# PLAN DOCUMENT
# SUMMARY PLAN DESCRIPTION

**FOR**

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# ECTOR COUNTY

**EMPLOYEE HEALTH BENEFIT PLAN**

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**G - 4808031A**

**REVISED AND RESTATED:**
**OCTOBER 1, 2018**

Ector County hereby amends and restates its self-funded health care plan for the benefit of eligible Employees, Retirees, and their eligible Dependents.

The purpose of the Ector County Employee Health Benefit Plan (the "Plan") is to provide reimbursement for covered charges incurred as a result of Medically Necessary treatment for Illness or Injury of the County's eligible Employees, Retirees, and their eligible Dependents.

The County caused this instrument to be executed by its duly authorized officers effective as of the 1st day of October 2018.

**ECTOR COUNTY**

By: ____________________________________________

Title: ____________________________________________

Date: ____________________________________________

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# FOREWORD

**TO ALL EMPLOYEES:**

We are all aware of the financial disaster that a family may experience as a result of a serious or prolonged Illness or accident. The medical benefits available under the Ector County Employee Health Benefit Plan (the Plan) and described in this Plan document and summary plan description (SPD) are designed to provide some protection for you and your family against such a disaster.

In sponsoring this Plan, the County has attempted to provide the best coverage possible within the financial limits of both the County and you. In keeping with this goal, we periodically review the Plan to ensure we maintain an adequate and reasonably priced program. The cost of this Plan is in direct proportion to the Claims paid. Therefore, it is important that all Employees and their families use the Plan wisely so the cost will remain affordable to all of us. In addition, the amount of your contribution to the Plan is subject to change at the discretion of the County.

The County has selected **INETICARE**, a health benefit management service, to provide pre-hospitalization and continued stay review for all persons covered by the Plan. A Covered Person must contact **INETICARE** at **(877) 608-2200** prior to any scheduled admission for a medical condition, Mental or Nervous Disorder, or Substance Abuse/Substance Dependence. In case of an emergency Hospital admission or emergency surgery, **INETICARE** must be notified within 72 hours of admission. Except in certain cases concerning childbirth, as described more fully in this Plan, all Covered Persons must use the **INETICARE** pre-hospitalization and continued stay review service to obtain full benefits under this Plan.

Prior to inception of any chemotherapy regimen, pre-authorization **must** be obtained by calling **INETICARE** at **(877) 208-5002**.

The administration of the Plan may include pre-admission reviews, length of stay reviews, utilization reviews, retrospective reviews, audits, and managed care; each and all of which to such extent as is appropriate to ensure that neither Covered Persons nor the County incur avoidable hospitalization or other costs in obtaining quality, appropriate medical care covered by the Plan.

Payment of covered charges will be withheld if pre-certification for treatment is based on a diagnosis for which treatment is covered, but the treatment is actually undertaken for a condition which is not covered by the Plan. In no event will pre-certification guarantee payment of any Claims.

In addition to describing your benefits, this Plan document and SPD explain other important procedures such as how you become eligible and how to file a claim for benefits.

**IMPORTANT:** If, at any time, you have questions about the Plan, please contact the Plan's Administrative Service Agent, Group Resources®, for assistance. Group Resources is always available to assist you with your questions. We are pleased to offer the benefits under this Plan for you and your covered family members as an expression of our appreciation for your efforts on behalf of our County.

Ector County

# PRIVACY AND SECURITY OF MEDICAL INFORMATION

We understand that your medical information is private, and we are committed to maintaining the privacy of your medical information. The Plan will follow the policies below to help ensure that your medical information remains private.

Each time you submit a claim to the Plan for reimbursement, and each time you see a health care Provider who is paid by the Plan, a record is created. The record may contain your medical information. In general, the Plan will only use or disclose your medical information without your authorization for the specific reasons detailed below. Except in limited circumstances, the amount of information used or disclosed will be limited to the minimum necessary to accomplish the intent of the use or disclosure.

The Plan does not operate by itself but rather is operated and administered by the Company acting on the Plan's behalf. As a result, medical information used or disclosed by the Plan (as discussed below) necessarily means that the Company is using or disclosing the medical information on behalf of the Plan. As a result, references to the Plan in "PRIVACY AND SECURITY OF MEDICAL INFORMATION" shall also be construed as references to the Company to the extent necessary to carry out the actions of the Plan.

**PERMITTED USES AND DISCLOSURES**. The following categories describe different ways that the Plan may use or disclose your medical information. Not every use or disclosure in a category will be listed. However, all of the ways the Plan is permitted to use and disclose information will fall within one of the categories.

**Treatment.** The Plan may use or disclose your medical information to facilitate medical treatment or services by Providers. The Plan may disclose your medical information to Providers, including doctors, nurses, technicians, pharmacists, medical students, or other hospital personnel who are involved in your care. For example, the Plan might disclose information about your prior prescriptions to a pharmacist to determine if a pending prescription is contraindicative with prior prescriptions.

**Payment.** The Plan may use and disclose your medical information to determine eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care Providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, the Plan may tell your health care Provider about your medical history to determine whether a particular treatment is Experimental/Investigational, or Medically Necessary or to determine whether the Plan will cover the treatment. The Plan may also share medical information with a utilization review or pre-certification service Provider. Likewise, the Plan may share medical information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

**Health Care Operations.** The Plan may use and disclose your medical information for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, the Plan may use medical information in connection with: conducting quality assessment and improvement activities; underwriting (with respect to medical information other than medical information which is genetic information), premium rating, and other activities relating to Plan coverage; submitting claims for stop-loss (or excess loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities.

**Family Members, Relatives, Close Personal Friends.** The Plan may disclose your medical information to your family members, relatives, or close personal friends, or any other person identified by you, if the medical information is directly relevant to the family member's, relative's or friend's involvement with your care or payment for your care.

**Business Associates.** The Plan contracts with individuals and entities ("business associates") to perform various functions on behalf of the Plan or provide services to the Plan. These business associates may receive, create, maintain, use, or disclose your medical information, but only after they agree in writing to safeguard your medical information. For example, the Plan may disclose your medical information to a business associate to administer claims, perform utilization review management, or review the Plan's financial records. The Business Associate may use PHI for the proper management and administration of the Business Associate or to carry out legal responsibilities of the Business Associate or for data aggregation services relating to the health care operations of the Plan. The Business Associate may disclose PHI in connection with a function, service or responsibility or service to be performed by the Business Associate and such disclosure is: required by law; or the Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will be held confidential, and used or further disclosed only as required by law or for the purposes for which it was disclosed, and the person agrees to notify the Business Associate of any breaches of confidentiality.

**Requirement by Law.** The Plan will disclose your medical information when required to do so by federal, state, or local law. For example, the Plan may disclose medical information when required by a court order in a litigation proceeding such as a malpractice action.

**Aversion of a Serious Threat to Health or Safety.** The Plan may use or disclose your medical information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, the Plan may disclose your medical information in a proceeding regarding the licensure of a physician.

**Organ and Tissue Donation**. If you are an organ donor, the Plan may release your medical information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

**Military and Veterans.** If you are a member of the armed forces, the Plan may release your medical information as required by military command authorities. The Plan may also release medical information about foreign military personnel to the appropriate foreign military authority.

**Workers' Compensation.** The Plan may release your medical information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

**Public Health Risks**. The Plan may disclose your medical information for public health activities. These activities generally include the following:

- to prevent or control disease, injury, or disability;
- to report births and deaths;

- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

**Health Oversight Activities.** The Plan may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

**Lawsuits and Disputes**. If you are involved in a lawsuit or dispute, the Plan may disclose your medical information in response to a court or administrative order. The Plan may also disclose your medical information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

**Law Enforcement**. The Plan may release your medical information if asked to do so by a law enforcement official:

- in response to a court order, subpoena, warrant, summons or similar process;
- to identify or locate a suspect, fugitive, material witness or missing person;
- if you are, or are suspected to be, the victim of a crime, under certain limited circumstances, and the Plan Administrator is unable to obtain your agreement;
- about a death the Plan Administrator believes may be the result of criminal conduct;
- about criminal conduct on the Company's premises; or
- in emergency circumstances to report a crime, the location of the crime or victims , or the identity, description, or location of the crime or victims, or the identity, description, or location of the person who committed the crime.

**Department of Health and Human Services.** The Plan will disclose your medical information to the U.S. Department of Health and Human Services when requested for purposes of determining the Plan's compliance with applicable regulations.

**Coroners, Medical Examiners, and Funeral Directors**. The Plan may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. The Plan may also release medical information to funeral directors as necessary to carry out their duties.

**National Security and Intelligence Activities.** The Plan may release your medical information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

**Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, the Plan may release your medical information to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

**Other Benefits.** The Plan may contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you. For example, if you are suffering from a complex illness, the Plan may contact you to discuss an alternate form of care or an alternate treatment facility.

**DISCLOSURES TO THE COMPANY.** The Plan will disclose your medical information to the Company for Plan administration purposes only upon receipt of a certification from the Company that the Plan sets forth the permitted uses and disclosures of medical information by the Company on behalf of the Plan, and that the Company has agreed to the following assurances:

- The Company will not further use or disclose medical information about you other than as permitted or required by the Plan documents or as required by law;
- The Company will ensure that any agents, including subcontractors, to whom it provides medical information (including electronic medical information) received from the Plan agree to the same restrictions and conditions that apply to the Company with respect to such information and agree to implement reasonable and appropriate security measures to protect the information;
- The Company will implement administrative, technical, and physical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic medical information that it creates, receives, maintains, or transmits on behalf of the Plan;
- The Company will not use or disclose the medical information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Company;
- The Company will report to the Plan any use or disclosure of medical information that is inconsistent with the permitted uses and disclosures, of which it becomes aware;
- The Company will report to the Plan, within a reasonable time after the Company becomes aware, any security incident that results in unauthorized access, use, disclosure, modification, or destruction of the Plan's electronic medical information;
- The Company will report to the Plan any other security incident on an aggregate basis every quarter or more frequently upon the Plan's request;
- The Company will make its internal practices, books, and records relating to the use and disclosure of medical information received from the Plan available to the Department of Health and Human Services for purposes of determining whether the Plan is complying with applicable regulations;
- The Company will, if feasible, return or destroy all medical information received from the Plan about you and retain no copies of the information when it is no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, to limit further uses or disclosures to those purposes that make such return or destruction infeasible;
- The Company will ensure that there is adequate separation between the Plan and the Company (as described below) and that the separation is supported by reasonable and appropriate security measures;

- The Company will make your medical information available to you (as described below);
- The Company will make your medical information available to you for amendment and incorporate any amendment into your medical information (as described below); and
- The Company will make available the information required to provide you an accounting of disclosures (as described below).

**ACCESS TO MEDICAL INFORMATION**. The Plan will make your medical information available to you for inspection and copying upon your written request to the Plan Administrator. The Plan may charge a fee for the costs of copying, mailing or other supplies associated with your request. The Plan may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed.

If the Plan uses or maintains an electronic health record with respect to your medical information, you have a right to obtain a copy of such information in an electronic format and, if you so choose, direct the Plan to transmit such copy directly to another entity or person.

**AMENDMENT OF MEDICAL INFORMATION**. If you feel that medical information the Plan has about you is incorrect or incomplete, you may ask the Plan to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan. Your request must be made in writing and submitted to the Plan Administrator. In addition, you must provide a reason that supports your request.

The Plan Administrator may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, the Plan Administrator may deny your request if you ask the Plan Administrator to amend information that:

- is not part of the medical information kept by or for the Plan;
- was not created by the Plan, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the information which you would be permitted to inspect and copy; or
- is accurate and complete.

**ACCOUNTING OF DISCLOSURES**. If you wish to know to whom medical information about you has been disclosed for any purpose other than (1) treatment, payment, or health care operations, (2) pursuant to your written authorization, and (3) for certain other purposes, you may make a written request to the Plan Administrator, as provided for in 45 C.F.R §164.528 of the HIPAA requirements.

Your request must state a time period which may not be longer than six years prior to the date of your request. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12-month period will be free. For additional lists, the Plan Administrator may charge you for the costs of providing the list. The Plan Administrator will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

The accounting will not include disclosure for the purposes of treatment, payment, or health care operations (provided, that, to the extent required by law, if the Plan maintains an electronic health record, the accounting will include such disclosures made through an electronic health record). In addition, the accounting will not include disclosures which you have authorized in writing.

**SEPARATION BETWEEN THE PLAN AND THE COMPANY**. Only Employees of the Company who are involved in the day-to-day operation and administrative functions of the Plan will have access to your medical information. In general, this will only include individuals who work in the Company's Human Resources or Employee Benefits departments. These individuals will receive appropriate training regarding the Plan's privacy policies. In the event an individual fails to comply with the Plan's provisions regarding the protection of your medical information, the Company will take appropriate action in accordance with its established policy for failure to comply with the Plan's privacy provisions.

**OTHER USES OF MEDICAL INFORMATION**. Any other uses and disclosures of medical information will be made only with your written authorization. If you provide the Plan authorization to use or disclose medical information about you, *you* may revoke that authorization, in writing, at any time. If you revoke your authorization, the Plan will no longer use or disclose medical information about you for the reasons covered by your written authorization. Please note that the Plan is unable to take back any disclosures it has already made with your authorization, and that the Plan is required to retain records of the care provided to you.

# VENDOR LISTING

| | |
|---|---|
| Plan Administrator | Ector County Commissioners Court<br>1010 East Eighth Street<br>Odessa, TX 79761<br>(432) 498-4011 |
| Administrative Service Agent | Group Resources<br>2100 Ross Avenue, Suite 900<br>Dallas, TX 75201<br>(214) 922-8880 |
| Pre-certification Administrator | Ineticare<br>(877) 608-2200 |
| Oncologic Pre-certification Program | Ineticare<br>(877) 208-5002 |
| Prescription Drug Program | MedTrak<br>(800) 771-4648<br>www.medtrakservices.com |
| Preferred Provider Organization (PPO) | PHCS<br>(800) 256-3730<br>www.multiplan.com |
| | Permian Basin Healthcare Network<br>(432) 640-2338<br>www.pbhn.org |

Benefits for a Covered Person are determined by the Covered Person's eligibility classification and by the terms of this Plan. Benefits under this Plan are paid according to the provisions, exclusions and limitations described in this Plan, subject to the schedule outlined below.

**This Plan treats Mental or Nervous Disorders, Substance Abuse/Substance Dependence as any other Illness. For benefits, please check below for the Provider who is performing the services.**

**CALENDAR YEAR DEDUCTIBLE**

**Employee** .......... $441
**Employee + One Dependent** .......... $882
**Family** .......... $1,333

**COMMON ACCIDENT DEDUCTIBLE** .......... Applies

This provision applies when two or more Covered Persons are Injured in the same accident. These persons need not meet separate Deductibles for treatment of Injuries incurred in this accident; instead, only one Deductible for the Calendar Year in which the accident occurred will be required for them.

**COINSURANCE** (After satisfaction of the Calendar Year Deductible)

**PBHN PPO PHYSICIAN** .......... 90%
**ALL OTHER PPO PROVIDERS & CONTRACTED FACILITIES** .......... 80%
**NON-PPO** .......... 60%
**OUT-OF-AREA** .......... 70%

Treatment rendered by a Non-PPO Provider for a Medical Emergency (see "DEFINITIONS") will be paid at the PPO rate. If the Covered Person is admitted for a Medical Emergency, benefits will be paid at the PPO rate until the Covered Person is stabilized and can be safely transferred to a PPO facility.

If a Covered Person lives more than 50 miles from a PBHN/PPO facility, benefits will be paid at the out-of-area rate.

When radiology, anesthesiology, pathology, or emergency room Physician services are rendered by a Non-PPO Provider at a PPO facility, benefits will be paid at the PPO rate.

**OUT-OF-POCKET MAXIMUM** (Not including Deductible)

**Single** .......... $3,057

After the Out-of-Pocket Maximum has been satisfied, all eligible charges subsequently incurred during that Calendar Year will be paid at 100%. However, charges applied to the Deductible, penalties, non-covered charges, and any amounts in excess of Room and Board limitations do not apply to the Out-of-Pocket Maximum.

**ALLERGY TESTING**

**PBHN PHYSICIAN** (Deductible applies) .......... 90%
**ALL OTHER PPO PROVIDERS & CONTRACTED FACILITIES** (Deductible applies) 80%
**NON-PPO** (Deductible applies) .......... 60%
**OUT-OF-AREA** (Deductible applies) .......... 70%

**AMBULANCE SERVICES**
**PPO** (Deductible applies) .................... 80%
**NON-PPO** (Deductible applies) .................... 80%
**OUT-OF-AREA** (Deductible applies) .................... 80%

**ANNUAL LIMIT ON ESSENTIAL HEALTH BENEFITS** .................... Unlimited

**CHEMOTHERAPY/RADIATION** (See "ONCOLOGIC PRE-AUTHORIZATION PROGRAM")
**PBHN PHYSICIAN** (Deductible applies) .................... 90%
**ALL OTHER PPO PROVIDERS & CONTRACTED FACILITIES** (Deductible applies) 80%
**NON-PPO** (Deductible applies) .................... 60%
**OUT-OF-AREA** (Deductible applies) .................... 70%

**CHIROPRACTIC CARE** (See Spinal Manipulation)

**COLONOSCOPY** (Routine – ages 50 and over once every ten years. Coverage of general anesthesia for a colonoscopy will be based on Medical Necessity.)
**PBHN PHYSICIAN** (Deductible applies) .................... 90%
**ALL OTHER PPO PROVIDERS & CONTRACTED FACILITIES** (Deductible applies) 80%
**NON-PPO** (Deductible applies) .................... 60%
**OUT-OF-AREA** (Deductible applies) .................... 70%

**DIAGNOSTIC LAB/X-RAY/BREAST TOMOSYNTHESIS (3D MAMMOGRAM)** (Including professional fees incurred for automated tests)
**PBHN PHYSICIAN** (Deductible applies) .................... 90%
**ALL OTHER PPO PROVIDERS & CONTRACTED FACILITIES** (Deductible applies) 80%
**NON-PPO** (Deductible applies) .................... 60%
**OUT-OF-AREA** (Deductible applies) .................... 70%

**DURABLE MEDICAL EQUIPMENT**
**PBHN PHYSICIAN** (Deductible applies) .................... 90%
**ALL OTHER PPO PROVIDERS & CONTRACTED FACILITIES** (Deductible applies) 80%
**NON-PPO** (Deductible applies) .................... 60%
**OUT-OF-AREA** (Deductible applies) .................... 70%

**EMERGENCY ROOM SERVICES**
**PBHN PHYSICIAN** (Deductible applies) .................... 90%
**ALL OTHER PPO PROVIDERS & CONTRACTED FACILITIES** (Deductible applies) 80%
**NON-PPO** (Deductible applies) .................... 60%
**OUT-OF-AREA** (Deductible applies) .................... 70%

**HOME HEALTH CARE**
**PPO** (Deductible waived) .................... 100%
**NON-PPO** (Deductible waived) .................... 100%
**OUT-OF-AREA** (Deductible waived) .................... 100%

**HOME INFUSION THERAPY**

**PBHN PHYSICIAN** (Deductible applies) .......... 90%
**ALL OTHER PPO PROVIDERS & CONTRACTED FACILITIES** (Deductible applies) 80%
**NON-PPO** (Deductible applies).......... 60%
**OUT-OF-AREA** (Deductible applies).......... 70%

**HOSPICE CARE**

**PPO** (Deductible waived).......... 100%
**NON-PPO** (Deductible waived) .......... 100%
**OUT-OF-AREA** (Deductible waived) .......... 100%

**INPATIENT HOSPITAL SERVICES** (Must be pre-certified or a $500 penalty will apply)

**PPO** (Deductible applies).......... 80%
**NON-PPO** (Deductible applies).......... 60%
**OUT-OF-AREA** (Deductible applies).......... 70%

**The Maximum Eligible Charge** for Room and Board in a Hospital will be:

a) for a semi-private room, the average semi-private room rate of the Hospital;
b) for a private room, the average semi-private room rate of the Hospital or, if the Hospital has private rooms only, the maximum eligible charge will be limited to 90% of the actual private room charge;
c) for intensive care, coronary care, and neonatal intensive care, the actual amount charged.

**OSSEOUS SURGERY**

**PPO** (Deductible applies).......... 80%
**NON-PPO** (Deductible applies).......... 80%
**OUT-OF-AREA** (Deductible applies).......... 80%
**Maximum Per Calendar Year** .......... $3,000
**Lifetime Maximum** .......... $5,000

**OUTPATIENT HOSPITAL SERVICES**

**PPO** (Deductible applies).......... 80%
**NON-PPO** (Deductible applies).......... 60%
**OUT-OF-AREA** (Deductible applies).......... 70%

**PHYSICAL/OCCUPATIONAL THERAPY** (Written prescription with frequency and duration is required from attending Physician)

**PBHN PHYSICIAN** (Deductible applies) .......... 90%
**ALL OTHER PPO PROVIDERS & CONTRACTED FACILITIES** (Deductible applies) 80%
**NON-PPO** (Deductible applies).......... 60%
**OUT-OF-AREA** (Deductible applies).......... 70%
**Maximum Visits Per Calendar Year**.......... 50 visits

**PHYSICIAN'S SERVICES**

**PBHN PHYSICIAN** (Deductible applies) .......... 90%
**ALL OTHER PPO PROVIDERS & CONTRACTED FACILITIES** (Deductible applies) 80%
**NON-PPO** (Deductible applies).......... 60%
**OUT-OF-AREA** (Deductible applies).......... 70%

**RENAL/PERITONEAL DIALYSIS**

**PBHN PHYSICIAN** (Deductible applies) .......... 90%
**ALL OTHER PPO PROVIDERS & CONTRACTED FACILITIES** (Deductible applies) 80%
**NON-PPO** (Deductible applies).......... 60%
**OUT-OF-AREA** (Deductible applies).......... 70%

**LIMITATION TO PERCENTAGE OF MEDICARE RATES IN CERTAIN CIRCUMSTANCES.** For dialysis and associated drugs, the eligible charge will not exceed 175% of the Medicare allowance for such incurred expenses. This limitation applies to both in and out-of-network claims.

**SKILLED NURSING FACILITY CARE**

**PBHN PHYSICIAN** (Deductible applies) .......... 90%
**ALL OTHER PPO PROVIDERS & CONTRACTED FACILITIES** (Deductible applies) 80%
**NON-PPO** (Deductible applies).......... 60%
**OUT-OF-AREA** (Deductible applies).......... 70%
**Maximum Days Per Calendar Year**.......... 60 days
**Room and Board**.......... 50% of the Hospital's average semi-private room rate

**SPEECH THERAPY** (Written prescription with frequency and duration is required from attending Physician)

**PBHN PHYSICIAN** (Deductible applies) .......... 90%
**ALL OTHER PPO PROVIDERS & CONTRACTED FACILITIES** (Deductible applies) 80%
**NON-PPO** (Deductible applies).......... 60%
**OUT-OF-AREA** (Deductible applies).......... 70%
**Maximum Visits Per Calendar Year**.......... 50 visits

**SPINAL MANIPULATION TREATMENT**

**PBHN PHYSICIAN** (Deductible applies) .......... 90%
**PPO** (Deductible applies).......... 80%
**NON-PPO** (Deductible applies).......... 60%
**OUT-OF-AREA** (Deductible applies).......... 70%
**Maximum Visits Per Calendar Year**..........26 visits

**WELLNESS EXPENSE** (Includes immunizations, routine physical examinations, pap smears, mammograms, breast tomosynthesis (3D mammogram), PSA tests for covered Employees and spouses, bone density testing, routine sigmoidoscopy for Covered Persons age 50 and over once every five years, and Well Child Care. **The vaccine Gardasil is not covered).**

**PBHN PHYSICIAN/FACILITY** ..................100% up to $300, then 90% (Deductible waived)
**ALL OTHER PPO PROVIDERS & CONTRACTED FACILITIES** (Deductible waived) 80%
**NON-PPO** (Deductible waived) .......................................................................................... 60%
**OUT-OF-AREA** (Deductible waived) .................................................................................. 70%

**WOMEN'S HEALTH AND CANCER RIGHTS ACT**. Pursuant to the Women's Health and Cancer Rights Act of 1998, this Plan provides benefits for Covered Persons for mastectomy-related services, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from mastectomy (including lymphedema). For further details, please see subsection 22 of "ELIGIBLE CHARGES."

**MASTECTOMY AND RELATED PROCEDURES**. The Plan shall not restrict benefits for any Hospital length of stay in connection with (a) a mastectomy, to less than 48 hours, or (b) a lymph node dissection for the treatment of breast cancer, to less than 24 hours, unless discharged earlier by a Physician after consultation with the patient.

**MOTHERS AND NEWBORNS**. The Plan shall not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child following (a) an uncomplicated vaginal delivery, to less than 48 hours, or (b) an uncomplicated cesarean delivery, to less than 96 hours, unless discharged earlier by a Physician after consultation with the mother.

**POST DELIVERY CARE**. If a decision is made to discharge a woman who has given birth to a child or the newborn child from Inpatient care before the expiration of the minimum hours of coverage required under “Mothers and Newborns,” a health benefit plan must provide to the woman and child coverage for timely post delivery care. The timeliness of the post delivery care shall be determined in accordance with recognized medical standards for that care. The post delivery care may be provided by a Physician, registered nurse, or other appropriate licensed health care Provider. The post delivery care may be provided at:

1) the woman’s home;
2) a health care Provider’s office;
3) a health care facility; or
4) another location determined to be appropriate under rules adopted by Texas law.

Although a woman is NOT required to give birth in a Hospital or other health care facility or remain under Inpatient care for any fixed term following the birth of a child, post delivery care will still be provided.

# PRESCRIPTION DRUG PROGRAM

**MEDTRAK PRESCRIPTION DRUG CARD PROGRAM**. MedTrak is able to provide many prescriptions for Covered Persons at a discounted price. Prescriptions may be purchased through the MedTrak prescription drug program in two ways. Short-term prescriptions may be filled at local MedTrak Network Pharmacies which will charge a flat fee (Copay) for up to a 30-day supply of medication. MedTrak home delivery pharmacy service is a mail order prescription drug service which charges a flat fee (Copay) for a 90-day supply of prescription maintenance drugs, such as birth control pills, ulcer medication, insulin, thyroid medication, etc. When using the mail order option, Employees will need to request two prescriptions from their Physician, one for a two or three week supply to be filled by their local MedTrak pharmacy, and another which can be mailed to the MedTrak home delivery service for the remainder of their 90-day supply. Regardless of whether the Covered Person uses the drug card or mail order option, if the actual cost of the medication is less than the Copay, the Covered Person will only be responsible for the actual prescription cost.

**PRESCRIPTION DRUG CARD PROGRAM**

**Copay For Each Prescription or Refill (30-day supply) (No Deductible)**

| | |
|---|---|
| **Prescription Drugs up to $249.99** | $30 |
| **Prescription Drugs up to $250 - $999.99** | $60 |
| **Prescription Drugs $1,000 or more** | $60 plus 30% of prescription cost |
| **Generic Drugs** | $6 |

**Copay For Each Prescription or Refill (90-day supply) (No Deductible)**

| | |
|---|---|
| **Prescription Drugs up to $249.99** | $60 |
| **Prescription Drugs up to $250 - $999.99** | $120 |
| **Prescription Drugs $1,000 or more** | $120 plus 30% of prescription cost |
| **Generic Drugs** | $12 |

**MAIL ORDER PRESCRIPTION DRUG PROGRAM**

**Copay For Each Prescription or Refill (90-day supply) (No Deductible)**

| | |
|---|---|
| **Prescription Drugs up to $249.99** | $60 |
| **Prescription Drugs up to $250 - $999.99** | $120 |
| **Prescription Drugs $1,000 or more** | $120 plus 30% of prescription cost |
| **Generic Drugs** | $12 |

**Prescriptions costing in excess of the prescription maximum will be covered if Medical Necessity is established. The Covered Person will be responsible for 30% of the excess charges, in addition to the appropriate Copay.**

**If the mail order or drug card program is not used, no benefits will be paid. The per prescription Copay is not eligible for reimbursement under the Plan.**

**If the Covered Person chooses a brand name drug when a generic equivalent is available, the Covered Person will be charged the applicable brand name Copay plus the difference in cost between the brand name and generic drug. This provision does not apply if the Physician requests "dispense as written."**

**Some drug expenses which are not covered:**

* Drugs which can be obtained without a Physician's prescription;
* Therapy devices or appliances regardless of their intended use including:
  - -hypodermic needles;
  - -syringes;
  - -support garments; and
  - -other non-medical substances;
* Antiseptic or fluoride mouthwashes, mouth rinses, or topical oral solutions;
* Retin-A or similar drug for Covered Persons age 25 and older; and
* Any drugs which are Experimental/Investigational (see "EXCLUSIONS AND LIMITATIONS" for further details).

**This is not a complete list of drugs that are excluded. Please contact MedTrak at (800) 771-4648 to determine specific drug coverage.**

# ONCOLOGIC PRE-AUTHORIZATION PROGRAM

A Covered Person who has a diagnosis of cancer (and his or her treating oncologist) must call **INETICARE** at least three business days prior to the inception of a chemotherapy regimen. The number for **INETICARE i**s **(877) 208-5002.**

The Covered Person (or his or her treating oncologist) must provide **INTETICARE** with the proposed treatment regimen, including the names and NDC numbers of all drugs to be used in the treatment process. The Covered Person is responsible for informing the attending Physician of the requirements of the oncologic managed care procedure.

If there is a change to the treatment regimen (introduction / removal / replacement), then the Covered Person (or his or her oncologist) needs to again contact **INETICARE** at least three business days prior to the beginning of the new treatment process.

The **INETICARE** medical care counselor will contact the Physician to discuss the proposed treatment regimen and make a determination as to the eligibility of the treatment regimen under the Plan.

<u>If the Covered Person fails to follow the Plan's procedures for pre-authorization of a chemotherapy regimen, the chemotherapy regimen may not be considered to be an eligible charge under the terms of the Plan.</u>

Benefits are payable only if the covered dental expenses are for treatment that is:

1) Incurred and completed while dental coverage is in effect; and
2) Provided by:
   - A licensed Dentist;
   - A licensed Doctor; or
   - A dental assistant or a Dental Hygienist working under the direct supervision of a Dentist; and
3) Provided according to generally accepted dental practice; and
4) Necessary for the diagnosis, prevention or correction of dental disease, defect or accidental Injury.

**CALENDAR YEAR DEDUCTIBLE PER PERSON** ............................................................ $50

**CALENDAR YEAR MAXIMUM BENEFIT FOR PERSONS AGE 19 AND OVER** ..... $1,000

**Percent of Covered Charges Payable**

**CLASS I-DIAGNOSTIC AND PREVENTIVE PROCEDURES** (Deductible waived) ........ 100%

**CLASS II-BASIC PROCEDURES** (Deductible applies) ........................................................ 80%

**CLASS III-MAJOR PROCEDURES** (Deductible applies) ..................................................... 50%

**CLASS I-DIAGNOSTIC AND PREVENTIVE PROCEDURES**

1) One routine oral examination and scaling and cleaning of teeth per Calendar Year;
2) One topical application of fluoride solutions for covered Dependent children age 13 and under;
3) One set of bitewing x-rays per Calendar Year; and
4) Vizilite (oral cancer screening).

**CLASS II-BASIC PROCEDURES**

1) One subsequent routine oral exam, including scaling and cleaning of teeth;
2) One subsequent set of supplementary bitewing x-rays;
3) One subsequent topical application of fluoride solutions for Dependent children age 13 and under;
4) Dental x-rays, including full mouth x-rays, but not more than once in any 36 month period and any other dental x-rays required for the diagnosis of a condition;
5) Extractions;
6) Amalgam, silicate, acrylic, synthetic porcelain, and composite filling restorations to restore diseased or accidentally broken teeth;
7) General anesthetics administered for oral or dental surgery when Medically Necessary;
8) Treatment of periodontal diseases and other diseases of the gums and tissues of the mouth;
9) Endodontic treatment, including root canal therapy;
10) Injection of antibiotic drugs by the attending Dentist;

11) Repair or recementing of crowns, inlays, onlays, bridgework or dentures, or relining or rebasing of dentures more than six months after the installation of an initial or replacement denture, but not more than once in any 36 month period;
12) Oral surgery;
13) Sealants;
14) Prescription drugs prescribed by the attending Dentist;
15) Local anesthesia or IV sedation for covered oral surgery;
16) Crowns for Dependent children age 13 and under;
17) Space maintainers for missing primary teeth; and
18) Emergency treatment for pain.

**CLASS III - MAJOR PROCEDURES**

1) First installation of fixed bridgework, including inlays and crowns as abutments;
2) First installation of partial or full removable dentures, including precision attachments and any adjustments during the six month period following installation;
3) Replacement of an existing partial or full removable denture or fixed bridgework by a new one, or the addition of teeth to an existing partial removable denture or bridgework, if satisfactory evidence is presented that:
   a) the replacement or addition of teeth is necessary to replace one or more teeth extracted after the existing denture or bridgework was installed;
   b) the existing denture or bridgework was installed at least five years prior to its replacement and the existing denture or bridgework cannot be fixed; or
   c) the existing denture is a temporary denture which cannot be made permanent and replacement is made within 12 months after the temporary one was installed.

   Normally, dentures will be replaced by dentures, but if a professionally adequate result can be achieved only with bridgework, the bridgework will be a covered dental expense; and
4) Inlays, onlays, gold fillings, or crown restorations 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.

**PROSTHODONTICS, FIXED**

Replacement of fixed bridges is covered only if the original bridge cannot be made serviceable, and (a) the Covered Person has been covered under this Plan for at least 12 consecutive months, and (b) five years have elapsed since the last placement.

**PROSTHODONTICS, REMOVABLE**

Replacement of full or partial removable dentures is covered only if the existing denture cannot be made serviceable, and (a) the Covered Person has been covered under this Plan for at least 12 consecutive months (not applicable if replacement is made necessary by the initial placement of an opposing full denture), and (b) five years have elapsed since the last placement. Covered Charges for removable prosthodontics do not include any additional charges for over dentures or for precision or semi-precision attachments.

**COVERED CHARGES**. Covered Charges will be the actual cost charged for the treatment or service for a dental condition.

If it is determined that more than one procedure could be performed to correct a dental condition, Covered Charges will be limited to the least expensive of the procedures that would provide professionally acceptable results.

**BEGINNING DATE FOR TREATMENT OR SERVICE**. Treatment or service will be considered to begin:
1) For root canal therapy, on the date pulp chamber is opened and the pulp canal explored to the apex;
2) For crowns, fixed bridgework, inlays or onlays restoration, on the date the tooth or teeth are fully prepared;
3) For full or partial dentures, on the date the master impression is made; or
4) For all other services, on the date the treatment or service is performed.

**LIMITATIONS AND EXCLUSIONS**. Dental benefits will not be paid for:
1) The services of any person who is not a Dentist or a licensed Dental Hygienist under the supervision of a Dentist;
2) The services of any person who is an immediate family member of a Covered Person;
3) Personalization of dentures or crowns or for any other treatment that is primarily cosmetic and any procedure that does not have uniform professional endorsement;
4) Implants;
5) Drugs and medicines, except for antibiotic injections;
6) Instructions for plaque control, oral hygiene, or diet;
7) Treatment or service to alter vertical dimension or restore occlusion or to duplicate a lost or stolen prosthetic device;
8) Treatment or service for which the Covered Person has no financial liability or that would be provided at no charge in the absence of coverage or that is paid for or furnished by the United States government or one of its agencies;
9) Treatment or service that results from war or act of war or from voluntary participation in criminal activities;
10) Treatment or service that is covered by a workers' compensation or occupational disease or similar law;
11) Temporary restorations; however, if temporary restoration is part of a course of treatment, the maximum benefit for a permanent restoration will include the fee for a temporary restoration;
12) Orthodontic treatment;
13) Nitrous oxide;
14) Night guards for bruxism;
15) To the extent not prohibited by federal law and regulations issued thereunder, no benefits will be paid for an Illness or Injury which is intentionally self-induced or self-inflicted;
16) Broken appointments or completion of claim forms or pre-treatment forms;
17) Any expense incurred prior to becoming covered under the Plan;

18) Dental treatment received from a dental or medical department maintained by the employer, a mutual benefit association, labor union, trustee, or similar type of group;
19) Any care or service covered in whole or in part under any other section of the Plan;
20) Temporomandibular joint syndrome (TMJ);
21) Any charges incurred more than 12 months prior to the date the claim for benefits is filed;
22) Any item which is not listed as a covered expense; and
23) Any expenses incurred for treatment rendered after the date of termination.

**PRE-TREATMENT DETERMINATION**. A Dental Treatment Plan should be filed with the Administrative Service Agent before treatment begins when charges for a Period of Dental Treatment (other than emergency treatment) are expected to exceed $200. Any such approved Dental Treatment Plan will be applicable for six months from the approval date.

As used in this Plan, the following words and phrases shall have the meanings indicated:

**ACCIDENTAL BODILY INJURY** means only a bodily Injury sustained accidentally and independently of all other causes by an outside traumatic event or due to exposure to the elements.

**ACTIVELY AT WORK** means an Employee is performing regular duties of his or her occupation at an established business location of the County or another location to which he or she may be required to travel to perform the duties of employment. An Employee shall be considered Actively At Work on normal holidays or vacation days of the County if the Employee is not Totally Disabled and if the Employee was "Actively At Work" on the last preceding regular work day. In no event, will an Employee be considered Actively At Work if he or she is not physically able to perform all of the regular duties of his or her employment of if he or she has effectively terminated employment.

**ADMINISTRATIVE SERVICE AGENT** means the firm providing administrative services to the Plan Administrator in connection with the operation of the Plan, such as maintaining current eligibility data, billing, processing and payment of Claims and providing the Plan Administrator with any other information considered necessary. Group Resources is the Administrative Services Agent for the Plan.

**ALLOWABLE EXPENSES** means any item of expense which is covered, at least in part, by one or more of the group plans under which an individual is covered. Amounts in excess of the Reasonable Charge or Customary Charge and amounts not considered Medically Necessary are not considered covered expenses under this Plan.

**ANNUAL LIMIT ON ESSENTIAL HEALTH BENEFITS** means the maximum amount that can be paid on behalf of a Covered Person during the period of time beginning on October 1 and ending on September 30 of the following year.

**AVERAGE WHOLESALE PRICE** means the average value at which wholesalers sell drugs to Physicians, pharmacies, and other customers. Average Wholesale Price is the generally accepted standard measure for calculating the cost of a particular medication.

**CALENDAR YEAR** means each period of time beginning on January 1 and ending on December 31 of the same year.

**COINSURANCE** means the percentage of an eligible charge that is paid by the Plan on behalf of the Covered Person.

**COSMETIC TREATMENT** means treatment performed for the purpose of improving appearance rather than for restoring bodily function.

**COUNTY** means Ector County or any affiliate which is participating in the Plan with the permission of Ector County.

**COVERED PERSON** means an Employee, Retired Employee, Elected Officials, District Judges, District Attorneys, Employees of the Ector County Appraisal District, or a Dependent for whom the coverage provided by this Plan is in effect. A Covered Person may be covered under this Plan as an Employee or as a Dependent, but not both at the same time.

**CUSTOMARY CHARGE** means a charge for medical services, care, or supplies that does not exceed the common level of charges made by other medical professionals with similar credentials, or health care facilities, pharmacies, or equipment suppliers of similar standing, which are located in the same geographic locale in which the charge is incurred.

The term "Customary" refers to the form and substance of a service, supply, or treatment provided in accordance with generally accepted standards of medical practice to one individual, which is appropriate for the care or treatment of a similarly situated person who receives such services or supplies within the same geographic locale.

The term "same geographic locale" means a city, county, or such greater area as may be necessary to establish a representative cross section of persons or organizations regularly furnishing the type of treatment, services, or supplies for which a specific charge is made.

The term "Customary" does not necessarily mean the actual charge made or the specific service or supply furnished to a Plan Participant by a provider of services or supplies, such as a physician, therapist, nurse, or hospital. The Plan will determine what the usual charge is, for any procedure, service, or supply, and whether a specific procedure, service, or supply is customary.

Customary Charges may alternatively be determined and established by the Plan using normative data such as Medicare cost to charge ratios, average wholesale price (AWP) for prescriptions, and/or manufacturer's retail pricing (MRP) for supplies and devices.

**DEDUCTIBLE** means the amount of eligible charges that a Covered Person must incur before benefits will be payable, as listed in "MEDICAL BENEFITS" and "DENTAL BENEFITS." The Covered Person must meet a new Deductible each Calendar Year. The Deductible will be applied separately to each Covered Person. Once a Covered Person's Deductible is met, no further Deductible for that Covered Person will be required during that Calendar Year. Once the family Deductible is met, no further Deductible will be required of any Covered Person in that family during that Calendar Year.

**DENTAL HYGIENIST** means a person who works under the supervision of a Dentist and is licensed to practice dental hygiene.

**DENTAL TREATMENT PLAN** means the Dentist's report of proposed treatment which:
1) lists the procedures required for the Period of Dental Treatment; and
2) shows the charges for each procedure; and
3) is accompanied by any diagnostic materials that might be required.

**DENTIST** means:
1) a person licensed to practice dentistry; and
2) a licensed Physician who provides dental treatment or service.

**DEPENDENT** means a person who meets one of the following requirements:
1) is an Employee's or Retired Employee's lawful licensed spouse including a separated spouse. The term "spouse" shall include only the person to whom the Employee is married and whose marriage has been licensed, solemnized and registered in accordance with the statutory law of the jurisdiction in which the marriage occurred; or
2) is the Employee's or Retired Employee's:
   a) child less than 26 years of age; or
   b) unmarried child age 26 or older meeting all of the following conditions:
      i) subject to a physical or mental impairment which can be expected to result in death or which has lasted or is expected to last for a continuous period of not less than 12 months; and
      ii) is unable to engage in any substantial gainful activity due to such physical or mental impairment; and
      iii) for whom proof of such physical or mental impairment is submitted to the Plan Administrator within 31 days of the date coverage would have ended as a result of the child's age.

The Plan Administrator may require at reasonable intervals, subsequent proof satisfactory to the Plan Administrator during the next two-year period following such date. After such two-year period, the Plan Administrator may require such proof, but not more often than once each year.

The term "child" includes:
1) the natural child of the Employee;
2) a legally adopted child of the Employee (including a child living with the adopting parents during the period of probation);
3) a stepchild of the Employee;
4) a child for whom the Employee or Employee spouse is Legal Guardian;
5) a child of the Covered Person whose coverage is ordered under a National Medical Support Notice and who otherwise meets the requirements above; and
6) a child for whom the Employee has received a court order issued under Chapter 154, Family Code, or enforceable by a Texas court requiring the Covered Person to have the financial responsibility for providing health coverage.

For purposes of continuation coverage pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, "Dependent" shall also include any child born to or placed for adoption with a Covered Person during the period of continuation coverage.

In the case of an individual whose parents are divorced, the individual may be considered the "child" of either parent.

The term "Dependent" does not include any person serving in the armed forces of any country; unless such a person is the child of the covered Employee who has not attained age 26. If a husband and wife are both Employees, their children may be considered Dependents of either the husband or wife but not of both.

**DURABLE MEDICAL EQUIPMENT** means equipment which is:
1) able to withstand repeated use; and
2) primarily and customarily used to serve a medical purpose; and
3) not generally used by a person in the absence of Illness or Injury; and
4) appropriate for use in the home.

**EMPLOYEE** means any person employed on a regular basis by the County in the conduct of the County's regular business, who is regularly scheduled to work at least 30 hours per week or 130 hours per month, and who is classified by the County, pursuant to its regular administrative practices, as a common law Employee, excluding any person who (a) is a leased Employee under Code Section 414 (n) or (b) is covered under a collective bargaining agreement which is the subject of good faith bargaining, unless the agreement provides for participation in the Plan. "Employee" also includes elected and appointed officials as defined by Ector County Policy. The term "Employee" shall exclude any individual classified by the County, in its sole discretion, in a designation which would exclude the person from being considered as an Employee under the County's customary worker classification procedures, regardless of whether such classification is in error.

**ESSENTIAL HEALTH BENEFITS**, includes, in addition to any other services that are required to be treated as "Essential Health Benefits" under the Patient Protection and Affordable Care Act of 2010, the following general categories and items and services covered within the categories: ambulatory patient services, emergency services, hospitalizations, maternity and newborn care, mental health and substance use disorder services (including behavioral health treatment), prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services (including oral and vision care).

**HOME HEALTH CARE** means the following services and supplies furnished in the home by a Home Health Care agency in accordance with a Home Health Care plan, provided that the Physician certifies that Hospital confinement would otherwise be required:
1) part-time or intermittent nursing care by a Registered Nurse (R.N.), or Licensed Practical Nurse (L.P.N.) under the supervision of a Registered Nurse (R.N.);
2) Occupational Therapy, Speech Therapy, and Physical Therapy which are provided by a Home Health Care Agency;
3) medical supplies and medications prescribed by a Physician and laboratory services of a Hospital if such items would have been covered while confined in a Hospital.

The term "Home Health Care" does not include:
1) services or supplies not included in the Home Health Care plan;
2) services of a person who ordinarily resides in a Covered Person's home or is a member of the Covered Person's family or the Covered Person's spouse's family;

3) custodial care consisting of services and supplies which are provided to the Covered Person primarily to assist in the activities of daily living;
4) care received in any period during which the Covered Person is not under the continuing care of a Physician; or
5) transportation.

**HOME INFUSION THERAPY** means the administration of fluids, nutrition or medication (including all additives and chemotherapy) by intravenous or gastrointestinal (enteral) infusion or by intravenous injection in the home setting, including:
1) drugs and I.V. solutions;
2) pharmacy compounding and dispensing services;
3) all equipment and ancillary supplies necessitated by the defined therapy;
4) delivery services;
5) patient and family education; and
6) nursing services.

Over-the-counter products which do not require a Physician's prescription, including, but not limited to standard nutritional formulations used for enteral nutrition therapy, are not included within this definition.

**HOSPICE** means a public agency or private organization which meets all of the following requirements:
1) is primarily engaged in providing care to terminally ill patients;
2) provides 24-hour care to control the symptoms associated with terminal Illness;
3) has on its staff an interdisciplinary team which includes at least one Physician, one Registered Nurse (R.N.), one social worker and one counselor;
4) is a licensed organization whose standards of care meet those of the National Hospice Organization;
5) maintains central clinical records on all patients;
6) provides appropriate methods of dispensing drugs and medicines; and
7) offers a coordinated program of home care and Inpatient care for the terminally ill patient and the patient's family.

The term "Hospice" does not include an organization or part thereof which is primarily engaged in providing:
1) custodial care;
2) care for drug addicts and alcoholics; or
3) domestic services.

The term "Hospice" does not include an organization or part thereof which is primarily:
1) a place of rest;
2) a place for the aged; or
3) a hotel or similar institution.

**HOSPITAL** means a place which meets all of the following requirements:
1) is either accredited by the Joint Commission on Accreditation of Hospitals (JCAH), the Commission on Accreditation of Rehabilitation Facilities (CARF), or is certified as a Hospital Provider under Medicare;
2) is open at all times;
3) is operated for the treatment of sick or injured persons through medical, diagnostic, and major surgical facilities on its premises;
4) has a staff of one or more Physicians available at all times;
5) provides 24 hour nursing services by Registered Nurses (R.N.'s);
6) if it is chiefly a place for the treatment of mental health or substance abuse/substance dependence, has bona fide arrangement by contract with an accredited Hospital to perform surgery or provide other medical care which may be required.

The term “Hospital” also includes a short-term acute care facility which operates primarily for the treatment of Chemical Dependency, or Mental or Nervous Disorders, if it meets these tests:
1) is either accredited by the Joint Commission on Accreditation of Hospitals (JCAH), the Commission on Accreditation of Rehabilitation Facilities (CARF), or is certified as a Hospital Provider under Medicare;
2) has a Physician in regular attendance;
3) has a full-time psychiatrist or psychologist on the staff;
4) maintains clinical records on all patients;
5) provides comprehensive multidisciplinary therapy and medical management with the expectation for improvement or when it is necessary to maintain a Covered Person’s functional level and prevent relapse.

The term “Hospital” does not include subacute/minimal care facilities, facilities providing custodial care, educational institutions, nursing homes, convalescent facilities, rest homes or similar establishments.

The term “Hospital” also does not include any facility providing luxury recovery or rehabilitation programs which may include amenities such as massage therapy, swimming, horseback riding, fine dining and private accommodations. These facilities are often located in desirable settings such as beaches or mountains.

All hospital treatment must be Medically Necessary (see “DEFINITIONS”) or no coverage will be available under this plan.

**ILLNESS** means a disorder of the body or mind, a disease, or pregnancy. All Illnesses which are due to the same cause or to a related cause or causes will be considered to be one Illness.

**INCURRED** means a covered expense is Incurred on the date the service is rendered or the supply is obtained. With respect to a course of treatment or procedure which includes several steps or phases of treatment, covered expenses are Incurred for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered. More specifically, covered expenses for the entire procedure or course of treatment are not Incurred upon commencement of the first stage of the procedure or course of treatment.

**INJURY** means bodily Injury caused by an accident and which results directly from the accident and independently of all other causes.

**INPATIENT** means an individual confined as a registered bed patient in a Hospital, Skilled Nursing Facility or Hospice.

**INTENSIVE CARE UNIT OR CARDIAC CARE UNIT** means only a separate, clearly designated service area which is maintained within a Hospital and which meets all of the following tests:

1) it is solely for the treatment of patients who require special medical attention because of their critical condition;
2) it provides within such area special nursing care and observation of a continuous and constant nature not available in the regular rooms and wards of the Hospital;
3) it provides a concentration of special life-saving equipment immediately available at all times for the treatment of patients confined within such area;
4) it contains at least two beds for the accommodation of critically ill patients; and
5) it provides at least one professional Registered Nurse (R.N.) who continuously and constantly attends the patient confined in such area on a 24 hour a day basis.

**MAXIMUM BENEFIT** means the maximum amount payable for the period indicated for a Covered Person for all eligible charges incurred while covered under the Plan.

**MEDICAL EMERGENCY** means a sudden and unexpected onset of a medical condition requiring medical care which the patient secures immediately after the onset and, as a general rule, is a condition which would be life threatening or would cause serious impairment if immediate care were not received.

**MEDICALLY NECESSARY** means health care services, supplies, or treatments which are for the purpose of evaluation, diagnosis, or treatment of the Covered Person's Injury or Illness and are:

1) recommended, approved, or ordered by a Physician or Dentist exercising prudent clinical judgment, and clinically appropriate in terms of type, frequency, extent, site, and duration for the diagnosis or treatment of the Covered Person's Illness or Injury;
2) consistent with the patient's condition or accepted standards of good medical and dental practice;
3) not performed for the convenience of the patient or the Provider of medical and dental services;
4) no more costly than alternative interventions, and at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Covered Person's Illness or Injury without adversely affecting the Covered Person's medical conditions;
5) not conducted for research purposes; and
6) the most appropriate setting and level of services which can be safely provided to the Covered Person, considering the Covered Person's medical symptoms and conditions.

All of these criteria must be met. Merely because a Physician or Dentist recommends, approves, or orders certain care does not mean that it is Medically Necessary. The determination of whether a service, supply, or treatment is or is not Medically Necessary may include findings of the American Medical Association and the Plan Administrator's own medical advisors. The Plan Administrator has final discretionary authority to decide whether care or treatment is Medically Necessary.

In addition, with respect to Mental or Nervous Disorders, Substance Abuse, and Substance Dependence, to be considered "Medically Necessary," the treatment, services, and/or supplies must not be (a) maintenance therapy or maintenance treatment, or (b) a listed item or treatment not allowed for reimbursement by CMS (Medicare).

The Plan reserves the right to incorporate CMS (Medicare) guidelines in effect on the date of treatment as additional criteria for determination of Medical Necessity.

**MENTAL OR NERVOUS DISORDER**: To be a Mental Disorder or Nervous Disorder, the disease or condition, regardless of whether the cause is organic, must be classified as a Mental or Nervous Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association. Mental or Nervous Disorder does not include Substance Abuse or Substance Dependence or any condition resulting therefrom.

**MORBID OBESITY** means a diagnosed condition in which the body weight exceeds the medically recommended weight by either 100 pounds or is twice the medically recommended weight in the most recent Metropolitan Life Insurance Co. tables (or similar actuarial tables) for a person of the same height, age and mobility as the Covered Person.

**NATIONAL MEDICAL SUPPORT NOTICE** means a qualified medical support order and serves notice that the employee identified on the document is obligated by a court or administrative child support order to provide health care coverage for the child(ren) identified in it. The NMSN meets the requirements for a Qualified Medical Child Support Order (QMCSO) if the child support agency correctly completes it and if coverage for the child(ren) is or will become available. The NMSN is a QMCSO under the Employee Retirement Income Security Act (ERISA) section 609 (a)(5)(s).

**OCCUPATIONAL THERAPY** means a program of care which focuses on the physical, cognitive and perceptual disabilities that influence the patient's ability to perform functional tasks. The therapist evaluates the patient's ability to use his fingers and hands (fine motor skills), perceptual skills, cognitive functioning and eye-hand coordination. Therapy sessions may also involve physical movement exercises. Functional tasks also may be used. The therapist may also perform splinting of the patient's arms or hands and may provide the patient with special equipment.

**OUT-OF-POCKET MAXIMUM** means the maximum amount that a covered Employee or Dependent will have to pay for covered expenses under the Plan. This does not include the Deductible amount on this Plan, non-covered items, and penalties.

**OUTPATIENT** means an individual receiving medical services, but not confined as a registered bed patient in a Hospital, Skilled Nursing Facility, or Hospice.

**OUTPATIENT SURGICAL CENTER** means any public or private establishment which:
1) has a staff of Physicians;
2) has permanent facilities that are equipped and operated primarily for the purpose of performing Surgical Procedures; and
3) provides continuous Physician and nursing services while patients are in the facility.

**PERIOD OF DENTAL TREATMENT** means all sessions of dental care that result from the same initial diagnosis and any related complications.

**PHYSICAL THERAPY** means a plan of care provided to return a patient to the highest level of motor functioning possible. The physical therapist extensively evaluates the patient's muscle tone, movement, balance, endurance, ability to ambulate, ability to plan motor movements, strength and coordination. If the patient requires special equipment (such as a wheelchair, walker or splint), the therapist evaluates the patient's ability to use the equipment and determines the correct size and type of equipment for the specific patient. The therapist constructs a program of exercises and movements to maximize the patient's motor skills.

**PHYSICIAN** means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dentistry (D.M.D. or D.D.S.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Audiologist, Certified Registered Nurse Anesthetist (C.R.N.A.), Licensed Professional Counselor (L.P.C.), Licensed Dietician, Midwife, Optometrist (O.D.), Psychologist (Ph.D.), Certified Social Worker-Advanced Clinical Practitioner, Speech and Language Pathologist, Nurse Practitioner, a Physician's Assistant (P.A.), acting under the direction of a Physician, and any other practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license.

The term "Physician" does not include a person who:
1) is the Covered Person receiving treatment; or
2) is a relative by blood or marriage of the Covered Person receiving treatment.

**PRE-ADMISSION TESTING** means x-ray and laboratory examinations which:
1) are performed on an Outpatient basis;
2) are performed within seven days of a scheduled surgery which is performed within 48 hours following the Covered Person's admission to the Hospital; and
3) are related to the Illness or Injury that caused Hospital confinement or the need for surgery.

**PREFERRED PROVIDER ORGANIZATION (PPO)** means the Plan has retained the services of a Preferred Provider Organization in order to provide quality medical care to participants who are within the PPO's area of operation, at lower cost to both the Plan and participants. PPOs vary among the type of services to be provided. Utilization of PPO network Providers will usually result in an increase in the amount of benefits paid on eligible expenses. A list of the Providers included in the PPO will be furnished automatically, without charge, and is also available on the internet at www.multiplan.com or www.pbhn.org. The PPO has a process for provisional credentialing status in compliance with the requirements for the National Committee for Quality Assurance.

The PPO may grant provisional credentialing status to a Physician who:

1) submits a completed standard credentialing application;
2) meets the health plan's requirements for provisional credentialing; and
3) joins as a partner, shareholder, or employee of another Physician who is contracted with a PPO to provide medical or health care services to enrollees.

The PPO must complete the credentialing process within 60 calendar days of the date a Physician is granted provisional status. In the event the Physician does not meet the health plan's credentialing standards, the Physician must be provided the same appeal process as any other Physician applying for participation with the PPO.

**PROVIDER** means a Hospital, Physician, or any other person, company, or institution furnishing to a Covered Person an item of service or supply listed as a covered expense in the Plan.

**REASONABLE CHARGE** means fee(s) for services or supplies which are Medically Necessary for the care and treatment of Illness or Injury not caused by the treating provider. When more than one treatment option is available, and one option is no more effective than another, the least costly option that is no less effective than any other option will be considered the "Reasonable Charge" for the treatment. The determination of whether a charge is a Reasonable Charge will consider, but will not be limited to, the findings and assessments of the following entities: (a) The national medical associations, societies, and organizations; and (b) The Food and Drug Administration. To be reasonable, fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures. Services, supplies, care and/or treatment that result from errors in medical care that are clearly identifiable, preventable, and serious in their consequence for patients, are not reasonable.

**RETIRED EMPLOYEE** means a covered Employee who is eligible for retirement under the Texas County and District Retirement System. Such covered Employee must meet Ector County's "rule of 75" requirement of combined years of service and years of age in addition to current guidelines for being vested and qualified to retire from Ector County.

The guidelines to qualify for retirement in force at the time of the covered Employee's retirement shall apply.

**Effective December 20, 2018:** In addition to meeting the Texas County and District Retirement System's definition of "retiree", the retiring employee must have a minimum of 12 years of service with Ector County to qualify for retiree insurance benefits and meet the Rule of 75 for years of service and age, or 35 years of service and any age. If the employee who meets all of the above requirements should die before electing to retire, the spouse of such qualifying employee may remain on Ector County insurance under the same conditions as if the deceased employee had retired with full benefits. This revision has no effect on individuals who have already retired.

Any employee who is eligible to retire with benefits prior to January 1, 2021, may do so without having to meet the above-referenced requirements adopted December 20, 2018.

**ROOM AND BOARD** means the Hospital's charge for:
1) room and linen service;
2) dietary service, including meals, special diets, and nourishments; and
3) general nursing service.

**SKILLED NURSING CARE** means those charges incurred for:
1) visiting nurse care by an R.N. or L.P.N. The term "visiting nursing care" means a visit of not more than two hours for the purposes of performing specific Skilled Nursing tasks; and
2) private duty nursing by an R.N. or L.P.N. if the patient condition requires Skilled Nursing services and visiting nurse care is not adequate.

The term "Skilled Nursing Care" does not include:
1) that part or all of any nursing care that does not require the skills of an R.N.; or
2) any nursing care given while the person is an Inpatient in a health care facility that could safely and adequately be furnished by the facility's general nursing staff if it were fully staffed.

**SKILLED NURSING FACILITY** means a place, or a distinct part of a place, which meets all of the following criteria:
1) is licensed according to state or local laws;
2) provides as its chief purpose Skilled Nursing treatment to patients who are recovering from an Illness or Injury;
3) includes areas for medical treatment;
4) provides 24-hour-a-day nursing services under the full-time supervision of a Physician or a Registered Nurse (R.N.);
5) maintains daily health records for each patient;
6) has an agreement which provides for the services of a Physician;
7) has a suitable method for providing drugs and medicines to patients;
8) has an arrangement with one or more Hospitals for the transfer of patients;
9) has an effective utilization review plan;
10) develops functions with the advice and review of a skilled group which includes at least one Physician; and
11) is not solely a place for:
    a) rest, rehabilitation or custodial care;
    b) the aged;
    c) the treatment of drug addiction or Substance Abuse/Substance Dependence;
    d) the treatment of alcoholism; or
    e) those who are mentally disabled or who have mental disorders.

**SOUND NATURAL TEETH** means teeth that are free of active or chronic clinical decay, have at least 50% bony support, are functional in the arch, and have not been excessively weakened by multiple dental procedures.

**SPEECH THERAPY** means a program of care which evaluates the patient's motor-speech skills, expressive and receptive language skills, writing and reading skills and determines if the patient requires an extensive hearing evaluation by an audiologist. The therapist also evaluates the patient's cognitive functioning, as well as his social interaction skills such as the ability to maintain eye contact and initiate conversation.

**SUBSTANCE ABUSE** means the excessive use of a substance, especially alcohol or a drug. The DSM-IV definition is applied as follows:

1) an inappropriate pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12-month period:
   a) recurrent substance use resulting in a failure to fulfill major role obligations at work, school or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions or expulsions from school; neglect of children or household);
   b) recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use);
   c) recurrent substance-related legal problems (e.g., arrests for substance-related disorderly conduct);
   d) continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights);
2) the symptoms have never met the criteria for Substance Dependence for the class of substance.

**SUBSTANCE DEPENDENCE** means substance use history which includes the following: (1) Substance Abuse; (2) continuation of use despite related problems; (3) development of tolerance (more of the drug is needed to achieve the same effect); and (4) withdrawal symptoms.

**SURGICAL PROCEDURE** includes, but is not limited to, incision and excision, sutures, debridement of tissue, correcting a fracture, reducing a dislocation, manipulating a joint under general anesthesia, electocauterizing, paracentesis, applying plaster casts, endoscopy, injecting sclerosing solution, arthroscopic procedures, lithotripsy, catheterization, and injections into a joint.

**TEMPOROMANDIBULAR JOINT (TMJ) SYNDROME** means a jaw/joint disorder causing pain, swelling, clicking, and difficulties in opening and closing the mouth; and complications including arthritis, dislocation, and bite problems of the jaw.

**TOTAL DISABILITY or TOTALLY DISABLED** means an Injury or Illness which:

1) with respect to an Employee, prevents the Employee from performing the main duties of the Employee's occupation with the County; and
2) with respect to a Dependent, prevents the Dependent from performing the normal activities of a healthy person of the same age and gender.

**WELL CHILD CARE** means preventative medical care, i.e., periodic checkups and immunizations as recommended by the AMA Board of Pediatrics.

## WHEN COVERAGE BEGINS

Benefits for a Covered Person are determined by the Covered Person's eligibility classification and by the terms of this Plan. Any change in benefits as a result of a change in the classification will be effective on the date the change in class occurs.

A Covered Person will not receive benefits:
1) for which such person is not eligible; or
2) in excess of the maximum amount provided under any benefit for which the person is covered.

**ELIGIBILITY CLASSIFICATION - DESCRIPTION OF ELIGIBLE CLASSES**:

| | |
|---|---|
| Class I | All active permanent full-time Employees |
| Class II | All elected officials |
| Class III | All retired Employees |
| Class IV | All district judges and district attorneys |

**REQUIRED EMPLOYEE CONTRIBUTIONS**:

Employees and Retired Employees contribute toward the cost of Employee, Dependent, and Retiree coverage.

This amount is subject to change at any time at the discretion of the Plan Administrator. The amount that Employees and Retirees contribute is calculated by the plan administrator and is a portion of the cost of coverage under the Plan.

**OPEN ENROLLMENT** means the period from September 1 through September 30 during which individuals who are currently enrolled or eligible to enroll in this Plan or any other healthcare plan sponsored by the County may make changes to their coverage. Coverage under any newly elected option will take effect on October 1 provided the individual is in full-time service on that date, and the enrollment requirements of this Plan have been met. If an Employee does not complete and return a new election form prior to October 1 of each year, the previous year's coverage will remain in effect.

**OPEN ENROLLMENT FOR APPRAISAL DISTRICT** means the period from December 1 through December 31 during which individuals who are currently enrolled or eligible to enroll in this Plan or any other healthcare plan sponsored by the County may make changes to their coverage. Coverage under any newly elected option will take effect on January 1 provided the individual is in full-time service on that date, and the enrollment requirements of this Plan have been met. If an Employee does not complete and return a new election form prior to January 1 of each year, the previous year's coverage will remain in effect.

**ELIGIBILITY FOR EMPLOYEE COVERAGE**. An Employee becomes eligible for coverage provided by this Plan on the later of:
1) For Class I Employees:
   a) the effective date of the Plan; or
   b) first of the month following completion of a 60 day waiting period;

2) For Class II Employees:
   a) the effective date of the Plan; or
   b) the first day of full-time service;
3) For Class III Employees:
   a) the effective date of the Plan; or
   b) the date of an eligible covered Employee's retirement; and
4) For Class IV Employees:
   a) the effective date of the Plan; or
   b) the first day following completion of a 30 day waiting period.

**SPECIAL ENROLLMENT RIGHTS.** If an Employee declines enrollment for himself or his Dependents (including spouse) because of other health insurance or group health plan coverage, the Employee may in the future be able to enroll himself or his Dependents in this Plan if the Employee or his Dependents lose eligibility for that other coverage (or if an employer stops contributing towards the Employee's or his Dependent's other coverage), provided that the Employee requests enrollment within 31 days after the other coverage ends (or within 31 days after an employer stops contributing towards the other coverage). In addition, if the Employee has a new Dependent as a result of marriage, birth, adoption, or placement for adoption, the Employee may be able to enroll himself and his Dependents, provided that the Employee requests enrollment within 31 days after the marriage, birth, adoption, or placement for adoption. The subsection entitled "SPECIAL ENROLLMENT PERIOD" below describes the procedures for Special Enrollment.

**SPECIAL ENROLLMENT PERIOD**. Notwithstanding any other provisions in the Plan to the contrary, Employees and their Dependents shall be eligible to enroll in the Plan upon the occurrence of one of the following:

1) the Employee or Dependent loses other health coverage and meets the following conditions:
   a) the individual had other health coverage at the time he became eligible for the Plan;
   b) the Employee stated in writing that he was declining to enroll himself and/or his Dependents in the Plan because of the other coverage;
   c) coverage being lost was (i) COBRA coverage that was exhausted, (ii) other coverage for which the individual is no longer eligible (for example, by reason of legal separation, divorce, death, termination of employment, reduction in the number of hours of employment, or incurring a claim that would meet or exceed a lifetime limit on all benefits under the other coverage), or (iii) provided by another employer which ceased to pay for it. (However, loss of coverage due to a failure to pay premiums will <u>not</u> trigger a Special Enrollment period; nor will loss of coverage for cause [such as making a fraudulent claim or an intentional misrepresentation] trigger a Special Enrollment period); and
   d) the individual makes a request for enrollment under the Plan within 31 days after losing the other coverage.

   If an Employee fails to provide the written statement required under b) above, the Plan may not provide special enrollment to the Employee or any of his Dependents.

2) If an Employee or Dependent gains eligibility for coverage under another employer's cafeteria plan (or Benefit Plan or Policy) as a result of a change in marital status or a change in employment status, the election to cease or decrease coverage for that individual under the Plan would correspond with a Change in Status *only* if coverage for that individual becomes effective or is increased under the other employer's plan.
3) the Employee marries, has a child, adopts a child, or has a child placed for adoption, and makes a request for enrollment under the Plan within 31 days of such event.
4) the Employee or Dependent loses coverage under Medicaid or Children's Health Insurance Coverage (CHIP) due to loss of eligibility for Medicaid or CHIP, and makes a request for enrollment under the Plan within 60 days of the loss of coverage.
5) the Employee or Dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP, and makes a request for enrollment under the Plan within 60 days of such event.

**EFFECTIVE DATE FOR EMPLOYEE COVERAGE**. Except as stated in "Delayed Effective Date for Employee Coverage" below, coverage for an Employee becomes effective as follows:

1) for a Special Enrollment:
   a) in the case of a loss of coverage or marriage, the date of a loss of coverage or marriage, provided that special enrollment is timely requested;
   b) in the case of a Dependent's birth, adoption, or placement for adoption, the date of the birth, adoption, or placement for adoption, respectively, provided that special enrollment is timely requested; and
   c) in the case of the Employee's or Dependent's loss of coverage under Medicaid or CHIP due to loss of eligibility for Medicaid or CHIP or the Employee's or Dependent's eligibility for a premium assistance subsidy under CHIP, the date which is the first day of the first calendar month beginning after the request for enrollment is received by the Plan Administrator, provided that special enrollment is timely requested; and
2) for all other enrollments, the date which is the later of:
   a) the date the Employee becomes eligible for coverage; or
   b) the date the Employee makes written application and written election to pay for coverage provided said application is made within 31 days of the eligibility date.

**DELAYED EFFECTIVE DATE FOR EMPLOYEE COVERAGE.** If an Employee fails to make written application for coverage within 31 days of his initial eligibility under the Plan (or, fails to request enrollment within 31 days of the occurrence of an event which would entitle him to Special Enrollment, if applicable), he shall be deemed a "Late Enrollee" and he may not apply for coverage until the earlier of (1) the next Open Enrollment period, or (2) a Special Enrollment period.

**EMPLOYEES ON MILITARY LEAVE.** Employees going into or returning from military services will have Plan rights mandated by the Uniformed Services Employment and Reemployment Rights Act. These rights include up to 24 months of extended health care coverage. In cases where leave is for more than 31 days, the Employee cannot be required to pay any more than 102 percent of the full premium. If the Employee performs services for less than 31 days, he or she cannot be required to pay more than the normal Employee share for such coverage.

Regardless of whether extended health care coverage is elected or declined, the Employee is entitled to immediate coverage under the Plan, upon return from service. These rights apply only to Employees and their Dependents covered under the Plan before leaving for military service. Plan exclusions and waiting periods may be imposed for an Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, military service.

**ELIGIBILITY FOR DEPENDENT COVERAGE**. An Employee becomes eligible for Dependent Coverage on the later of:
1) the date the Employee becomes eligible for coverage; or
2) the date the Employee first acquires a Dependent.

**EFFECTIVE DATE FOR DEPENDENT COVERAGE.** Except as stated in "Delayed Effective Date for Dependent Coverage" below, coverage for a Dependent becomes effective as follows:
1) for a Special Enrollment:
   a) in the case of a loss of coverage or marriage, the date of a loss of coverage or marriage, provided that special enrollment is timely requested;
   b) in the case of a Dependent's birth, adoption, or placement for adoption, the date of the birth, adoption, or placement for adoption, respectively, provided that special enrollment is timely requested; and
   c) in the case of the Employee’s or Dependent’s loss of coverage under Medicaid or CHIP due to loss of eligibility for Medicaid or CHIP or the Employee’s or Dependent’s eligibility for a premium assistance subsidy under CHIP, the date which is the first day of the first calendar month beginning after the request for enrollment is received by the Plan Administrator, provided that special enrollment is timely requested; and
2) for all other enrollments, the date which is the later of:
   a) the date the Employee becomes eligible for Dependent coverage; or
   b) the date the Employee makes written application and written election to pay for Dependent coverage, provided said application is made within 31 days of the eligibility date.

**DELAYED EFFECTIVE DATE FOR DEPENDENT COVERAGE**. If an Employee fails to make written application for coverage of the Dependent when the Dependent first becomes eligible (or during a Special Enrollment period, if applicable), the Dependent shall be deemed a "Late Enrollee" and the Employee may not apply for coverage for the Dependent until the earlier of (1) the next Open Enrollment period or (2) a Special Enrollment period.

**NEWBORNS**. The Employee’s newborn child will be covered from the date of birth only if the newborn is properly enrolled as outlined under “Special Enrollment Period.” If the enrollment for a newborn is not requested within 31 days of the date of birth, the newborn cannot be enrolled until (1) the next Open Enrollment period or (2) a Special Enrollment period. A newborn child is covered separately and must meet its own Deductible and Out-of-Pocket.

**NO MULTIPLE STATUS.** You may not have multiple status under the Plan (*i.e.,* you may not receive benefits under this Plan as both an Employee and as a Dependent).

**SPECIAL CONDITIONS FOR RETIREES.**

1) Active full-time Employees who were hired prior to October 1, 2015, and who retire at the end of each month will be eligible to participate in the retiree health care plan effective the first day of the following month without a lapse in coverage. This election must be made at the time the active employment **with Ector County** ends.
2) Appraisal District Employees who have satisfied the retirement qualifications and were hired prior to October 1, 2015, will be eligible to participate in the retiree health care plan effective the first day of the following month without a lapse in coverage. This election must be made at the time active employment **with Ector County** ends.
3) If a Retired Employee specifically declines Personal coverage at the time of retirement or cancels enrollment at any time, the retiree will not be allowed to re-enroll at a later date.
4) If a Retired Employee declines coverage for any eligible Dependent at the time of retirement, or cancels a Dependent's enrollment at any time, that Dependent will not be allowed to re-enroll at a later date.
5) If a Retiree marries, has a child, adopts a child, or has a child placed for adoption, they shall be able to enroll the eligible spouse and/or children in the Plan provided the Retiree makes a request for enrollment under the Plan within 31 days from the date either event occurs.
6) In addition to meeting the Texas County and District Retirement System's definition of "retiree", the retiring employee must have a minimum of 12 years of service with Ector County to qualify for retiree insurance benefits and meet the Rule of 75 for years of service and age, or 35 years of service and any age. If the employee who meets all of the above requirements should die before electing to retire, the spouse of such qualifying employee may remain on Ector County insurance under the same conditions as if the deceased employee had retired with full benefits. No additional dependents may be added by the surviving spouse. This revision has no effect on individuals who have already retired.

**EXCEPTION.** If a Retired Employee declines coverage for his spouse because the spouse is employed by the County and the spouse terminates employment with the County, the Retired Employee will be allowed to enroll his spouse for Dependent Coverage provided application is made to the County within 31 days of the spouse's termination.

## WHEN COVERAGE ENDS

**EMPLOYEE COVERAGE**. An Employee's coverage will terminate on the earliest of:

1) the date this Plan is terminated;
2) the end of the period for which the last required Employee contribution for the Employee's coverage has been paid;
3) the last day of the month in which the covered Employee ceases to be in a class eligible for coverage under the Plan;
4) the last day of the month in which the covered Employee's employment with the County terminates; or
5) the date the covered Employee declines further coverage under the Plan in writing furnished to the Plan Administrator.

Ceasing active work is considered termination of employment unless:

1) cessation of work is due to an approved leave of absence. In that event, coverage may be continued for up to 12 weeks of family and medical leave (or up to 26 weeks of military care-giver leave to care for a covered service member with a serious Injury or Illness) during any 12-month period to eligible Employees, in compliance with the Family and Medical Leave Act Implementing Regulations as revised effective January 16, 2009. The County will measure the 12-month period as a rolling 12-month period measured backward from the date an Employee uses any leave under the FML Policy. For military caregiver leave only, the County will measure the 12-month period as a rolling 12-month period measured forward. The leave may be paid, unpaid, or a combination of paid and unpaid depending on the circumstances of the leave and as specified by the Ector County Family and Medical Leave Policy in effect at the time the leave is taken. Ector County will require employees to utilize FMLA leave concurrently with other paid leave, including sick leave, vacation leave, emergency leave, holiday leave and if appropriate, sick pool leave and workers' comp leave, if the reason for the leave qualifies for FMLA leave, regardless of whether or not the Employee requested FMLA leave. During the leave period, health insurance benefits and other benefits specified in the Ector County FMLA Policy will be continued as though the employee were actively at work, subject to any restrictions or conditions set forth by Ector County policies. Required contributions, if any, must be made by the covered Employee in accordance with the agreement reached by between the Employee and County prior to the leave of absence becoming effective;
2) Employees who fail to return to work after the maximum FMLA leave expires as described in the Ector County FMLA Policy, shall automatically be separated for job abandonment and all benefits shall cease unless:
    a) the Employee has accrued paid leave in excess of the 12 week period allowed by FMLA, and the employee has told the employee's Elected Official or Department Head prior to the 12 week FMLA leave being exhausted that the employee will be taking additional accrued leave; or
    b) the Employee's medical condition qualifies under the Americans with Disabilities Act as Amended (ADAA) and an extension of leave is required as a reasonable accommodation; or
3) If a covered Employee is Totally Disabled due to Illness or Injury and is not eligible for Family and Medical Leave or other benefit which otherwise would have caused the Employee to be retained on the Plan, the Employee may pay the total insurance premium, both Ector County and the Employee's share, in either a half-month or full-month increment, depending on the length of absence, for a period not to exceed 90 days.

If the covered Employee pays the total premium, then there shall be no break in coverage. However, if the covered Employee described above chooses not to pay the total premium during this period of unpaid leave, then the Employee's insurance coverage shall lapse and upon return to work, the Employee shall be treated as a new hire with all the same conditions as a new hire; or

4) If an Employee does not qualify for Family Medical Leave, but has approved paid time off, the Employee shall remain eligible for insurance as an Employee and Employee premiums will remain in effect. If the Employee's leave continues and turns into unpaid leave, the Employee will have insurance as an Employee, owing Employee premiums until the last day in the month the Employee was last paid. Any additional unpaid leave will result in the Employee no longer being eligible for Employee insurance. The Employee will be offered Cobra or can drop the coverage and be eligible 90 days from the Employee's return to work date.

A covered Employee's coverage for any specific benefit will terminate on the <u>earlier</u> of:
1) the date coverage under the Plan for such benefit ends; or
2) the date the covered Employee ceases to be eligible for that benefit.

Coverage under this Plan will be terminated immediately upon finding that Covered Person has committed, participated in, or is participating in the commission of, fraud against the Plan. Fraud against the Plan includes, but is not limited to:
1) a Covered Person furnishing or participating in furnishing fraudulent information to the Plan for the purpose of obtaining benefits under the Plan (i.e., false health-related treatment claims);
2) permitting improper use of his or her identification card;
3) use of another Covered Person's Plan identification card; or
4) prescription forgery, falsification, or transfer of medication.

**RETIRED EMPLOYEE COVERAGE**. A Retired Employee's coverage will terminate on the <u>earliest</u> of:
1) the date the Plan is terminated;
2) the end of the period for which the last required retiree contribution has been paid, if the next premium is not paid or is delinquent;
3) the date the Retired Employee ceases to be in a class eligible for coverage under the Plan; or
4) the date the Retired Employee declines further coverage under the Plan in writing furnished to the Plan Administrator.

**An Employee who retires with health benefits before October 1, 2015, and then returns to work for Ector County after October 1, 2015, will be placed back on the health plan as a current Employee. If that Employee later separates from employment and is reinstated as a Retiree, that individual will resume coverage under the Health Benefit Plan, without a lapse in coverage and with the same benefits for the Retiree and his/her Dependents. The individual is not required to vest a second time with Ector County to qualify as a Retiree with health benefits.**

When a Retired Employee or eligible Dependent becomes eligible for Medicare, the Retired Employee or eligible Dependent is required to apply for Medicare Parts A & B, and this Plan will become the secondary payer of benefits, with Medicare paying as primary.

Employees, retirees, and Dependents who become eligible for Medicare disability benefits must provide proof of application of Ector County Insurance Department.

If you have questions about your eligibility for Medicare Part A or Part B, or if you want to apply for Medicare, call the Social Security Administration at (800) 772-1213 or visit their web site at (www.medicare.gov). The TTY-TDD number for the hearing impaired is (800) 325-0778. You can also get information about buying Part A as well as Part B if you do not qualify for premium-free Part A.

**DEPENDENT COVERAGE**. Dependent coverage will cease for any Dependent on the earliest of:

1) the date the covered Employee's coverage terminates;
2) the date this Plan is terminated;
3) the date Dependent coverage is discontinued under this Plan;
4) the date the covered Employee ceases to be in a class eligible for Dependent coverage;
5) the end of the period for which the last required Employee contribution for Dependent coverage has been paid;
6) the date the Dependent ceases to meet the definition of a Dependent under this Plan;
7) after the 31st day following the birth of a newborn child, with respect to such child, unless prior to the expiration of such 31 day period, the County has been notified of the birth of such child and the Employee has agreed to make any required contributions; or
8) the last day of the calendar month following 90 days after the death of the Employee.

**EXCEPTION**: If an Employee is also a Retiree of Ector County, drawing a retirement check from TCDRS, and that Employee has a spouse who has been a Dependent under the individual's status as a retiree and Employee, then that Dependent shall be eligible for coverage under the same terms and conditions as if the Employee had remained in a "Retired" status.

**RETIREE DEPENDENT COVERAGE**. Coverage for the Dependent of any retiree will terminate on the earliest of:

1) the date the Retired Employee's coverage terminates (the covered spouse of a retiree will retain eligibility for coverage upon the death of the retiree;
2) the date this Plan is terminated;
3) the date Dependent coverage is discontinued under this Plan;
4) the end of the period for which the last required retiree contribution has been paid, if the next premium is not paid or is delinquent;
5) the date the Retired Employee ceases to be in a class eligible for Dependent coverage; or
6) the date the Dependent ceases to meet the definition of a Dependent under this Plan.

When a Retiree's Dependent becomes eligible for Medicare, the Dependent is required to apply for Medicare Parts A & B, and this Plan will become the secondary payer of benefits, with Medicare paying as primary.

**DELINQUENCY AND TERMINATION FOR NON-PAYMENT**. Notwithstanding the above, termination of coverage for Employees, Retired Employees, and eligible Dependents will occur according to the following schedule for non-payment or delinquency of premiums:

1) Payments are due by the 5th of the month, and are considered delinquent after 30 days. Delinquent payments will be charged a $25 late fee.
2) Benefits are suspended for the remainder of the first 30 days, and notification is sent to the Employee, Retired Employee, or eligible Dependent of the potential cancellation of insurance coverage.
3) Coverage is terminated if premium is not paid by the 61st day.

Retirees and their Dependents will not be allowed to reinstate insurance once it has been terminated for failure to pay premium.

**LIMITED CONTINUATION OF COVERAGE.** As described below, and in accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA), Covered Persons may be able to continue their coverage under this Plan in certain limited circumstances. A Covered Person may elect to continue coverage under this Plan for up to 18 months if his coverage terminates because:
1) the covered Employee's employment is terminated (for reasons other than gross misconduct); or
2) the covered Employee's number of hours of employment is reduced such that he is no longer eligible for coverage under this Plan.

The 18 months of continuation coverage may be extended in two situations: (1) if a Covered Person is determined to be disabled, or (2) another event occurs which would cause a covered Employee's covered Dependent to lose coverage, provided certain notices are timely provided to the Plan Administrator. See the paragraphs below titled "Notice: Disability Extension" and "Notice: Second Qualifying Events."

A covered Dependent may elect to continue coverage under this Plan for up to 36 months, if such Dependent's coverage terminates because:
1) the covered Employee dies;
2) the covered Employee is divorced or legally separated;
3) the covered Employee becomes entitled to Medicare benefits under Title XVIII of the Social Security Act; or
4) a child covered under the Plan ceases to be a Dependent.

Notwithstanding the foregoing:
- If the covered Employee has a nonforfeitable right to a benefit any portion of which is to be paid by the Pension Benefit Guarantee Corporation as of the date of his or her termination of employment (other than for gross misconduct) or reduction in hours of employment, coverage may be continued until the covered Employee's death, or, in the case of his or her covered Dependents, for 24 months after the covered Employee's date of death; provided, in no event will coverage be continued under this provision later than December 31, 2013, or any later date as required under applicable law.
- If a covered Employee is a TAA-eligible individual as of the date his continuation coverage would otherwise terminate, coverage may be continued until the date the covered Employee ceases to be a TAA-eligible individual; provided, however, that in no event will coverage be continued under this provision beyond December 31, 2013, or any later date as required under applicable law.

**NOTICE: GENERAL.** Covered Person's Responsibility. A Covered Person must notify the Plan Administrator of a divorce or legal separation or when a child ceases to be a Dependent within 60 days of such event. Failure to do so will result in the loss of coverage under this Limited Continuation of Coverage provision. A Covered Person must give this notice prior to the qualifying event or as soon as possible thereafter, and not later than 60 days after the qualifying event occurs. This notice must be provided on the "COBRA Notification Form," which can be obtained from the Plan Administrator.

The "COBRA Notification Form" must be sent, along with applicable documentation indicated on the form (such as a divorce decree, separation order, death certificate, birth certificate, or other documentation verifying a Dependent child's age), to the Plan Administrator at the address listed below under "PLAN INFORMATION."

When the Plan Administrator receives this notice, it or its designee will notify the applicable Covered Persons (individually or jointly) of the right to elect COBRA coverage.

If a Covered Person fails to provide the Plan Administrator with timely notice when one of these qualifying events occur the right to COBRA coverage will be waived. A Covered Person who elects COBRA coverage will have the same annual enrollment rights that apply to active employees.

County's Responsibility. For other qualifying events (a covered Employee's end of employment or reduction of hours of employment, death of a covered Employee, or the covered Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the County will notify the Plan Administrator. When the Plan Administrator receives this notice, it or its designee will notify the applicable Covered Persons (individually or jointly) of the right to elect COBRA coverage.

**NOTICE: DISABILITY EXTENSION.** If a Covered Person is totally disabled under the Social Security definition at the time of a reduction in hours or termination of employment, or becomes disabled within 60 days of beginning COBRA coverage, all Covered Persons with respect to the disabled individual may extend the continuation coverage period an additional 11 months for up to a total of 29 months.

To extend coverage beyond the 18-month period, a Covered Person must notify the Plan Administrator of the Social Security Administration's ("SSA's") determination within 60 days after the later of: (1) the date of the SSA's determination, or (2) the date on which the qualifying event occurs under this Plan, and in all cases before the end of the 18-month period of COBRA coverage. This notice must be provided on the "COBRA Notification Form," which can be obtained from the Plan Administrator, and must be sent, along with a copy of the SSA's disability determination, to the Plan Administrator at the address listed below under "PLAN INFORMATION."

If a Covered Person is determined by the SSA to no longer be disabled, the Covered Person must notify the Plan Administrator of that fact within 30 days of the SSA's determination. This notice must be provided on the "COBRA Notification Form," which can be obtained from the Plan Administrator, and which must be sent along with a copy of the SSA's disability determination, to the Plan Administrator at the address listed below under "PLAN INFORMATION."

Upon receipt of this notice, COBRA coverage extended beyond the maximum that would otherwise apply will be terminated on the first day of the month which is 30 days after the determination that the Covered Person is no longer disabled.

**NOTICE: SECOND QUALIFYING EVENTS.** If a covered Dependent experiences another qualifying event while already on COBRA coverage due to the covered Employee's employment termination or reduction in hours, the covered Dependent may elect to extend the period of COBRA coverage for up to 36 months from the date of the employment termination or reduction in hours. For example, assume that the covered Employee and his covered Dependents elect COBRA coverage because of the covered Employee's employment termination. If the covered Employee dies during the first 18 months of COBRA coverage, the covered Dependents could elect to continue COBRA coverage for up to 36 months from the covered Employee's date of employment termination.

A Covered Person must notify the Plan Administrator of the second qualifying event within 60 days of the second qualifying event. This notice must be provided on the "COBRA Notification Form," which can be obtained from the Plan Administrator and must be sent, along with applicable documentation, to the Plan Administrator at the address listed below under "PLAN INFORMATION."

**ELECTION.** A Covered Person is entitled to an election period of 60 days in which to elect to continue coverage under the Plan. The 60-day election period begins on the date the Covered Person would lose Plan coverage because of one of the events described above, and ends on the later of 60 days following such date or the date the Covered Person is sent a notice about eligibility to elect to continue coverage.

If a Covered Person elects continuation coverage within the 60-day election period, continuation coverage will generally begin on the date regular Plan coverage ceases. If a Covered Person waives continuation coverage, but within the 60-day election period revokes the waiver, continuation coverage will begin on the date the waiver is revoked. A Covered Person may not revoke a waiver after the end of the 60-day election period.

If a Covered Person who is certified as eligible for Trade Adjustment Assistance ("TAA") elects continuation coverage during the second election period described below, continuation coverage will begin on the first day of the second election period.

If a Covered Person does not choose continuation coverage within the 60-day election period, eligibility for continuation coverage under the Plan ends at the end of that period.

However, if a Covered Person fails to make an election during the 60-day election period, and is certified as TAA-eligible under the Trade Adjustment Assistance Extension Act of 2011, the TAA-eligible Covered Person may elect continuation coverage during the 60-day period that begins on the first day of the month in which the individual is certified to be eligible for TAA benefits, but only if the election is made no later than six months after the date of the TAA-related loss of coverage under the Plan (the "second election period").

**COST OF CONTINUATION COVERAGE.** To receive continuation coverage, the Covered Person, or any third party, must pay the required monthly premium plus a two percent administrative charge. If a Covered Person is eligible for an extension of coverage due to disability, then the cost of continuation coverage will be 150 percent of the normal required monthly premium for all months after the 18th month of continuation coverage.

Each monthly premium for continuation coverage is due on the first day of the month for which coverage is being continued. However, the first such monthly premium is not due until 45 days after the date on which the Covered Person initially elects continuation coverage.

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation ("PBGC") (eligible individuals).

Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the health Coverage Tax Credit Customer contact center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact/2002law.cfm.

**BENEFITS UNDER CONTINUATION COVERAGE.** If a Covered Person chooses continuation coverage, the coverage is identical to the coverage then being provided under the Plan to similarly situated Employees, their spouses, and their Dependent children who have not experienced a qualifying event. If their coverage changes, continuation coverage will change in the same way.

**PAYMENT OF CLAIMS.** No claim will be payable under this Limited Continuation of Coverage provision until the Plan Administrator receives the applicable premium.

**TERMINATION.** A Covered Person's Coverage under this Limited Continuation of Coverage provision will terminate on the earliest of:

1) the date on which the Company ceases to provide a group health plan to any Employee;
2) the date the Covered Person first becomes covered under any other group health plan after electing continuation coverage;
3) the date the Covered Person becomes entitled to Medicare benefits under Title XVIII of the Social Security Act;
4) the date the required monthly premium is due, if the Covered Person fails to make payment within 30 days after the due date; or
5) the end of the applicable continuation coverage period described above.

In no case will coverage extend beyond 36 months from the original qualifying event, even if a second qualifying event occurs during the continuation coverage period.

# ELIGIBLE CHARGES

**BENEFITS**. After a Covered Person has satisfied any applicable Deductible, eligible charges will be paid subject to exclusions, limitations and other terms of the Plan. The amount payable for any eligible charge will generally be equal to the percentage of the lesser of the billed amounts or the PPO allowances or, in the absence of PPO allowances, the Reasonable Charges or Customary Charges as described in "MEDICAL BENEFITS."

**MAXIMUM BENEFITS**. The benefits paid for a Covered Person's Illnesses and Injuries will not exceed the maximum for a Covered Person shown in "MEDICAL BENEFITS." Only charges incurred by a Covered Person while covered under this Plan may be considered "eligible charges." An eligible charge is considered to be incurred on the date a service is provided, and not when the Covered Person is formally billed or pays for the service. Other eligible charges are incurred when the purchase is made. Eligible charges are the lesser of the billed amounts or the PPO allowances or, in the absence of PPO allowances, the Reasonable Charges or Customary Charges, when charges are incurred for an Illness or Injury for one or more of the following:

1) Room and Board and routine nursing services for each day of confinement in a Hospital;
2) Intensive or cardiac care Room and Board if Medically Necessary;
3) Medical services and supplies furnished by a Hospital;
4) Anesthetics and their administration by a Physician (see "DEFINITIONS");
5) Fees of Physicians for medical treatment including, but not limited to, fees for Surgical Procedures and charges of an assistant surgeon, not to exceed 25% of the lesser of the billed amount, the Reasonable Charge, Customary Charge, or PPO allowance allowed for the surgeon;
6) Charges for non-physician assistants at surgery, if the assistant is certified by his or her professional association, licensed with the state where employed, is credentialed by the facility to assist with the procedure, and is performing a service that would otherwise be performed by a Physician, and is performing a procedure which, according to the National Correct Coding Initiative allows an assistant at surgery;
7) Services of a Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocational Nurse (L.V.N.) for private duty nursing when prescribed by a Physician and subject to the following:
    a) the nurse cannot be related to the Covered Person by blood or marriage or a person who resides in the Covered Person's home. Only Medically Necessary care prescribed by a Physician is covered by the Plan. No benefits will be provided for custodial care and services that are not medical treatment requiring the skills of a Registered Nurse (R.N.), Licensed Vocational Nurse (L.V.N.), or Licensed Practical Nurse (L.P.N.). The fact that such care has been prescribed or recommended by a Physician does not always mean the services are Medically Necessary or reimbursable; and
    b) services of a private duty nurse require prior written approval in order for benefits to be provided. Only upon examination of the actual services rendered can a determination of the Medical Necessity of such services be made;
8) Services of a licensed physical therapist or occupational therapist if such treatment is prescribed by a Physician;
9) Services of a Licensed Dietician, when recommended by a Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.), except services which are otherwise excluded under the Plan;
10) Speech Therapy administered by a speech therapist, that is expected to restore speech to a person who has lost existing speech function as the result of Illness or Injury;

11) Charges for Outpatient skeletal adjustment, adjunctive therapy, vertebral manipulation, and services for the care or treatment of dislocations or subluxations of the vertebrae;
12) X-rays (other than dental), laboratory tests, and other diagnostic services which:
    a) are performed as a result of definite symptoms of an Illness or Injury; or
    b) reveal the need for medical treatment;
13) X-ray and radiation therapy, chemotherapy, and renal/peritoneal dialysis;
14) The transport of a Covered Person:
    a) within the continental United States and Canada;
    b) by means of a professional ground or air ambulance service (excluding commercial flights);
    c) to a Hospital for a Medical Emergency, and returning from a Hospital if Medically Necessary;
    d) including "CARE" and "LIFE" flights in a life-threatening situation.

    If a Covered Person experiences a Medical Emergency while traveling in a foreign country for business or pleasure, coverage will be provided within that country, subject to the limitations of b), c), and d) above;
15) Medical supplies as follows:
    a) drugs and medicines (Including diabetic supplies, prenatal vitamins, and birth control pills):
        i) which are approved by the Food and Drug Administration;
        ii) which require the written prescription of a Physician;
        iii) which must be dispensed by a licensed pharmacist or Physician; and
        iv) which are purchased through the "PRESCRIPTION DRUG PROGRAM";
    b) Depo Provera injections and birth control implants, including their insertion and removal - early removal of a birth control implant is not covered unless Medically Necessary;
    c) blood and blood plasma, marrow, or other fluids;
    d) orthosis casting and lab charges for one pair of orthotics per Calendar Year;
    e) artificial limbs and eyes to replace natural limbs and eyes;
    f) repair and adjustment of prosthetic devices, when Medically Necessary;
    g) contact lenses or lenses for standard glasses only if required promptly after, and because of, cataract surgery or due to Accidental Bodily Injury (not to include replacement of such), provided treatment is received within six months from the date of the accident or surgery;
    h) casts, splints, trusses, braces, crutches, and surgical dressings; and
    i) rental or purchase, if less expensive, of Hospital-type equipment including, but not limited to wheelchairs, Hospital beds, and oxygen equipment;
16) Charges for services performed in an Outpatient Surgical Center;
17) Charges for each day of confinement in a Skilled Nursing Facility if the confinement:
    a) follows a Hospital confinement for which at least three straight days of Hospital Room and Board charges were included as eligible charges under the Plan;
    b) begins within 14 days after the Covered Person is released from such Hospital confinement;
    c) is for treatment of the same Illness or Injury which resulted in such Hospital confinement; and
    d) is one during which a Physician is present and consults with the Covered Person at least once every seven days;
18) Second surgical opinion;

19) Routine Inpatient newborn care for a newborn child who is either a Covered Person at the time of birth or is enrolled in the Plan within 31 days of his/her birth. Routine newborn care includes:
    a) Hospital charges for Room and Board, services, and supplies;
    b) charges related to circumcision; and
    c) fees from Physicians for routine Inpatient pediatric care;
20) Hospice care for a Covered Person who is a terminally ill patient and for members of the Covered Person's family who are also Covered Persons under this Plan. A terminally ill patient is someone who has a life expectancy of six months or less as certified in writing by the Physician who is in charge of the Covered Person's care and treatment. Hospice care expenses for a Covered Person will be limited to the following:
    a) Hospice care in a Hospital-based Hospice, an extended care Hospice facility or nursing home Hospice;
    b) care received from an interdisciplinary team of professionals for Hospice and home care;
    c) pre-bereavement counseling; and
    d) post-bereavement counseling during the 12 months following the death of the terminally ill patient, up to a limit of six sessions;
21) Home Health Care provided by a Home Health Care Provider if:
    a) on an intermittent basis, the Covered Person requires nursing services, therapy, or other services provided by a Home Health Care Provider;
    b) the Covered Person is Totally Disabled and is essentially confined to the home;
    c) the Covered Person is examined by the attending Physician at least once every 60 days; and
    d) the plan of treatment including Home Health Care is:
        i) established in writing by the attending Physician prior to the commencement of such treatment; and
        ii) certified by the attending Physician at least once every month;

    Eligible Home Health Care services will not include:
    a) custodial care;
    b) meals or nutritional services;
    c) housekeeper services;
    d) services or supplies not specified in the Home Health Care plan;
    e) services of a relative of the Covered Person;
    f) services of any social worker;
    g) transportation services;
    h) care for tuberculosis;
    i) care for Substance Abuse/Substance Dependence;
    j) care for the deaf or blind; or
    k) care for senility, mental deficiency, retardation or mental Illness;
22) For Covered Persons undergoing covered mastectomies, and upon consultation with the Covered Person's Physician:
    a) reconstruction of the breast on which the mastectomy has been performed;
    b) surgery or reconstruction of the other breast to produce a symmetrical appearance; and
    c) prostheses and physical complications of all stages of a mastectomy, including lymphedemas;

23) Services related to organ transplants when the Covered Person is the recipient for the following procedures:

| | |
|---|---|
| a) cornea; | e) pancreas; |
| b) heart; | f) liver; |
| c) lung; | g) kidney; and |
| d) heart/lung; | h) bone marrow. |

Benefits will be provided only when a Hospital and a Physician customarily bill a transplant recipient for such care and service, subject to the following conditions:
  a) when only the transplant recipient is a Covered Person, the benefits of the Plan will be provided for the recipient and donor, to the extent benefits to the donor are not provided under any other form of coverage. In no case under this provision will any payment of a "personal service fee" be made to any donor. Only the necessary Hospital and Physician's medical care and services expenses attendant to the donation will be considered for benefits;
  b) when the transplant recipient is not a Covered Person and the donor is a Covered Person, the donor will receive benefits for care and services necessary; to the extent such benefits are not provided by any coverage available to the recipient for the organ or tissue transplant procedure. Benefits will not be provided to any recipient who is not a Covered Person; and
  c) when the transplant recipient and the donor are both Covered Persons, benefits will be provided for both in accordance with their respective covered expenses;

24) Charges for Accidental Injury to or care of mouth, teeth, gums, and alveolar processes, but only if that care is for:
  a) treatment of an Accidental Injury to Sound Natural Teeth, including the replacement of such teeth or setting of a jaw fractured or dislocated in an accident, if received within six months after such accident. Injuries to teeth resulting from chewing or biting will not be considered Accidental Injuries;
  b) the removal of impacted teeth;
  c) treatment of fractures and traumatic dislocations of the jawbone;
  d) cutting procedures in the oral cavity for tumors or cysts of the jawbone; or
  e) cutting procedures on gums or mouth tissues needed to treat a disease;

25) General anesthesia and associated facility charges for dental treatment performed in a Hospital are covered when such treatment is Medically Necessary because a Covered Person has a mental or physical condition which requires hospitalization or general anesthesia;

26) Charges for acupuncture due to an Illness or Injury;

27) Diabetes treatment, self-management training, and education which includes, but is not limited to:
  a) diabetic supplies and equipment such as blood-glucose monitors (non-invasive glucose monitors and monitors designed to be used by blind individuals), insulin pumps and associated appurtenances, insulin infusion devices, podiatric appliances for prevention of complications associated with diabetes, test strips for blood glucose monitors, visual reading and urine test strips, lancets and lancet devices, insulin and insulin analogs, injections aids, syringes, prescriptive and nonprescriptive agents for controlling blood sugar levels, and glucagon emergency kits (see "PRESCRIPTION DRUG PROGRAM");
  b) nutritional counseling; and

   c) new or improved equipment or supplies approved by the FDA if determined by a Physician or other health care practitioner to be Medically Necessary and appropriate.

   For purposes of the coverage outlined above, Covered Persons must have been diagnosed with:
   a) insulin dependent or noninsulin dependent diabetes;
   b) elevated blood glucose levels induced by pregnancy; or
   c) another medical condition associated with elevated blood glucose levels;

28) Medically Necessary diagnostic or surgical treatment of conditions affecting the Temporomandibular Joint if treatment is a result of an Accident, a trauma, a congenital defect, a developmental defect, or a pathology;
29) Orthognathic surgery (surgery to correct congenital, developmental or acquired maxillofacial deformities of the mandible and maxilla);
30) Fertility treatment, infertility testing, infertility medication, or corrective surgery. Charges for in-vitro fertilization will be covered if the Covered Person meets the following criteria:
    a) the patient must be a Covered Person under the Plan;
    b) fertilization or attempted fertilization of the Covered Person's oocytes is made only with the sperm of the Covered Person's spouse;
    c) the Covered Person and the Covered Person's spouse must have a history of infertility of at least five continuous years duration or the infertility is associated with:
       i) endometriosis;
       ii) exposure in utero to diethylstibestrol (DES);
       iii) blockage of or surgical removal of one or both fallopian tubes; or
       iv) oligospermia;
    d) the Covered Person has been unable to attain a successful pregnancy with less costly applicable fertility treatments for which coverage is available under this Plan; and
    e) the procedures are performed at a facility that conforms to the minimum standards for programs of in vitro fertilization adopted by the American Society for Reproductive Medicine;
31) Charges for tubal ligation and vasectomy;
32) Charges for treatment, services, and/or supplies for a Mental or Nervous Disorder, Substance Abuse, or Substance Dependence; and
33) Routine services for Employees, Retired Employees, and covered spouses as outlined in "MEDICAL BENEFITS."

**LIMITATION TO PERCENTAGE OF MEDICARE RATES IN CERTAIN CIRCUMSTANCES.** For dialysis and associated drugs, the eligible amount will not exceed 175% of the Medicare allowance for such incurred expenses. This limitation applies to both in and out-of-network claims.

1) **ABORTION**. No benefits will be paid for abortion, unless the abortion is Medically Necessary because the life of the mother would be endangered if the fetus were carried to term, if the pregnancy is the result of rape or incest, or if a fetal or chromosomal abnormality exists which was diagnosed prior to the abortion. Benefits for treatment of complications arising from, or as a result of, any voluntary interruption of a pregnancy will be paid on the same basis as another Illness.

2) **BREAST SURGERY**. No benefits will be paid for that portion of breast surgery which involves the implanting or injecting of any substance into the body for restoring breast shape. Charges will, however be covered as part of the treatment plan for a Medically Necessary mastectomy due to Illness, as set forth in "ELIGIBLE CHARGES." Charges related to the removal of a prosthesis due to medical complications will be covered; however no benefits will be allowed for the replacement of a prosthesis which was originally inserted as a part of a voluntary breast augmentation.

3) **COMPLICATIONS OF NON-COVERED TREATMENT**. Except for breast surgery as outlined above, no benefits will be paid for care, services, or treatment required as a result of complications from a treatment not covered under this Plan.

4) **COSMETIC TREATMENT**. No benefits will be paid for Cosmetic Treatment, except for that which:
   a) results from an Illness or Injury and is performed within 12 months of the date of such Illness or Injury; or
   b) is indicated because of congenital birth defects, trauma, tumors, or developmental deformities.

5) **COUNSELING**. No benefits will be paid for any psychiatric or psychological services in the nature of family counseling or marriage counseling, any self-therapy to another Psychiatrist or Doctor in Psychology as part of training, or any services of a Master of Science in Social Work who is not a Certified Social Worker-Advanced Clinical Practitioner or Licensed Professional Counselor.

6) **COURT MANDATED**. No benefits will be paid for services that are provided due to a court order, except as required by federal law.

7) **CUSTODIAL CARE**. No benefits will be paid for services which are custodial in nature or primarily consist of bathing, feeding, homemaking, moving the patient, giving medication, or acting as a companion or sitter.

8) **DURABLE MEDICAL EQUIPMENT**. No benefits will be paid for the purchase of Durable Medical Equipment or supplies which remain with the Provider following the Covered Person's use thereof.

9) **EDUCATIONAL/RECREATIONAL/BIOFEEDBACK**. No benefits will be paid for any services or supplies considered to be educational in nature, or for any services or supplies related to self-care or self-help training and any related diagnostic training, except diabetes self-management training.

10) **EXPERIMENTAL/INVESTIGATIONAL**. Benefits will not be paid for any services or supplies which are experimental/investigational in nature. A drug, device, or medical treatment or procedure is experimental/investigational:
    1) if the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished;
    2) if reliable evidence shows that the drug, device or medical treatment or procedure is the subject of ongoing Phase I, II, or III clinical trials or under study to determine its:
        a) maximum tolerated dose;
        b) toxicity;
        c) safety;
        d) efficacy; and
        e) efficacy as compared with the standard means of treatment or diagnosis; or
    3) if reliable evidence shows that the consensus among experts regarding the drug, device, or medical treatment or procedure is that further studies or clinical trials are necessary to determine its:
        a) maximum tolerated dose;
        b) toxicity;
        c) safety;
        d) efficacy; and
        e) efficacy as compared with the standard means of treatment or diagnosis.

    Reliable evidence shall mean:
    a) only published reports and articles in the authoritative medical and scientific literature;
    b) the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, or medical treatment or procedure; or
    c) the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, or medical treatment or procedure.

11) **FOOT CARE LIMITATION**. No benefits will be paid for any medical services or supplies furnished for the treatment of (a) weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions, or (b) corns, calluses or toenails, except for surgery performed for a condition listed in (a) or removal of nail roots, and treatment of a condition listed in (b) because of any metabolic or peripheral vascular disease.

12) **GOVERNMENT AGENCIES**. No benefits will be paid for Hospital confinement, services, treatments or supplies furnished by the United States or a foreign government or any agency of either, unless federal laws dictate that the Plan is primary.

13) **HEARING AIDS**. No benefits will be paid for examinations to determine the need for, or for the fitting or purchase of hearing aids.

14) **HOSPITAL WEEKEND ADMISSIONS**. No benefits will be paid for the initial Friday, Saturday, and Sunday Room and Board charges incurred in connection with a Hospital confinement which begins on Friday, Saturday, or Sunday except for emergency Hospital admissions or scheduled surgery within the 24 hours immediately following Hospital admission.

15) **HYPNOSIS**. No benefits will be paid for hypnosis, except as part of the Physician's treatment of a Mental or Nervous Disorder or when used in lieu of an anesthetic.

16) **ILLEGAL ACTIVITY**. No benefits will be paid for any Illness or Injury which occurs due to a Covered Person's commission of, or attempt to commit assault, battery, felony, driving while intoxicated, insurrection, rebellion, or participation in a riot or civil disturbance, regardless of whether the Covered Person is charged with, or convicted of, such activity.

17) **ION THERAPY**. No benefits will be paid for chelation or metallic ion therapy.

18) **JAW AND JAW JOINTS**. No benefits will be paid for osteotomy or dental facial orthopedics.

19) **LEARNING/BEHAVIOR DISORDERS**. No benefits will be paid for special education, treatment, or training for learning or behavior disorders or developmental delay, except those conditions which qualify as Mental or Nervous Disorders.

20) **LEGAL DUTY**. Coverage is provided only for services and supplies for which the Covered Person has a legal duty to pay. No coverage will be provided for any services, supplies, or treatment (1) for which the Covered Person is not legally required to pay, (2) for which no charge would usually be made, (3) for which a charge if made would not usually be collected if no coverage existed, or (4) to the extent the charge for services, supplies, or treatment exceeds the charge that would have been made and collected if no coverage existed.

21) **MATERNITY EXPENSES**. No benefits will be paid for pregnancy expenses incurred by a Dependent child.

22) **MEDICALLY NECESSARY**. No benefits will be paid for charges which are not Medically Necessary.

23) **NICOTINE ADDICTION**. No benefits will be paid for the treatment of nicotine use or addiction.

24) **ORTHOPEDIC SHOES**. No benefits will be paid for orthopedic shoes unless attached to a brace or due to an Injury.

25) **OTHER**. Benefits will not be paid for charges not listed under "ELIGIBLE CHARGES."

26) **OUTSIDE THE UNITED STATES**. No benefits will be paid for charges incurred outside the United States if the Covered Person traveled to such location for the sole purpose of obtaining medical services, drugs or supplies or to obtain those services, drugs, and supplies that are unavailable or illegal in the United States.

27) **PERSONAL COMFORT ITEMS**. No benefits will be paid for personal comfort items, including but not limited to, air conditioners, dehumidifiers, humidifiers, and air purifiers, whether or not recommended by a Physician.

28) **PHYSICIAN'S DIRECT CARE**. Benefits will be paid only for eligible charges incurred by a Covered Person under the direct care of a Physician.

29) **REASONABLE AND CUSTOMARY**. No benefits will be paid for charges which are more than the Reasonable Charge or Customary Charge.

30) **RELATIVE PERFORMING SERVICE**. No benefits will be paid for charges for the services of a Physician or any other Provider of services:
    a) who usually resides in the same household with the Covered Person; or
    b) who is related by blood, marriage or legal adoption to the Covered Person or to the Covered Person's spouse.

31) **REVERSAL OF STERILIZATION**. No benefits will be paid for the reversal of sterilization.

32) **SELF-INFLICTED**. To the extent not prohibited by federal law and regulations issued thereunder, no benefits will be paid for an Illness or Injury which is intentionally self-induced or self-inflicted.

33) **SEXUAL DYSFUNCTION**. No benefits will be paid for sex change surgery or any treatment of gender identity disorders, including medications, implants, hormone therapy, surgery, medical or psychiatric treatment.

34) **TREATMENT OF TEETH AND GUMS**. Except as described in “ELIGIBLE CHARGES”, no benefits will be paid under “MEDICAL BENEFITS” for teeth, gums, alveolar process, or supplies used in such treatment, or for dental appliances.

35) **VISION CARE**. No benefits will be paid for:
    a) treatment of refractive errors including, but not limited to, routine eye examinations, eye glasses or contact lenses or the fitting of them, eye exercises, visual therapy, fusion therapy, visual aids or orthoptics, or any related examinations; or
    b) Surgical Procedures to eliminate the need for eyeglasses or to correct refractive errors of the eye (such as radial keratotomy, LASIK (laser in-situ keratomileusis) or any other vision enhancement surgery solely to correct nearsightedness, farsightedness or astigmatism), including any confinement, treatment, services, or supplies given in connection with or related to the surgery.

This exclusion does not apply to surgery for cataracts or replacement of the lens of the eye following cataract surgery. This exclusion also does not apply to soft lenses or scleral shells used as corneal bandages.

36) **WAR**. No benefits will be paid for any Illness or Injury which is due to revolt, war or any act of war, whether declared or not.

37) **WEIGHT CONTROL**. No benefits will be paid for the treatment of, or services or supplies related to, obesity, Morbid Obesity, weight control, or diet, including but not limited to surgery, treatment of complications or adverse reactions to any prior surgery, nutritional counseling, food products, and medications.

38) **WORK RELATED ILLNESS OR INJURY**. No benefits will be provided for an Illness or Injury which arises out of or in the course of employment, regardless of whether workers' compensation or other similar coverage is available.

**PRE-CERTIFICATION/CONTINUED STAY REVIEW**. Except in certain cases concerning childbirth, a Covered Person must call INETICARE prior to Hospital admission for a medical condition, Mental or Nervous Disorder, or Substance Abuse/Substance Dependence and in case of an emergency hospitalization, must call within hours following admission. The number for **INETICARE** is **(877) 608-2200**.

Prior to inception of any chemotherapy regimen, pre-authorization **must** be obtained by calling **INETICARE** at **(877) 208-5002.**

The Covered Person must provide INETICARE with the name, address, and birth date of the patient, the names, addresses, and telephone numbers of the Physician and Hospital, and the reason for hospitalization or surgery. The Covered Person is responsible for informing the attending Physician of the requirements of the pre-hospitalization review procedure. Continued stay review is also conducted by INETICARE.

The INETICARE medical care counselor will contact the Physician to discuss the proposed admission and treatment plan. If the diagnosis and treatment meet the criteria for Inpatient Hospital care, the counselor and the Physician will discuss the length of time required in the Hospital, as well as any care appropriate for recovery.

If the Covered Person fails to follow the Plan's procedures for pre-admission or continued stay review, the Pre-certification Penalty described in “MEDICAL BENEFITS” will be applicable.

Payment of covered charges will be withheld if pre-certification for treatment is based on a diagnosis for which treatment is covered, but the treatment is actually undertaken for a condition which is not covered by the Plan.

**Pre-certification by INETICARE does not guarantee coverage or Preferred Provider Organization benefits. It is the Employee's responsibility to verify that the medical facility and Physicians are members of their PPO and that the proposed service is covered by this Plan.**

**MOTHERS AND NEWBORNS**. Notwithstanding any other provision, the Plan shall not require any Covered Person or Provider to obtain authorization under the pre-certification features of this section in conjunction with any Hospital stay that does not exceed the number of hours set forth below:

a) an uncomplicated vaginal delivery, to less than 48 hours; and
b) an uncomplicated cesarean delivery, to less than 96 hours.

**CASE MANAGEMENT PROGRAM**. The case management program is a special program designed for Covered Persons who are suffering from a complex Illness requiring continued medical care.

Alternate forms of treatment or alternate treatment facilities may be recommended as part of the case management program.

Subject to the Administrative Service Agent's approval, expenses for such alternative forms will be payable under this Plan on the same basis as the treatment or facilities for which they are substituted.

The Administrative Service Agent will have the authority to implement the alternate forms of care and treatment recommended by the case management program.

Case management is a voluntary service. There are no reductions of benefits or penalties if the Covered Person chooses not to participate.

**ALTERNATIVE CARE**. The Plan may elect to offer benefits for services furnished by any Provider pursuant to an alternative treatment plan for a Covered Person whose condition would otherwise require Hospital care.

The Plan shall provide such alternative benefits at its sole discretion and only when and for so long as it determines that alternative services are Medically Necessary and cost effective, and that the total benefits paid for such services will not exceed the total benefits to which the Covered Person would otherwise be entitled under this Plan in the absence of such alternative benefits.

If the Plan elects to provide alternative benefits for a Covered Person in one instance, it shall not be obligated to provide the same or similar benefits for other Covered Persons under this Plan in any other instance, nor shall it be construed as a waiver of the right to administer this Plan thereafter in strict accordance with its express terms.

# COORDINATION OF BENEFITS

To prevent duplicate benefit payments if a Covered Person is covered under more than one plan, the Coordination of Benefits (COB) provision of this Plan is included to coordinate all the benefits provided by this Plan with benefits payable under any other medical plan or policy.

In this section, the term "plan" means any health care arrangement which provides medical or dental care benefits on an insured or uninsured basis. It includes, but is not limited to:

1) group, blanket, or individual insurance;
2) Hospital or medical service pre-payment plans;
3) labor-management trustee plans, union welfare plans, employer or employee organization plans;
4) government plans or programs;
5) coverage required or provided by law;
6) no fault auto insurance, including medical payments coverage (“MPC”) and personal injury protection (“PIP”);
7) third party liability insurance; and
8) any other source, including, but not limited to, crime victim restitution funds, any medical, disability, or other benefit payments.

**The term “plan” does not apply to any other employer-sponsored ancillary coverage.**

**COORDINATION PROCEDURES**. The procedure hereinafter described will be used to determine the amount of benefits payable under this Plan for a Covered Person when the Covered Person is covered under any other plan. In that event, one plan is the primary plan, and all other plans are secondary, in the order described below. The primary plan pays its benefits first, without taking the other plans into consideration. The secondary plan then pays benefits up to the extent of its liability. When this Plan is secondary, it will only pay benefits if the primary plan pays less than this Plan would have paid if it had been primary. If the first plan pays as much or more than the benefits this Plan would have paid as the primary plan, there will be no additional payment from this Plan. Benefits under any other plan include benefits which a Covered Person could have received if such benefits had been claimed. The benefits paid by this Plan when this Plan is secondary will not exceed the benefits that would be payable in the absence of other coverage.

1) If a plan has no COB provision, it is automatically the primary plan;
2) If all the plans have COB provisions, a plan is primary if it covers the person as an Employee, and secondary if it covers the person as a Dependent;
3) If a person is covered as a Dependent child under more than one plan:
    a) the plan of the parent whose birthday falls earlier in the year is the primary plan;
    b) if the father and mother share the same birthday, the Plan covering the parent longer is the primary plan;
    c) if the other plan coordinates benefits according to the sex of the parents, then the plan that covers the person as a Dependent of a male is the primary plan;
    d) if parents are separated or divorced, the following applies:

        the plan which covers a child as a Dependent of the parent with legal custody of the child is the primary plan, unless a court decree outlines the obligation for medical expenses for the child in which case the plan which covers the child as a Dependent of the parent with such obligation for medical expenses is primary;

4) If a plan is no fault auto insurance (including MPC and PIP), required by law, or third party liability insurance, it is the primary plan; and
5) If the primary plan is still not established by the rules above, then the plan that has covered such person for the longest continuous period of time will be the primary plan.

**COORDINATION WITH HEALTH MAINTENANCE ORGANIZATION (HMO) OR PREFERRED PROVIDER ORGANIZATION (PPO) PLANS.** This Plan will not consider any charges in excess of what an HMO or PPO Provider has agreed to accept as payment in full. When an HMO is the primary plan and the Covered Person did not use the services of an HMO Provider, this Plan will not consider as an allowable charge any charge that would have been covered by the HMO had the Covered Person used the services of an HMO Provider.

**VEHICLE LIMITATION**. When medical payments are available under any vehicle insurance, the Plan will pay excess benefits only, without reimbursement for vehicle plan and/or policy deductibles. This Plan will always be considered secondary to such plans and/or policies. This applies to all forms of medical payments under vehicle plans and/or policies regardless of its name, title, or classification.

**RIGHT TO EXCHANGE DATA**. The Plan Administrator has the right to exchange benefit information with any plan, insurance company, organization or person to determine benefits payable using this COB provision. Any such data may be exchanged without the consent of, or notice to, any person. Any person who Claims benefits under this Plan must provide the Plan Administrator with data it requires to apply this provision. Notwithstanding the preceding, the Plan Administrator will comply with applicable federal regulations regarding the privacy of medical information on and after the effective date of such regulations.

**PAYMENT AND OVERPAYMENT**. If payments have been made under any other plan which should have been made under this Plan, this Plan will have the right to reimburse such other plan to the extent necessary to satisfy the intent of this COB provision. This Plan also has the right to recover any overpayment made because of coverage under another plan. This Plan may recover this overpayment from any insurance company, organization or person to whom or for whom this Plan paid benefits.

**GOVERNMENT BENEFITS**. Except as set forth below, no benefits will be paid for any services, treatment, or supplies, to the extent that the services, treatment, or supplies were furnished by the United States, a state, a municipality, or a foreign government or any agency thereof, unless federal law dictates that the Plan is primary.

**EFFECT OF MEDICARE ON BENEFITS**. If an active permanent full-time Employee, elected official, district attorney or district judge reaches age 65 and continues full-time employment, then this Plan will continue to be the primary payer of benefits and Medicare, if elected, will be secondary for that person and their dependent spouse. However, when a Retiree or eligible dependent becomes eligible for Medicare, the Retiree or eligible dependent is required to apply for Medicare parts A & B, and this Plan will become the secondary payer of benefits, with Medicare paying as primary.

Employees, retirees, and Dependents who become eligible for Medicare disability benefits must provide proof of application of Ector County Insurance Department.

If you have questions about your eligibility for Medicare Part A or Part B, or if you want to apply for Medicare, call the Social Security Administration at (800) 772-1213 or visit their web site at (www.medicare.gov). The TTY-TDD number for the hearing impaired is (800) 325-0778. You can also get information about buying Part A as well as Part B if you do not qualify for premium-free Part A.

Notwithstanding the above, Medicare shall be the primary payer of benefits for an individual after the individual's first 30 months of entitlement to Medicare due to end stage renal disease, or as of the date coverage under the Plan is exhausted, whichever occurs first.

# SUBROGATION AND REIMBURSEMENT

**WHEN THIS PROVISION APPLIES**. You or your Dependent(s) (hereinafter "beneficiary") may incur medical or dental expenses because of Illness or Injuries for which benefits are paid by the Plan but which were caused by another party. The beneficiary may therefore have a claim against the other party for payment of the medical or dental expenses incurred. In these instances, , the Plan has no duty or obligation to pay claims related to this Illness or Injury. However, if the Plan chooses to pay benefits, it has both a right of subrogation and a right of reimbursement. Each right is separate and the waiver of one right by the Plan shall not be deemed to waive the other right. Under the Plan's right of subrogation, the Plan is subrogated to all of the rights the beneficiary may have against that other party. This right of subrogation also applies when a beneficiary has a right to recover under an uninsured or underinsured motorist's plan, homeowner's plan, renter's plan, or any other insurance policy under which the beneficiary is insured. The Plan also retains a right of first lien against any monies received by the beneficiary from the other person. Any monies received by a beneficiary or his attorney to which this Plan has a right of subrogation or reimbursement shall be held in trust for the benefit of the Plan. Under this right of reimbursement, the beneficiary will be required to reimburse the Plan out of any monies the beneficiary receives from the other person or on behalf of the other person as a result of judgment, settlement, or otherwise, without regard as to whether the recovery has been apportioned between medical and other damages, and without regard as to whether full or complete recovery of damages has occurred. The Plan specifically rejects the "make-whole doctrine" and the "common-fund doctrine" with respect to its rights of subrogation and reimbursement. The Plan will not be responsible for expenses or attorney's fees incurred by a beneficiary in connection with any recovery. Accordingly, beneficiaries must pay their own legal fees. Furthermore, the Plan is subrogated to attorney's fees and expenses in enforcing its rights.

The beneficiary may be required to execute a Subrogation Reimbursement Agreement and/or a Trust Agreement to receive benefits under the Plan. Failure to execute these documents upon request by the Plan Administrator may result in the non-payment of any related Claims. Further, if the beneficiary fails to return signed copies of these documents within the time period specified by the Plan Administrator, the Plan may refuse to pay Claims incurred with respect to the Illness or Injury from the date of your Injury or Illness through the date the Plan Administrator receives the signed documents. If the documents are received after the deadline established by the Plan Administrator, the Plan will pay eligible Claims incurred subsequent to its receipt of the signed documents.

Notwithstanding the foregoing, even if the Plan chooses not to have the beneficiary execute a Subrogation Reimbursement Agreement or the beneficiary fails to return a signed Subrogation Reimbursement Agreement, and the Plan pays any claims on behalf of the beneficiary and the beneficiary accepts payment of the claims, (1) the Plan will not be considered to have waived its right to pursue Subrogation and/or Reimbursement with respect to any claims it pays on behalf of the beneficiary, (2) the beneficiary will be deemed to have accepted the terms of the Plan, including the Subrogation and Reimbursement provisions described in this section, and (3) the beneficiary will be deemed to agree to maintain any payment received from another party in a constructive trust.

**AMOUNT SUBJECT TO SUBROGATION OR REIMBURSEMENT**. In no case will the amount subject to subrogation or reimbursement exceed the amount of medical or dental benefits paid for the Illness or Injuries under the Plan.

The beneficiary is required to provide information and assistance including testimony or the execution of documents to enforce the Plan's rights of Subrogation and Reimbursement. In addition, the beneficiary must notify the Plan Administrator of any action, judgment, settlement or other recovery for which the Plan has rights of Subrogation and Reimbursement. Further, the beneficiary will do nothing to prejudice the right of the Plan to Subrogation or Reimbursement. The Plan also reserves the right to initiate an action in the name of the Plan or in the name of the beneficiary to recover the Plan's subrogation and/or reimbursement interest.

The beneficiary shall be entitled to recover payment for benefits under the Plan only once. In the event a beneficiary becomes entitled to recovery from the Plan Administrator for a work-related Illness or Injury, and the amount of such recovery includes amounts for medical benefits previously paid by the Plan, the Plan Sponsor shall be entitled to offset the amount of such recovery by the amount of benefits previously paid by the Plan.

**DEFINED TERMS**

1) **"Recovery"** means monies paid to the beneficiary by way of judgment, settlement, claim, or otherwise by the other party to compensate for the Illness or Injuries sustained;
2) **"Subrogation"** means the Plan's right to pursue the beneficiary's Claims for medical or dental charges against the other party and to be compensated in accordance with appropriate laws and regulations; and
3) **"Reimbursement"** means repayment or reimbursement to the Plan of medical or dental benefits that it has paid toward care and treatment of the beneficiary's Illness or Injuries.

**RIGHTS OF RECOVERY**. Whenever payments have been made by the Plan with respect to allowable expenses in excess of the maximum amount of payment necessary to satisfy the intent of this Plan, the Plan shall have the right, exercisable alone and in its sole discretion, to recover such excess payments.

# FILING A CLAIM FOR BENEFITS

To receive benefits under the Plan as quickly as possible, complete the claim forms clearly and accurately.

To assist the Administrative Service Agent in processing your claim, please follow the steps listed below in the order they appear.

**WHEN YOU HAVE A CLAIM:**

To assist the Administrative Service Agent in processing your Claim, please follow the steps listed below in the order in which they appear.

Step 1) You must provide the Administrative Service Agent with current information regarding other coverage you may have. This information is requested on your enrollment form and must be furnished each year.

Step 2) Also on the enrollment form is an important authorization request, which requires your signature. Your signature allows the Administrative Service Agent to request the necessary information from your Physician, in order to process your Claims for payment. If you have a spouse covered under the Plan, they must also sign this authorization to release information.

Step 3) If items 1 and or 2 above are not on file with the Administrative Service Agent, a Claim form will be requested, which may result in a delay in the processing of your Claim.

Step 4) In the case of Hospital confinement, a form provided by the Hospital must be completed by the Hospital and submitted directly to the Administrative Service Agent.

Step 5) Other bills or receipts relating to a covered expense may be submitted directly to the Administrative Service Agent. All bills must show the following:

a) the employer's name, or group number;
b) the Employee's name;
c) the Employee's social security number or Employee identification number;
d) the patient's name;
e) the Physician's name;
f) the type of service rendered;
g) an itemization of the charges;
h) the condition for which the service was incurred;
i) the date of service; and
j) accident/Injury detail, if applicable (can be provided by the Plan participant on a separate document).

Step 6) Forward all related bills and receipts to the Administrative Service Agent for processing.

Step 7) Provide any additional information that may be requested by the Plan or Administrative Service Agent.

**QUESTIONS ON CLAIMS CALL:**

**GROUP RESOURCES AT: (214) 922-8880**
**MONDAY THROUGH FRIDAY, BETWEEN 8:00 AM AND 5:00 PM CST.**
**OR VISIT OUR WEBSITE AT: www.groupresources.com**

**PRE-ADMISSION CERTIFICATION CONTACT:**

**INETICARE AT: (877) 608-2200**
**THIS SERVICE IS AVAILABLE 24 HOURS A DAY, SEVEN DAYS A WEEK.**

**PROOF OF LOSS**. A Claim must be made no later than 12 months from the date of service unless the claimant was legally incapacitated. The Plan Administrator may require, as part of the proof, authorization to obtain medical and non-medical information.

**PHYSICAL EXAMINATIONS**. The Plan Administrator, at its expense, may have a Covered Person examined as often as reasonably necessary while any Claim is pending.

**AUTOPSY**. The Plan Administrator reserves the right to have an autopsy performed upon any deceased Covered Person whose condition, Illness, or Injury is the basis of a claim. This right may only be exercised where not prohibited by law.

**RIGHTS OF REVIEW AND APPEAL**. If a claim is partially or wholly denied for any reason, the claimant will be notified in writing. The written denial will give:
1) specific reasons for the denial with references to pertinent Plan provisions; and
2) a description and need for any other material pertinent to the claim.

If a claim is not processed within 90 days of receipt by Ector County or its designee, the claim is considered to be denied and a claimant may proceed to the review procedure.

**REVIEW PROCEDURE**. A claimant who wishes to have a denied claim reviewed must request such a review by filing a written notice with Ector County within 60 days of receipt of the denial notice. This written notice requesting review should:
1) state the reason why the claimant feels the claim should not have been denied; and
2) include any additional documentation which the claimant feels supports the claim.

**DECISION ON REVIEW**. The Plan Administrator will make a full and fair review of the claims and give final written notice of its decision within 60 days (120 days under special circumstances) after the request is received. The written notice on the review will include specific reasons for the decision and include references to the Plan provisions on which the decision was based. If a decision on review is not received within 60 days (or 120 days, if applicable) after the request for review, the claim is considered to be denied on appeal.

**TIME BAR TO LEGAL ACTION**. No legal action may be commenced or maintained against the Plan prior to the Covered Person's exhaustion of the claims procedures. In addition, no legal action may be commenced or maintained against the Plan more than 90 days after the Plan Administrator's decision on review.

# CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

**Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)**

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

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**If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2014. Contact your State for more information on eligibility –**

| **ALABAMA** – Medicaid | **COLORADO** – Medicaid |
|---|---|
| Website: http://www.medicaid.alabama.gov<br><br>Phone: 1-855-692-5447 | Medicaid Website: http://www.colorado.gov/<br><br>Phone (In state): 1-800-866-3513<br>Phone (Out of state): 1-800-221-3943 |
| **ALASKA** – Medicaid | |
| Website:<br>http://health.hss.state.ak.us/dpa/programs/medicaid/<br><br>Phone (Outside of Anchorage): 1-888-318-8890<br><br>Phone (Anchorage): 907-269-6529 | |

| **ARIZONA** – CHIP | **FLORIDA** – Medicaid |
|---|---|
| Website: http://www.azahcccs.gov/applicants<br><br>Phone (Outside of Maricopa County): 1-877-764-5437<br>Phone (Maricopa County): 602-417-5437 | Website: https://www.flmedicaidtplrecovery.com/<br><br>Phone: 1-877-357-3268<br><br>**GEORGIA** – Medicaid<br><br>Website: http://dch.georgia.gov/ - Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP)<br><br>Phone: 1-800-869-1150 |
| **IDAHO** – Medicaid | **MONTANA** – Medicaid |
| Medicaid Website: http://healthandwelfare.idaho.gov/Medical/Medicaid/PremiumAssistance/tabid/1510/Default.aspx<br><br>Medicaid Phone: 1-800-926-2588 | Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml<br><br>Phone: 1-800-694-3084 |
| **INDIANA** – Medicaid | **NEBRASKA** – Medicaid |
| Website: http://www.in.gov/fssa<br><br>Phone: 1-800-889-9949 | Website: www.ACCESSNebraska.ne.gov<br><br>Phone: 1-855-632-7633 |
| **IOWA** – Medicaid | **NEVADA** – Medicaid |
| Website: www.dhs.state.ia.us/hipp/<br><br>Phone: 1-888-346-9562<br><br>**KANSAS** – Medicaid<br><br>Website: http://www.kdheks.gov/hcf/<br><br>Phone: 1-800-792-4884 | Medicaid Website: http://dwss.nv.gov/<br><br>Medicaid Phone: 1-800-992-0900 |

| **KENTUCKY** – Medicaid | **NEW HAMPSHIRE** – Medicaid |
|---|---|
| Website: http://chfs.ky.gov/dms/default.htm<br><br>Phone: 1-800-635-2570 | Website:<br>http://www.dhhs.nh.gov/oii/documents/<br>hippapp.pdf<br><br>Phone: 603-271-5218 |
| **LOUISIANA** – Medicaid | **NEW JERSEY** – Medicaid and CHIP |
| Website: http://www.lahipp.dhh.louisiana.gov<br><br>Phone: 1-888-695-2447<br><br>**MAINE –** Medicaid<br><br>Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html<br><br>Phone: 1-800-977-6740<br>TTY 1-800-977-6741 | Medicaid Website:<br>http://www.state.nj.us/humanservices/<br>dmahs/clients/medicaid/<br><br>Medicaid Phone: 609-631-2392<br><br>CHIP Website:<br>http://www.njfamilycare.org/index.html<br><br>CHIP Phone: 1-800-701-0710 |
| **MASSACHUSETTS** – Medicaid and CHIP | **NEW YORK –** Medicaid |
| Website: http://www.mass.gov/MassHealth<br><br>Phone: 1-800-462-1120 | Website:<br>http://www.nyhealth.gov/health_care/<br>medicaid/<br><br>Phone: 1-800-541-2831 |
| **MINNESOTA** – Medicaid | **NORTH CAROLINA** – Medicaid |
| Website: http://www.dhs.state.mn.us/<br><br>Click on Health Care, then Medical Assistance<br><br>Phone: 1-800-657-3629 | Website: http://www.ncdhhs.gov/dma<br><br>Phone: 919-855-4100 |
| **MISSOURI** – Medicaid | **NORTH DAKOTA** – Medicaid |
| Website:<br>http://www.dss.mo.gov/mhd/participants/pages/hipp.htm<br><br>Phone: 573-751-2005 | Website:<br>http://www.nd.gov/dhs/services/medicalserv/<br>medicaid/<br><br>Phone: 1-800-755-2604 |

| **OKLAHOMA** – Medicaid and CHIP | **UTAH** – Medicaid and CHIP |
|---|---|
| Website: http://www.insureoklahoma.org<br><br>Phone: 1-888-365-3742 | Website: http://health.utah.gov/upp<br><br>Phone: 1-866-435-7414 |
| **OREGON** – Medicaid | **VERMONT**– Medicaid |
| Website: http://www.oregonhealthykids.gov<br>http://www.hijossaludablesoregon.gov<br><br>Phone: 1-800-699-9075 | Website: http://www.greenmountaincare.org/<br><br>Phone: 1-800-250-8427 |
| **PENNSYLVANIA** – Medicaid | **VIRGINIA** – Medicaid and CHIP |
| Website: http://www.dpw.state.pa.us/hipp<br>Phone: 1-800-692-7462 | Medicaid Website:<br>http://www.coverva.org/programs_premium_assistance.cfm<br>Medicaid Phone: 1-800-432-5924<br><br>CHIP Website:<br>http://www.coverva.org/programs_premium_assistance.cfm<br>CHIP Phone: 1-855-242-8282 |
| **RHODE ISLAND** – Medicaid | **WASHINGTON** – Medicaid |
| Website: www.ohhs.ri.gov<br><br>Phone: 401-462-5300 | Website:<br>http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx<br><br>Phone: 1-800-562-3022 ext. 15473 |
| **SOUTH CAROLINA** – Medicaid | **WEST VIRGINIA** – Medicaid |
| Website: http://www.scdhhs.gov<br><br>Phone: 1-888-549-0820 | Website: www.dhhr.wv.gov/bms/<br>Phone: 1-877-598-5820, HMS Third Party Liability |

| **SOUTH DAKOTA** - Medicaid | **WISCONSIN** – Medicaid |
|---|---|
| Website: http://dss.sd.gov<br>Phone: 1-888-828-0059 | Website: http://www.badgercareplus.org/pubs/p-10095.htm<br><br>Phone: 1-800-362-3002 |
| **TEXAS** – Medicaid | **WYOMING** – Medicaid |
| Website: https://www.gethipptexas.com/<br><br>Phone: 1-800-440-0493 | Website:<br>http://health.wyo.gov/healthcarefin/equalitycare<br><br>Phone: 307-777-7531 |

To see if any other states have added a premium assistance program since July 31, 2014, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

OMB Control Number 1210-0137 (expires 10/31/2016)

# MISCELLANEOUS PLAN PROVISIONS

**AMENDMENT OR TERMINATION**. The continued maintenance of the Plan is completely voluntary on the part of the County and neither its existence nor its continuation shall be construed as creating any contractual right to or obligation for its future continuation. While the County intends to continue the Plan indefinitely, it reserves the right at any time and for any reason, in its sole and absolute discretion, through the procedure of an execution of a document by any officer who is authorized, to curtail benefits under, or otherwise amend or terminate the Plan or any portion thereof, including, without limitation, those portions of the Plan outlining the benefits provided or the classes of Employees or Dependents eligible for benefits under the Plan.

**PLAN ADMINISTRATOR DISCRETION**. The Plan Administrator shall have the sole discretionary authority to construe the terms of the Plan and all facts surrounding Claims for benefits under the Plan and shall determine all questions arising in the administration, interpretation and application of the Plan, including, but not limited to, those concerning eligibility for benefits. Accordingly, benefits under this Plan shall be paid only if the Plan Administrator decides at its discretion that an applicant is entitled to them. All determinations of the Plan Administrator shall be conclusive and binding on all parties.

**COMPLIANCE WITH FEDERAL LAWS.** The terms of the Plan shall be construed and administered in a manner calculated to meet the requirements of the following laws, as the laws are applicable to this Plan:

1) Americans With Disabilities Act of 1990;
2) Family and Medical Leave Act of 1993;
3) Uniformed Services Employment and Reemployment Rights Act of 1994, as amended;
4) Personal Responsibility and Work Opportunity Reconciliation Act of 1996;
5) The Newborns' and Mothers' Health Protection Act of 1996;
6) The Mental Health Parity Act of 1996, as amended;
7) The Women's Health and Cancer Rights Act of 1998;
8) The U.S. Trade Promotion Authority Act of 2002;
9) The Working Families Tax Relief Act of 2004 (H.R.1308);
10) The Genetic Information Non-Discrimination Act of 2008;
11) The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008;
12) The American Recovery and Reinvestment Act of 2009, as amended (the "HITECH Act");
13) The Children's Health Insurance Program Reauthorization Act of 2009;
14) The Patient Protection and Affordable Care Act of 2010;
15) The Trade Adjustment Assistance Extension Act of 2011; and
16) The requirements of the final modifications to the HIPAA Privacy, Security, Enforcement and Breach Notification Rules (75 Fed. Reg. 5566 (Jan. 25, 2013).

To the extent a Plan provision is contrary to or fails to address the minimum requirements of these laws, the Plan shall provide the coverage or benefit necessary to comply with the minimum requirements thereof.

**PATIENT PROTECTION AND AFFORDABLE CARE ACT**. This Plan believes it is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the '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 the law was enacted.

Being a grandfathered health plan means that the 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. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at (866) 444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

**GOVERNING LAW.** Any assignee of a Covered Person under this Plan shall be treated as the Covered Person with respect to any claim or request for payment of expenses for medical services submitted to the Plan, the Plan Administrator, the Plan Sponsor, the Third Party Administrator, or any agent or Employee thereof.

Further, the Plan shall not (a) adjust premium contribution amounts based on genetic information, (b) request or require an individual or family member of an individual to undergo a genetic test (except in certain circumstances related to research), or (c) request, require, or purchase genetic information with respect to any individual prior to the individual's enrollment in the Plan or coverage in connection with enrollment in the Plan.

**SEVERABILITY**. If any provision, or any portion thereof, contained in this Plan is held to be unconstitutional, illegal, invalid, or unenforceable, the remainder of this Plan shall not be affected and shall remain in full force and effect.

**ASSIGNABILITY**. Amounts payable at any time may be used to make direct payments to health care Providers. Except as applicable law may otherwise require, no amount payable at any time hereunder shall be subject in any manner to alienation by anticipation, sale, transfer, assignment, bankruptcy, pledge, attachment, charge, or encumbrance of any kind. Any attempt to alienate, sell, transfer, assign, pledge, attach, charge, or otherwise encumber any such amount, whether presently or hereafter payable, shall be void. The Plan shall not be liable for or subject to the debts or liabilities of any person entitled to any amount payable under the Plan, or any part thereof.

No appeal rights granted to the Covered Person in this Plan may be assigned, transferred, or in any way made over to another party by a Covered Person. Nothing contained in the written description of the medical coverage shall be construed to make the Plan liable to any third-party to whom a Covered Person may be liable for medical care, treatment, or services.

**NATIONAL CORRECT CODING INITIATIVE**. Where not otherwise specified, this Plan follows National Correct Coding Initiative ("NCCI") for coding, modifiers, bundling/unbundling, and payment parameters. Other guidelines may be applicable where NCCI is silent. The Plan Administrator has full discretionary authority to select guidelines and/or vendors to assist in determinations.

**FIDUCIARY**. A fiduciary exercises discretionary authority or control over management of the Plan or the disposition of its assets, renders investment advice to the Plan or has discretionary authority or responsibility in the administration of the Plan.

**FIDUCIARY DUTIES**. A fiduciary must carry out his or her duties and responsibilities for the purpose of providing benefits to the Employees and their Dependent(s) and defraying reasonable expenses of administering the Plan. These are duties that must be carried out:

1) with care, skill, prudence and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation; and
2) by diversifying the investments of the Plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so.

**ADMINISTRATIVE SERVICE AGENT IS NOT A FIDUCIARY**. An Administrative Service Agent is not a fiduciary under the Plan by virtue of paying claims in accordance with the Plan's rules as established by the Plan Administrator.

**PLAN IS NOT AN EMPLOYMENT CONTRACT**. The Plan is not to be construed as a contract for or of employment.

**CLERICAL ERROR**. Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, due to a clerical error, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Plan Participant, if it is requested, the amount of overpayment will be deducted from future benefits payable.

**REIMBURSEMENT GUIDELINES**. On the written request of a Non-PPO Provider, a managed care entity shall furnish to the Provider a written description of the factor considered by the entity in determining the amount of reimbursement the Provider may receive for goods or services provided to an individual enrolled in or insured under the entity's managed care plan. This section does not require a managed care entity to disclose proprietary information that is prohibited from disclosure by a contract between the entity and a vendor that supplies payment or statistical data to the entity. A contract between a managed care entity and a vendor that supplies payment or statistical data to the entity may not prohibit the entity from disclosing under this section:

1) the name of the vendor; or
2) the methodology and origin of information used to determine the amount of reimbursement.

# PLAN INFORMATION

| | |
|---|---|
| Name of the Plan: | Ector County<br>Employee Health Benefit Plan |

Name, address, and telephone number of the Plan Sponsor and Plan Administrator:

Ector County Commissioners Court
1010 East Eighth Street
Odessa, TX 79761
(432) 498-4011

| | |
|---|---|
| Employer Identification Number (EIN): | 75-6000934 |
| Plan Number: | 501 |
| Type of Plan: | Self-Funded welfare benefit plan providing health and hospitalization benefits. Claims under the Plan are paid solely from the general assets of the County. While the County may obtain insurance to limit its losses under the Plan, no insurance protects any of the benefits or Claims under this Plan. |

Name, address, and telephone number of the Administrative Service Agent:

Group Resources
2100 Ross Avenue
Suite 900
Dallas, TX 75201
(214) 922-8880

The designated agent for service of legal process is:

Ector County
1010 East Eighth Street
Odessa, TX 79761

Service of legal process may also be served upon the Plan Trustee or the Plan Administrator.

Names and addresses of the Plan's Trustees:

| | |
|---|---|
| | Ector County Commissioners Court<br>1010 East Eighth Street<br>Odessa, TX 79761 |
| Claims Administration: | The plan is administered by the Plan Administrator, with Group Resources, an Administrative Service Agent, acting as Claims paying agent. |
| Plan Funding: | County and Employee contributions cover the cost of the Plan. Any after-tax Employee contributions may be held in trust by the trustee. The amount of all such contributions is actuarially determined where necessary. |
| The Plan fiscal year ends on: | September 30 |