



McLennan County

Employee Benefit Plan

Summary Plan Description

Administered by:
Scott and White Health Plan

October 1, 2016

INTRODUCTION

This McLennan County Employee Benefit Plan Booklet (also referred to as the Summary Plan Description or SPD) is issued to describe, in general, the Medical Benefits of the County's self-funded employee health plan. This Booklet also describes the Plan's Prescription Drug (Pharmacy) Benefits. The services listed in this Booklet as being eligible for payment are referred to as Covered Services.

The Plan of benefits described in this Booklet is effective as of October 1, 2016. This Booklet has been updated to comply with federal requirements including applicable provisions of the recently enacted federal health care reform laws. The Plan is not considered a "Grandfathered Plan" as defined under the Affordable Care Act. As the Plan Administrator receives additional guidance and clarification on the new health reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Services, the Plan Administrator or the Contract Administrator on behalf of the Plan Administrator may be required to make additional changes to the Summary Plan Description. See for the pages immediately following for additional SPECIAL NOTICES.

In addition, this booklet's general information is not intended to be an exhaustive or all-inclusive description of services, which are covered, limited or excluded. It is only a simplified summary, and is subject to changes in the governing law and regulations. PLEASE CONTACT HUMAN RESOURCES FOR A COPY OF THE MOST CURRENT SUMMARY PLAN DESCRIPTION.

The benefits under McLennan County Benefit Plan are self-insured. These benefits are made available to you based upon your eligibility as defined by the Plan. McLennan County expects you to use your Benefit Plan to its full extent, in a prudent manner, when you or one of your covered dependents is ill or injured. McLennan County is the Administrator of this self-funded benefit program and provides a major portion of the contributions necessary to properly fund these programs in order to make these benefits available to you.

This Plan is not a contract. The plan shall not be deemed to constitute a contract between McLennan County and any Employee or to be a consideration for, or an inducement or condition of, the employment of any Employee. Nothing in the Plan shall be deemed to give any Employee the right to be retained in the service of McLennan County or to interfere with the right of McLennan County to discharge any Employee at any time.

We recommend that you contact the Contract Administrator to verify that your Plan will cover the Medical expenses necessary to treat your illness or injury PRIOR to starting any suggested plan of Medical treatment.

Your Plan Administrator is McLennan County. They may be contacted at:
Human Resources Department
214 N. 4th Street, Suite 200
Waco, Texas 76701
(254)757-5158

Your Contract Administrator is Scott and White Health Plan (hereinafter Scott & White). They may be contacted at:

Scott and White Health Plan
Attn: Claims
P.O. Box 21800
Eagan, MN 55121-0800
800-321-7947

SPECIAL NOTICES

GENERAL HEALTH CARE REFORM NOTICE

This Booklet has been updated to comply with federal requirements including applicable provisions of the recently enacted federal health care reform laws. As the Plan Administrator receives additional guidance and clarification on the new health reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Services, the Plan Administrator or the Contract Administrator on behalf of the Plan Administrator may be required to make additional changes to the Summary Plan Description. Please contact Human Resources for a copy of the most current Summary Plan Description.

NOTICE OF PATIENT PROTECTION RIGHTS

The Plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Contract Administrator.

For children, you may designate a pediatrician, who participates in our network, as the primary care provider.

You do not need prior authorization from the Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Contract Administrator.

NOTICE CONCERNING RIGHTS UNDER THE WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 (WHCRA)

Group health plans and issuers are required to provide Coverage for the following services in connection with a mastectomy that has been performed and that is covered under the Plan:

- 1)** All stages of reconstruction of the breast on which the mastectomy was performed;
- 2)** Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- 3)** Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes).

The Plan is required to notify the Covered Person of his or her WHCRA rights each year.

NOTICE CONCERNING RIGHTS UNDER THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996

Group health plans and issuers generally may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the group health plan or issuer may pay for a shorter stay if the attending Health Care Provider (e.g. your Physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48 or 96-hour stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a group health plan or issuer may not, under federal law, require a Physician or other Health Care Provider to obtain authorization for prescribing a length of stay of up to 48 or 96-hours.

UNIFORMED SERVICES EMPLOYMENT AND RE-EMPLOYMENT RIGHTS ACT OF 1994 (USERRA)

The Uniformed Services Employment and Re-employment Rights Act of 1994 (USERRA) sets requirements for continuation of health coverage and re-employment in regard to a Covered Employee's military leave of absence. These requirements apply to medical and dental coverage for the Employee and his or her Dependents.

For leaves of less than 31 days, coverage will continue for the duration of such leave. For leaves of 31 days or more, the Employee may continue Employee and Dependent coverage by paying the required contribution to the Employer, until the earliest of the following: 24 months from the last day of employment with the Employer; the day after the Employee fails to return to work; or the date the Plan is canceled. The Employer may charge the Employee and his or her Dependents up to 102% of the total coverage cost.

If coverage ends during the leave of absence because the Employee does not elect USERRA and the Employee is reemployed by the Employer, coverage for the Employee and his or her Dependents may be reinstated if: (a) the Employee gave the Employer advance written or verbal notice of his or her military service leave; and (b) the duration of all military leaves while the Employee is employed with the Employer does not exceed 5 years. The Employee and his or her Dependents will be subject to only the balance of any waiting period that was not yet satisfied before the leave began. If coverage under this Plan terminates as a result of the Employee's eligibility for military medical and dental coverage and the Employee's order to active duty is canceled before active duty service commences, these reinstatement rights will apply.

FAMILY AND MEDICAL LEAVE ACT

The Plan shall at all times comply with the Family and Medical Leave Act of 1993 as promulgated in regulations issued by the Department of Labor.

During any leave taken under the Family and Medical Leave Act, the Employer will maintain coverage under the Plan on the same conditions as coverage would have been provided if the Covered Employee had been continuously employed during the entire leave period.

If Plan coverage terminates during the FMLA leave, coverage will be reinstated for the Employee and his or her covered Dependents if the Employee returns to work in accordance with the terms of the FMLA leave. Coverage will be reinstated only if the person(s) had coverage under the Plan when the FMLA leave started, and will be reinstated to the same extent that it was in force when that coverage terminated. For example, Waiting Periods will not be imposed unless they were in effect for the Employee and/or his or her Dependents when Plan coverage terminated.

NOTICE CONCERNING NON-DISCRIMINATION

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

McLennan County:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact the McLennan County Human Resources Department

If you believe that McLennan County has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Human Resources Director, 214 N 4th Street, Suite 200, Waco, Texas 76701-1366, Phone: 254-757-5158, Fax: 254-757-5073 or via email Human.Resources@co.mclennan.tx.us . You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Human Resources Director is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services

200 Independence Avenue, SW

Room 509F, HHH Building

Washington, D.C. 20201

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

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

Effective date of the Plan: **October 1, 2016**

For Plan Sponsor:

Scott Felton, County Judge
McLennan County

Signature

Date

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McLennan County Employee Health Plan Schedule of Benefits 2016- 2017

Effective October 1, 2016	Plan 1 Base Plan	Plan 2 Consumer Driven Health Plan
Calendar Year Deductible (Deductible applies to Out-of-Pocket Maximum and resets to Zero each January 1st)	\$1,000 Individual	\$3,500 Individual
	\$2,000 Family	\$7,000 Family (Embedded)
Calendar Year Out-of-Pocket Maximum (Medical and Prescription Drug Deductibles, Copayments, and Coinsurance amounts apply toward Out-of-Pocket Maximum)	\$4,500 Individual	\$3,500 Individual
	\$9,000 Family	\$7,000 Family (Embedded)
Outpatient Services		
Primary Care Office Visit	\$30 Copay	\$0 Copay after deductible
Specialty Care Office Visit	\$50 Copay	\$0 Copay after deductible
Preventive Services (including lab and x-ray)	No Charge	No Charge
Standard Lab and X-Ray (Routine Office Visit)	No Charge	0% after deductible
Diagnostic/Radiology (Limited to: angiograms, CT scans, MRIs, PET scans, myelography, stress tests, ultrasound)	20% After Deductible	0% after deductible
Outpatient Surgery	20% After Deductible	0% after deductible
Allergy Serum	20 % After Deductible	0% after deductible
Immunizations (Age & Gender Appropriate)	No Charge	No Charge
Eye Exam (1 refraction annually)	\$30 Copay	0% after deductible
Maternity (Pre- and Post- Natal Care)	No Charge	No Charge
Other Outpatient Services (Including other services, treatments, or procedures received at time of visit)	20% after deductible	0% after deductible
Outpatient Specialty Drugs		
	No Calendar Year Deductible	Calendar Year Deductible Applies
Level 1	10% Copay	0% after deductible
Level 2 (Preferred)	20% Copay	0% after deductible
Level 3 (Premium Preferred)	30% Copay	0% after deductible
Level 4 (Non-Preferred)	50% of charges	0% after deductible

Effective October 1, 2016	Plan 1 Base Plan	Plan 2 Consumer Driven Health Plan
Inpatient Services		
Hospital Room, Semi-private	20 % After Deductible	0% after deductible
Intensive Care Unit	20 % After Deductible	0% after deductible
Other Hospital Services	20 % After Deductible	0% after deductible
Skilled Nursing Facility (requires pre-authorization)	20% After Deductible	0% after deductible
Therapeutic Services		
Speech & Hearing (20 Visit Limit)	\$30 Copay	\$0 Copay after deductible
Physical Therapy (20 Visit Limit)	\$30 Copay	\$0 Copay after deductible
Durable Medical Equipment		
Durable Medical Equipment (includes blood glucose meters, continuous glucose monitoring systems, as applicable)	50% After Deductible	\$0 after deductible
Diabetic Self-Management Training		
Education/Nutrition Counseling (for SWHP ONLINE Self-Management tools –no charge; deductible does not apply)	\$30 Copay	\$0 Copay after deductible
Outpatient - Behavioral Health/Chemical Abuse Services		
Behavioral Health	\$30 Copay	\$0 Copay after deductible
Alcohol and Drug Dependency	\$30 Copay	\$0 Copay after deductible
Inpatient - Behavioral Health/Chemical Abuse Services		
Mental Illness, Serious Mental Illness, Treatment of Chemical Dependency	20% After Deductible	0% after deductible
Alcohol and Drug Dependency	20% After Deductible	0% after deductible
Home Infusion Therapy		
Home Infusion Therapy (requires pre-authorization)	20% After Deductible	0% after deductible
Home Health Services		
Home Health (requires pre-authorization)	\$30 Copay	\$0 Copay after deductible
Hospice (requires pre-authorization)	No Charge	0% after deductible

Effective October 1, 2016	Plan 1 Base Plan	Plan 2 Consumer Driven Health Plan
Emergency Care Services		
Emergency Room: in-network / out-of-network-subject to balance billing	20% After Deductible	0% after deductible
Urgent Care: in-network / out-of-network-subject to balance billing	\$50 Copay	0% after deductible
Ambulance	20% After Deductible	0% after deductible
Prescription Drug (Rx) Coverage (Can use any in-network Rx provider)		
Annual Benefit Maximum	Unlimited	Unlimited
Annual Deductible	None	Included with medical deductible
		<i>Note: Copays only apply to preventive drugs as appropriate (deductible does not apply). All non-preventive drugs are subject to the deductible.</i>
Retail Quantity (Up to a 30-day supply)		
Generic	\$10 Copay	\$10 Copay
Preferred Brand	\$30 Copay	\$30 Copay
Non-Preferred	Lesser of \$55 or 50%	Lesser of \$55 or 50%
Non-Formulary	Greater of \$55 or 50%	Greater of \$55 or 50%
Maintenance Quantity (Up to a 90-day supply) Maintenance quantities must be obtained from a Scott & White Health Plan pharmacy or Wal-Mart Mail Order)		
Generic	\$20 Copay	\$20 Copay
Preferred Brand	\$60 Copay	\$60 Copay
Non-Preferred	Lesser or \$110 or 50%	Lesser or \$110 or 50%
Non-Formulary	N/A	N/A
Diabetic Supplies (Unlimited Benefit)		
Preferred Diabetic Supplies: test strips, lancets, lancet device, control solution	Tier 1 - \$10 Copay as appropriate	Tier 1 - \$10 Copay as appropriate
Non-Preferred Diabetic Supplies: test strips, lancets, lancet device, control solution	Tier 2- \$30 Copay as appropriate	Tier 2- \$30 Copay as appropriate
Diabetic Syringes and Needles	Tier 1 - \$10 Copay as appropriate	Tier 1 - \$10 Copay as appropriate
<p>Certain exclusions may apply. This is not intended to be an all-inclusive description of the health plan. For more information, please refer to the provisions of the Summary Plan Description.</p> <p>BENEFITS ARE PROVIDED ONLY FOR IN NETWORK PROVIDERS, EXCEPT FOR CERTAIN SITUATIONS INVOLVING EMERGENCY CARE. ACCESSING OUT OF NETWORK PROVIDERS IN NON-EMERGENCY SITUATIONS WITHOUT PRIOR APPROVAL WILL RESULT IN NO BENEFIT PAYMENTS AND THE MEMBERS WILL BEAR FULL FINANCIAL RESPONSIBILITY FOR ALL COSTS INCURRED.</p> <p style="text-align: center;">To view a complete list of providers and other plan details, go to https://mclennan.swhp.org/. Customer Service 800-299-8640.</p> <p style="text-align: center;"><i>McLennan County complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.</i></p>		

I. DEFINITIONS

ALLOWABLE AMOUNT

For Network Providers, the amounts such providers have agreed to accept from the Plan for Covered Expenses. The Allowable Amount is based upon a percentage of the amount that would be paid under Medicare for a given service. The Allowed Amount schedule is available at mclennan.swhp.org.

AMBULATORY SURGICAL CENTER

An institution or facility, either free-standing or as a part of a Hospital with permanent facilities, equipped and operated for the primary purpose of performing surgical procedures and to which a patient is admitted to and discharged from within a twenty-four (24) hour period. An office maintained by a Physician for the practice of medicine or dentistry, or for the primary purpose of performing terminations of Pregnancy, shall not be considered to be an Ambulatory Surgical Center.

BENEFIT MAXIMUMS

Total Plan payments for each Covered Person are limited to certain maximum benefit amounts. A benefit maximum can apply to specific benefit categories of benefits. A benefit maximum amount also applies to a specific time period, such as annual. The benefit maximums applicable to this Plan are shown in the Schedule of Benefits for the Base Plan and CDHP options, respectively.

CALENDAR YEAR

The 12-month consecutive period beginning on January 1st and ending on December 31st of each year.

COMPANY

The Company is McLennan County, Texas.

CONTRACT ADMINISTRATOR

Scott and White Health Plan is the Contract Administrator. The Contract Administrator is responsible for the day to day functions and management of the Plan and shall act as agent for service of legal process for the Plan. The Contract Administrator is not a Named Fiduciary of the Plan.

COVERED PERSON

Any Eligible Employee or Eligible Dependent, who has satisfied the Waiting Period, who has elected coverage under the Plan and who has made the required contribution for coverage, if any, under the Base Plan or CDHP. A Covered Person may also be referred to as a Covered Spouse, Covered Dependent, Covered Retiree, or similar description.

COSMETIC PROCEDURES

Cosmetic Procedures are the alteration of tissue (usually surgical) for the improvement of appearance, but which is not intended to effect a substantial improvement or restoration of bodily function. These procedures are:

- 1) Due to neither injury nor sickness;
- 2) Performed solely to improve the appearance rather than the function or usefulness of a structure of the body.

CREDITABLE COVERAGE

Coverage provided under:

- 1) A self-funded or self-insured employee welfare benefit plan that provides health benefits and that is established in accordance with the Employee Retirement Income Security Act of 1974 (290 U.S.C. Section 1001 et seq.);
- 2) A group Health Benefit Plan provided by a health insurance carrier or health maintenance organization;
- 3) An individual health insurance policy or evidence of coverage;
- 4) Part A or Part B of Title XVIII of the Social Security Act (42 U.S.C. Section 1395c et seq.);

- 5) Part XIX of the Social Security Act (42 U.S.C. Section 1395c et seq.), other than coverage consisting solely of benefits under Section 1928 of that Act (42 U.S.C. Section 1396s et. seq.);
- 6) Chapter 55, Title 10, United States Code (10 U.S.C. Section 1071 et seq.);
- 7) A medical care program of the Indian Health Service or of a tribal organization;
- 8) A state or political subdivision health benefits risk pool;
- 9) A health plan offered under Chapter 89, Title 5, United States Code (5 U.S.C. Section 8901 et seq.)
- 10) A public health plan as defined by federal regulations; or
- 11) A Health Benefit Plan under Section 5(e), Peace Corps Act;
- 12) Short term limited duration insurance.

Creditable Coverage does not include:

- 1) Accident only, disability income insurance, or a combination of accident only and disability income insurance;
- 2) Coverage issued as a supplement to liability insurance;
- 3) Liability insurance, including general liability insurance and automobile liability insurance;
- 4) Workers' compensation or similar insurance;
- 5) Automobile medical payment insurance;
- 6) Credit-only insurance;
- 7) Coverage for onsite medical clinics;
- 8) Other coverage that is:
 - a) Similar to the coverage described by this subsection under which benefits for medical care are secondary or incidental to other insurance benefits; and
 - b) Specified in federal regulations
 - (i) Coverage that provides limited-scope dental or vision benefits;
 - (ii) Long term care coverage or benefits, Nursing home care coverage or benefits, Home Health Care coverage or benefits, community-based care coverage or benefits, or any combination of those coverages or benefits
 - (iii) Coverage that provides other limited benefits specified by federal regulations;
 - (iv) Coverage for a specified disease or illness; or
 - (v) Hospital indemnity or other fixed indemnity insurance; or
 - (vi) Medical supplemental health insurance defined under Section 1882 (g)(1), Social Security Act ((42 U.S.C. Section 1395s), coverage supplemental to the coverage provided under Chapter 55, Title 10, United States Code (10 U.S.C. Section 1071 et seq.), and similar supplemental coverage provided under a group plan.

CUSTODIAL CARE

Care comprised of services and supplies provided primarily to assist in the activities of daily living.

DEDUCTIBLE

The amount of expenses a Covered Person must pay before benefits are payable under the Base Plan and CDHP. The Deductible amount is applied on a Calendar Year basis.

DRUGS

Please See "Prescription Benefits" section for complete information.

DURABLE MEDICAL EQUIPMENT

Durable Medical Equipment shall include equipment which:

- 1) Can withstand repeated use, and
- 2) Is primarily and customarily used to serve a medical purpose, and
- 3) Generally is not useful to a person in the absence of an illness or injury, and
- 4) Is appropriate for use in the home.

All requirements of the definition must be met before an item can be considered to be Durable Medical Equipment.

ELECTIVE SURGICAL PROCEDURE

A non-emergency surgical procedure scheduled at the patient's convenience without jeopardizing the patient's life or causing serious impairment to the patient's bodily function.

ELIGIBLE DEPENDENT

An Eligible Dependent shall mean the lawful spouse or common law spouse (with certificate of common law union) of an Eligible Enrolled Employee. It shall also mean the children of an Eligible Enrolled Employee who are:

- 1) Under age 26, are the natural children, legally adopted children, step children, or children for whom the employee is a legal guardian; or
- 2) Upon reaching the age of 26 and having been covered under this Plan as an Eligible Dependent, are mentally or physically handicapped and are incapable of earning a living, may continue to be covered as an Eligible Dependent. The Plan Sponsor may require the employee to furnish periodic proof of this individual's continued incapacity or dependency, but not more often than annually. If such proof is not satisfactory, and further proof, which is satisfactory, is not provided upon request, coverage for the individual will end immediately.

ELIGIBLE EMPLOYEE and ELIGIBLE ENROLLED EMPLOYEE

An Eligible Employee is any full time employee, including a county officer or county judicial officer who has satisfied the applicable Waiting Period and is eligible to Enroll in the Plan. Full time shall mean a minimum of 30 hours per week on average. An Eligible Employee shall also include retired employees choosing to continue benefits under the Plan at the time of retirement. It shall also include all State District Judges of judicial districts covering only McLennan County. An **ELIGIBLE ENROLLED EMPLOYEE is an Eligible Employee who has Enrolled in the Plan.**

EMERGENCY CARE

Emergency Care means health care services provided in a Hospital emergency facility or comparable facility to evaluate and stabilize medical conditions of a recent onset and severity, including but not limited to severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that the person's condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in:

- 1) Placing the patient's health in serious jeopardy;
- 2) Serious impairment to bodily functions;
- 3) Serious dysfunction of any bodily organ or part;
- 4) Serious disfigurement; or
- 5) In the case of a pregnant woman, serious jeopardy to the health of the fetus.

EMPLOYER

The Employer is McLennan County.

ENROLL or ENROLLMENT

Enrollment is the election by an Eligible Employee or Eligible Dependent for coverage under the Plan. Refer to the Section entitled Enrollment and Individual Effective Date for details concerning the Plan's enrollment requirements and when coverage becomes effective. A Timely Enrollee is an individual who enrolls in the Plan within the time period allotted by the Plan for enrolling for Coverage as an Eligible Employee or Eligible Dependent. Late Enrollee, as defined by HIPAA, is an individual who enrolls in the Plan after the first available enrollment period, not including an individual who is enrolling during a HIPAA Special Enrollment Period. The enrollment provisions of the Plan are explained in detail in the section entitled "Enrollment and Effective Date."

EXPERIMENTAL OR INVESTIGATIONAL DRUG, DEVICE, TREATMENT OR PROCEDURE:

- 1) A drug or device which cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and which has not been so approved for marketing at the time the drug or device is furnished; or
- 2) A drug, device, treatment or procedure which was reviewed and approved (or which is required by federal law to be reviewed and approved) by the treating facility's Institutional Review Board or other body serving a similar function, or a drug, device, treatment or procedure which is used with a patient informed consent document which was reviewed and approved (or which is required by federal law to be reviewed and approved) by the treating facility's Institutional Review Board or other body serving a similar function; or
- 3) A drug, device, treatment or procedure which Reliable Evidence shows is the subject of on-going phase I, II or III clinical trials or is under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or
- 4) A drug, device, treatment or procedure for which the prevailing opinion among experts, as shown by Reliable Evidence, is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy as compared with a standard means of treatment or diagnosis.

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

EXTENDED CARE FACILITY

The term "Extended Care Facility" means an institution (or a distinct part of an institution) which:

- 1) Provides for inpatients 24 hours nursing care and related services for patients who require medical or nursing care, or service for the rehabilitation of injured or sick persons; and
- 2) Has policies developed with the advice of (and subject to review by) professional personnel to cover nursing care and related services; and
- 3) Has a physician, a registered professional nurse, or a medical staff responsible for the execution of such policies; and
- 4) Requires that every patient be under the care of a physician, and makes a physician available to furnish medical care in case of emergency; and
- 5) Maintains clinical records on all patients, and has appropriate methods for dispensing drugs and biologicals; and
- 6) Has at least one registered professional nurse on duty at all times; and
- 7) Provides for periodic review by a group of physicians to examine the need for admissions, adequacy of care, duration of stay, and medical necessity of continuing confinement of patients; and
- 8) Is licensed pursuant to law, or is approved by appropriate authority as qualifying for licensing.

However, such term does not include a place, which is primarily for Custodial Care.

FISCAL YEAR

The 12-month consecutive period ending on the last day in the month of September.

FREE STANDING FACILITY/SURGICAL AMBULATORY FACILITY

Stand-alone outpatient facility. Operates exclusively to patients not requiring hospitalization.

HEALTH CARE PROVIDER

A Health Care Provider is legally licensed in the USA and provides medical care or diagnostic treatment to individuals for a covered illness or injury. The requirement that the Health Care Provider be legally licensed in the USA will be waived when treatment is provided to a Covered Person by a Health Care Provider licensed in the country where services are provided, in an emergency while traveling outside the United States. Examples, though not an exhaustive list, of Health Care Providers are as follows:

- 1) Ambulatory Surgical Center
- 2) Extended Care Facility
- 3) Home Health Agency
- 4) Hospice
- 5) Hospital
- 6) Laboratory
- 7) Nurse
- 8) Nurse Practitioner
- 9) Midwife
- 10) Physician
- 11) Psychologist
- 12) Therapist
- 13) Master of Social Work
- 14) Licensed Clinical Social Worker

HOME HEALTH AGENCY

A Home Health Agency means a public or private agency which:

- 1) Is certified as a Home Health Agency under Medicare or is licensed as a Home Health Agency by the state; and
- 2) Is primarily engaged in providing skilled nursing and other therapeutic services; and
- 3) Has its policies set by a professional group which governs the services provided; and
- 4) Maintains records for each patient.

HOME HEALTH CARE SERVICES

Covered Services, that are provided in the home according to a treatment plan by a certified home health care agency under active physician and nursing management. Registered nurses must coordinate the services on behalf of the home health care agency and the patient's physician.

HOSPICE

Hospice means a public or private entity, which is licensed or certified as a Hospice by Medicare and by the State. The care provided by a Hospice means the palliative, supportive and related care for the person diagnosed as terminally ill with a medical prognosis of a life expectancy of six (6) months or less; but only where the Hospice:

- 1) Provides this care on a 24-hour basis to include providing control of symptoms associated with the terminal illness; and
- 2) Has an interdisciplinary team consisting of at least one (1) Medical Doctor (M.D.) or Doctor of Osteopathy (D.O.); at least one (1) Registered Nurse (R.N.); at least one (1) volunteer and a volunteer program; and
- 3) Maintains central clinical records on all patients; and
- 4) Provides appropriate methods of dispensing and administering drugs and medicines; and
- 5) is not an organization or part thereof which is primarily engaged in providing custodial care; care for drug addicts and alcoholics; domestic services; or is a place for rest; a place for the aged; a hotel or similar institution.

HOME INFUSION THERAPY

The administration of fluids, nutrition, or medication (including all additives and chemotherapy) by intravenous or gastrointestinal (enteral) infusion or by intravenous injection in the home setting. Home Infusion Therapy shall include:

- 1) Drugs and IV solutions;
- 2) Pharmacy compounding and dispensing services;
- 3) All equipment and ancillary supplies necessitated by the defined therapy;
- 4) Delivery services;
- 5) Patient and family education; and
- 6) Nursing services.

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

HOME INFUSION THERAPY PROVIDER

An entity that is duly licensed by the appropriate state agency to provide Home Infusion Therapy.

HOSPITAL

An institution for care of the sick or injured, which is properly licensed to operate as such, and which has licensed graduate registered nurses on duty 24 hours a day, a "physician" on call at all times, and facilities for diagnosis of illness and related equipment for performing surgery. The requirement of surgical facilities shall not apply to a treatment center, which is duly licensed for, and specialized in, the care and treatment of those who are ill. In no event will the term Hospital include an institution which:

- 1) Furnishes primarily domiciliary or custodial care; or
- 2) Furnishes training in the routines of daily living; or
- 3) Is operated primarily as a school.

For the treatment of chemical dependency, the term Hospital shall also include a Chemical Dependency Treatment Center. The term Chemical Dependency Treatment Center means a facility which provides a program for the treatment of alcohol and other chemical dependence pursuant to a written treatment plan approved and monitored by a physician and which facility is also:

- 1) Affiliated with a Hospital under the contractual agreement with an established system for patient referral, or
- 2) Accredited as such a facility by the Joint Commission on Accreditation of Hospitals, or
- 3) Licensed as an Chemical Treatment Program by the Texas Commission on Alcohol and Drug Abuse (TCADA), or
- 4) Licensed, Certified, or Approved as a Chemical Dependency Treatment Program or Center by any other State Agency having legal authority to so license, certify or approve.

HOSPITAL CONFINEMENT

A stay in a Hospital is considered a Hospital Confinement when a Covered Person is admitted as an inpatient, and is charged room and board for at least one full day.

INCURRED EXPENSES

An expense is deemed to be incurred on the date a service is rendered or a supply is furnished.

INJURY

Injury means an accidental bodily injury, which requires treatment by a physician. It must result in loss independently of sickness and other causes.

IN-NETWORK

In-Network shall mean treatment or services provided by Network Health Care Providers.

LABORATORY

A Laboratory means a public or private entity which is equipped for scientific experimentation, research, testing, or clinical studies of materials, fluids, or tissues obtained from patients and is properly approved or licensed as such by an agency of the governing jurisdiction.

LEAVE OF ABSENCE

A period of time during which the employee does not work but which is of stated duration; after which time, the employee is expected to return to regular, active, full time employment. Refer to the McLennan County Employee Policy Guide for additional information regarding the duration of leaves of absence.

MEDICAL CASE MANAGEMENT PROGRAM

Medical Case Management Program shall mean a program, which provides for a nurse case manager to coordinate the medical services required by a Covered Person in the event such Covered Person suffers a serious Sickness or Injury which involves ongoing care or Hospital Confinement. The nurse case manager shall explore with the Covered Person (includes the Covered Employee's family) and the treating Physician, the availability and feasibility of possible alternative treatment plans.

MEDICALLY NECESSARY

Medically Necessary shall mean services, treatment, supplies or drugs ordered or authorized by a Physician and which is determined by the Contract Administrator to be:

- 1) Provided for the diagnosis or direct treatment of an injury or sickness;
- 2) Appropriate and consistent with the symptoms and findings or diagnosis and treatment of the Covered Person's injury or sickness;
- 3) Provided in accordance with generally accepted medical practice on a national basis; and
- 4) The most appropriate supply or level of service, which can be provided on a cost effective basis (including, but not limited to, inpatient versus outpatient care, electric versus manual wheelchair, surgical versus medical or other types of care).

The fact that the Covered Person's physician prescribes services or supplies does not automatically mean such services or supplies is medically necessary and **covered by the Plan**.

MEDICALLY APPROPRIATE

Medically Appropriate shall mean:

- 1) Required for the symptoms and diagnosis associated with the medical or psychological Sickness, Injury or Surgical Procedure of the Covered Person;
- 2) Provided in the facility, setting, or environment which can provide the most appropriate and cost effective level of care for the Covered Person's medical or psychological Sickness, Injury or Surgical Procedure; and
- 3) Determined in the discretion of each of the applicable Administrators specified below to be within acceptable standards of medical or psychological practice for the specific Covered Person's medical or psychological Sickness, Injury or Surgical Procedure:
 - a) The Contract Administrator for the Out-of-Area Plan and for treatment or services provided by Out-of-Network Health Care Providers under the Managed Care Plan;
 - b) The designated Contract Administrator for treatment or services provided by Network Health Care Providers under the Plan.

MEDICARE

Medicare means the Part A and Part B Plans described in Title XVIII of the United States Social Security Act, as amended.

MIDWIFE

A registered nurse/Practitioner who has completed specialized theory and clinical courses in obstetrics and gynecology and is acting within the scope of applicable state licensure/certification requirements.

NEGOTIATED RATE

Negotiated Rate shall mean the amount, which a Network Health Care Provider has agreed to accept as payment in full for a specified treatment, service or supply provided to a Plan Covered Person, pursuant to a contract between the applicable Network Health Care Provider and the Network.

NETWORK

Network shall mean the Health Care Providers, which have contracted with the Network to provide medical services to Covered Persons who have elected to participate in the Plan.

NETWORK HEALTH CARE PROVIDER/OUT-OF-NETWORK HEALTH CARE PROVIDER

Network Health Care Provider shall mean a Health Care Provider who has contracted with the Network to provide treatment or services to Covered Persons under the Plan and to accept Negotiated Rates as payment in full for such treatment and services. Out-of-Network Health Care Providers shall mean a Health Care Provider who has not contracted with the Network to provide treatment or services to a Covered Person under the Plan.

NON-OCCUPATIONAL

A condition, which does not arise out of or in the course of employment for pay or profit and does not qualify under any Workers' Compensation law or similar legislation.

NURSE

A Nurse is a properly licensed person holding the degree of Registered Nurse (R.N.), Licensed Vocational Nurse (L.V.N.), or Licensed Practical Nurse (L.P.N.).

NURSE PRACTITIONER

A registered nurse with additional education, skills, and specialization in various fields of medicine. They must be licensed as an Advanced Nurse Practitioner.

OFFICE VISIT

Office Visit shall mean the following services provided by a Physician in his office or in an Outpatient setting:

- 1) Time spent with or on behalf of the patient;
- 2) Reviewing of patient history;
- 3) Examination of the patient;
- 4) Diagnosis;
- 5) Medical decision-making;
- 6) Counseling; and
- 7) Coordination of medical care.

OUT-OF-AREA BENEFITS

Out-of-Area Benefits shall mean the Benefits that are payable for treatment or services provided by Health Care Providers who are not in the Network Service Area. Members are encouraged to utilize the "National Network" in order for benefits to be paid at the In Network level.

OUT-OF-NETWORK BENEFITS

Out-of-Network Benefits shall mean Benefits provided by Health Care Providers who are located within the greater McLennan County Area, but are not Network Health Care Providers.

OUTPATIENT

A Covered Person shall be considered to be an Outpatient if he/she is treated at a Hospital and is confined less than 24 consecutive hours.

OUTPATIENT HOSPITAL CO-PAYMENT

A separate co-payment applies to services rendered in the outpatient department of the Hospital, when applicable. Examples are Outpatient Lab, Outpatient MRI, Outpatient CT Scan, Outpatient Physical Therapy, Outpatient X-rays, and Outpatient Surgeries.

PHYSICIAN

Shall be a properly licensed person holding the degree of Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Podiatry (D.P.M.), Doctor of Dental Surgery (D.D.S.), Doctor of Chiropractic (D.C.), and Doctor of Optometry (O.D.).

PLAN

The Plan is the benefits and the provisions for payment of these same described benefits herein and is called McLennan County Health Plan. Options under the Plan include the Base Plan (Plan 1) and Consumer Driven Health Plan (Plan 2).

PLAN ADMINISTRATOR

The Plan Administrator is McLennan County, Texas. The Plan Administrator is the Named Fiduciary of the Plan.

As used herein, the person or firm providing technical services and advice to the Company in connection with the operation of the Plan and performing such other functions including processing any payment of claims as may be delegated to it, providing Network administration services and making Pre-Authorization, case management services and utilization review determinations shall mean the **Contract Administrator**. The Contract Administrator is currently Scott & White.

PLAN SPONSOR

The Plan Sponsor is McLennan County, Texas. The Plan Sponsor shall be the employer that maintains and sponsors the Plan.

PRE AUTHORIZATION

Pre-Authorization is a procedure, completed in advance of obtaining services, which justifies the Medical Necessity of specific types of care and services covered under this Plan. When utilizing an In-Network Medical Care Health Care Provider, it is that Health Care Provider's responsibility to handle Pre-Authorization. When utilizing Out-of-Network or Out-of-Area Health Care Providers, it is the responsibility of the Covered Person to handle Pre-Authorization. In order to pre-certify or check on Pre-Authorization, please contact the Contract Administrator.

PREFERRED HOSPITAL

The benefits described in the schedule of benefits are payable to the preferred Hospitals in accordance with other plan provisions.

PREFERRED LAB

Designated laboratory entity that will offer the Plan maximum benefit in which contracted/negotiated fees are considered payment in full.

PREGNANCY

Shall include resulting childbirth, except for complications arising there from, as defined herein as Pregnancy Complications. If, while covered under the Plan, a female employee or a covered dependent wife or dependent daughter becomes pregnant and on account of such pregnancy incurs Hospital, surgical or other medical expense, the Plan shall pay such expense in the same manner as any other covered illness. Pregnancy is considered to have commenced nine months before its termination, unless a doctor's written statement to the company states otherwise. Hospital charges for well-baby care for a newborn child born to an *employee* or a *dependent wife* are considered to be eligible charges of the mother during the Hospital stay.

PREGNANCY COMPLICATIONS

Shall include the following:

- 1) Conditions requiring Hospital confinement (when the pregnancy is not terminated) whose diagnosis are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity, but shall not include false labor, occasional spotting, physician prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, pre-eclampsia and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy, and
- 2) Non-elective Caesarean Section, ectopic pregnancy which is terminated and spontaneous termination of pregnancy, which occurs during a period of gestation in which a viable birth is not possible, a miscarriage or a non-elective abortion.

PSYCHOLOGIST

A Psychologist shall only include a practitioner who is duly licensed or certified in the state where the service is rendered and has a doctorate degree in psychology and has had at least two years clinical experience in a recognized health setting, or has met the standards of the National Register of Health Service Health Care Providers in Psychology.

QUALIFYING EVENT

Refer to the **Section II MEDICAL BENEFITS AND ENROLLMENT PERIOD FOR OTHER MID YEAR CHANGES**

REASONABLE AND CUSTOMARY (For HMO Plans Only)

A Reasonable and Customary Charge shall be a charge which is the same or less than the usual charges made by a Physician or supplier of services, medicines, or supplies and shall not exceed the general level of charges made by others rendering or furnishing such services, medicines, or supplies within the area* in which the charge is incurred for sickness or injuries comparable in severity and nature to the sickness or injury being treated.

Reasonable and Customary means the lesser:

- 1) Provider usual charge for furnishing the service or supply; or
- 2) the charge the Contract Administrator determines is reasonable based on the cost of providing the same or similar service or supply in the same geographical area.

To determine the reasonable charge for a service or supply that is unusual, not often provided in the area, or provided by only a small number of Providers, the Contract Administrator will consider:

- 1) the complexity of the service or supply;
- 2) the degree of skill needed;
- 3) the Provider's specialty
- 4) the range of services or supplies provided by a facility; and
- 5) similar charges in other areas

If an Out-of-Network Exception applies (SEE MEDICAL BENEFIT INFORMATION UNDER THE PLAN), the Plan covers Covered Expenses up to the "reasonable and customary" amount when an Out-of-Network Provider is used.

*The term "Area" as it would apply to any particular service, medicine, or supplies means a county or such greater geographic area as is necessary to obtain a representative cross section of the level of charges. The Contract Administrator shall make the determination of Reasonable and Customary Charge based on established criteria in determining available benefits under the Plan.

With respect to a Network Health Care Provider, the Reasonable and Customary charge shall be the Negotiated Rates. For a Network Health Care Provider, payment shall be based on the Allowable Amount.

RETIRED EMPLOYEE

A retiree is defined in the McLennan County Employee Policy Guide. The definition is subject to change.

PLEASE NOTE: Upon retirement of a participating employee, only the Eligible Dependents covered under the employee at the time of retirement will be allowed to continue coverage as Eligible Dependents under the retired employee's benefits.

SERVICE AREA

Service Area shall mean the geographic area composed of United States Postal Service Zip Codes in which the Networks have selected, established, and maintain a contracted network of Health Care Providers.

SKILLED NURSING FACILITY

A facility or part of a facility that:

- 1) is licensed in accordance with state or local law; and
- 2) is a Medicare - participating facility; and
- 3) is primarily engaged in providing skilled nursing care to inpatients under the supervision of a duly licensed
- 4) physician; and
- 5) provides continuous 24 - hour nursing service by or under the supervision of a registered nurse; and
- 6) does not include any facility that is primarily a rest home, a facility for the care of the aged, or for treatment of
- 7) tuberculosis, or for intermediate, custodial care or educational care.

SURGICAL PROCEDURE

Surgical Procedure shall mean cutting, suturing, treating burns, correcting fractures, reducing a dislocation, manipulating a joint under general anesthesia, electrocauterizing, tapping (paracentesis), applying plaster casts, administering pneumothorax, endoscopy or injecting sclerosing solution.

TERMINATION OF EMPLOYMENT

Termination of Employment shall mean a COUNTY employee whose employment with the County ends, whether voluntarily or involuntarily.

THERAPIST

A Therapist shall include a person who is duly licensed or certified in the state where the service is rendered to provide services for Physical, Speech or Occupational Therapy.

TOTAL DISABILITY

Total Disability, as applied to the Employee, means the complete inability of the employee to perform all of the substantial and material duties and functions of his/her occupation or any other gainful occupation in which the employee earns substantially the same compensation earned prior to disability and, as applied to Dependent, means confinement as a bed patient in a Hospital.

WAITING PERIOD

The Waiting Period is the period of time an Employee must be employed prior to becoming eligible to Enroll in the Plan. The Waiting Period shall be 31 days of continuous full-time employment. They would be eligible the 1st or 16th of month after 31 days. If someone leaves, but returns within 30 days, there will be no break in coverage.

II. MEDICAL BENEFITS

ELIGIBILITY

ELIGIBLE EMPLOYEE

An Eligible Employee is any full time employee, including a county officer or county judicial officer, who has satisfied the applicable Waiting Period and is eligible to Enroll in the Plan. Full time shall mean a minimum of 30 hours per week, on average. An Eligible Employee shall also include retired employees choosing to continue benefits under the Plan at the time of retirement. It shall also include all state District Judges of judicial districts covering only McLennan County. An **ELIGIBLE ENROLLED EMPLOYEE is an Eligible Employee who has Enrolled in the Plan.**

ELIGIBLE DEPENDENT

An Eligible Dependent shall mean the lawful spouse or common law spouse (with certificate of common law union) of an Eligible Enrolled Employee. It shall also mean the children of an Eligible Enrolled Employee who are:

- Under age 26, are the natural children, legally adopted children, step children, or children for whom the employee is a legal guardian; or
- Upon reaching the age of 26 and having been covered under this Plan as an Eligible Dependent, are mentally or physically handicapped and are incapable of earning a living, may continue to be covered as an Eligible Dependent. The Plan Sponsor may require the employee to furnish periodic proof of this individual's continued incapacity or dependency, but not more often than annually. If such proof is not satisfactory, and further proof, which is satisfactory, is not provided upon request, coverage for the individual will end immediately.

DEPENDENT OF RETIRED EMPLOYEE

A retiree is defined in the McLennan County Employee Policy Guide. The definition is subject to change.

Upon retirement of a participating employee, only the Eligible Dependents covered under the employee at the time of retirement will be allowed to continue coverage as Eligible Dependents under the retired employee's benefits.

In the event of a covered retiree's death, the previously covered dependents of the deceased retiree shall have the right to continue benefits under the Plan, subject to further provisions hereof, until:

- The date benefits for all individuals in this class are terminated;
- If dependent children, the date that they do not meet the definition of an Eligible Dependent. In this case, continuation of coverage will be offered under COBRA.
- Remarriage of the surviving spouse.

RETURNING EMPLOYEE: A Returning Employee is an Eligible Employee who has left full time employment with the Employer, but returns as a full time Eligible Employee within 30 days from the effective date of the termination of their prior employment. If a Returning Employee was an Eligible Enrolled Employee, the Returning Employee, upon written request to Employer, may be reinstated as an Eligible Enrolled Employee without any break in coverage.

BENEFITS FOR THE SURVIVORS OF CERTAIN PUBLIC SERVANTS

Eligible survivors of certain public servants, who died as a result of personal injury or illness sustained in the line of duty in the individual's position, as described, are entitled to purchase or continue to purchase health insurance benefits under Chapter 1551, Texas Insurance Code, as provided in this section.

A survivor is eligible if he or she is the surviving spouse of the individual or surviving dependent of the individual.

CERTAIN PUBLIC SERVANTS

This entitlement is available to eligible survivors of individuals who served in the following positions:

1. an individual elected, appointed, or employed as a peace officer by the state or a political subdivision of the state under Article 2.12, Code of Criminal Procedure, or other law;
2. a member of the class of employees of the correctional institutions division formally designated as custodial personnel under section 615.006 by the Texas Board of Criminal Justice or its predecessor in function;
3. a jailer or guard of a county jail who is appointed by the sheriff and who:
 - (a) performs a security, custodial, or supervisory function over the admittance, confinement, or discharge of prisoners; and
 - (b) is certified by the Commission on Law Enforcement
4. an individual who is employed by the state or a political or legal subdivision and is subject to certification by the Texas Commission on Fire Protection or an individual employed by the state or a political or legal subdivision whose principal duties are aircraft crash and rescue fire fighting who is employed by a political subdivision of the state; or
5. an individual who is employed by the state or a political subdivision of the state and who is considered by the governmental employer to be a trainee and is employed as a trainee for a position otherwise described in section 615.071 of the Texas Government Code.

ELIGIBLE SURVIVING SPOUSE

1. provided by or through a political subdivision under:
 - a. a health insurance policy or health benefit plan written by a health insurer; or
 - b. a self-insured health benefits plan.
2. under Chapter 172, Local Government Code.

The surviving spouse is entitled to purchase or continue to purchase health insurance coverage until the date the surviving spouse becomes eligible for federal Medicare benefits.

ELIGIBLE SURVIVING DEPENDENT

An eligible surviving dependent who is a minor child is entitled to purchase or continue to purchase health insurance coverage until the date the dependent reaches the age of 26 or a later date to the extent required by state or federal law.

An eligible surviving dependent who is not a minor child is entitled to purchase or continue to purchase health insurance coverage until the earlier or:

1. the date the dependent becomes eligible for group health insurance through another employer; or
2. the date the dependent becomes eligible for federal Medicare benefits.”

ENROLLMENT & INDIVIDUAL EFFECTIVE DATE

EMPLOYEE ENROLLMENT

An Eligible Enrolled Employee's coverage will become effective on the 1st or the 16th day following the satisfaction of the Waiting Period. Enrollment must be completed by an employee to be enrolled for coverage with the employee making a positive election or declination.

The Waiting Period is the period of time an Employee must be employed prior to becoming eligible to elect coverage under the Plan. The Waiting Period shall be 31-days of continuous full-time employment.

If an Eligible Employee waives Coverage for himself/herself, no coverage is available for the dependent under the Plan. If an employee waives coverage, or simply does not enroll when initially eligible, and later wishes to be covered under the Plan, the employee must wait for the annual Open Enrollment unless (s)he becomes eligible for Coverage prior to Open Enrollment due to a Special Enrollment Period or Qualifying Event.

Where an individual is covered as an Eligible Enrolled Employee under this Plan, they may not be additionally covered under this Plan as the dependent of another Eligible Enrolled Employee of this Plan.

DEPENDENT ENROLLMENT

An Eligible Employee may elect coverage within 31 days following acquisition of a dependent through marriage, birth or adoption, as described below. If an Eligible Employee does not elect coverage within the 31 days that the employee first acquires Eligible Dependents, the employee will be required to wait for the annual Open Enrollment. If an employee elects coverage for Eligible Dependents and at a later time acquires additional Eligible Dependents, the employee must notify the McLennan County Human Resources Department and properly complete and submit all necessary forms detailing the names and other information of these additional dependents within 31 days of the acquisition, (the qualifying event), in order for the newly acquired dependents to receive coverage.

Under HIPAA, marriage, birth of a child, adoption of a child and placement for adoption of a child constitute a Special Enrollment Period. A Special Enrollment Period is an additional enrollment opportunity for the Eligible Employee to enroll for Coverage following his or her initial eligibility date.

BIRTH OR ADOPTION

In the event of the birth of a child or adoption or placement for adoption of a child, the child will automatically be covered for the first 31 days following birth of adoption. For Coverage to continue beyond 31 days, you must notify the Employer of the birth/adoption, complete all necessary paperwork and pay any required premiums (premiums are required beginning the first of the calendar month following the birth/adoption month). If notification and required premiums are not made, Coverage will terminate at the end of the 31 days following the birth or adoption of the child. In addition, the Eligible Employee and Spouse, if not already covered, will also be eligible to enroll for Coverage. Please note, the claim for maternity care is not considered an enrollment application for enrollment of the newborn infant.

MARRIAGE

In the event a Covered Employee marries after his or her Coverage has become effective, the employee may add his or her spouse to the Coverage by submitting to the Employer a completed application within 31 days of the event. In this event, Coverage will be effective on the date of the marriage. In this instance, the Eligible Employee, the Spouse and any Dependent Children who are newly acquired as the result of the marriage, who did not enroll under the Plan when initially eligible or during a subsequent open enrollment period, if applicable, are permitted to enroll during this special enrollment period.

ENROLLMENT DUE TO BECOMING ELIGIBLE FOR MEDICAID OR CHIP COVERAGE

Becoming eligible for state premium assistance under Medicaid under Title XIX of the Social Security Act or the state children's health insurance program (CHIP) under Title XXI of the Social Security Act will result in a Special Enrollment Period under HIPAA. An employee who is eligible, but not enrolled, for Coverage under the Plan (or a Dependent who is eligible, but not enrolled) may enroll in the Plan upon becoming eligible for premium assistance provided enrollment is requested within 60 days of becoming eligible for the assistance.

ENROLLMENT DUE TO LOSS OF OTHER COVERAGE

Eligible Employees who are covered under another health plan and subsequently lose such coverage are eligible for Coverage following the loss of the other coverage provided they submit a completed application to the Employer within 31 days following termination of the other coverage. If an employee submits the application within this 31-day enrollment period, Coverage will be effective on the date of the loss of other coverage. The employee is eligible only if he submitted a written declination of Coverage to the Employer when he was initially eligible to enroll under the Plan. As used herein, loss of the other coverage must be due to: (a) exhaustion of COBRA benefits; (b) Loss of Eligibility under the prior coverage; or (c) termination of contributions by the employer under the prior plan of coverage.

If the loss of other coverage is due to loss eligibility under Medicaid under Title XIX of the Social Security Act or the

state children's health insurance program (CHIP), the individual has 60 days to request coverage under the Plan.

Enrollment due to loss of other coverage is also considered a Special Enrollment Period under HIPAA.

ENROLLMENT PERIOD FOR OTHER MID-YEAR ELECTION CHANGES

This provision applies if the Employer offers a Section 125 Plan, including but not limited to a Section 125 Premium Only Plan, in which the employee is participating. The Section 125 Plan allows pre-tax deductions for eligible payroll deductions by employees.

When the Covered Employee experiences an event ("Qualifying Event") that would allow him to make a mid-year election change to his current premium payment elections under his Section 125 Plan, the employee is also permitted to make a corresponding change under this medical Plan provided such change is permitted in accordance with the IRS regulations governing Section 125 Plans. For example, if the Covered Employee experiences a Qualifying Event that would permit him to revoke or change his election under the Section 125 Plan, he will be permitted to change his current elections under this Plan or cancel his Coverage under this Plan.

The Qualifying Events that would allow such a revocation or change include, but are not limited to the following types of events:

- 1) Change in Family Status (i.e. birth, adoption, marriage, divorce, legal separation, dissolution, death, child reaching limiting age). Some of these events may also be a HIPAA Special Enrollment under the Plan.
- 2) Change in Family Status Due to Change in Employment (i.e. change of employment for the Employee or the Spouse);
- 3) Change of address that results in a service area limitation: This applies only when a change of address renders Covered Persons ineligible for coverage (e.g., moving outside of an HMO coverage area). To revoke or change enrollment, an enrollment application should be completed indicating new address and new benefit option, if applicable.
- 4) Judgment, decree or order: If the Employee or Employee's spouse is subject to a judgment, decree or order resulting from a divorce or similar proceeding that affects the requirements for the Employee to provide medical coverage for a Dependent child, an enrollment form should be completed adding the Dependent child accordingly.
- 5) Medicare or Medicaid: If an Employee's covered spouse or covered child Dependent loses coverage under Medicare or Medicaid, coverage under this Plan may be obtained by an enrollment application being completed per the Special Enrollment provisions of the Plan. If an Employee or a covered Dependent gains coverage under Medicare or Medicaid, elections under this Plan may be revoked by completing a termination of coverage form (the Covered Person should refer to the Coordination of Benefits section for further information regarding dual coverage rules).
- 6) Eligibility of COBRA: If the Employee, Employee's spouse or Dependent becomes eligible for and elects COBRA under the Plan, the Employee may make a corresponding election to pay for the continuation coverage on a pre-tax basis.
- 7) Family and Medical Leave Act: If the Employee takes leave under the Family and Medical Leave Act ("FMLA"), he/she may revoke coverage under the Plan during the leave or may continue group health coverage as provided for by the Employer's FMLA policy.
- 8) Significant Cost Increases: If the cost of benefits significantly increases during a Plan Year, as determined by the Employer, the Employee may elect coverage under another benefit option, if any, that offers similar coverage, as determined by the Employer.
- 9) Coverage Changes: If coverage under a benefit option is significantly curtailed during a Plan Year, as determined by the Employer, the Employee may revoke his or her election or elect coverage under another benefit option that offers similar coverage. If the Employer adds a new benefit option during a Plan Year, the Employee may elect the new benefit option.
- 10) Changes Under Another Employer's Plan: The Employee may also change his or her elections to correspond to certain changes that the Employee's spouse or Dependent makes to his or her benefit elections under a benefit plan offered by his or her employer. These rights are subject to conditions

or restrictions that may be imposed by the employer or any insurance company providing benefits under the plan.

Any change or revocation must be consistent with the events permitted as a mid-year change under the Section 125 Plan (as regulated by the IRS) to the extent that it is necessary or appropriate as the result of such change. All requests for changes in relation to the Covered Employee experiencing a Qualifying Event must be submitted as a written request to the Employer no later than 31 days prior to making such change. If the request for change is submitted within this 31-day enrollment period, the change will be effective either as of the date of the qualifying event, or at the next pay period.

TERMINATION OF COVERAGE

TERMINATION OF COVERAGE- GENERAL

The coverage of any Covered Person covered under the Plan shall terminate on the earliest of the following dates:

- 1) The date the Plan terminates ; or
- 2) The date a Covered Person ceases to qualify under the Plan, whether because his/her membership ceases to be in an eligible class or with respect to a dependent the date such dependent no longer is an Eligible Dependent; or
- 3) Death of a Covered Person; or
- 4) The date all coverage or certain benefits are terminated on his/her particular class by modification of the Plan; or
- 5) The date he/she fails to make a required contribution to the Plan, if any; or
- 6) After the 31st day following the birth of a child, with respect to such child, unless prior to the expiration of such 31 day period the Contract Administrator has been notified of the birth of such child and you have agreed to make any required contributions; or
- 7) The date on which full time employment with the County or eligible affiliate terminates.
- 8) The date of termination pursuant to termination of coverage for false representations, fraud, or failure to pay premiums, as further described below.
- 9) As otherwise allowed by law or regulation.

With the exception an employee's failure to pay the required premium, rescission or cancellation pursuant to termination for false representations, fraud, or failure to pay premiums, or as otherwise provided by law or regulation, termination of coverage must occur on a prospective basis and requires that the Plan Sponsor provide 30 days advance notice of the loss of coverage to the individual losing coverage.

TERMINATION OF COVERAGE FOR FALSE REPRESENTATIONS, FRAUD OR FAILURE TO PAY PREMIUMS

If any Eligible Enrolled Enrollee or Covered Person makes an intentional misrepresentation, or commits any fraud under or with respect to, the Plan, the Contract Administrator has the right to permanently terminate coverage for the Eligible Enrolled Enrollee, Covered Person and his or her Dependents, to the extent permitted by law. Intentional misrepresentation includes, but is not limited to, submitting falsified claims or obtaining coverage for an individual who is ineligible.

Any termination of coverage under this Section may be terminated by the Contract Administrator on a retroactive basis (a "rescission" of coverage), in which case the individual will receive a notice of the rescission, as required by the Affordable Care Act.

To the extent permitted by law, the Contract Administrator may also seek reimbursement from the individual for all claims or expenses paid by the Plan as a result of the false representation or fraud, and may pursue legal action against the individual.

Recovery of Benefit Overpayment

If any benefit from a Benefit Program paid to or on behalf of a Covered Person should not have been paid or should have been paid in a lesser amount, and the Covered Person or other recipient fails to repay the amount promptly, then the overpayment may be recovered by the Plan Administrator to the extent permitted by law from any monies then payable, or which may become payable, in the form of salary, wages, or benefits payable under any Employer sponsored benefit programs, including the applicable Benefit Program.

The Contract Administrator may terminate coverage for a Participant or enrolled Dependent under any Benefit Program 90 days after the date the Contract Administrator requests repayment from the Participant (or any Dependent) of amounts that are subject to reimbursement under any Benefit Program, overpayments or mistaken payments from a Benefit Program, unless such Participant (or Dependent) repays such amounts or sets up a repayment schedule for the same that is approved by the Contract Administrator in its sole discretion. The Contract Administrator also reserves the right to recover any such overpayment by appropriate legal action.

COBRA RIGHTS

The COBRA Administrator is Conexis.

COBRA CONTINUATION COVERAGE

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "Qualifying Event." Specific Qualifying Events are listed later in this notice. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Plan because of a Qualifying Event. Depending on the type of Qualifying Event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. The Employer does not contribute any amount toward the cost of COBRA coverage.

If you are an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because either one of the following Qualifying Events happens:

- 1) Your hours of employment are reduced, or
- 2) Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because any of the following Qualifying Events happens:

- 1) Your spouse dies;
- 2) Your spouse's hours of employment are reduced;
- 3) Your spouse's employment ends for any reason other than his or her gross misconduct;
- 4) Your spouse becomes enrolled in Medicare (Part A, Part B, or both); or
- 5) You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they will lose coverage under the Plan because any of the following Qualifying Events happens:

- 1) The parent-employee dies;
- 2) The parent-employee's hours of employment are reduced;
- 3) The parent-employee's employment ends for any reason other than his or her gross misconduct;
- 4) The parent-employee becomes enrolled in Medicare (Part A, Part B, or both);
- 5) The parents become divorced or legally separated; or
- 6) The child stops being eligible for coverage under the plan as a "dependent child."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a Qualifying Event. If a proceeding in bankruptcy is filed with respect to McLennan County and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee is a qualified beneficiary with

respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also be qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the COBRA Administrator has been notified that a Qualifying Event has occurred. When the Qualifying Event is the end of employment or reduction of hours of employment, death of the employee commencement of a proceeding in bankruptcy with respect to the employer, or enrollment of the employee in Medicare (Part A, Part B, or both), the employer must notify the COBRA Administrator of the Qualifying Event within 30 days of any of these events.

For the other Qualifying Events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the COBRA Administrator. The Plan requires you to notify the McLennan County within 60 days after the qualifying event occurs. You must also send this notice to the McLennan County Human Resources Department. The notice needs to include name, address, and telephone number, plan name and the Qualifying Event. If the Qualifying Event is a divorce or legal separation, legal documentation must be furnished. Failure to notify the COBRA Administrator in the above stated time frames and prescribed manner will nullify your right to COBRA continuation of coverage.

Once the COBRA Administrator receives notice that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin this Plan on the date of the Qualifying Event

COBRA continuation coverage is a temporary continuation of coverage. When the Qualifying Event is the death of the employee, enrollment of the employee in Medicare (Part A, Part B, or both), your divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the Qualifying Event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage lasts for up to 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

DISABILITY EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled at any time during COBRA continuation coverage and you notify the COBRA Administrator in a timely fashion, (within 60 days, in writing) you and your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. You must make sure that the COBRA Administrator is notified of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage. This notice should also be sent to the McLennan County Human Resources Department. The notification should include name, address, telephone number, plan name, and a copy of the Social Security Administration's determination.

SECOND QUALIFYING EVENT EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If your family experiences another Qualifying Event while receiving COBRA continuation coverage, the spouse and dependent children in your family can get additional months of COBRA continuation coverage, up to a maximum of 36 months. This extension is available to the spouse and dependent children if the former employee dies, or gets divorced or legally separated. The extension is also available to a dependent child when that child stops being eligible under the Plan as a dependent child. **In all of these cases, you must make sure that the COBRA Administrator is notified of the second Qualifying Event within 60 days of the second Qualifying Event. This notice must also be sent to the McLennan County Human Resources Department. The notification should include name, address, telephone number, plan name, and qualifying event. Copies of documentation such as death certificate, Medicare card, divorce decree or legal separation papers must be included with the notification.**

If you have questions about your COBRA continuation coverage, you should contact the McLennan County Human Resources Department or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's web site at www.dol.gov/ebsa.

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES AT ALL TIMES

In order to protect your family's rights, you should keep the COBRA Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the COBRA Administrator. **Please note that, as it is the sole responsibility of the Plan participants to notify the COBRA Administrator in writing of any address changes for all family members, you and/or your family members may lose their rights for continuation of coverage in the event documentation is not received or sent due to your failure to notify of an address change.**

HOW CAN YOU ELECT CONTINUATION COVERAGE?

Each qualified beneficiary has an independent right to elect continuation coverage. For example, both the employee and the employee's spouse may elect continuation coverage, or only one of them. Parents may elect to continue coverage on behalf of their dependent children only. A qualified beneficiary must elect coverage by the date specified on the Election Form. Failure to do so will result in loss of the right to elect continuation coverage under the Plan. A qualified beneficiary may change a prior rejection of continuation coverage any time until that date.

In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage may affect your right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed above or eligibility for enrollment in the Federal Health Market Exchange. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

HOW MUCH DOES CONTINUATION COVERAGE COST?

Each qualified beneficiary may be required to pay the entire cost of continuation coverage, including for any employee the portion that was previously contributed by the Employer. The amount a qualified beneficiary may be required to pay may not exceed 102 percent of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage (or, in the case of an extension of continuation coverage due to a disability, 150 percent).

WHEN AND HOW MUST PAYMENT FOR CONTINUATION COVERAGE BE MADE?

FIRST PAYMENT FOR CONTINUATION COVERAGE

If you elect continuation coverage, you do not have to send any payment for continuation coverage with the Election Form. However, you must make your first payment for continuation coverage within 45 days after the date of your election. (This is the date the Election Notice is post-marked, if mailed.) If you do not make your first payment for continuation coverage within those 45 days, you will lose all continuation coverage rights under the Plan.

Your first payment must cover the cost of continuation coverage from the time your coverage under the Plan would have otherwise terminated up to the time you make the first payment. You are responsible for making sure that the amount of your first payment is enough to cover this entire period. You may contact the CONEXIS, the COBRA Administrator to confirm the correct amount of your first payment.

Your first payment for continuation coverage should be sent to:

CONEXIS
P. O. Box 660212
Dallas, TX 75266-0212

PERIODIC PAYMENTS FOR CONTINUATION COVERAGE

After you make your first payment for continuation coverage, you will be required to pay for continuation coverage for each subsequent month of coverage. Under the Plan, these periodic payments for continuation coverage are due on the 1st of each month of coverage. If you make a periodic payment on or before its due date, your coverage under the Plan will continue for that coverage period without any break. The Plan will send periodic notices of payments due for these coverage periods.

Currently, periodic payments for continuation coverage should be sent to:

CONEXIS
P. O. Box 660212
Dallas, TX 75266-0212

GRACE PERIODS FOR PERIODIC PAYMENTS

Although periodic payments are due on the dates shown above, you will be given a grace period of 30 days to make each periodic payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if you pay a periodic payment later than its due date but during its grace period, your coverage under the Plan will be suspended as of the due date and then retroactively reinstated (going back to the due date) when the periodic payment is made. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you fail to make a periodic payment before the end of the grace period for that payment, you will lose all rights to continuation coverage under the Plan.

For more information about your rights, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the U.S. Department of Labor’s Employee Benefits Security Administration (EBSA) in your area or visit the EBSA web site at www.dol.gov/ebsa.

COVERED EXPENSE

A Covered Expense under the medical portion of your Plan shall mean a service or supply which is provided to a Covered Person, and which service or supply is:

- 1) Received while a person is covered under the Plan; and
- 2) Recommended by a physician; and
- 3) Medically necessary for the care and treatment of a covered illness or injury of a Covered Person; and
- 4) Provided by a Health Care Provider of these services or supplies.

These services and supplies which are furnished by, and fall within the scope of the authorized practice of, a Health Care Provider must be recognized throughout the Health Care Provider's profession to be the usual and customary treatment for the illness or injury, and will be covered subject to the terms and conditions outlined in this Booklet.

Preventive Care Services means the following, as further defined and interpreted by appropriate statutory, regulatory, and agency guidance:

- 1) Evidence-based items or services with an “A” or “B” rating from the U.S. Preventive Services Task Force (USPSTF);

- 2) Immunizations for routine use in children, adolescents and adults with a recommendation in effect from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.
- 3) Evidence-informed preventive care screenings for infants, children and adolescents provided in guidelines supported by the Health Resources and Services Administration (HRSA); and
- 4) Evidence-informed preventive care and screening for women provided in guidelines supported by HRSA and not otherwise addressed by the USPSTF.

The most current guidelines are available at <http://www.HealthCare.gov/center/regulations/prevention.html>.

Covered Persons are entitled to the Preventive Care Services of Network Physicians and Providers without being subject to a Copayment or Deductible. Preventive Care Services obtained from non-Network Providers will be subject to applicable Copayments.

You and Your Covered Dependents may access preventative Health Care Services and health education programs as determined by Health Plan. Under the Affordable Care Act, certain preventive services from Network Providers are paid at 100% (at no cost to the Covered Person), depending on the billing and diagnosis.

The determination of whether a service is a Preventive Care Service may be influenced by the type of service for which your Physician or Provider bills the Health Plan. Specifically (1) if a recommended preventive service is billed separately from an office visit, then a plan may impose cost-sharing requirements with respect to the office visit, (2) if a recommended preventive service is not billed separately from an office visit and the primary purpose of the office visit is the delivery of a preventive service, then a plan may not impose cost-sharing requirements with respect to the office visit, and (3) if a recommended preventive service is not billed separately from an office visit and the primary purpose of the office visit is not the delivery of a preventive service, then Health Plan may impose cost-sharing requirements with respect to the office visit.

Coverage of Counseling for a particular condition or disease as a Preventive Care Service does not equate to treatment of that particular condition or disease. While the counseling visit may be considered to be a Preventive Care Service and thus not subject to Deductibles or Copayments, the treatment of such condition or disease will be subject to appropriate Deductibles and Copayments, and to the Exclusions and Limitations provisions of the Health Plan.

COVERED PREVENTIVE SERVICES FOR ALL ADULTS

- **Abdominal Aortic Aneurysm** one-time screening by ultrasonography for men ages 65 to 75 who have ever smoked
- **Alcohol Misuse** screening and counseling
- **Aspirin to prevent CVD: men** – the use of aspirin for men age 45 to 79 years, when the potential benefit due to a reduction in myocardial infarctions outweighs the potential harm of an increase in gastrointestinal hemorrhage
- **Aspirin to prevent CVD: women**: the use of aspirin for women age 55 to 79 years, when the potential benefit of a reduction in ischemic strokes outweighs the potential harm of an increase in gastrointestinal hemorrhage
- **Blood Pressure** screening for all adults age 18 and older
- **Cholesterol** screening for men age 35 and older for lipid disorders, men age 20 to 35 for lipid disorders if they are at increased risk for coronary heart disease, women age 45 and older for lipid disorders, and women age 20 to 45 for lipid disorders if they are at increased risk for coronary heart disease
- **Colorectal Cancer** screening for adults at least 50 years of age and at normal risk for developing cancer, limited to: an annual fecal occult blood test and a flexible sigmoidoscopy once every five years; or a colonoscopy once every ten years
- **Depression** screening for adults when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment, and follow-up
- **Type 2 Diabetes** screening for adults with sustained blood pressure (either treated or untreated) greater than 135/80 mm Hg

- **Diet** intensive behavioral dietary counseling for adults with hyperlipidemia and other known risk factors for cardiovascular and diet related chronic disease. Intensive counseling can be delivered by primary care clinicians or by referral to other specialists, such as nutritionists or dietitians
- **Hepatitis B** screening in persons at high risk for infection
- **Hepatitis C** screening in persons at high risk for infection and a one-time screening for HCV infection for adults born between 1945 and 1965
- **HIV** screening for all adults at higher risk
- **Immunization** vaccines recommended by the Advisory Committee on Immunization Practices (ACIP) :
 - Hepatitis A
 - Hepatitis B
 - Herpes Zoster
 - Human Papillomavirus
 - Influenza (Flu Shot)
 - Measles, Mumps, Rubella
 - Meningococcal
 - Pneumococcal
 - Tetanus, Diphtheria, Pertussis
 - Varicella

- **Lung Cancer** screening annually with low-dose tomography in adults ages 55 to 80 years who have a 30 pack per year smoking history and currently smoke or have within the past 15 years. Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery
- **Counseling for skin cancer**- counseling for children, adolescents, and young adults ages 10 to 24 years who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer
- **Falls prevention in older adults: exercise or physical therapy**- exercise or physical therapy to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls
- **Falls prevention in older adults: vitamin D**- vitamin D supplementation to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls
- **Obesity** screening for all adults and intensive counseling and behavioral interventions to promote sustained weight loss for obese adults
- **Sexually Transmitted Infection (STI)** prevention counseling for adults at higher risk
- **Tobacco Use** screening for all adults and cessation interventions for tobacco users
- **Syphilis** screening for all pregnant women and all adults at higher risk

COVERED PREVENTIVE SERVICES FOR WOMEN INCLUDING PREGNANT WOMEN

- **Anemia** screening on a routine basis for pregnant women
- **Bacteriuria** urinary tract or other infection screening for pregnant women at the later of 12 to 16 weeks' gestation or at the first prenatal visit
- **BRCA** screening for women whose family history is associated with an increased risk for deleterious mutations in BRCA1 or BRCA2 genes; genetic counseling for women with positive screening results and, if indicated, BRCA testing
- **Breast Cancer Low-dose Mammography** for women with or without clinical breast examinations (CBE), for women age 35 and older, annually. Low-dose mammography means the X-ray examination of the breast using equipment dedicated specifically for mammography, including an X-ray tube, filter, compression device, screens, films and cassettes, with an average radiation exposure delivery of less than one rad mid-breast, with two views for each breast
- **Breast Cancer Chemoprevention** counseling for women at higher risk for breast cancer and at low risk for adverse effects of chemoprevention. For women, age 35 and older, without a prior diagnosis of breast cancer, but who are at increased risk for breast cancer and at low risk for adverse medication effects, clinician should offer to prescribe risk-reducing medications, such as tamoxifen or raloxifene. These risk reducing medications are covered

as preventive services, which qualify for the waiver of applicable cost-sharing requirements only if used for prevention. They are not considered preventive if used for the treatment of a Covered Person already diagnosed with breast cancer.

- **Breastfeeding** comprehensive support and counseling from trained providers access to breastfeeding supplies, for pregnant and nursing women. Health Plan shall make a particular mid-range make and model of breast pump available, and this benefit shall be limited to the cost to the Health Plan of that model of breast pump. If You or Your Covered Dependent wishes to purchase a different model, or to rent rather than purchase a breast pump, this benefit will be subject to this limit.
- **Cervical Cancer and Human Papillomavirus** screening for women, including the provider's charge for administration of the test, for any covered female age 18 or older, not to exceed one per Year for: a conventional Pap smear screening or a screening using liquid-based cytology methods, as approved by the United States Food and Drug Administration (FDA), alone or in combination with a test approved by the FDA for the detection of the human papillomavirus. A screening test must be performed in accordance with the guidelines adopted by the American College of Obstetricians and Gynecologists or another similar national organization of medical professionals.
- **Chlamydia Infection screening** for all sexually active non-pregnant women age 24 and younger and for older non-pregnant women who are at increased risk
- **Chlamydia Infection screening** for all pregnant women age 24 and younger and for older pregnant women who are at increased risk
- **Contraception**-Food and Drug Administration-approved contraceptive drugs or devices, and outpatient contraceptive service, including, sterilization procedures, and patient education and counseling, but not including abortifacient drugs. Coverage of contraception may be subject to step therapy and preauthorization requirements.
- **Domestic and Interpersonal Violence** screening and counseling for all women
- **Folic Acid** supplements containing 0.4 to 0.8 mg of folic acid for women who may become pregnant
- **Gestational Diabetes** screening for women 24 to 28 weeks pregnant and at the first prenatal visit for those at high risk of developing gestational diabetes
- **Gonorrhea** screening for all sexually active women, including those who are pregnant, at higher risk for infection
- **Hepatitis B** screening for pregnant women at their first prenatal visit
- **Human Immunodeficiency Virus (HIV)** screening and counseling for sexually active women
- **Human Papillomavirus (HPV)** DNA high risk HPV DNA testing
- **Low-dose aspirin (81 mg/d)** as preventive medication after 12 weeks of gestation in women who are at high risk for preeclampsia
- **Rh Incompatibility** screening for all pregnant women and follow-up testing for all unsensitized Rh (D)-negative women at 24 to 28 weeks' gestation, unless the biological father is known to be Rh (D)-negative
- **Tobacco Use** screening and interventions for all women, and expanded counseling for pregnant tobacco users
- **Sexually Transmitted Infections (STI)** counseling for sexually active women
- **Syphilis** screening for all pregnant women or other women at increased risk
- **Well-Woman Visits** to obtain recommended preventive services

COVERED PREVENTIVE SERVICES FOR CHILDREN

- **Alcohol and Drug Use** assessments for adolescents
- **Autism** screening for children at 18 and 24 months
- **Behavioral** assessments for children of all ages (one assessment for each of the following age ranges): Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years
- **Blood Pressure** screening for children (one screening for each of the following age ranges): Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years
- **Cervical Dysplasia** screening for sexually active females
- **Critical Congenital Heart Disease** screening using pulse oximetry for newborns, after 24 hours of age, before discharge from the hospital
- **Congenital Hypothyroidism** screening for newborns
- **Depression** screening for adolescents (12 to 18 years of age) for major depressive disorder (MDD) when systems are in place to ensure accurate diagnosis, psychotherapy (cognitive-behavioral or interpersonal), and follow-up
- **Developmental** screening for children under age 3, and surveillance throughout childhood

- **Dyslipidemia** screening for children at higher risk of lipid disorders (one screening for each of the following age ranges): Ages: 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
- **Fluoride Chemoprevention** supplements for children older than 6 months whose primary water source is deficient in fluoride
- **Prophylactic medication for Gonorrhea** for the eyes of all newborns against gonococcal ophthalmia neonatorum
- **Hearing** screening for all newborns from birth through the date the child is 30 days old; and Medically Necessary diagnostic follow-up care to the screening test for a child from birth through the date the child is 24 months old
- **Height, Length, Weight, Head Circumference, Weight for Length, and Body Mass Index** measurements for children at recommended intervals
- **Hemoglobinopathies** or sickle cell disease screening for newborns
- **HIV** screening for adolescents at higher risk
- **Hepatitis B screening and counseling for adolescents**
- **Immunization** vaccines for children from birth to age 18 as required for the child by law or recommended by the Advisory Committee on Immunization Practices (ACIP), including:
 - Diphtheria, Tetanus, Pertussis
 - Haemophilus influenzae type b
 - Hepatitis A
 - Hepatitis B
 - Herpes zoster
 - Human Papillomavirus
 - Inactivated Poliovirus
 - Influenza (Flu Shot), including H1N1 influenza
 - Measles, Mumps, Rubella
 - Meningococcal
 - Polio
 - Pneumococcal polysaccharide
 - Rotavirus
 - Varicella
- **Iron** supplements for children ages 6 to 12 months at risk for anemia
- **Lead** screening for children at risk of exposure
- **Medical History** for all children throughout development (one history for each of the following age ranges) Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years
- **Newborn** blood screening
- **Obesity** screening for children age 6 and older and referral to comprehensive, intensive behavioral interventions to promote improvement in weight status
- **Oral Health** risk assessment for young children (one assessment for each of the following age ranges) Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years
- **Phenylketonuria (PKU)** screening for this genetic disorder in newborns
- **Sensory Screening** to assess, detect or identify which sensory systems may be affecting learning or developmental disorders
- **Sexually Transmitted Infection (STI)** prevention counseling and screening for adolescents at higher risk
- **Skin Cancer Counseling** for children, adolescents, and young adults aged 10 to 24 years who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer
- **Tobacco use intervention**, including education or brief counseling, to prevent initiation of tobacco use in school-aged children and adolescents
- **Tuberculin** testing for children at higher risk of tuberculosis (one test for each of the following age ranges): Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years
- **Vision** screening for all children to detect amblyopia, strabismus, and defects in visual acuity in children younger than 5 years old

IN ADDITION TO THE ABOVE REFERENCED PREVENTIVE CARE SERVICES, THE FOLLOWING STATE OF TEXAS MANDATED BENEFITS ARE ALSO CONSIDERED PREVENTIVE CARE SERVICES:

PROSTATE CANCER SCREENING EXAM

You and Your Covered Dependents, if male, are eligible for an annual screening exam to detect prostate cancer. The benefits provided under this subparagraph include the following once per Year: (1) a physical examination to detect prostate cancer, (2) a prostate-specific antigen test for a male Covered Person who is at least 50 years of age with no symptoms or who is at least 40 years of age and has a family history of prostate cancer or another prostate cancer risk factor.

COLORECTAL CANCER SCREENING EXAM

You and Your Covered Dependents are eligible for an annual fecal occult blood test. In addition, if You are 50 years of age or older You may receive a flexible sigmoidoscopy every five (5) years or a colonoscopy every ten (10) years.

EXAM FOR DETECTION AND PREVENTION OF OSTEOPOROSIS

Qualified Enrollees are eligible for medically accepted bone mass measurement for the detection of low bone mass and to determine the enrollee's risk of osteoporosis and fractures associated with osteoporosis. As used in this section, a "Qualified Enrollee" is: a postmenopausal woman who is not receiving estrogen replacement therapy; an individual with vertebral abnormalities, primary hyperparathyroidism, or a history of bone fractures; or an individual who is receiving long-term glucocorticoid therapy or being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy.

LOW DOSE MAMMOGRAPHY

If You or Your Covered Dependent is a female 35 years or older, an annual screening by low-dose mammography is covered.

CERVICAL CANCER SCREENING

You and Your Covered Dependents, if female and over age 18, are eligible for a medically recognized annual diagnostic examination, including a conventional Pap smear screening or a screening using liquid-based cytology methods alone or in combination with a test for the detection of the human papillomavirus, for the early detection of cervical cancer.

PHENYLKETONURIA (PKU) OR HERITABLE METABOLIC DISEASE

Coverage for formulas necessary to treat phenylketonuria (PKU) or a heritable metabolic disease are available to You or Your Covered Dependent as prescribed by a health care provider.

The determination of whether a service is a Preventive Care Service may be influenced by the type of service for which Your health care provider bills the Health Plan. Specifically (1) if a recommended preventive service is billed separately from an office visit, then a plan may impose cost-sharing requirements with respect to the office visit, (2) if a recommended preventive service is not billed separately from an office visit and the primary purpose of the office visit is the delivery of a preventive service, then a plan may not impose cost-sharing requirements with respect to the office visit, and (3) if a recommended preventive service is not billed separately from an office visit and the primary purpose of the office visit is not the delivery of a preventive service, then Health Plan may impose cost-sharing requirements with respect to the office visit.

Coverage of Counseling for a particular condition or disease as a Preventive Care Service does not equate to Treatment of that particular condition or disease. While the counseling visit may be considered to be a Preventive Care Service and thus not subject to Deductibles or Copays, the Treatment of such condition or disease will be subject to appropriate Deductibles and Copays, and to the Exclusions and Limitations provisions of the Health Plan.

AMBULANCE SERVICES

Covered Persons are covered for charges by a licensed ambulance service to or from the nearest hospital where the needed emergency medical care and treatment can be provided.

EMERGENCY/URGENT MEDICAL CARE

Services that are required to stabilize or initiate treatment in an emergency are eligible expenses. Emergency Services must be received on an outpatient basis at a hospital or alternate facility. The Plan covers the following expenses incurred in a doctor's office, ambulatory surgical center, or emergency room:

- emergency transportation charges,
- emergency room charges,
- doctors expenses for diagnosis and treatment, and
- diagnostic x-ray and laboratory tests.

In an emergency, the plan pays the in-network rate for eligible expenses provided that the visit qualifies as an emergency. If the Covered Person is admitted into the hospital due to the emergency, the emergency room Copayment is waived.

We realize that in emergency situations you may not have a choice about using a network hospital. Therefore, the same benefit level applies regardless of whether the services are provided by Network or Non-Network hospitals, provided that the visit is for a qualified emergency medical condition.

Under an HMO Plan, if a Covered Person goes to an emergency room and the condition is not an emergency, expenses are not covered.

An emergency is a serious medical condition or symptom resulting from injury, sickness or mental illness, which arises suddenly and, in the judgment of a reasonable person, requires immediate care and treatment, generally received within 24 hours of onset, to avoid jeopardy to the life or health of a covered person.

Emergency care includes immediate mental disorder treatment when the lack of the treatment could reasonably be expected to result in the patient harming their self and / or other persons.

Examples of emergency conditions include: chest pain, severe bleeding, appendicitis, poisoning, seizures, strokes or loss of consciousness.

Examples of non-emergency conditions include: routine colds, flu, sore throat, ear infection, sprains, strains, cuts, fatigue, weakness, rashes or skin disorders, chronic pain or illness, or low back pain.

HOSPITAL SERVICES

Covered Persons are entitled to the Medically Necessary services of any Hospital to which Covered Person may be admitted by a Physician. Health Plan will cover the cost of a semi-private room, or the equivalent thereof, for covered hospital admissions for routine acute care. For more intense levels of care, that level of care which is Medically Necessary will be covered.

BEHAVIORAL HEALTH

Treatment for mental disorder and substance use disorder is provided by providers specializing in mental health care management.

Services must be provided by a covered professional, which include: a psychiatrist, licensed clinical psychologist, a mental health care professional with a master's degree in social work (MSW), a certified alcoholism counselor (CAC) or certified marriage and family therapist (CMFT).

The medical plan options cover the treatment, evaluation and assessment, diagnosis, medication management, crisis intervention, psychological testing, treatment planning, referral services and short-term individual, family and group therapeutic services for mental disorders and substance use disorder. Mental disorder means any disease or condition, regardless of whether the cause is organic, that is classified as a mental disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services, or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association. Substance use disorder is the abuse of or psychological or physical dependence on or addiction to alcohol, a toxic inhalant or a substance designated as a controlled substance in the Texas Health and Safety Code. A toxic inhalant is a volatile chemical or abusable glue or aerosol paint under the Texas Health and Safety Code. This does not include dependence on tobacco and ordinary caffeine – containing drinks.

The medical plan options also include benefits for detoxification from abusive chemicals or substances, which is limited to physical detoxification when necessary to protect your physical health and well-being.

INPATIENT CARE AND INTENSIVE OUTPATIENT MENTAL DISORDER AND SUBSTANCE USE DISORDER CARE

If Covered Persons are hospitalized or receive intensive outpatient treatment as a result of a psychiatric condition or for a condition related to substance use disorder, the following services are considered eligible expenses:

- semi-private room and board,
- services and supplies, and
- in-hospital doctor's visits.

REHABILITATIVE THERAPY

Medically Necessary outpatient rehabilitative therapy services are available for services for physical, inhalation, speech, hearing, and occupational therapies.

HOME HEALTH SERVICES

Home health services consist of Medically Necessary nursing care that is approved in advance by the Medical Director, and provided by a licensed home health care agency. Home health services shall not be covered for Custodial Care or primarily for convenience, as determined by the Medical Director.

HOSPICE SERVICES

Hospice services consist of Medically Necessary Hospice care that is approved in advance by the Medical Director, and provided by a licensed Hospice agency.

MATERNITY SERVICES

Maternity services include physician obstetrical care, labor and delivery services, pre- and post- natal care, hospital room and board and the care of complicated pregnancies in conjunction with the delivery of a child or children a Covered Person.

Coverage includes a minimum of forty-eight (48) hours of inpatient care to a mother and her newborn child following an uncomplicated vaginal delivery and ninety-six (96) hours of inpatient care to a mother and her newborn following an uncomplicated delivery by caesarean section, if such inpatient care is determined to be Medically Necessary by a Physician or is requested by the mother.

The determination whether a delivery is complicated shall be made by the attending Physician. If the decision is made to discharge a mother or newborn child from inpatient care before the expiration of the above time frames, Health Plan shall provide coverage for timely post-delivery care, to be provided by a Physician, registered nurse or other appropriate Health Care Professional, and may be provided at the mother's home, a health care provider's office, health care facility or other appropriate location. The mother has the option to have the care provided in the mother's home. The timeliness of the care shall be determined in accordance with recognized medical standards for that care.

FAMILY PLANNING AND INFERTILITY SERVICES

Family planning and services relating to the diagnosis and Treatment of infertility shall be provided as Medically Necessary. Examples of such services include:

- Counseling,
- Sex education, instruction in accordance with medically acceptable standards,
- Contraceptive devices,
- Placement of contraceptive devices,
- Diagnostic procedures to determine the cause of infertility,
- Vasectomies,
- Tubal ligations, and
- Laparoscopies.

DURABLE MEDICAL EQUIPMENT, ORTHOTICS, PROSTHETIC MEDICAL APPLIANCES

As approved by the Scott & White Medical Director, Medically Necessary durable medical equipment may be covered under the Plan. The Medical Director shall determine the conditions under which such equipment and appliances shall be covered. The conditions include, but are not limited to the following: the length of time covered, the equipment covered, the supplier, and the basis of coverage; i.e., rental, purchase, or loan.

Consumable supplies associated with the use of covered durable medical equipment and prosthetic medical appliances are covered under this Agreement only to the extent that such supplies are required in order to use the specific piece of durable medical equipment or prosthetic medical appliance. Repair, maintenance, and cleaning due to abnormal wear and tear or abuse is Covered Person's responsibility. Benefits for consumable supplies will be applied to the maximum benefit for the device with which the consumable supply is associated.

Orthotics may be covered under this Agreement if determined as Medically Necessary by the Medical Director. Orthotics is equipment intended for repeated use, primarily and customarily used to treat a medical condition covered under this Plan, and not customarily useful in the absence of a covered illness or injury. Rented or loaned equipment must be returned in satisfactory condition and Covered Person is responsible for cleaning and repair required due to abnormal wear and tear or abuse. Coverage for rented or loaned equipment is limited to the amount such equipment would have cost if purchased by Health Plan from a Network DME provider. Health Plan shall have no liability for installation, maintenance or operation of such equipment for home-based use.

Prosthetic Medical Appliances may be covered under the conditions determined by the Medical Director and as are medically Necessary to replace defective parts of the body following injury or illness. Prosthetic Medical Appliances are artificial substitutes for missing body parts, such as an arm or leg, used for functional purposes. Health Plan shall cover the initial device, replacements due solely to growth, other Medically Necessary replacements for medical reasons and normal repairs.

OUTPATIENT RADIOLOGICAL AND DIAGNOSTIC EXAMS

Outpatient Radiological and Diagnostic exams shall be covered as Medically Necessary. Examples of such services include:

- Angiograms (but not including cardiac angiograms);
- CT scans;
- MRIs;
- Myelography;
- PET scans; and
- Stress tests with radioisotope imaging.

Subject to the Radiology Daily Copayment Maximum listed in the Schedule of Benefits, Covered Person is required to pay the Copayments listed in the schedule of benefits for Outpatient Radiological or Diagnostic Examinations contained in this Section. In no event will the total Copayments Covered Person is required to pay for Covered

Radiological or Diagnostic Examinations performed on the same calendar day exceed the Radiology Daily Copayment Maximum listed in the schedule of benefits.

An ultrasound or cardiac angiogram shall not be subject to a Radiological or Diagnostic Examination Copayment, but if performed in conjunction with an office visit or outpatient surgery, Covered Person will be responsible for the appropriate office visit or outpatient surgery Copayment as listed in the Schedule of Benefits.

BREAST RECONSTRUCTION BENEFITS

If Covered Person has had or will have a mastectomy, coverage for Breast Reconstruction incident to mastectomy shall be provided under the same terms and conditions of this Agreement as for the mastectomy, as deemed medically appropriate by Physician who will perform the surgery. Breast Reconstruction means surgical reconstruction of a breast and nipple areola complex to restore and achieve breast symmetry necessitated by mastectomy surgery. The term includes surgical reconstruction of a breast on which mastectomy surgery has been performed under the terms of this Plan as well as surgical reconstruction of an unaffected breast to achieve or restore symmetry with such reconstructed breast. The term also includes prostheses and treatment of physical complications, including lymphedemas, at all stages of mastectomy. Once symmetry has been attained, the term does not include subsequent breast surgery to affect a cosmetic change, such as cosmetic surgery to change the size and shape of the breasts. However, the term shall include Treatment for functional problems, such as functional problems with a breast implant used in the Breast Reconstruction. Symmetry means the breasts are similar, as opposed to identical, in size and shape.

MINIMUM INPATIENT STAY FOLLOWING MASTECTOMY OR RELATED PROCEDURE

Coverage for the treatment of breast cancer includes coverage of a minimum of forty-eight (48) hours of inpatient care following a mastectomy and twenty-four (24) hours of inpatient care following a lymph node dissection for the treatment of breast cancer unless Covered Person, and the attending Physician determine that a shorter period of inpatient care is appropriate.

TRANSPLANT SERVICES

Covered transplants, using human tissue only, if determined Medically Necessary and approved by the Medical Director as not Experimental or not Investigational for the Covered Person's condition may include:

- Kidney transplants;
- Cornea transplants;
- Liver transplants;
- Bone marrow transplants for aplastic anemia, leukemia, severe combined immunodeficiency disease, and Wiskott-Aldrich syndrome;
- Heart;
- Heart-lung;
- Lung;
- Pancreas;
- Pancreas-kidney.

Donor/procurement costs for covered transplants for matching, removal, and transportation of the organ are covered if:

- 1) The recipient of the organ is Covered Person, and
- 2) The donor/procurements costs are not covered by the donor's Health Benefit Plan.

If the donor's Health Benefit Plan does not cover donor/procurement costs, such costs will be covered.

BARIATRIC (WEIGHT LOSS) SURGERY:

Bariatric (weight loss) surgery may be considered medically necessary and a covered expense for carefully selected adults with clinically severe obesity, when less invasive methods of weight loss have failed and the individual is at high risk for obesity-related medical problems. Criteria for coverage include, but are not limited to;

- Age ≥ 18, and
- Body Mass Index (BMI) ≥ 40 or BMI ≥ 35 with associated co-morbidities, and
- Recent participation in a physician directed weight loss program, and
- Psychological evaluation, and
- Surgery performed at a Tier 1 facility.

There are numerous techniques for bariatric surgery and only certain of those with evidence based results will be considered for coverage. Bariatric surgery may result in redundant skin and fat deposits following significant weight loss. Surgical excision and/or liposuction, to treat such redundant skin and/or fat deposits, are not covered benefits.

CLINICAL TRIALS

Routine patient costs in correction with a phase I, II, III, or IV clinical trial, if the clinical trial is conducted in relation to the prevention, detection or treatment of a life – threatening disease or condition and is classified in one of the following sub paragraphs:

- A)** Federally funded trials. The study or investigation is approved or funded by one or more of the following:
- 1) The Centers for Disease Control and Prevention of the United States Department of Health and Human Services;
 - 2) The National Institutes of Health;
 - 3) The Agency for Health Care Research and Quality;
 - 4) The Centers for Medicare and Medicaid Services;
 - 5) Cooperative group or center of any of the entities described in (1) - (4) or the Department of Defense or the Department of Veteran Affairs;
 - 6) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants;
 - 7) An institutional review board of an institution in this state that has an agreement with the office of Human Research Protections of the United States Department of Health and Human Services;
 - 8) Any of the following, if the study or investigation conducted by such Department has been reviewed and approved through a system of peer review that the Secretary of the Health and Human Services Department determines to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review:
 - (i) The United States Department of Defense;
 - (ii) The United States Department of Veterans affairs; or
 - (iii) The United States Department of Energy
- B)** The study or investigation is conducted under an investigational new drug application reviewed by the United States Food and Drug Administration.
- C)** The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

We are **not** required to: reimburse the Research Institution conducting the clinical trial for the cost of routine patient care provided through the Research Institution unless the Research Institution, and each health care professional providing routine patient care through the Research Institution, agrees to accept reimbursement under this Plan, at the rates that are established under the Plan, as payment in full for the routine patient care

provided in connection with the clinical trial; or provide benefits for services that are a part of the subject matter of the clinical trial and that are customarily paid for by the Research Institution conducting the clinical trial.

Life-threatening disease or condition means a disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Research Institution means the institution or other person or entity conducting a phase I, phase II, phase III, or phase IV clinical trial.

Routine Patient Care Costs means the costs of any Medically Necessary health care service for which benefits are provided under this Plan, without regard to whether a Covered Person is participating in a clinical trial. Routine Patient Care Costs do not include:

- (i) The cost of an investigational new drug or device that is not approved for any indication by the United States Food and Drug Administration, including a drug or device that is the subject of the clinical trial;
- (ii) The cost of a service that is not a health care service, regardless of whether the service is required in connection with participation in a clinical trial;
- (iii) The cost of a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;
- (iv) A cost associated with managing a clinical trial; or
- (v) The cost of a health care service that is specifically excluded from coverage under this Plan.

SPECIALTY PHARMACY DRUGS

This Plan provides benefits for certain Specialty Pharmacy Drugs.

Covered Persons may be entitled to Medically Necessary prescription drugs depending upon the type of drug and the setting in which the drug is administered. This provision sets forth the circumstances in which prescription drugs are covered.

INPATIENT PRESCRIPTION DRUGS

Prescription Drugs, including Specialty Pharmacy Drugs, administered while admitted to an Inpatient facility will be covered as part of the Inpatient benefit, and no additional Copayments are required for prescription drugs so administered.

OUTPATIENT SPECIALTY PHARMACY DRUGS

Outpatient prescription drugs designated on the drug formulary as Specialty Pharmacy drugs are covered, subject to the Outpatient Specialty Pharmacy Copayments, Coinsurance and Deductibles indicated in the Schedule of Benefits.

Covered Persons may contact Health Plan to obtain a copy of the Specialty Pharmacy Drugs appearing on the drug formulary.

Specialty Pharmacy Drugs may require preauthorization by the Scott & White Medical Director and be subject to medical coverage requirements.

OUTPATIENT NON-SPECIALTY PHARMACY DRUGS ADMINISTERED IN OUTPATIENT SETTING

Outpatient Prescription Drugs which do not meet the definition of Specialty Pharmacy Drugs and which are dispensed and administered to a Covered Person in the office of a Provider or in another Outpatient setting, will be covered as a part of the Medical Services benefit, and no additional Copayments are required for outpatient prescription drugs so dispensed and administered. Outpatient Prescription Drugs which do not meet the definition of Specialty Pharmacy Drugs and which are dispensed and administered to a Covered Person in the office of a Provider or in another Outpatient setting which cost \$175 or more for a single dose, and refillable prescriptions

whose total cost during a twelve (12) month period could equal or exceed \$1,000, will require preauthorization by the Medical Director.

Outpatient Prescription Drugs which do not meet the definition of Specialty Pharmacy Drugs and which are dispensed by a pharmacy and administered to a Covered Person in the office of a Provider, or in another Outpatient setting, require approval of the Scott & White Medical Director in order to be covered as a part of the Medical Services benefit. Without the prior approval of the Scott & White Medical Director, coverage for Outpatient Prescription Drugs which do not meet the definition of Specialty Pharmacy Drugs and are dispensed by a pharmacy and administered by a Provider will be excluded under this Plan, unless covered under the Outpatient Prescription Drug Benefit.

Outpatient Specialty Pharmacy Drugs will be covered pursuant to the Outpatient Specialty Pharmacy Drugs benefit of this Summary Plan Description, regardless of whether or not the Specialty Pharmacy Drug is administered in the office of a Provider or other Outpatient setting.

OUTPATIENT PRESCRIPTION DRUGS

Except as covered by the Outpatient Prescription Drug Benefit, this Plan excludes Outpatient prescription drugs that:

- 1) Do not meet the definition of Specialty Pharmacy Drugs,
- 2) Are not dispensed and administered in the office of a Provider or other Outpatient setting; or
- 3) Are dispensed at a pharmacy and administered in the office of a Provider, or other Outpatient setting, without prior approval of a Medical Director.

DETERMINATION OF COVERAGE LEVEL FOR PRESCRIPTION DRUG BENEFITS

The determination of the coverage level of prescription drugs under this Plan shall be assigned in the following order:

- 1) Prescription Drug administered while admitted in an inpatient setting;
- 2) Outpatient Specialty Pharmacy Drug;
- 3) Outpatient Prescription Drug that is not a Specialty Pharmacy Drug, administered in the office of a Provider or other Outpatient setting; or
- 4) Outpatient Prescription Drug that is not a Specialty Pharmacy Drug and is not administered in the office of a Provider, or other Outpatient setting, if covered under the Outpatient Prescription Drug Benefit.

NOTE: All Prescription Drug Coverage is subject to the Limitations provision.

MEDICAL BENEFIT INFORMATION UNDER THE PLAN

Refer to the Schedule of Benefits for Medical Benefits applicable to your respective Plan to determine the specific deductible, co-payment, coinsurance and maximum benefit amounts.

GENERAL

For Covered Persons in this Plan, the obligations of the Plan and the Employer shall be fully satisfied by the payment of Benefits in accordance with the Schedule of Benefits for the applicable Plan earlier described in this Summary Plan Description. Benefits shall be paid for the reimbursement of Medical Expenses incurred by a Covered Person if:

- 1) The Medical Expenses are included in Covered Medical Expenses Section; and
- 2) The Medical Expenses are not excluded under the General Limitations and Exclusions Section; and
- 3) Benefits payable by this Plan are not reduced by the Coordination of Benefits and Order of Benefit Determination provisions;
- 4) The Claims Procedures have been followed; and
- 5) All other requirements of the Plan are satisfied.

PLAN TYPES

Two different types of Plans are available to Covered Persons, the Base Plan and CDHP (Consumer Driven Health Plan).

HMO PLAN

Under a HMO plan, services must be provided through Network Providers. Unless one of the Out-of-Network exceptions described below exist, a Covered Person will not receive benefits if care is obtained from a Non-Network Provider.

OUT-OF-NETWORK EXCEPTIONS

Certain services when performed by an Out-of-Network Health Care Provider will be covered at the In-Network Provider Benefit level. These services are described below:

SERVICES NOT AVAILABLE IN-NETWORK

Benefits for Covered Medical Expenses incurred by a Covered Person shall be paid at In-Network benefit level if the type of services or supply for which the Medical Expense is incurred:

- 1) Is not available within the Service Area; or
- 2) Is available within the Service Area, but is not available within the Network.

The Benefits paid in accordance with this Section shall not exceed the Reasonable and Customary Charges for the Service Area.

MEDICAL EMERGENCIES

In the event that a Covered Person is admitted as an inpatient into an Out-of-Network facility through an emergency room due to a covered emergency or accident, benefits will be paid at the In-Network Benefit level for post-stabilization services originating in a Hospital emergency facility or comparable facility.

The Covered Person's Covered Medical Expenses will be reimbursed at the In-Network Benefit level for services rendered by an Out-of-Network Health Care Provider located either within or outside the Network Service Area, for those expenses, less any applicable deductibles, co-payments or cost sharing amounts described in the Plan, which are incurred up to the time the Covered Person is determined by the Contract Administrator to be medically able to travel or to be transported to a Network Health Care Provider.

In the event that the Covered Person elects to remain in the Out-of-Network Hospital or facility after the date that the Contract Administrator has determined and advised the Covered Person 1) that the Covered Person no longer meets the criteria for continued inpatient confinement and 2) is able to travel or be transported to a Network Health Care Provider, the Covered Person shall be fully responsible for the appropriate deductibles, co-payments or cost sharing provisions of the benefit level associated with the Health Care Provider of the post emergency or accident services.

UTILIZATION MANAGEMENT AND PRE-AUTHORIZATION

The Covered Person must obtain Pre-authorization from the Contract Administrator for the certain covered services, procedures or supplies in order to receive Coverage. Failure to receive the required pre-authorization will result in loss of coverage for the service, procedure or supply. The list of services which must receive Pre-authorization are available on the website: www.swhp.org

Pre-authorization is not required for Covered Persons when Medicare is their primary coverage.

The Plan will also perform case management services through the Contract Administrator on an as needed basis.

DEDUCTIBLE

Depending upon which Plan is selected; a Covered Person may have to pay Covered Charges each Calendar Year in the amount of the deductible before the Plan will pay Benefits for the Calendar Year.

The deductible provision will apply to all Covered Charges unless explicitly modified in this Section. Refer to the Schedule of Benefits for the deductible amounts.

CO-PAYMENTS

The Plan requires that a Covered Person pay a Co-payment for certain services. Co-payments shall be used to satisfy out-of-pocket maximums.

COINSURANCE

The Plan will pay Benefits in the percentage amount of Covered Charges as indicated in the Schedule of Benefits. The Covered Person's share is considered Coinsurance. The coinsurance provision will apply to all Covered Charges unless explicitly modified in this Section.

OUT-OF-POCKET MAXIMUM

The Plan will pay 100% of Covered Charges after the Covered Person has paid Covered Charges in the amount of the Out-Of-Pocket Maximum for the Calendar Year. The Out-Of-Pocket Maximum shall consist of the Covered Person's out-of-pocket expenses arising out of deductible, co-payments, and coinsurance payments. The Schedule of Benefits indicates if certain out-of-pocket expenses do not count towards the Out-of-Pocket Maximum.

MAXIMUM BENEFITS

Some benefits have a day, visit or dollar limit on the benefit. This is shown in the Schedule of Benefits.

LIFETIME MAXIMUM BENEFIT

There is an unlimited lifetime maximum benefit under the Plan. This means for all Covered Services combined; there is no limit on the Coverage.

OUT-OF-AREA

Covered Persons will have access to the specified Health Care Providers in the National Network:

- 1) If they reside outside of the McLennan County service area
- 2) If they require services not available within the local Service Area
- 3) If they require "Emergency Services" outside of the McLennan County area as a result of an injury or the sudden onset of illness - (An emergency is a serious medical condition or symptom resulting from injury, sickness or mental illness, which arises suddenly and, in the judgment of a reasonable person, requires immediate care and treatment, generally received within 24 hours of onset, to avoid jeopardy to the life or health of a covered person. Examples of emergency conditions include: chest pain, severe bleeding, appendicitis, poisoning, seizures, strokes or loss of consciousness. Examples of non-emergency conditions include: routine colds, flu, sore throat, ear infection, sprains, strains, cuts, fatigue, weakness, rashes or skin disorders, chronic pain or illness, or low back pain.)
- 4) If a Health Care Provider is in the "National Network", the Health Care Provider has agreed to the negotiated/contracted fee as payment in full.
- 5) Once re-pricing is received from the National Network, claims will be paid at the In-Network level of benefits.

GENERAL LIMITATIONS AND EXCLUSIONS**EXCLUDED EXPENSES**

The term Excluded Expenses shall include any expense for a service or supply that is provided by someone other than a Health Care Provider or an expense (provided by a Health Care Provider) that does not meet the definition of Covered Expense. The term Excluded Expenses shall also include expenses for a service or supply which is

provided by a Health Care Provider for any of the following items. The Plan does not cover, and the Plan and Contract Administrators will not pay for, the following expenses incurred by a Covered Person:

ABORTIONS

Elective abortions, which are not necessary to preserve Covered Person's, health are excluded.

ALTERED SEXUAL CHARACTERISTICS

Any procedures or treatments designed to alter physical characteristics of Covered Person from Covered Person's biologically determined sex to those of another sex, regardless of any diagnosis of gender role disorientation or psychosexual orientation, including treatment for hermaphroditism and any studies or treatment related to sex transformation or hermaphroditism, are excluded.

BLOOD AND BLOOD PRODUCTS

Blood, blood plasma, and other blood products are excluded.

BREAST IMPLANTS

Non-Medically Necessary implantation of breast augmentation devices, removal of breast implants, and replacement of breast implants are excluded, except as provided for Breast Reconstruction Benefits.

COSMETIC OR RECONSTRUCTIVE PROCEDURES OR TREATMENTS

Unless otherwise covered under the Plan, cosmetic or reconstructive procedures or other Treatments which improve or modify a Covered Person's appearance are excluded. Examples of excluded procedures include, but are not limited to, liposuction, abdominoplasty, blepharoplasty, face lifts, osteotomies, correction of malocclusions, rhinoplasties, and mammoplasties. The only exceptions to this exclusion include certain procedures determined as Medically Necessary and approved by the Medical Director which are required solely because of any of the following: (1) an accidental bodily injury; (2) disease of the breast tissue; (3) a congenital or birth defect which was present upon birth; or (4) surgical Treatment of an illness. As medically appropriate and at the discretion of the Medical Director, any Treatment which would result in a cosmetic benefit may be delayed until such time as Covered Person has completed other alternative, more conservative Treatments recommended by the Medical Director.

COURT-ORDERED CARE

Health Care Services provided solely because of the order of a court or administrative body, which Health Care Services would otherwise not be covered under this Plan, are excluded.

CUSTODIAL CARE

Custodial Care as follows is excluded:

- Any service, supply, care or Treatment that the Medical Director determines to be incurred for rest, domiciliary, convalescent or Custodial Care;
- Any assistance with activities of daily living which include activities such as walking, getting in and out of bed, bathing, dressing, feeding, toileting, and taking drugs; or
- Any Care that can be performed safely and effectively by a person who does not require a license or certification or the presence of a supervisory nurse. Such services will not be Covered Services no matter who provides, prescribes, recommends or performs those services. The fact that certain Covered Services are provided while Covered Person is receiving Custodial Care does not require the Plan to cover Custodial Care.

DENTAL CARE

All dental care is excluded.

DISASTER OR EPIDEMIC

In the event of a major disaster or epidemic, services shall be provided insofar as practical, according to the best

judgment of Health Professionals and within the limitations of facilities and personnel available; but neither Health Plan, nor any Health Professional shall have any liability for delay or failure to provide or to arrange for services due to a lack of available facilities or personnel.

ELECTIVE TREATMENT OR ELECTIVE SURGERY

Elective Treatments or Elective Surgery, and complications of Elective Treatments or Elective Surgery, are excluded.

EXCEEDING BENEFIT LIMITS

Any Services provided to Covered Person who has exceeded any Benefit Maximum is excluded from Coverage.

EXPERIMENTAL OR INVESTIGATIONAL TREATMENT

Any Treatments that are considered to be Experimental or Investigational are excluded except as stated for Clinical Trials.

FAMILY MEMBER (SERVICES PROVIDED BY)

Treatments or services furnished by a Physician or Provider who is related to Participant, by blood or marriage, and who ordinarily dwells in Covered Person's household, or any services or supplies for which Covered Person would have no legal obligation to pay in the absence of the Plan or any similar coverage; or for which no charge or a different charge is usually made in the absence of health care coverage, are excluded.

FAMILY PLANNING TREATMENT

The reversal of an elective sterilization procedure; condoms, foams, contraceptive jellies and ointments are excluded.

GENETIC TESTING

Genetic tests are excluded, unless specifically required to be covered as Preventive Care under the Affordable Care Act.

HOUSEHOLD EQUIPMENT

The purchase or rental of household equipment which has a customary purpose other than medical, such as, but not limited to: exercise cycles, air purifiers, central or unit air conditioners, water purifiers, allergenic pillows, mattresses or waterbeds are excluded.

HOUSEHOLD FIXTURES

Fixtures, including, but not limited to, the purchase or rental of escalators or elevators, saunas, swimming pools or other household fixtures are excluded.

INFERTILITY DIAGNOSIS AND TREATMENT

The following infertility services are not covered:

- In vitro fertilization;
- Artificial insemination;
- Gamete intrafallopian transfer;
- Zygote intrafallopian transfer, and similar procedures;
- Drugs whose primary purpose is the Treatment of infertility;
- Reversal of voluntarily induced sterility;
- Surrogate parent services and fertilization;
- Donor egg or sperm;
- Abortions unless determined to be Medically Necessary or required to preserve the life of the mother.

MISCELLANEOUS

Artificial aids, corrective appliances, and medical supplies, such as batteries, condoms, dressings, syringes (except

for insulin syringes), dentures, hearing aids, eyeglasses and corrective lenses, are excluded.

NON-COVERED BENEFITS/SERVICES

Treatments, which are excluded from coverage under this Agreement and complications of such Treatments, are excluded.

NON-PAYMENT FOR EXCESS CHARGES

No payment will be made for any portion of the charge for a service or supply in excess of the Allowable Amount.

PERSONAL COMFORT ITEMS

Personal items, comfort items, food products, guest meals, accommodations, telephone charges, travel expenses, private rooms unless Medically Necessary, take home supplies, barber and beauty services, radio, television or videos of procedures, vitamins, minerals, dietary supplements and similar products except to the extent specifically listed as covered under the Plan, are excluded.

PHYSICAL AND MENTAL EXAMS

Physical, psychiatric, psychological, other testing or examinations and reports for the following are excluded:

- Obtaining or maintaining employment,
- Obtaining or maintaining licenses of any type,
- Obtaining or maintaining insurance
- Otherwise relating to insurance purposes and the like;
- Educational purposes,
- Services for non-medically necessary special education and developmental programs,
- Premarital and pre-adoptive purposes by court order,
- Relating to any judicial or administrative proceeding,
- Medical research.

CERTAIN DRUGS

Over-the-counter drugs are not covered. Coverage for drugs is limited to:

- Those pharmaceutical products prescribed or ordered by a Physician, utilized by the Covered Person while in the hospital, approved by the Food and Drug Administration (FDA) to sell for the use in humans, and used for the purpose approved by the FDA.
- Specialty Pharmacy Drugs as provided in the Outpatient Specialty Pharmacy Drugs provision of this Plan.
- Non-Specialty Pharmacy Drugs that are dispensed and administered in the office of a Provider, or other Outpatient setting, pursuant to the Coverage of Prescription Drugs provision of this Plan.
- Non-Specialty Pharmacy Drugs that are dispensed at a pharmacy and administered in the office of a Provider, or other Outpatient Setting, with prior approval of a Medical Director pursuant to the Coverage of Prescription Drugs provision of this Agreement.

REFRACTIVE KERATOTOMY

Radial Keratotomy and other refractive eye surgery are excluded.

REIMBURSEMENT

Health Plan shall not pay any provider or reimburse Covered Person for any Health Care Service for which Covered Person would have no obligation to pay in the absence of coverage under this Plan.

ROUTINE FOOT CARE

Services for routine foot care, including, but not limited to, trimming of corns, calluses and nails, except those services related to systemic conditions are excluded.

SPEECH AND HEARING LOSS

Services for the loss or impairment of speech or hearing are limited to those rehabilitative services described in the Rehabilitative Therapy provision.

STORAGE OF BODILY FLUIDS AND BODY PARTS

Long term storage (longer than 6 months) of blood and blood products is excluded. Storage of semen, ova, bone marrow, stem cells, DNA, or any other bodily fluid or body part is excluded unless approved by Medical Director.

TRANSPLANTS

Organ and bone marrow transplants and associated donor/procurement costs for Covered Person are excluded except to the extent specifically listed as covered in the Plan.

TREATMENT RECEIVED IN STATE OR FEDERAL FACILITIES OR INSTITUTIONS

No payment will be made for services, except Emergency Care, received in Federal facilities or for any items or services provided in any institutions operated by any state, government or agency when Member has no legal obligation to pay for such items or services; except, however, payment will be made to the extent required by law provided such care is approved in advance by Medical Director.

UNAUTHORIZED SERVICES

Non-emergency Health Care Services which are not provided, ordered, prescribed or authorized by a Provider are excluded.

VISION CORRECTIVE SURGERY, INCLUDING LASER APPLICATION

Traditional or laser surgery for the purposes of correcting visual acuity is excluded.

WAR, INSURRECTION OR RIOT

Treatment for Injuries or sickness as a result of war, riot, civil insurrection, or act of terrorism are excluded.

WEIGHT REDUCTION

Services for Gastric Bypass surgery are limited to those services specified in the Gastric Bypass surgery provision of the Plan. Weight reduction programs, food supplements, services, supplies, surgeries including but not limited to gastric stapling, Vertical Banding, or gym memberships, even if the Covered Person has medical conditions that might be helped by weight loss; or even prescribed by a physician are not covered.

III. PRESCRIPTION BENEFITS

PRESCRIPTION DRUG BENEFITS

The Plan uses a formulary (a list of drugs) that has been selected by a committee of Physicians and Pharmacists. These medications are selected based on research that shows their safety and effectiveness. Since there can be many brands of similar prescription medicines, the formulary is used to select the medication that proves to be the most cost effective in treating an illness.

PRESCRIPTION DRUG BENEFIT LIMITATIONS

Scott & White Prescription Services will cover the cost of the generic medications when they are available. If a brand name drug is dispensed when there is a generic available, the member will pay a 50% Non-Formulary Copayment.

PRESCRIPTION DRUG BENEFIT EXCLUSIONS

This drug benefit does not provide coverage for over-the-counter (OTC) medications and selected prescription drugs and therapeutic devices. Common examples include but are not limited to drugs used primarily for cosmetic purposes, drugs used primarily for the treatment of infertility, and drugs used primarily for weight loss.

IV. CLAIMS

By accepting the coverage of the Plan and benefits under the Plan the Covered Person is deemed to have agreed to the provisions of the Plan stated herein. Such agreement is a condition of participation.

COORDINATION OF BENEFITS

The Plan has been designed to help meet the cost of sickness or injury. Since it is not intended that greater benefits be paid you than your actual medical expenses, the amount of benefits payable by the Plan will take into account any coverage you or a family member has with other "plans". The benefits under the Plan will be coordinated with the benefits of the other "plans".

The Plan will always pay either its regular benefits in full, or a reduced amount which, when added to the benefits payable by the other plan or plans, will equal 100 percent of "Allowable Expenses".

"Allowable Expenses" means any necessary, Reasonable and Customary expense, incurred while you are eligible for benefits under the Plan, part or all of which would be covered under any of the plans, but not any expenses contained in the list of Exclusions. "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 by group insurance, self-insurance, or any similar plan or program.

Other Plan or Another Plan shall mean any plan, other than McLennan County's Plan, providing benefits or services for or by reason of medical or dental care or treatment, which benefits or services are provided by any of the following:

- 1) Group, blanket or franchise insurance coverage;
- 2) Service plan contracts, group practice, individual practice or other prepayment coverage;
- 3) Any coverage under labor-management trusteed plans, union welfare plans, employer organization plans, or employee benefit organization plans;
- 4) Any coverage under governmental programs and any coverage required or provided by any statute;
- 5) Group or individual no-fault automobile contracts or group traditional automobile medical expense contracts; and
- 6) Student coverage obtained through an educational institution above the high school level.

The benefits of Another Plan will be ignored for the purposes of determining Benefits under McLennan County's Plan if:

- 1) The Other Plan which contains a provision coordinating its benefits with those of This Plan would, according to its rules, determine its benefits after the Benefits of McLennan County's Plan have been determined; and
- 2) The rules set forth in this Section would require McLennan County's Plan to determine its Benefits before the Other Plan.

ORDER OF BENEFITS DETERMINATION & SUBROGATION

ORDER OF BENEFIT DETERMINATION

The following rules will be used to establish the order of benefit determination:

- 1) The benefits of a plan which covers the Covered Person as a dependent with the earliest birth date, month and date will determine its benefits first, except that when a claim is made for a dependent child of divorced or separated parents, the following rules will apply:
 - a) A plan which covers a child as a dependent of a parent who by court decree must provide health coverage will determine its benefits first;
 - b) When there is no court decree, which requires a parent to provide health coverage to a dependent child, the following rules will apply:

- (i) When a parent who has custody of the child has not remarried, that parent's plan will determine its benefits first;
- (ii) When a parent who has custody of the child has remarried:
 - (1) That parent's plan will determine its benefits first;
 - (2) The stepparent's plan will determine its benefits next; and
 - (3) The plan of the parent without custody will determine its benefits third.
- 2) When the rules explained in #1 (above) do not establish an order of benefit determination, the benefits of a plan which has covered the person on whose expenses claim is based for the longer period of time will be determined before the benefits of a plan which has covered the person the shorter period of time; and
- 3) When a plan does not contain a provision coordinating its benefits, that plan is always primary and always pays first.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

For the purpose of determining the applicability of and implementing the terms of this provision of McLennan County's Plan or any provision of similar purpose of any other plan, McLennan County may, without the consent of or notice to any person, release to or obtain from any Insurance Company or other organization or person any information, with respect to any person, which McLennan County deems to be necessary for such purposes. Any person, claiming benefits under McLennan County's Plan shall furnish to McLennan County such information as may be necessary to implement this provision

FACILITY OF BENEFIT PAYMENT

Whenever payments which would have been made under McLennan County's Plan in accordance with this provision have been made under any other plans, McLennan County shall have the right, exercisable alone and in its sole discretion, to pay over to any organization making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision, and amounts so paid shall be deemed to be benefits paid under McLennan County's Plan and, to the extent of such payments, McLennan County shall be fully discharged from liability under McLennan County's Plan.

SUBROGATION LIEN/ASSIGNMENT/REIMBURSEMENT

If McLennan County's Plan pays or provides medical benefits for an illness or injury that was caused by an act or omission of any person or entity, the Plan will be subrogated to all rights of recovery of a Covered Person, to the extent of such benefits provided or the reasonable value of services or benefits provided by the Plan. The Plan, once it has provided any benefits, is granted a lien on the proceeds of any payment, settlement, judgment, or other remuneration received by the Covered Person from any sources, including but not limited to:

- A third party or any insurance company on behalf of a third party, including but not limited to premises, automobile, homeowners, professional, DRAM shop, or any other applicable liability or excess insurance policy whether premium funded or self-insured;
- Underinsured/uninsured automobile insurance coverage regardless of the source;
- No fault insurance coverage, such as personal injury or medical payments protection regardless of the source;
- Any award, settlement or benefit paid under any worker's compensation law, claim or award;
- Any indemnity agreement or contract;
- Any other payment designated, delineated, earmarked or intended in whole or in part to be paid to a Covered Person as compensation, restitution, remuneration for injuries sustained or illness suffered as a result of the negligence or liability, including contractual, of any individual or entity;
- Any source that reimburses, arranges, or pays for the cost of care.

ASSIGNMENT

Upon being provided any benefits from the Plan, a Covered Person is considered to have assigned his or her rights of recovery from any source including those listed herein to the Plan to the extent of the reasonable value of services as determined by the Plan or benefits provided by the Plan.

No Covered Person may assign, waive, compromise or settle any rights or causes of action that he/she or any dependent may have against any person or entity who causes an injury or illness, or those listed herein, without the express prior written consent of the Plan.

REIMBURSEMENT

The Plan, by providing benefits, acquires the right to be reimbursed for the benefits provided or the reasonable value of services or benefits provided to a Covered Person, and this right is independent and separate and apart from the subrogation, lien and/or assignment rights acquired by the Plan and set forth herein.

The Plan is also entitled to recover from Covered Person the benefits provided or value of benefits and services provided, arranged, or paid for, by anyone including those listed herein.

If a Covered Person does not reimburse the Plan from any settlement, judgment, insurance proceeds or other source of payment, including those identified herein, the Plan is entitled to reduce current or future benefits payable to or on behalf of a Covered Person until the Plan has been fully reimbursed.

PLAN'S ACTIONS

The Plan in furtherance of the rights obtained herein may take any action it deems necessary to protect its interest, which will include, but not be limited to:

- Place a lien against a responsible party or insurance company and/or anyone listed herein;
- Bring an action on its own behalf, or on the Covered Person's behalf, against the responsible party or his insurance company and/or anyone listed herein;
- Cease paying the Covered Person's benefits until the Covered Person provides the Plan Sponsor with the documents necessary for the Plan to exercise its rights and privileges; and
- The Plan may take any further action it deems necessary to protect its interest.

OBLIGATIONS OF THE COVERED PERSON TO THE PLAN

- If a Covered Person receives services or benefits under the Plan, the Covered Person must immediately notify the Plan Sponsor of the name of any individual or entity against whom the Covered Person might have a claim as a result of illness or injury (including any insurance company that provides coverage for any party to the claim) regardless of whether or not the Covered Person intends to make a claim. For example, if a Covered Person is injured in an automobile accident and the person who hit the Covered Person was at fault, the person who hit the Covered Person is a person whose act or omission has caused the Covered Person's illness or injury.
- A Covered Person must also notify any third-party and any other individual or entity acting on behalf of the third-party and the Covered Person's own insurance carriers of the Plan's rights of subrogation, lien, reimbursement and assignment.
- A Covered Person must cooperate with the Plan to provide information about the Covered Person's illness or injury including, but not limited to providing information about all anticipated future treatment related to the subject injury or illness.
- The Covered Person authorizes the Plan, the Contract Administrator and any attorneys for the Plan or Contract Administrator, to pursue, sue, compromise and/or settle any claims described herein, including but not limited to, subrogation, lien, assignment and reimbursement claims in the name of the Covered Person and/or Plan. The Covered Person agrees to fully cooperate with the Plan in the prosecution of such a claim. The Covered Person agrees and fully authorizes the Plan, the Contract Administrator and any attorneys for the Plan or Contract Administrator to obtain and share medical information on the Covered Person necessary to investigate, pursue, sue, compromise and/or settle the above-described claims. The Plan, the Contract Administrator and any attorneys for the Plan or Contract Administrator specifically are granted by the Covered Person the authorization to share this information with those individuals or entities responsible for reimbursing the Plan through claims of subrogation, lien, assignment or reimbursement in an effort to recoup those funds owed to the Plan. This authorization includes, but is not be limited to, granting to the Plan, the Contract Administrator and any attorneys for the Plan or Contract Administrator the right to discuss the Covered Person's medical care and treatment

and the cost of same with third and first-party insurance carriers involved in the claim. Should a written medical authorization be required for the Plan to investigate, pursue, sue, compromise, prosecute and/or settle the above-described claims, the Covered Person agrees to sign such medical authorization or any other necessary documents needed to protect the Plan's interests.

- Additionally, should litigation ensue, the Covered Person agrees to and is obligated to cooperate with the Plan and/or any and all representatives of the Plan, including subrogation counsel, in completing discovery, obtaining depositions and/or attending and/or cooperating in trial in furtherance of the Plan's subrogation, lien, assignment or reimbursement rights.
- The Covered Person agrees to obtain written consent of the Plan before settling any claim or suit or releasing any party from liability for the payment of medical expenses resulting from an injury or illness. The Covered Person also agrees to refrain from taking any action to prejudice the Plan's recovery rights.
- Furthermore, it is prohibited for Covered Person to settle a claim against a third party for non-medical elements of damages, by eliminating damages relating to medical expenses incurred. It is prohibited for a Covered Person to waive a claim for medical expenses incurred by Covered Persons who are minors.
- To the extent that a Covered Person makes a claim individually or by or through an attorney for an injury or illness for which services or benefits were provided by the Plan, the Covered Person agrees to keep the plan updated with the investigation and prosecution of said claim, including, but not limited to providing all correspondence transmitted by and between any potential defendant or source of payment; all demands for payment or settlement; all offers of compromise; accident/incident reports or investigation by any source; name, address, and telephone number of any insurance adjuster involved in investigating the claim; and copies of all documents exchanged in litigation should a suit be filed.
- Nothing in these provisions requires the Plan to pursue the Covered Person's claim against any party for damages or claims or causes of action that the Covered Person might have against such party as a result of injury or illness.
- The Plan may designate a person, agency or organization to act for it in matters related to the Plan's rights described herein, and the Covered Person agrees to cooperate with such designated person, agency, or organization in the same manner as if dealing with the Plan itself.

MADE WHOLE DOCTRINE

The Plan's right of subrogation, lien, assignment or reimbursement as set forth herein will not be affected, reduced or eliminated by the "made whole doctrine" and/or any other equitable doctrine or law which requires that the Covered Person be "made whole" before the Plan is reimbursed. The Plan has the right to be repaid 100% first from any settlement, judgment, remuneration, insurance proceeds or other source of funds a Covered Person receives. The Plan has the right to be reimbursed first whether or not a portion of the settlement, judgment, remuneration, insurance proceeds or other source of funds are identified as a reimbursement for medical expenses. The plan has the right to be reimbursed first whether or not a Covered Person makes a claim for medical expenses.

ATTORNEYS' FEES

The Plan will not be responsible for any expenses, fees, costs or other monies incurred by the attorney for the Covered Person and/or his or her beneficiaries, commonly known as the common fund doctrine. The Covered Person is specifically prohibited from incurring any expenses, costs or fees on behalf of the Plan in pursuit of his rights of recovery against a third-party or Plan's subrogation, lien, assignment or reimbursement rights as set forth herein. No court cost, filing fees, experts' fees, attorneys' fees or other cost of a litigation nature may be deducted from the Plan's recovery without prior, express written consent of the Plan.

A Covered Person must not reimburse their attorney for fees or expenses before the Plan has been paid in full. The Plan has the right to be repaid first from any settlement, judgment, or insurance proceeds a Covered Person receives. The Plan has a right to reimbursement whether or not a portion of the settlement, judgment, insurance proceeds or any other source or payment was identified as a reimbursement of medical expenses.

WRONGFUL DEATH/SURVIVORSHIP CLAIMS

In the event that the Covered Person dies as a result of his/her injuries and a wrongful death or survivorship claim is asserted the Covered Person's obligations become the obligations of the Covered Person's wrongful death beneficiaries, heirs and/or estate.

DEATH OF COVERED PERSON

Should a Covered Person die, all obligations set forth herein shall become the obligations of his/her heirs, survivors and/or estate.

CONTROL OF SETTLEMENT PROCEEDS

A Covered Person may not use an annuity or any form of trust to hold/own settlement proceeds in an effort to bypass obligations set forth herein. A Covered Person agrees that they have actual control over the settlement proceeds from the underlying tort or first party claim from which they are to reimburse the plan whether or not they are the individual or entity to which the settlement proceeds are paid.

PAYMENT

The Covered Person agrees to include the Plan's name as a co-payee on any and all settlement drafts or payments from any source.

The fact that the Plan does not assert or invoke its rights until a time after a Covered Person, acting without prior written approval of the authorized Plan representative, has made any settlement or other disposition of, or has received any proceeds as full or partial satisfaction of, Covered Person's loss recovery rights, shall not relieve the Covered Person of his/her obligation to reimburse the Plan in the full amount of the Plan's rights.

SEVERABILITY

In the event that any section of these provisions is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of the Plan. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the plan.

INCURRED BENEFITS

The Plan reserves the right to reverse any decision associated with the reduction or waiver of charges related to services or benefits provided if and when the Plan discovers that the Covered Person has been involved in an injury or accident and may be compensated by one of the sources set forth herein. Should this occur, the Covered Person is deemed to have incurred the full billed charges or the full cost of the benefits or services rendered.

NON-EXCLUSIVE RIGHTS

The rights expressed in this document in favor of the Plan are cumulative and do not exclude any other rights or remedies available at law or in equity to the Plan or anyone in privity with the Plan.

The provisions herein bind the Covered Person, as well as the Covered Person's spouse, dependents, or any members of the Covered Person's family, who receives services or benefits from the Plan individually or through the Covered Person.

CLAIMS PROCEDURES**QUESTIONS RELATING TO ELIGIBILITY, CLASSIFICATION, COVERAGE**

All questions relating to eligibility, classification, or coverage under the Plan shall be submitted to the Contract Administrator. The Contract Administrator may make a determination on whether or not a particular medical service is covered by the Plan or is medically necessary either before services are rendered or after services are rendered.

When the Covered Person receives Covered Services, a claim must be filed on the Covered Person's behalf to obtain benefits. If the Health Care Provider is a Network Health Care Provider, the Network Health Care Provider will file the claim on your behalf. If you receive services from a Non-Network Health Care Provider, the Health Care Provider may not submit the claim on behalf of the Covered Person. If the Covered Person submits the claim, (s)he should use a claim form. It is in the Covered Person's best interest to ask the Health Care Provider if the claim will be filed on his or her behalf by the Health Care Provider.

CLAIM FORMS

When the Covered Person is submitting the claim on his or her own behalf, (s)he may obtain a claim form from the Employer. If forms are not available, send a written request for claim forms to Scott & White. Written notice of services rendered may also be submitted to Scott & White without the claim form. The same information that would be given on the claim form must be included in the written notice of claim. This includes:

- 1) Name of patient;
- 2) Patient's relationship to the Covered Employee;
- 3) Identification number;
- 4) Date, type and place of service;
- 5) Name of Health Care Provider;
- 6) The explanation of benefits worksheet from the Primary carrier when filing for secondary claim benefits.
and
- 7) The Covered Person's signature and the Health Care Provider's signature.

TIME FRAME FOR SUBMITTING CLAIM

All claims for benefits must be submitted within 90 days of the date the claimed Expenses were incurred or as soon as is reasonably possible, but not later than one year from the date the claimed Expenses were incurred.

The claim form should be submitted to the address shown on the Covered Person's identification card.

CLAIMS REVIEW PROCEDURE

This section describes the claims review procedures under the Plan. A claim is defined as any request for a benefit made by a Covered Person or by a Health Care Provider on behalf of the Covered Person that complies with the Plan's reasonable procedure for making a claim for benefits. The times shown in this section are maximum times only. A period of time begins at the time the claim is filed. The days shown in this section are counted as calendar days.

Under the Plan, the Covered Person can check on the status of a claim at any time by contacting the Customer Service number appearing on the Covered Person's identification card.

There are different time frames for reviewing a claim and providing notification concerning the claim. The time frames are based on the category of the claim. For the purpose of this provision, there are three categories of claims: Pre-Service Claims, Urgent Care Claims and Post-Service Claims.

PRE-SERVICE CLAIMS

Pre-Service Claims are those claims for which the Plan requires prior notification and approval of the benefit prior to receiving the service. These are services, for example, that are subject to pre-authorization or pre-determination. For Pre-Service Claims (other than Urgent Care Claims), the following time frames apply concerning review and notification of the benefit determination:

NOTIFICATION CONCERNING FAILURE TO FOLLOW PROCEDURE

In the event the Covered Person, or Health Care Provider on behalf of the Covered Person, fails to follow the proper procedure for providing notification of a Pre-Service Claim, the Covered Person or Health Care Provider will be notified within 5 days.

BENEFIT DETERMINATION PERIOD

The Covered Person will be notified of the benefit determination within 15 days following receipt of notification concerning the Pre-Service Claim.

EXTENSION OF BENEFIT DETERMINATION PERIOD

If a benefit determination cannot be made within the standard 15-day benefit determination period due to matters beyond the Contract Administrator's control, the period may be extended by an additional 15 days, provided the Covered Person is notified of the need to extend the period prior to the end of the initial 15-day benefit determination period. Only one extension is permitted for each Pre-Service Claim.

If a benefit determination cannot be made within the standard 15-day benefit determination period due to the Covered Person's failure to provide sufficient information to make the benefit determination, the benefit determination period may be extended, provided the Covered Person is notified of the need to extend the period. The Covered Person must be notified prior to the end of the initial 15-day benefit determination period. The notification must include a detailed explanation of the information needed in order to make the benefit determination. The Covered Person has 45 days following the receipt of the notification to provide the requested information.

As defined by the Department of Labor, an adverse benefit determination is a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Covered Person's eligibility to participate in a Plan .

URGENT CARE CLAIMS

Urgent Care Claims are those **Pre-Service Claims** in which the time periods for making claim determinations for Pre- or Post-Service Claims could seriously jeopardize the Covered Person's life, health or ability to regain maximum function or when a Physician with knowledge of the Covered Person's medical condition determines that the Covered Person would be subject to severe pain that cannot be adequately managed or controlled without the treatment that is the subject of the claim. For Urgent Care Claims, the following time frame applies concerning review and notification concerning the benefit determination:

- 1) **Notification Concerning Incomplete Claim** - In the event the Covered Person, or Health Care Provider on behalf of the Covered Person, fails to submit complete information in connection with an Urgent Care Claim, the Covered Person or Health Care Provider will be notified of the specific information needed to complete the claim within 24 hours.
- 2) **Benefit Determination Period** – The Covered Person will be notified of the benefit determination concerning an Urgent Care Claim within 24 hours following receipt of notification concerning the Urgent Care Claim.
- 3) **Extension of Benefit Determination Period** - In the event additional information is needed in order to make a benefit determination, the Covered Person must be notified within 24 hours following receipt of notification concerning the Urgent Care Claim. Notification of the extension will include a detailed explanation of the information needed to make the benefit determination. Upon receipt of the notification of the required extension, the Covered Person has 48 hours to provide the requested information. The determination will be made within 48 hours following receipt of the requested information from the Covered Person. If the Covered Person fails to provide the requested information, the benefit determination will be made within 48 hours following the end of the period allowed for providing said information.
- 4) **Benefit Determination Period For Request of Continuation of Treatment** - Any request to continue the course of treatment that is an Urgent Care Claim shall be decided as soon as possible. The Covered Person will be notified of the benefit determination within 24 hours of the receipt of the claim, provided

that such claim is made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

POST-SERVICE CLAIMS

Post-Service Claims are those claims for services, other than Pre-Service and Urgent Care Claims, which have been rendered by a Health Care Provider. For Post-Service Claims, the following time frames apply concerning review and notification of the benefit determination:

- 1) **Benefit Determination Period** - The Covered Person will be notified of the benefit determination within 30 days following receipt of notification concerning the Post-Service Claim.
- 2) **Extension of Benefit Determination Period** - If a benefit determination cannot be made by the Contract Administrator within the standard 30-day benefit determination period due to matters beyond its control, the period may be extended by an additional 15 days, provided the Covered Person is notified of the need to extend the period prior to the end of the initial 30-day benefit determination period. Only one extension is permitted for each Post-Service Claim.

If a benefit determination cannot be made within the standard 30-day benefit determination period due to the Covered Person's failure to provide sufficient information to make the benefit determination, the benefit determination period may be extended, provided the Covered Person is notified of the need to extend the period. The Covered Person must be notified prior to the end of the initial 30-day benefit determination period. The notification must include a detailed explanation of the information needed in order to make the benefit determination. The Covered Person has 45 days following the receipt of the notification to provide the requested information.

CLAIMS APPEAL PROCESS

The Plan has a claims appeal process. The claims appeal process and the time limits associated with requesting and responding to a request for Claims Appeal is described in this section. The Covered Person and the Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact the local U.S. Department of Labor Office.

Under the Plan, the Covered Person can check on the status of a claim appeal at any time by contacting the Customer Service number appearing on the reverse side of the Identification Card.

REQUESTING A CLAIMS APPEAL

The Plan has a claims appeals process that allows the Covered Person to submit a request for appeal to the fiduciary who has been named by the Plan Administrator to review a claims appeal ("Named Fiduciary"). Under the Plan, the Plan Administrator will serve as the Named Fiduciary, unless the Plan Administrator has specifically delegated this responsibility to another party. The Named Fiduciary has the sole responsibility for making the decision on an appeal of an adverse benefit determination.

Under the claims appeal process, the Covered Person will be provided with a full and fair review of an adverse benefit determination. This review of an adverse benefit determination must be done by an individual who is neither the individual who made the original adverse benefit determination nor the subordinate of such individual. In addition, if the adverse benefit determination is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is experimental, investigational, or not Medically Necessary, the Named Fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment.

In the event the Covered Person disagrees with a claims decision concerning the denial of a benefit or scope of benefits, the Covered Person or the Covered Person's authorized representative may submit a request for appeal within 180 days from receipt of the notice of denial or adverse benefit determination. Absent an express written authorization by the Covered Person providing otherwise, the authorized representative includes a medical Health

Care Provider only for an Urgent Care Claims Appeal.

Under the claims appeal process:

- 1) The Covered Person is permitted to submit written documents, comments, records, evidence, testimony and other information relating to the claim;
- 2) The Covered Person is allowed reasonable access to any copies of documents, records and other information relevant to the claim, including his or her claim file;
- 3) The Covered Person is permitted to request the name of the medical Health Care Provider used in making the initial adverse benefit determination; and
- 4) All comments, documents, records and other information submitted without regard to whether such information was submitted or considered in the initial determination will be taken into account.

The Covered Person's request for an appeal must be submitted in writing and should be submitted to:

**Dispute Resolution Department
Scott & White Health Plan
1206 West Campus Drive
Temple, TX 76502**

EXTERNAL APPEALS PROCESS

In cases where a denial is upheld in whole or in part, through the internal appeal review process above, a Covered Person may submit an appeal through the external review process.

REQUEST FOR EXTERNAL REVIEW

The Covered Person must file a request for an external review within four months after the date of receipt of a notice of an adverse benefit determination or final internal adverse benefit determination. If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

PRELIMINARY REVIEW

Within five business days following the date of receipt of the external review request, the Plan shall complete a preliminary review of the request to determine whether:

- 1) The claimant is or was covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided;
- 2) The adverse benefit determination or the final adverse benefit determination does not relate to the claimant's failure to meet the requirements for eligibility under the terms of the group health plan (e.g., worker classification or similar determination);
- 3) The claimant has exhausted the Plan's internal appeal process, unless the claimant is not required to exhaust the internal appeals process; and
- 4) The claimant has provided all the information and forms required to process an external review.

Within one business day after completion of the preliminary review, the Plan must issue a notification in writing to the claimant. If the request is complete but not eligible for external review, such notification must include the reasons for its ineligibility and contact information for the Staff Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, the written notification must describe the information needed to complete the request, and the claimant shall be permitted to perfect the request for external review within the four-month filing period or within the 48 hour period following the receipt of the notification, whichever is later.

REFERRAL TO INDEPENDENT REVIEW ORGANIZATION

The Plan shall assign an Independent Review Organization (IRO) that is accredited by the Utilization Review Accreditation Committee ("URAC") or by a similar nationally-recognized accrediting organization to conduct the external review. The Plan, through its Contract Administrator will contract with at least three (3) IROs and rotate claims assignments among them (or incorporate other independent unbiased methods for selections of IROs such as random selection). The IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

The assigned IRO will timely notify the claimant in writing of the request's eligibility and acceptance for external review. This notice will include a statement that the claimant may submit in writing to the assigned IRO within 10 business days following the date of receipt of the notice, additional information that the IRO must consider when conducting the external review. The IRO is not required to, but may accept and consider additional information submitted after ten business days.

Within five business days after the date of assignment of the IRO, the Plan must provide to the assigned IRO the documents and any information considered in making the adverse benefit determination or final internal adverse benefit determination. Failure by the Plan to timely provide the documents and information must not delay the conduct of the external review. If the Plan fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to reverse the adverse benefit determination or final internal adverse benefit determination and provide coverage or payment. Within one business day after making the decision, the IRO must notify the claimant and the Plan.

Upon receipt of any information submitted by the claimant, the assigned IRO must within one business day forward the information to the Plan. Upon receipt of any such information, the Plan may reconsider its adverse benefit determination or final internal adverse benefit determination that is the subject of the external review. Reconsideration by the Plan must not delay the external review. The external review may be terminated as a result of the reconsideration only if the plan decides, upon completion of its reconsideration, to reverse its adverse benefit determination or final internal benefit determination and provide coverage or payment. Within one business day after making such a decision, the Plan must provide written notice of its decision to the claimant and the assigned IRO. The assigned IRO must terminate the external review upon receipt of the notice from the Plan if the Plan reverses its decision.

The IRO will review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim de novo and not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. In addition to the documents and information provided, the assigned IRO will consider the following in reaching a decision to the extent the information and documents are available and the IRO considers them appropriate:

- 1) The claimant's medical records;
- 2) The attending healthcare professional's recommendation;
- 3) Reports from appropriate health care professionals and other documents submitted by the plan or claimant or claimant's treating provider;
- 4) The terms of the Plan to ensure that the IRO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law;
- 5) Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal Government, National or Professional Medical Societies, Boards, and Associations;
- 6) Any applicable clinical review criteria developed and used by the Plan, unless the criteria are inconsistent with the terms of the Plan or with applicable law;
- 7) The opinion of the IRO's clinical reviewer or reviewers after considering information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

The assigned IRO must provide written notice of the final external review decision within 45 days after the IRO receives the request for the external review. The IRO must deliver the notice of final external review decision to the claimant and the Plan.

REVERSAL OF PLAN'S DECISION

Upon receipt of a notice of a final external review decision reversing the adverse benefit determination or final internal adverse benefit determination, the Plan immediately must provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

REQUEST FOR EXPEDITED EXTERNAL REVIEW

The Plan shall allow a claimant to make a request for an expedited external review if the claimant receives:

- 1) An adverse benefit determination if the adverse benefit determination involves a medical condition of the claimant for which the timeframe for completion of an expedited internal appeal under the interim final regulations would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function and the claimant has filed a request for an expedited internal appeal; or
- 2) A final internal adverse benefit determination, if the claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services, but has not been discharged from a facility.

Immediately upon receipt of the request for expedited external review, the Plan shall determine whether the request meets the reviewability requirements described above for standard external review. The Plan must immediately send a notice that meets the requirements set forth above for standard external review to the claimant of its eligibility determination.

Upon a determination that a request is eligible for external review following the preliminary review, the Plan will assign an IRO pursuant to the requirements set forth above for standard review. The Plan must provide or transmit all necessary documents and information considered in making the adverse benefit determination or final internal adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO must review the claim de novo and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

The contract with the assigned IRO must require the IRO to provide notice of the final external review decision, in accordance with the requirements set forth above, as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, the assigned IRO must provide written confirmation of the decision to the claimant and the Plan within 48 hours after the date of providing that notice.

V. MISCELLANEOUS

GENERAL PROVISIONS

FUNDING

Medical and prescription claims are paid directly by McLennan County Health Fund. McLennan County has employed a Contract Administrator to assure accurate, impartial and timely payment of benefits to and in behalf of Covered Employees and Dependents. The contributions payable to the trust shall not exceed the Plan's qualified cost for the taxable year as provided by Internal Revenue Code Sections 419 and 419A; which limitations are hereby incorporated into this Plan by reference.

CONFORMITY WITH STATUTES

Any provision of the Plan, which on its Effective Date is in conflict with applicable statutes of the United States or of the jurisdiction of Texas, is hereby amended to conform to the minimum requirements of such statutes.

CLAIMS PROCEDURE

McLennan County, upon receipt of notice required by the Plan, will furnish to the Covered Person or to any other person notifying McLennan County of Claim such forms as usually furnished by it for filing proof of loss. Failure to furnish notice or proof of a claim within the time provided in the Plan shall not invalidate or reduce any claims if it shall be shown not to have been reasonably possible to furnish such notice or proof and that such notice or proof was furnished as soon as possible.

REVIEW PROCEDURE

McLennan County or a person or persons authorized by County shall have the power to initiate a review of a claim made under the Plan. Such officer shall conduct the review in a manner in which he/she determines is in accordance with the best interests of the Plan and of the claimant and may utilize (but is not limited to) any or all of the following procedures:

- 1) Consulting with Contract Administrator with respect to such claim;
- 2) Requesting Contract Administrator to review all matters relevant to such claim;
- 3) Requesting Contract Administrator to furnish all records pertaining to such claim to County for County review;
- 4) Appointing a committee to review the claim (size and content of committee to be determined by McLennan County).

FACILITY OF PAYMENT

If, in the opinion of McLennan County, a valid release cannot be rendered for the payment of any benefit payable under the Plan, McLennan County may, at its option, make such payment to the individuals as have, in McLennan County's opinion, assumed the care and principal support of the Covered Person and are therefore equitably entitled thereto. In the event of the death of the Covered Person prior to such time as all benefit payments due him/her have been made, McLennan County may, at its sole discretion and option, honor benefit assignments, if any, prior to the death of such Covered Person.

Any payment made by McLennan County in accordance with the above provisions shall fully discharge McLennan County to the extent of such payment.

PLAN ADMINISTRATION

The Plan Administrator shall have full charge of the operation and management of the Plan.

The Plan Administrator and Plan Sponsor have contracted with the Contract Administrator to assist with the operation of the Plan including the performance of: claims administration services, network administration and Pre-Authorization, case management services and utilization review management, and such other services as may be delegated to it under the terms of their contract. Specifically, the Contract Administrator shall have the authority and responsibility to:

- 1) Adjudicate claims and make claim payments where appropriate;
- 2) Determine the eligibility, participation selection and participation termination of each Network Health Care Provider;
- 3) Determine whether treatment or service is due to a Medical Emergency or is Medically Necessary or Appropriate;
- 4) Provide Pre-Authorization, case management services and administration of the utilization review program.

In addition, the Plan Sponsor and Plan Administrator may designate any person or persons to carry out their respective responsibilities. Any person or group of persons may serve in more than one fiduciary capacity with respect to the Plan.

PLAN MODIFICATION AND AMENDMENTS OF PLAN

The Plan and any provision thereof may be modified or amended at any time by McLennan County upon its due approval of such modification or amendment. The modification or amendment will be effective at the date of approval or at such later date as McLennan County may determine in connection therewith. Such modification or amendment shall be duly incorporated in writing into the master copy of the Plan on file with McLennan County or written copy thereof shall be deposited with such master copy of the Plan.

PLAN TERMINATION

The Plan may be terminated at any time by McLennan County upon due authorization of such termination effective as of the date of such authorization or at such later date as McLennan County may provide. In the event of such termination, McLennan County shall have no obligation under the Plan beyond paying the difference between the claims incurred (even though later filed) and expenses of the Plan due up to the date of termination. Such claims and expenses shall be paid from the funds as normal expenses of the Plan.

PHYSICAL EXAMINATION

The Contract Administrator, at the expense of the Plan, will have the right and opportunity to examine the person or any individual whose Injury or Sickness is the basis of a claim when and as often as it may reasonably require while the claim is pending.

FREE CHOICE OF PHYSICIAN

A claimant has free choice of any in-network Physician, and the Physician-patient relationship will be maintained.

CONTRIBUTIONS

The Plan Sponsor shall determine the amount of contribution required for coverage for each Covered Person. Such determination shall be made within a reasonable time.

HIPAA PRIVACY

PRIVACY RIGHTS POLICY AND PROCEDURES

POLICY

McLennan County ["Health Plan"] has implemented policies and procedures to ensure privacy rights as required by and specified in the Privacy rule of the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996.

PROCEDURES

PERMITTED AND REQUIRED USES AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Subject to obtaining written certification pursuant to paragraph 3 (below) of the Plan, the Plan or a health insurance issuer or HMO with respect to the Plan, may disclose Protected Health Information to the Plan Sponsor, provided the Plan Sponsor does not use or disclose such Protected Health Information except for the following purposes:

- a. To perform Plan administrative functions which the Plan Sponsor performs for the Plan;
- b. Obtaining premium bids from insurance companies, HMOs or other health plans for providing health insurance coverage under the group health plan; or
- c. Modifying, amending, or terminating the group health plan.

Notwithstanding the provisions of this Plan to the contrary, in no event shall the Plan Sponsor be permitted to use or disclose Protected Health Information in a manner that is inconsistent with 45 CFR §164.504(f).

Under the American Recovery and Reinvestment Act of 2009 (ARRA), the Health Plan will be required to limit its distribution, use or requests for protected health information, to the extent practicable, to a limited data set, or if more information is needed, to the minimum necessary amount of information needed to accomplish the intended purpose of the data use. The Secretary of HHS issues guidance on what constitutes minimum necessary for the purposes of this provision.

CONDITIONS OF DISCLOSURE

The Plan or a health insurance issuer or HMO with respect to the Plan, shall not disclose Protected Health Information to the Plan Sponsor unless the Plan Sponsor agrees to:

- a. Not use or further disclose the Protected Health Information other than as permitted or required by the Plan or as required by law.
- b. Ensure that any agents, including a subcontractor, to whom it provides Protected Health Information received from the Plan, agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to Protected Health Information, including implementing reasonable and appropriate security measures to protect Electronic Protected Health Information.
- c. Not use or disclose the Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.
- d. Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware.
- e. Make available to a Plan participant who requests access the Plan participant's Protected Health Information in accordance with 45 CFR §164.524.
- f. Make available to a Plan participant who requests an amendment the participant's Protected Health Information and incorporate any amendments to the participant's Protected Health Information in accordance with 45 CFR §164.526.
- g. Make available to a Plan participant who request an accounting of disclosures of the participant's Protected Health Information the information required to provide an accounting of disclosures in accordance with 45 CFR §164.528. To the extent the Health Plan uses or maintains Electronic Health

Records (EHRs), the Health Plan must be able to account for uses and disclosures of that information, even for treatment, payment and/or health care operations purposes. This detail must be retained for a period of at least three years. You have a right to obtain a copy of the record in an electronic format and to direct the Health Plan to transmit a copy of the record to any entity or person designated by you. This provision is effective January 1, 2014 or the date EHR is acquired for all EHRs acquired after January 1, 2009. For EHRs acquired on or before January 1, 2009, the provision will be effective January 1, 2014.

- h.** Make its internal practices, books, and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with 45 CFR §164.504(f).
- i.** If feasible, return or destroy all Protected Health Information received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which the disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information feasible.
- j.** Ensure that the adequate separation between Plan and Plan Sponsor required in 45 CFR §164.504(f)(2)(iii) is satisfied, including ensuring reasonable and appropriate security measures.
- k.** Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of Electronic Protected Health Information that it creates, receives, maintains, or transmits on behalf of the Plan.
- l.** Report to the Plan any security incident relating to Electronic Protected Health Information of which it becomes aware. A security incident is defined at 45 C.F.R. § 164.304 as "the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system."

CERTIFICATION OF PLAN SPONSOR

The Plan shall disclose Protected Health Information to the Plan Sponsor only upon the receipt of a Certification by the Plan Sponsor that the Plan has been amended to incorporate the provisions of 45 CFR § 164.504(f)(2)(ii), and that the Plan Sponsor agrees to the conditions of disclosure set forth titled **Permitted and Required Uses and Disclosure of Protected Health Information** of this section of this Summary Plan Description.

PERMITTED USES AND DISCLOSURE OF SUMMARY HEALTH INFORMATION

The Plan or a health insurance issuer or HMO with respect to the Plan, may disclose Summary Health Information to the Plan Sponsor, provided such Summary Health Information is only used by the Plan Sponsor for the purpose of:

- a.** Obtaining premium bids from health plan Health Care Providers for providing health insurance coverage under the Plan; or
- b.** Modifying, amending, or terminating the Plan.

PERMITTED USES AND DISCLOSURE OF ENROLLMENT AND DISENROLLMENT INFORMATION

The Plan or a health insurance issuer or HMO with respect to the Plan, may disclose enrollment and disenrollment information and information on whether individuals are participating in the Plan to the Plan Sponsor, provided such enrollment and disenrollment information is only used by the Plan Sponsor for the purpose of performing administrative functions that the Plan Sponsor performs for the Plan.

ADEQUATE SEPARATION BETWEEN PLAN AND PLAN SPONSOR

The Plan Sponsor shall only allow certain employees, or classes of employees, access to the Protected Health Information. Such employees shall only have access to and use such Protected Health Information to the extent necessary to perform the administration functions that the Plan Sponsor performs for the Plan. In the event that any such employees do not comply with the provisions of this Section, the employee shall be subject to disciplinary action by the Plan Sponsor for non-compliance pursuant to the Plan Sponsor's employee discipline and termination procedures. The individuals or classes of employees who are permitted access to Protected Health Information as set forth in this paragraph are:

AUTHORIZED EMPLOYEES OF THE HUMAN RESOURCES AND COUNTY AUDITOR'S DEPARTMENTS

BREACH

The Covered Entity is required to notify each individual whose unsecured protected health information is the subject of a breach, or is reasonably believed to be subject of a breach. Notification must occur within 60 days of the discovery of the breach. In addition, the Health Plan must notify the Secretary of the Department of Health and Human Services. If the breach involves 500 or more individuals, the Covered Entity is also required to notify a local media outlet serving the state or jurisdiction in which the individuals reside. This provision will be effective 180 days after enactment date of the American Recovery and Reinvestment Act of 2009 (ARRA). The enactment date of ARRA is February 17, 2009.

NOTICE OF PRIVACY PRACTICES POLICY AND PROCEDURES

POLICY

The privacy practices of McLennan County ["Health Plan"] designed to protect the privacy, use and disclosure of Protected Health Information (PHI), are clearly delineated in the [Health Plan's] Notice of Privacy Practices which was developed and is used in accordance with the Privacy Rule.

PROCEDURES

The privacy practices of McLennan County Health Plan are described in its Notice.

The Notice is distributed to all new Covered Persons at enrollment. All current Covered Persons received the Notice as of the compliance date. All Covered Persons receive a revised Notice within 60 days of any material revision to the Notice. The Notice is provided to the named Covered Person or employee for the benefit of all dependents.

The Notice is available to anyone who requests it. Covered Persons have the right to receive a paper copy of the Notice, even if they previously agreed to receive the Notice electronically.

All current Covered Persons are notified at least once every three years of the availability of the Notice and provided with instructions on how to obtain it.

The Notice is given to all Business Associates.

The Notice is reviewed with all current workforce members who perform Health Plan functions during their initial training and annually thereafter. The Notice is revised as needed to reflect any changes in the Health Plan's privacy practices. Revisions to the policies and procedures are not implemented prior to the effective date of the revised Notice.

When revisions to the Notice are necessary, all current Covered Persons, workforce members who perform Health Plan functions and Business Associates receive a revised copy of the Notice.

The Privacy Official retains copies of the original Notice and any subsequent revisions for a period of six (6) years from the date of its creation or when it was last in effect, whichever is later.

All workforce members who perform Health Plan functions and Business Associates are required to adhere to the privacy practices as detailed in the Notice, Privacy Policies and Procedures and Business Associate Contracts.

Violations of the Health Plan's privacy practices will result in disciplinary action up to and including termination of employment or contracts.

The Notice is available electronically and in hard copy.

NOTICE OF HEALTH PLAN'S PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

USE AND DISCLOSURE OF HEALTH INFORMATION

McLennan County ("Health Plan") may use your health information, that is, information that constitutes protected health information as defined in the Privacy Rule of the Administrative Simplification provision of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), for purposes of making or obtaining payment for your care and conducting health care operations. Health Plan has established a policy to guard against unnecessary disclosure of your health information.

The following is a summary of the circumstances under which and purposes for which your health information may be used and disclosed:

TO MAKE OR OBTAIN PAYMENT

Health Plan may use or disclose your health information to make payment to or collect payment from third parties, such as other health plans or Health Care Providers, for the care you receive. For example, Health Plan may provide information regarding your coverage or health care treatment to other health plans to coordinate payment of benefits.

TO CONDUCT HEALTH CARE OPERATIONS

Health Plan may use or disclose health information for its own operations to facilitate the administration of Health Plan and as necessary to provide coverage and services to all of Health Plan's Covered Persons. Health care operations includes such activities as:

- Quality assessment and improvement activities.
- Activities designed to improve health or reduce health care costs.
- Clinical guideline and protocol development, case management and care coordination.
- Contacting Health Care Providers and Covered Persons with information about treatment alternatives and other related functions.
- Health care professional competence or qualifications review and performance evaluation.
- Accreditation, certification, licensing or credentialing activities. Underwriting, premium rating or related functions to create, renew or replace health insurance or health benefits.
- Review and auditing, including compliance reviews, medical reviews, legal services and compliance programs.
- Business planning and development including cost management and planning related analyses and formulary development.
- Business management and general administrative activities of Health Plan, including customer service and resolution of internal grievances.

FOR TREATMENT ALTERNATIVES

Health Plan may use and disclose your health information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

FOR DISTRIBUTION OF HEALTH-RELATED BENEFITS AND SERVICES

Health Plan may use or disclose your health information to provide to you information on health-related benefits and services that may be of interest to you.

FOR DISCLOSURE TO THE PLAN SPONSOR

Health Plan may disclose your health information to the plan sponsor for plan administration functions performed by the plan sponsor on behalf of Health Plan. Health Plan also may provide summary health information to the plan sponsor so that the plan sponsor may solicit premium bids from other health plans or modify, amend or terminate the plan.

WHEN LEGALLY REQUIRED

Health Plan will disclose your health information when it is required to do so by any federal, state or local law.

TO CONDUCT HEALTH OVERSIGHT ACTIVITIES

Health Plan may disclose your health information to a health oversight agency for authorized activities including audits, civil administrative or criminal investigations, inspections, licensure or disciplinary action. Health Plan, however, may not disclose your health information if you are the subject of an investigation and the investigation does not arise out of or is not directly related to your receipt of health care or public benefits.

IN CONNECTION WITH JUDICIAL AND ADMINISTRATIVE PROCEEDINGS

As permitted or required by state law, Health Plan may disclose your health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order or in response to a subpoena, discovery request or other lawful process, but only when Health Plan makes reasonable efforts to either notify you about the request or to obtain an order protecting your health information.

FOR LAW ENFORCEMENT PURPOSES

As permitted or required by state law, Health Plan may disclose your health information to a law enforcement official for certain law enforcement purposes, including, but not limited to, if Health Plan has a suspicion that your death was the result of criminal conduct or in an emergency to report a crime.

IN THE EVENT OF A SERIOUS THREAT TO HEALTH OR SAFETY

Health Plan may, consistent with applicable law and ethical standards of conduct, disclose your health information if Health Plan, in good faith, believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public.

FOR SPECIFIED GOVERNMENT FUNCTIONS

In certain circumstances, federal regulations require Health Plan to use or disclose your health information to facilitate specified government functions related to the military and veterans, national security and intelligence activities, protective services for the president and others, and correctional institutions and inmates.

FOR WORKER'S COMPENSATION

Health Plan may release your health information to the extent necessary to comply with laws related to worker's compensation or similar programs.

LIMIT DISTRIBUTION, USE OR REQUESTS TO LIMITED DATA SET

Notwithstanding the provisions of this Plan to the contrary, in no event shall the Plan Sponsor be permitted to use or disclose Protected Health Information in a manner that is inconsistent with 45 CFR §164.504(f).

Under the American Recovery and Reinvestment Act of 2009 (ARRA) and guidance provided by the Secretary of Health and Human Services, the Health Plan will be required to limit its distribution, use or requests for protected

health information, to the extent practicable, to a limited data set, or if more information is needed, to the minimum necessary amount of information needed to accomplish the intended purpose of the data use.

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Other than as stated above, Health Plan will not disclose your health information other than with your written authorization. If you authorize Health Plan to use or disclose your health information, you may revoke that authorization in writing at any time.

YOUR RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION

You have the following rights regarding your health information that Health Plan maintains:

RIGHT TO REQUEST RESTRICTIONS

You may request restrictions on certain uses and disclosures of your health information. You have the right to request a limit on Health Plan's disclosure of your health information to someone involved in the payment of your care. However, Health Plan is not required to agree to your request. If you wish to make a request for restrictions, please contact the McLennan County Human Resources Department.

RIGHT TO RECEIVE CONFIDENTIAL COMMUNICATIONS

You have the right to request that Health Plan communicate with you in a certain way if you feel the disclosure of your health information could endanger you. For example, you may ask that Health Plan only communicate with you at a certain telephone number or by email. If you wish to receive confidential communications, please make your request in writing to the McLennan County Human Resources Department, Health Plan will attempt to honor your reasonable requests for confidential communications.

RIGHT TO INSPECT AND COPY YOUR HEALTH INFORMATION

You have the right to inspect and copy your health information. A request to inspect and copy records containing your health information must be made in writing to the McLennan County Human Resources Department. If you request a copy of your health information, Health Plan may charge a reasonable fee for copying, assembling costs and postage, if applicable, associated with your request.

RIGHT TO AMEND YOUR HEALTH INFORMATION

If you believe that your health information records are inaccurate or incomplete, you may request that Health Plan amend the records. That request may be made as long as the information is maintained by Health Plan. A request for an amendment of records must be made in writing to the McLennan County Human Resources Department. Health Plan may deny the request if it does not include a reason to support the amendment. The request also may be denied if your health information records were not created by Health Plan, if the health information you are requesting to amend is not part of Health Plan's records, if the health information you wish to amend falls within an exception to the health information you are permitted to inspect and copy, or if Health Plan determines the records containing your health information are accurate and complete.

RIGHT TO AN ACCOUNTING

You have the right to request a list of disclosures of your health information made by Health Plan for any reason other than for treatment, payment or health operations. The request must be made in writing to the McLennan County Human Resources Department. The request should specify the time period for which you are requesting the information, but may not start earlier than **April 14, 2003**. Accounting requests may not be made for periods of time going back more than six (6) years. Health Plan will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee. Health Plan will inform you in advance of the fee, if applicable.

The Health Plan is required to make available to a Covered Person who request an accounting of disclosures of the Covered Person's Protected Health Information the information required to provide an accounting of disclosures in accordance with 45 CFR §164.528. To the extent the Health Plan uses or maintains Electronic Health Records (EHRs), the Health Plan must be able to account for uses and disclosures of that information, even for treatment, payment and/or health care operations purposes. This detail must be retained for a period of at least three years.

You have a right to obtain a copy of the record in an electronic format and to direct the Health Plan to transmit a copy of the record to any entity or person designated by you.

RIGHT TO A PAPER COPY OF THIS NOTICE

You have a right to request and receive a paper copy of this Notice at any time, even if you have received this Notice previously or agreed to receive the Notice electronically. To obtain a paper copy, please contact McLennan County.

DUTIES OF HEALTH PLAN

Health Plan is required by law to maintain the privacy of your health information as set forth in this Notice and to provide to you this Notice of its duties and privacy practices. Health Plan is required to abide by the terms of this Notice, which may be amended from time to time. Health Plan reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all health information that it maintains. If Health Plan changes its policies and procedures, Health Plan will revise the Notice and will provide a copy of the revised Notice to you within 60 days of the change. You have the right to express complaints to Health Plan and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. Any complaints to Health Plan should be made in writing to the McLennan County Human Resources Department . The Plan encourages you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

CONTACT PERSON

Health Plan has designated the Human Resources Director of McLennan County as its contact person for all issues regarding patient privacy and your privacy rights. You may contact this person at 254-757-5158.

EFFECTIVE DATE

This Notice is effective **October 1, 2016 and is amended as set forth herein.**

IF YOU HAVE ANY QUESTIONS REGARDING THIS NOTICE, PLEASE CONTACT THE MCLENNAN COUNTY HUMAN RESOURCES DEPARTMENT 254-757-5158.

ADMINISTRATIVE INFORMATION

Name of Plan: McLennan County Employee Benefit Plan

Plan Sponsor: McLennan County Employee Benefit Plan
Address: 214 North 4th, #100 Waco, Texas 76701
Business Phone Number: (254) 759-5614
Plan Sponsor ID Number (EIN): 74-6002492
Plan Year: October 1, 2016 thru September 30, 2017

Plan Benefits: Medical, Drug

Plan Administrator: McLennan County Employee Benefit Plan
Address: 214 North 4th, #100 Waco, Texas 76701
Business Phone Number: (254) 759-5614

Designated Legal Agent: Scott and White Health Plan
Address: 1206 West Campus Drive Temple, TX 76501
(Legal process may also be served upon the Plan Administrator.)

Participating Employers: McLennan County
Contract Administrator: Scott and White Health Plan
Street Address: 1206 West Campus Drive Temple, TX 76501
Mailing Address: 1206 West Campus Drive Temple, TX 76501
Phone: (254) 298-3000 / (800) 321-7947