treatment program or center by any other state agency having legal authority to so license, certify or approve.
10. Fees charged by a Surgeon, Assistant Surgeon or Surgical Technician for surgical procedures. Assistant Surgeon's fees will be eligible if the procedure required an Assistant Surgeon or the facility where the surgery was performed requires an Assistant Surgeon. Assistant Surgeon fees will be limited to a maximum payment of twenty-five percent (25%) of the eligible, Medically Necessary and Reasonable or Maximum Eligible Charges of the Surgeon as determined by the plan or twenty-five percent (25%) of the negotiated discounted fee of a Preferred Provider Physician.
11. Services of an Outpatient Surgical Facility;

12. Professional Nursing Services – fees charged for professional services by a Registered Nurse (RN), Licensed Vocational Nurse (LVN) or a Licensed Practical Nurse (LPN), excluding services by one who is a member of the patient’s immediate family provided that;
- a) The services are ones which can be performed for compensation only by a person holding an RN license, LVN license, or other license requiring a higher level of medical skill and training;
 - b) The level of skill of an RN or LVN is Medically Necessary;
 - c) The charges are only for the portion of time for which such level of skill is medically required; and
 - d) Provided treatment is recommended by the attending Physician.

Examples of private-duty nursing services not covered are those simply for the convenience of the patient or patient’s family or those consisting primarily of such acts as bathing, feeding, mobilizing, exercising, homemaking, giving medication, or acting as a companion or sitter.

13. Physiotherapy rendered by a physiotherapist other than one whom ordinarily resides in the patient’s home or who is a member of the patient’s immediate family, provided such treatment is recommended by the attending Physician;
14. Diagnostic procedures, radiology, oxygen, and blood transfusions to the extent blood charges are not reduced by blood donations;
15. Artificial limbs, artificial eyes, trusses, braces and crutches including replacement when required because of pathological change but not repair or maintenance. Replacement of any of the aforementioned artificial devices shall be limited to one replacement every five (5) years for adults. Dependent children’s prosthetic replacements will be determined by their Physician and the Plan, but not to exceed one replacement for a pathological change every two years;
16. Rental of iron lung, Tens Unit, and other similar durable therapeutic medical equipment (which can be used only for the diagnosed medical condition and only by the person for whom it is prescribed) or the purchase cost when it is more reasonable than to cover the cost of rental of the equipment;
17. Room and board and normal nursing care provided by an extended care facility if:
- a) After being in a Hospital for three (3) consecutive days or more, and with fourteen (14) consecutive days of termination of that confinement a Participant becomes confined in the Extended Care Facility; and
 - b) The attending Physician certifies twenty-four (24) hour nursing care is necessary for recuperation from the Injury or Sickness, which required the Hospital Confinement;
 - c) Is approved by and is a participating Extended Care Facility of Medicare; and
 - d) Has organized facilities for medical treatment and provides twenty-four (24) hour nursing service under the full-time supervision of a Physician or Registered Graduate Nurse; and
 - e) Maintains daily clinical records on each patient and has available the services of a Physician under an established agreement; and
 - f) Provides Appropriate methods of dispensing and administering drugs and medicine; and
 - g) Has transfer arrangements with one or more Hospitals, a utilization review plan in effect and operational policies developed with the advice of, and reviewed by, a professional group including at least one Physician; and
 - h) Not to exceed the Daily Room Rate for Extended Care shown in the Schedule of Benefits for each day of such confinement, in lieu of any other payment under this benefit. Payment will continue for a Maximum Period of Payment for Extended Care, as set forth in the Schedule of Benefits, but only so long as the attending Physician certifies such confinement remains necessary for recuperation; and the facility is licensed pursuant to state and local laws and is operated primarily for the purpose of providing skilled nursing care and treatment for individuals convalescing from Injury or Sickness; and

- i) Excluding any institution, which is other than incidentally a rest home, a home for the aged, or a place for the treatment of mental disease, substance abuse or alcoholism.
18. Services provided by a legally qualified Physician or qualified speech therapist for restoration of speech or rehabilitative speech therapy for speech loss or impairment due to an Illness or accident, other than a functional nervous disorder. If the speech loss or impairment is due to a congenital anomaly, surgery to correct the anomaly must have been performed prior to the therapy;
19. Home Health Care provided by a Home Health Care Agency upon the order of the Physician when services can be provided at home as an alternative to a Hospital confinement with the exception of meals, personal comfort items, and housekeeping service;
20. Dental treatment, except *orthodontia and *periodontia expenses, which result from necessary services for the correction of damage to sound, natural teeth caused by accidental Injury which occurred while the Participant was covered by the Plan and treatment is begun or recommended within six (6) months of the accidental Injury, or the surgical removal of bony impacted wisdom teeth. *Orthodontia and Periodontia treatment, which results from Medically Necessary services for the correction of Mandibular Hyperplasia with Malocclusion will have a Plan benefit limit of \$15,000.00 per lifetime per Participant including any related medical procedures or surgical procedures (such limit will not apply to pediatric services);
21. Legal drugs and medicine, including the following contraceptives: oral, injectable, implant and transdermal patches, intravaginal rings, and emergency contraceptive (the early removal of implanted contraceptives is only covered subject to medical necessity) for the purposes of birth control and obtainable only on a Physician's written prescription. Outpatient Prescription Drugs must be purchased with your Prescription Drug card. No reimbursement will be made for outpatient Prescription Drugs submitted to this benefit Plan;
22. Contraceptive devices, such as intrauterine device (IUD).
23. Eligible medical expenses incurred for treatment while confined to a Hospice for the physical and emotional needs of terminally ill patients;
24. Benefits for Eligible Medical Expenses incurred will be payable according to the Schedule of Benefits in effect on the day the expenses are incurred;
25. The Plan will pay for routine nursery care (Well-Baby Care) at the time of delivery.
26. Routine immunizations are covered, except when for the purpose of international travel.
27. The Plan will pay for the purchase of a nebulizer up to the maximum purchase price of **\$100.00**. The Participant will be required to pay a copay of **\$30.00** and the Plan will pay the balance at **100%**. This will be subject to proof of medical necessity as approved by the contract claims administrator;
28. Eligible conditions for mental Illness under this Plan shall be defined by the latest edition of the International Classification of Diseases (ICD-9) Codes. Eligible mental Illness conditions shall begin at 290 through and including 319 of the ICD-9 Code Book;
29. Observation Room Services:
- a) Observation services are defined as the use of a bed and periodic monitoring and/or short term treatment by a hospital's nursing or other staff. These services are considered reasonable and necessary to evaluate a patient's condition to determine the need for possible inpatient admission. Observation care provides a method of evaluation and treatment as an alternative to inpatient hospitalization. The services may be considered eligible for coverage only when provided under a physician's order or under the order of another person who is authorized by state statute and the hospital's by laws to admit patients and order outpatient testing. The observation services must be patient specific and not part of a standard

- operating procedure or facility protocol for a given diagnosis or service.
- b) In order for an observation stay (a period not to exceed 48 hours) to be considered medically necessary, the following conditions must be met:
- 1) The patient is clinically unstable for discharge; **AND**
 - 2) Clinical monitoring, and/or laboratory, radiologic, or other testing is necessary in order to assess the patient's need for hospitalization; **OR**
 - 3) The treatment plan is not established or based upon the patient's conditions, is anticipated to be completed within a period not to exceed 48 hours; **OR**
 - 4) Change in status or condition are anticipated and immediate medical intervention may be required.
- c) Observation room services are not covered when the above criteria are not met. Observation services that extend beyond a 48 hour period are not covered. Providers must contact Boon Chapman and obtain approval for inpatient status for services beyond the initial 48 hour period.
- d) The following is a list of services that are not considered appropriate for observation room services (this list is not all inclusive):
- 1) Service are not reasonable or necessary for the diagnosis and treatment of the patient
 - 2) Outpatient blood or chemotherapy administration
 - 3) Lack of/delay in patient transportation
 - 4) When used as a substitute for inpatient admission or services would normally require inpatient stay
 - 5) When it is provided only as a convenience for the physician, patient or patient's family
 - 6) While waiting for transfer to another facility
 - 7) When inpatients discharged to observation status
30. The treatment of temporomandibular joint dysfunction or TMJ syndrome will be limited to \$1,000.00 per lifetime per Participant, unless such treatment is considered an essential health benefit under the Affordable Care Act because it is rehabilitative, habilitative or pediatric oral care.
31. Services and supplies provided in connection with human organ or tissue transplant procedures (including high dose chemotherapy, bone marrow or stem cell transplants for the treatment of cancer), subject to the following conditions:
- a) A second opinion must be obtained prior to undergoing the transplant procedure. This mandatory second opinion must concur with the attending Physician's finding that this procedure is Medically Necessary. The Physician rendering this second opinion must be qualified to render such a service either through experience, specialist training or education, or such similar criteria, and must not be affiliated in any way with the Physician who will be performing the actual surgery;
 - b) If the donor is covered under this Plan, eligible medical expenses incurred by the donor will be considered for benefits only if the recipient is a Participant under this Plan;
 - c) When recipient is covered by this Plan, eligible medical expenses incurred by the recipient will be considered for benefits. Expenses incurred by the donor who is not ordinarily covered under this Plan according to Participant eligibility requirements will not be considered Eligible Expenses;
 - d) Benefits will be provided only when the Hospital and Physician customarily charge a transplant recipient for such care and services;
 - e) Eligible Non-PPO charges for services and supplies in connection with human organ or tissue transplant procedures will never be paid by the Plan at **100%**;
 - f) Benefits payable will be subject to all Plan provisions and limited to the maximum as stated in the schedule of benefits;
 - g) No benefits will be payable for the purchase, storage, or transportation of any organ to be used for transplant.
32. A Participant will be paid **50%** of any amount that the Participant can identify as an error on the Participant's Hospital bill up to a maximum payment of **\$1,000.00** per calendar year.

B. LIMITATIONS AND EXCLUSIONS

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

1. In excess of the Maximum Eligible Charges, as determined by the Plan;
2. Resulting from Sickness covered by a Workers' Compensation Act or similar law;
3. Resulting from accidental Injury arising out of or in the course of employment for wages or profit;
4. Resulting from war, declared or undeclared, any act of war, or any type of military conflict;
5. Resulting from any intentionally self-inflicted Injury whether sane or insane. However, with respect to any Injury which is otherwise covered by the Plan, the Plan will not deny benefits otherwise provided for treatment of the Injury if the Injury results from an act of domestic violence or a medical condition (including both physical and mental health conditions);
6. For services furnished by a Hospital or facility operated by the United States Government or any authorized agency of the United States Government, or furnished at the expense of such government or agency, with the exception of a V.A. Hospital;
7. For eye refractions or eye examinations for the correction of vision or fitting of glasses or contact lenses, furnishing or replacement of glasses or contact lenses;
8. For routine hearing examinations in which there is no medical diagnosis requiring the examination, (except screening test for hearing loss from birth through the date that a child is 30 days of age or for necessary diagnostic follow up care related to the screening test from birth through the date a child is 24 months of age; testing and follow up deductible will be waived but coinsurance will still apply), or the furnishing of hearing aids beyond the limits in the Schedule of Benefits;
9. For dental treatment, except as cited in Article VI, A;
10. For treatment to the feet resulting from bursitis, tendonitis, tarsalgia, metatarsalgia, weak, unstable or flat feet, bunions, corns and calluses, unless an open cutting operation is performed; or for treatment of toenails, unless at least part of the nail root or matrix is removed, or purchase of orthopedic shoes or other orthotic devices for support of the feet unless an open cutting operation is performed. The initial office visit, including x-rays, for the purposes of diagnosis will be allowed;
11. For Cosmetic Procedures, unless required because of an accidental Injury;
12. For the diagnosis or treatment of mental, nervous, or emotional disorders, including drug and alcohol related disorders whether as an outpatient or as an inpatient; beyond the limits in the Schedule of Benefits subject to the definition of mental illness in Article IV;
13. For health check-ups, routine physical examinations beyond the limits specified in the Schedule of Benefits, or nutritional supplements not Medically Necessary for the treatment of an Injury or Illness;
14. Resulting from care or treatment not reasonably necessary for the care and treatment of Sickness or accidental Injury;
15. For any expenses incurred for mandibular or maxillofacial surgery due to growth defects, jaw disproportions or appliances or restorations used solely to increase vertical dimension, reconstruct occlusion except when these conditions are in a direct result of an accident up to a maximum benefit of \$1,000.00 per lifetime of the Participant (Article IV) for the treatment of temporomandibular joint dysfunction or TMJ syndrome, but such maximum will not apply if such treatment is considered an essential health benefit under the Affordable Care Act because it is rehabilitative, habilitative or pediatric oral care.

16. Housekeeping or Custodial Care;
17. Charges for orthognatic disorders, except Orthodontia and Periodontia treatment, which results from Medically Necessary services for the correction of Mandibular Hyperplasis with Malocclusion, including any related medical procedures or surgical procedures;
18. Illness or Injury caused by, or contributed to, engagement in an illegal occupation or commissions or attempt to commit a felony;
19. Enrollment in a health, athletic, or similar club or nicotine cessation or similar program (except participation in one of the nicotine cessation programs that have been approved in advance by the Plan Administrator);
20. Purchased or rented supplies of common use such as exercise cycles, air purifies, air conditioners, water purifiers, hypoallergenic pillows or mattresses, or waterbeds or convenience items;
21. Purchase or rental of motorized transportation equipment, escalators or elevators, saunas, steam baths, swimming pools, hot tubs, blood pressure kits, blood sugar test machines (except syringes, test strips, and lancets);
22. In vitro fertilization, artificial insemination, surgical reversal of elective sterilization, and fertility drugs
23. Vitamins (except prenatal vitamins prescribed by a doctor) or dietary supplements, minerals, any drugs that can be purchased without a written prescription;
24. Sex transformation, or the treatment of or for trans-sexual purposes;
25. Treatment for sexual dysfunctions of inadequacy, which includes implants, pumps and related hormones and/or drug therapy. Expenses for drug therapy may be considered eligible under this Plan when sexual dysfunction of inadequacy is not the primary diagnosis;
26. Treatment of obesity; but not morbid obesity. In addition to other medical requirements determined by the Contract Claims Administrator and the pre-certification company, the weight requirement for morbid obesity shall be defined as a minimum of 100 pounds over your normal body weight as determined by your physician. Surgical procedures and all associated costs will be limited to one procedure per covered participant under this medical plan.
27. Recreational or educational therapy, vocational therapy or non-medical self-care or self-help training;
28. Radial keratotomy or keratoplasty;
29. Chelation therapy;
30. Experimental procedures, see definition of Medical Necessity;
31. For an elective or therapeutic abortion unless such abortion is necessary due to an acute life-threatening condition with respect to a pregnant Covered Employee, Covered Spouse, or Dependent;
32. Charges that are not Medically Necessary for services, supplies or treatments not recognized by the American Medical Association as generally accepted and Medically Necessary for the diagnosis and/or treatment of an active Illness or Injury; or charges for procedures, surgical or otherwise, which are specifically listed by the American Medical Association as having no medical value;
33. Charges for services rendered by a Physician, nurse, or licensed therapist if such Physician, nurse, or licensed therapist is a Close Relative of the Participant.
34. Charges incurred outside the United States if the Participant traveled to such a location for the sole purpose

- of obtaining medical services, drugs or supplies;
35. Charges for Physician fees for any treatment, which is not rendered by or in the physical presence of a Physician;
 36. Charges for replacement of a lost, missing, or stolen prosthetic device;
 37. Treatment of eating disorders; beyond the limits in the Schedule of Benefits subject to the definition of mental illness in Article IV;
 38. Charges incurred as a result of or in connection with diagnosis or treatment of a learning disability or learning impairment by any name called, including but not limited to autism, mental retardation or behavioral problems. This exclusion includes, but is not limited to, charges for initial testing; room and board by a Remedial Clinic; remedial education or training. Educational Therapy (including multisensory teaching techniques); periodic achievement tests; tutoring; rental or purchase of books, tools, equipment, implements, or supplies of any kind; travel; recreational activities; beyond the limits in the Schedule of Benefits subject to the definition of mental illness in Article IV. Attention deficit disorder is considered a learning disorder and is not covered except for medication as covered under "Outpatient Prescription Drugs" or for medical examinations to measure Appropriateness of medications;
 39. For any charges in connection with growth hormone deficiencies, including diagnosis and treatment, unless this condition is incurred by a dependent child under the age of 18;
 40. Charges for the purchase, storage or transportation of organs that is being used for transplant purposes;
 41. Charges or expenses incurred for massage therapy or acupuncture;
 42. For any elective surgery that is not Medically Necessary, except for eligible elective sterilization as specified in this Plan;
 43. For any services or charges made in connection with a mental and nervous condition, substance abuse or alcoholism; beyond the limits in the Schedule of Benefits subject to the definition of mental illness in Article IV;
 44. Weight loss programs beyond the limits in the Article VI, B;
 45. Sleep disorders unless there is medical diagnosis. If there is not a sleep apnea or other medical diagnosis after the testing, only the office visit and the testing for diagnosis on an outpatient basis will be considered Eligible Expense.
 46. Adult immunizations other than what are listed in the Schedule of Benefits under Section A. Annual Health Screening/Well Care/PPO Providers Only;
 47. For wigs, unless hair loss is due to radiation or chemotherapy with a diagnosis of cancer;
 48. Breast prosthesis, breast implants, tram flap surgery or bras unless a Medically Necessary mastectomy was performed. No more than two (2) bra replacements per year.

ARTICLE VII
COORDINATION OF BENEFITS / SUBROGATION

A. COORDINATION OF BENEFITS

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

1. Applicability

- a) This Coordination of Benefits (“COB”) provision applies to This Plan when an Employee or the Employee’s covered Dependent has health care coverage under more than one Plan. “Plan” and “This Plan” are defined below.
- b) If this COB provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of This Plan area determined before or after those of another Plan. The benefits of This Plan:
 - 1) Shall not be reduced when, under the order of benefit determination rule, This Plan determines its benefits before another plan; but
 - 2) May be reduced when under the order of benefit determination rules, another Plan determines its benefits first. The above reduction is described in Article VII, “Effect on Benefits” of This Plan.

2. Definitions

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

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

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

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

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

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

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

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

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

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

- a) **General** - When there is a basis for a claim under This Plan and another Plan, This Plan is a Secondary Plan, which has, its benefits determined after those of the other Plan, unless:
1. The other Plan has rules coordinating its benefits with those of this Plan; and
 2. Both those rules and this Plan's rules, subparagraph b) below, require that This Plan's benefits be determined before those of the other Plan.

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

- b) **Rules** – This Plan determines its order of benefits using the first of the following rules which applies:
1. For **State Eligible Elected Officials** and any eligible dependents, The Fort Bend County Plan will determine County benefits after the benefits of their state offered plan.
 2. **Non-Dependent/Dependent** - The benefits of the Plan which covers the person as an Employee, member or subscriber (that is, other than as a Dependent) are determined before those of the Plan which covers the person as a Dependent.
 3. **Dependent Child/Parents Not Separated or Divorced** - Except as stated in section (3) below, when This Plan and another Plan cover the same child as a Dependent of different persons, called "parents":
 - a) The benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in that year; but
 - b) If both parents have the same birthday, the benefits of the Plan, which covered the parent longer, are determined before those of the Plan, which covered the other parent for a shorter period of time.
 4. **Dependent Child/Separated or Divorced Parents** - If two or more Plans cover a person as a Dependent child of divorced or separated parents, benefits for the child are determined in this order:
 - a) First, the Plan of the parent with custody of the child;
 - b) Then, the Plan of the Spouse of the parent with custody of the child; and
 - c) Finally, the Plan of the parent not having custody of the child.

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

which any benefits are actually paid or provided before the entity has that actual knowledge.

5. **Active/Inactive Employee** - The benefits of a Plan, which covers a person as an Employee who is neither laid off nor retired (or as that Employee's Dependent) are determined before those of a Plan, which covers that person as a laid off or retired Employee (or as that Employee's Dependent). If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule "b)" is ignored.
6. **Longer/Shorter Length of Coverage** - If none of the above rules determines the order of benefits, the benefits of the Plan which covered an Employee, member or subscriber longer are determined before those of the Plan which covered that person for the shorter period of time.

4. Effect on Benefits

- a) **When This Section Applies** - This section 4 applies when, in accordance with section 3, "Order of Benefit Determination Rules", this Plan is a Secondary Plan as to one or more other Plans. In that event, the benefits of This Plan may be reduced under this section. Such other Plan or Plans are referred to as "the other Plans" in b) immediately below.
- b) **Reduction in This Plan's Benefits** - The benefits of this Plan will be reduced when the sum of:
 1. The benefits that would be payable for the Allowable Expenses under this Plan in the absence of this COB provision; and
 2. The benefits that would be payable for the Allowable Expenses under the other Plans, in absence of a provision with a purpose like that of this COB provision, whether or not claim is made;
 3. Exceed those Allowable Expenses in a Claim Determination Period. In that case, the benefits of this Plan will be reduced so that they and the benefits payable under the other plans do not total more than those Allowable Expenses.
- c) **Medicare Coordination of Benefits** -
 1. If you are age sixty-five (65) or over and a full time Employee of Fort Bend County, This Plan will be the primary payer. If your Dependent Spouse is sixty-five (65) or over and covered under your Plan while you are a full time Employee, this Plan will be the primary payer; and
 2. For all other Participants who are eligible to be covered under Medicare or disability Medicare, the benefits payable by the plan for Eligible Expenses will be reduced by the amount for which such persons are eligible for comparable benefits under Full Medicare Coverage. This Plan will assume that any person age sixty-five (65) and over will have full Medicare coverage (Part A, Part B, or Part C if elected, and any other optional coverage offered by Medicare). The benefits of this Plan would be reduced after Medicare has paid. In the event you have not chosen the optional coverage offered by Medicare, this Plan would still assume and pay eligible benefits as if full Medicare coverage had already been applied.

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

5. Right to Receive and Release Necessary Information

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

6. Facility of Payment

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

7. Right of Recovery

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

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

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

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

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

B. SUBROGATION AND REIMBURSEMENT

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

1. Benefits Subject to this Provision

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

- a) “Recovery” means any and all monies and property paid by a Third Party to (i) the Participant, (ii) the Participant’s attorney, assign, legal representative, or Beneficiary, (iii) a trust of which the Participant is a beneficiary, or (iv) any other person or entity on behalf of the Participant, by way of judgment, settlement, compromise or otherwise (no matter how those monies or property may be characterized, designated or allocated and irrespective of whether a finding of fault is made as to the Third Party) to

compensate for any losses or damages caused by, resulting from, or in connection with, the injury or illness.

- b) “Reimbursement” means repayment to the Plan for medical or other benefits that it has paid to or on behalf of the Participant toward care and treatment of the injury or illness and for the expenses incurred by the Plan in collecting this amount, including the Plan’s equitable rights to recovery.
- c) “Subrogation” means the Plan’s right to pursue the Participant’s claims against a Third Party for any or all medical or other benefits or charges paid by the Plan.
- d) “Third Party” will include the party or parties who caused the injury or illness; the insurer, guarantor or other indemnifier or indemnitor of the party or parties who caused the injury or illness; a Participant’s own insurer, such as an uninsured, underinsured, medical payments, no fault, homeowner’s, renter’s or any other liability insurer; a workers’ compensation insurer; and any other individual or entity that is or may be liable or legally or equitably responsible for Reimbursement or payment in connection with the injury or illness.

2. When this Provision Applies

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

Furthermore, the Plan will have a right of first and primary Reimbursement enforceable by an equitable lien against any Recovery paid by the Third Party. The equitable lien will be equal to one hundred percent (100%) of the amount of benefits paid by the plan for the Participant’s injury or illness and expenses incurred by the Plan in enforcing the provisions of this section B (including, without limitation, attorneys’ fees and costs of suit, and without regard to the outcome of such an action), regardless of whether or not the participant has been made whole by the Third Party. This equitable lien will attach to the Recovery regardless of whether (a) the Participant receives the Recovery or (b) the Participant’s attorney, a trust of which the Participant is a beneficiary, or other person or entity receives the Recovery on behalf of the Participant.

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

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

In addition to the foregoing, the Participant:

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

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

When a right of Recovery exists, and as a condition to any payment by the Plan (including payment of future benefits for the same or other illnesses or injuries), the Participant will execute and deliver all required instruments and papers, including any S&R Agreement provided by the Plan, as well as doing and providing whatever else is needed, to secure the Plan's rights of Subrogation and Reimbursement, before any medical or other benefits will be paid by the Plan for the injury or illness. The Plan may file a copy of an S&R Agreement signed by the Participant and his attorney (and if applicable, signed by the parent or guardian on behalf of the covered Dependent) with such other entities, or the Plan may notify any other parties of the existence of Plan's equitable lien; provided, the Plan's rights will not be diminished if it fails to do so.

To the extent the Plan requires execution of an S&R Agreement by a Participant (and his attorney, as applicable), a Participant's claim for any medical or other benefits for any injury or illness will be incomplete until an executed S&R Agreement is submitted to the Plan Administrator. Such S&R Agreement must be submitted to the Plan Administrator within the time frame applicable to the particular type of benefits claimed by the Participant, as specified in the Plan's claims procedures. Any failure to timely submit the required S&R Agreement in accordance with the Plan's claims procedures will constitute the basis for denial of the Participant's claim for benefits for the injury or illness, and will be subject to the Plan's claims appeal procedures. The Plan Administrator may determine, in its sole discretion, that it is in the Plan's best interests to pay medical or other benefits for the injury or illness before an S&R Agreement and other papers are signed and actions taken (for example, to obtain a prompt payment discount); however, in that event, any payment by the Plan of such benefits prior to or without obtaining a signed S&R Agreement or other papers will not operate as a waiver of any of the Plan's Subrogation and Reimbursement rights and the Plan still will be entitled to Subrogation and Reimbursement. In addition, the Participant will do nothing to prejudice the Plan's right to Subrogation and Reimbursement, and hereby acknowledges that participation in the Plan precludes operation of the "made whole" and "common fund" doctrines. A Participant who receives any Recovery as an absolute obligation to immediately tender the Recovery (to the extent of 100% of the amount of benefits paid by the Plan for the Participant's injury or illness and expenses incurred by the Plan in enforcing the provisions of this section B, including attorneys' fees and costs of suit, regardless of an action's outcome) to the Plan under the terms of this section B. A Participant who receives any such Recovery and does not immediately tender the Recovery to the plan will be deemed to hold such Recovery in constructive trust for the Plan because the Participant is not the rightful owner of such Recovery to the extent the Plan has not been fully reimbursed. By participating in the Plan, or receiving benefits under the Plan, the Participant automatically agrees, without further notice, to all the terms and conditions of this section B, and any S&R Agreement.

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

3. Amount Subject to Subrogation or Reimbursement

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

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

In certain circumstances, a Participant may receive a Recovery that includes amounts intended to be compensation for past and/or future expenses for treatment of the illness or injury that is the subject of the Recovery. The Plan will not cover any expenses for which compensation was provided through a previous Recovery. This exclusion will apply to the full extent of such Recovery or the amount of the expenses submitted to the Plan for payment, whichever is less. Participation in the Plan also precludes operation of the "made whole" and "common fund" doctrines in applying the provisions of this section B.

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

5. When a Participant Retains an Attorney

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

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

Any Recovery paid to the Participant's attorney will be subject to the Plan's equitable lien, and thus an attorney who receives any Recovery has an absolute obligation to immediately tender the Recovery (to the extent of 100% of the amount paid by the Plan for the Participant's injury or illness and expenses incurred by the Plan in enforcing the provisions of this section B, including attorneys' fees and costs of suit regardless of an action's outcome) to the Plan under the terms of this section B. A Participant's attorney who receives any

such Recovery and does not immediately tender the recovery to the Plan will be deemed to hold the Recovery in constructive trust for the Plan because neither the Participant nor his attorney is the rightful owner of the Recovery to the extent the Plan has not received full Reimbursement.

6. When a Participant Does Not Comply

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

ARTICLE VIII CLAIMS PROCEDURES

A. HOW TO FILE A CLAIM

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

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

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

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

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

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

B. PAYMENT OF BENEFITS

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

C. NOTICE OF CLAIM

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

D. CLAIM FORMS

The Plan upon receipt of such notice will furnish to the Employee such forms as are usually furnished by it for

filing proofs of loss. If such forms are not so furnished within thirty (30) days after the receipt of such notice, the Employee shall be deemed to have complied with the requirements of the Plan as to proof of loss, upon submitting, within the time fixed in the Plan for filing proofs of loss, written proof covering the occurrence, character and extent of the loss of which claim is made.

E. PROOF OF LOSS

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

F. TIME OF PAYMENT OF CLAIM

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

G. PHYSICAL EXAMINATIONS

The Contract Administrator acting on behalf of the Plan shall have the right and opportunity to examine the person of the Employee or Dependent when and as often as it may be reasonably required during the pendency of claim hereunder. The Plan may also request or require an autopsy in the case of a death when law does not forbid it.

H. PRESENTING CLAIMS FOR BENEFITS

If Participant thinks they are eligible for a benefit described in this Plan, Participant must file a claim. Forms required for filing proof of loss for claims are available at Risk Management or can be found at the EConnect website <http://econnect.co.fort-bend.tx.us/>, under Departments, Risk Management, and Forms. Completed forms must be filed with the Contract Claims Administrator at least annually.

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

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

I. REQUESTING A REVIEW OF CLAIMS DENIED

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

If Participant has not received a response from the Contract Claims Administrator regarding the claim within ninety (90) days of filing the claim or if the claim has been denied, Participant can send a written appeal to the Contract Claims Administrator for a review of the denied claim(s). Participant has sixty-one (61) days to appeal from the time a participant is notified of a denial.

Those reviewing the Participant's claim have to act within sixty (60) days of receiving Participant's request. However, in special cases, they may be allowed one hundred-twenty (120) days. The final decision will be sent to the Participant in writing, together with an explanation of how the decision was made. If the Participant is

not satisfied with the result of the Participant's appeal, Participant may file a suit and serve process on The Fort Bend County Employee Benefit Medical Plan.

Appointment of Authorized Representative – A Claimant is permitted to appoint an authorized representative to act on his behalf with respect to a benefit claim or appeal of a denial. An assignment of benefits by a Claimant to a provider will not constitute appointment of that provider as an authorized representative. To appoint such a representative, the Claimant must complete a form, which can be obtained from the Plan Administrator or the Contract Administrator. In the event a Claimant designates an authorized representative, all future communications from the Plan will be with the representative, rather than the Claimant, unless the Claimant directs the Plan Administrator, in writing, to the contrary.

J. LEGAL ACTIONS

No actions at law or in equity shall be brought to recover on the Plan prior to the expiration of sixty (60) days after proof of loss has been filed in accordance with the requirements of the Plan, nor shall such action be brought at all unless brought within three (3) years from the expiration of the time within which proof of loss is required by the Plan. A Participant may not bring an action at law or equity until ninety (90) days after all claims appeal procedures have been exhausted.

K. THIRD PARTY LIABILITY

If a Participant has medical charges:

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

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

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

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

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

ARTICLE IX GENERAL PROVISIONS

A. INTERPRETATION OF THE PLAN

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

B. AMENDMENT AND TERMINATION OF THE PLAN

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

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

C. CHOICE OF PHYSICIANS

An Employee or covered Dependent will have the choice of any Physician. The Physician-patient relationship will not be disturbed in any way.

D. LEAVE OF ABSENCE

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

E. ASSIGNMENT OF BENEFITS

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

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

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

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

F. PROTECTION AGAINST CREDITORS

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

G. RATE REDUCTION

An Employee who voluntarily participates in a health risk assessment which includes biometric testing (“HRA”) will be eligible for a rate reduction in the next Plan year if the assessment (HRA) and screening are completed by October 31. Written confirmation, which does not include personal health information, from a medical provider must be received in Risk Management by October 31 of each year in order to be eligible for the rate reduction in the following Plan Year. Dependents are not eligible to participate in the rate reduction. HRA’s and biometric screenings are available at no cost to employees at the Fort Bend County Employee Health and Wellness Center; however the HRA and biometric screening may be performed by a medical provider of the Employee’s choice subject to the Plan’s provisions.

Notice of Non-Discrimination

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

Fort Bend County:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages
- If you need these services, contact Director of Human Resources or their designee

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

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

U.S. Department of Health and Human

Services 200 Independence Avenue, SW

Room 509F, HHH

Building Washington,

D.C. 20201

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

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

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

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

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

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

مقررہ اتصل . ناجملا بر فاوتت لکلا تمیوغللا ءدعاسملا تامدخ نإف، ءمغللا ت دحتت رکذا تنک اذإ : طوحلمة 1-xxx-xxx-xxxx مقرر

مکبلاو مصلا اهتف 281-341-8617

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

281-341-8617

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

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

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

1-xxx-xxx-xxxx) पर कॉल करें।

281-341-8617

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

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

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

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

281-341-8617

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

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

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EXHIBIT C

FORT BEND COUNTY EMPLOYEE BENEFIT DENTAL PLAN DOCUMENT

JANUARY 1, 2022

Fort Bend County, the Employer, hereby amends and restates effective January 1, 2022 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, 2022.

K. George

County Judge

[Signature]

County Commissioner, Precinct 1

[Signature]

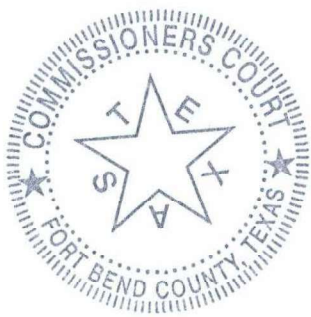
County Commissioner, Precinct 2

[Signature]

County Commissioner, Precinct 3

[Signature]

County Commissioner, Precinct 4



Approved by Commissioners Court on
December 14, 2021

Attest:
[Signature]

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

FINANCING OF THE BENEFITS PLAN

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

ARTICLE IV **DEFINITIONS**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Dependent means any one or more of the following:

1. The lawful Spouse of an Employee;
2. Unmarried natural children of the Employee under the age of twenty-five (25), including legally adopted children and step-children;
3. Unmarried natural children of the Employee, including legally adopted children and step-children, who have attained age twenty-five (25), 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 twenty-five (25), and Dependent was covered prior to attainment of such age. Proof of dependency or mental or physical disability must be furnished by you when required by the Plan Administrator;
4. 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;
5. Unmarried Grandchild of the Plan Participant who is a dependent of the Plan Participant for federal income tax purposes at the time application for coverage of the child is made; up to the age of twenty-five (25);
6. Unmarried Grandchild of a Plan Participant who is a dependent of the Plan Participant for federal income tax purposes at the time application for coverage of the child is made; and who have attained age twenty-five (25), reside with the Employee, are principally dependent upon the Employee for support and maintenance, are incapable of self-sustaining employment due to mental or physical disability, provided such disability commenced prior to attainment of age twenty-five (25), and child was covered prior to attainment of such age (proof of dependency or mental or physical disability must be furnished by you when required by the Plan Administrator); or
7. Child for whom the Plan Participant must provide medical support under a court order issued under Chapter 154, Family Code, or enforceable by a court in the State of Texas, stating Employee must provide dental support for child, and child has not attained age eighteen (18) or graduated from high school, whichever occurs later; and is unmarried.

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

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

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

contractor by reporting payments for the person's services on IRS Form 1099 (or its successor), regardless of whether any agency (governmental or otherwise) or court concludes that the person is, or was, a common law employee of the Employer even if such determination has a retroactive effect.

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

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

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

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 58 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 58 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 thirty (30) 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 thirty (30) days of employment or eligibility to participate in the Plan.

All other persons are excluded.

3. Effective Date of Coverage

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

4. Termination of Coverage

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

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

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

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

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

B. DEPENDENT PARTICIPATION

An Employee participating in the Plan may cover their Dependent who meets the definition of Dependent (see Article IV) and the following requirements.

1. Required Documentation for Proof of Dependent

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

- a) **Spouse:** Certified Marriage License or Certified Informal Marriage Certificate, and Social Security Number.
- b) **Natural/Adopted Child:** Certified Birth Certificate, which shows name of mother and father (mother or father must be the Employee); Certified, signed and filed, Adoption Decree (parent must be the Employee), original Certified Birth Certificate and new Certified Birth Certificate with the name change, etc., with certified, signed and filed, supporting documents for changes; court order (signed by a Judge or the Attorney General) or order for support by the Attorney General for the State of Texas; Social Security Number.
- c) **Stepchild:** Certified, signed and filed Divorce Decree stating the individual responsible for Dependent dental coverage; Certified Birth Certificate which shows name of mother and father, Certified Marriage License showing that Employee is legally married to Stepchild's parent; Stepchild's Social Security Number.
- d) **Grandchild:** Certified Birth Certificate; Social Security Number; and proof the child is a dependent of the Plan Participant for federal income tax purposes at the time application for coverage of the child is made.
- e) **Court Ordered Child:** Certified Birth Certificate; Social Security Number; and Certified, signed and filed court order issued under Chapter 154, Family Code, or enforceable by a court in the State of Texas, stating Plan Participant must provide dental support for child.

2. Eligibility

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

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

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

The Risk Management Department must be notified in writing of Eligible Dependents, complete any necessary enrollment applications and supply all necessary documentation as required by the Plan within the first thirty (30) 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 fifty-eight (58) 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 fifty-eight (58) days after the Late Entrant's waiting period begins. The Plan reserves the right to approve or deny any Late Entrant applicant. If additional information is received by the Plan after the Late Entrant's acceptance that would disqualify the Late Entrant from coverage, the Plan will have the right to terminate coverage back to the original effective date and the Employer will refund any contribution that was already made towards said coverage. The Employee will be responsible for paying all claims paid by the Plan on behalf of the ineligible person.

Mid-Year Late Entrants – Participants who do not participate in the Section 125 Plan may add eligible Dependents mid-year with a Family Status Change. All new Participants will be considered Late Entrants and must fulfill the requirements as stated above. The fifty-eight (58) 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 fifty-eight (58) 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. .

Family Status Change – An Employee who participates in the Section 125 Plan may add eligible Dependent(s) mid-year only if there is a qualified Family Status Change and the Participant has all required documentation turned into Risk Management within thirty-one (31) days of the Family Status Change event. Qualified Family Status Changes for adding an eligible Dependent include, but are not limited to, marriage, birth, adoption, or a change in a Spouse or Dependent’s employment status as specified by Section 125 of the Internal Revenue Code.

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

In the event of a change in a Spouse’s or Dependent’s employment, all new Participants will be considered Late Entrants and must fulfill the requirements as stated above. The fifty-eight (58) 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 twenty-five (25) years of age or older (2) ex-Spouses and ex-step-children, . In the case of divorce, a certified divorce decree is required before the Plan will terminate the Dependents no longer eligible.

It is the Employee’s responsibility to notify Risk Management of a Dependent who is no longer eligible and complete the proper form(s). Notification is subject to COBRA notification requirements. Verbal notification is unacceptable. The Plan will refund Plan Participant contributions paid after effective date and prior to the submission and receipt in Risk Management of the proper forms within required time frames of the life event. In addition, the Employee will be responsible for paying all claims paid by the Plan on behalf of the Dependent during the ineligible period.

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

1. Continuation of Coverage

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

- a) Covered Dependents of a Covered Person who dies.
- b) A covered Person and their Covered Dependents upon the Covered Person’s termination of employment (other than termination for gross misconduct), or whose work hours have been reduced to less than the minimum required for coverage under the Plan.

- c) A Covered Dependent Spouse upon divorce from the Covered Person.
- d) A Covered Dependent child loses coverage due to attainment of the maximum age to which Dependents may be covered under this Plan.

2. Notice Requirements – Employer/Employee

- a) When eligibility for continuation results from a Covered Person's death, termination, reduction in working hours, or entitlement to Medicare, the Covered Person or Dependent will notify the Employer of that event. Notice must be given to Risk Management within thirty (30) days of the Covered Person's death, termination, reduction of working hours, or entitlement to Medicare.
- b) When eligibility for continuation results from a covered Spouse being divorced from a Covered Person (Employee) or a Dependent child's marriage or attainment of the maximum age for coverage under the Plan, the covered person or Dependent must notify the Employer of that event within sixty (60) days of the event.
- c) Within thirty (30) days of receiving notice, the Employer will notify the COBRA administrator of the termination of coverage. Within fourteen (14) days of receiving the notice from the Employer, the COBRA administrator will mail the covered person information regarding their right to continue benefits.
- d) After receiving that notice, the Covered Person or Dependent has sixty (60) days in which to decide whether to elect continued benefits. These sixty (60) days begins on the later of:
 - 1) The date coverage under the Plan would otherwise end; or
 - 2) The date the person receives notice from the Employer of their rights under the law.If the Covered Person or Dependent chooses to have continued benefits, they must advise the Employer in writing of this decision. The Employer must receive this written notice before the end of sixty (60) days.
- e) Within forty-five (45) days after the date of the Covered Person or Dependent notifies the Employer that they have chosen to continue dental insurance, the first premium must 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 are determined before or after those of another Plan. The benefits of This Plan:
 - 1) Shall not be reduced when, under the order of benefit determination rule, This Plan determines its benefits before another plan; but
 - 2) May be reduced when under the order of benefit determination rules, another Plan determines its benefits first. The above reduction is described in Article V, #4, “Effect on Benefits” of This Plan.

2. Definitions

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

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

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

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

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

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

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

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

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

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

- a) General - When there is a basis for a claim under This Plan and another Plan, This Plan is a Secondary Plan, which has, its benefits determined after those of the other Plan, unless:
1. The other Plan has rules coordinating its benefits with those of this Plan; and
 2. Both those rules and This Plan's rules, subparagraph b) below, require that This Plan's benefits be determined before those of the other Plan.
- b) Rules – This Plan determines its order of benefits using the first of the following rules which applies:
1. Non-Dependent/Dependent the benefits of the Plan which covers the person as an Employee, member or subscriber (that is, other than as a Dependent) are determined before those of the Plan which covers the person as a Dependent.
 2. Dependent Child/Parents Not Separated or Divorced except as stated in section (3) below, when This Plan and another Plan cover the same child as a Dependent of different persons, called "parents":
 - a) The benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in that year; but
 - b) If both parents have the same birthday, the benefits of the Plan, which covered the parent longer, are determined before those of the Plan, which covered the other parent for a shorter period of time.
 3. Dependent Child/Separated or Divorced Parents if two or more Plans cover a person as a Dependent child of divorced or separated parents, benefits for the child are determined in this order:
 - a) First, the Plan of the parent with custody of the child;
 - b) Then, the Plan of the Spouse of the parent with custody of the child; and
 - c) Finally, the Plan of the parent not having custody of the child.
 - d) Active/Inactive Employee-The benefits of a Plan, which covers a person as an Employee who is neither laid off nor retired (or as that Employee's Dependent) are determined before those of a Plan, which covers that person as a laid off or retired Employee (or as that Employee's Dependent). If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule "d)" is ignored.

- e) Longer/Shorter Length of Coverage if none of the above rules determines the order of benefits, the benefits of the Plan which covered an Employee, member or subscriber longer are determined before those of the Plan which covered that person for the shorter period of time.

4. Effect on Benefits

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

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

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

5. Right to Receive and Release Necessary Information

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

6. Facility of Payment

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

7. Right of Recovery

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

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

and deliver to the Plan all assignments and other documents necessary or useful to the Plan Administrator for the purpose of enforcing its' rights under this provision.

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

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

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

B. SUBROGATION AND REIMBURSEMENT

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

1. Benefits Subject to this Provision

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

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

2. When this Provision Applies

A Participant may incur medical or other charges related to any injury or illness caused by the act or omission of a Third Party. Consequently, such Third Party May be liable or legally or equitably responsible, for payment of charges incurred in connection with the injury or illness. If so, the Participant may have a claim against

that Third Party for payment of the medical or other charges. In that event, the Plan will be secondary payer, not primary, and the Plan will be Subrogated to all rights the Participant may have against that Third Party.

Furthermore, the Plan will have a right of first and primary Reimbursement enforceable by an equitable lien against any Recovery paid by the Third Party. The equitable lien will be equal to one hundred percent (100%) of the amount of benefits paid by the plan for the Participant's injury or illness and expenses incurred by the Plan in enforcing the provisions of this Section B (including, without limitation, attorneys' fees and costs of suit, and without regard to the outcome of such an action), regardless of whether or not the participant has been made whole by the Third Party. This equitable lien will attach to the Recovery regardless of whether (a) the Participant receives the Recovery or (b) the Participant's attorney, a trust of which the Participant is a beneficiary, or other person or entity receives the Recovery on behalf of the Participant.

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

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

In addition to the foregoing, the Participant:

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

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

When a right of Recovery exists, and as a condition to any payment by the Plan (including payment of future benefits for the same or other illnesses or injuries), the Participant will execute 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.

EXHIBIT D

CAFETERIA PLAN
PREMIUM REDUCTION OPTION *PLUS*
FLEXIBLE SPENDING ACCOUNTS

PLAN DOCUMENT

AS ADOPTED BY
FORT BEND COUNTY

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Section 125 Cafeteria Plan

1. INTRODUCTION

1.1 PURPOSE OF PLAN

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

2. DEFINITIONS

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

2.1 ADMINISTRATOR

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

2.2 AFFILIATED EMPLOYER

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

2.3 ANNIVERSARY DATE

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

2.4 BENEFIT ELECTION FORM

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

2.5 BENEFIT PACKAGE OPTION(S)

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

2.6 CHANGE IN STATUS

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

2.7 CLAIM SUBMISSION GRACE PERIOD

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

2.8 CLOSING PERIOD

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

2.9 CODE

The Internal Revenue Code as amended from time to time.

2.10 COMMISSIONERS COURT

Commissioners Court

2.11 COMPANY

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

2.12 COMPENSATION

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

- (a) any salary deferral elections made under Code Sec. 401(k), 403(b), 408(k) or 457 (if any) plans,
- (b) any salary reduction elections made under this Plan, and
- (c) any salary reduction elections made under a Code Section 132 transportation fringe benefit plan maintained by the Employer.

2.13 CONTRIBUTIONS

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

2.14 DEPENDENT

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

2.15 EFFECTIVE DATE

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

2.16 ELECTION PERIOD

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

2.17 ELIGIBLE EMPLOYEE

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

2.18 ELIGIBILITY REQUIREMENTS

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

2.19 EMPLOYEE

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

2.20 EMPLOYER

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

2.21 ENTRY DATE

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

2.22 HIGHLY COMPENSATED INDIVIDUAL

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

2.23 INSURANCE BENEFITS

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

2.24 KEY EMPLOYEE

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

2.25 PARTICIPANT

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

2.26 PLAN

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

2.27 PLAN YEAR

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

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

2.28 QUALIFIED BENEFITS

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

2.29 REIMBURSEMENT ACCOUNT

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

2.30 REIMBURSABLE EXPENSE

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

2.31 SALARY REDUCTION AGREEMENT

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

2.32 SPOUSE

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

2.33 SUMMARY PLAN DESCRIPTION OR "SPD"

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

3. ELIGIBILITY AND PARTICIPATION

3.1 ELIGIBILITY REQUIREMENTS

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

3.2 PARTICIPATION TERMINATION

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

3.3 NON-FMLA LEAVE OF ABSENCE

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

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

3.4 QUALIFIED LEAVE UNDER FAMILY AND MEDICAL LEAVE ACT

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

3.5 AUTOMATIC TERMINATION OF ELECTION AND REINSTATEMENT OF PARTICIPATION

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

4. ELECTION OF BENEFITS

4.1 ELECTION OF BENEFITS

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

4.2 ELECTION PERIOD PRIOR TO EFFECTIVE DATE

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

4.3 ANNUAL ELECTION PERIOD

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

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

4.4 INITIAL ELECTION PERIOD

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

4.5 CHANGES BY ADMINISTRATORS

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

4.6 REVOCATION OF ELECTIONS

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

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

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

5. CONTRIBUTIONS

5.1 CONTRIBUTIONS FOR ELECTED BENEFIT PACKAGE OPTIONS

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

5.2 SOURCE OF CONTRIBUTIONS

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

5.3 ALLOCATIONS IRREVOCABLE DURING PLAN YEAR

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

5.4 REDUCTION OF CERTAIN ELECTIONS TO PREVENT DISCRIMINATION

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

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

5.5 ADJUSTMENT OF ELECTIONS DUE TO CONTRIBUTION CHANGES

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

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

5.6 CREDITS AND DEBITS TO MEDICAL EXPENSE REIMBURSEMENT ACCOUNTS

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

5.7 CREDITS AND DEBITS TO DEPENDENT CARE EXPENSE REIMBURSEMENT ACCOUNTS

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

6. BENEFIT PACKAGE OPTIONS

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

6.1 INSURANCE BENEFITS

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

6.2 MEDICAL EXPENSE REIMBURSEMENT BENEFIT (HEALTH FSA)

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

6.3 DEPENDENT CARE ASSISTANCE PLAN (DCAP FSA)

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

7. PLAN ADMINISTRATION

7.1 APPOINTMENT OF ADMINISTRATORS

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

7.2 ALLOCATION OF RESPONSIBILITY FOR ADMINISTRATION

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

- (a) Require any person to furnish such reasonable information as the Plan Administrator may request for the purpose of the proper administration of the Plan as a condition to receiving any benefits under the Plan,
- (b) Make and enforce such rules and regulations and prescribe the use of such forms as the Plan Administrator shall deem necessary for the efficient administration of the Plan,
- (c) Decide on questions concerning the Plan and the eligibility of any Employee to participate in the Plan and to make or revoke elections under the Plan, in accordance with the provisions of the Plan,
- (d) Determine the amount of benefits which shall be payable to any person in accordance with the provisions of the Plan, to inform the Employer, insurer as appropriate, of the amount of such benefits, and to provide a full and fair review to any Participant whose claim for benefits has been denied in whole or in part,
- (e) Designate other persons to carry out any duty or power, which may or may not otherwise be a fiduciary responsibility of the Plan Administrator, under the terms of the Plan,
- (f) Keep records of all acts and determinations, and to keep all such records, books of account, data, and other documents as may be necessary for the proper administration of the Plan, and
- (g) Do all things necessary to operate and administer the Plan in accordance with its provisions.

7.3 PROVISION FOR THIRD-PARTY PLAN SERVICE PROVIDERS

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

7.4 FIDUCIARY LIABILITY

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

7.5 COMPENSATION OF PLAN ADMINISTRATOR

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

7.6 BONDING

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

7.7 PAYMENT OF ADMINISTRATIVE EXPENSES

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

7.8 FUNDING POLICY

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

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

- (a) Once insurance is applied for or obtained, the Employer will not be liable for any loss which may result from the failure to pay premiums to the extent premium notices are not received by the Employer;
- (b) To the extent premium notices are received by the Employer, the Employer's liability for the payment of such premiums will be limited to such premiums and will not include liability for any other loss which result from such failure;
- (c) The Employer will not be liable for the payment of any insurance premium or any loss, which may result from the failure to pay an insurance premium if the benefits available under this plan are not enough to provide for such premium cost at the time it is due. In such circumstances, the Employee will be responsible for and see to the payment of such premiums. The Employer will undertake to notify a Participant if available benefits under this plan are not enough to provide for an insurance premium, but will not be liable for any failure to make such notification;
- (d) When employment ends, the Employer will have no liability to take any step to maintain any policy in force except as may be specifically required otherwise in this plan, and the Employer will not be liable for or responsible to see to the payment of any premium after employment ends.

7.9 DISBURSEMENT REPORTS

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

7.10 INDEMNIFICATION

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

7.11 STATEMENTS

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

8. CLAIMS PROCEDURES

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

9. PLAN AMENDMENT AND TERMINATION

9.1 PERMANENCY

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

9.2 EMPLOYER'S RIGHT TO AMEND

The Employer reserves the right to:

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

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

9.3 EMPLOYER'S RIGHT TO TERMINATE

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

9.4 DETERMINATION OF EFFECTIVE DATE OF AMENDMENT OR TERMINATION

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

10. MISCELLANEOUS PROVISIONS

10.1 INFORMATION TO BE FURNISHED

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

10.2 LIMITATION OF RIGHTS

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

10.3 NOT AN EMPLOYMENT CONTRACT

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

10.4 GOVERNING LAW

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

10.5 POSTMORTEM PAYMENTS

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

10.6 NON-ALIENATION OF BENEFITS

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

10.7 MENTAL OR PHYSICAL INCOMPETENCY

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

10.8 INABILITY TO LOCATE PAYEE

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

10.9 REQUIREMENT FOR PROPER FORMS

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

10.10 SOURCE OF PAYMENTS

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

10.11 MULTIPLE FUNCTIONS

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

10.12 TAX EFFECTS

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

10.13 GENDER, NUMBER, AND HEADINGS

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

10.14 CODE AND ERISA COMPLIANCE

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

10.15 INCORPORATION BY REFERENCE

The actual terms and conditions of the separate Benefit Package Options offered under this Plan are contained in separate, written documents governing each respective benefit, and will govern in the event of a conflict between the individual plan document and this Agreement as to substantive content. To that end, each such separate document, as amended or subsequently replaced, is hereby incorporated by reference as if fully recited herein.

10.16 SEVERABILITY

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

APPENDIX A: DEPENDENT CARE ASSISTANCE PLAN

1. PURPOSE

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

2. DEFINITIONS

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

2.1 DEPENDENT CARE ASSISTANCE ACCOUNT

The Reimbursement Account referenced in Section 6.3 of the Plan.

2.2 DEPENDENT CARE EXPENSES

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

2.3 EDUCATIONAL INSTITUTION

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

2.4 ELIGIBLE DAY CARE CENTER

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

- (a) complies with all applicable laws and regulations of the state and town, city, or village in which it is located; and
- (b) receives a fee, payment, or grant for services for any of the individuals to whom it provides services (regardless of whether such facility is operated for profit).

2.5 QUALIFYING INDIVIDUAL

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

2.6 PARTICIPANT

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

2.7 PROGRAM AGREEMENT

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

2.8 SPOUSE

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

2.9 STUDENT

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

3. PARTICIPATION

3.1 COMMENCEMENT OF PARTICIPATION

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

3.2 CESSATION OF PARTICIPATION

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

3.3 ELECTION OF BENEFITS

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

3.4 PLAN LIMITS

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

3.5 OTHER ADMINISTRATIVE DOCUMENTATION

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

3.6 MAXIMUM CONTRIBUTION AMOUNTS

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

4. DEPENDENT CARE ASSISTANCE ACCOUNTS

4.1 ESTABLISHMENT OF ACCOUNTS

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

4.2 CREDITING AND DEBITING OF ACCOUNTS

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

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

4.3 SOURCE OF PAYMENTS

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

4.4 FORFEITURE OF DEPENDENT CARE ASSISTANCE ACCOUNTS

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

5. PAYMENT OF DEPENDENT CARE ASSISTANCE

5.1 CLAIMS FOR REIMBURSEMENT

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

5.2 REIMBURSEMENT OR PAYMENT OF EXPENSES

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

5.3 REPORT(S) TO PARTICIPANTS

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

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

5.4 LIMITATION ON REIMBURSEMENTS OR PAYMENTS WITH RESPECT TO CERTAIN PARTICIPANTS

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

6. ADMINISTRATION

6.1 ADMINISTRATOR

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

6.2 RECORDS

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

6.3 RELIANCE ON DETERMINATIONS, ETC.

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

6.4 DENIED CLAIMS PROCEDURE UNDER THE PLAN

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

6.5 PRESERVATION OF REMEDIES

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

6.6 EXCESS REIMBURSEMENT

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

7. AMENDMENT AND TERMINATION

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

8. MISCELLANEOUS

8.1 FUNDING STATUS OF DCAP

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

- (a) Any amount, by which a Participant's taxable compensation is reduced by reason of an election made under this DCAP, will remain part of the general assets of the Employer.
- (b) The benefits provided hereunder will be paid solely from the general assets of the Employer.
- (c) Nothing herein will be construed to require any Employer or the Plan Administrator to maintain any fund or segregate any amount for the benefit of any Participant.
- (d) No Participant or other person shall have any claim against, right to, or security, or other interest in any fund, account, or asset of the Employer from which any payment under the DCAP may be made.

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

8.2 ASSIGNMENT

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

8.3 NO GUARANTEE OF TAX CONSEQUENCE

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

8.4 INDEMNIFICATION OF EMPLOYER BY PARTICIPANTS

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

APPENDIX B: MEDICAL EXPENSE REIMBURSEMENT PLAN

1. PURPOSE

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

2. DEFINITIONS

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

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

2.1 COVERAGE AMOUNT

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

2.2 DEPENDENT

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

2.3 ELIGIBLE MEDICAL EXPENSE

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

2.4 MEDICAL EXPENSE REIMBURSEMENT ACCOUNT

The Reimbursement Account described in Section 6.2 of the Plan.

2.5 PARTICIPANT

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

2.6 PROGRAM AGREEMENT

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

3. PARTICIPATION

3.1 COMMENCEMENT OF PARTICIPATION

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

3.2 CESSATION OF PARTICIPATION

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

3.3 COVERAGE DURING A LEAVE OF ABSENCE

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

4. ELECTIONS

4.1 ELECTION OF BENEFITS

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

4.2 PLAN LIMITS

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

4.3 DURATION OF ELECTIONS

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

5. MEDICAL REIMBURSEMENT ACCOUNTS

5.1 ESTABLISHMENT OF ACCOUNTS

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

5.2 CREDITING AND DEBITING OF ACCOUNTS

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

5.3 SOURCE OF PAYMENTS

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

5.4 FORFEITURE OF HEALTH CARE ACCOUNTS

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

6. PAYMENT OF ELIGIBLE MEDICAL CARE EXPENSES

6.1 CLAIMS FOR REIMBURSEMENT

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

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

6.2 REIMBURSEMENT OR PAYMENT OF EXPENSES

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

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

6.3 REPORT(S) TO PARTICIPANTS

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

6.4 LIMITATION ON REIMBURSEMENTS OR PAYMENTS WITH RESPECT TO CERTAIN PARTICIPANTS

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

6.5 EXCESS REIMBURSEMENTS

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

7. COBRA CONTINUATION COVERAGE

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

8. ADMINISTRATION

8.1 ADMINISTRATION

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

8.2 RECORDS

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

8.3 RELIANCE ON DETERMINATIONS, ETC.

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

8.4 DENIED CLAIMS PROCEDURE UNDER THE PLAN

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

8.5 PRESERVATION OF REMEDIES

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

9. AMENDMENT AND TERMINATION

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

10. MISCELLANEOUS

10.1 FUNDING STATUS OF HEALTH FSA PLAN

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

- (a) Any amount by which a Participant's taxable Compensation is reduced by reason of an election made under this Health FSA Plan will remain part of the general assets of the Employer.
- (b) The benefits provided hereunder will be paid solely from the general assets of the Employer.
- (c) Nothing herein will be construed to require any Employer or the Plan Administrator to maintain any fund or segregate any amount for the benefit of any Participant.
- (d) No Participant or other person shall have any claim against, right to, or security or other interest in, any fund, account or asset of the Employer from which any payment under the Health FSA Plan may be made.

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

10.2 ASSIGNMENT

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

10.3 NO GUARANTEE OF TAX CONSEQUENCE

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

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

10.4 INDEMNIFICATION OF EMPLOYER BY PARTICIPANTS

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

11. HIPAA PRIVACY

11.1 SCOPE AND PURPOSE

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

11.2 EFFECTIVE DATE

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

11.3 USE AND DISCLOSURE OF PHI

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

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

- (i) The Plan document has been amended to incorporate the provisions in this Article XI; and
- (ii) The Employer agrees to implement the provisions in Section 11.04 herein.

11.4 CONDITIONS IMPOSED ON EMPLOYER

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

- (a) Not to use or disclose PHI other than as permitted or required by this Article VIII or as required by law;
- (b) To ensure that any agents, including a subcontractor, to whom the Employer provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Employer with respect to PHI received or created on behalf of the Plan;
- (c) Not use or disclose an individual's PHI for employment-related purposes (including hiring, firing, promotion, assignment or scheduling) unless authorized by the Individual;
- (d) Not to use or disclose an Individual's PHI in connection with any other non-health benefit program or employee benefit plan of the Employer unless authorized by the Individual;
- (e) To report to the Plan any use or disclosure of PHI that is inconsistent with this Article VIII, if it becomes aware of an inconsistent use or disclosure;
- (f) To provide Individuals with access to PHI in accordance with 45 C.F.R. § 164.524;
- (g) To make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 C.F.R. § 164.526;
- (h) To make available the information required to provide an accounting of disclosures in accordance with 45 C.F.R. § 164.528;

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

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

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

11.5 DESIGNATED EMPLOYEES WHO MAY RECEIVE PHI

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

11.6 RESTRICTIONS ON EMPLOYEES WITH ACCESS TO PHI

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

11.7 POLICIES AND PROCEDURES

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

11.8 ORGANIZED HEALTH CARE ARRANGEMENT

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

11.9 PRIVACY OFFICIAL

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

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

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

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

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

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

11.10 NONCOMPLIANCE

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

11.11 DEFINITIONS

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

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

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

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

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

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

11.12 INTERPRETATION AND LIMITED APPLICABILITY

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

11.13 SERVICES PERFORMED FOR THE EMPLOYER

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

**Fort Bend County
Section 125 Cafeteria Plan
PLAN INFORMATION SUMMARY**

Effective Date: 01/01/2007

Employer Organization

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

Plan Design Options

Plan Information

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

*This Plan is designed to run on a 12-month plan year period as stated above. A Short Plan Year may occur when the Plan is first established, when the plan year period changes, or at the termination of a Plan.

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

Benefits Coordinator

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

Acceptance of Legal Process

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

The appointed Plan Service Provider in conjunction with the Administrator will perform the functions of accounting, record keeping, changes of participant family status, and any election or reporting requirements of the Internal Revenue Code.

ELIGIBILITY REQUIREMENTS

- a) Except as provided in (b) below, the Classification of eligible employees consists of All employees.
- (b) Employees excluded from this classification group are those individual employees who fall into one or more of the following categories below:
 - Individuals under 18 years of age.
 - Employees who work less than 40.0 hours per week.

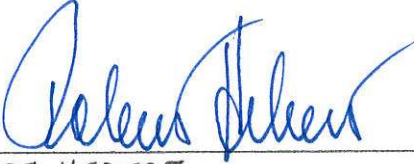
Service Period Requirement

For All plan years, eligibility is the following:

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

PLAN ENTRY DATE

The Plan Entry Date is the date when an employee who has satisfied the Eligibility Requirements may commence participation in the Plan. The Plan Entry Date is the later of the date the Employee files a Salary Reduction Agreement during the applicable Enrollment Period or Date requirements are met.

Signature: 

Date: 12 / 12 / 06

Name: ROBERT HEBERT

Title: COUNTY JUDGE

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

AMENDMENT III

TO THE

CAFETERIA PLAN

**PREMIUM REDUCTION OPTION PLUS
FLEXIBLE SPENDING ACCOUNTS**

**As adopted by
Fort Bend County**

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

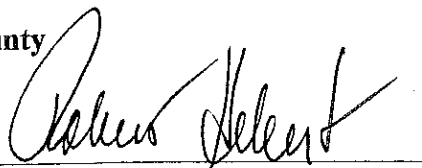
- (a) The maximum annual reimbursement amount an Employee may elect for any Plan Year is \$2,500.00.

Such modifications are effective January 1, 2013

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

Fort Bend County

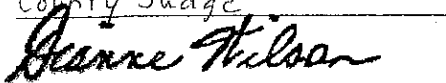
By:

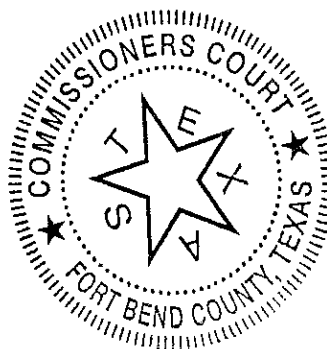


Robert E. Hebert
County Judge

Title:

Witness:
Attest:


Dianne Wilson
County Clerk



2012 AUG 31 PM 4:13

RECORDED
FORT BEND COUNTY
RISK MANAGEMENT

**AMENDMENT IV
TO THE
CAFETERIA PLAN**

**PREMIUM REDUCTION OPTION PLUS
FLEXIBLE SPENDING ACCOUNTS**

**As adopted by
Fort Bend County**

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

(a) Service period requirements

For all plan years, eligibility is the following:

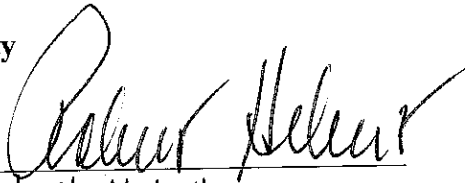
First of the month, following the 58th day after hire.

Such modifications are effective January 1, 2014

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

Fort Bend County

By:



Robert Hebert
County Judge

Title:

Witness:



DIANNE WILSON,
Fort Bend County Clerk



2014 DEC 19 AM 11:19

FORT BEND COUNTY
CLERK'S OFFICE
1000 W. 10TH ST.
HOUSTON, TX 77030

**CAFETERIA PLAN
PREMIUM REDUCTION OPTION PLUS
FLEXIBLE SPENDING ACCOUNTS
PLAN DOCUMENT
AS ADOPTED BY
FORT BEND COUNTY**

**AMENDMENT TO ALLOW HEALTH FSA CARRYOVER AND OTHER OPTIONS
TO BE EFFECTIVE AS OF JANUARY 1, 2017**

**ARTICLE I
PREAMBLE**

- 1.1 **Adoption and effective date of amendment.** The Employer adopts this Amendment to Fort Bend County Cafeteria Plan ("Plan") to reflect recent law and regulatory changes. The sponsor intends this Amendment as good faith compliance with the requirements of these changes. This Amendment shall be effective on or after the dates the Employer elects in Article II below.
- 1.2 **Supersession of inconsistent provisions.** This Amendment shall supersede the provisions of the Plan to the extent those provisions are inconsistent with the provisions of this Amendment.
- 1.3 **Construction.** Except as otherwise provided in this Amendment, any reference to "Section" in this Amendment refers only to sections within this Amendment, and is not a reference to the Plan. The Article and Section numbering in this Amendment is solely for purposes of this Amendment, and does not relate to any Plan article, section or other numbering designations.

**ARTICLE II
ELECTIONS**

- 2.1 **Health FSA \$500 Carryover.** The Section 3.1 below. The effective date of this provision is January 1, 2017.

**ARTICLE III
PROVISIONS**

3.1 \$500 Carryover.

A Participant in the Health Flexible Spending Account may roll over up to \$500 of unused amounts in the Health Flexible Spending Account remaining at the end of one Plan year to the immediately following Plan Year. These amounts can be used during the following Plan Year for expenses incurred in that Plan Year. Amounts carried over do not affect the maximum amount of salary redirection contributions for the Plan Year to which they are carried over. Unused amounts are those remaining after expenses have been reimbursed during the run out period. These amounts may not be cashed out or converted to any other taxable or nontaxable benefit. Amount in excess of \$500 will be forfeited. The plan is allowed, but not required, to treat claims as being paid first from the current year amounts, then from the carryover amounts. This carryover option provides an alternative to the current grace period rule (terminated as of 1/1/2017) and administrative relief similar to that rule (terminated as of 1/1/2017).

**ARTICLE IV
PREMIUM REDUCTION OPTION PLUS FLEXIBLE SPENDING ACCOUNTS**


The maximum annual reimbursement amount an Employee may elect for any Plan Year is \$2550. The effective date of this provision is January 1, 2017.

Amendment approved by Commissioners Court on 4 day of April 2017

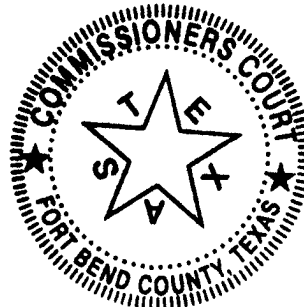


Robert E. Hebert, County Judge

Attest:



Laura Richard, County Clerk



Modification of "Use-or-Lose" Rule For Health Flexible Spending Arrangements (FSAs) and Clarification Regarding 2013-2014 Non-Calendar Year Salary Reduction Elections Under § 125 Cafeteria Plans

Notice 2013 -71

I. PURPOSE

This notice contains modifications to the rules for § 125 cafeteria plans. First, sections II through V of the notice modify the "use-or-lose" rule for health FSAs that is currently set forth in proposed regulations under § 125 of the Internal Revenue Code (the Code). This modification permits § 125 cafeteria plans to be amended to allow up to \$500 of unused amounts remaining at the end of a plan year in a health FSA to be paid or reimbursed to plan participants for qualified medical expenses incurred during the following plan year, provided that the plan does not also incorporate the grace period rule. This carryover of up to \$500 does not affect the maximum amount of salary reduction contributions that the participant is permitted to make under §125(i) of the Code (\$2,500 adjusted for inflation after 2012). This carryover option provides an alternative to the current grace period rule and administrative relief similar to that rule.

Second, section VI of this notice clarifies the scope of the transition relief provided in the preamble to proposed regulations under § 4980H that allows greater flexibility for individuals to make changes in salary reduction elections for accident and health plans provided through § 125 cafeteria plans for non-calendar cafeteria plan years beginning in 2013.

II. BACKGROUND

Section 125(d)(1) defines a § 125 cafeteria plan as a written plan maintained by an employer under which all participants are employees, and all participants may choose among two or more benefits consisting of cash and qualified benefits. Section 125(f) defines a qualified benefit as any benefit which, with the application of § 125(a), is not includable in the gross income of the employee by reason of an express provision of the Code (with certain exceptions). Qualified benefits include employer-provided accident and health plans excludable from gross income under §§ 106 and 105(b), but exclude long term care insurance and certain qualified health plans offered through an Exchange (also referred to as a Marketplace) established under § 1311 of the Patient Protection and Affordable Care Act (the Act).¹

Pursuant to § 125(d)(2)(A), a § 125 cafeteria plan generally does not include any plan that provides for deferred compensation. Proposed regulations under § 125 that predated the enactment of the Act generally have prohibited participants from using

¹ Public Law 111-148 (124 Stat. 1029 (2010)), amended by § 10104 and § 10203 of the Act.

contributions made for one plan year to purchase a benefit that will be provided in a subsequent plan year. Commonly referred to as the “use-or-lose” rule, this requires that unused benefits or contributions remaining as of the end of the plan year (that is, amounts credited to a health FSA participant’s account that remain unused, referred to below as “unused amounts”) be forfeited. See Prop. Treas. Reg. §§ 1.125-1(c)(7)(C), 1.125-1(o), and 1.125-5(c).

In 2005, the Treasury Department and the IRS modified the use-or-lose rule by adopting the grace period rule. Under the grace period rule, a § 125 cafeteria plan may permit an employee to use amounts remaining from the previous year (including amounts remaining in a health FSA) to pay expenses incurred for certain qualified benefits during the period of up to two months and 15 days immediately following the end of the plan year. See Notice 2005-42, 2005-1 C.B. 1204, and Prop. Treas. Reg. § 1.125-1(e). This exception was based on other areas of tax law that do not treat certain arrangements as providing for deferred compensation if the compensation payment is made no later than the fifteenth day of the third month after the taxable year in which the services are performed. See, for example, Treas. Reg. § 1.404(b)-1T, Q&A-2.

Section 125(i)² provides that, beginning in 2013, a health FSA is not treated as a qualified benefit unless the § 125 cafeteria plan limits each employee’s salary reduction contributions to the health FSA to no more than \$2,500 per taxable year (as indexed for cost-of-living adjustments). Notice 2012-40, 2012-1 C.B. 1046, provides that the term “taxable year” in § 125(i) refers to the plan year of the § 125 cafeteria plan, so that the limit is applicable only beginning with the first day of the first plan year beginning in 2013.

Notice 2012-40 stated that “[t]he \$2,500 limit, while not addressing the ‘use-or-lose’ rule, limits the potential for using health FSAs to defer compensation and the extent to which salary reduction amounts may accumulate over time. Given the \$2,500 limit, the Treasury Department and the IRS are considering whether the use-or-lose rule for health FSAs should be modified to provide a different form of administrative relief (instead of, or in addition to, the current 2½ month grace period rule).” Notice 2012-40 requested comments on whether the proposed regulations under § 125 should be modified to provide flexibility with respect to the operation of the use-or-lose rule for health FSAs in addition to the 2½-month grace period rule. Numerous comments were submitted in response to this request, the overwhelming majority favoring modification of the use-or-lose rule.

III. FURTHER MODIFICATION OF USE-OR-LOSE RULE

The public comments argued for additional flexibility with respect to the operation of the use-or-lose rule for a number of reasons. These included the difficulty for

² Section 125(i) was added to the Code by § 9005 of the Act, amended by § 10902 of the Act, and further amended by § 1403(b) of the Health Care and Education Reconciliation Act of 2010 (HCERA), Pub. L. No. 111-152.

employees of predicting their future needs for medical expenditures, the desirability of minimizing incentives for unnecessary spending at the end of a year or grace period, the possibility that lower- and moderate-paid employees are more reluctant than others to participate because of aversion to even modest forfeitures of their salary reduction contributions, and the opportunity to ease and potentially to simplify the administration of health FSAs. In light of these comments, the Treasury Department and the IRS have determined that it is appropriate to modify the use-or-lose rule to permit the use of up to \$500 of unused amounts in a health FSA in the immediately following plan year.

Accordingly, an employer, at its option, is permitted to amend its § 125 cafeteria plan document to provide for the carryover to the immediately following plan year of up to \$500 of any amount remaining unused as of the end of the plan year in a health FSA. The carryover of up to \$500 may be used to pay or reimburse medical expenses under the health FSA incurred during the entire plan year to which it is carried over. For this purpose, the amount remaining unused as of the end of the plan year is the amount unused after medical expenses have been reimbursed at the end of the plan's run-out period³ for the plan year. In addition to the unused amounts of up to \$500 that a plan may permit an individual to carry over to the next year, the plan may permit the individual to also elect up to the maximum allowed salary reduction amount under § 125(i). Thus, the carryover of up to \$500 does not count against or otherwise affect the indexed \$2,500 salary reduction limit applicable to each plan year. Although the maximum unused amount allowed to be carried over in any plan year is \$500, the plan may specify a lower amount as the permissible maximum (and the plan sponsor has the option of not permitting any carryover at all).

A plan adopting this carryover provision is not permitted to also provide a grace period with respect to health FSAs. Nor is the plan, for any plan year, permitted to allow an individual to salary reduce for qualified health FSA benefits more than the indexed \$2,500 salary reduction limit or permitted to reimburse claims incurred during the plan year that exceed the applicable indexed \$2,500 salary reduction limit (and any nonelective employer flex credits) plus the carryover amount of up to \$500. If an employer amends its plan to adopt a carryover, the same carryover limit must apply to all plan participants. A § 125 cafeteria plan is not permitted to allow unused amounts relating to a health FSA to be cashed out or converted to any other taxable or nontaxable benefit. Unused amounts relating to a health FSA may be used only to pay or reimburse certain § 213(d) medical expenses (excluding health insurance, long-term care services

³ A "run-out period" is a period immediately following the end of a plan year during which a participant can submit a claim for reimbursement of expenses incurred for qualified benefits during the plan year. See Prop. Treas. Reg. § 1.125-1(f). By contrast, a grace period is a period of up to two months and 15 days immediately following the end of a plan year during which a participant may use amounts remaining from the previous plan year (including amounts remaining in a health FSA) to pay expenses incurred for certain qualified benefits during that two-month-and-15-day period. See Notice 2005-42, 2005-1 C.B. 1204, and Prop. Treas. Reg. § 1.125-1(e). (A run-out period may also be provided immediately following the end of a grace period instead of immediately following the end of a plan year, so that participants can submit claims for reimbursement of expenses incurred during the grace period or the previous plan year.)

or insurance, see Prop. Treas. Reg. §1.125-1(q)). With respect to a participant, the amount that may be carried over to the following plan year is equal to the lesser of (1) any unused amounts from the immediately preceding plan year or (2) \$500 (or a lower amount specified in the plan). Any unused amount in excess of \$500 (or a lower amount specified in the plan) that remains unused as of the end of the plan year (that is, at the end of the run-out period for the plan year) is forfeited. Any unused amount remaining in an employee's health FSA as of termination of employment also is forfeited (unless, if applicable, the employee elects COBRA continuation coverage with respect to the health FSA).

The uniform coverage rule requires that the maximum amount of reimbursement from the health FSA (including both salary reduction amounts and any nonelective employer flex credits) be available for claims incurred at all times during the period of coverage (properly reduced as of any particular time for prior reimbursements for the same period of coverage). That rule continues to apply to § 125 cafeteria plans adopting the carryover of up to \$500.

Use of the carryover option permitted under this notice does not affect the ability of a health FSA to provide for the payment of expenses incurred in one plan year during a permitted run-out period at the beginning of the following plan year (just as a run-out period can also be provided when using the grace period rule). Thus, for plans using the new carryover option, a participant's unused health FSA balance at the end of the prior plan year may be used (a) for expenses incurred in the prior plan year, but only if claimed during the plan's run-out period that begins at the end of the prior plan year (in effect retroactively reducing the unused amount as of the end of the prior plan year) or (b) to the extent of the permitted carryover amount of up to \$500 from the final prior plan year unused amount, for expenses that are incurred at any time in the current plan year. In contrast, salary reduction or other amounts credited to a health FSA with respect to service in the current plan year may be used only for expenses incurred in the current plan year (unless and to the extent that these current plan year amounts may later be carried over to the following plan year).

For ease of administration, a § 125 cafeteria plan is permitted to treat reimbursements of all claims for expenses that are incurred in the current plan year as reimbursed first from unused amounts credited for the current plan year and, only after exhausting these current plan year amounts, as then reimbursed from unused amounts carried over from the preceding plan year. Any unused amounts from the prior plan year that are used to reimburse a current year expense (a) reduce the amounts available to pay prior plan year expenses during the run-out period, (b) must be counted against the permitted carryover of up to \$500, and (c) cannot exceed the permitted carryover. For examples of how the carryover operates, see section V of this notice.

IV. WRITTEN § 125 CAFETERIA PLAN AMENDMENT

To utilize the new carryover option permitted under this notice, a § 125 cafeteria plan offering a health FSA must be amended to set forth the carryover provision. The

amendment must be adopted on or before the last day of the plan year from which amounts may be carried over and may be effective retroactively to the first day of that plan year, provided that the § 125 cafeteria plan operates in accordance with the guidance under this notice and informs participants of the carryover provision, and provided further that a plan may be amended to adopt the carryover provision for a plan year that begins in 2013 at any time on or before the last day of the plan year that begins in 2014.

A § 125 cafeteria plan that incorporates a carryover provision may not also provide for a grace period in the plan year to which unused amounts may be carried over. Accordingly, if, pursuant to the carryover provision, a plan permits amounts that were unused in a plan year to be carried over to the following plan year, the plan is not permitted to provide for a grace period that occurs in that following plan year. For example, a calendar year plan permitting a carryover to 2015 of unused 2014 health FSA amounts (as determined at the end of the run-out period in early 2015) would not be permitted to have a grace period in 2015, but would be permitted to have had a grace period during the first 2 ½ months of 2014.

If a plan has provided for a grace period and is being amended to add a carryover provision, the plan must also be amended to eliminate the grace period provision by no later than the end of the plan year from which amounts may be carried over. The ability to eliminate a grace period provision previously adopted for the plan year in which the amendment is adopted may be subject to non-Code legal constraints.

V. EXAMPLES

The preceding rules of this notice are illustrated by the following examples:

Example 1. Employer sponsors a § 125 cafeteria plan and health FSA with a calendar plan year, an annual run-out period from January 1 through March 31 in which participants can submit claims for expenses incurred during the preceding plan year, and an annual open enrollment season in November in which participants elect a salary reduction amount (not to exceed \$2,500) for the following plan year. The plan is timely amended to provide for a carryover that allows all participants to apply up to \$500 of unused health FSA amounts remaining at the end of the run-out period to the health FSA for expenses incurred at any time during that plan year. The plan does not provide for a grace period with respect to the health FSA. The plan also does not provide for nonelective employer flex credits.

In November 2014, Participant A elects a salary reduction amount of \$2,500 for 2015. By December 31, 2014, A's unused amount from the 2014 plan year is \$800. On February 1, 2015, A submits claims and is reimbursed with respect to \$350 of expenses incurred during the 2014 plan year, leaving a carryover on March 31, 2015 (the end of the run-out period) of \$450 of unused health FSA amounts from 2014. The \$450 amount is not forfeited; instead, it is carried over to 2015 and available to pay claims incurred in that year so that \$2,950 (that is, \$2,500 + \$450) is available to pay claims incurred in

2015. A incurs and submits claims for expenses of \$2,700 during the month of July 2015, and does not submit any other claims during 2015. A is reimbursed with respect to the \$2,700 claim, leaving \$250 as a potential unused amount from 2015 (depending upon whether A submits claims during the 2015 run-out period in early 2016).

This § 125 cafeteria plan satisfies the preceding rules of this notice.

Example 2. The same facts as Example 1, except that A's expenses of \$2,700 are incurred and submitted during the month of January 2015 (and not July 2015). The plan may treat \$500 of the \$800 unused amounts as of December 31, 2014, as available to pay current year expenses. Accordingly, A is reimbursed with respect to the \$2,700 claim. The plan treats the first \$2,500 of the claim as reimbursed with health FSA contributions for 2015, and the remaining \$200 of the claim as reimbursed with the unused amounts as of December 31, 2014. The unused amount remaining from 2014 from which claims for expenses incurred during the 2014 plan year may be reimbursed during the 2014 run-out period in early 2015 is reduced to \$600 (\$800 - \$200). On February 1, 2015, A submits and is reimbursed with respect to \$350 of claims for expenses incurred during the 2014 plan year. After the \$350 reimbursement, the unused amount remaining for 2014 from which claims for expenses incurred during the 2014 plan year may be reimbursed during the 2014 run-out period in early 2015 is reduced to \$250 (\$600 - \$350). A submits no further claims for expenses incurred during the 2014 plan year, so that in addition to the \$200 previously used to reimburse the January 2015 claim, \$250 is carried over to the 2015 plan year. A submits no further claims for 2015. The amount carried over to 2016 is \$250.

This § 125 cafeteria plan satisfies the preceding rules of this notice.

Example 3. The same facts as Example 2, except that on February 1, 2015, A submits claims with respect to \$700 of expenses incurred during the 2014 plan year. Because the unused amount remaining from 2014 from which claims for expenses incurred during the 2014 plan year may be reimbursed has been reduced to \$600 prior to February 1, 2015, the plan reimburses A for only \$600 of the total \$700 of claims. After the \$600 reimbursement, the unused amount remaining from 2014 from which claims for expenses incurred during the 2014 plan year may be reimbursed is reduced to zero (\$600 - \$600). A submits no further claims for expenses incurred during the 2014 plan year, so that the amount carried over to the 2015 plan year is \$0 (the entire \$800 of unused amounts as of December 31, 2014, having been used to reimburse claims submitted in January 2015 (\$200) and February 2015 (\$600)).

This § 125 cafeteria plan satisfies the preceding rules of this notice.

Example 4. The same facts as Example 1, except that, for 2014, A elects a salary reduction amount of \$600 and, on December 31, 2014, A still has \$600 of unused health FSA amounts.

For 2015, A elects no salary reduction for the health FSA, submits no claims

during the run-out period, and as of the end of the run-out period on March 31, 2015, \$600 in unused health FSA amounts remains. Of that amount, \$100 is forfeited because it exceeds the \$500 carryover limit, and \$500 is carried over to the 2015 plan year. A incurs \$200 in expenses during the 2015 plan year, which are reimbursed during that plan year. As of December 31, 2015, A has \$300 in unused health FSA amounts.

For 2016, A elects no salary reduction for the health FSA but has the \$300 carryover from 2015, which is not forfeited. A incurs medical expenses of \$300 in 2016, which are reimbursed using the \$300 carryover from 2015.

This § 125 cafeteria plan satisfies the preceding rules of this notice.

VI. CLARIFICATION OF SCOPE OF TRANSITION RULE APPLICABLE TO NON-CALENDAR PLAN YEARS BEGINNING IN 2013 FOR PARTICIPANT CHANGES IN SALARY REDUCTION ELECTIONS UNDER HEALTH PLANS PROVIDED THROUGH § 125 CAFETERIA PLANS

A. BACKGROUND

Generally, § 125 cafeteria plan elections must be made before the start of the plan year, and are irrevocable during the plan year, with limited exceptions, including certain changes in status. See Prop. Treas. Reg. § 1.125-2, Treas. Reg. § 1.125-4. Under existing regulations, the availability of health plan coverage through an Affordable Insurance Exchange (also referred to in other published guidance as a Marketplace) beginning with calendar year 2014 does not constitute such a change in status. As a result, employees would not be able to change their salary reduction elections for health coverage during a plan year in order to, for example, cease their salary reductions and § 125 cafeteria plan coverage and purchase coverage through an Exchange. However, the Treasury Department and the IRS previously concluded that transition relief is appropriate for individuals with respect to non-calendar § 125 cafeteria plan years beginning in 2013. For individuals eligible for such a plan, health plan coverage through an Exchange will first become available in the middle of the plan's 2013-2014 non-calendar plan year (that is, January 2014). Accordingly, the Treasury Department and the IRS have provided transition relief from the election rules in Prop. Treas. Reg. § 1.125-2 with respect to salary reduction elections under a § 125 cafeteria plan for an employer-provided accident and health plan with a non-calendar plan year beginning in 2013. The transition relief was provided in Section IX.B of the preamble to proposed regulations (issued on December 28, 2012) under § 4980H (referred to below as "Section IX.B"). See 78 Fed. Reg. 218, 237 (Jan. 2, 2013).

Specifically, Section IX.B permits an employer, at its election, to amend one or more of its written § 125 cafeteria plans to allow employees to make either or both of the following changes in salary reduction elections, whether or not the employee experienced a change in status event described in Treas. Reg. § 1.125-4:

1. An employee who elected to salary reduce through the employer's § 125 cafeteria plan for accident and health plan coverage with a non-calendar plan year

beginning in 2013 is allowed to prospectively revoke or change his or her election with respect to the accident and health plan once during that plan year; and

2. An employee who failed to make a salary reduction election through the employer's § 125 cafeteria plan for accident and health plan coverage with a non-calendar plan year beginning in 2013 before the deadline in Prop. Treas. Reg. § 1.125-2 for making elections for the § 125 cafeteria plan year beginning in 2013 is allowed to make a prospective salary reduction election for accident and health coverage on or after the first day of the 2013 plan year of the § 125 cafeteria plan.

B. CLARIFICATION OF § 125 CAFETERIA PLAN TRANSITION RULE FOR PARTICIPANT SALARY REDUCTION ELECTIONS AS SET FORTH IN SECTION IX.B

Although the description of the § 125 cafeteria plan transition rule in Section IX.B refers to applicable large employer members (generally meaning a person that, together with one or more other persons, is treated as a single employer that is an applicable large employer), the relief is available, subject to the rules set forth in Section IX.B, to an employer with a § 125 cafeteria plan non-calendar plan year beginning in 2013 whether or not the employer is an applicable large employer or applicable large employer member under § 4980H.

Stakeholders have asked whether employees may use the relief set forth in Section IX.B if their employer amends its § 125 cafeteria plan to allow changes in salary reduction elections but adopts an amendment that is more limited than the two options listed in Section IX.B, as described above. An amendment to a § 125 cafeteria plan adopted pursuant to Section IX.B may be more restrictive than the amendments described in Section IX.B but may not be less restrictive. For example, an employer may amend its § 125 cafeteria plan to allow an employee who elected to salary reduce through the § 125 cafeteria plan to pay for accident and health plan coverage under the § 125 cafeteria plan with a non-calendar plan year beginning in 2013 to prospectively revoke or change his or her election with respect to the accident and health plan once, during a limited period (for example, the first month of 2014 only rather than the entire plan year) without regard to whether the employee experienced a change in status event described in Treas. Reg. § 1.125-4.

VII. EFFECTIVE DATES

An employer may adopt the carryover provision (of up to \$500) authorized in this notice to health FSAs for the current § 125 cafeteria plan year (and/or subsequent § 125 cafeteria plan years) by amending the § 125 cafeteria plan document in the manner and within the time frames described in section IV of this notice.

The clarifications described in section VI of this notice of the relief provided in Section IX.B may be applied beginning on or after December 28, 2012 (the date on which the proposed regulations that included Section IX.B were issued).

VIII. EFFECT ON OTHER DOCUMENTS

The Treasury Department and the IRS intend to amend Prop. Treas. Reg. §§ 1.125-1(o) and 1.125-5(c) to reflect the guidance in this notice; taxpayers may rely on the guidance in this notice pending the issuance and effectiveness of those amendments to the regulations.

IX. DRAFTING INFORMATION

The principal author of this notice is Janet A. Laufer of the Office of Division Counsel/Associate Chief Counsel (Tax Exempt and Government Entities). For further information regarding the modification of the use or lose rules contained in this notice, contact Ms. Laufer at (202) 927-9639 (not a toll-free call). For further information regarding the clarifications to Section IX.B, contact Ms. Katy Johnson at (202) 927-9639 (not a toll-free call).

AMENDMENT VI
TO THE
CAFETERIA PLAN

PREMIUM REDUCTION OPTION PLUS
FLEXIBLE SPENDING ACCOUNTS

As adopted by
Fort Bend County

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

- (a) The maximum annual reimbursement amount an Employee may elect for any Plan Year is \$2,700.00.

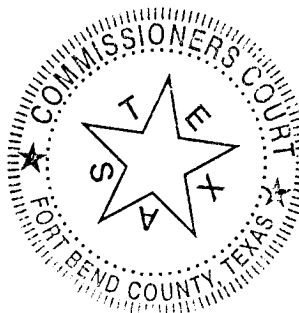
Such modifications are effective January 1, 2020

In witness whereof, we have executed the Plan Amendment by its duly authorized office,
this 24 day of September, 2019.

FORT BEND COUNTY

BY: KP George
KP George, County Judge

ATTEST: Laura Richard
Laura Richard, County Clerk



Request for Taxpayer Identification Number and Certification

**Give Form to the
 requester. Do not
 send to the IRS.**

Print or type See Specific Instructions on page 2.	1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.			
	2 Business name/disregarded entity name, if different from above			
	3 Check appropriate box for federal tax classification; check only one of the following seven boxes:		4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3): Exempt payee code (if any) _____ Exemption from FATCA reporting code (if any) _____ <i>(Applies to accounts maintained outside the U.S.)</i>	
	<input type="checkbox"/> Individual/sole proprietor or single-member LLC	<input type="checkbox"/> C Corporation		<input type="checkbox"/> S Corporation
	<input type="checkbox"/> Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶ _____	<input type="checkbox"/> Partnership		
	<input type="checkbox"/> Trust/estate	<input type="checkbox"/> Other (see instructions) ▶ _____		
	5 Address (number, street, and apt. or suite no.)		Requester's name and address (optional)	
6 City, state, and ZIP code				
7 List account number(s) here (optional)				

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Social security number											
				-			-				
or											
Employer identification number											
				-							

Note. If the account is in more than one name, see the instructions for line 1 and the chart on page 4 for guidelines on whose number to enter.

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 3.

Sign Here	Signature of U.S. person ▶	Date ▶
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General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. Information about developments affecting Form W-9 (such as legislation enacted after we release it) is at www.irs.gov/fw9.

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following:

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)

- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding? on page 2.

By signing the filled-out form, you:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income, and
4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct. See *What is FATCA reporting?* on page 2 for further information.

Note. If you are a U.S. person and a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien;
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States;
- An estate (other than a foreign estate); or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax under section 1446 on any foreign partners' share of effectively connected taxable income from such business. Further, in certain cases where a Form W-9 has not been received, the rules under section 1446 require a partnership to presume that a partner is a foreign person, and pay the section 1446 withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid section 1446 withholding on your share of partnership income.

In the cases below, the following person must give Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States:

- In the case of a disregarded entity with a U.S. owner, the U.S. owner of the disregarded entity and not the entity;
- In the case of a grantor trust with a U.S. grantor or other U.S. owner, generally, the U.S. grantor or other U.S. owner of the grantor trust and not the trust; and
- In the case of a U.S. trust (other than a grantor trust), the U.S. trust (other than a grantor trust) and not the beneficiaries of the trust.

Foreign person. If you are a foreign person or the U.S. branch of a foreign bank that has elected to be treated as a U.S. person, do not use Form W-9. Instead, use the appropriate Form W-8 or Form 8233 (see Publication 515, Withholding of Tax on Nonresident Aliens and Foreign Entities).

Nonresident alien who becomes a resident alien. Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the payee has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement to Form W-9 that specifies the following five items:

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.
2. The treaty article addressing the income.
3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.
4. The type and amount of income that qualifies for the exemption from tax.
5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

Example. Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a nonresident alien or a foreign entity, give the requester the appropriate completed Form W-8 or Form 8233.

Backup Withholding

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS 28% of such payments. This is called "backup withholding." Payments that may be subject to backup withholding include interest, tax-exempt interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, payments made in settlement of payment card and third party network transactions, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will not be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester,
2. You do not certify your TIN when required (see the Part II instructions on page 3 for details),

3. The IRS tells the requester that you furnished an incorrect TIN,

4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or

5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See *Exempt payee code* on page 3 and the separate Instructions for the Requester of Form W-9 for more information.

Also see *Special rules for partnerships* above.

What is FATCA reporting?

The Foreign Account Tax Compliance Act (FATCA) requires a participating foreign financial institution to report all United States account holders that are specified United States persons. Certain payees are exempt from FATCA reporting. See *Exemption from FATCA reporting code* on page 3 and the Instructions for the Requester of Form W-9 for more information.

Updating Your Information

You must provide updated information to any person to whom you claimed to be an exempt payee if you are no longer an exempt payee and anticipate receiving reportable payments in the future from this person. For example, you may need to provide updated information if you are a C corporation that elects to be an S corporation, or if you no longer are tax exempt. In addition, you must furnish a new Form W-9 if the name or TIN changes for the account; for example, if the grantor of a grantor trust dies.

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of \$50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a \$500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of federal law, the requester may be subject to civil and criminal penalties.

Specific Instructions

Line 1

You must enter one of the following on this line; **do not** leave this line blank. The name should match the name on your tax return.

If this Form W-9 is for a joint account, list first, and then circle, the name of the person or entity whose number you entered in Part I of Form W-9.

a. **Individual.** Generally, enter the name shown on your tax return. If you have changed your last name without informing the Social Security Administration (SSA) of the name change, enter your first name, the last name as shown on your social security card, and your new last name.

Note. ITIN applicant: Enter your individual name as it was entered on your Form W-7 application, line 1a. This should also be the same as the name you entered on the Form 1040/1040A/1040EZ you filed with your application.

b. **Sole proprietor or single-member LLC.** Enter your individual name as shown on your 1040/1040A/1040EZ on line 1. You may enter your business, trade, or "doing business as" (DBA) name on line 2.

c. **Partnership, LLC that is not a single-member LLC, C Corporation, or S Corporation.** Enter the entity's name as shown on the entity's tax return on line 1 and any business, trade, or DBA name on line 2.

d. **Other entities.** Enter your name as shown on required U.S. federal tax documents on line 1. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on line 2.

e. **Disregarded entity.** For U.S. federal tax purposes, an entity that is disregarded as an entity separate from its owner is treated as a "disregarded entity." See Regulations section 301.7701-2(c)(2)(iii). Enter the owner's name on line 1. The name of the entity entered on line 1 should never be a disregarded entity. The name on line 1 should be the name shown on the income tax return on which the income should be reported. For example, if a foreign LLC that is treated as a disregarded entity for U.S. federal tax purposes has a single owner that is a U.S. person, the U.S. owner's name is required to be provided on line 1. If the direct owner of the entity is also a disregarded entity, enter the first owner that is not disregarded for federal tax purposes. Enter the disregarded entity's name on line 2, "Business name/disregarded entity name." If the owner of the disregarded entity is a foreign person, the owner must complete an appropriate Form W-8 instead of a Form W-9. This is the case even if the foreign person has a U.S. TIN.

Line 2

If you have a business name, trade name, DBA name, or disregarded entity name, you may enter it on line 2.

Line 3

Check the appropriate box in line 3 for the U.S. federal tax classification of the person whose name is entered on line 1. Check only one box in line 3.

Limited Liability Company (LLC). If the name on line 1 is an LLC treated as a partnership for U.S. federal tax purposes, check the "Limited Liability Company" box and enter "P" in the space provided. If the LLC has filed Form 8832 or 2553 to be taxed as a corporation, check the "Limited Liability Company" box and in the space provided enter "C" for C corporation or "S" for S corporation. If it is a single-member LLC that is a disregarded entity, do not check the "Limited Liability Company" box; instead check the first box in line 3 "Individual/sole proprietor or single-member LLC."

Line 4, Exemptions

If you are exempt from backup withholding and/or FATCA reporting, enter in the appropriate space in line 4 any code(s) that may apply to you.

Exempt payee code.

- Generally, individuals (including sole proprietors) are not exempt from backup withholding.
- Except as provided below, corporations are exempt from backup withholding for certain payments, including interest and dividends.
- Corporations are not exempt from backup withholding for payments made in settlement of payment card or third party network transactions.
- Corporations are not exempt from backup withholding with respect to attorneys' fees or gross proceeds paid to attorneys, and corporations that provide medical or health care services are not exempt with respect to payments reportable on Form 1099-MISC.

The following codes identify payees that are exempt from backup withholding. Enter the appropriate code in the space in line 4.

- 1—An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2)
- 2—The United States or any of its agencies or instrumentalities
- 3—A state, the District of Columbia, a U.S. commonwealth or possession, or any of their political subdivisions or instrumentalities
- 4—A foreign government or any of its political subdivisions, agencies, or instrumentalities
- 5—A corporation
- 6—A dealer in securities or commodities required to register in the United States, the District of Columbia, or a U.S. commonwealth or possession
- 7—A futures commission merchant registered with the Commodity Futures Trading Commission
- 8—A real estate investment trust
- 9—An entity registered at all times during the tax year under the Investment Company Act of 1940
- 10—A common trust fund operated by a bank under section 584(a)
- 11—A financial institution
- 12—A middleman known in the investment community as a nominee or custodian
- 13—A trust exempt from tax under section 664 or described in section 4947

The following chart shows types of payments that may be exempt from backup withholding. The chart applies to the exempt payees listed above, 1 through 13.

IF the payment is for . . .	THEN the payment is exempt for . . .
Interest and dividend payments	All exempt payees except for 7
Broker transactions	Exempt payees 1 through 4 and 6 through 11 and all C corporations. S corporations must not enter an exempt payee code because they are exempt only for sales of noncovered securities acquired prior to 2012.
Barter exchange transactions and patronage dividends	Exempt payees 1 through 4
Payments over \$600 required to be reported and direct sales over \$5,000 ¹	Generally, exempt payees 1 through 5 ²
Payments made in settlement of payment card or third party network transactions	Exempt payees 1 through 4

¹ See Form 1099-MISC, Miscellaneous Income, and its instructions.

² However, the following payments made to a corporation and reportable on Form 1099-MISC are not exempt from backup withholding: medical and health care payments, attorneys' fees, gross proceeds paid to an attorney reportable under section 6045(f), and payments for services paid by a federal executive agency.

Exemption from FATCA reporting code. The following codes identify payees that are exempt from reporting under FATCA. These codes apply to persons submitting this form for accounts maintained outside of the United States by certain foreign financial institutions. Therefore, if you are only submitting this form for an account you hold in the United States, you may leave this field blank. Consult with the person requesting this form if you are uncertain if the financial institution is subject to these requirements. A requester may indicate that a code is not required by providing you with a Form W-9 with "Not Applicable" (or any similar indication) written or printed on the line for a FATCA exemption code.

A—An organization exempt from tax under section 501(a) or any individual retirement plan as defined in section 7701(a)(37)

B—The United States or any of its agencies or instrumentalities

C—A state, the District of Columbia, a U.S. commonwealth or possession, or any of their political subdivisions or instrumentalities

D—A corporation the stock of which is regularly traded on one or more established securities markets, as described in Regulations section 1.1472-1(c)(1)(i)

E—A corporation that is a member of the same expanded affiliated group as a corporation described in Regulations section 1.1472-1(c)(1)(i)

F—A dealer in securities, commodities, or derivative financial instruments (including notional principal contracts, futures, forwards, and options) that is registered as such under the laws of the United States or any state

G—A real estate investment trust

H—A regulated investment company as defined in section 851 or an entity registered at all times during the tax year under the Investment Company Act of 1940

I—A common trust fund as defined in section 584(a)

J—A bank as defined in section 581

K—A broker

L—A trust exempt from tax under section 664 or described in section 4947(a)(1)

M—A tax exempt trust under a section 403(b) plan or section 457(g) plan

Note. You may wish to consult with the financial institution requesting this form to determine whether the FATCA code and/or exempt payee code should be completed.

Line 5

Enter your address (number, street, and apartment or suite number). This is where the requester of this Form W-9 will mail your information returns.

Line 6

Enter your city, state, and ZIP code.

Part I. Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. If you are a resident alien and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see *How to get a TIN* below.

If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN. However, the IRS prefers that you use your SSN.

If you are a single-member LLC that is disregarded as an entity separate from its owner (see *Limited Liability Company (LLC)* on this page), enter the owner's SSN (or EIN, if the owner has one). Do not enter the disregarded entity's EIN. If the LLC is classified as a corporation or partnership, enter the entity's EIN.

Note. See the chart on page 4 for further clarification of name and TIN combinations.

How to get a TIN. If you do not have a TIN, apply for one immediately. To apply for an SSN, get Form SS-5, Application for a Social Security Card, from your local SSA office or get this form online at www.ssa.gov. You may also get this form by calling 1-800-772-1213. Use Form W-7, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or Form SS-4, Application for Employer Identification Number, to apply for an EIN. You can apply for an EIN online by accessing the IRS website at www.irs.gov/businesses and clicking on Employer Identification Number (EIN) under Starting a Business. You can get Forms W-7 and SS-4 from the IRS by visiting IRS.gov or by calling 1-800-TAX-FORM (1-800-829-3676).

If you are asked to complete Form W-9 but do not have a TIN, apply for a TIN and write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

Note. Entering "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon.

Caution: A disregarded U.S. entity that has a foreign owner must use the appropriate Form W-8.

Part II. Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if items 1, 4, or 5 below indicate otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). In the case of a disregarded entity, the person identified on line 1 must sign. Exempt payees, see *Exempt payee code* earlier.

Signature requirements. Complete the certification as indicated in items 1 through 5 below.

1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983. You must give your correct TIN, but you do not have to sign the certification.

2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983. You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.

3. Real estate transactions. You must sign the certification. You may cross out item 2 of the certification.

4. Other payments. You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments made in settlement of payment card and third party network transactions, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), IRA, Coverdell ESA, Archer MSA or HSA contributions or distributions, and pension distributions. You must give your correct TIN, but you do not have to sign the certification.

What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account)	The actual owner of the account or, if combined funds, the first individual on the account ¹
3. Custodian account of a minor (Uniform Gift to Minors Act)	The minor ²
4. a. The usual revocable savings trust (grantor is also trustee) b. So-called trust account that is not a legal or valid trust under state law	The grantor-trustee ¹ The actual owner ¹
5. Sole proprietorship or disregarded entity owned by an individual	The owner ³
6. Grantor trust filing under Optional Form 1099 Filing Method 1 (see Regulations section 1.671-4(b)(2)(i)(A))	The grantor*
For this type of account:	Give name and EIN of:
7. Disregarded entity not owned by an individual	The owner
8. A valid trust, estate, or pension trust	Legal entity ⁴
9. Corporation or LLC electing corporate status on Form 8832 or Form 2553	The corporation
10. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
11. Partnership or multi-member LLC	The partnership
12. A broker or registered nominee	The broker or nominee
13. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity
14. Grantor trust filing under the Form 1041 Filing Method or the Optional Form 1099 Filing Method 2 (see Regulations section 1.671-4(b)(2)(i)(B))	The trust

¹ List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

² Circle the minor's name and furnish the minor's SSN.

³ You must show your individual name and you may also enter your business or DBA name on the "Business name/disregarded entity" name line. You may use either your SSN or EIN (if you have one), but the IRS encourages you to use your SSN.

⁴ List first and circle the name of the trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.) Also see *Special rules for partnerships* on page 2.

*Note. Grantor also must provide a Form W-9 to trustee of trust.

Note. If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.

Secure Your Tax Records from Identity Theft

Identity theft occurs when someone uses your personal information such as your name, SSN, or other identifying information, without your permission, to commit fraud or other crimes. An identity thief may use your SSN to get a job or may file a tax return using your SSN to receive a refund.

To reduce your risk:

- Protect your SSN,
- Ensure your employer is protecting your SSN, and
- Be careful when choosing a tax preparer.

If your tax records are affected by identity theft and you receive a notice from the IRS, respond right away to the name and phone number printed on the IRS notice or letter.

If your tax records are not currently affected by identity theft but you think you are at risk due to a lost or stolen purse or wallet, questionable credit card activity or credit report, contact the IRS Identity Theft Hotline at 1-800-908-4490 or submit Form 14039.

For more information, see Publication 4535, Identity Theft Prevention and Victim Assistance.

Victims of identity theft who are experiencing economic harm or a system problem, or are seeking help in resolving tax problems that have not been resolved through normal channels, may be eligible for Taxpayer Advocate Service (TAS) assistance. You can reach TAS by calling the TAS toll-free case intake line at 1-877-777-4778 or TTY/TDD 1-800-829-4059.

Protect yourself from suspicious emails or phishing schemes. Phishing is the creation and use of email and websites designed to mimic legitimate business emails and websites. The most common act is sending an email to a user falsely claiming to be an established legitimate enterprise in an attempt to scam the user into surrendering private information that will be used for identity theft.

The IRS does not initiate contacts with taxpayers via emails. Also, the IRS does not request personal detailed information through email or ask taxpayers for the PIN numbers, passwords, or similar secret access information for their credit card, bank, or other financial accounts.

If you receive an unsolicited email claiming to be from the IRS, forward this message to phishing@irs.gov. You may also report misuse of the IRS name, logo, or other IRS property to the Treasury Inspector General for Tax Administration (TIGTA) at 1-800-366-4484. You can forward suspicious emails to the Federal Trade Commission at: spam@uce.gov or contact them at www.ftc.gov/idtheft or 1-877-IDTHEFT (1-877-438-4338).

Visit IRS.gov to learn more about identity theft and how to reduce your risk.

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons (including federal agencies) who are required to file information returns with the IRS to report interest, dividends, or certain other income paid to you; mortgage interest you paid; the acquisition or abandonment of secured property; the cancellation of debt; or contributions you made to an IRA, Archer MSA, or HSA. The person collecting this form uses the information on the form to file information returns with the IRS, reporting the above information. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation and to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their laws. The information also may be disclosed to other countries under a treaty, to federal and state agencies to enforce civil and criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism. You must provide your TIN whether or not you are required to file a tax return. Under section 3406, payers must generally withhold a percentage of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to the payer. Certain penalties may also apply for providing false or fraudulent information.

EXHIBIT B
SCOPE OF WORK

EXHIBIT B: SCOPE OF WORK

SECTION 1 — ADMINISTRATIVE SERVICES MEDICAL AND DENTAL PLAN

Boon-Chapman shall provide County with the following services as required for the administration and operation for each of the benefit plans identified in RFP 24-004.

A. ACCOUNT SERVICES

DEVELOPMENT, COMMUNICATION, AND INSTALLATION FOR EACH OF THE BENEFIT PLANS IDENTIFIED IN RFP 24-004

- a. Recommendations as to initial development and design of each Plan and Plan Document and future revisions thereof; as requested by County.
- b. Cost projections of benefits and administration; as requested by County.
- c. Assistance in preparation of employee communications material and benefit booklets; as requested by County.
- d. Communication and enrollment of employees and dependents through meetings provided and arranged by County; as requested by County.
- e. Development and design of forms and procedures for processing requests for benefits payment; as requested by County.
- f. Boon-Chapman will submit any advertising relating to the Plan to County for approval prior to its use.

REPORTS AND RECORDS: PREPARATION OF SUCH ACCOUNTING REPORTS AS ARE NEEDED IN THE FINANCIAL MANAGEMENT AND ADMINISTRATIVE CONTROL OF THE PLAN, SUCH AS INCLUDING BUT NOT LIMITED TO: PROJECTIONS OF INITIAL AND RENEWAL UNIT COST AND TOTAL COST AND LISTINGS OF BENEFITS PAID.

B. BOON-CHAPMAN MAY PROVIDE COUNTY WITH THE OTHER SPECIAL SERVICES TO WHICH THE PARTIES MUTUALLY AGREE AS DOCUMENTED IN A WRITTEN AMENDMENT TO THE AGREEMENT.

C. MEDICAL AND DENTAL PLAN CLAIMS ADMINISTRATION (See Exhibit C for pricing)

1. Boon-Chapman shall, in accordance with the terms of County's Plan Document(s):
 - a. Process medical and dental benefits with respect to Covered Persons and determine the amount due and payable;
 - b. Process any written requests, issues or comments received from Covered Persons on appeals of denied benefits and forward the information to County for review and decision;
 - c. Upon receipt of County's decision of benefit appeals, calculate any amount due and payable and make payment, or issue a denial notice, all in accordance with written instructions of County;
 - d. Issue checks in payment of benefits to Covered Persons or to such other person or assignee entitled thereto;
 - e. Maintain records and files of benefit payments for each Covered Person;
 - f. Submit reports of benefit payments as agreed upon with County at mutually agreeable times.

2. When so directed by County, Boon-Chapman shall suspend payment of benefits until resumption is authorized by County.
3. Any protest of a benefit payment that the County would reasonably expect to be notified of shall be brought to the immediate attention of County.
4. Boon-Chapman shall not be liable for or be required to use its funds for the payment of claims under the Plan. Boon-Chapman shall not be considered the insurer or underwriter of the liability of the County to provide benefits for the Plan's Covered Persons, and the County shall have the final responsibility and liability for payment of claims in accordance with the provisions of the Plan. All review of denied benefits and final benefit decisions will be the responsibility of the County. The County shall be responsible for all expenses of the operation of the Plan, except as provided under this Agreement.
5. If a payment is made to or on behalf of an ineligible person or if an overpayment is made to a covered person, Boon-Chapman shall attempt, with full cooperation and assistance of the County, to recover such payment through reimbursement or from future benefits that become due to such person or entity, but shall not be responsible for such payment or overpayment unless it was due to gross negligence of the Boon-Chapman.

D. MEDICAL PLAN UTILIZATION MANAGEMENT/ PRE-AUTHORIZATION
(See Exhibit C for pricing)

1. Pre-Authorization/Inpatient Utilization Management
 - a. Inpatient Hospital Pre-Authorization, including mental nervous and/or chemical dependency. When Boon-Chapman receives notification of an acute care hospital admission before the admission, Boon-Chapman will attempt to communicate with the appropriate health care providers to determine the diagnosis, proposed treatment and requested length of stay. Using clinical knowledge and clinical criteria, Boon-Chapman will review whether the proposed admission and length of stay is medically necessary and advise the covered person or the health care provider of its decision.
 - b. Concurrent Review, including mental nervous and/or chemical dependency. Boon-Chapman will review requests for approval of additional days for on-going hospital admissions and approve such days when appropriate.
 - c. Lower Level Care Admission: Boon-Chapman will review admission to skilled nursing facility, rehabilitation facility, long-term acute care facility to determine whether they are medically necessary and advise the covered person or the health care provider of its decision.
 - d. Retrospective Review: If Boon-Chapman receives notification of an acute care hospital admission, emergency admission or lower level care admission including mental nervous and/or chemical dependency after the initial admission, Boon-Chapman will attempt to communicate with the appropriate health care providers to determine the diagnosis, proposed treatment and requested length of stay. Using clinical knowledge and clinical criteria, Boon-Chapman will review whether the admission and length of stay is medically necessary and advise the covered person or the health care provider of its decision.

- e. Coordination with Fort Bend County Employee Benefit Plan and Employee Assistance Program (“EAP”): Boon-Chapman will work with patient, provider, and EAP to facilitate a smooth transfer to a network provider after EAP visits are exhausted and benefits are to be rendered under the medical plan.
2. Outpatient Utilization Management: Boon-Chapman will review mutually agreed upon outpatient surgeries and services, diagnostic tests, mental nervous and/or chemical dependency services that are outlined in the plan document.
3. Prime DX: Boon-Chapman will perform its utilization duties under the Agreement Sections D2 and D3 by and through PrimeDx, a Utilization Management company, wholly owned by Boon-Chapman. However, Boon-Chapman will remain responsible for the execution of those duties according to the terms of this Agreement. PrimeDx’s hours of operation will be no less than Monday through Thursday, 8am to 6pm Central time and Friday, 8am to 5pm Central time.
4. Case Management: Case management services including mental nervous and/or chemical dependency are available to those members with catastrophic illnesses, chronic diseases, acute episodes of illness, traumatic injuries or individuals requiring multiple healthcare services. It also includes a covered person becoming a candidate for an organ transplant or becoming pregnant under high-risk circumstances. If Boon-Chapman determines, that an alternative plan of treatment or a fee negotiation for services will likely result in cost savings to County, it will encourage the physician or covered person to use the alternative treatment plan or the services available at a discounted fee. If the physician or covered person chooses not to do so, Boon-Chapman’s responsibilities with respect to alternative plan of treatment will be complete. County will reimburse Boon-Chapman for the cost of any outside medical review.

E. MEDICAL PLAN/MEDICARE REPRICING SERVICES

(See Exhibit C for pricing)

1. Boon-Chapman will limit the allowable charges for non-network hospital and facility charges, as directed by County’s Director of Risk Management, which will be an agreed percentage of what Medicare would allow, for a fee of 10% of savings. The savings will be calculated as the difference between the Medicare allowable and what the Fort Bend County Employee Benefit Plan’s liability would have been if the Fort Bend County Employee Benefit Plan had paid at the non-network coinsurance benefit level, based on billed charges. If the Fort Bend County Employee Benefit Plan, in its discretion, agrees to allow a higher payment amount after the provider has been paid the Medicare allowable rate, Boon-Chapman will refund County its fee, prorated to the extent of the adjustment.
2. Boon-Chapman will reprice dialysis claims to a percentage of Medicare as directed by County’s Director of Risk Management.

F. MEDICAL AND DENTAL PLAN RETIREE PREMIUM COLLECTION SERVICES

(See Exhibit C for pricing)

Boon-Chapman will bill and collect monthly premiums from Fort Bend County Retirees on any benefit plan offered or sponsored by Fort Bend County.

**G. MEDICAL AND DENTAL PLAN COBRA ADMINISTRATIVE SERVICES:
(See Exhibit C for pricing)**

1. Boon-Chapman shall provide County with the following services as required for the administration of the continuation of coverage provisions of COBRA for certain employees and their dependents:
 - a. Provide the following forms which are necessary to administer continuation of coverage:
 - i. Notice of right to continue coverage;
 - ii. Continuation enrollment form;
 - iii. Payment Coupons; and
 - iv. Termination notices
 - b. Provide direct contact with the continuing individuals on behalf of County.
 - c. Make available to County actuarial services to determine a reasonable rate amount. County shall reimburse Contract Claims Administrator for reasonable actuarial services that County authorizes.
 - d. Send notification of continuation to qualified individuals to the last known address, within ten working days of receiving notice of qualifying event.
 - e. Collect premiums from continuing individuals. Contract Claims Administrator will have no responsibility to remit any premiums not collected from any continuing individual.
 - f. Remit premiums collected to the Plan.
 - g. Notify County when a participant's COBRA coverage ends.
 - h. Provide County with a monthly list of COBRA participants.
 - i. Provide County with information about changes in COBRA that affect the services being performed under this agreement.
2. It is mutually understood that it is the responsibility of County to notify Boon-Chapman in a form provided by County within three working days after County is aware of a COBRA qualifying event.

**H. MEDICAL PLAN OUT-PATIENT PRESCRIPTION DRUG CARD ADMINISTRATION
(See Exhibit C for pricing)**

Boon-Chapman will transmit eligibility to the appropriate prescription benefit management company, include prescription information on the employee ID card, and respond to benefit inquiries.

**I. MEDICAL PLAN DIALYSIS REPRICING
(See Exhibit C for pricing)**

Boon-Chapman will reprice dialysis claims to a percentage as directed by County's Director of Risk Management.

**J. MEDICAL PLAN DISEASE MANAGEMENT SERVICES
(See Exhibit C for pricing)**

Boon-Chapman, working through PrimeDx, will evaluate medical and pharmacy claims to identify Plan participants that have selected chronic conditions that warrant disease management. The nursing staff will provide disease specific education and facilitate coordination of care with the objective of improving Plan participant health and reducing Plan costs. Boon-Chapman/PrimeDx staff may provide on-site disease management activities as needed. If Boon-Chapman is unable to contact a Plan Participant, County will assist Boon-Chapman upon request.

**K. MEDICAL PLAN PROVIDER NEGOTIATIONS NON P.P.O.
(See Exhibit C for pricing)**

At the direction of the County, Boon-Chapman will attempt to obtain discounts from out-of-network providers in order to decrease both Plan costs and balance billing to the member. Negotiated claims will be processed at the out of network coinsurance level, and all negotiations will be signed off on by the provider. Savings will be measured as follows: The actual monetary difference between what the FBC medical plan would have paid, according to the most current plan document versus the negotiated discount obtained by Boon-Chapmans Cost Containment Unit. The percentage of savings payment to Boon-Chapman will be as stated on Exhibit C.

**L. MEDICAL PLAN TRANSPARENCY TOOL
(See Exhibit C for pricing)**

Offer the services of Healthcare Bluebook, or other similar vendors. Using this service, participants search procedures to find out how much cost should be in a service area and use Fair Price information to compare procedure costs which should assist in reducing out-of-pocket costs every time when receiving medical care. Services also include viewing of quality metrics, allowing the participants to get the highest quality care at the lowest price.

**M. MEDICAL PLAN HIGH TOUCH CUSTOMER SERVICE
(See Exhibit C for pricing)**

Boon-Chapman will provide a Member Champion to provide patient advocacy services which will assist members and their dependents with navigating the complicated field of medical and dental insurance. Specific tasks include, but are not limited to: working directly with members and their dependents to help them understand medical terminology and medical bills, researching network providers, researching possible solutions for patients, discussing explanation of benefits and contacting medical or dental providers on behalf of a patient to gather information and negotiate payment plans, bill reductions, etc. The Member Champion would also proactively contact members when we need additional information and before certain claim denials and perform other tasks as directed to provide superior customer service.

N. EXCEPT AS OTHERWISE STATED IN THIS SECTION (SECTION N), THE FOLLOWING SERVICES WILL BE OFFERED AT NO ADDITIONAL FEE OR CHARGE BY BOON-CHAPMAN. IF A PRODUCT OR SERVICE IS OFFERED BY A VENDOR OTHER THAN BOON-CHAPMAN FOR ANY OF THE AREAS

BELOW, THOSE VENDORS RATES OR FEES MUST BE APPROVED BY SIGNED CONTRACT AMENDMENT PRIOR TO ANY IMPLEMENTATION.

1. Medical and Dental Plan Subrogation Services

Identify claims with potential third party liability and work with plan participant and legal counsel, if applicable, to attempt recovery of claims.

2. Medical Plan Reinsurance/Stop-Loss

Assist in marketing, analysis and placement of reinsurance.

3. Medical and Dental Plan P.P.O./E.P.O./H.M.O Networks

Assist in marketing, analysis, placement and administration of networks.

4. Prescription Benefit Management Selection Services

Assist in marketing, analysis and placement of program, which may include a fee.

5. Medical Plan Medical Tourism

i. *Domestic* –Assist participants in obtaining applicable outpatient surgical care at Surgery Center of Oklahoma or other facilities that use “transparent pricing”. We will work with the County to implement and communicate Plan language to incent participants to use this facility. Provide Medical Plan language. Applicable Plan benefits apply to services rendered.

ii. *International* –Assist participants in obtaining applicable care Health City Cayman Islands or other like facilities. We will work with the County to implement and communicate Plan language to incent participants to use this facility. Provide Plan language. Applicable Plan benefits apply to services rendered.

6. Medical Plan Hospital Bill Audit

Assist in the evaluation, procurement, contracting, and implementation of the services of a hospital bill audit company to scrub bills to find billing code errors, gross overcharges, and other types of common billing errors for an additional fee. If the county decides to engage an outside auditor Boon-Chapman will reasonably cooperate with an outside auditor but may charge an additional fee. Any such fees described in this Section must be approved in advance, and in writing, by the County Director of Risk Management.

7. Employee Assistance Programs

Assist in the evaluation, procurement, contracting, and implementation of Employee Assistance Programs.

8. Ancillary Products

Assist in the evaluation, procurement, contracting, and implementation of insured ancillary products, including but not limited to, short term disability, long

term disability, life, accidental death and dismemberment, insured vision programs and long term care coverage. Additional information is required for a charge/fee quote. If the County chooses to self-fund the vision benefit, we can assist with plan design and contribution recommendations

9. Debit card for Cafeteria Plan/Section 125 Plan

The Benny Prepaid Benefits Card is a special-purpose MasterCard® Card or Visa® Card that gives participants an easy, automatic way to pay for eligible health care or benefit expenses. The Card lets participants electronically access the pre-tax amounts set aside in their respective employee benefits accounts such as Flexible Spending Accounts (FSAs), Health Reimbursement Accounts (HRAs), and Health Savings Accounts (HSAs). There is a \$5 additional fee for replacement card charged to cardholder, which may be adjusted upon notice.

10. Patient-Centered Outcomes Research Institute Fee

Provide necessary census reporting to the County so that County can complete the required Internal Revenue Service form.

11. Medical Plan Medicare Part D reporting

Creditable coverage disclosure to Centers for Medicare and Medicaid “CMS” Assist in the online annual reporting to CMS.

12. Medical Plan Section 6055/6056 reporting

Assist in the evaluation, procurement, contracting, and implementation of a vendor to track and/or provide appropriate tax forms.

13. Benefit administration outsourcing (if requested by County)

Offer combined billing and online enrollment services. Additional information will be need to determine the fee at the time of a request for this service.

14. Medicare Part D retiree drug subsidy recovery assistance (if requested by County)

Assist in subsidy recoupment. The fee for this service is \$2.00 per retiree per month, plus the cost of the actuarial attestation.

SECTION 2 – HIPAA SERVICES

- A. NOTIFY IN WRITING, EACH NEW HEALTH PLAN PARTICIPANT OF THEIR PRE-EXISTING CONDITION EXCLUSION PERIOD AND THEIR RIGHTS TO ITS REDUCTION THROUGH EVIDENCE OF PRIOR CREDITABLE COVERAGE.**
- B. OBTAIN FROM GROUP OR NEW HEALTH PLAN PARTICIPANT EVIDENCE OF PRIOR CREDITABLE COVERAGE AND/OR ASSIST THE NEW PLAN PARTICIPANT IN SECURING SUCH EVIDENCE.**
- C. CALCULATE, DETERMINE, RECORD AND APPLY ACTUAL PRE-EXISTING CONDITION EXCLUSION PERIOD AFTER APPLYING PRIOR CREDITABLE COVERAGE.**

- D. PROVIDE CUSTOMER SERVICE SUPPORT TO HEALTH PLAN PARTICIPANTS REGARDING HIPAA QUESTIONS AND ISSUES.**
- E. CALCULATE AND PROVIDE CERTIFICATES OF CREDITABLE COVERAGE TO THESE HEALTH PLAN PARTICIPANTS TERMINATING FROM THE HEALTH PLAN.**
- F. MONITOR AND IMPLEMENT PROCEDURES TO INSURE HEALTH PLAN COMPLIANCE AS MAY BE NECESSARY DUE TO REGULATORY CHANGES AND NEW CASE LAW.**

SECTION 3 — ADMINISTRATIVE SERVICES CAFETERIA PLAN/ IRS SECTION 125

(See Exhibit C for pricing)

- A. BOON-CHAPMAN SHALL PROVIDE COUNTY WITH THE FOLLOWING ADMINISTRATIVE SERVICES FOR OPERATION OF THE PLAN:**
 - 1. Receipt of contributions for employees from County and their deposit in a special bank account;
 - 2. Posting of contributions to each employee's account by benefit;
 - 3. Issuing of payments from employee's benefit account for designated benefits or reimbursement to employees for eligible expenses, to the extent that funds are available;
 - 4. Posting of disbursements to employee's benefit account;
 - 5. Providing County and each employee with a record of contributions, disbursements, and account balances on a quarterly basis; and
 - 6. Providing County with a record of bank account transactions monthly.
- B. BOON CHPAMAN SHALL KEEP ALL RECORDS FILES, RECORDS, AND REPORTS PREPARED AND MAINTAINED BY BOON-CHAPMAN FOR THE PROVISION OF THE ADMINISTRATIVE SERVICES CAFETERIA PLAN/ IRS SECTION 125 SHALL BE KEPT IN STRICT ACCORDANCE WITH AGREEMENT FOR THIRD PARTY CLAIMS ADMINISTRATION SERVICES PURSUANT TO RFP 24-004 AND AS REQUIRED BY THE INTERNAL REVENUE SERVICE.**

EXHIBIT C
SERVICE AND FEE SCHEDULE


	A	B	C	F
3			Proposal For:	Fort Bend County
4	EXCEPTIONAL SERVICE MATTERS		Rate Effective Date:	January 01, 2024
6	ADMIN / STOP LOSS RENEWAL		IN FORCE POLICY	OPTION
7	<i>As of 11/15/2023</i>			
10	Proposal Status			FIRM
11	Underwriter		Aetna - Renewals	Aetna - Renewals
12	Administrator		Boon-Chapman	Boon-Chapman
13	Network		Aetna	Aetna
14	PBM		ExpressScript	CVS Caremark
15	Enrollment			
16	Employee	2,084	2,084	2,084
17	Family	1,424	1,424	1,424
18	Total Enrollment	3,508	3,508	3,508
19	SPECIFIC			
20	Terms			
21	Specific Contract Basis		12/36	12/36
25	Benefits Covered Under Specific		MEDICAL,RX	MEDICAL,RX
29	Annual Maximum		Unlimited	Unlimited
35	Liability			
36	Specific Deductible		\$375,000	\$425,000
39	Laser Liability		<i>Roctavian excluded</i>	
40	Laser 1 (TR)		\$800,000	\$725,000
41	Laser 2 (DF)		\$1,000,000	\$800,000
42	Laser 3 (MG) - REMOVED		\$750,000	
50	Additional Laser Liability		\$1,425,000.00	\$675,000.00
51	Premium			
52	Specific Premium Rates			
64	Composite		\$84.98	\$75.87
65	Annual Specific Premium		\$3,577,318.08	\$3,193,823.52
66		<i>\$ Increase</i>		-\$383,494.56
67		<i>% increase</i>		-10.7%
125	ADMINISTRATIVE FEES			
126	PEPM Total			
127	Medical Claims Admin	3,508	\$17.76	\$18.50
128	Dental Claims Admin (stand alone)	3,087	\$3.98	\$3.98
129	Member Advocacy	3,508	\$1.00	\$1.00
130	*UR/CM/DM/CN Package (PDX/AHH)	3,508	\$10.00	\$10.00
131	Healthcare Bluebook	3,508	\$1.90	\$2.00
132	Stop Loss Marketing/Negotiations		\$10,200.00	\$10,200.00
133	Subtotal		\$1,448,298.48	\$1,483,659.12
134	Flex/Total			
135	Flex Plan Administration (PPPM)	645	\$3.00	\$3.00
136	Subtotal		\$23,220.00	\$23,220.00
137	Other B-C Services Total			
138	Retiree billing (per Retiree)	794	\$3.00	\$3.00
139	Subtotal		\$28,584.00	\$28,584.00
140	Network Fee			
141	*AETNA PPO	3,508	\$13.36	\$11.25
142	Teladoc - NEW!	3,508		\$2.25
143	Subtotal		\$562,402.56	\$568,296.00
144	Total Administrative Fees		\$2,062,505.04	\$2,103,759.12
145		<i>\$ Increase</i>		\$41,254.08
146		<i>% increase</i>		2.0%
148	GRAND TOTALS			
149	Annual Specific Premium		\$3,577,318.08	\$3,193,823.52
151	Admin Fees		\$2,062,505.04	\$2,103,759.12
152	Total Fixed Costs		\$5,639,823.12	\$5,297,582.64
153		<i>\$ Increase</i>		-\$342,240.48
154		<i>% increase</i>		-6.1%
163	CARRIERS:			
164	Declinations:		No Response to RFP:	
165	Accurisk (Pricing not competitive)		Berkley	
166	Berkshire Hathaway (Poor loss history)		Liberty Mutual	
167	Certus Management Group (Poor loss history)		Orien/FAIRCO	
168	IOA Re (Unsatisfied carrier requirements)			
169	SL Management Partners (Pricing not competitive)			
170	Sun Life (Pricing not competitive)			
171	Swiss Re (Pricing not competitive)			
172	Optum (Poor loss history)			
173	Skyward Specialty Insurance (Poor participation numbers)			

EXHIBIT D
BUSINESS ASSOCIATE AGREEMENT

STATE OF TEXAS §

§

COUNTY OF FORT BEND §

BUSINESS ASSOCIATE AGREEMENT

I. INTRODUCTION

A. Parties.

This Business Associate Agreement (“Agreement”) is entered into as of January 1, 2024 by and between the County of Fort Bend, Texas and Boon-Chapman Benefit Administrators, Inc., located at 9401 Amberglen Blvd., Building I, Suite 100, Austin, Texas 78729.

B. Underlying Agreement.

Business Associate and Covered Entity are parties to the AGREEMENT FOR THIRD PARTY CLAIMS ADMINISTRATION SERVICES PURSUANT TO RFP 24-004 (“Underlying Agreement”) to which Business Associate provides certain services to Covered Entity.

C. HIPAA.

In relation to the performance of services, Business Associate may receive protected health information from Covered Entity or otherwise have access to protected health information that must be kept confidential in accordance with the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) and regulations promulgated thereunder, as may be amended from time to time. Therefore, in consideration of the foregoing premises and the mutual covenants and conditions set forth below and in the Underlying Agreement, Business Associate and Covered Entity, agree to the terms and conditions set forth in this Agreement.

II. DEFINITIONS

- A. **“Business Associate”** shall mean Boon Chapman, located at 9401 Amberglen Blvd., Building I, Suite 100, Austin, Texas 78729.
- B. **“Catch-all definition”** shall mean that terms used, but not otherwise defined, in this Agreement shall have the same meaning as those terms in the Privacy Rule.
- C. **“Covered Entity”** shall mean Fort Bend County.
- D. **“Disclosure”** shall mean the release, transfer, provision of access to, or divulging in any other manner, of Protected Health Information, outside Business Associate’s

organization, i.e., to anyone other than its employees who have a need to know or have access to the PHI or EPHI.

- E. **“Individual”** shall have the same meaning as the term “individual” in 45 CFR §160.103 and shall include a person who qualifies as a personal representative in accordance with 45 CFR §164.502 (g).
- F. **“Individually Identifiable Health Information”** means information collected from an individual that is created by or received by Covered Entity and relates to a past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual or the past, present or future payment for health care, and which identifies the individual and with respect to which there is a reasonable basis to believe the information can be used to identify the individual.
- G. **“Privacy Rule”** shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR part 160 and part 164, subparts A and E.
- H. **“Protected Health Information” or “PHI”** means information that is or has been electronically transmitted by or maintained in electronic media or any other form or medium, including demographic information collected from an individual, that (a) relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual; (b) individually identifies the individual or, with respect to which, there is a reasonable basis for believing that the information can be used to identify the individual; and (c) is received by Business Associate from or on behalf of Covered Entity, or is created by Business Associate, or is made accessible to Business Associate by Covered Entity. PHI shall have the same meaning as the term “protected health information” in 45 CFR §160.103, limited to the information created or received by Business Associate from or on behalf of Covered Entity.
- I. **“EPHI”** means electronic Protected Health Information.
- J. **“Required by Law”** shall have the same meaning as the term “required by law” in 45 CFR §164.501.
- K. **“Secretary”** shall mean the Secretary of the Department of Health and Human Services or any other officer or employee of the Department of Health and Human Services to whom the authority involved has been delegated.
- L. **“Security Rule”** shall mean the standards for the security of electronic protected health information at 45 CFR Parts 160,162, and 164.
- M. **“Services”** has the same meaning as in the Underlying Agreement.

- N. **“Use”** (whether capitalized or not and including the other forms of the word) means, with respect to Protected Health Information, the sharing, employment, application, utilization, transmission, examination, or analysis of such information to, from or within Business Associate’s organization.

III. **CONFIDENTIALITY OBLIGATIONS OF BUSINESS ASSOCIATE**

- A. **Privacy, Security, and Confidentiality.** Business Associate shall maintain the privacy, security, and confidentiality of all PHI or EPHI, in accordance with HIPAA and this Agreement.
- B. **Use of PHI or EPHI.** Business Associate is authorized to use and disclose PHI or EPHI only in accordance with the provisions of this Agreement, and only to the extent reasonably necessary (a) to provide the Services; (b) for the proper management and administration of Business Associate; and (c) to carry out the legal responsibilities of Business Associates.
- C. **Notice of Breach or Violation.** Business Associate acknowledges that, under HIPAA, Covered Entity could be deemed to be in violation of HIPAA if Covered Entity knows of a pattern of activity or practice of Business Associate that constitutes a material breach or violation of Business Associate’s obligations under this Agreement to maintain privacy, security, and confidentiality of PHI or EPHI, unless Covered Entity takes reasonable steps to cure the breach or end the violation; and, if such steps are unsuccessful, terminates the Underlying Agreement or reports the problem to the Secretary. Accordingly, Business Associate shall promptly notify Covered Entity of any pattern of activity or practice of Business Associate that constitutes any such material breach or violation.
- D. **Additional Obligations.** Business Associate shall:
1. Review and understand the HIPAA Rules as it applies to Business Associate, and to comply with the applicable requirements of the HIPAA Rules, as well as any applicable amendments.
 2. Not use or disclose PHI or EPHI other than as permitted or required by the Underlying Agreement, this Agreement or as required by law.
 3. Implement industry best practices in administrative, physical, and technical safeguards that protect the confidentiality, integrity, and availability of EPHI that it creates, receives, maintains or transmits on behalf of the Covered Entity in accordance with 45 C.F.R. §164.314(a)(2)(i)(A).
 4. Report to Covered Entity any Security Incident without unreasonable delay, and in no event later than ten (10) calendar days, after becoming aware that such Security Incident affects Covered Entity’s information, as such term is defined in the HIPAA Security Rule.

5. Business Associate agrees to report to Covered Entity any breach of unsecured Protected Health Information, as identified in 45 C.F.R. §164.314(a)(2)(i)(C), without unreasonable delay and in no case later than ten (10) calendar days after becoming aware that such Breach affects Covered Entity's Protected Health Information. Such notice shall include the date of the security incident, the scope of the security incident, the Business Associate's response to the security incident and the identification of the party responsible for causing the security incident, if known. Thereafter, Business Associate shall provide periodic updates regarding the security incident, at Covered Entity's written request.
6. Perform breach notification to individuals as directed by Covered Entity. Business Associate's duty to notify Covered Entity of any breach does not permit Business Associate to notify those individuals whose PHI or EPHI has been breached by Business Associate without the express written permission of Covered Entity to do so. Any and all notification to those individuals whose PHI has been breached shall be made under the direction, review and control of Covered Entity. The Business Associate will notify the County Risk Management Director via telephone with follow-up in writing to include; name of individuals whose PHI or EPHI was breached, information breached, date of breach, form of breach, etc. All cost of the notification will be paid by the Business Associate regardless of which party performs the notification, if the breach is caused by Business Associate.
7. Ensure that any agent, including a subcontractor, to whom it provides PHI or EPHI agrees in writing to implement reasonable and appropriate safeguards to protect EPHI. 45 C.F.R. §164.314(a)(2)(i)(B).
8. Mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI or EPHI by Business Associate in violation of the Underlying Agreement or this Agreement.
9. Promptly report to Covered Entity any use or disclosure of PHI or EPHI not provided for by the Underlying Agreement or this Agreement of which Business Associate becomes aware.
10. Ensure that any agent or subcontractor, to whom it provides PHI or EPHI received from, or created or received by Business Associate on behalf of Covered Entity agrees to the same restrictions and conditions, in writing, that apply through the Underlying Agreement or this Agreement to Business Associate with respect to such information.
11. Provide access, at the request of Covered Entity, and in reasonable time and manner, to PHI or EPHI in a Designated Record Set to an Individual to whom the particular PHI or EPHI pertains for the purposes of inspecting and obtaining a copy of such PHI or EPHI, In accordance with the Privacy Rule, specifically 45 CFR §164.524.
12. Make any amendment(s) to PHI or EPHI in a Designated Record Set as instructed by Individual or Covered Entity, in accordance with the Privacy Rule, specifically 45 CFR §164.526.
13. Make its internal practices, books, records (including policies and procedures, PHI or EPHI and the pertinent provisions of this Agreement and the Underlying

Agreement), relating to the use and disclosure of PHI or EPHI received from, or created or received by Business Associate on behalf of, Covered Entity available to the Covered Entity or the Secretary, in a time and manner designated by the Secretary, for the purposes of the Secretary determining Covered Entity's compliance with the Privacy Rule (in all events, Business Associate shall immediately notify Covered Entity upon receipt by Business Associate of any such request, and shall provide Covered Entity with copies of any such materials).

14. Document such disclosures of PHI or EPHI and information related to such disclosures as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI or EPHI, in accordance with the Privacy Rule, specifically 45 CFR §164.528.
15. Provide to an Individual as directed by Covered Entity, in a reasonable time and manner, information collected in accordance with the Underlying Agreement, to permit Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI or EPHI, in accordance with the Privacy Rule, specifically 45 CFR §164.528.
16. Return or destroy all PHI or EPHI received from Covered Entity that Business Associate still maintains in any form and Business Associate agrees to retain no copies of such information upon termination of the Underlying Agreement. In the event that Business Associate determines that returning or destroying the PHI or EPHI is infeasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction infeasible. Business Associate shall extend the protections of this Agreement to such PHI or EPHI to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such PHI or EPHI

IV. PERMITTED USES AND DISCLOSURES BY BUSINESS ASSOCIATE

- A. Except as otherwise limited in this Agreement, Business Associate may use or disclose PHI or EPHI to perform functions, activities, or services for, or on behalf of, Covered Entity as specified in the Underlying Agreement, provided that such use or disclosure would not violate the Privacy Rule if done by Covered Entity or the minimum necessary policies and procedures of the Covered Entity.
- B. Business Associate may use Protected Health Information to report violations of law to appropriate Federal and State authorities, consistent with 45 CFR §164.502 (j) (1).

V. OBLIGATIONS OF COVERED ENTITY

- A. Covered Entity shall notify Business Associate of any limitation(s) in its notice of privacy practices of Covered Entity in accordance with 45 CFR §164.520, to the extent that such limitation may affect Business Associate's use or disclosure of PHI or EPHI.

- B. Covered Entity shall notify Business Associate of any changes in, or revocation of, permission by Individual to use or disclose PHI or EPHI, to the extent that such changes may affect Business Associate's use or disclosure of PHI or EPHI.
- C. Covered Entity shall notify Business Associate of any restriction to the use or disclosure of PHI or EPHI that Covered Entity has agreed to in accordance with 45 CFR §164.522 to the extent that such restriction may affect Business Associate's use or disclosure of PHI or EPHI.

VI. **PERMISSIBLE REQUESTS BY COVERED ENTITY**

Covered Entity shall not request Business Associate to use or disclose PHI or EPHI in any manner that would not be permissible under the Privacy Rule if done by Covered Entity.

VII. **TERM AND TERMINATION**

- A. **Term.** The Term of this Agreement shall be effective as of January 1, 2024 and shall terminate when all of the PHI or EPHI provided by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity, is destroyed or returned to Covered Entity, or, it is infeasible to return or destroy PHI or EPHI, protections are extended to such information, in accordance with the termination provisions of this section.
- B. **Termination for Cause.** Without limiting the rights and remedies of Covered Entity elsewhere set forth in this Agreement or available under applicable law, Covered Entity may terminate this Agreement without penalty or recourse to Business Associate if Covered Entity determines that Business Associate has violated a material term of the provisions of this Agreement or Underlying Agreement, or such violation is imminent and material. Upon Covered Entity's knowledge of a material breach by Business Associate, Covered Entity shall either:
 - 1. Provide an opportunity for Business Associate to cure the breach or end the violation and terminate this Agreement if Business Associate does not cure the breach or end the violation with the time specified by Covered Entity.
 - 2. Immediately terminate this Agreement if Business Associate has breached a material term of this Agreement and cure is not possible; or
 - 3. If neither termination nor cure is feasible, Covered Entity shall report the violation to the Secretary.

VIII. **DEFAULT.**

A breach under this Agreement shall be deemed to be a material default under the Underlying Agreement.

IX. EFFECT OF TERMINATION.

- A. Except as provided in paragraph VII.B.1 of this Agreement, upon termination of the Agreement, for any reason, Business Associate shall return or destroy all PHI OR EPHI received from Covered Entity. This provision shall apply to PHI or EPHI that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the PHI or EPHI.
- B. In the event that Business Associate determines that returning or destroying the PHI or EPHI is infeasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction infeasible. Business Associate shall extend the protections of this Agreement to such PHI or EPHI to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such PHI or EPHI.

X. MISCELLANEOUS

- A. **Regulatory References.** A reference in this Agreement to a section in the Privacy Rule means the section as in effect or as amended.
- B. **Amendment.** The Parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for Covered Entity to comply with the requirements of the Privacy Rule and the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191.
- C. **Survival.** The respective rights and obligations of Business Associate under Section 4 of this Agreement shall survive the termination of this Agreement.
- D. **Interpretation.** Any ambiguity in this Agreement shall be resolved to permit Covered Entity to comply with the Privacy Rule.
- E. **Inconsistencies.** To the extent there are any inconsistencies between this Agreement, and the terms of the Underlying Agreement, the terms of this Agreement shall prevail.
- F. **Mitigation.** If Business Associate violates this Agreement or the HIPAA Rules, Business Associate agrees to mitigate any damage caused by such breach.
- G. **Indemnification.** Business Associate agrees to indemnify and hold harmless Covered Entity from and against all claims, demands, liabilities, judgments or causes of action of any nature for any relief, elements of recovery or damages recognized by law (including, without limitation, attorney's fees, defense costs, and equitable relief), for any damage or loss incurred by Covered Entity arising out of, resulting from, or attributable to any acts or omissions or other conduct of Business Associate or its

agents in connection with the performance of Business Associate's or its agents' duties under this Agreement.

IN WITNESS WHEREOF, the parties have hereunto set their hands.

FORT BEND COUNTY

**BOON-CHAPMAN
BENEFIT ADMINISTRATORS, INC.**

KP George, County Judge

Authorized Agent- Signature

Authorized Agent- Printed Name

Title

ATTEST:

Laura Richard, County Clerk

i:\agreements\2024 agreements\purchasing\risk management\boon-chapman benefit (24-risk-100276)\exhibit d - business associate agreement fbc and boon chapman (kcj – 12.12.2023)

EXHIBIT E
SECURITY POLICIES



SECTION 7J

**DATA CLASSIFICATION POLICY
BUILDING ACCESS POLICY
INCIDENT RESPONSE POLICY
RECORD RETENTION POLICY**

Data Classification Policy | July 2023

Boon-Chapman | Soluta | Prime Dx

Data Classification Policy	1
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II. Scope	2
III. Policy	2
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VI. Data Retention	3
Revision History	4

I. Purpose

The purpose of the Data Classification Policy is to protect information that is critical to BC&L (“the Company”) from creation to disposal.

II. Scope

This Policy applies to all Company personnel at all Company Offices and Data Centers. Workforce members working with confidential information must familiarize themselves with this policy.

III. Policy

The Company must protect Company information throughout its life cycle. That protection must be appropriate with the information’s sensitivity, regardless of where it resides, what form it takes, technology used to access it, or purpose(s) the information serves. Data classification distinguishes the separation of Company information based on criticality and helps the Company prepare with appropriate safeguards and protections. See *Security + Privacy Policy*.

The Company is committed to protecting Company information from unauthorized and unnecessary exposure, so we handle Company information on a need to know basis. Employees may only access the minimum necessary amount of Company information in order to perform their duties and reduce the exposure to more information than is appropriate. Any inappropriate exposure of Company information may lead to a data breach investigation and appropriate disciplinary action. See *Breach Notification Policy*.

IV. Information Classification Labels

- **Public:** Available to the public and intended for distribution outside the Company. The Company freely shares this information and exposure poses no potential harm. (Ex: product and service brochures, advertisements, job opening announcements)
- **For Internal Use Only:** Meant for use within the Company. All Company personnel have access to this data. Unauthorized disclosure, modification or destruction not expected to have a serious or adverse impact (Ex: telephone directory, new employee training materials, and internal policy manuals).
- **Confidential:** Intended for use within the Company, access to data limited based on role. Unauthorized disclosure could have adverse impact for the Company (Ex: appointment schedules, department financial data, contracts and agreements).
- **Restricted Confidential:** The most sensitive medical and business information handled by the Company, intended strictly for use within the organization. Access heavily controlled based on role and assigned project. Unauthorized disclosure could lead to fines and legal ramifications, or otherwise damage the Company’s ability to do business (Ex: protected health information, corporate level strategic plans, software code, etc.).

V. Other Definitions

- **BC&L (the Company):** Describes the operations of eight commonly owned companies. These affiliated companies share the same privacy and security rules, including this policy.
 - **BC&L, Inc.:** Company that sponsors the health and retirement plan, and administers payroll. BC&L, Inc. technically employs all employees.
 - **Boon-Chapman Administrators, Inc.:** New corporation forming in 2023
 - **Boon-Chapman Benefit Administrators, Inc. (“Boon-Chapman”):** Third Party Administrator (TPA)
 - **Boon-Chapman, Inc.:** Corporate insurance agency
 - **Boon-Chapman, Ltd.:** Original company

-
- **Capitol Healthcare Review, Inc., dba PrimeDX (“Prime Dx”)**: Medical management company
 - **MedCorp Southwest, Inc.**: Preferred Provider Organization (PPO)
 - **Soluta, Inc. (“Soluta”)**: Software development and clinic management company
 - **Company Co-Locations (“Data Centers”)**: Refers to facilities the Company uses to store physical servers holding Company data, and backup servers used to back up that data.
 - **Cyrus One Data Center (Austin, TX)**: Tier IV Data Center owned by Cyrus One, Inc.
 - **Databank Data Center (Waco, TX)**: Tier III Data Center owned by Databank Holdings, Ltd.
 - **Company Offices**: The Company operates at a main office and two satellite offices:
 - **Austin Office (Austin, TX)**: the “Main Office, “Corporate Office”
 - **New Braunfels Office (New Braunfels, TX)**: Satellite Office (“New Braunfels Office”)
 - **The Woodlands Office (The Woodlands, TX)**: Satellite Office (“Woodlands Office”)
 - **Company Personnel**: Employees, contractors, consultants, volunteers, trainees, auditors and other persons under the policies and procedures of the Company.
 - **Company Systems**: All Company-owned computer, network and software equipment. This includes all platforms (operating systems), all computer sizes (personal digital assistants, desktops, servers, mainframes, etc.), and all applications and data (whether developed in-house or licensed from third parties) contained on those systems.
 - **Off-Site Equipment**: Company owned equipment being used outside the protection of Company offices. Equipment may need special features to access Company Systems, such as a remote desktop/VPN.
 - **Compliance Department**: Responsible for issuing counsel on compliance with best practices and applicable security and privacy law. Led by the Vice President/Chief Compliance Officer/Legal Counsel. Also includes the Compliance Officer and Operational Compliance Liaison. The CCO is the designated Privacy and Security Officer.
 - **Information Technology (IT) Department**: Led by Chief Technical Officer. Includes the Director of Information Technology and Director of Security and Network Operations.

VI. Data Retention

See *Record Retention & Disposal Policy*.

Revision History

Revision	Date	Name	Description
7.0	July 15, 2023	Daniel Chapman	Compliance Officer
6.0	January 13, 2022	Daniel Chapman	Compliance Officer
5.0	January 28, 2021	Daniel Chapman	Compliance Officer
4.0	July 27, 2020	Daniel Chapman	Compliance Officer
3.0	January 5, 2018	Daniel Chapman, Ali Chapman	Compliance Officer, Marketing Manager
2.0	April 11, 2016	Daniel Chapman, Betsy D'Acierno	Compliance Officer, Director of Clinic Operations
1.0	April 24, 2015	Daniel Chapman, Josh Rynearson	Compliance Officer, IT Director

Building Access Policy | August 2023

Boon-Chapman | Soluta | Prime Dx

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I. Purpose and Scope

This document provides building access rules for Company personnel, visitors and vendors of BC&L (“Company”) Offices. This policy applies to all Company personnel, vendors or visitors of Company offices.

II. Definitions

- **BC&L (the Company):** Describes the operations of eight commonly owned companies. These affiliated companies share the same privacy and security rules, including this policy.
 - **BC&L, Inc.:** Company that sponsors the health and retirement plan, and administers payroll. BC&L, Inc. technically employs all Company personnel.
 - **Boon-Chapman Administrators, Inc.:** New corporation forming in 2023
 - **Boon-Chapman Benefit Administrators, Inc. (“Boon-Chapman”):** Third Party Administrator (TPA)
 - **Boon-Chapman, Inc.:** Corporate insurance agency
 - **Boon-Chapman, Ltd.:** Original company
 - **Capitol Healthcare Review, Inc., dba PrimeDX (“Prime Dx”):** Medical management company
 - **MedCorp Southwest, Inc.:** Preferred Provider Organization (PPO)
 - **Soluta, Inc. (“Soluta”):** Software development and clinic management company
- **Company Co-Locations (“Data Centers”):** Refers to facilities the Company uses to store physical servers holding Company data, and backup servers used to back up that data.
 - **Cyrus One Data Center (Austin, TX):** Tier IV Data Center owned by Cyrus One, Inc.
 - **Databank Data Center (Waco, TX):** Tier III Data Center owned by Databank Holdings, Ltd.
- **Company Offices:** The Company operates at a main office and two satellite offices:
 - **Austin Office (Austin, TX):** the “Main Office, “Corporate Office”
 - **New Braunfels Office (New Braunfels, TX):** Satellite Office (“New Braunfels Office”)
 - **The Woodlands Office (The Woodlands, TX):** Satellite Office (“Woodlands Office”)
- **Company Personnel:** Employees, contractors, consultants, volunteers, trainees, auditors and other persons under the policies and procedures of the Company.
- **Compliance Department:** Responsible for issuing counsel on compliance with best practices and applicable security and privacy law. Led by the Vice President/Chief Compliance Officer/Legal Counsel. Also includes the Compliance Officer and Operational Compliance Liaison. The CCO is the designated Privacy and Security Officer.
- **Human Resources (HR) Department:** Department responsible for assigning visitor badges.
- **Information Technology (IT) Department:** Led by Chief Technical Officer. Includes the Director of Information Technology and Director of Security and Network Operations.
- **Leadership:** The CEO/President, Treasurer, CFO, COO and Vice-Presidents
- **Main Entrance:** Where the Company office’s HR representative is located and can assign necessary visitor badges.
- **Secure Areas:** Areas of the Main Office that are restricted to enter without special privileges.
- **Service Desk:** Internal troubleshooting resource for Company personnel. Responsible for maintaining the Manage Engine Service Desk Ticketing System (incident reporting, technical issues) and the JitBit Help Desk Ticketing System (data breach reporting, day-to-day operations). Run by Chief Technical Officer.
- **Service Desk (E-Ticket) System:** Company Helpdesk system provided by vendor Manage Engine. Used for IT and HR-related support requests and asset management.
- **Vendors:** Business partners that may send representatives to Company offices for vendor tasks or business-related meetings.
 - **Authorized Vendors (AVs):** Usually reserved for delivery, maintenance and cleaning personnel, these vendors have signed the *BC&L Vendor Agreement* and their representatives have been cleared with background checks. Because of this, AVs are granted special privileges, and a No Escort Badge may be provided when they visit, which will allow them to move freely within unrestricted areas of the Main Office.

Still, managers arranging visits should notify leadership. Representatives must report to the Main Entrance of the Company office to receive an Escort Badge.

- **Unauthorized Vendors (UVs):** Vendors to Company offices who have not signed the *BC&L Vendor Agreement*. These visits must be approved by a manager, representatives of the UV must be assigned an escort by the manager, and notification of visits must be shared with leadership. Representatives must report to the Main Entrance of the Company office to receive an Escort Badge.
- **Visitors:** Non-Company personnel and non-vendor persons visiting a Company office. Must be given an Escort Badge and assigned an escort. Representatives must report to the Main Entrance of the Company office to receive an Escort Badge.

III. Policy

1. Building Access

Company office hours are Monday to Friday, 5:30AM to 8:00PM, except for certain holidays and unforeseen needed office closures (i.e. inclement weather). Company personnel and visitors may gain access to Company offices during Company hours. The office security system is enabled after company hours. Only Unlimited Access holders may be granted the Leadership Badge Disarm role, which allows them to disarm the security system with their badge, allowing access after Company hours.

The company has three access levels to the Main Office:

1. **Regular Access:** 5:30AM – 8:00PM Monday – Friday (Company personnel)
2. **Weekend Access:** 6:00AM – 8:00PM Saturday – Sunday (Approved by manager weekend access)
3. **Unlimited Access:** 24 x 7 Access and Leadership Badge Disarm ability

Company personnel receive Regular Access upon hire. Regular Access allows for entrance into Company offices during regular office hours only.

Weekend Access may be granted to Company personnel with permission from a manager, allowing Company office access on the weekend, as long as a manager is on site to disable the office security system.

Unlimited Access allows access to Company offices 24 x 7 and grants the Leadership Badge Disarm ability, allowing personnel to disable the office security system with a Company issued badge.

Managers and approved vendors (i.e. building maintenance, the cleaning crew) may receive Weekend Access or Unlimited Access (a manager and the IT Department must preapprove Weekend Access and Unlimited Access).

** In the event a company-issued badge does not work properly after Company hours, a manager or supervisor may use their best judgement on granting Company personnel access to a Company Office. If a manager or supervisor does let in an employee that cannot enter on their own (i.e. lost badge, badge issues) it is the manager or supervisor's responsibility to request appropriate access for their personnel to the IT Department.*

2. Company Personnel

Company personnel must wear their assigned Company-issued ID badges at all times at Company offices. To enter Company offices, Company personnel must scan their ID badge on key card readers at Company office entrances. Company personnel have access to Company offices and secure areas based on their department and role.

Company personnel without their Company badges must go to the Main Entrance and obtain a temporary No Escort badge from the HR Receptionist. The receptionist will verify employment status. Once confirmed, the receptionist will fill out the *Visitor Sign-In Sheet* and issue the employee a No Escort Badge. This badge will grant access to the Main Office. Company personnel must return temporary badges to the HR Receptionist at the end of the day. Company personnel who lose their badges can have them replaced for a \$10 fee.

**If the receptionist cannot verify the person's employment, the person will be treated as a visitor.*

3. Visitors

Managers and directors should notify the HR Department of visits to Company offices. When visitors arrive, they must go to the Main Entrance and to the HR Receptionist.

Upon arrival, visitors must provide the HR Receptionist with their government-issued ID for identification. From there, the HR Receptionist will document the visitor's name, phone number, badge number and reason for visit on the *Visitor Sign-In Sheet*. Then, the HR Receptionist will return the visitor's government issued-ID badge, provide them their Escort Badge and notify the assigned escort of their arrival. A visitor may not enter a Company Office without an escort beyond the reception area.

It is the escort's responsibility to look after the visitor during their visit. Visitors may be without an escort in the restroom.

At the end of their visit, visitors will return their Escort Badge to the HR Receptionist. The Company reserves the right to ask the visitor to leave for any reason, including if they are acting in a way deemed dangerous or inappropriate.

4. Vendors

A. Authorized Vendors (AVs)

Authorized Vendors have signed the *BC&L Vendor Agreement* and enjoy special privileges at Company offices. AVs are assigned No Escort badges that allow them to enter the building during or after Company hours, depending on their agreed upon privileges. Any AVs receiving a No Escort Badge for a temporary visit will return the No Escort Badge at the end of their visit to the HR Receptionist.

If deemed necessary, AVs may gain access to certain Secure Areas, which are normally restricted. The Company reserves the right to disable an AV's badge, including if the business relationship with the AV ends. The Company reserves the right to ask the AV to leave for any reason, including if they are acting in a way deemed dangerous or inappropriate.

B. Unauthorized Vendors (UVs)

Unauthorized Vendors have not signed the *BC&L Vendor Agreement* and have no special privileges at Company offices. Like visitors, UVs must enter through the Main Entrance and give the receptionist their name, phone number, company name and reason for visit. UVs will show their government-issued ID, be provided an Escort Badge to wear at all times, and be assigned an escort.

It is the escort's responsibility to look after the UV during their visit. UVs may be without an escort in the restroom.

At the end of their visit, UVs will return their Escort Badge to the HR Receptionist. The Company reserves the right to ask the UV to leave for any reason, including if they are acting in a way deemed dangerous or inappropriate.

5. Photographs and Cameras

We do not permit visitors to take photographs inside Company offices, unless approved in advance with leadership. If Company personnel have any questions about the suitability of photographs, they should consult the HR Department.

6. Information Disclosure

Visitors should not be requesting information that does not pertain to their visit. Managers must approve documentation requests. Any request deemed to be out of bounds will be denied.

7. Exit Inspection

Visitors may be subject to a brief search of their bags as they enter and exit Company offices.

8. Emergency Evacuation & Disaster Response

In the event of an emergency, Company personnel, vendors and visitors should evacuate a Company office, following the instructions of leadership, the Disaster Team and first responders. Human Resources will notify Company personnel, vendors and visitors when it is safe to reenter the office. Visitors will eventually be asked to return their badges.

9. Network and WiFi Access

Visitor or Vendor access to the Company network must be approved by leadership and the IT Department in advance of an on-site meeting.

Access to the Company wireless internet contains no access to the Company network and is available to Company personnel, vendors and visitors to use. See *Employee Handbook* and *Acceptable Use Policy*.

10. Unacceptable Behavior

The Company does not tolerate sexual harassment, illegal acts under local/state/federal law, or otherwise harmful acts to Company personnel or to Company property. Anyone conducting such acts at a Company office may be asked to leave.

IV. Badges

1. Company Personnel ID Badge

A Company-issued ID badge allows Company personnel to enter Company offices during Regular Business Hours. This badge is issued by the HR Department. Company personnel have access to Company offices and secure areas based on their department and role.

2. No Escort Badge

A No Escort Badge allows Company personnel (temporarily) and Authorized Vendors access to enter Company offices during Regular Business Hours. In some cases, access that is more elevated may be granted. This badge is issued by the HR Department.

2. Escort Badge

An Escort Badge allows visitors and Unauthorized Vendors access to enter Company offices during Regular Business Hours. These badges have no special access or privileges. Escort Badge holders must be assigned an escort during their visit and return their badges at the end of their visit.

V. Responsibility

The Compliance Department maintains and updates this document annually. The HR Department is in charge of administering check-in and check-out of Company personnel who've lost their Company issued badge, visitors and vendors.

VI. Penalties

Violation of any of the requirements in this policy by Company personnel may result in disciplinary action, up to and including termination.

Satellite Office Address

1650 Independence Drive, Suite #200, New Braunfels, TX 78132

Building Access

Company personnel working at the New Braunfels Office will be assigned a Company-issued ID badge for access to the building via key-card reader. This badge is provided by the HR Department. Access controls are handled by the IT Department and the Service Desk.

Company Personnel

Company personnel must have their Company-issued ID badge with them at all times at the New Braunfels Office. To enter the building, Company personnel must scan their card on the key reader. Company personnel without their Company-issued ID badge must ring the doorbell for access to the suite. Company personnel without an ID badge can receive a temporary Company badge from the New Braunfels HR Receptionist.

**Lost or stolen key cards will be disabled and can be replaced for a \$10 fee.*

Visitors and Vendors

All visits to the New Braunfels Office must be logged in advance with the HR Receptionist. Visitors will go to the reception desk of the suite and sign in. They will be assigned an escort for the entirety of their visit. The responsibility of the visitor falls upon the assigned escort.

Information Disclosure

Visitors should not request information that does not pertain to their visit or the work being performed at the New Braunfels Office.

Exit Inspection

Visitors may be subject to a brief search of their bags or other luggage as they enter and exit the New Braunfels Office.

Network Access

Visitors will not have internet or network access at the New Braunfels Office.

Responsibility

This document is maintained and updated annually by the Compliance Department. Administering the check-in and check-out of visitors is the responsibility of the HR Department.

Penalties

Violation of any of the requirements in this policy by Company personnel may result in disciplinary action, up to and including termination. Violation of this policy by a vendor or visitor can result in the person being asked to leave or being escorted from the building by security or the authorities.

Satellite Office Address

24 Waterway Ave., Suite #650, The Woodlands, TX 77380

Building Access

Leadership assigns Company personnel working at the Woodlands Office a Company-issued ID badge, as well as a badge provided by TransWestern, the building manager. The Woodlands Facility Manager manages any changes in access to the office suite.

Company Personnel

Company personnel must wear their Company-issued ID and TransWestern-issued badge at all times at the Woodlands Office. To enter the Woodlands Office, Company personnel must scan their TransWestern-issued badge on the key-card reader. Company personnel without their badge and Company-issued ID must ring the doorbell at the front of the suite for access. Afterwards, the employee must tell the Facility Manager so a replacement can be ordered. An employee without a badge cannot work in the office without manager supervision.

**Lost or stolen badges will be disabled and can be replaced for a \$10 fee.*

Visitors and Vendors

Visitors and vendors must log their visits to the Woodlands Office in advance with the Facility Manager. Visitors will go to the front door of the suite and ring the doorbell, where they will be greeted, assigned an escort, and escorted to the conference room. Responsibility for the visitor falls upon the assigned escort.

Information Disclosure

Visitors should not request information that does not pertain to their visit or the work performed at the Woodlands Office.

Exit Inspection

Visitors may be subject to a brief search of their bags or other luggage as they enter and exit the office.

Network Access

Visitors will not have internet or network access at the Woodlands Office.

Responsibility

This document is maintained and updated annually by the Compliance Officer. Administering the check-in and check-out of Woodlands Office visitors is the responsibility of the Facility Manager.

Penalties

Violation of any of the requirements in this policy by Company personnel may result in disciplinary action, up to and including termination. Violation of this policy by a vendor or visitor can result in the person being asked to leave or being escorted from the building by security or the authorities.

Revision History			
Revision	Date	Name	Description
9.0	August 2023	Daniel Chapman	Compliance Officer
8.0	January 2022	Daniel Chapman Randy Hargraves	Compliance Officer Helpdesk Supervisor
7.0	January 2021	Daniel Chapman	Compliance Officer
6.0	July 2020	Daniel Chapman	Compliance Officer
5.0	January 2019	Daniel Chapman Ali Chapman	Compliance Officer Marketing Manager
4.0	January 2018	Daniel Chapman Ali Chapman	Compliance Officer Marketing Manager
3.0	September 2016	Daniel Chapman	Compliance Officer
2.0	April 2015	Daniel Chapman Jill Monsees	Compliance Officer HR Manager
1.0	September 2014	Daniel Chapman Dayne Miller	Technical Writer Help Desk Lead

Incident Response Policy | July 2023

Boon-Chapman | Soluta | Prime Dx

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I. Purpose

The purpose of the Incident Response Policy is to provide guidance to BC&L (the “Company”) personnel at all Company offices and data centers in the event of a security incident or in an event that disrupts Company operations.

In the event that a security incident occurs, the Company is responsible for responding to and resolving the incident, as well as implementing necessary corrective actions to prevent future incidents from occurring. The Company will carry out this Incident Response Plan in compliance with HIPAA and best practices.

II. Definitions

- **BC&L (the Company):** Describes the operations of eight commonly owned companies. These affiliated companies share the same privacy and security rules, including this policy.
 - **BC&L, Inc.:** Company that sponsors the health and retirement plan, and administers payroll. BC&L, Inc. technically employs all employees.
 - **Boon-Chapman Administrators, Inc.:** New corporation forming in 2023
 - **Boon-Chapman Benefit Administrators, Inc. (“Boon-Chapman”):** Third Party Administrator (TPA)
 - **Boon-Chapman, Inc.:** Corporate insurance agency
 - **Boon-Chapman, Ltd.:** Original company
 - **Capitol Healthcare Review, Inc., dba PrimeDX (“Prime Dx”):** Medical management company
 - **MedCorp Southwest, Inc.:** Preferred Provider Organization (PPO)
 - **Soluta, Inc. (“Soluta”):** Software development and clinic management company
- **Breach:** The acquisition, access, use or disclosure of Company data in a manner not permitted by Company rules or law (ex. HIPAA, PCI DSS, etc.). The Company covers breaches in more detail in the *Breach Notification Policy*, not in this plan. A breach excludes:
 - Any unintentional acquisition, access, or use of Company information by an employee or person acting under the authority of the Company, if such acquisition, access, or use was made in good faith and within the scope of authority and does not result in further use or disclosure.
 - Inadvertent disclosure to someone authorized to access the Company information, or organized health care arrangement in which the Company participates, and information received is not further used or disclosed.
 - Unauthorized disclosure where the Compliance Officer has a good faith belief that an unauthorized person to whom the disclosure was made would not reasonably have been able to retain such information.
- **Company Co-Locations (“Data Centers”):** Refers to facilities the Company uses to store physical servers holding Company data, and backup servers used to back up that data.
 - **Cyrus One Data Center (Austin, TX):** Tier IV Data Center owned by Cyrus One, Inc.
 - **Databank Data Center (Waco, TX):** Tier III Data Center owned by Databank Holdings, Ltd.
- **Company Offices:** The Company operates at a main office and two satellite offices:
 - **Austin Office (Austin, TX):** the “Main Office, “Corporate Office”
 - **New Braunfels Office (New Braunfels, TX):** Satellite Office (“New Braunfels Office”)
 - **The Woodlands Office (The Woodlands, TX):** Satellite Office (“Woodlands Office”)
- **Company Personnel:** Employees (Full-time, Part-time, Temporary), contractors, consultants, volunteers, trainees and other persons under the policies and procedures of the Company.
- **Company Rules:** Includes all Company rules established in Company documents (i.e. Company Security Policy, Company Employee Handbook). Management enforces these rules.
- **Company Rules Violation:** Refers to a breach of Company rules by an employee, contractor or visitor of the Company. Management issues disciplinary actions based on the severity of the violation; may treat as an Incident.
- **Company Systems:** All Company-owned computer, network and software equipment. This includes all platforms (operating systems), all computer sizes (personal digital assistants, desktops, servers, mainframes, etc.), and all applications and data (whether developed in-house or licensed from third parties) contained on those systems.

- **Off-Site Equipment:** Company owned equipment being used outside the protection of Company offices. Equipment may need special features to access Company Systems, such as a remote desktop/VPN.
- **Compliance Department:** Responsible for issuing counsel on compliance with best practices and applicable security and privacy law. Led by the Vice President/Chief Compliance Officer/Legal Counsel. Also includes the Compliance Officer and Operational Compliance Liaison. The CCO is the designated Privacy and Security Officer.
- **Disaster:** An event that prevents the Company's ability to function normally without some loss in functionality or downtime. The Company covers disasters in the *Disaster Recovery & Continuity Plan*.
- **Incident:** An event impacting Company systems or the workforce during the normal course of business.
- **Incident Manager:** The person selected by the IT Department to investigate a security incident, find out how it occurred, determine how to mitigate the damage and implement any corrective action.
- **Information Technology (IT) Department:** Led by Chief Technical Officer. Includes the Director of Information Technology and Director of Security and Network Operations. Responsible for addressing security incidents, resolving them, and mitigating them.
- **Risk Assessment:** An investigation of a Company's overall "Level of Risk" based on discovered vulnerabilities and threats. The Assessment ends with a final report and recommended corrective actions to mitigate issues found.
- **Service Desk:** Internal troubleshooting resource for employees. Responsible for maintaining the Manage Engine Service Desk Ticketing System (incident reporting, technical issues) and the JitBit Help Desk Ticketing System (data breach reporting, day-to-day operations). Run by Chief Technical Officer.
- **Service Desk E-Ticket:** Electronic system used to report security incident at the Company; specifically the Security Incident E-Ticket
- **Webex:** An internal company chat service used by employees and managers to communicate.
- **Webex Incident Management Team Chat Box:** A group consisting of management, compliance and IT personnel. Used for reporting day-to-day issues, such as one user's inability to log on to a computer or slow internet speed. Serious issues are expected to be escalated to a Service Desk E-Ticket.
- **Workplace Injury:** An event leading to the injury or death of a workforce member. The Company covers workplace injuries in the *Accident Prevention Plan* and through Workplace Injury E-Tickets. It is not covered in this plan.

III. Incident Response Plan

Incidents may occur during the normal course of business. A good plan should reduce the potential impact of a security incident and provide corrective actions to prevent future incidents.

1. Discovery

An incident is "discovered" the day the Company is aware of it, or by exercising reasonable diligence, would have become aware of it.

2. Notification

The discoverer of a security incident should immediately report it to the Service Desk. The IT Department is responsible for investigating, resolving and mitigating security incidents without unreasonable delay.

While day-to-day issues may be handled in the Webex Incident Management Team chat box, serious issues should be reported via a Service Desk E-Ticket.

3. Investigation

An incident investigation determines the cause of an incident (ex: a Company rules violation), the impact of an incident and the efforts necessary to mitigate the damage. Security incident investigations are led by an Incident Manager and the entire workforce is expected to cooperate.

4. Resolution

The Incident Manager will close the investigation when investigation, mitigation and disciplinary action from management for rules violations (if necessary) is complete, resolving the incident.

5. Corrective Action

The Incident Manager will be responsible for providing and executing any corrective actions.

IV. Procedure

See below the three-step process for handling a security incident.

1. Notify the Service Desk
2. Investigate the Incident
3. Perform Risk Assessment (if necessary)

1. Notify the Help Desk

Following the discovery of a security incident, the incident discoverer will report the incident to the Service Desk via the Manage Engine Service Desk Ticketing System. The **Incident Report E-Ticket** should include at least the following information:

- Description of security incident
- Reporter's name
- Incident occurrence and discovery date
- Cause of incident (if determined)
- Individuals Involved/affected by incident

2. Investigate the Incident

After receiving this information, the IT Department will select an Incident Manager to investigate the security incident, find out how it occurred and determine how to mitigate damage. By the end of a security incident investigation, the corresponding Incident Report E-Ticket should include the following information:

- Date/Time Reported
- Priority Level (Low, Normal, High, Critical)
- Description of the Incident
- System affected
- Date/Time Resolved
- Steps to resolve
- Any post incident notes, recommended corrective actions

3. Perform Risk Assessment (if necessary)

If a security incident reveals systemic problems with the Company, Company changes may be required. To do this, the Compliance Department and Incident Manager will perform a Risk Assessment, which is an investigation of a Company's

overall “Level of Risk” based on discovered vulnerabilities and threats. The Assessment ends with a final report and recommended corrective actions to mitigate issues found.

V. Training

The Company trains the workforce for proper conduct and privacy and security best practices.

1. *Privacy, Security & Office Safety Courses & Exams*

Upon hire and annually thereafter, employees are required to take and pass four courses and exams (HIPAA Security, HIPAA Privacy, OSHA Office Safety and Phishing Awareness Training). These tests teach employees privacy, security and office safety best practices.

2. *Employee Handbook & Security Policy*

Upon hire and annually thereafter, employees are required to read and electronically sign Company policies and procedures, including the *Employee Handbook* and *Security and Privacy Policy*.

VI. Sanctions

Company personnel who fail to comply with this Policy shall be subject to disciplinary action, up to and including termination. Those sanctions are determined by Company managers and supervisors.

VII. Retaliation/Waiver

The Company provides individuals the ability to make complaints concerning the Company’s privacy policies and procedures without fear of retaliation. The Company will not intimidate, threaten, coerce, discriminate against, or take other retaliatory action against any individual for submitting a breach report, or otherwise exercising his or her privacy rights. Individuals shall not be required to waive their privacy rights as a condition of the provision of treatment, payment, enrollment in a health plan or eligibility for benefits.

Revision History			
Revision	Date	Name	Description
7.0	July 11, 2023	Casey Clinkenbeard	CTO
6.0	January 14, 2022	Chris Zak	Director of Information Technology
5.0	January 29, 2021	Daniel Chapman Chris Zak	Compliance Officer Tech Ops Manager
4.0	July 29, 2020	Daniel Chapman	Compliance Officer
3.0	September 6, 2019	Ali Chapman Chris Zak Daniel Chapman	Marketing Manager Tech Ops Manager Compliance Officer
2.0	January 5, 2018	Chris Zak Daniel Chapman Ali Chapman	Technical Operations Manager Compliance Officer Marketing Manage
1.0	March 10, 2016	Chris Zak	Technical Operations Manager

Record Retention & Disposal Policy | August 2023

Boon-Chapman | Soluta | Prime Dx

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I. Purpose

The purpose of the Record Retention and Disposal Policy is to ensure that BC&L (the “Company”) adequately protects and maintains necessary records and documents, and properly disposes of documents held past an agreed upon retention time. This Policy should help the workforce understand how to protect, maintain and if applicable, dispose of Company records and documents.

II. Policy

This policy represents the Company’s policy regarding the retention and disposal of physical records and electronic documents.

III. Process

When deemed necessary, the Company implements a disposal of damaged or retired hard drives through a disposal vendor “Computer Crusher Recycling, LLC.” Offsite storage vendor “Iron Mountain” retains Company physical documents and later disposes through shredding.

The Company and our vendors keep certificates of disposal to verify proper disposal of records are completed.

IV. Administration

The Company has a Record Retention Schedule (*Appendix A*) for the initial maintenance, retention and disposal of physical records and electronic documents. The Compliance Officer administers and updates this Policy on an annual basis, and may make modifications to the Record Retention Schedule to ensure its compliance with local, state and federal laws.

V. Litigation

The Company takes record requests and subpoenas very seriously. The Company will cooperate with all legal investigations, including subpoenas and record requests. The Company may suspend the disposal of documents related to the subpoena or investigation.

VI. Applicability

This Policy applies to all physical and electronic records and documents, including original documents and reproductions, at all Company offices and data centers generated in the course of the Company’s operation.

Appendix A: Records Retention Schedule

This document outlines the types of documents generated in each department. It was created using information gathered during interviews with department managers. Record retention periods were determined using applicable legal requirements for each document category. This document is intended to be a living document that will be amended as necessary.

For questions about retention periods for documents not listed on this schedule, please contact the Compliance Officer.

Important Reminders:

- **Retention Period:** This is the number of years that the document must be kept. The retention period begins the date the document was created.
- **Storage Site:** This indicates whether the document type is stored onsite, offsite or in an electronic format. This may change as we continue to transition our records to electronic storage. Please communicate any changes in record storage locations to the records team so that updates to the schedule can be made.

Section Topic

The Record Retention Schedule is Organized as Follows:

1. Accounting
 2. Benefits
 3. Cardholder Data
 4. Clinical Data
 5. Compliance
 6. Eligibility and Premiums
 7. Flex
 8. Human Resources
 9. Legal Files and Papers
 10. Pre-Processing
 11. Prime DX
 12. Service
-

Records Retention Schedule: Accounting

Document Type/Description	Class	Retention Period	Storage Site
Payroll Information	Restricted Confidential	3 Years	Offsite After 1 Year
W2s	Restricted Confidential	4 Years	Onsite
Payables (Vender Invoices, Receipts, Expense Reports)	Confidential	4 Years	Onsite
Receivables (Copies of All Checks Payable to the Company)	Confidential	4 Years	Onsite
Terminated Employee Information	Restricted Confidential	3 Years	Offsite After 1 Year
HIPAA Releases	Restricted Confidential	7 Years	Electronic
HIPAA Agreements	Restricted Confidential	7 Years	Onsite

Records Retention Schedule: Benefits

Document Type	Retention Period	Storage Site
UB Claim Forms	7 Years	Electronic
HCFA Claim Forms	7 Years	Electronic
Claims Correspondence	7 Years	Electronic
Dental X-Rays	7 Years	Electronic (Prior to 7/1/11 are Offsite)
Appeals	7 Years	Electronic
Refunds	7 Years	Electronic
Group Information	7 Years*	Electronic
Vendor Information	7 Years	Electronic
Claims Procedures	7 Years*	Electronic
Vision Claim Forms	7 Years	Electronic
Dental Claim Forms	7 Years	Electronic
Audit Information	7 Years	Electronic
Phone Reports and Stats	7 Years	Electronic
Subrogation Documents	7 Years	Electronic

*Retention period begins at group termination date

Records Retention Schedule: Cardholder Data

Document Type	Description	Retention Period	Storage Site
Payment (Paper/Electronic)	Primary Account Number (PAN)	1 Year***	Onsite or Electronic
Payment (Paper/Electronic)	Expiration Date	1 Year***	Onsite or Electronic
Payment (Paper/Electronic)	Cardholder Name	1 Year***	Onsite or Electronic
Payment (Paper/Electronic)	Service Code	1 Year***	Onsite or Electronic

*** BC&L does not currently retain cardholder information. We outsource our electronic transactions with Zelis and RedCard. This section is included to meet PCI-DSS requirements in case we ever do hold cardholder data.

Records Retention Schedule: Clinical Data

Document Type	Class	Retention Period	Storage Site
Medical Records (Paper/Electronic)	Confidential	7 Years	Onsite or Electronic
Patient Consents (Paper/Electronic)	Confidential	7 Years	Onsite or Electronic
Referral Tracking (Paper/Electronic)	Confidential	7 Years	Onsite or Electronic
Lab/Diagnostic Referrals (Paper/Electronic)	Confidential	7 Years	Onsite or Electronic

Records Retention Schedule: Compliance

Document Type	Description	Retention Period	Storage Site
Policies and Procedures	Original	7 Years; Current Version with Revision History	Electronic
Policies and Procedures	Copies	Retain Current Version Only	Electronic
Annual Reports	-	Permanent	Electronic
Contracts and Related Correspondence	-	7 Years After Expiration or Termination	Onsite or Electronic

Records Retention Schedule: Eligibility and Premiums

Document Type	Retention Period	Storage Site
Eligibility Records	7 Years	Electronic (in Eldorado)
Enrollment Forms	7 Years	Electronic (Prior to 2010 Offsite)
Change Forms	7 Years	Electronic (Prior to 2010 Offsite)
Member Correspondence	7 Years	Electronic (Prior to 2010 Offsite)
Broker Files	7 Years*	Electronic (Prior to 2010 Offsite)
Check Registers	7 Years	Electronic (Prior to 2010 Offsite)
Monthly Invoices	7 Years	Electronic (Prior to 2010 Offsite)
Payments for Self-Funded Groups	7 Years	Electronic (Prior to 2010 Offsite)
End of Month Commission – AVS and 32 Dental	7 Years	Electronic (Prior to 2010 Offsite)
Cobra Documents	4 Years	Electronic (Prior to 2010 Offsite)

*Retention period begins at termination of broker relationship

Records Retention Schedule: Flex

Document Type	Class/Description	Retention Period	Storage Site
Claim Forms	-	7 Years	Electronic (2010 and Previous Years Offsite)
Premium Payments	Montgomery County	7 Years	Offsite

Records Retention Schedule: Human Resources

Document Type	Description	Retention Period	Storage Site
I-9 Forms	-	3 Years*	Electronic
EEO-1	-	Permanent	Electronic
FMLA	All Related Forms and Documentation	5 Years	Onsite (Electronic Conversion in Process)
Occupational Injury and Illness Records	Including Annual Summary and Record in Detail on OSHA	5 Years	Onsite (Electronic Conversion in Process)
Personnel Records	-	3 Years*	Onsite (Electronic Conversion in Process)
Job Postings, Resumes and Applications	-	1 Year	Electronic
Employment Action Records	Promotions, Transfers, Demotions and Terminations	1 Year	Onsite (Electronic Conversion in Process)
Training Records	-	1 Year	Onsite (Electronic Conversion in Process)
Certificates of Age	-	Until Termination of Employment	Onsite (Electronic Conversion in Process)

*Retention period begins after employee's employment is terminated

Records Retention Schedule: Legal Files and Papers

Document Type	Description	Retention Period	Storage Site
Legal Memoranda and Opinions	Including All Subject Matter Files	10 Years After Close of Matter	Onsite
Litigation Files	-	10 Years After Expiration of Appeals or Time for Filing Appeals	Onsite
Court Orders	-	Permanent	Onsite

Records Retention Schedule: Pre-Processing

Document Type	Class/Description	Retention Period	Storage Site
MedCorp Southwest Contracts	-	7 Years*	Electronic
W9s	-	4 Years	Electronic
1099 Letters	-	4 Years	Electronic
EDI 837 Files	Inbound Claim Files	7 Years	Electronic
EDI 837 Files	Inbound and Outbound Files from Trading Partner Exchanges	7 Years	Electronic
EDI 834 Files	-	7 Years	Electronic
EDI 835 Files	-	7 Years	Electronic

*Retention period begins at last date of effect

Records Retention Schedule: Prime Dx

Document Type	Retention Period	Storage Site
Denial Letters and Related Documents	7 Years	Electronic, Older than 1 Year Offsite
Fax Confirmations	7 Years	Electronic
Medical Management Records	7 Years	Electronic

Records Retention Schedule: Service

Document Type	Retention Period	Storage Site
Plan Documents	Permanent	Onsite
Carrier Contracts	7 Years	Onsite
Agreement Contracts	7 Years	Onsite
BDS Files	7 Years	Onsite
Group Correspondence	7 Years	Offsite After 2 Years
Reports	7 Years	Offsite After 2 Years
Initial Implementation Files	7 Years	Onsite
Stop Loss Documents	7 Years	Electronic

Revision History

Revision	Date	Name	Description
9.1	August 10, 2023	Daniel Chapman	Compliance Officer
9.0	July 15, 2023	Daniel Chapman	Compliance Officer
8.0	January 13, 2022	Daniel Chapman	Compliance Officer
7.0	January 28, 2021	Daniel Chapman	Compliance Officer
6.0	July 27, 2020	Daniel Chapman	Compliance Officer
5.0	January 25, 2019	Daniel Chapman, Ali Chapman	Compliance Officer, Marketing Manager
4.0	January 5, 2018	Daniel Chapman, Ali Chapman	Compliance Officer, Marketing Manager
3.0	April 12, 2016	Daniel Chapman, Betsy D'Acierno	Compliance Officer
2.0	August 11, 2015	Daniel Chapman, Josh Rynearson	Compliance Officer
1.0	August 12, 2014	Daniel Chapman	Technical Writer

Security & Privacy Policy | May 2023

Boon-Chapman | Soluta | Prime Dx

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I. Policy

Boon-Chapman and Soluta (the “Company”) personnel are responsible for maintaining the security and privacy of Company information in all its forms (written, spoken, recorded electronically or printed) from unauthorized modification, destruction or disclosure. This protection includes an appropriate level of security over the equipment and software used to process, store and transmit that information.

II. Scope

The scope of this policy applies to all Company personnel and Company data (public, internal, confidential) in all forms (written, spoken, etc.) at Company Offices and Data Centers. Additional policies and procedures may be developed to detail the implementation of this policy, and address any additional information systems functionality. All policies must be consistent with this one.

This policy assumes that any business partners or outside organizations that utilizes Company systems and information maintain and update their own policies and procedures in accordance with applicable privacy and security laws.

III. Security Definitions

- **Boon-Chapman and Soluta (the “Company”)**: Describes the operations of nine commonly owned companies. These affiliated companies share the same privacy and security rules, including this policy.
 - **Soluta Acquisition Sub, Inc.:** Company has ownership of the other eight companies
 - **BC&L, Inc. (“BC&L”)**: Company that sponsors the health and retirement plan, and administers payroll. BC&L, Inc. technically employs all employees.
 - **BCA, Inc:** Newly formed entity, will become a licensed Third Party Administrator (TPA)
 - **Boon-Chapman Benefit Administrators, Inc. (“Boon-Chapman”)**: currently active and licensed Third Party Administrator (TPA)
 - **Boon-Chapman, Inc.:** Corporate insurance agency
 - **Boon-Chapman, Ltd.:** Original company
 - **Capitol Healthcare Review, Inc., dba PrimeDX (“Prime Dx”)**: Medical management company
 - **MedCorp Southwest, Inc.:** Preferred Provider Organization (PPO)
 - **Soluta, Inc. (“Soluta”)**: Software development company
- **Breach:** The acquisition, access, use, or disclosure of Company data in a manner not permitted by Company rules or law (ex. HIPAA, HITECH, etc.). Breach excludes:
 - Any unintentional acquisition, access, or use of Company information by an employee or person acting under the authority of the Company, if such acquisition, access, or use was made in good faith and within the scope of authority and does not result in further use or disclosure.
 - Inadvertent disclosure to someone authorized to access the Company information, or organized health care arrangement in which the Company participates, and information received is not further used or disclosed.
 - Unauthorized disclosure where the Compliance Officer has a good faith belief that an unauthorized person to whom the disclosure was made would not reasonably have been able to retain such information.
- **Clean Desk Policy:** Personnel must keep desk clean and lock away all confidential materials (including personal health information) when leaving workstation.
- **Company Co-Locations (“Data Centers”)**: Refers to facilities the Company uses to store physical servers holding Company data, and backup servers used to back up that data.
 - **Cyrus One Data Center (Austin, TX):** Tier IV Data Center owned by Cyrus One, Inc.
 - **Databank Data Center (Waco, TX):** Tier III Data Center owned by Databank Holdings, Ltd.
- **Company Offices:** The Company operates at a main office and two satellite offices:
 - **Austin Office (Austin, TX):** the “Main Office, “Corporate Office”

- **New Braunfels Office (New Braunfels, TX):** Satellite Office (“New Braunfels Office”)
 - **The Woodlands Office (The Woodlands, TX):** Satellite Office (“Woodlands Office”)
- **Company Personnel:** Employees (full-time, part-time, temporary), contractors, consultants, volunteers and interns of the Company.
- **Company Systems:** All Company-owned equipment, including hardware, firmware and software. This includes all platforms (operating systems), computers (personal digital assistants, desktops, servers, mainframes, etc.), networking equipment (hubs, switches, routers, firewalls), applications and data (whether developed in-house or licensed from third parties) contained on those systems.
- **Encryption:** The conversion of electronic data into another form, called cipher text, which cannot be easily understood by anyone except authorized parties. All confidential information sent electronically outside the Company network must be transported securely in this form.
- **HIPAA (the Health Insurance Portability and Accountability Act of 1996, amended by HITECH Act of 2009 and Omnibus Rule of 2013):** a federal law that enforces rules on the privacy and security of information used by the healthcare industry. A key goal of HIPAA regulations is to protect the privacy and confidentiality of protected health information (PHI) by setting and enforcing standards.
- **Data/Information:** Facts and figures that the Company is in possession of and has a legal obligation protect. Protection levels depend on the kind of information handled. See *Data Classification Policy*.
 - **Public:** Available to the public and intended for distribution outside the Company. The Company freely shares this information and exposure poses no potential harm. (Ex: product and service brochures, advertisements, job opening announcements)
 - **Internal:** For internal use only. All Company personnel have access to this data. Unauthorized disclosure, modification or destruction not expected to have a serious or adverse impact. (Ex: telephone directory, new employee training materials, and internal policy manuals)
 - **Confidential:** Intended for use within the Company, access to data limited based on role. Unauthorized disclosure could have adverse impact for the Company. (Ex: appointment schedules, department financial data, contracts and agreements)
 - **Restricted Confidential:** The most sensitive medical and business information handled by the Company, intended strictly for use within the organization. Access heavily controlled based on role and assigned project. Unauthorized disclosure could lead to fines and legal ramifications, or otherwise damage the Company’s ability to do business. (Ex: protected health information, corporate level strategic plans, software code, etc.)
- **Executive Management:** The Chief Executive Officer/President (CEO/President), the Chief Financial Officer (CFO), Legal Counsel/Chief Compliance Officer, the Vice Presidents (VPs) and the Secretary.
- **Minimum Necessary Rule:** HIPAA standard that employees should be given the least amount of information necessary to complete a job.
- **Protected Health Information (PHI):** Individually identifiable information that includes any part of a person’s past, current or future medical condition (ex: medical record, billing history). PHI can be transmitted by electronic media, maintained in electronic media or transmitted and maintained in a hard copy form.
 - Medical information with individually identifying variables removed, such as name, address, telephone number, SSN or other individually identifying elements removed is not considered PHI. Contact Compliance Officer with any questions.
- **Security Incident:** A violation or imminent threat of violation of computer security policies, acceptable use policies, or standard security practices.
- **Service Desk:** Internal troubleshooting resource for employees. Responsible for maintaining the ManageEngine Service Desk Ticketing System (incident reporting, technical issues) and the JitBit Help Desk Ticketing System (data breach reporting, day-to-day operations).
- **User Access Controls:** Restrictions put in place to limit access to company information based on the Minimum Necessary Rule; access limited based on department, role, and manager discretion.
- **Visitors:** Non-workforce persons who do not have authorization to enter Company Offices without signing in through the Visitor Sign-In process. This includes business partners, job applicants, and family and friends of Company personnel.

IV. Security Responsibilities

- **CEO/President:** Responsible for designating Company responsibilities and making final management decisions.
- **CFO:** Oversees day-to-day Accounting operations.
- **CTO:** Oversees day-to-day Soluta operations
- **VPs:** Oversees certain day-to-day Company operations.
- **Legal Counsel/Chief Compliance Officer:** Runs the Compliance Department. Administers operations with the Company's compliance program. Offers legal advice and counsel.
- **Compliance Officer:** Privacy/Security Officer of the Company. Handles day-to-day operations with the Company's compliance program, conducts access reviews, leads breach investigations, and writes compliance documentation. Answers to Legal Counsel/Chief Compliance Officer.
- **Director of Information Technology:** Oversees the information technology strategy of the Company, developing and implementing goals for the IT Department. Supervises the Service Desk and Director of Security and Network Operations. Answers to CEO/President.
- **Director of Security and Network Operations:** Manages the IT architecture and its overall effectiveness, understands changing business requirements and defines detailed technical solutions. Responsible for installing and configuring system hardware and software, upgrading software, backup and recovery tasks. Answers to CEO/President.
- **User:** Personnel who access Company equipment and the Company network, responsible for abiding by Company rules on that equipment.

V. Record Retention & Disposal

All HIPAA documentation such as policy and procedures, risk assessment, incident investigation, breach notification, and training records will be maintained for at least seven years. Any record retention questions should be submitted to Legal Counsel or the Compliance Officer.

See *Record Retention and Disposal Policy*.

VI. Risk Assessment

A Risk Assessment or "Risk Analysis" is a privacy and security audit of all departments, systems and offices. The Assessment tests a list of Company controls for potential threats and vulnerabilities to Company information. The Assessment determines a level of risk to the Company and presents potential corrective actions to address them. The Compliance Officer conducts the assessment annually, presents findings to management, then recommends and tracks progress on any needed corrective actions.

For more information, please see the company's *Risk Assessment*.

VII. HIPAA Compliance Assessment

The HIPAA Compliance Assessment or "Non-Technical Security Evaluation," is an audit of the Company's compliance with HIPAA and its amendments. The Compliance Officer conducts the assessment annually, presents findings to management, then recommends and tracks progress on any needed corrective actions.

For more information, see the Company's *Compliance Assessment*.

VIII. Vulnerability Assessments

Vulnerability Assessments, or “Technical Security Evaluations,” are scans and reviews of the Company network performed by the IT Department to insure technical security of Company information is adequate. This includes external and internal vulnerability scans. The Director of Information Technology and Director of Security and Network Operations review vulnerabilities in the network, present findings to management, and perform needed corrective actions.

IX. User Access Audits

The Compliance Team conducts logical access audits of Company Systems to verify appropriate access privileges. The Compliance Team documents audits and submits results to Legal Counsel or Executive Management. Inappropriate access will be noted in the user access report and send to the appropriate party to address discrepancies as soon as is reasonable. The Compliance Team will recommend and track progress on needed corrective actions. Audits performed include:

- Annual User Access Audits – Performed annually of Company Systems and building access. Verifies access levels of administrator roles and a percentage of randomly selected users.
- Monthly User Access Audits – Performed monthly of select users who had a change in employment over the past month (i.e. new hires, terminations, transfers, rehires). Verifies access to Company systems and building access based on change request ticket.

See the *User Access Policy*.

X. Incident Reporting

Employees may report privacy and security incidents to the IT Department using the ManageEngine Service Desk. The Service Desk will investigate reported incidents, report findings to management and perform needed corrective actions. In an exception of cases, where the Service Desk is unavailable, the Company may use alternative methods to communicate an incident has occurred. See the *Incident Report Policy*.

XI. Data Breaches

Employees report suspected breaches of confidential data and PHI to the Compliance Officer using a JitBit Helpdesk ticket. The Compliance Officer investigates reported breaches, determines the severity of the breach, and determines the appropriate course of action. In cases where a breach is confirmed, Compliance would make sure victims and groups are notified, that findings are reported to the correct agency, and that corrective action requests are shared with Operations. See the *Breach Notification Process*.

XII. Disaster Recovery & Continuity

The Disaster Recovery and Continuity Plan (“Disaster Plan”) is the Company’s plan to respond to and operate during a disaster, or event that disrupts the Company’s ability to function normally. The Company Disaster Team handles disaster response. The Team includes Company personnel from Executive Management, Compliance and IT. Depending on the nature of the disaster, more team members may be added.

When a disaster occurs, the Company decides to activate the Disaster Team. The Team determines damage during a disaster, the cost and time to restoration, then decides on a business restoration plan. The Disaster Team annually undergoes training and testing of the Plan by performing annual Disaster Plan tests. See the *Disaster Recovery and Continuity Plan*.

XIII. Company Personnel Testing and Training

The Company requires its personnel to undergo periodic mandatory training, including the following:

- **Courses and Exams** – Upon hire and annually thereafter, Company personnel must take and pass the following:
 - HIPAA Privacy Course and Exam (annually updated),
 - HIPAA Security Course and Exam (or equivalent, annually updated), and
 - OSHA Office Safety Course and Exam (annually updated).
- **Company Policies** – Upon hire and annually thereafter, Company personnel must read and acknowledge key company policies, including the following:
 - Security and Privacy Policy
 - Employee Handbook
- **Annual Developer Training** – Annually, Developers will be assigned OWASP security training. This training must be read and acknowledged.
- **Quarterly Reminders** – Quarterly, Company will be assigned privacy and security reminders. These must read and acknowledged.
- **Phishing Training** – Periodically, Company personnel will be assigned phishing training in the form of fake phishing emails. Personnel may be assigned additional testing if they inappropriately interact with these fake phishing attempts, such as clicking on phishing links or attempting to download phishing attachments. This will improve the quality of Company personnel's ability to identify and respond to real phishing threats.

XIV. Law Enforcement & Judicial Proceedings

Executive Management and Legal Counsel handle actions regarding law enforcement and other legal issues as determined by law. In certain cases, management may seek additional legal counsel to address issues.

XV. Access Controls

The Company controls physical and electronic access to Company systems, information and equipment based on the Minimum Necessary Rule. Mechanisms to control access to company information and PHI include the following methods:

1. Authorization

Managers and IT determine appropriate access to Company systems and information.

2. Identification/Authentication

IT provides users with personal credentials and access privileges granted by a manager. Credentials include:

- **Key Card:** A Company-issued photo ID used by employees to gain access to Company Offices and restricted areas. Letting people into Company offices without proper credentials is strictly prohibited. See the *Building Access Policy*.
- **User Name and Password:** Used to gain access to Company systems. IT and managers determine access levels.

Unauthorized usage of an employee's key card or user name and password may lead to disciplinary action.

3. Data Security

The Company has technical security mechanisms in place to guard against unauthorized access to data stored on the Company network. This includes data encryption at rest in company servers, the requirement of 24/7 anti-virus and anti-malware software, firewalls, vulnerability scanning of software inside and outside the network periodically, and annual penetration testing.

4. Data Integrity

The Company performs data backups and disk redundancy (RAID) to guarantee the integrity of Company data. This includes daily electronic backups and monthly physical tape backups.

5. Transmission Security

The Company has technical security mechanisms in place to guard against unauthorized access to data transmitted in and out of the Company network. These include email encryption, secure file transfer protocol (SFTP), secure remote connection through VPN, and protection of outward facing websites with SSL and HTTPS protection. The IT Department maintains these systems under the supervision of the CTO. Employees must send confidential information through secure means (SFTP, encrypted email, etc.).

6. Remote Access

The Company allows off-site access into the Company network. Managers and IT may grant remote access to Company personnel based on need and availability. Users may use Company issued laptops or personal computers with Company software that allows for a secure remote connection. Remote connection requires two-factor authentication.

Remote access and access to Company laptops are a privilege. Any misuse of this privilege may lead to access revocation and disciplinary action. Lost devices should be reported, as they may constitute a potential data breach.

7. Physical Security

The Company limits physical access to Company offices and restricted areas. Managers may approve access to locations and restricted areas based on business need. See our *Building Access Policy*.

- **Restricted Areas:** Certain areas contain sensitive systems and information. Depending on business need, management may grant access to restricted areas (i.e. IT Room, Mail Room, Server Room, Wiring Room).
- **Fire, Water & Environmental Protection:** Company offices and secure areas contain protection against fire, water, and other environmental hazards such as power outages and extreme temperature situations.
- **Work Stations:** Company personnel must maintain a Clean Desk Policy. When not at their desks, Company data must be placed out of sight and screens should be locked. Screens automatically lock after 15 minutes of inactivity.
- **Data Centers:** Off-site facilities operated by service providers that house some Company systems and equipment. Access to data centers restricted based on business need. Access to facilities controlled by service providers.

8. Wireless Access

The Company Wireless Network is separate from the Company firewall and Company network. The wireless network is secured through acceptance of rules. Company personnel and visitors must accept the Company Wireless Terms of Use to use the wireless network.

9. Mobile Device Access

Access to Company data through mobile devices (smart phones, tablet PCs, etc.) is regulated by the IT Department. Access to the network and Company data may be virtually revoked by IT at any time.

Before being issued a Company mobile device, users must sign the *Off-Site Equipment Agreement*.

Company mobile devices must have the following minimum security requirements implemented:

- Auto log-off or screen saver lock with password
- Encryption
- Screen-lock passwords
- Secure VPN and two-factor authentication for remote connection

Mobile devices with remote access to Company information should never be left unattended or in unsecured areas. A lost or stolen device should be reported to the Compliance Officer for a breach investigation. Criminal or negligent handling of devices containing Company information may lead to disciplinary action.

10. Emergency Access

In the event of an emergency in which IT personnel are unavailable, Executive Management has access to enter and secure areas where Company information is stored.

This Policy applies to all users of Company information including physicians, employees (full-time, part-time, and temporary), contractors, consultants, volunteers, interns, etc. Failure to comply may result in disciplinary action up to and including termination in accordance with applicable Company procedures, or, in the case of outside affiliates, termination of the affiliation. Further, penalties associated with state and federal laws may apply.

Possible disciplinary action may be instituted for, but is not limited to, the following:

1. Unauthorized disclosure of PHI or Confidential information as specified in Confidentiality Statement.
2. Unauthorized disclosure of a sign-on code (User ID) or password.
3. Attempting to obtain a sign-on code or password that belongs to another person.
4. Using or attempting to use another person's sign-on code or password.
5. Unauthorized use of an authorized password to invade patient privacy by examining records or information for which there has been no request for review.
6. Installing or using unlicensed software on Company computers.
7. The intentional unauthorized destruction of Company information.
8. Attempting to get access to sign-on codes for purposes other than official business, including completing fraudulent documentation to gain access.

I. Non-Retaliation Policy

An employee who, in good faith and belief that a privacy or security policy has been violated, reports such concern shall not be subject to retaliation, harassment, or intimidation as a result of such communication.

The Boon-Chapman and Soluta *Security and Privacy Policy* requires the use of **strictly** controlled passwords for accessing Protected Health Information (PHI), confidential information (CI) and Internal Information (II) on Company systems. (See the *Security and Privacy Policy* for the definitions of these protected classes of information.)

Listed below are the minimum standards that must be implemented in order to ensure the effectiveness of password controls.

Standards for Accessing PHI, CI & II:

Company personnel and applications should comply with the following password standards:

1. Passwords must never be shared with another person, unless the person is the Director of Information Technology or a designated Service Desk specialist.
2. Passwords changed every 30-90 days.
3. Passwords with minimum length of eight characters, with one capital letter, one lower case letter, one digit and one special symbol.
4. When creating a password, it is important not to use words that can be found in dictionaries or words that are easily guessed due to their association with the user (i.e. children's names, pets' names, birthdays, etc...). A combination of alpha and numeric characters are more difficult to guess.
5. The past ten passwords cannot be reused.

Where possible, system software must enforce the following password standards:

1. Passwords routed over a network must be encrypted.
 2. Passwords must be entered in a non-display field.
 3. System software must disable the user identification code when more than five consecutive invalid password are given with a 15-minute timeframe. A lockout is then put in place unless removed by the Service Desk.
 4. System software must maintain a history of previous passwords and prevent their reuse.
-

Attachment 2 – Privacy Policy & Standards

I. Assignment of HIPAA Privacy/Security Officer

The Compliance Officer is the designated HIPAA Security and Privacy Officer. Unless directed differently by Legal Counsel/Chief Compliance Officer or Executive Management, the Compliance Officer has the authority to establish, implement, and enforce compliance policies and procedures for security and privacy of confidential information and protected health information (PHI).

The Compliance Officer performs an annual HIPAA risk assessment of the Company. Periodic risk assessments may occur when deemed necessary:

- (1) by a newly discovered risk,
- (2) when new software or hardware is acquired,
- (3) when a new service or procedure is initiated,
- (4) when there is a significant change in an existing service or procedure, or
- (5) when there is a change or addition to the physical layout of Company offices.

The Compliance Officer periodically checks the DHHS's HIPAA website for any changes in the HIPAA Rules and regulations, and then determines if any changes or modifications to this policy are needed.

II. Confidentiality of All Forms of PHI

The Company keeps PHI confidential, and only allows individuals with a business need to know the ability to view, read, or discuss PHI. Employees receive training for handling PHI during initial new hire orientation, annual retraining and with quarterly reminders.

III. Security of Electronic PHI (e-PHI)

Employees may access the network with their Company issued username and secure, unique password. Passwords must follow the Company's Password Control Standards. Employees who leave the Company have access to PHI terminated immediately.

PHI transmitted to third parties will be transmitted on secured lines. The security of transmission lines will be verified via contract with third party responsible for transmitting our patient's PHI.

No digitally stored PHI shall leave this facility without being first protected through encryption; this includes laptops, flash drive devices, CDs and emails. Hardcopies of PHI should not be transported out of the Company offices unless necessary, and should be under constant supervision when traveling from one secure location to another. Reach out to the IT Department on how to secure your data.

IV. Member Requests for Disclosures

Members have a right to request an accounting of all disclosures of their PHI. When a patient makes a request, notify your manager. The member will be told when the information will be available.

Patients who pay for a procedure, test, or service out of pocket (fully paid for by patient, with no reimbursement or additional payment by a third party), have a right to have all information regarding such procedure/test held confidential and not released to third parties. To exercise this right the patient must (1) pay for test/procedure and (2) make known to Company their desire to have information regarding the procedure/test held in confidence and not released to third parties. Any employee who receives such a request must immediately inform who will flag the information as being restricted.

HIPAA allows for the release of restricted PHI

- (1) in compliance to a subpoena;

- (2) in compliance to statutory reporting requirement; or
- (3) upon receiving an unrestricted, HIPAA compliant authorization for release of medical records from the patient, patient's legal representative, or executor of deceased patient's estate.

V. Charges for e-Copies of Medical Records

The HIPAA Privacy Rule permits a healthcare provider to impose reasonable, cost-based fees for paper copies of PHI. According to HITECH, the covered entity (or the business associate, working on behalf of the covered entity) may charge for the labor cost of making the e-copy. This does not include the cost for searching the database to find medical record(s).

VI. HIPAA Incident / Breach Investigation

Any incident in which the privacy/security of a patient's PHI may have been compromised will be reported immediately to the Compliance Officer. The Compliance Officer will initiate an incident investigation without unreasonable delay. The Compliance Officer will investigate incidents and determine if the incident rises to the level of a breach. Please refer to the *Breach Notification Policy*.

VII. Sanction Policy

All employees will receive training regarding expected employee behavior for sanctioning employees who violate Company policies. Employees shall receive training prior to assuming work duties and annually thereafter. See Compliance [§ 164.308(a)(1)(ii)(C)].

VIII. Document Retention Policy

All HIPAA documentation such as policy and procedures, risk assessment, incident investigation, breach notification, and training records will be maintained for at least seven years. Please refer to the *Record Retention and Disposal Policy*.

Revision History			
Revision	Date	Name	Description
9.0	May 25, 2023	Daniel Chapman	Compliance Officer
8.0	January 14, 2022	Daniel Chapman	Compliance Officer
7.0	May 12, 2021	Daniel Chapman	Compliance Officer
6.0	July 29, 2020	Daniel Chapman	Compliance Officer
5.0	March 15, 2019	Daniel Chapman, Ali Chapman	Compliance Officer, Marketing Manager
4.0	January 5, 2018	Daniel Chapman, Ali Chapman	Compliance Officer, Marketing Manager
3.0	July 15, 2016	Daniel Chapman	Compliance Officer
2.0	August 7, 2015	Daniel Chapman	Compliance Officer

Breach Notification Policy | July 2023

Boon-Chapman | Soluta | Prime Dx

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I. Purpose

The Breach Notification Policy is intended to assist BC&L (the “Company”) personnel at all Company offices and data centers in the event of an unauthorized breach of protected health information (PHI). PHI is protected from unauthorized disclosure by the Health Insurance Portability and Accountability Act of 1996 and its amendments (“HIPAA”).

In the event a HIPAA breach occurs, the Company is responsible for notifying individuals of their compromised PHI, as well as securing the breach and mitigating the errors that caused the breach. The Company’s breach notification process will be carried out in compliance with HIPAA and all future amendments.

II. Definitions

- **BC&L (the Company):** Describes the operations of eight commonly owned companies. These affiliated companies share the same privacy and security rules, including this policy.
 - **BC&L, Inc.:** Company that sponsors the health and retirement plan, and administers payroll. BC&L, Inc. technically employs all employees.
 - **Boon-Chapman Administrators, Inc.:** New corporation forming in 2023
 - **Boon-Chapman Benefit Administrators, Inc. (“Boon-Chapman”):** Third Party Administrator (TPA)
 - **Boon-Chapman, Inc.:** Corporate insurance agency
 - **Boon-Chapman, Ltd.:** Original company
 - **Capitol Healthcare Review, Inc., dba PrimeDX (“Prime Dx”):** Medical management company
 - **MedCorp Southwest, Inc.:** Preferred Provider Organization (PPO)
 - **Soluta, Inc. (“Soluta”):** Software development and clinic management company
- **Breach:** The acquisition, access, use or disclosure of Company data in a manner not permitted by Company rules or law (ex. HIPAA, PCI DSS, etc.). Breach excludes:
 - Any unintentional acquisition, access, or use of Company information by an employee or person acting under the authority of the Company, if such acquisition, access, or use was made in good faith and within the scope of authority and does not result in further use or disclosure.
 - Inadvertent disclosure to someone authorized to access the Company information, or organized health care arrangement in which the Company participates, and information received is not further used or disclosed.
 - Unauthorized disclosure where the Compliance Department has a good faith belief that an unauthorized person to whom the disclosure was made would not reasonably have been able to retain such information.
- **Compliance Department:** Responsible for issuing counsel on compliance with best practices and applicable security and privacy law. Led by the Vice President/Chief Compliance Officer/Legal Counsel. Also includes the Compliance Officer and Operational Compliance Liaison. The CCO is the designated Privacy and Security Officer.
- **Company Co-Locations (“Data Centers”):** Refers to facilities the Company uses to store physical servers holding Company data, and backup servers used to back up that data.
 - **Cyrus One Data Center (Austin, TX):** Tier IV Data Center owned by Cyrus One, Inc.
 - **Databank Data Center (Waco, TX):** Tier III Data Center owned by Databank Holdings, Ltd.
- **Company Offices:** The Company operates at a main office and two satellite offices:
 - **Austin Office (Austin, TX):** the “Main Office, “Corporate Office”
 - **New Braunfels Office (New Braunfels, TX):** Satellite Office (“New Braunfels Office”)
 - **The Woodlands Office (The Woodlands, TX):** Satellite Office (“Woodlands Office”)
- **Company Personnel:** Employees, contractors, consultants, volunteers, trainees and other persons under the policies and procedures of the Company.
- **Information Technology (IT) Department:** Led by Chief Technical Officer. Includes the Director of Information Technology and Director of Security and Network Operations.
- **Jit Bit:** Company Extranet system used to report breaches of Company information; specifically the HIPAA Breach E-Ticket

- **Protected Health Information (PHI):** Individually identifiable health information that includes any part of a person's past, current or future medical condition (i.e. medical record, billing history). PHI can be transmitted by electronic media, maintained in electronic media or transmitted and maintained in a hard copy form.
 - Medical information with individually identifying variables removed, such as name, address, telephone number, SSN or other individually identifying elements is not considered PHI. Contact Compliance Officer with any questions.
- **Service Desk:** Internal troubleshooting resource for employees. Responsible for maintaining the Manage Engine Service Desk Ticketing System (incident reporting, technical issues) and the JitBit Help Desk Ticketing System (data breach reporting, day-to-day operations). Run by Chief Technical Officer.
- **Unsecured Protected Health Information (Unsecured PHI):** Any PHI not rendered unusable, unreadable or indecipherable to unauthorized persons with technology or methodology, such as encryption or destruction.

III. Policy

When a HIPAA breach occurs, the Company is required to notify victims the impermissible access, acquisition, use or disclosure of PHI. The Compliance Officer will investigate all suspected breaches of PHI.

1. Breach Discovery

A breach is "discovered" the day the Company is aware of it, or by exercising reasonable diligence, would have become aware of it.

2. Compliance Officer Notification

Any suspected breaches should be passed along to the Compliance Department. The Compliance Department is responsible for investigating, resolving and mitigating breaches.

3. Breach Investigation

A breach investigation determines whether an incident is a breach. The Compliance Department is responsible for conducting investigations. Company personnel will cooperate with HIPAA breach investigations.

4. Notification

If the investigation finds evidence of a breach, the victims of the breach must be notified by letter with all necessary information included.

A. Website Posting (10 victims or more)

Breaches affecting 10 policyholders or more may require a notification posting to the Company website, if the Company cannot locate contact information for the victims. The posting must remain up for 90 days and include Company contact information.

B. Health and Human Services (500 victims or more)

Breaches affecting 500 policyholders or more require notification to HHS within 60 days. Otherwise, notifications are made annually.

C. Press (500 victims or more)

Breaches affecting 500 residents of one state require notification to the press, or prominent media outlets serving the state and region within 60 calendar days. The notice shall be provided in the form of a press release.

D. Law Enforcement

If authorized by law enforcement and/or a court order, the Company will delay submission of notification, so it will not impede a criminal investigation.

5. Mitigation

After the Compliance Department concludes a breach investigation, any needed corrective actions will be notated and sent to needed Company personnel to carry out. A member of the Compliance Department will track progress of corrective actions until completion.

IV. Procedure

See below the four-step process for handling a breach.

1. Notify the Compliance Department
2. Investigate the Breach
3. Distribute Breach Notification Letter
4. Perform Risk Assessment (if necessary)

1. Notify the Compliance Officer

Following the discovery of a potential breach, the breach discoverer will report the breach to the Compliance Department via the HIPAA Breach E-Ticket. The E-Ticket must include these fields:

- Description of breach, impact, cost
- Reporter's name
- Breach occurrence and discovery date
- Type of medium breached (electronic, oral, paper)
- Cause of breach (loss, misuse, theft)
- Individuals Involved/affected by breach

2. Investigate the Breach

After receiving notification, a member of the Compliance Department will investigate the suspected HIPAA breach. The Compliance Department must discover when and where the breach occurred, identify any PHI breached, identify who is responsible for the breach occurring, and identify who has received the PHI without authorization. Members of the Compliance Department may interview Company personnel for information about the suspected breach. Once the Compliance Department identifies the scope of the breach, the Compliance Department and Company personnel will work to seal the breach. This includes retrieving confirmation of deletion from all who received the PHI without authorization. Any instances where confirmation of deletion is not received will be notated.

3. Distribute Breach Notification Letter

If the investigation finds evidence of a HIPAA breach, the Company will notify victims of the breach. To do this, a member of the Compliance Department will draft a *Breach Notification Letter* for a manager to approve. The letter must contain:

- **Brief Description:** Explanation of breach, including date of breach and discovery.
- **PHI Breached:** Name, SSN, DOB, address, medical/billing info, etc.
- **Safety Steps:** Plan for the victim(s) to follow to protect themselves from potential harm.
- **Status of Investigation:** A description of the breach investigation and how the Company is fixing the problem and preventing others from occurring in the future.
- **Company Contact Information:** This way, the victim(s) have a way to file a complaint.

The *Breach Notification Letter* must be sent within 60 days of discovery of the breach. If the victim is deceased, the letter will be sent to next of kin or legal representative.

4. *Perform Risk Assessment (if necessary)*

If a breach reveals systemic problems with the Company, the Compliance Department may recommend corrective actions be taken. To do this, a member of the Compliance Department will perform a Risk Assessment, which is an investigation of a Company's overall "Level of Risk" based on discovered vulnerabilities and threats (see *BC Risk Assessment*). The assessment will conclude with a final report and recommended changes to Company processes to mitigate issues found. A member of the Compliance Department will monitor corrective actions until completion.

V. Training

The Company trains employees for proper conduct, privacy and security laws, so they can accurately identify a security event or a privacy breach.

1. *Privacy, Security and Office Safety Courses and Exams*

Upon hire and annually thereafter, Company personnel are required to take and pass three courses and exams (Security Awareness Training, HIPAA HITECH Privacy for Business Associates, and OSHA Office Safety). These courses teach employees applicable privacy and security laws, office safety, general reporting requirements and useful tips to prevent a security event or privacy breach, such as an unauthorized breach of PHI.

2. *Employee Handbook and Security Policy*

Upon hire and annually thereafter, employees are required to read, acknowledge and electronically sign Company policies and procedures, including the *Employee Handbook* and *Security + Privacy Policy*.

VI. Sanctions

Members of Company personnel who fail to comply with this policy shall be subject to disciplinary action, up to and including termination. Company managers and supervisors have final authority to determine the appropriate level of sanction. See *Employee Handbook*.

VII. Retaliation/Waiver

The Company provides individuals the ability to make complaints concerning the Company's privacy policies and procedures without fear of retaliation. The Company will not intimidate, threaten, coerce, discriminate against, or take other retaliatory action against any individual for submitting a breach report, or otherwise exercising his or her privacy rights. Management cannot require individuals to waive their privacy rights as a condition of the provision of treatment, payment, enrollment in a health plan or eligibility for benefits.

Revision History

Revision	Date	Name	Description
8.0	July 11, 2023	Daniel Chapman	Compliance Officer
7.0	January 13, 2022	Daniel Chapman	Compliance Officer
6.0	January 26, 2021	Daniel Chapman	Compliance Officer
5.0	July 29, 2020	Daniel Chapman	Compliance Officer
4.0	January 25, 2019	Daniel Chapman Ali Chapman	Compliance Officer Marketing Manager
3.0	January 5, 2018	Daniel Chapman Ali Chapman	Compliance Officer Marketing Manager
2.0	March 10, 2016	Daniel Chapman	Compliance Officer
1.0	July 8, 2014	Daniel Chapman	Compliance Officer

EXHIBIT F
BOON CHAPMAN ORIGINAL RESPONSE DATED SEPTEMBER 8, 2023,
OPTIONAL SERVICES

SECTION 4

OPTIONAL SERVICES & VARIATIONS AVAILABLE

Please explain all optional services your firm can offer by name, with a full description of the service and any additional charges involved. If a charge/fee for an Optional Service cannot be quoted at this time due to a lack of information, please state in your proposal “Additional Information is required for a charge/fee quote”.

NOTE: The services listed below with an asterisk (*) indicates the County already access some or all of that service.

Preferred Provider (PPO) Networks – Medical

1. **Aetna Signature Administrators***. Our strongest network partner is Aetna. This national PPO network consists of well over 1.1 million healthcare professionals and over 8,500 hospitals. One of many reasons they are our strongest network partner is their willingness to allow us to deploy various cost containment programs where other carriers and networks expressly prohibit it. Examples of these programs are dialysis carve-out and Care Navigation.

IMPORTANT: In order to access the Aetna PPO network, the Health Plan is required to utilize the services in one of the following scenarios:

- a. **Aetna 1.0** requires the group’s specific stop loss coverage (and aggregate if selected) be placed with Aetna. In this case, the Health Plan’s utilization review services can be placed with Prime Dx (a Boon-Chapman sister company). This is the option the County currently uses and the associated fee is included under the “Pricing” section of this RFP.
 - b. **Aetna 2.0** requires the group’s aggregate stop loss coverage be placed with Aetna and the utilization review and case management services placed with American Health Holdings. If the group chooses this option, the PPO access fee starts at \$16.25 PEPM.
 - c. **Aetna 2.0 lite** allows both the specific and aggregate (up to \$750,000) coverage to be placed with any other carrier, but requires Aetna maintain a layer of reinsurance from \$750,000 to \$1,000,000 for an annual fee of \$10,000 divided by the number of employees rounded up to the nearest \$0.25 PEPM. Example: $\$10,000 / 150 / 12 = \5.56 rounded up to \$5.75 PEPM. This option also requires utilization review and case management services placed with American Health Holdings. The PPO access fee associated with this option starts at \$16.25 PEPM. Note: This option is only available to groups coming off of fully insured coverage.
 - d. **Aetna 3.0** requires the use of one of the following approved MGUs: TMHCC, HIIG or Swiss Re for stop loss with whom Aetna retains a layer of coverage. In this case, the Health Plan’s utilization review services can be placed with Prime Dx (a Boon-Chapman sister company). Coverage placed under this 3.0 option must stay with the selected carrier upon renewal unless the renewal is greater than 19% or new lasers have been assigned. In these cases, we are able to shop any of the other 3.0 approved carriers. The PPO access fee associated with this option starts at \$16.25 PEPM.
2. **Cigna PPO Network**. We offer access to a number of other network options, such as Cigna. This national PPO network consists of more than 800,000 healthcare professionals and over 6,200 hospitals. Cigna, while a very viable option, will not allow for certain carve-out cost containment programs such as Care Navigation, code editing or dialysis carve-out.

Direct Contracting

Employers can often obtain direct contracts with local providers, which can be a very effective cost containment strategy. If a direct contract is possible, we can assist. Our past and current experience with network maintenance means we have in-house expertise at negotiating, administering and monitoring the effectiveness of direct contracts for our clients. Some networks limit a plan's ability to enter into direct negotiations with out of network providers; therefore this would need to be addressed with them initially. We have the ability to administer multi-tiered plan designs, which encourage the utilization of preferred providers, direct primary care arrangements, and on-site or near-site clinics. An additional fee could apply.

Provider Negotiations*

At the direction of the County, our Cost Containment unit will attempt to obtain discounts from out-of-network providers in order to decrease both Plan costs and balance billing to the member. Negotiated claims will be processed at the out of network coinsurance level, and all negotiations will be signed off on by the provider. The fee for this service is 25% of savings.

Transplants

Institutes of Excellence*— We provide access to a number of excellent transplant networks including the Aetna contracted Institutes of Excellence transplant network as well as Cigna's. These are included in your associated network access fees.

Fully Insured Carve Out— Upon request, we can carve-out transplant exposure from the self-funded program and offer such coverage through a fully-insured program. This offering requires underwriting from Tokio Marine HCC to determine the associated premiums.

Reference-Based Pricing

Boon-Chapman can assist the County in the evaluation of this uniquely aggressive plan design and if selected, assist with procurement, contracting, and implementation of an associated vendor. More information is needed in order to provide a cost.

Surprise Bill Support

Many of us have heard of a time when someone received an unexpectedly high medical bill—especially after an ambulance ride to an emergency room. In these situations, the large balance due is often the result of services provided by an ancillary, out-of-network provider. In many of these scenarios, it's likely that the patient had no choice in selecting the provider, had no idea that the provider was out-of-network, and was not informed about the cost of services upfront. We refer to these providers as “forced” providers.

These ancillary "forced" providers don't contract with the network because they don't have to. Unlike hospitals who have an incentive to negotiate reduced fees in return for the PPO to steer patients to them, forced providers don't have to compete for their patients because the hospital provides them. This lack of competition allows them to keep their fees high. While the No Surprises Act limited balance billing activities in some situations, it does not protect the patient in all situations. We offer Surprise Bill Support to help plan sponsors and plan members safeguard against these unexpectedly high medical bills.

Wellness Program

Medical and pharmacy claims data are a wealth of information for health risk management programs. However, they don't identify all risk factors. For example, claims data doesn't identify undiagnosed hypertension or

hyperlipidemia (high cholesterol), which are common causes of cardiovascular disease — the number one killer of Americans. Often, patients don't know they have cardiovascular disease until they have a heart attack.

To combat this trend, we offer Health Risk Assessments questionnaires to identify risk factors, and help members take control of their healthcare. Our HRA combined with biometric screening data, including Body Mass Index (BMI), waist circumference, blood pressure, heart rate, blood glucose, cholesterol levels, and more, and provides a short questionnaire. We use this data to stratify members based on risk, identify intervention opportunities, provide care intervention, and establish a baseline for comparison with future results.

Online Enrollment

Manage enrollment and benefits administration in one place at no cost to you. With Boon-Chapman, employers have access to the Selerix BenSelect platform for all administered plans, including medical, dental, vision and flex.

Quarterly One-on-One Employee Meetings*

Boon-Chapman Subject Matter Experts (SMEs) will visit specific Fort Bend County locations at least once quarterly to meet with participants who have questions about EOBs, benefits, precertification questions, or other challenges with their providers. There is no charge for this service.

Employee Communications*

Boon-Chapman will assist in the design and content of employee communications to be used at enrollment and/or other educational meetings. There is no charge for this service, unless Boon-Chapman prints and/or mails communication pieces. In that case, all printing, supplies, postage, and labor will be passed through at cost.

Enrollment Meetings*

Boon-Chapman will assist the Risk Management department in conducting annual enrollment meetings. Generally there are no additional fees for this service.

High Touch Customer Service*

In addition to serving your group with exceptional account management staff, we provide the plan members with next-level customer service. In addition to our traditional customer service offering, we provide High Touch Customer Service (HTCS). With HTCS, members have a dedicated Member Advocate who can assist with a range of services to navigate the complicated healthcare system, including reaching out to members when additional information is needed to process a claim. Unlike traditional health insurance companies who respond to non-clean claims with EOBs and letters requesting additional information—often followed by a claim denial or a balance bill – our Member Advocates proactively contact members and request information to avoid unnecessary confusion or frustration.

This service offers the Risk Management staff the opportunity to refer benefit questions to a support person dedicated to understanding the benefit plan, network services and general questions.

Legal Notices

Boon-Chapman will provide the following annual notices as required by the federal law:

1. Women's Health and Cancer Rights Act "WHCRA"
2. Medicare Part D Creditable Coverage

3. Children’s Health Insurance Program Reauthorization Act “CHIPRA”
4. Grandfathered Health Plan Notification
5. ...and many more...

The fee for this service is \$1.00 per employee per month.

Reinsurance/Stop Loss Marketing, Negotiations and Placement*

Boon-Chapman will market, negotiate and secure reinsurance annually prior to renewal. This service is provided at \$10,200 annually.

Plan Analysis, Review, and Management Services

Boon-Chapman will prepare a financial status report as to the financial history of the Plan, current financial status with options available, and prepare periodic and annual reports as they relate to Plan performance and the financial status. We will also assist in the development of, and continued review of, Plan design of existing and new plan options, and recommend employer contributions consistent with current budget. We will also analyze the current Medical Plan in terms of participation and the most effective use of employer contributions. The charge for this service is \$2.00 per employee per month.

Patient-Centered Outcomes Research Institute Fee*

Boon-Chapman will provide necessary census reporting to the County in accordance with regulations so that the County can file the associated IRS Form 720 and pay the required fee. There is no charge for this service.

Medicare Part D Reporting

- Annual notices to participants – see “Legal Notices” section above.
- Creditable coverage disclosure to Centers for Medicare and Medicaid “CMS” – Boon-Chapman will assist the County in the online annual reporting to CMS. There is no charge for this service.
- Medicare Part D Retiree Drug Subsidy (RDS) recovery assistance* –
 - Boon-Chapman will assist the County and its PBM in managing the RDS application, reporting and recoupment process.
 - Boon-Chapman will assist the County with identifying and securing an actuary for the required annual attestation associated with RDS. The cost of the actuary will be passed through to the County as is, no markup.

Prescription Benefit Management (PBM) Services*

We offer the County access to several PBMs to choose from which are marketed and renegotiated every three (3) years for with market checks annually. The services offered through our PBM Consultant, Innovative RX Strategies (IRXS) include RFPs, market checks, annual audits and true-up process, as well as ongoing plan oversight and assistance with day-to-day PBM challenges. These full services are offered at \$3 per RX (\$2 to IRXS and \$1 to Boon-Chapman).

Drug Cost Reporting*

In accordance with the Consolidated Appropriations Act (CAA), health plans are require to report complete Drug Cost Reporting to CMS annually. Boon-Chapman offers this services at \$2,000 annually.

Non-Quantitative Treatment Limitation Analysis (Mental Health Parity)

In general, the Mental Health Parity and Addiction Equity Act (MHPAEA) requires health plans to conduct an annual review of their health plan, administration and network offerings to ensure compliance with this rule. Boon-Chapman can assist the County in the evaluation, procurement, contracting, and implementation of these services. More information is needed in order to provide a cost.

Care Navigation – Medical Tourism*

Domestic – Boon-Chapman assists participants in fulfilling their surgical needs at any number of state of the art surgery centers with best in class surgeons across the United States. Through our bundled pricing, we are able to significantly reduce the cost to the health plan as well as to the patient, while also improving overall outcomes. . The charge for this service is itemized on the current pricing sheet included herein.

Expanded Offerings – This program changes and grows into other areas of need regularly. Boon-Chapman is currently expanding to include services such as Infusion Therapy and Durable Medical Equipment. These services may come at an additional cost, to be disclosed upon initial roll out of the expanded services.

Hospital Bill Audit*

Boon-Chapman works with Ceris, an Aetna approved hospital bill audit company to scrub bills to find coding errors, gross overcharges, and other types of common billing errors. Aetna requires certain claims go through this review prior to stop loss reimbursement. The fee for this service is 30% of savings.

Plan Document Services

Development and maintenance of plan document (using the Boon-Chapman template document), including regulatory language updates as applicable. There is no charge for this service. However, if additional legal opinions are requested, these will be secured and provided at pass through cost to the County.

Employee Assistance Programs

Boon-Chapman will assist the County in the evaluation, procurement, contracting, and implementation of Employee Assistance Programs to best meet the needs of your members. There is no charge for this service.

Dental Preferred Provider Organization (“PPO”)

Boon-Chapman will assist the County in the evaluation, procurement, contracting, and implementation of a dental PPO. Working with Aetna, Guardian, Cigna, or Connection Dental, can enhance the current self-funded dental offering. The PEPM fees vary by PPO.

Mobile Healthcare Application

Boon-Chapman will assist the County in the evaluation, procurement, contracting, and implementation of the services of Healthee, or other similar vendors, to deliver convenient access to concierge support and benefits information. Participants will save time and money through easy in-network appointment scheduling and 24/7 access to health professionals. Benefit information, including ID cards, claims information, deductibles, and out of pocket amounts, are also accessible. Additional information is required for a charge/fee quote.

Price Shopping Tools*

Boon-Chapman offers the services of Healthcare Bluebook for compliance with the No Surprises Act and Transparency in Coverage rules to offer healthcare related online shopping tools to your members and to maintain and publically post the required Machine Readable Files. Additional fees apply.

Teladoc (including Mental Health)

Boon-Chapman has partnered with Teladoc, the original telemedicine company for offering telemedicine for general medicine, mental health, dermatology, nutritional services and a variety of others. The additional of the Mental Health services comes at a time of significant need while access to providers becomes more and more difficult daily. Through Teladoc, participants may request a visit with a doctor 24 hours a day, 365 days a year, by web, phone, or mobile app. Additional fees apply depending on the services listed. Under the “Pricing” section of this RFP, we have included an offering for general medicine and mental health.

Dialysis Program*

The objective of the dialysis program is to limit the financial exposure to self-funded employer groups produced by long-term dialysis care. PPO contracts do not sufficiently control the exorbitant costs associated with this care. Our dialysis program leverages existing Medicare regulations to provide a solution that addresses both the direct impact to claim costs, as well as stop loss insurance rates. This program can generate hundreds of thousands of dollars in savings on even one dialysis case. We can provide this service for \$200 per dialysis claim.

Non-Network Hospital Claims*

There is no accepted usual and customary pricing data available for hospital claims. Consequently, health plans are at risk of paying too much to non-network hospitals with inflated charges. We are one of the few third party administrators that license sophisticated software to determine the Medicare allowable for charges at every hospital in the United States. This gives our health plans the option of setting a non-network allowable at a percentage of Medicare to avoid this risk. The fee for this service is 10% of savings.

Vision Benefits

Fully-Insured. Boon-Chapman can assist in the evaluation, procurement, contracting, and implementation of fully-insured vision coverage. Additional information is required for a charge/fee quote.

Self-Funded. If the County chooses to self-fund a vision benefit, we can assist with plan design, rates and administration. There is fee of \$0.50 PEPM for this service.

Ancillary Products

Boon-Chapman will assist the County in the evaluation, procurement, contracting, and implementation of insured ancillary products, including but not limited to, short term disability, long term disability, life, accidental death and dismemberment, and long term care coverage. Additional information is required for a charge/fee quote.

Section 6055/6056 reporting

Boon-Chapman will assist the County in the evaluation, procurement, contracting, and implementation of a vendor to track and/or provide appropriate tax forms. There is no additional fee for this assistance.

Bank Management & Reconciliation

Boon-Chapman can setup a bank account for your various health plan related health funds, manage the funds and then provide monthly reconciliation services on behalf of the County. The fee charged by the bank will be passed through at cost to the County and Boon-Chapman would charge an additional \$1.50 PEPM for the management and reconciliation processes.

Fiduciary Services

Boon-Chapman will assist the County in the evaluation, procurement, contracting, and implementation of these services. More information is needed in order to provide costs.

TempoPay – Interest-free Healthcare Loans

Boon-Chapman has begun offering employers access to TempoPay, a company that provides interest free loans to your employees with repayment of the loan over 12 months via payroll deduction. The way it works is the member has access to an app on their smartphone or a toll-free number and at the time of service, they simply use one of these methods to request the loan (with no credit check) and once quickly approved, immediate funding is provided. The fee for this offering is \$3 PEPM.

Specialty and High Dollar Drug Assistance

1. **Prescription Assistance.** Boon-Chapman will assist the patients in finding manufacturer's assistance for their high dollar medication. These are income based options for which all may not be eligible.
2. **Copay Assistance.** Boon-Chapman will assist in finding copay assistance for their medications.
3. **J-Code Rebates.** Boon-Chapman will assist the County in securing drug rebates on medications running through the medical plans instead of the prescription plan.

Note, some of these offerings could be offered in conjunction with Boon-Chapman's vendor partner and could impact the County's grandfathered status. Additional fees will apply depending on the services selected.

EXHIBIT G
PBM SCOPE OF WORK

PBM SCOPE OF WORK

STATEMENT OF WORK. Boon-Chapman Benefit Administrators, Inc. ("Boon-Chapman") will provide the following pharmacy benefit management services to Fort Bend County through Boon-Chapman's Prescription Drug Program Agreement with CaremarkPCS Health, L.L.C. ("Caremark" or "CVS/caremark"): implementation of Fort Bend County's pharmacy benefit plan design; pharmacy network contracting for retail pharmacy services; pharmacy claims processing; mail and specialty drug pharmacy services; cost containment, clinical, safety, adherence and other clinical programs; formulary and rebate administration. Boon-Chapman will pass-through any rebates it receives from Caremark for Fort Bend County's brand drug utilization at retail, mail, and specialty. Boon-Chapman will pay any rebates it receives from Caremark on behalf of Fort Bend County within forty-five (45) days of receipt of the money and full accounting of the breakdown by client. However, if Fort Bend County is in arrears on any payments for prescription drug costs, Boon-Chapman will be entitled to offset any amounts owed to Boon-Chapman for Fort Bend County's prescription drug costs from the rebates that Boon-Chapman receives from Caremark for Fort Bend County's brand drug utilization.

EXHIBIT H
STOP LOSS SCOPE OF WORK

EXHIBIT H
STOP LOSS SCOPE OF WORK

- A. Boon Chapman will provide Stop-Loss coverage services to include: securing coverage with a vendor acceptable to the County's Risk Management Director, billing for the stop-loss premiums in the monthly billing cycle, and remitting the premium to the stop-loss vendor. Additionally, Boon Chapman will file the specific and aggregate stop-loss claims as they occur, and provide monthly reports to the stop-loss vendor on County's behalf and provide copies of same to County. The fee for this service shall not exceed \$10,200.00 which shall be payable in one sum in accordance with Section 4.2 of the AGREEMENT FOR THIRD PARTY CLAIMS ADMINISTRATION SERVICES PURSUANT TO RFP 24-004.
- B. The Parties also agree that in the provision of Stop Loss Services, Boon Chapman will collect the carrier's premiums from County and remit the premiums to the carrier, serving as intermediary between County and the carrier in collecting and remitting both the premiums and the authorized payments. Boon Chapman does not retain premiums. Payment of premiums owed to the carrier is separate from payment to Boon Chapman for compensation for services, even though Boon Chapman's services include payment of premiums. The Parties acknowledge and agree that this described distinction of service fee and coverage premium memorializes the process intended and used since execution of the original Agreement.
- C. Boon Chapman will ensure that the Stop Loss coverage rates and factors are based upon the most recent claims experience as requested by the carrier and meets the following requirements:
- i. **Specific Coverage:** Boon Chapman will secure specific coverage with Aetna for a 12/36 contract covering both medical and prescriptions to eliminate large claim run off liability. The applicable deductible shall not exceed \$425,000 per individual, except any specific lasers identified by the stop loss carrier. Premium cost shall not exceed \$75.87 per employee per month or an estimated \$3,193,823.52/year. To secure these rates, County authorizes Boon Chapman to accept two lasers, which are identified instances with Individual Specific Stop Loss Deductibles with higher coverage attachment points based on individual prior claims experience or the likelihood of high-cost claims in the future, as more specifically described in the attached Exhibit "I" - Lasers for Calendar Year 2024 – attached hereto and incorporated by reference.

EXHIBIT I

Lasers for Calendar Year 2024

EXHIBIT I

Lasers for Calendar Year 2024

The following are the Individual Specific Stop Loss Deductibles with higher coverage attachment points that County has authorized:

Instance 1	\$725,000.00 Laser
Instance 2	\$800,000.00 Laser

CERTIFICATE OF INTERESTED PARTIES

FORM 1295

1 of 1

Complete Nos. 1 - 4 and 6 if there are interested parties.
Complete Nos. 1, 2, 3, 5, and 6 if there are no interested parties.

OFFICE USE ONLY CERTIFICATION OF FILING

1 Name of business entity filing form, and the city, state and country of the business entity's place of business.
Boon-Chapman Benefit Administrators, Inc.
Austin, TX United States

Certificate Number:
2023-1094662

Date Filed:
11/14/2023

2 Name of governmental entity or state agency that is a party to the contract for which the form is being filed.
Fort Bend County

Date Acknowledged:
12/19/2023

3 Provide the identification number used by the governmental entity or state agency to track or identify the contract, and provide a description of the services, goods, or other property to be provided under the contract.
RFP 24-004
Medical, Dental and Cafeteria Plans Third Party Claims Administration Services

4	Name of Interested Party	City, State, Country (place of business)	Nature of interest (check applicable)	
			Controlling	Intermediary
	Durham, Matt	Austin, TX United States	X	
	White, Gregory	Dallas, TX United States	X	
	Burns, Steve	San Francisco, CA United States	X	
	Grinnan, Daniel	Dallas, TX United States	X	
	Soluta Acquisition Sub, Inc.	Austin, TX United States	X	

5 Check only if there is NO Interested Party.

6 UNSWORN DECLARATION

My name is _____, and my date of birth is _____.

My address is _____, _____, _____, _____, _____.
(street) (city) (state) (zip code) (country)

I declare under penalty of perjury that the foregoing is true and correct.

Executed in _____ County, State of _____, on the ____ day of _____, 20____.
(month) (year)

Signature of authorized agent of contracting business entity
(Declarant)