

**MONTGOMERY COUNTY EMPLOYEE BENEFIT PLAN**

**PLAN DOCUMENT**

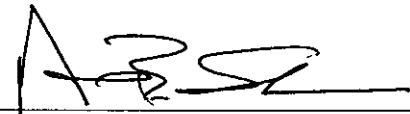
**January 1, 2009**

Montgomery County, Texas, the Employer, hereby establishes a self-funded medical coverage Plan under Chapter 172 of the Local Government Code for the benefit of the eligible employees, retirees of Montgomery County, Texas and their eligible dependents. The Employer's current group medical Plan will be replaced by this self-funded Plan entitled "Montgomery County Employee Benefit Plan", effective January 1, 2009.

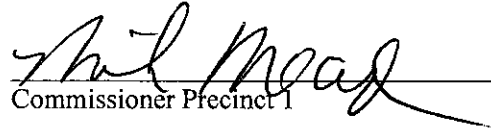
Retirees and their eligible dependents will also be eligible to participate in this Plan subject to the rules established by this Plan, as approved by Montgomery County Commissioners Court and Chapter 175 of the Local Government Code. Employees, who meet additional requirements and qualifications at the time of retirement, may be eligible for County Paid / Subsidized rates for retiree coverage. A full listing of these additional requirements and qualifications, as approved by Commissioners Court on February 25, 2008, are available at the Montgomery County Risk Management Department. Montgomery County reserves the right to amend these requirements and qualifications at any time.

The purpose of this Plan is to provide reimbursement for covered charges incurred as a result of medically necessary treatment for an illness or injury of the Employer's eligible employees / retirees and their eligible dependents. In consideration of any required contributions by its employees, the Employer agrees to make payment as provided in this Plan document. Montgomery County reserves the right to amend this Plan. All amendments previous to January 1, 2009 have been included in this document. The Plan document constitutes the entire Plan.

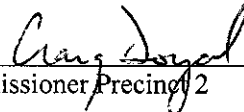
The employer has caused this instrument to be executed by its duly authorized officers with the effective date of the 1st day of January 2009



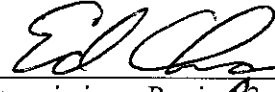
County Judge -



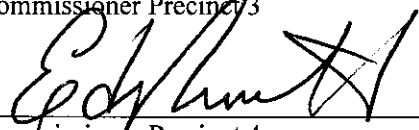
Commissioner Precinct 1



Commissioner Precinct 2



Commissioner Precinct 3



Commissioner Precinct 4

**MONTGOMERY COUNTY  
EMPLOYEE BENEFIT PLAN DOCUMENT**

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**MONTGOMERY COUNTY EMPLOYEE BENEFIT PLAN**

**MAJOR MEDICAL BENEFITS  
SCHEDULE OF BENEFITS  
&  
SUMMARY PLAN DESCRIPTION**

**LIFE INSURANCE & ACCIDENTAL DEATH AND DISMEMBERMENT,  
DEPENDENT LIFE INSURANCE**  
\$20,000.00 for a full-time employee.

**OUTSIDE P.P.O. / INSIDE P.P.O.**

**LOW DEDUCTIBLE PLAN OPTION**

Per Person per calendar year,  
With three (3) month carryover provision

	<b>DEDUCTIBLE</b>	
	<b>\$500.00</b>	<b>\$250.00</b>

Inside PPO plan deductible can be used to satisfy Outside PPO plan deductible  
**Deductibles are per plan participant.**  
**Maximum deductibles per family: No family maximum.**

Separate per hospital confinement deductible

	<b>\$450.00</b>	<b>\$-0-</b>
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**LOW DEDUCTIBLE PLAN CO-INSURANCE PROVISIONS PER CALENDAR YEAR**

**Inside the P.P.O.:** All qualified and eligible medical expenses will be paid by the Plan at **90% up to the first \$20,000.00 of qualified and eligible medical expenses** (unless otherwise stated in the Schedule of Benefits), after the appropriate deductibles have been satisfied. When qualified and eligible medical expenses reach **\$20,000.00**, the Plan will pay **100% of qualified and eligible medical expenses** up to the **\$2,000,000.00** Lifetime Maximum per participant. **Maximum co-insurance out-of-pocket is \$2,000.00 per plan participant. NO FAMILY CO-INSURANCE MAXIMUM.**

**Outside the P.P.O.:** All qualified and eligible medical expenses will be paid by the Plan at **50% up to the first \$15,000.00 of qualified and eligible medical expenses** (unless otherwise stated in the Schedule of Benefits), after the appropriate deductibles have been satisfied. When qualified and eligible medical expenses reach **\$15,000.00**, the Plan will pay **100% of qualified and eligible medical expenses** up to the **\$2,000,000.00** Lifetime Maximum per participant. **Maximum co-insurance out-of-pocket is \$7,500.00 per plan participant. NO FAMILY CO-INSURANCE MAXIMUM.**

**Whether inside or outside the P.P.O.,** any expenses other than qualified and eligible expenses will be disallowed and cannot be used to satisfy deductibles or your maximum medical co-insurance provisions. **Any expense related to mental health care, substance abuse, alcoholism, or prescription drugs purchased with or without your ID/Prescription card will not be applied to your maximum medical co-insurance provision or any required deductibles. These provisions apply to each covered participant.**

## OUTSIDE P.P.O. / INSIDE P.P.O.

### **HIGH DEDUCTIBLE PLAN OPTION**

	DEDUCTIBLE	
Per Person per calendar year, With three (3) month carryover provision	<b>\$2,000.00</b>	<b>\$1,000.00</b>
Inside PPO plan deductible can be used to satisfy Outside PPO plan deductible <b>Deductibles are per plan participant</b>		
Maximum deductibles per family	<b>3</b>	<b>3</b>
Separate per hospital confinement deductible	<b>\$450.00</b>	<b>\$-0-</b>

### **HIGH DEDUCTIBLE PLAN CO-INSURANCE PROVISIONS PER CALENDAR YEAR**

**Inside the P.P.O.:** All qualified and eligible medical expenses will be paid by the Plan at **90% up to the first \$10,000.00 of qualified and eligible medical expenses** (unless otherwise stated in the Schedule of Benefits), after the appropriate deductibles have been satisfied. When qualified and eligible medical expenses reach **\$10,000.00**, the Plan will pay **100% of qualified and eligible medical expenses** up to the **\$2,000,000.00** Lifetime Maximum per participant. **Maximum co-insurance out-of-pocket is \$1,000.00 per plan participant with a maximum of three (3) per family.**

**Outside the P.P.O.:** All qualified and eligible medical expenses will be paid by the Plan at **50% up to the first \$7,500.00 of qualified and eligible medical expenses** (unless otherwise stated in the Schedule of Benefits), after the appropriate deductibles have been satisfied. When qualified and eligible medical expenses reach **\$7,500.00**, the Plan will pay **100% of qualified and eligible medical expenses** up to the **\$2,000,000.00** Lifetime Maximum per participant. **Maximum co-insurance out-of-pocket is \$3,750.00 per plan participant with a maximum of three (3) per family.**

**Whether inside or outside the P.P.O.,** any expenses other than qualified and eligible expenses will be disallowed and cannot be used to satisfy deductibles or your maximum medical co-insurance provisions. **Any expense related to mental health care, substance abuse, alcoholism, or prescription drugs purchased with or without your ID/Prescription card, will not be applied to your maximum medical co-insurance provision or any required deductibles. These provisions apply to each covered participant.**

**THE FOLLOWING MEDICAL BENEFITS WILL BE PAID BY THE PLAN AT THE STATED PERCENTAGE LEVELS AFTER THE DEDUCTIBLE HAS BEEN SATISFIED, BASED ON THE HIGH OR LOW DEDUCTIBLE PLAN THAT YOU PARTICIPATE IN.**

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

	<b><u>OUTSIDE P.P.O. CO-INSURANCE PERCENTAGE</u></b>	<b><u>INSIDE P.P.O. CO-INSURANCE PERCENTAGE</u></b>
<b><u>*IN-PATIENT HOSPITAL EXPENSES</u></b>		
<b>1. Average Semi-private room</b> All usual hospital services including blood, plasma and intensive care	<b>50%</b>	<b>90%</b>
<b>2. Mental Health Care, Alcohol &amp; Substance abuse</b> <b><u>See Cost Containment Section for any additional limitations. Must access E.A.P. before these benefits are eligible (see page 11)</u></b>	<b>0%</b>	<b>80%</b>
<b>3. Calendar Year Maximum Benefits for:</b> Mental Health Care / Alcohol and Substance abuse	<b>0%</b>	<b>\$10,000.00</b>
<b>4. Anesthesiologist Charges</b>	<b>50%</b>	<b>90%</b>
<b>5. Newborn Well Care</b> Includes pediatric charges, room and board and newborn testing at time of birth until discharge	<b>0%</b>	<b>90%</b> <b>Not to exceed \$750.00 per child</b>
<b><u>OTHER MEDICAL EXPENSES</u></b>		
<b>1.* Surgery – Inpatient</b>	<b>50%</b>	<b>90%</b>
<b>2.* Surgery – Outpatient</b>	<b>80%</b>	<b>90%</b>
<b>3. Pre-admission Testing, including X-Ray and Lab (Outpatient) (see page16)</b>	<b>80%</b>	<b>100%</b>
<b>4. Second Surgical Opinion (see page 17)</b>	<b>100%</b>	<b>100%</b>
<b>5. Other eligible expenses except</b> outpatient mental health care, alcohol and substance abuse	<b>50%</b>	<b>90%</b>
<b>6. Outpatient Mental Health Care,</b> Alcohol and Substance abuse including psychiatrist charges and day treatments, with a calendar year maximum benefit of: <b><u>EAP benefits must be accessed before outpatient mental health care benefits will be eligible by this plan.</u></b>	<b>0%</b> <b>0%</b>	<b>Maximum Charge Per Visit \$80.00 Payable at: 80% \$5,000.00</b>
<b>7. Chiropractic Charges</b> with a calendar year maximum	<b>50%</b> <b>\$1,000.00</b>	<b>50%</b> <b>\$1,000.00</b>

<u><b>OUTSIDE P.P.O.</b></u> <b>CO-INSURANCE</b> <b>PERCENTAGE</b>	<u><b>INSIDE P.P.O.</b></u> <b>CO-INSURANCE</b> <b>PERCENTAGE</b>
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- |    |  |                   |                   |
|----|--|-------------------|-------------------|
| 8. | <b>Allergy Treatment</b><br>with a calendar year maximum of:   | 50%<br>\$1,000.00 | 90%<br>\$1,000.00 |
| 9. | <b>Elective Sterilization</b><br>Vasectomy, Tubal Ligation and Hysteroscopic Sterilization -<br>(See page 38, #55) | 50%               | 90%               |

10. **Annual Health Screening Benefit / Well Care**

Effective January 1, 2007, all covered employees, and their dependents that participate in the Plan are eligible to receive the following benefits without a medical diagnosis as indicated below. **Any service listed below that is billed with a diagnosis will not be considered as an eligible benefit under the “Annual Health Screening Benefit / Well Care” benefit.** The benefits listed below will be subject to the \$25.00 office co-pay and the balance will be paid by the plan at 100%, not to exceed \$750.00 per calendar year for any one benefit or a total of all benefits listed below. These benefits may be used only once during the calendar year with the exception of “F” below. Any expenses over \$750.00 during the calendar year will be the responsibility of the covered person. Any expenses you incur for this benefit are not subject to the annual calendar year deductible regardless of High Deductible or Low Deductible Plan Option. Any expenses incurred by the participant cannot be used to satisfy the calendar year deductible or maximum co-insurance provisions.

- a. Mammogram, including interpretation by radiologist **at Columbia Conroe Regional Medical Center, Memorial Hermann The Woodlands Hospital and TOPS Surgical Center (The Woodlands & Spring locations).** Interpretations for TOPS Surgical Centers will only be performed by Rose Imaging Specialists.
- b. Pap smear-including office visit **at a PPO physician only.**
- c. Colon rectal screening-including office visit, diagnostic proctoscopy, occult blood work and prostate specific antigen (P.S.A.) Test **at a PPO physician only.**
- d. Physical exams including cholesterol testing and blood work **at a PPO physician or facility only.**
- e. Bone density testing **at a PPO physician or facility only.**
- f. Well baby checkups **out-patient office visits** will be limited to no more than six (6) visits up to the first birthday, three (3) visits up to the second birthday, and one (1) visit per calendar year thereafter **at a PPO physician or facility only,** not to exceed the annual calendar year maximum benefit of \$750.00. You will be required to pay the office co-pay on a per visit basis when accessing the benefit.

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

The participant is required to pay \$25.00 per visit toward the medical physician’s charge for an office visit, and if incurred prior to satisfying the calendar year deductible, the \$25.00 will count toward satisfying the calendar year deductibles of the plan option that you participate in. The balance of physician’s charges due after the \$25.00 per visit co-payment has been made will be paid by the Plan at 100%.

All eligible charges incurred during an office visit, other than physician’s charges, shall be subject to the deductible and co-insurance provisions of the plan option that you participate in. **Children’s immunizations will be an eligible expense at P.P.O. providers only. Allowable immunizations are those immunizations that are required for attendance in school in the State of Texas only. Immunization charges incurred at a non-P.P.O. provider will be excluded.**

**EXAMPLE**

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

P.P.O. Medical Physician’s charge	<b>\$100.00</b>
Minus P.P.O. Discount	<b>- \$30.00</b>
Balance	<b>\$70.00</b>
Minus Participant co-pay	<b>- \$25.00</b>
Plan pays 100% of balance of physician charge	<b>\$45.00</b>

The plan will pay other charges incurred during office visit such as Lab, X-Ray, injections and any other eligible charges, **at 50% if billed from a provider Outside the P.P.O or at 90% if billed by a provider Inside P.P.O. ,after patient Deductible is Satisfied**

- 12. Out-Patient, Non-emergency Office Visits (Medical) NON PREFERRED PROVIDERS**  
 The participant will be required to satisfy the per person calendar year deductible of the plan option that they participate in, before expenses will be eligible for reimbursement. The Plan will pay for any eligible services performed by a non-P.P.O. provider at the 50% co-insurance level subject to reasonable and customary charge for the service they received.
- 13. Emergency Room at a Preferred Provider Hospital or a Non Preferred Provider Hospital (Inside the P.P.O. Service Area)**  
 All eligible charges associated with an accidental injury or emergency illness when incurred at the emergency room of a Preferred Provider Hospital or a Non Preferred Provider Hospital will be paid at 90%, including physician's charges, if the patient has met the appropriate deductible of the plan option that they participate in. \$150.00 emergency room co-pay will be assessed in addition to any calendar year deductible. If the patient is admitted to the hospital directly from the emergency room, all additional eligible charges incurred during that confinement would be paid by the plan at 90% if billed by a P.P.O. provider or 50% if billed by a non-P.P.O. provider and the \$150.00 emergency room co-pay will be waived. **Pre-certification is required for any hospital admission, or a 50% reduction in benefits will occur.**
- 14. Accidental Injury or Emergency Illness (Outside the P.P.O. Service Area)**  
 If you incur an accidental injury or emergency illness and you are outside the P.P.O. network (not within 100 miles of a P.P.O. facility), eligible benefits will be paid as if you were inside the P.P.O. network after the patient has met the appropriate deductibles of the plan option that they participate in. **Pre-certification is required for any hospital admission, or a 50% reduction in benefits will occur.** Texas True Choice (P.P.O.) provides physicians and ancillary providers throughout the State of Texas. PHCS (P.P.O.) provides hospitals nationally
- 15. Dependents and Retirees Office Visits/Non-Emergency or Scheduled Hospital Admissions (Outside the P.P.O. Service Area)**  
 If you reside outside the P.P.O. service area and there are no preferred providers within 100 miles, benefits will be paid at the 75% co-insurance level to \$15,000.00 rather than the 50% co-insurance level, subject to all applicable deductibles of the plan option that they participate in subject to the reasonable and customary charges for the location where the services were incurred. All other plan provisions will remain the same. Texas True Choice (P.P.O.) provides physicians and ancillary providers throughout the State of Texas. PHCS (P.P.O.) provides hospitals nationally

**THE FOLLOWING BENEFITS, IF ELIGIBLE , WILL BE PAID BY THE PLAN AT THE STATED PERCENTAGE LEVELS AFTER THE DEDUCTIBLE HAS BEEN SATISFIED, BASED ON THE HIGH OR LOW DEDUCTIBLE PLAN THAT YOU PARTICIPATE IN.**

	<b>OUTSIDE P.P.O. CO-INSURANCE PERCENTAGE</b>	<b>INSIDE P.P.O. CO-INSURANCE PERCENTAGE</b>
<b>EXTENDED CARE</b>		
<b>1. Skilled nursing facility services</b> (Maximum of 120 days or \$25,000.00 per calendar year, whichever occurs first)	<b>50%</b>	<b>90%</b>
<b>2. Home health care</b> (Maximum of 120 visits or \$25,000.00 per calendar year, whichever occurs first)	<b>50%</b>	<b>90%</b>
<b>3. Hospice</b> (Maximum of 180 facility days or \$25,000.00 per calendar year, whichever occurs first)	<b>50%</b>	<b>90%</b>

**PLAN MAXIMUM BENEFITS COMBINED FOR ALL PLANS AND ALL BENEFITS**

Maximum lifetime benefits available to each plan participant

**\$2,000,000.00 / Lifetime**

Contained **within** the Maximum lifetime plan participant maximum, the following lifetime or annual maximums also apply for:

- 1. Mental Health Care\* **\$25,000.00 / Lifetime**
- 2. Alcohol and Substance Abuse\* **\$10,000.00 / Lifetime**
- 3. Chiropractic Services **\$5,000.00 / Lifetime**
- 4. Allergy Treatment\* **\$1,000.00 / Annually**
- 5. Morbid Obesity
  - Non surgical treatment **\$1,500.00 / Lifetime**
  - Surgical treatment **\$25,000.00 / Lifetime**

\*Including out-patient prescriptions

**16. Outpatient PRESCRIPTION DRUG EXPENSE COVERAGE WITHOUT DRUG CARD**

Employees and their eligible dependents who participate in this plan and who were hired after January 1, 2004 will not be eligible for the OUTPATIENT PRESCRIPTION DRUG CARD. You must submit your prescription drug receipts to the claims administrator for payment. Eligible drugs will be reimbursed by the plan at 80% of the usual and necessary price as determined by the claims administrator. Prescription drug expenses will be subject to all plan provisions including the pre-existing limitation provision and cannot be used to satisfy deductibles or co-insurance maximums of the High Deductible Option Plan or Low Deductible Option Plan. After you and your participating dependents have satisfied 18 months of continuous participation in this plan you will be issued a prescription drug card and will be eligible for the benefits listed below (See #17) Outpatient prescription drug expense with drug card)

**17. Outpatient PRESCRIPTION DRUG EXPENSE COVERAGE WITH DRUG CARD**

Outpatient prescription drugs must be filled with your prescription drug card if you have been in the plan for more than 18 months and hired before January 1, 2004. Employee and dependents that are eligible for the drug card are not eligible for reimbursement under the medical Plan, with the exception of Compound Prescriptions. Co-pays and any additional Rx charges cannot be used to satisfy deductibles or co-insurance maximums of the High Deductible Option Plan or Low Deductible Option Plan (See page 9 & 10) for additional information and limitations. \*This coverage pays benefits for prescription drugs bought for the medical care of a Plan Participant’s sickness or injury. All outpatient prescription drugs must be filled with your drug card. Reimbursement will not be allowed under the medical plan. The plan will not be responsible for prescriptions filled after your termination date. Participants will be required to use their ID card for prescription drugs and pay the following amounts:

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

<b>Generic</b>	<b>\$15.00 minimum co-pay or a 10%co-pay, whichever is greater</b> , per prescription. **If your prescription cost is less than the \$15.00 minimum co-pay you will only pay the actual cost of the prescription.**
<b>Preferred Brand Name</b>	<b>\$25.00 minimum co-pay or a 20%co-pay, whichever is greater</b> , per prescription. **If your prescription cost is less than the \$25.00 minimum co-pay you will only pay the actual cost of the prescription.**
<b>Non-Preferred Brand Name</b>	<b>\$35.00 minimum co-pay or a 30%co-pay, whichever is greater</b> , per prescription. **If your prescription cost is less than the \$35.00 minimum co-pay you will only pay the actual cost of the prescription.**
<b>Compound Prescriptions</b>	<b>\$35.00 minimum co-pay or a 30%co-pay, whichever is greater</b> , per prescription. **If your prescription cost is less than the \$35.00 minimum co-pay you will only pay the actual cost of the prescription.**

(List of Non-Preferred Brand Name and Preferred Name drugs is provided by MAXOR, and in addition, their list of Preferred and Non-Preferred Drugs is subject to change. Contact 1-800-687-0707 for a current list.) \*Co-payments will be required for refills.

**MAXOR MAIL ORDER PHARMACY—Greater than a 30 day supply**

<b>Generic</b>	<b>\$15.00* co-pay</b> per prescription per participant or the actual cost, if less
<b>Preferred Brand Name</b>	<b>\$25.00* co-pay</b> per prescription per participant or the actual cost, if less
<b>Non-Preferred Brand Name</b>	<b>\$35.00* co-pay</b> per prescription per participant or the actual cost, if less

**(List of Non-Preferred Brand Name and Preferred Brand Name drugs is provided by MAXOR, and in addition, their list of Preferred and Non-Preferred Drugs is subject to change. Contact 1-800-687-0707 for a current list.)**

**\*Co-payments will be required for refills.**

Not all charges are eligible; see definition of Eligible Charges (**page 8**). A person's protection under this coverage may be extended after the date that person ceases to be a Covered Person. See COBRA (**pages 29- 30**) Continuation of Health Care. The Plan is not liable for any prescription filled after the termination of coverage under this benefit. Any benefits paid after termination will be recovered from the former Plan Participant.

The Montgomery County Employee Benefit Plan ID card with the RX information will be honored by most local pharmacies. **MAXOR will be responsible for contracting with all pharmacies that will accept the ID card. They may be contacted at 1-800-687-0707.**

**For drugs ordered through the MAXOR Mail Order pharmacy, you may receive up to a 90-day supply prescribed by your physician for the \$15, \$25 or \$35 co-pay. Employees are required to use the mail order service for maintenance drugs or any prescription that is written for greater than a 30-day supply. Contact the Risk Management Department for additional information. Any amounts spent on prescriptions, whether actual costs or co-pays, do not apply toward deductibles or co-insurance provisions. This Plan will not coordinate benefits with any other entity in regard to outpatient prescription drugs purchased with your drug card or submitted for reimbursement to this plan during your first 18 months of coverage.**

A Prescription Drug means:

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

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

**ELIGIBLE CHARGES**

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

- 1) It is prescribed in writing by a licensed physician in the United States;
- 2) It is bought while the person is a Covered Person;
- 3) It is dispensed by a pharmacy or any other person or organization licensed to dispense drugs in the United States;
- 4) If it is approved by the plan administrator.

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

**CHARGES NOT COVERED**

- 1) Charges for a prescription or a refill of a prescription that are more than the charges for a 90-day supply;
- 2) A charge for a refill of a prescription that is:
  - a. in excess of the number specified by the Doctor; or
  - b. furnished more than one year after the date of the Doctor's original order of the Prescription Drug;
- 3) Drugs or medicines for which reimbursement is provided under any workers compensation law, or by any municipal, state, or federal program;

- 4) Medicines or drugs which are lawfully obtainable without a prescription written by a licensed physician (“Over-the-counter” medications), except insulin, including vitamins (except prenatal vitamins), cosmetics, and dietary supplements, or drugs that have an over-the-counter equivalent;
- 5) Any charge for the administration or injection of any drug including injectable insulin;
- 6) Medicines or drugs prescribed for the treatment of infertility, nicotine addiction, hair loss, or to change skin pigmentation;
- 7) Replacement of lost, stolen, or damaged prescriptions;
- 8) Drugs or medications which are covered under the Major Medical Coverage section;
- 9) Any Generally Excluded Charges shown in the Limitations and Exclusions (page 36 Article IV);
- 10) For weight reduction beyond the limits in Article IV. Limitations and Exclusions (page 37 #25);
- 11) Prescriptions or drugs which are considered by the plan as prescribed for a pre-existing condition during your first 18 months of coverage under this plan.

## COST CONTAINMENT PROVISIONS Schedule of Benefits (Continued)

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

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

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

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

Precertification is required for hospital admissions or outpatient surgery (page 13)

Utilization Review (page 13-16)

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

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Home Health Care Benefits (pages 18))  
Limitations (page 18 - 19)

Hospice Benefits (pages 19)

Employee Assistance Program (E.A.P.) (page 5, 11,12,15,16 & 17)

Mental Health, Substance Abuse or Alcoholism Benefits (pages 5,11,12, 20 & 35 # 25)

Employees and eligible dependents are required to contact the Employee Assistance Program (Deer Oaks E.A.P. Services at 1-866-327-2400 or T.D.D. 1-800-735-2989 (24 hour-7 days a week) before using mental health and substance abuse benefits. The E.A.P. will work in conjunction with Healthfirst/TriSurant to manage your treatment. You will be eligible to receive up to eight (8) visits for –0- cost to you. These visits are not subject to any deductible regardless of the HIGH Deductible or LOW deductible plan you have chosen to participate in. In the event of an in-patient emergency hospital admission or a scheduled in-patient hospital admission, you must utilize the providers approved by Healthfirst/TriSurant or benefits will be disallowed.

All covered persons seeking mental health, substance abuse, or an alcoholism evaluation and/or treatment must receive acute care in-patient services from the providers listed and pre-approved by Healthfirst/TriSurant.

**In the event of an inpatient emergency hospital admission or a scheduled inpatient hospital admission, you must utilize the providers listed below or benefits will be disallowed. You must receive inpatient services from the providers listed below:**

Cypress Creek Hospital  
17750 Cali Drive  
Houston, Texas  
(281) 586-7600

24-hour all levels of care for child, adolescent, and adult substance abuse and psychiatric problems.  
(Inpatient and Outpatient Services Available)

Cullen Bayou Place/Depelchin  
4815 Dickson  
Houston, Texas 77007  
(713) 861-4309

24-hour evaluation services for child and adolescent psychiatric problems  
(Day Treatment and Outpatient Services available)

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

**PREFERRED PROVIDER ORGANIZATIONs (P.P.O.)**  
**TEXAS TRUE CHOICE INC. and P.H.C.S (HOSPITAL ONLY) P.P.O.'s.**

1-800-683-4856

**Texas True Choice Inc P.P.O. and Private Health Care Systems** are organizations of preferred health care providers (P.P.O.) . All practitioners are governed by a board or panel of their peers and have agreed to a credentialing process and ongoing peer and utilization review of their hospital and office practices.

Under your present health care plan, maximum benefits can be obtained by utilizing the large selection of preferred providers and facilities listed in the **Texas True Choice Inc. P.P.O. for physicians and ancillary providers**. **You may access these physicians and ancillary providers by going on-line @ [www.texastruechoice.com](http://www.texastruechoice.com).**

You must use Private Health Care Systems (P.H.C.S) for eligible Hospitals. P.H.C.S. Hospitals are listed @ [http://www.multiplan.com/search/facility\\_form.cfm?originator=84451](http://www.multiplan.com/search/facility_form.cfm?originator=84451).

Please read the front and back of your card carefully so that you may obtain the maximum benefit from this plan. You have unrestricted access to any practitioner or facility within this directory. **It is the participant's responsibility to verify if the provider is within the P.P.O.**

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

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

**PRE-CERTIFICATION**  
**HEALTHFIRST/TRISURANT / 1-866-810-7613**

**Expenses incurred while confined to a hospital as an inpatient, or any out-patient surgical procedure is subject to the Pre-certification provisions, consisting of Pre-Admission Evaluation and Concurrent Review. This program must be utilized on all hospital admissions and outpatient surgeries to receive maximum medical benefits. Pre-certification is required before being admitted to the hospital or incurring an out-patient surgery or surgical procedure. Non-compliance will result in a 50% reduction of benefits.**

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

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

**UTILIZATION REVIEW**  
**HEALTHFIRST/TRISURANT / 1-866-810-7613**  
**General Overview**

Utilization Review is the review of a hospital confinement by the Plan (through Healthfirst/TriSurant) prior to the date of such confinement and/or during such confinement. The purpose is to possibly avoid unnecessary hospital confinements and/or reduce the length of some confinements without affecting the quality of treatment. Healthfirst/TriSurant will review the hospital confinement with your physician; however, in all cases the necessity of hospital confinement and you and your doctor, not the Contract Administrator or the Plan determines the length of stay.

In order for Healthfirst/TriSurant to review a hospital confinement with your physician, they must be advised of such confinement. Notification of such confinement is considered "compliance" and will vary based on different types of confinements as described later.

Benefits under the Plan (as to percentages payable) will be more favorable if a covered person goes through the Utilization Review System. The Schedule of Benefits outlines the differences in payment between compliance with the Utilization Review System and non-compliance.

**A. Definitions**

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

**B. Types of Review**

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

**C. Compliance Guidelines**

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

1. **Scheduled Hospital Admission Including Pregnancy**  
Healthfirst/TriSurant must be notified by the employee or a personal representative by telephone well before such scheduled admission so that the attending physician can submit the pre-admission certification form to Healthfirst/TriSurant at least ten (10) working days prior to scheduled admission. Pregnancies must have the pre-admission certification process completed by the 36<sup>th</sup> week of pregnancy.
2. **Urgent Admission**  
Healthfirst/TriSurant must be notified by the employee, physician, or a personal representative by telephone immediately prior to actual admission.
3. **Emergency Admission**  
Healthfirst/TriSurant must be notified by the employee, physician, or a personal representative within 48 hours of admission (72 hours on weekends or legal holidays).

Once the employee has complied with these provisions, Healthfirst/TriSurant will proceed to work with the physician and hospital in the employee's behalf for necessary medical care in compliance with the physician's recommendations.

#### **D. Mental and Nervous, Alcohol and Substance Abuse Guidelines**

**Participants in the Montgomery County Employee Benefit Plan will be required to contact Deer Oaks E.A.P. Services at 1-866-327-2400 or T.D.D. 1-800-735-2989 (24 hour-7 days a week) in order to access the mental health/substance abuse benefits. If benefits received from the E.A.P. are exhausted and continuation of services are required, the E.A.P. will refer you to the mental health coordinator at Healthfirst/TriSurant. If access to the P.P.O and the Montgomery County Employee Benefit Plan is required, Healthfirst/TriSurant will coordinate this referral. You will be subject to all plan provisions, deductibles and co-insurance provisions when accessing the Montgomery County Employee Benefit Plan.** Coverage for diagnosis or treatment relating to Mental and Nervous conditions, Alcoholism and Substance Abuse are subject to the following guidelines and the Schedule of Benefits. (Page 4, 9, 11, 17 & 33 #25)

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

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

##### **2. Treatment or Therapies Requiring Pre-Authorization as Inpatient Care**

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

3. **Sub-acute (Residential) Inpatient Confinements (Pre-Certification Required)** – necessary when outpatient treatment is not effective or programmatic inpatient treatment is needed without the need for an acute-care confinement. Sub-acute care shall also apply to treatment modalities listed as residential inpatient; social model inpatient; social psychiatric residential; light psychiatric; group home; halfway inpatient treatment and psychiatric health facility.

4. **Treatment or Therapies Requiring Pre-Authorization as Outpatient Care**
  - a. Psychological testing;
  - b. Day treatment – necessary when outpatient treatment is not effective or programmatic treatment is necessary without the need for inpatient care;
  - c. Multiple sessions per week;
  - d. Necessary when used to prevent hospitalization or re-hospitalization;
  - e. For a severe multiple problem family situation;
  - f. To significantly shorten the length of standard (i.e. once per week) therapy to achieve the same therapeutic goals.
5. **Treatment or Therapies Excluded**
  - a. Rest cures;
  - b. Custodial care;
  - c. Health and well being enhancement programs (i.e. weight control programs; smoking cessation programs; stress reduction programs; marriage enrichment programs; any program significantly educational in nature and not giving special emphasis and treatment to a diagnosed illness).

**E. THE ATTENDING PHYSICIAN RETAINS FULL CONTROL OVER THE MEDICAL TREATMENT PROVIDED**

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

**OUT-PATIENT TESTING**

Any eligible testing that is performed on an outpatient basis, the Plan will pay 50% co-insurance if a non-P.P.O. provider performs service and the Plan will pay 90% co-insurance if a P.P.O. provider performs the service.

**PRE-ADMISSION TESTING**

Under this provision Covered Persons may receive 100% payment of charges for outpatient X-rays and lab tests performed prior to surgery at a P.P.O. provider or charges will be paid at 80% of usual and customary charges at a non P.P.O. provider. Charges for pre-admission testing will be covered under the Major Medical Benefits. **The Calendar Year Deductible Amount will not apply.** The Benefit Percent paid by the plan will be 100% for Eligible Charges for Pre-Admission Testing at a P.P.O. provider or 80% of the usual and customary charges at a non P.P.O. provider. "Pre-Admission Testing" means X-ray and laboratory exams made in contemplation of and within four days of a scheduled surgery, which is performed within the 48 hours following the Covered Persons admission to the hospital. If for medical reasons, the scheduled hospitalization is canceled or postponed for more than two weeks, benefits will be payable for any similar diagnostic, X-ray and laboratory examinations again made in connection with and prior to the rescheduled hospitalization. Benefits will not be paid for any duplication of the same tests after hospital confinement.

**WEEKEND ADMISSIONS**

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

1. Surgery is performed within 24 hours immediately following the Covered Person's admission to the hospital; or
2. The Covered Person is admitted for an acute illness not requiring surgery.
3. Pre-certification is required within 72 hours for an emergency hospital admission.

## **SECOND AND THIRD SURGICAL OPINIONS**

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

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

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

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

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

## **OUT-PATIENT SURGERY** **Precertification is Required**

Whenever possible, Covered Persons are encouraged to have necessary surgery performed on an outpatient basis. When incurred in connection with outpatient surgery, the following will be covered under Major Medical Benefits after the Deductible is satisfied, at a Benefit Percentage of 80% outside P.P.O. or 90% inside the P.P.O., including surgery centers.

1. All related charges for outpatient services including lab fees, biopsies, and supplies by a surgery center or outpatient department of a hospital for charges incurred on the day surgery is performed on a Covered Person;
2. Anesthesiologist charges will be paid at 90% if charges were incurred at a surgery center or at a participating P.P.O. Hospital. They will be paid at 80% at all other facilities in connection with an outpatient surgery.
3. Fees by surgeons for surgery performed on an outpatient basis. “Outpatient services and supplies” means services and supplies furnished by the center or by a hospital on the day the procedure is performed.
4. Any eligible outpatient surgeries or related charges including anesthesiologist charges will be paid at 80% if performed at a non-P.P.O. hospital.

“Surgery center” means a freestanding surgical facility that:

1. Meets licensing standards;
2. Is equipped and operated for general surgery;
3. Makes charges on its behalf;
4. Is directed by a staff of Physicians. A Physician must be present when surgery is performed and during the recovery period;
5. Has at least one certified anesthesiologist present when surgery which requires general or spinal anesthesia is performed and during the recovery period;
6. Extends surgical staff privileges to Physicians who practice surgery in an area hospital and dentists who perform oral surgery;
7. Has at least two operating rooms and one recovery room;
8. Provides or arranges with a medical facility in the area for diagnostic x-ray and lab services necessary for surgery;
9. Is equipped and has a staff trained for medical emergencies, which requires:
  - a. A Physician trained in cardiopulmonary resuscitation;
  - b. A defibrillator;
  - c. A tracheotomy set; and
  - d. A blood volume expander;

10. Has a written agreement with a hospital in the area for immediate emergency transfer of patients;
11. Provides an ongoing quality assurance program with review Physicians who do not own or direct the facility;
12. Keeps a medical record on each patient

**HOME HEALTH CARE BENEFITS**  
**Precertification is Required**

Covered Persons are encouraged to receive care at home, when possible, rather than in a hospital. Home Health Care Benefits are a basic medical coverage benefit and are not part of the Major Medical Benefits. Benefits for Home Health Care will be payable for up to 120 visits in a calendar year. Each visit by a person providing services under a Home Health Care Plan or evaluating the need for or developing a Plan will be viewed as one Home Health Care visit. Up to 4 consecutive hours of home health aide service in a 24-hour period will be eligible for payment as one Home Health Care visit. The amount paid will be at 50% outside P.P.O. or 90% inside P.P.O. of the eligible Home Health Care charges and subject to Plan deductible. The Maximum Eligible Charge will not be more than the usual and customary charge for such visit.

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

Home Health Care includes one or more of the following:

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

**LIMITATIONS**

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

B. The Home Health Care Plan must:

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

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

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

### **HOSPICE BENEFITS** **Precertification is Required**

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

1. The Plan will pay Hospice Benefits if a Covered Person incurs Eligible Hospice Charges. Benefits are payable if the Covered Person is terminally ill, and the attending Physician expects him or her to live no more than six months after the date services are performed and has recommended a formal program of Hospice care. The amount paid will be at 50% of Eligible Hospice Charges for Non-P.P.O. Providers or 90% of Eligible Hospice Charges for P.P.O. Providers. Some charges may be payable under other provisions of this Plan.

“Hospice” means a licensed or certified agency which:

Is primarily engaged in providing counseling, medical services or room and board to terminally ill persons and is licensed by the appropriate licensing authority;

Has professional service policies established by a group associated with it and the group includes one Physician, one registered nurse (R.N.) and one social service coordinator;

Has full-time supervision by a Physician;

Has a full-time administrator;

Provides services 24 hours a day, 7 days a week; and maintains a complete medical record of each patient.

Eligible Hospice Charges are charges made by a Hospice for:

Room and board;

Private duty nursing care provided by, or under the supervision of, a registered nurse (R.N.);

Part-time or intermittent home health aid services by employees of the Hospice;

Social work performed by a licensed social worker; and

Nutritional services, including special meals.

Exclusions:

Services provided by volunteers or others who do not usually charge for their services;

Services by a person who lives in your home or is a close relative;

Any period during which you are not under the care of a physician; and

Bereavement counseling.

## **EMPLOYEE ASSISTANCE PROGRAM**

All participants of Montgomery County Employee Benefit Plan and their eligible dependents are offered assistance in a variety of areas such as debt management, budget planning, legal advice, supervisory consultations and referrals to Employee Assistance Program (E.A.P.) counselors. This program will assist you in obtaining mental health and substance abuse counseling. **If you and your eligible dependents participate in the Montgomery County Employee Benefit Plan, you will be required to contact Deer Oaks E.A.P. Services at 1-866-327-2400 or T.D.D. 1-800-735-2989 (24 hour-7 days a week) in order to access your mental health/substance abuse benefits.** The E.A.P. counselor will assess your needs and determine what steps need to be taken in order to help resolve your situation. You are eligible to receive eight (8) free visits at a provider referred through the E.A.P. Should you need to access the Texas True Choice P.P.O. network of providers after you have received the eight (8) free visits through the E.A.P., the E.A.P. provider will coordinate your benefits with Healthfirst/TriSurant. **Your E.A.P. provider is Deer Oaks E.A.P. Services and they can be reached toll-free at 1-866-327-2400 or T.D.D. 1-800-735-2989 (24 hour / 7 days a week) or accessed through the internet at: <http://www.deeroaks.com/deer-oaks-employee-assistance-program>**

## PLAN INFORMATION

### **EMPLOYER**

Montgomery County, Texas  
301 North Thompson  
Conroe, Texas 77301 Telephone 936-760-6935

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

Montgomery County, Texas  
Attention: County Attorney's Office  
301 North Thompson; Suite 106  
Conroe, Texas 77301 Telephone: 936-760-6935 H.I.P.A.A. Facsimile: 936-538-8169

### **PLAN NAME**

**Montgomery County Employee Benefit Plan** – This is an employee benefit plan formed under Chapter 172 of the Local Government Code, providing Comprehensive Medical Benefits, Prescription Drug Benefits, and Life Insurance & Accidental Death & Dismemberment Insurance.

### **PLAN NUMBER/IDENTIFICATION** – 248

**BENEFIT YEAR** – January 1 through December 31.

**PLAN YEAR** – October 1 through September 30.

### **CONTRACT CLAIMS ADMINISTRATOR**

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

### **PREFERRED PROVIDER Organizations'**

Texas True Choice: for Physicians and ancillary providers. Private Health Care Systems (PHCS): for Hospitals Only  
5000 Legacy Drive, # 190 PHCS is contracted through Healthfirst/TriSurant listed below.  
The  
Plano, Texas 75024 Telephone: 1-800-683-4856 Web address to access the PHCS directory is listed below:  
[www.texastruechoice.com](http://www.texastruechoice.com) [www.multiplan.com/search/facility\\_form.cfm?originator=8445](http://www.multiplan.com/search/facility_form.cfm?originator=8445)

### **PRECERTIFICATION/UTILIZATION REVIEW**

Healthfirst/TriSurant T.P.A. Inc.  
509 N. Sam Houston Parkway East #500  
Houston, Texas 77060-4001 Telephone: 1-866-810-7613 or 281-999-9600

### **PRESCRIPTION DRUG CARD PROGRAM**

MAXORPLUS  
320 South Polk, Suite 700  
Amarillo, Texas 79101 Telephone: 1-800-687-0707 or 806-324-5430 Fax: 806-324-5493  
[www.maxor.com](http://www.maxor.com)

### **EMPLOYEE ASSISTANCE PROGRAM-E.A.P.**

Deer Oaks E.A.P. Services  
7272 Wurzbach Rd; Suite 601  
San Antonio, Texas 78240 Telephone (24HR) 1-866-327-2400 or T.D.D. 1-800-735-2989  
[www.deeroaks.com/deer-oaks-employee-assistance-program](http://www.deeroaks.com/deer-oaks-employee-assistance-program)

### **FINANCING OF THE BENEFITS PLANS**

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

## **INTERPRETATION OF THE PLAN**

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

## **PRESENTING CLAIMS FOR BENEFITS**

If you think you are eligible for a benefit described in this Plan, you have to file a claim. Forms necessary for filing proof of loss for claims are available from your employer.

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

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

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

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

If your claim has been denied, or if you have not heard anything within 90 days after you have sent it in, you can appeal the denial in writing and have your claim reviewed. You have 61 days to appeal from the time you are notified of the denial or 61 days from the end of the processing period, if you have heard nothing by that time.

Those reviewing your claim have to act within 60 days of receiving your request. However, in special cases, they may be allowed 120 days. The final decision will be sent to you in writing, together with an explanation of how the decision was made. If you are not satisfied with the result of your appeal, you may file a suit and serve process on **The Montgomery County Employee Benefit Plan**. (See page 21)

# ARTICLE I

## PLAN DEFINITIONS

**Active Service** means the Employee is performing in the customary manner all of the regular duties of his employment on a full-time basis either at his customary place of employment or at some location at which that employment requires him to travel on a scheduled work day, or if he is absent from work solely by reason of vacation and at the time his coverage would otherwise become effective he has not been absent from work for a period of more than three (3) consecutive weeks. An Employee will be considered in Active Service on a day, which is not a scheduled workday only if he was performing in the customary manner all of the regular duties of his employment on the last preceding scheduled workday.

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

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

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

**Benefit Period** means the period of time from January 1 through December 31.

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

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

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

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

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

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

1. The lawful spouse of the Employee not legally separated from the Employee, and
2. Unmarried natural children of the Employee, legally adopted children and step-children principally dependent upon the Employee for support up to the dependents 19<sup>th</sup> birthday, and
3. Unmarried natural children of the Employee, legally adopted children and step-children who reside with the employee, up to the dependents 19<sup>th</sup> birthday or up to the dependents 25<sup>th</sup> birthday, if a full-time student in a public or private secondary school, accredited college, university, trade school or business school and principally dependent upon the Employee for support; and
4. Unmarried natural children of the Employee, legally adopted children and step-children who reside with the employee, up to the dependents 19<sup>th</sup> birthday or up to the dependents 25<sup>th</sup> birthday, if a full-time student in a public or private secondary school, accredited college, university, trade school or business school and are principally dependent upon the Employee for support and maintenance. Eligible dependents are also dependents that are incapable of self-sustaining employment due to mental or physical disability, provided such disability commenced prior to attainment of the dependents 19<sup>th</sup> birthday, whichever is applicable under 2 or 3 above and dependent were covered prior to attainment of such age and continuously thereafter. Proof of dependency or mental or physical disability must be furnished by you when required by the Plan Administrator.

Cessation of full-time school attendance shall terminate coverage with respect to the student; however, if cessation is due to school vacation, coverage shall terminate on the date the school reconvenes if the student has not enrolled and is not attending. If cessation is due to graduation, coverage will terminate at the expiration of the third calendar month following graduation. If cessation is due to disability that prevents the student's full-time attendance, coverage will terminate on the first day of the schools next regular session if a physician's written statement to the contract administrator shows that the student is capable of full time school attendance. If the student's disability continues, normal disability provisions will apply. (See page 27 #6.)

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

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

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

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

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

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

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

**Hospital** means a legally constituted institution which:

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

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

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

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

**Inside P.P.O** means receiving eligible services from providers who are participants in the Preferred Provider Organization that this plan has adopted as Preferred Providers.

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

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

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

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

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

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

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

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

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

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

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

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

**Retiree** means any person who meets the definition of retiree as defined by Montgomery County, Texas Commissioners Court.

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

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

## ARTICLE II

### PARTICIPATION IN HEALTH CARE BENEFITS

#### A. EMPLOYEE PARTICIPATION

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

An employee has the right to waive their medical coverage under this plan. If employee coverage is not selected, dependent coverage will not be available. If an employee elects to waive participation and later decides to enroll in the medical plan, beyond 31 days of first becoming eligible to participate in this plan, the applicant will be considered a “**late entrant**,” as defined by the Montgomery County Employee Benefit Plan and will be required to comply with any and all plan provisions for enrollment in the plan as a “**late entrant**”. If approved for coverage, the earliest time the employee’s or dependents medical coverage will be effective, will be the 1<sup>st</sup> day of the month, following 90-days. The employee will also be subject to the 18 month pre-existing condition requirement and will not have prescription drug card coverage until after the 18 month period from their effective date. Eligible dependents of the employee who elected to waive coverage and then later request coverage under the plan, will be subject to “**late entrant**” requirements. If an employee terminates medical coverage, they must also terminate their dependent medical coverage.

##### 2. Eligibility for Health Care Benefits

- a. All full-time regular Employees in a budgeted position, in Active Service at their customary place of employment on the day their health care benefits become effective, who work a minimum of 30 hours per week for the Employer and their eligible dependents shall be eligible for Health Care Benefits under this Plan. Eligible employees will be required to notify the Risk Management Department in writing, complete any necessary enrollment applications and supply all necessary documentation as required by the plan within the first 90 days of employment.
- b. All eligible retirees.
- c. All other persons are excluded.

##### 3. Waiting Period

For all Employees the waiting period is ninety (90) days of continuous Active Service.

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

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

##### 5. Termination of Health Care Benefits

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

- a. If the Employee fails to remit required contributions for his Health Care Benefits when due, his benefits will terminate at the end of the period for which contribution is made;
- b. The last of the month in which you terminate your employment or lose your eligibility status as long as any required contributions have been paid;
- c. Participation may be continued for an Employee on an employer-approved leave of absence, but for no longer than 6 continuous months.
- d. On the termination date of the Plan.

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

- a. The day the Employee’s coverage terminates;

- b. If the Employee fails to remit required contributions for dependent Health Care Benefits when due, dependent's benefits will terminate at the end of the period for which contribution is made;
- c. The day you cease to be an eligible dependent as defined by the Plan;
- d. The day of the month in which the Employee ceases to be in a class eligible for coverage as long as contributions are paid for the month in which you are terminated;
- e. On the termination date of the Plan.

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

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

- a. The Employee must be totally disabled when Health Care Benefits terminate;
  - b. The Employee must remain totally and continuously disabled through the date on which the medical expenses are incurred;
  - c. Only expenses incurred for the treatment of the condition causing the total disability will be eligible for consideration under this benefit.
7. **Total Disability** means the complete inability of an Employee, because of sickness or accidental injury, to engage in or perform the duties of the Employee's regular occupation or employment, or in the case of a Dependent, unable to perform their normal, routine activities or confined to a hospital.
8. **Changes in Health Care Benefits** will be effective for all Employees in Active Service and their participating dependents on the date the Plan is amended.

**B. DEPENDENT PARTICIPATION**

**1. Required Documentation for Proof of Dependent**

- a. **Spouse:** Certified Marriage License or Certified Informal Marriage Certificate, and Social Security Number.
- b. **Natural Child:** Certified Birth Certificate which shows name of mother and father (mother or father must be an employee); Certified Divorce Decree, court order or order for support by the Attorney General for the State of Texas stating responsibility for medical coverage, and Social Security Number.
- c. **Step-child:** Certified, signed and filed Divorce Decree stating responsibility for dependent medical/dental coverage, Proof of Residency (certified school record), Certified Birth Certificate which shows name of mother and father, and Social Security Number. Residency of the step-child must be with the employee of the County.
- d. **Adopted Children:** Certified copy of a legal certificate of Adoption Decree (adopted parent must be the employee) and Social Security Number.

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

A Dependent will be eligible to participate in the Health Care Benefits Plan on:

- a. The date the Employee is eligible for benefits under the Plan, if on that date he has such Eligible Dependents and enrolls them in the plan; or,
- b. The date the Employee gains an Eligible Dependent, if on that date he is covered by the Plan, and has made any necessary contributions; and has notified the plan within 31 days of gaining that dependent. If notification is given after 31 days of gaining the dependent, the dependent will be considered a late entrant and will be subject to the late entrant provisions.
- c. If a Dependent, other than a well newborn child, is hospitalized on the date participation would normally commence, participation of that Dependent will not be effective until the day after the Dependent is discharged from the hospital;

d. In no event will the Dependent's coverage begin before the Employee's.

**In the event a husband and wife are both eligible to participate in the Plan as Employees, only one spouse will be eligible to cover any Eligible Dependent children they might have. If the employee covering a dependent terminates his or her employment, the dependents may be added to the coverage of the remaining (spouse) employee, provided that there is no lapse in coverage. (Page 32, G)**

### **3. Change in Dependent Health Care Benefits**

Changes in the Health Care Benefits will be effective for Dependents only if the Employee is still eligible and the Dependent is not confined in a hospital, or other institution.

### **4. Disability Extension**

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

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

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

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

All Plan provisions apply during this extension.

## **C. LATE ENTRANTS**

You, the Employee, must enroll on behalf of yourself and your eligible dependents within 31 days of the date you become eligible. If you or your eligible dependents fail to enroll within 31 days, you or your dependents will be considered late entrants and you must complete and submit evidence of your medical history. If you gain a new Dependent, you will be required to notify the Plan within 31 days of gaining that Dependent. A physical examination is required for all late entrants. This exam will be at your expense. All Late entrant forms are available at the Montgomery County Risk Management Department.

If approved to be a participant in the Plan, the earliest date that a late entrant's coverage may take effect will be the first day of the first month following ninety (90) days after the late entrant has completed all necessary information as required by the plan and the Employer, and made application to be a covered participant. Applications will not be submitted to the claims administrator until all information has been completed and received by the Risk Management Department. You will be notified of such approval or denial. The Plan reserves the right to approve or deny any late entrant. If additional information is received by the Plan after your acceptance or your dependents acceptance into the plan that would have disqualified you or your dependent from coverage originally, the plan will have the right to terminate coverage back to your original effective date and the employer will refund any contributions that you have paid. The employee will be responsible for paying for all claims paid by the plan on behalf of the ineligible employee or ineligible dependent.

## **D. AGE DISCRIMINATION IN EMPLOYMENT ACT**

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

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

**1. Continuation of Coverage**

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

- a. Covered dependents of a Covered Person (employee) who dies.
- b. A Covered Person and his or her covered dependents upon the Covered Person's termination of employment (other than termination for gross misconduct), or whose work hours have been reduced to less than the minimum required for coverage under the Plan.
- c. A covered spouse upon divorce or legal separation from the Covered Person (employee).
- d. Covered dependents of a Covered Person who is terminated from the Plan upon becoming eligible for benefits under Medicare.
- e. A covered dependent child who marries or attains the maximum age at which dependents may be covered under this Plan.

**2. Notice Requirements**

- a. When eligibility for continuation results from a Covered Person's death, termination, reduction in working hours, or entitlement to Medicare, the Covered Person or dependent will notify the Employer of that event. Notice must be given within 30 days of the Covered Person's death, termination, reduction in working hours or entitlement to Medicare.
- b. When eligibility for continuation results from a covered spouse being divorced or separated from a Covered Person (employee) or a dependent child's marriage or attainment of the maximum age for coverage under the Plan, the covered person or dependent must notify the Employer of that event.
- c. Within 14 days of receiving notice, the Employer will advise the Covered Person or dependent of his or her rights to continued benefits.
- d. After receiving that notice, the Covered Person or dependent has 60 days in which to decide whether to elect continued benefits. This 60 days begins on the later of:
  - i) the date coverage under the Plan would otherwise end; or
  - ii) the date the person receives notice from the Employer of his or her rights under the law.

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

- e. Within 45 days after the date the Covered Person or dependent notifies the Employer that he or she has chosen to continue medical coverage, the covered person must pay the first premium. The first payment will be the amount needed to provide coverage from the date continued benefits begin to the date that the first payment is made. Thereafter, premiums for the continued benefits are to be paid monthly on the day of each month stated by the Employer.
- f. A Covered Person's dependent must pay the premium for any coverage being continued.

**3. Length of Continuation**

For Covered Persons who are terminated or have their hours reduced, coverage may be continued for up to 18 months after the termination or reduction in hours. For all others who qualify for continuation of benefits, coverage may be continued for up to 36 months after the event, which makes the Covered Person eligible for continued benefits. Continuation will end on the earliest of:

- a. The end of the 18 or 36 month period noted above;

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

The following applies when this Plan replaces another Plan of group medical coverage. If, on the day before the effective date of the Employer's coverage under this Plan, eligible employee or dependent coverage is being continued under that prior Plan under COBRA (the Consolidated Omnibus Budget Reconciliation Act of 1985):

That person will have the right to become covered under this Plan. Coverage may be provided until the end of the period for which the person could have been covered under the prior Plan if it had not been replaced; and

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

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

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

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

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

**HIPAA PRIVACY RULE**

This Plan complies with the requirements of § 164.504(f) of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations, 45 C.F.R. parts 160 through 164 (the regulations are referred to herein as the "HIPAA Privacy RULE" and § 164.504(f) is referred to as "the "504" provisions") which establish the extent to which the Plan sponsor will receive, use and/or disclose Protected Health Information.

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

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

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

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

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

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

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

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

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

The Plan sponsor will not use or further disclose members’ Protected Health Information other than as described in the Plan Documents and permitted by the “504” provisions.

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

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

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

#### **Disclosure of members’ Protected Health Information – Disclosure by the Plan sponsor**

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

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

The Plan sponsor will make and maintain an accounting so that it can make available those disclosures of members’ Protected Health Information that it must account for in accordance with 45 C.F.R. § 164.528.

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

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

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

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

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

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

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

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

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

1. Director and Assistant Director of Risk Management
2. Risk Management Analyst
3. Information Technology personnel
4. Financial Accountants
5. Legal advisors who represent the plan

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

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

#### **Security Standards**

##### **Plan Sponsor Obligations**

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

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

Plan sponsor shall report to the plan within a reasonable time after Plan sponsor becomes aware, any Security Incident that results in unauthorized access, use, disclosure, modification, or destruction of the Plan’s Electronic Protected Health Information; and

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

#### **G. DUAL COVERAGE PRECLUDED**

No person will be covered under the Plan simultaneously:

1. As both an Employee and a Dependent;
2. As a Dependent of more than one Employee.

## **ARTICLE III.**

### **HEALTH CARE BENEFITS ELIGIBLE MEDICAL AND MENTAL HEALTH CARE EXPENSES**

The following are considered eligible for reimbursement under the Health Care Benefits Plan unless they are specifically excluded under the Schedule of Benefits. These eligible expenses are limited to the medically necessary, usual and customary charges incurred as a result of accidental injury or sickness. An expense will be considered to be incurred at the time the service or the supply is provided. All eligible expenses must be incurred for the treatment of an accidental injury or sickness. The following are considered eligible expenses.

1. The hospital's charge for an average semi-private room;
2. Intensive Care Unit or Coronary Care Unit charges when deemed medically necessary and recommended by a physician;
3. Miscellaneous hospital services and supplies directly related to the sickness or injury causing the hospital confinement;
4. Administration of Anesthesia - fees charged by a physician or Certified Registered Nurse Anesthetist (C.R.N.A.) for administration or anesthetics;
5. Local ambulance service, including air ambulance to and from the hospital provided that it is medically necessary;
6. Fees charged by a Physician or a Physician Assistant for medical care or specified treatment of an accidental injury or sickness;
7. Charges for a birthing center and the medically necessary supplies used there during a patient's stay;
8. Pre-admission diagnostic testing performed within four (4) days of hospital confinement for use during hospitalization;
9. Charges by a hospital or alcohol dependency treatment center which provides a program for the treatment of alcohol dependency pursuant to a written treatment plan approved and monitored by a physician and which facility is also:  
**(See limits shown in the Schedule of Benefits and Cost Containment Section).**
  - a. Affiliated with a hospital under a contractual agreement with an established system for patient referral; or
  - b. Accredited as such a facility by the Joint Commission on Accreditation of Hospitals; or
  - c. Licensed as an alcohol treatment program by the Texas Commission on Alcoholism; or
  - d. Licensed, certified, or approved as an alcohol dependency treatment program or center by any other state agency having legal authority to so license, certify or approve.
10. Fees charged by a Surgeon, Assistant Surgeon or Surgical Technician for surgical procedures. Assistant Surgeon's fees will be eligible if the procedure required an Assistant Surgeon or the facility where the surgery was performed requires an Assistant Surgeon. Assistant Surgeon fees will be limited to a maximum payment of twenty-five percent (25%) of the eligible and reasonable and necessary charges of the Surgeon as determined by the Plan or twenty-five (25%) of the negotiated discounted fee of a Preferred Provider Physician.
11. Services of an Outpatient Surgical Facility;
12. Professional Nursing Services - fees charged for professional services by a Registered Nurse (RN), Licensed Vocational Nurse (LVN) or a Licensed Practical Nurse (LPN), excluding services by one who is a member of the patient's immediate family provided that:
  - a. These services are ones which can be performed for compensation only by a person holding an R.N. license, LVN license, or other license requiring a higher level of medical skill and training;
  - b. The level of skill of an RN or LVN is medically necessary;
  - c. The charges are only for the portion of time for which such level of skill is medically required; and



Norplant implants, but not the removal) for the purposes of birth control and obtainable only on a physician's written prescription. Outpatient prescription drugs must be purchased with your prescription drug card unless you are in your first 18 months of employment and you were hired after January 1, 2004. No reimbursement will be made for outpatient prescription drugs submitted to this benefit Plan unless you are in your first 18 months of employment or you have received a compound medication that is not reimbursable with your prescription card.

22. Expenses incurred for treatment while confined to a hospice for medical expenses incurred for the physical and emotional needs of terminally ill patients.
23. Benefits for Eligible Medical Expenses incurred will be payable according to the Schedule of Benefits in effect on the day the expenses are incurred.
24. Immunizations required by the State of Texas for admission to schools in Texas, will be covered for eligible dependent children at a P.P.O. provider only. This benefit will be subject to the \$25.00 P.P.O. office co-pay and the balance of the eligible charges will be covered at the 90% co-insurance level by the plan after the participant's deductible has been satisfied.
25. Eligible conditions for mental illness under this Plan shall be defined by the International Classification of Diseases 9<sup>th</sup> Edition (ICD-9) Codes. Eligible mental illness conditions shall begin at 290.0 through and including 315.9 of the ICD-9 CodeBook.
26. The treatment of temporomandibular joint dysfunction or TMJ syndrome will be limited to \$1,000.00 per lifetime per participant.

## ARTICLE IV.

### LIMITATIONS AND EXCLUSIONS

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

1. In excess of the Reasonable or Usual and Customary charge, as determined by the Plan;
2. Resulting from sickness covered by a Workers' Compensation Act or similar law;
3. Resulting from accidental injury or illness arising out of or in the course of employment for wages or profit;
4. Resulting from war, declared or undeclared, any act of war, or any type of military conflict;
5. Resulting from any intentionally self-inflicted injury whether sane or insane;
6. For services furnished by a hospital or facility operated by the United States Government or any authorized agency of the United States Government, or furnished at the expense of such government or agency;
7. For eye refraction's or eye examinations for the correction of vision or fitting of glasses or contact lenses, furnishing or replacement of glasses or contact lenses, or for hearing examinations or the furnishing of hearing aides;
8. For dental treatment, except necessary repair of sound natural teeth as a consequence of accidental injury that occurs while covered hereunder, or surgical removal of bony impacted wisdom teeth;
9. For treatment to the feet resulting from bursitis, tendinitis, tarsalgia, metatarsalgia, weak, unstable or flat feet, bunions, corns and calluses, unless an open cutting operation is performed; or for treatment of toenails, unless at least part of the nail root or matrix is removed, or purchase of orthopedic shoes or other orthotic devices for support of the feet unless an open cutting operation is performed. The initial office visit, including x-rays, for the purposes of diagnosis will be allowed;
10. For cosmetic surgery, unless required because of an accidental injury which occurs while covered hereunder or because of a congenital malformation of a dependent child unless the child was born while covered under this Plan and has remained continuously covered under this Plan since birth;
11. For the diagnosis or treatment of mental, nervous, or emotional disorders, including drug and alcohol related disorders whether as an outpatient or as an inpatient; beyond the limits in the Schedule of Benefits subject to the definition of mental illness in (page 35 #25);
12. For health check-ups, routine physical examinations or nutritional supplements not medically necessary for the treatment of an injury or illness beyond the limits specified in the Schedule of Benefits (page 6, #10)
13. Resulting from care or treatment not reasonably necessary for the care and treatment of sickness or accidental injury;
14. For any expenses incurred for mandibular or maxillofacial surgery due to growth defects, jaw disproportions or appliances or restorations used solely to increase vertical dimension, reconstruct occlusion except when these conditions are a direct result of an accident that occurred when covered as an eligible participant under this Plan or because of a congenital malformation of a dependent child that was born while covered under the Plan and has remained continuously covered under the Plan since birth up to a maximum benefit of \$1000.00 per lifetime of the participant (page 35, #26) for the treatment of temporomandibular joint dysfunction or TMJ syndrome.)
15. Housekeeping or custodial care;
16. Charges for orthognatic disorders;
17. Illness or injury caused by, or contributed to, engagement in an illegal occupation or commissions or attempt to commit a felony;
18. Enrollment in a health, athletic, or similar club or smoking cessation or similar program;
19. Purchased or rented supplies of common use such as: exercise cycles, air purifiers, air conditioners, water purifiers, hypo-allergenic pillows or mattresses, or waterbeds;

20. Purchase or rental of: motorized transportation equipment, escalators or elevators, saunas, steam baths, swimming pools, hot tubs, blood pressure kits, blood sugar kits or any convenience item;
21. In vitro fertilization, artificial insemination, surgical reversal of elective sterilization, fertility drugs, contraceptives other than birth control pills or Depo-Provera injections for the purpose of birth control or Norplant implants for the purposes of birth control, but not the removal of Norplant implants (see page 35, #21);
22. Vitamins, except physician prescribed for prenatal care when necessary, for dietary supplements, minerals, any drugs that can be purchased without a written prescription;
23. Sex transformation, or the treatment of or for trans-sexual purposes;
24. Treatment for sexual dysfunction of inadequacy, which includes implants, pumps and related hormones and/or drug therapy. Expenses for drug therapy may be considered eligible under this Plan when sexual dysfunction of inadequacy is not the primary diagnosis;
25. Treatment of obesity; but not morbid obesity. In addition to other medical requirements, the weight requirement for morbid obesity shall be defined as a minimum of 100 pounds over your normal body weight as determined by your physician. Payment for non-surgical treatment for morbid obesity shall be limited to a lifetime maximum of \$1,500.00. Surgical procedures and all associated costs will be limited to \$25,000.00 per lifetime of the covered plan participant. **NO SURGICAL PROCEDURES FOR MORBID OBESITY ARE ALLOWED OR CONSIDERED ELIGIBLE FOR COVERAGE DURING YOUR FIRST 18 MONTHS OF COVERAGE UNDER THIS PLAN;**
26. Recreational or educational therapy, vocational therapy or non-medical self-care or self-help training;
27. Radial keratotomy or keratoplasty;
28. Chelation therapy;
29. Experimental procedures;
30. Eligible expenses do not include any charges incurred by an individual with respect to any injury, illness, including pregnancy, which existed within the 12 months prior to being covered under this Plan. These injuries, illnesses, pregnancies or related conditions shall be considered a pre-existing condition. Any expenses associated with these conditions, including prescription drugs, will not be considered as eligible expenses until after the participant has been covered by the Plan for 18 months. (See page 24 for definition of injury or illness)
31. For an elective or therapeutic abortion unless such abortion is necessary due to an acute life-threatening condition with respect to a pregnant Covered Employee, Covered Spouse, or dependent;
32. Charges for services, supplies or treatments not recognized by the American Medical Association as generally accepted and medically necessary for the diagnosis and/or treatment of an active illness or injury; or charges for procedures, surgical or otherwise, which are specifically listed by the American Medical Association as having no medical value;
33. Charges for services rendered by a physician, nurse, or licensed therapist if such physician, nurse, or licensed therapist is a Close Relative of the Covered Person;
34. Charges incurred outside the United States if the Covered Person traveled to such a location for the sole purpose of obtaining medical services, drugs or supplies;
35. Charges for physician fees for any treatment, which is not rendered by or in the physical presence of a physician;
36. Charges for experimental procedures, drugs, or research studies or for any services or supplies not considered legal in the United States;
37. Charges for replacement of a lost, missing, or stolen prosthetic device;
38. Treatment of eating disorders; beyond the limits in the Schedule of Benefits subject to the definition of mental illness in (see page 35 #25);

39. Charges incurred as a result of or in connection with diagnosis or treatment of a learning disability or learning impairment by any name called. This exclusion includes, but is not limited to, charges for initial testing; room and board by a Remedial Clinic; remedial education or training, Educational Therapy (including multisensory teaching techniques); periodic achievement tests; tutoring; rental or purchase of books, tools, equipment, implements, or supplies of any kind; travel; recreational activities; beyond the limits in the Schedule of Benefits subject to the definition of mental illness on page 35 #25. Attention deficit disorder will be considered a learning disorder and is not covered except for medications or for medical examinations to measure appropriateness of medications by a licensed physician and the initial office visit to determine diagnosis;
40. For any charges in connection with growth hormone deficiencies, including diagnosis and treatment, unless this condition is incurred by a dependent child who was born while covered under this Plan and has remained continuously covered under this Plan before diagnosis;
41. For any procedures that have not been formally approved by the Federal Food and Drug Administration and/or the American Medical Association, and are experimental or for research purposes, or for procedures that require an Informed Consent Form;
42. Drugs labeled "Caution--limited by a federal law to investigational use" or experimental drugs even though a charge is made to the covered Individual; drugs that have no FDA-approved indications for use; FDA-approved drugs or dosage regimens used for indications or routes of administration outside of FDA approval;
43. Solid Organ Transplants or any associated costs or procedures. This exclusion **does not** apply to stem cell transplants for the treatment of breast cancer, high dose chemotherapy or bone marrow transplants. Donor charges for the non-excluded procedures listed above will be considered eligible, if the donor is a covered participant under this plan and if the hospital and physician customarily charge a transplant recipient for such care and services;
44. Charges or expenses incurred for massage therapy or acupuncture;
45. For any elective surgery that is not medically necessary;
46. For any services or charges made in connection with a mental and nervous condition, substance abuse or alcoholism; beyond the limits in the Schedule of Benefits subject to the definition of mental illness (see page 35 #25);
47. Weight loss programs beyond the limits in the Schedule of Benefits (see page 37 #25);
48. Sleep disorders unless there is medical diagnosis. If there is not a sleep apnea or other eligible medical diagnosis after the testing, only the office visit and the testing for diagnosis on an outpatient basis will be considered eligible expense.
49. For wigs, unless hair loss is due to radiation or chemotherapy with a diagnosis of cancer;
50. Breast prosthesis, breast implants, tramflap surgery or bras unless a medically necessary mastectomy was performed. No more than two (2) bra replacements per year;
51. Allergies or the treatment of allergies in excess of \$1000.00 annually;
52. Charges resulting for any pregnancy or the resulting childbirth for a dependent child;
53. Adult immunizations at a P.P.O. provider or Non-P.P.O. provider and Immunizations for children that are not administered at a P.P.O. provider;
54. For well baby care or charges for a newborn child care beyond the limits in the Schedule of Benefits. (See Annual Health Screening Benefit/ Well Care - page 6, #10-F, and In-Patient Hospital Expense page 5, #5), Tests for a newborn that are required in the State of Texas at the time of birth for newborn children will be eligible subject to the plan provisions;
55. For the cost of any appliance, device or implant related to a Hysteroscopic sterilization;
56. Routine circumcision.

## ARTICLE V.

### COORDINATION OF BENEFITS/SUBROGATION

#### A. COORDINATION OF BENEFITS

All of the Benefits provided under the Plan are subject to these provisions, with the exception of outpatient prescription drugs. **No coordination of benefits will be allowed for outpatient prescription drugs provided through a prescription drug card or submitted during your first 18 months of coverage under this plan for reimbursement.**

##### 1. Applicability

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

##### 2. Definitions

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

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

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

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

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

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

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

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

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

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

- a. **General.** When there is a basis for a claim under This Plan and another Plan, This Plan is a Secondary Plan, which has, its benefits determined after those of the other Plan, unless:

- (i) The other Plan has rules coordinating its benefits with those of this Plan; and
- (ii) Both those rules and This Plan's rules, subparagraph b) below, require that This Plan's benefits be determined before those of the other Plan.

- b. **Rules.** This Plan determines its order of benefits using the first of the following rules which applies:

- (i) **Non-dependent/Dependent** The benefits of the Plan which covers the person as an Employee, member or subscriber (that is, other than as a Dependent) are determined before those of the Plan which covers the person as a Dependent.
- (ii) **Dependent Child/Parents Not Separated or Divorced** Except as stated in subparagraph b) (iii) below, when This Plan and another Plan cover the same child as a Dependent of different persons, called "parents":
  - (a) The benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in that year; but
  - (b) If both parents have the same birthday, the benefits of the Plan, which covered the parent longer, are determined before those of the Plan, which covered the other parent for a shorter period of time.
- (iii) **Dependent Child/Separated or Divorced Parents** If two or more Plans cover a person as a Dependent child of divorced or separated parents, benefits for the child are determined in this order:
  - (a) First, the Plan of the parent with custody of the child;
  - (b) Then, the Plan of the spouse of the parent with custody of the child; and
  - (c) Finally, the Plan of the parent not having custody of the child.

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

- (iv) **Active/Inactive Employee** The benefits of a Plan, which covers a person as an Employee who is neither laid off nor retired (or as that Employee's Dependent) are determined before those of a Plan, which covers that person as a laid off or retired Employee (or as that Employee's Dependent).

If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule (iv) is ignored.

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

#### 4. **Effect on Benefits**

- a. **When This Section Applies.** Number 4. applies when, in accordance with Number 3 (page 40), "Order of Benefit Determination Rules", this Plan is a Secondary Plan as to one or more other Plans. In that event the benefits of This Plan may be reduced under this section. Such other Plan or Plans are referred to as "the other Plans" in b) immediately below.
- b. **Reduction in This Plan's Benefits.** The benefits of This Plan will be reduced when the sum of:
  - (i) The benefits that would be payable for the Allowable Expenses under this Plan in the absence of this COB provision; and
  - (ii) The benefits that would be payable for the Allowable Expenses under the other Plans, in the absence of a provision with a purpose like that of this COB provision, whether or not claim is made;
- c. **Medicare Coordination of Benefits**
  - (i) If you are age 65 or over and a full time employee of Montgomery County, this Plan will be the primary payer. If your dependent spouse is 65 or over and covered under your Plan while you are a full time employee, this Plan will be the primary payer; and
  - (ii) For all other Covered Persons, the benefits payable by the Plan for Eligible Expenses will be reduced by the amount for which such persons are eligible for comparable benefits under Full Medicare Coverage. This Plan will assume that any person age 65 and over will have full Medicare coverage (Part A and Part B and any other optional coverage offered by Medicare). The benefits of this Plan would be reduced after both Part A and Part B of Medicare has paid. In the event you have not chosen the optional coverage offered by Medicare, this Plan would still assume and pay eligible benefits as if full Medicare coverage had already been applied.

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

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

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

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

#### 6. **Facility of Payment**

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

7. **Right of Recovery**

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

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

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

8. **Exception**

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

**B. SUBROGATION AND REIMBURSEMENT**

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

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

arising under state, federal, or local law;

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

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

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

under worker's compensation laws or regulations or pursuant to any group accident and health insurance policy or any pre-paid health or accident benefit plan; and

or from any source whatsoever.

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

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

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

## ARTICLE VI.

### MISCELLANEOUS PROVISIONS

#### HOW TO FILE A CLAIM

The covered employee should submit a completed claim form directly to Boon-Chapman, Inc. A copy of all material submitted should be maintained by the covered employee.

1. Send in expense or expenses as soon as possible. We do suggest holding small expenses until a minimum of \$50 is accumulated.
2. Attach all expenses to a fully completed Claim Form. These statements should be "itemized", that is, they should at least show the minimum information:
  - a. Name of the provider of service;
  - b. The date and type of service;
  - c. Diagnosis;
  - d. The cost of service; and
  - e. The name of the person who received the service.
3. Complete the "other insurance" portion of the claim form. Failure to do this can result in a delay in processing the claim.
4. Claim forms and itemized statement of expenses should be forwarded by the Employee directly to:

**Boon-Chapman Benefit Administrators, Inc.**  
**Attn: Claims Department / Montgomery County**  
**P. O. Box 9201**  
**Austin, Texas 78766**  
**1-800-252-9653**  
[www.boonchapman.com](http://www.boonchapman.com)

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

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

#### **A. CHOICE OF PHYSICIANS**

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

#### **B. PAYMENT OF BENEFITS**

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

#### **C. NOTICE OF CLAIM**

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

**D. CLAIM FORMS**

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

**E. PROOF OF LOSS**

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

**F. TIME OF PAYMENT OF CLAIM**

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

**G. PHYSICAL EXAMINATIONS**

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

**H. LEGAL ACTIONS**

No actions at law or in equity shall be brought to recover on the Plan prior to the expiration of sixty (60) days after proof of loss has been filed in accordance with the requirements of the Plan, nor shall such action be brought at all unless brought within two (2) years from the expiration of the time within which proof of loss is required by the Plan.

**I. THIRD PARTY LIABILITY**

If a Covered Person has medical charges:

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

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

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

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

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

**J. LEAVE OF ABSENCE**

Leave of Absence means the employee has obtained an approved leave of absence from the employer as provided for in the employer's rules, policies, procedures, and/or practices. This Plan will follow the employer's rules, policies, procedures and or practices. An approved leave of absence will be no longer than six (6) continuous months.

**K. ASSIGNMENT OF BENEFITS**

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

**L. P.P.O. PHYSICIAN REFERRALS**

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

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

The calendar year deductible amount of \$500.00 (non P.P.O.) or \$250.00 (P.P.O.), considered the LOW DEDUCTIBLE PLAN or \$2000.00 (non P.P.O.) or \$1000.00 (P.P.O.) considered the HIGH DEDUCTIBLE PLAN will be deducted from the covered expenses before benefits are computed, unless the "SCHEDULE OF BENEFITS" indicates otherwise. In the event a plan participant is hospital confined on December 31, satisfaction of a deductible for the following year shall not be applied until after the date of discharge.

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

1. When two or more covered family members are injured in the same accident, only one Deductible will be applied in any calendar year to the expenses directly resulting from injuries sustained in that accident;
2. Covered Medical Expenses incurred by any plan participant in the last three months of any calendar year, and applied to satisfy the Deductible for that calendar year, may also be used toward satisfaction of the deductible in the next calendar year, if no other claims had been incurred and paid previously in the year;
3. **HIGH DEDUCTIBLE PLAN ONLY** - When three covered family members satisfy their individual Deductibles, the Deductible will be considered satisfied for all covered family members. Satisfaction of the family deductible is based on the date expenses are incurred. The family deductible also applies when both spouses are Montgomery County employees and covered by this Plan;
4. The Plan reserves the right to allocate the Deductible to any Covered Medical Expenses and to apportion the benefits to the covered person and any assignees.

**N. EMPLOYEE HOSPITAL AUDIT PROGRAM**

Any employee who participates in the Plan will be eligible for this benefit. You will be paid 50% of any amount that you can identify as an error on your hospital bill up to a maximum payment of \$1,000.00 per year AFTER THE CONTRACT CLAIM ADMINISTRATOR HAS MADE PAYMENT ON BEHALF OF THE PLAN.

**O. PLAN RIGHTS**

In addition to other rights of the plan, this plan has the right to increase, decrease or modify any benefit in this document when it is in the best interest of the plan to avoid unnecessary hospitalizations. In no event will any modification exceed the lifetime annual maximum benefit of the plan.

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

1. Montgomery County, Texas will offer continued health benefits subject to the provisions of Chapter 175 of the Local Government Code. A retiring employee (“retiree”), who meets the eligibility requirements, as defined by Montgomery County Commissioners Court and their currently covered eligible dependents will be eligible for the then current benefits, but not greater benefits than the retiree would receive during employment. The retiree shall not be eligible for the health benefits if the retiree is eligible for group health benefits through another employer. Upon the retiree’s death, dependent medical benefits will cease, surviving dependents will be eligible for C.O. B.R.A. up to 36 months.
2. Dependent eligibility is based on the retired employee. If the Retired Employee does not choose retiree coverage, dependent coverage will not be available. If the retiree elects retiree coverage and also elects dependent coverage, those eligible dependents must be covered under the plan prior to the employees’ retirement, to be considered eligible.
3. The retiree must satisfy the eligibility for retirement requirements under the Texas County and District Retirement System and any additional requirements, as adopted by Montgomery County Commissioners Court, to be eligible for this benefit.
4. When the retiree or their eligible dependent becomes eligible for Federal Medicare Benefits, Montgomery County may substitute this Plan for another plan as authorized by law.
5. Written notification will be given to the Montgomery County Risk Management Department on or before the last day of employment. Late notification will result in ineligibility. All other plan provisions and requirements will apply. Should the retiree elect to discontinue coverage under this Plan, the retiree and/or dependent may not re-enroll. Should the retiree elect to discontinue coverage on a dependent, that dependent will no longer be eligible for coverage and will not be eligible to reenroll in this plan. Retirees covered under this plan may only enroll dependents that are covered under the plan at the time of retirement. No new dependents will be eligible for coverage once the retiree is receiving retiree benefits
6. The amount of contributions, if any, for this Health Benefits Plan by the retiree, for coverage’s selected by the retiree, will be adjusted, as necessary, by Montgomery County Commissioners Court.
7. Full payments of the required contributions are due monthly, payable on the first day of the month. Any payments not received by the 10th day of the month in which due may result in termination of benefits. No partial payments are accepted and no reinstatement in this Health Benefit Plan will be allowed.
8. Retiree benefits under this Employee Benefits Plan will be coordinated with Medicare and it will be assumed that the Retiree or eligible dependent has chosen Medicare and all its options when they attain the age of 65. Benefits from this plan will pay as if the retiree or eligible dependent had enrolled in Parts A & B of Medicare in the event that the retiree does not choose to enroll in Parts A & B of Medicare.
9. Retirees who are married to a County employee when they retire who have coverage under this plan, will be allowed to add to their coverage the remaining spouse/employee when the remaining spouse/employee leaves the employment of Montgomery County as long as there is no lapse in coverage and as long as the spouse/employee was covered under the plan for at least 24 continuous months prior to separation of employment with Montgomery County.
10. Montgomery County currently offers County Paid / Subsidized for employees who can meet additional requirements at the time of retirement. Employees who are eligible to retire, choose to retire and who also have fifteen (15) years of continuous fulltime employment and fifteen (15) years of continuous health coverage under the County’s medical plan immediately prior to retirement may be eligible for County Paid / Subsidized Retiree Health Benefits. Please call the Risk Management Department for a complete copy of “Qualifications for County Paid / Subsidized Health Benefits” as approved in Commissioners Court on 2/25/2008. Montgomery County, Texas reserves the right, at any time to change, delete or add to any benefit or policies which have previously been adopted by Montgomery County Commissioners Court.