-

WILLIAMSON COUNTY
PURCHASING DEPARTMENT
301 SE INNER LOOP - SUITE 106
GEORGETOWN, TEXAS 78626

http://www.williamson-county.org/Procurement

REQUEST FOR PROPOSAL

HEALTH RELATED SERVICES
FOR WILLIAMSON COUNTY EMPLOYMENT BENEFIT ADMINISTRATION
PROPOSAL NUMBER: 12RFP00004

PROPOSALS MUST BE RECEIVED ON OR BEFORE: TUESDAY, FEBRUARY 28, 2012–1:30 PM

PROPOSALS WILL BE PUBLICLY ACKNOWLEDGED: TUESDAY, FEBRUARY 28, 2012– 2:00 PM

PROPOSER MAY SUBMIT A PROPOSAL FOR ONE OR MORE OF THE FOLLOWING:

SELF-INSURED MEDICAL, DENTAL AND VISION CLAIMS ADMINISTRATION, DISEASE MANAGEMENT, PRECERTIFICATION MANAGEMENT, LARGE CASE MANAGEMENT, PRESCRIPTION DRUG CARD/MAIL ORDER, PREFERRED PROVIDER NETWORK, EMPLOYEE ASSISTANCE PROGRAM AND SECTION 125 CLAIMS ADMINISTRATION

PROPOSAL SUBMISSION

DEADLINE: Proposals must be received in the Williamson County Purchasing Department **on or before 1:30 PM on Tuesday, February 28, 2012**. **Proposals will be publicly acknowledged at 2:00 pm or soon thereafter** in the Williamson County Purchasing Dept., 301 SE Inner Loop-Suite 106, Georgetown, Texas.

METHODS: Sealed proposals (CD's in sealed envelopes will be accepted) may be hand-delivered or mailed to the *Williamson County Purchasing Department, Attn: Kerstin Hancock, Suite 106, Williamson County Inner Loop Annex, 301 SE Inner Loop, Georgetown, Texas 78626.*

FAX/EMAIL: Facsimile and electronic mail transmittals will not be accepted.

PROPOSAL REQUIREMENTS

SUBMITTAL: All proposals must be submitted as follows: Three (3) copies (CD's in sealed envelopes will be accepted for all copies) of each proposal AND one (1) original proposal set which MUST be submitted on CD AND paper including all required documentation. A "proposal set" consists of the COMPLETED AND SIGNED Proposal Form and any other required documentation. All copies must have the same attachments as the original.

SEALED: All proposals must be returned in a sealed envelope with the proposers name, address, proposal name, number, opening date, and time clearly marked on the outside. **If an overnight delivery service is used**, the proposers name, address, proposal name, number, opening date and time must be clearly marked on the outside of the delivery service envelope.

REFERENCES: Williamson County may require proposer to supply a list of at least three (3) references where like services have been supplied by their firm if proposer has not done business with the County within the past five (5) years. Include name of firm, address, phone number and name of representative

LEGIBILITY: Proposals must be legible and of a quality that can be reproduced.

FORMS: All proposals must be submitted on the forms provided in this proposal document. Changes to proposal forms made by proposers shall disqualify the proposal. Proposals cannot be altered or amended after submission deadline. All information required by the Request for Proposal Form must be furnished or the proposal may be deemed non-responsive. Where there is an error in the extension of price, the unit price will govern.

LATE PROPOSAL: Proposals received after submission deadline will not be opened and will be considered void and unacceptable. Williamson County is not responsible for lateness of mail, courier service, etc.

RESPONSIBILITY: It is expected that a prospective

proposer will be able to affirmatively demonstrate proposer's responsibility. A prospective proposer should be able to meet the following requirements:

a) have adequate financial resources, or the ability to obtain such resources as required;
b) be able to comply with the required or proposed delivery schedule;
c) have a satisfactory record of performance;
d) be otherwise qualified and eligible to receive an award.

Williamson County may request representation and other information sufficient to determine proposer's ability to meet these minimum standards listed above.

AWARD

ONE HUNDRED TWENTY DAYS: Awards should be made no later than one hundred twenty (120) days after the proposal opening date. Therefore all proposed rates or fees must be guaranteed for that period. Results may be obtained by contacting the Consultant, identified below.

REJECTION OR ACCEPTANCE: No more than one proposal will be awarded for any item, single department or area. Proposals may be rejected for some items, departments or areas, even though awards are made for others. The convenience of having a single source for similar items will be taken into consideration together with price in determining the lowest and best proposal.

It is understood that the Commissioners Court of Williamson County, Texas, reserves the right to accept or reject any and/or all Proposals for any or all materials and/or services covered in this Proposal request, and to waive informalities or defects in the Proposal or to accept such Proposal it shall deem to be in the best interest of Williamson County.

CONTRACT: This Proposal, when properly accepted by Williamson County, shall constitute a contract equally binding between the successful proposer and Williamson County.

The successful proposer may be required to sign an additional agreement containing terms necessary to ensure compliance with the proposal.

CONTRACT ADMINISTRATION: Under this contract, Lisa R. Zirkle, SPHR/CCP, Associate Director of Human Resources, Williamson County, shall be the contract administrator with designated responsibility to ensure compliance with contract requirements, such as but not limited to, acceptance, inspection and delivery. The contract administrator will serve as liaison between Williamson County Commissioner's Court and the successful proposer.

CONTRACT PERIOD(S): The Initial Contract Period is November 1, 2012 through October 31, 2015**.**

Possible extensions include:

November 1, 2015 through October 31, 2016
November 1, 2016 through October 31, 2017

POLICY EXTENSIONS: At the end of the Initial Contract Period, the Commissioners Court reserves the right to extend this policy, by mutual agreement of both parties, as it deems to be in the best interest of the County. The extension may be negotiated if renewal indications are provided within Williamson County's timeframe which reflect renewal terms for the forthcoming policy year that are deemed by Williamson County to be competitive with current market conditions. However, Williamson County may terminate the contract at any time if funds are restricted, withdrawn, not approved, or if service is unsatisfactory. This extension will be in twelve (12) month increments for up to an additional twenty-four (24) months, with the terms and conditions remaining the same. The total period of this contract, including all extensions will not exceed a maximum combined period of sixty (60) months. The extension of the contract is contingent on the appropriation of necessary funds by Commissioners Court for the fiscal year in question. Upon the failure of Commissioners Court to so appropriate in any year, the Proposer may elect to terminate the contract, with no additional liability to the County. The County and the Proposer agree that termination shall be the Proposer's sole remedy under this circumstance.

PROPOSAL CONTACTS

Any questions, clarifications or requests for general information should be directed to the cont acts listed below. **Question submittals must be made via email, and are due by 5:00 pm Tuesday, February 21, 2012.** Questions will be answered as soon as possible with an email response. Submitted questions with their answers will be posted to the Williamson County portal, http://wilco-online.org/ebids/bids.aspx.

PURCHASING CONTACT:

Kerstin Hancock, Assisting Purchasing Agent
301 SE Inner Loop – Suite 106
Georgetown, TX 78626
(512) 943-1546
Khancock@wilco.org

CONSULTANT CONTACT (PRIMARY):

Eric Smith
Smith & Associates Consulting
P O Box 92398
Southlake, TX 76092
(817) 310-3422
Fax (817) 310-3439
eric.smith@smith-associates.com

TECHNICAL CONTACT (SECONDARY):

Lisa R. Zirkle, SPHR/CCP
301 SE Inner Loop – Suite 108
Georgetown, TX 78626
(512) 943-1533 or
(512) 943-1534
Fax: (512) 943-1535
lzirkle@wilco.org

MISCELLANEOUS

FOB DESTINATION: All of the items listed are to be Free On Board to final destination (FOB Destination) with all transportation charges if applicable to be included in the price, unless otherwise specified in the Request for Proposal. The title and risk of loss of the goods shall not pass to the County until receipt and acceptance takes place at the FOB point.

FIRM PRICING: For unit price items, all of the items listed are to be on a "per unit" basis, stating a firm price per unit or unit quantity of each item. Proposer must submit a firm price that must be good from the date of proposal opening for a fixed period of time. Unless the Proposal expressly states otherwise, this period shall be until the end of the Initial Contract Period. Proposals which do not state a fixed price, or which are subject to change without notice, will not be considered. The Court may award a contract for the period implied or expressly stated in the lowest and best proposal.

ESTIMATED QUANTITIES: The estimated quantity (i.e., number of participants) of each item listed in the notice is only an estimate -- the actual quantity to be purchased may be more or less. The County is not obligated to purchase any minimum amount, and the County may purchase any reasonable amount greater than the estimate for the same unit price. Any limit on quantities available must be stated expressly in the proposal.

FUNDING: County intends to budget and make sufficient funds available and authorize funds for expenditure to finance the costs of this contract. Proposers understand and agree that the County's payment of amounts under this contract shall be contingent on the County receiving appropriations or other expenditure authority sufficient to allow the County, in the exercise of reasonable administrative discretion, to make payments under this contract.

SALES TAX: Williamson County is by statute, exempt from the State Sales Tax and Federal Excise Tax.

STATEMENTS: No oral statement of any person shall modify or otherwise change, or affect the terms, conditions, plans and/or specifications stated in the various Proposal Packages and/or Proposal Instructions/Requirements.

DELIVERY: The delivery time and location for the commodity and/or service covered by this proposal shall be as stated in the various proposal packages.

PURCHASE ORDER: If required by the Williamson County Purchasing Department a purchase order(s) may be generated to the successful proposer for products and/or services. If a purchase order is issued the purchase order number must appear on all itemized invoices and/or requests for payment.

RIGHT TO AUDIT: Proposer further agrees that County or its duly authorized representatives shall, until the expiration of three (3) years after final payment under this Contract, have access to and the right to examine and photocopy any and all books, documents, papers and records of Proposer, which are directly pertinent to the services to be performed under this Contract for the purposes of making audits, examinations, excerpts, and transcriptions. Proposer agrees that County shall have access during normal working hours to all necessary Proposer facilities and shall be provided adequate and appropriate work space in order to conduct audits in compliance with the provisions of this section. County shall give Proposer reasonable advance notice of intended audits.

PAYMENT: Payment shall be made by check from the County upon satisfactory completion and acceptance of items and submission of the Invoice to the ordering department for work specified by this Contract.. All payments owed will be paid no later than thirty (30) days after the goods or services are received OR the date that the invoice is received by the Auditor's Office whichever is later. As a minimum, invoices shall include:

(1) Name, address, and telephone number of Vendor and similar information in the event the payment is to be made to a different address
(2) County contract, Purchase Order, and/or delivery order number
(3) Identification of items or service as outlined in the contract
(4) Quantity or quantities, applicable unit prices, total prices, and total amount
(5) Any additional payment information which may be called for by the contract

Payment inquiries should be directed to the Auditor's Office, Donna Baker (512) 943-1558.

CONFLICT OF INTEREST: No public official shall have interest in a contract, in accordance with Vernon's Texas Codes Annotated, Local Government Code Title 5, Subtitle C, Chapter 171.

As of January 1, 2006 Proposers are responsible for complying with Local Government Code Title 5, Subtitle C, Chapter 176. Additional information may be obtained from Williamson County's website at the following link:

http://www.wilco.org/CountyDepartments/Purchasing/Co

nflictofInterestDisclosure/tabid/689/language/en-US/Default.aspx

The Williamson County Conflict of Interest Statement is included as Attachment A of this RFP. This form should be completed, signed, and submitted with your proposal.

ETHICS: The proposer shall not accept or offer gifts or anything of value nor enter into any business arrangement with any employee, official or agent of Williamson County.

DOCUMENTATION: Proposer shall provide with this proposal response, all documentation required by this proposal. Failure to provide this information may result in rejection of the proposal.

TERMINATION FOR CAUSE: In the event of breach or default of this contract or any other additional agreement containing terms necessary to ensure compliance with the Proposer's proposal, Williamson County reserves the right to enforce the performance of this contract or any additional agreement by any manner prescribed by law or deemed to be in the best interest of Williamson County. At Williamson County's sole discretion, the Proposer may be given reasonable time to cure its breach or default prior to Williamson County's termination under this provision. Williamson County's option to offer time to cure a default or breach shall, however, in no way be construed as negating the basis for termination for non-performance.

TERMINATION FOR CONVENIENCE: Williamson County may terminate this contract and/or any additional agreement containing terms necessary to ensure compliance with the Proposer's proposal, for convenience and without cause or further liability, upon sixty (60) days written notice to Proposer. In the event Williamson County exercises its right to terminate without cause, it is understood and agreed that only the amounts due to Bidder for goods, commodities and/or services provided and expenses incurred to and including the date of termination, will be due and payable. No penalty will be assessed for Williamson County's termination for convenience

SILENCE OF SPECIFICATIONS: The apparent silence of these specifications as to any detail or to the apparent omission from it of a detailed description concerning any point, shall be regarded as meaning that only the best practices are to prevail. All interpretations of these specifications shall be made on the basis of this statement.

COMPLIANCE WITH LAWS: The successful proposer shall comply with all applicable federal, state and local laws and regulations pertaining to the practice of the profession and the execution of duties under this proposal including the TEXAS HAZARD COMMUNICATION ACT and THE WILLIAMSON COUNTY HAZARD COMMUNICATION PROGRAM POLICY.

PROPRIETARY INFORMATION: All material submitted to the County becomes public property and is subject to the Texas Open Records Act upon receipt. If a Proposer does not desire proprietary information in the proposal to be disclosed, each page that is deemed proprietary must be identified and marked as such at time of submittal. Simply stating that the entire proposal is proprietary is not allowed. The County will, to the extent allowed by law, endeavor to protect such information from disclosure. The final decision as to what information must be disclosed, however, lies with the Texas Attorney General. Failure to identify proprietary information will result in all unmarked sections being deemed non-proprietary and available upon public request.

WORKER'S COMPENSATION

This contract contemplates services that do not require Worker's Compensation insurance coverage. However, if it becomes necessary that the proposer provide services related to the project such as delivering equipment or materials, an amended contract will be executed which fully complies with the Texas Labor Code and the Texas Worker's Compensation Commission requirements.

PROPOSAL REQUIREMENTS

Proposers must fill in all information asked for in the blanks provided under each item. Failure to comply may result in rejection of the proposal at the County's option.

The total proposal amount for each proposal submitted must include any applicable taxes. Although the County is exempt from most City, State and Federal taxes, this is not true in all cases. It is suggested that taxes, if any, be separately identified, itemized and stated on each proposal. The County cannot determine for the proposer whether or not the proposal is taxable to the County. The proposer through the proposer's attorney or tax consultant must make such determination. Bills submitted for taxes after the proposals are awarded will not be honored.

Request for non-consideration of proposals must be made in writing to the Purchasing Contact and received by the County before the time set for unopened proposals. After other proposals are opened, the proposal for which non-consideration is requested may be returned unopened. The proposal may not be withdrawn after the proposals have been received, and the proposer, in submitting the same, warrants and guarantees that this proposal has been carefully reviewed and checked and that it is in all things true and accurate and free of mistakes and that such proposal will not and cannot be withdrawn because of any mistake or mistaken assumption of fact committed by the Proposer.

Proposals will be publicly recognized. Proposals will be tabulated for comparison based on the proposal prices and guaranties shown in the proposal. Proposals will be considered and evaluated based upon the factors identified in Section B, General Carrier/Administrator Requirements, Paragraph 18. Until final award of the Contract, the County reserves the right to reject any or all proposals, to waive technicalities, to request new proposals, or proceed to do the work otherwise in the best interest of the County.

The County reserves the right to reject any or all proposals in whole or in part, to waive any informality in any proposal, to declare inadequate or inappropriate any proposer failing to meet the specifications, and to accept the proposal which, in its discretion, is in the best interest of Williamson County, and all proposals submitted are subject to this reservation. Proposals may be considered irregular and rejected, among other reasons, for any of the following specific reasons:

1. Proposals received after the time limit for receiving proposals as stated in the advertisement;
2. Proposals containing any irregularities, omissions, alterations of form, additions or conditions not called for, or unauthorized alternate proposals of any kind;
3. Unbalanced value of any items; and/or
4. Failure to comply with the enclosed specifications

Proposers may be disqualified and their proposals not considered, among other reasons, for any of the following specific reasons:

1. Reason for believing collusion exists among the proposers;

2. Reasonable grounds for believing that any proposer is interested in more than one proposal for the work contemplated;
3. The proposer being interested in any litigation against the County;
4. The proposer being in arrears on any existing contract or having defaulted on a previous contract;
5. Lack of competency as revealed by a financial statement, experience and equipment, questionnaires, etc.;
6. Uncompleted work which, in the judgment of the County, will prevent or hinder the prompt completion of additional work if awarded; and/or
7. Failure to comply with the enclosed contract language.

The County is conducting enrollment through an on-line enrollment system**.** The selected carrier must be able to accept electronic eligibility files from an outside vendor.

The successful proposal/proposer may not assign its rights and duties under the award without the written consent of the County. Such consent shall not relieve the assignor of liability in event of default by his assignee.

Proposals will be received only at the following addresses:

Williamson County
Purchasing Department
Attn: Kerstin Hancock
Williamson County Inner Loop Annex
301 SE Inner Loop, Suite 106
Georgetown, TX 78626

It is the proposer's responsibility to check with our office prior to submitting your proposal to ensure that you have a complete, up-to-date package. The Purchasing Department takes no responsibility to ensure any interested proposer has obtained any outstanding addenda or additional information.

Responses for the Self-Insured Medical, Dental & Vision Claims Administration, Disease Management, Precertification Management, Large Case Management, Prescription Drug Card/Mail Order, Preferred Provider Network, Employee Assistance Program, and Section 125 Claims Administration may be considered as proposals of professional services.

All proposals must be at the above address by **Tuesday, February 28, 2012, at 1:30 p.m. CDST**. There must be three copies (CD's in sealed envelopes will be accepted) of each proposal AND one (1) original proposal set which MUST be submitted on CD AND paper including all required information. All proposals received after the prescribed deadline, regardless of the mode of delivery, shall be returned unopened.

All proposers must include a financial statement audited by an independent third party.

All proposers must clearly mark cost proposal sections and place them at the front of the proposal.

If you have any technical questions about the specifications, please put all questions in writing to the attention of Eric Smith and FAX to (817) 310-3439 or e-mail at eric.smith@smith-associates.com.

WILLIAMSON COUNTY REQUEST FOR PROPOSAL FORM

HEALTH RELATED SERVICES FOR WILLIAMSON COUNTY

SELF-INSURED MEDICAL, DENTAL, AND VISION CLAIMS ADMINISTRATION, DISEASE MANAGEMENT, PRECERTIFICATION MANAGEMENT, LARGE CASE MANAGEMENT, PRESCRIPTION DRUG CARD/MAIL ORDER, PREFERRED PROVIDER NETWORK, EMPLOYEE ASSISTANCE PROGRAM, AND SECTION 125 CLAIMS ADMINISTRATION

PROPOSAL NUMBER: 12RFP00004

NAME OF PROPOSER: _____

Mailing Address: _____

City: _____ State: _____ Zip:_____

Email Address: _____

Telephone: (_____) _____ Fax: (_____) _____

The undersigned, by his/her signature, represents that he/she is authorized to bind the proposer to fully comply with the terms and conditions of the attached Request for Proposal, Specifications, and Special Provisions for the amount(s) shown on the accompanying proposal sheet(s). By signing below, you have read the entire document and agreed to the terms therein.

_____ Date of PROPOSAL: _____
Signature of Person Authorized to Sign Proposal

Printed Name and Title of Signer:_____

DO NOT SIGN OR SUBMIT WITHOUT READING ENTIRE DOCUMENT

THIS FORM MUST BE COMPLETED, SIGNED, AND RETURNED WITH PROPOSAL

ATTACHMENT A

WILLIAMSON COUNTY CONFLICT OF INTEREST STATEMENT

I hereby acknowledge that I am aware of the Local Government Code of the State of Texas, Section 176.006 regarding conflicts of interest and will abide by all provisions as required by Texas law.

Printed name of person submitting form:
Name of Company:
Date:
Signature of person submitting form:

Notarized:

Sworn and subscribed before me by:_____ **on** _____**.** **(date)**

INTENT TO PROPOSE FORM

Due on or Before Tuesday, February 28, 2012

Proposal Number: _____

Company Name _____

Representative Name _____

Phone Number _____

_____

Address _____

_____

Email Address _____

Coverage or Services Being Quoted

- ☐ **Self Insured Medical, Dental, & Vision Claims Administration**
- ☐ **Disease Management**
- ☐ **Precertification Management**
- ☐ **Large Case Management**
- ☐ **Prescription Drug Retail/Mail Order**
- ☐ **Preferred Provider Network**
- ☐ **Employee Assistance Program**
- ☐ **Section 125 Claims Administration**

PROPOSAL AGREEMENT

A prospective proposer must affirmatively demonstrate Proposer's responsibility. A prospective proposer must have adequate financial resources, or the ability to obtain such resources as required, be able to comply with the required or proposed delivery schedule, have a satisfactory record of performance and be otherwise qualified and eligible to receive an award. Williamson County may request representation and other information sufficient to determine Proposer's ability to meet these minimum standards listed above.

Before submitting a Proposal, each Proposer shall carefully consider the amount and character of the work to be done as well as the difficulties involved in its proper execution. Proposer shall provide with their proposal response, all documentation required by the proposal. Failure to provide this information may result in rejection of the proposal.

It is understood that the Commissioners Court of Williamson County, Texas, reserves the right to accept or reject any and/or all proposals for any or all materials and/or services covered in this proposal request, and to waive informalities or defects in the proposal or to accept such proposal it shall deem to be in the best interest of Williamson County.

_____ _____

Company Officer Signature Date

_____

Printed Name

NON-COLLUSION AFFIDAVIT

STATE OF _____)
) ss.
COUNTY OF _____)

_____, of lawful age, being first duly sworn, on oath says, that (s) he is the agent authorized by the proposal to submit the attached proposal. Affiant further states that the proposal has not been a party to any collusion among proposals/proposers in restraint of freedom of competition by agreement to proposal at a fixed price or to refrain from proposing; or with any state official, County employee, Commissioners Court Member, or benefit consultant as to quantity, quality, or price in the prospective contract, or any other terms of said prospective contract; or in any discussions or actions between proposals/proposers and any state official, County employee, Commissioners' Court Member, or benefit consultant concerning exchange of money or other things of value for special consideration in the letting of this contract.

Carrier/Administrator: _____

Proposer: _____

Date:_____

Subscribed and sworn to before me this _____ day of _____, 2012.

_____
(Notary Public)

State of _____

My Commission Expires:_____

STATEMENT OF COMPLIANCE

Please submit as a part of your proposal the following information:

RE: WILLIAMSON COUNTY

We hereby acknowledge receipt of Request for Proposal for a Self Insured Medical, Dental & Vision Claims Administration, Disease Management, Precertification Management, Large Case Management, Prescription Drug Retail/Mail Order, Preferred Provider Network, Employee Assistance Program and Section 125 Claims Administration and certify that our proposal conforms to the RFP except as detailed below:

Organization	Signature
Date	Title

FELONY CONVICTION NOTICE

State of Texas Legislative Senate Bill No. 1, Section 44.034, Notification of Criminal History, Subsection (a), states "a person or business entity that enters into a contract with a County must give advance notice to the County if the person or an owner or operator of the business entity has been convicted of a felony. The notice must include a general description of the conduct resulting in the conviction of a felony."

Subsection (b) states "a county may terminate a contract with a person or business entity if the County determines that the person or business entity failed to give notice as required by Subsection (a) or misrepresented the conduct resulting in the conviction. The County must compensate the person or business entity for services performed before the termination of the contract."

THIS NOTICE IS NOT REQUIRED OF A PUBLICLY-HELD CORPORATION

I, the undersigned agent for the firm named below, certify that the information concerning notification of felony convictions has been reviewed by me and the following information furnished is true to the best of my knowledge.PROPOSER'S NAME:_____

_____

AUTHORIZED COMPANY OFFICIAL'S NAME (PRINTED):_____

A. My firm is a publicly held corporation; therefore, this reporting requirement is not applicable.

Signature of Company Official:_____

B. My firm is not owned nor operated by anyone who has been convicted of a felony:

Signature of Company Official:_____

C. My firm is owned or operated by the following individual(s) who has/have been convicted of a felony:

Name of Felon(s):_____

Detail of Conviction(s):_____

_____

Signature of Company Official:_____

Recommended
Time Table for

WILLIAMSON COUNTY
PROPOSAL SPECIFICATIONS

Advertise	**January 22, January 29, February 12 & February 22, 2012**
Mail Specifications	**January 17, 2012**
Deadline for Proposals	**February 28, 2012 1:30 pm CDST**
Proposal Analysis	**February 29, 2012 Through March 15, 2012**
Interview Schedule	**March 28-29, 2012**
Vendor Approval	**July, 2012**
Enrollment	**August, 2012**
Effective Date	**November 1, 2012**

TABLE OF CONTENTS

SECTION A

BACKGROUND INFORMATION

SECTION A: BACKGROUND INFORMATION

The County has a self-funded Medical benefit program that provides benefits to its employees and dependents. The County has three (3) self-funded PPO Type Medical Plans administered by United Healthcare that differ by deductible and coinsurance amounts. This year the County instituted a Diabetic Plan administered by UHC and details of this plan are included in Section K. As of December 2011, there are approximately 1308 employees and 72 retirees enrolled on the three medical plans and 211 employees and retiree's enrolled in the Diabetic Plan. The County is currently utilizing United Healthcare's Choice Plus PPO Network. The County also offers an Employee Assistance Program to all employees and their dependants. Professional Assistance of Central Texas administers this program and it provides six free EAP outpatient visits per episode. The County offers a self-funded PPO Dental Plan with two (2) Plan Options to choose from with 1272 employees and 58 retirees participating and a Vision Program with 1037 employees and 54 retirees participating which are both administered by Ameritas. The County offers Basic Life Insurance, AD&D, Voluntary Term Life, Long Term Disability and Self-Funded Short Term Disability and Cigna Life Insurance Company of North America currently administers these programs.

United Healthcare is currently administering the Section 125 Cafeteria Plan. The maximum an employee can elect to contribute for the Health Care Reimbursement Account is $5,000 and $5,000 for the Dependent Care Account.

The bulk of this RFP is for differing types of administration. Proposers can submit proposals for all or selected services. The services are:

- Third Party Administrator Services for Self Insured Medical, Dental & Vision Programs
- PPO Network Options
- Prescription Drug Card Services – retail card and mail order
- Precertification/Large case management
- Disease Management/ Diabetic Plan Management
- Employee Assistance Program
- Section 125 Claims Administration

Please note that your inability to quote any of the above options **would not** preclude you from being selected as a finalist. Should you have standard products which do not, in their entirety, meet the RFP, please feel free to quote based upon your standard package. However, you must specify any and all deviations in your quotation and the RFP on the "Statement of Compliance." It will be assumed that your proposal is in compliance if deviations are not noted in the "Statement of Compliance."

Any prospective proposer will be responsible for having qualified personnel and computerized systems capable of handling a case of this size and their plan of benefits.

The proposer must provide references and proof of the provider's ability to satisfactorily serve the County**. All proposers must be completely HIPAA compliant - a statement of compliance is required with any proposals submitted to the County.**

It is not the intent of Williamson County that any commissions are built into the proposal. Commissions, fees or other reimbursement arrangements must be disclosed.

SECTION B

GENERAL ADMINISTRATOR REQUIREMENTS

SECTION B: GENERAL ADMINISTRATOR REQUIREMENTS

1. **PPO Network**

   The current Preferred Provider Network is United Healthcare's Choice Plus PPO Network. The County will consider all network options that have adequate coverage in their area.

2. **Commission**

   No commissions or service fees shall be paid to any party without full disclosure.

3. **Compliance with the Request for Proposal**

   All responses are to be prepared according to the Request for Proposal. Any item(s) your company cannot accommodate are to be disclosed in writing prior to binding acceptance by the consultant and the County. Any deviations from this request are to be discussed with the consultant in advance of the due date. After a commitment has been made by the County, the Proposer will be held responsible for all items contained in the specifications.

4. **Effective Date**

   The effective date of the new contract(s) will be November 1, 2012.

5. **Enrollment**

   The selected carrier will be responsible for enrollment support and informational meetings at the County during open enrollment to be held during the month of ***August***.

6. **Plan Design**

   Please provide your proposal based on the current plan designs.

7. **Quoted Rates**

   A minimum rate guarantee of 12 (twelve) months is required. Please confirm this guarantee in your response to the proposal and denote any additional guarantees your company may wish to extend to the County. **It is the County's desire to have a three-year rate guarantee with the new administrator with the option to renew for up to two (2) additional one year periods provided renewal rates are acceptable and can be given within your proposal. Multiple year, rate guaranteed contracts will receive preference.**

   a) The guaranteed period of time. Any adjustments on an annual basis must have an acceptable negotiable cap; and

b) Must include a clause retaining the County's continuing right to terminate the contract at the end of the County's budget period; and
c) A clause conditioning the continuation of the contract on the County's best efforts to appropriate funds for the payment of the contract.

8. Renewal Rates

The selected administrator is asked to deliver a rate adjustment no later than 90 days prior to the anniversary date each year. An adjustment request will be effective after approval of Commissioners Court.

9. Ownership of Records

All records, member files and miscellaneous data necessary to administer the plan shall be the property of the County. The selected carrier will be asked to transfer records to the County within 30 days of notice of termination.

10. Master Contract

The County's purchasing Procedures stipulate that an approved Contract must be negotiated and executed by the selected vendor prior to being presented to the Commissioner's Court for approval. A sample contract with approved language is included in Section K. All Proposers must supply the County with what they feel is an executable contract based upon the language in the sample contract. Failure to do so may affect a Proposers selection.

11. Plan Changes and Amendments

If changes in the plan of benefits or servicing requirements are needed, such changes will be made in writing and deemed as an amendment to the contract.

12. Administrator Selection

The selection of the administrator will be made on or by July, 2012.

13. Right to Audit

The County reserves the right to audit the claim records and other financial records of its insurers/providers, as they pertain to the employee benefit program whenever it is deemed appropriate using whatever methodology the County chooses. Such audits may be performed by the County's personnel or by outside auditors selected by the County. By submitting a proposal to the County, you are agreeing to this provision and agree to **not place any limitation** on the County with regard to this provision unless stated herein. Included in the requirements of the Proposal is a Post Implementation Audit. This **will be at the expense** of the selected proposer. If the selected proposer does not have a 95% procedural accuracy as a result of the Post Implementation Audit, the new proposer **will incur the cost of a focused claims audit a**t **the end of year one**. The

costs of such audit(s) are included in this document. Any deviations to this section must be clearly outlined on the "Statement of Compliance" Form.

14. Data Caveat

The data contained herein has been supplied by the County, UHC and Ameritas. It has been gathered and coordinated by the consultant and reviewed as to accuracy on a "best effort" manner. This request for proposal is qualified to the extent the data provided is accurate. Consultant cannot be held liable for any data errors or omissions.

15. Data Files

The County will require that an electronic data file be sent from the chosen administrator, in the format of the County's choice. The cost for the development of this data file should be included in the fees to the County and shall be sent to the consultant at least quarterly but not more frequently than once per month. All costs associated with this process must be included in the proposer's fees.

16. Biography

Please provide a brief biography or relevant experience on key personnel in management, claims, eligibility, and data processing.

17. Client Information

The Proposer data needed:

- 3 termed clients within last 5 years
- 2 new clients within last year
- 5 existing clients for 3 or more years

18. Awards

The award to the successful proposer will be based upon responses to questions outlined in these specifications and an estimate of the quality and effectiveness of each proposer's services in the following areas:

1. Experience in servicing self-insured public entities;
2. Claims adjudication service(s) offered;
3. Quality of risk management information services and report capabilities;
4. Internal and external claims audit reports; and
5. Written and oral presentations and representations.

In addition, the County may also consider:

1. The purchase price;
2. The reputation of the vendor and the vendor's goods or services;
3. The quality of the vendor's goods or services;
4. The extent to which the goods or services meet the County's needs;

5. The proposer's past relationship with the County;
6. The total long-term cost to the County to acquire the proposer's goods or services; and
7. Any other relevant factor that a private business entity would consider in selecting a vendor.

19. The selected administrator must agree to add their proposal response as an Addendum to the Administrative Service Agreement between the selected administrator and the County and agree to be bound contractually to all the requirements outlined in the Request for Proposal.

SECTION C

FEE QUOTATIONS – SELF INSURANCE

All proposers must clearly mark the cost proposal sections and place them at the front of the proposal.

SECTION C: FEE QUOTATIONS – SELF INSURANCE

Give costs in your normal fashion. Show your cost separately for each category of service assuming (a) that the full range of administrative services is taken and (b) that each category may not be purchased. All carrier/administrators should assume that they will be responsible for claims that arrive after November 1, 2012.

			Your Charge per Participant per Month	
I.	Claims Settlement and Statistics		First Year	Second Year Cap
	A.	Medical Claims Settlement	$_____	$_____
	B.	Dental Claims Settlement	$_____	$_____
	C.	Vision Claims Settlement	$_____	$_____
	D.	Per Claim Basis	$_____	$_____
	E.	Run-In (if transferred)	$_____	$_____
	R.	Run-Out (at termination)	$_____	$_____
II.	Documentation and Plan Drafting			
	A.	Plan Document (Contract Text)	$_____	
	B.	Booklets	$_____	
	C.	ID Cards	$_____	
III.	Start-Up Costs		$_____	

IV. Conversion Plan for Terminating Employee

State your charge, if any, per subscribed plan (your charge may be on the basis of a flat dollar amount per conversion $_____ or on a per employee cost per month $_____).

V.	COBRA Administration	Employee	Dependents
	Installation Fee	$_____	$_____
	Annual Service Fee	$_____	$_____
	Enrollment Fee	$_____	$_____
	Monthly Charge Per COBRA Participant	$_____	$_____

VI.	Utilization Review		$ Per Employee
	A.	Hospital Pre-Admission Review	$_____
	B.	Concurrent Review	$_____
	C.	Out-Patient Surgery Review	$_____
	D.	Second Surgical Opinion	$_____
	E.	Ambulatory Procedure Review	$_____
	F.	Maternity Management	$_____
	G.	Large Case Management	$_____
		Per Case (Hourly)	$_____
		Medical Bill Audit	$_____
	H.	Mental and Nervous Chemical Dependency	$_____
	I.	Comprehensive Rate	$_____
	J.	Additional Charges	$_____
	K.	Start-Up Costs	$_____
	TOTAL		$_____

SECTION D

MEDICAL AND DENTAL CLAIMS ADMINISTRATION

All proposers must clearly mark the cost proposal sections and place them at the front of the proposal.

SECTION D: MEDICAL, DENTAL & VISION CLAIMS ADMINISTRATION

This section will detail the administrative services the County wishes to consider. In reviewing this section, please note the County may or may not wish to purchase each major category of service. In view of this desired flexibility, you will be required to quote a separate cost factor for each major service category. Therefore, make sure your costs quotes for each section are self-supporting and independent of each other.

The bulk of this section outlines the typical services provided by a claims administrator. Attached is an outline of the requested services to be provided by the administrator. Any proposer must consider this as a minimum level of service and must provide a cost estimate that is all-inclusive of the minimum services.

The administrator should prepare a quarterly financial report and attend quarterly staff and consultant meetings to review special reports and discussions on utilization review. These meetings are held at the County in Georgetown, Texas.

REQUIRED SERVICES

1. Provide information concerning Plan eligibility and benefits (including deductibles met as of date of inquiry) to all participants, beneficiaries, and health care providers by telephone during normal business hours, including toll-free access and by mail in response to written inquiries.

2. Administer claims in accordance with the terms of the Plan, including any summaries or "write-ups" as may be approved by the Plan Sponsor or Plan Administrator as the correct interpretation of Plan provisions.

3. Claims administration services shall include:

    a. The receipt and review of claims and claim documents.

    b. Verification of eligibility and determination of medical necessity and amounts payable under the Plan in light of Plan provisions concerning reasonableness of charges and preferred providers or other service arrangements.

    c. Correspondence with claimants to obtain any required additional information and to determine whether other coverage for the claim exists under subrogation rights or other benefit plans, insurance contracts, health maintenance organizations, or government-sponsored benefit programs.

    d. Preparation and mailing explanations of benefits (or denial of benefits), and benefit payment checks drawn on designated demand deposit accounts.

    e. Reasonable steps, in accordance with Plan provisions, to recover or offset erroneous payments of plan benefits.

    f. Administration of claims review and appeals procedure in accordance with Plan

provisions. Advise the Plan Administrator of all appeals of denied claims and the Plan Administrator shall make all final benefit determinations in such cases.

g. Quarterly claims review meetings.

h. Coordinate and provide any necessary information to the selected Disease Management, PBM, and Wellness providers for the County's plans to ensure continuity within the necessary components of the plan.

4. Provide one copy of the Plan Document and/or summary plan description and all related standard administrative forms and assist with the design and printing of claim forms, ID cards, and other supplies designed specifically for the Plan.

5. Provide all reports included, from time to time, in standard comprehensive reporting package.

6. Provide the Plan Sponsor with any data maintained by TPA that is required by the Plan in the preparation of required reports and filings.

7. Receive, Network re-pricing information and accurately re-price all Network claims.

8. Attend meetings with the Plan Sponsor as reasonably requested and necessary for the provision of services under this Agreement, including scheduled quarterly meetings.

PLEASE PROVIDE YOUR ABILITY AND WILLINGNESS TO PERFORM BASED ON THE FOLLOWING:

I. Claims Settlement and Statistics

A. Claims Settlement

1. ASO - a County account will be established and you will be given authority to draw benefit checks from this account. The County would like to operate a zero balance account for this plan. Please indicate if this is a problem for your organization.

2. It will be your responsibility to maintain computer eligibility. The County would like an adequate "direct" claim status system for review of claim processing as well. You will be responsible for training on the claim status system.

3. You will be responsible for the complete calculation of the benefits payable, including investigation, follow-up coordination of benefits, preparation and sending of Form 1099 to providers, and the drawing and mailing of checks. Other than PPO providers, checks are to be mailed directly to the employee unless he/she specifies on the claim form that payment should be sent directly to the medical/dental providers.

The TPA will be fully responsible for preparation and dissemination of any

information to be sent to the I.R.S. If penalties are assessed because of incorrect or late filings by the TPA, the TPA will be responsible for any such assessments and will hold the County harmless.

4. If the County or an employee of the County has a question concerning the settlement or status of a claim, it is your responsibility to provide a satisfactory and timely answer to the question.

5. In settling the claim, you will be required to perform up to the following minimum standards:

    a. All claims received in your office(s) in proper, complete order will be calculated and paid within 10 working days;

    b. All benefit checks must reach the employee or provider within 30 days after submission of a claim, unless more information or C.O.B. is involved;

    c. No claim shall go un-worked for more than 21 days. The status of a pending or C.O.B. claim must be updated on the system within this time;

    d. No claim can be over 60 days old for any reason; and

    e. The clerical error ratio on claims must be less than two percent and dollar ratio of one percent;

    f. Meet all federal guidelines on claims turnaround and processing standards;

    g. Meet all electronic standards for transmission of electronic claims;

    h. Be completely compliant with all HIPAA requirements for claims administrators

6. TPA will be responsible for re-pricing of all claims for PPO discounts.

7. A 1-800 number shall be provided to the employees for customer service from 6 a.m. to 10 p.m. Central Standard time.

8. Administrative service personnel shall be available for on-site consultations with County personnel as necessary.

9. All records, member files and miscellaneous data necessary to administer the plan shall be the property of Williamson County. The selected administrator will be asked to transfer records to the County in an electronic format of their choice.

10. The administrator shall not charge against the plan experience any claim payment not authorized under the health policy (except those specifically authorized in writing by the County). **In the event of such an error, the administrator shall**

be responsible for all collections and/or plan reimbursement expenses.

11. THE ADMINISTRATOR SHALL INDEMNIFY, HOLD, AND SAVE THE COUNTY, THE CONSULTANT AND THEIR AGENTS, OFFICERS AND EMPLOYEES HARMLESS FROM LIABILITY OF ANY NATURE OR KIND, INCLUDING COSTS, EXPENSES, AND ATTORNEY'S FEES, FOR HARM SUFFERED BY AN ENTITY OR PERSON AS A RESULT OF THE NEGLIGENT, RECKLESS, OR WILLFUL ACTS OF OMISSIONS BY THE CARRIER, ITS OFFICERS, AGENTS OR EMPLOYEES.

12. The proposals/proposers must quote a price for all services. The County does not wish to pay additional/separate fees under the contract for the following items, whether or not they are customized:

- ad hoc reports requested on as needed basis
- enrollment materials
- claim forms
- identification cards
- plan booklets
- PPO savings reports
- provider reports monthly, quarterly and annual
- reasonable and customary information
- dedicated service professional to assist the County with electronic claims status system

13. The County may conduct an annual written randomly selected employee satisfaction survey. The TPA must meet an employee satisfaction level of 80% as determined by the County.

14. Annual renewal prices will not exceed the percentage increase specified in the proposal. All proposals/proposers must sign and agree to this stipulation in order to be considered.

15. All proposals/proposers must sign and agree to the standard contract language regarding indemnification, ownership of records and databases, term of agreement, and no arbitration clause in order to be considered.

16. When a claim is submitted for payment, please check below how the following procedures are addressed:

Function	**Automated**	**Manual**
Claims inventory	_____	_____
Eligibility of employees	_____	_____
Eligibility of dependent	_____	_____
Track dual addresses (i.e. QMSCO)	_____	_____
Usual, customary, reasonable	_____	_____
Benefit plan excluded charges	_____	_____
Pre-existing conditions	_____	_____
Adjudication	_____	_____

Coordination of benefits	_____	_____
Check issuance	_____	_____
Subrogation	_____	_____
Explanation of benefits issuance	_____	_____
UR authorized in-patient days	_____	_____
Medical necessity	_____	_____
Deductible	_____	_____
Out-of-pocket benefit maximums	_____	_____
Co-insurance	_____	_____
Duplicate charges	_____	_____
Second opinion program	_____	_____
Co-pays	_____	_____
Preferred provider/ non preferred provider	_____	_____
Unbundling of charges	_____	_____
Physician referrals	_____	_____

17. Does your claims system have the following capabilities:

		Yes	No
a.	to process in-network, out-of-network and out-of-area claims on the system;	o	o
b.	integrated access to provider-specific data including contractual and financial arrangements;	o	o
c.	to maintain historical eligibility information;	o	o
d.	to separate eligibility dates for employees and each covered dependent;	o	o
e.	flexibility to process benefits at different coinsurance and out-of-pocket levels for in-network, out-of-network and out-of-area plans?	o	o
f.	to identify authorized referrals and admissions in-network?	o	o
g.	to process hospital and all other medical plan related claims including prescription drugs and capture hospital revenue codes?	o	o
h.	to apply stringent utilization and price controls for out of network usage?	o	o
i.	to automatically match claims with utilization management information (both in- and out-of network)?	o	o
j.	common database for edits, pricing, production of EOBs and reporting?	o	o
k.	to customize EOB messages?	o	o

l.	to report account specific per capita utilization and savings statistics by network site?	o	o
m.	to show, on the EOB, the actual charge?	o	o
n.	to show, on the EOB, the negotiated charge?	o	o
o.	to show, on the EOB, both the actual and the negotiated charges?	o	o
p.	to show the applicable procedure code?	o	o
q.	to show the percentage of payment?	o	o
r.	to show the amount of deductible satisfied?	o	o
s.	automatic rollover of flexible spending account claims	o	o
t.	if automatic rollover of flexible spending accounts claims is available, can it be accepted or rejected on an individual employee basis	o	o

18. Besides on-line claims adjudication services, the Administrator must maintain a detailed eligibility file that includes date of birth, social security number, premium detail and address information for the employee and/or dependent(s). The Administrator should be able to calculate premium listings by line of coverage and disburse reinsurance payments for the clients. Claim checks must be run on a client directed schedule. The Administrator must be able to administer all of the benefits offered by the County accurately and timely. The Administrator must be capable of designing and assisting in booklet preparation, plan documents, custom claim forms, ID Cards, and worksheets. **Failure to fulfill these provisions on a consistent basis will result in cancellation of this contract.**

B. Statistics

1. The County has not designed nor developed their own informational system. Therefore, the major portion of your statistical responsibilities will be to provide the County with monthly appropriate claims information they deem necessary for their operations.

2. The other type of statistical reporting you must provide for the medical benefits is a monthly total of the paid claims by plan. This monthly total must be provided by the 15th of the following month.

3. Daily, weekly and monthly check registers must be available.

II. Documentation and Plan Drafting

It is contemplated that the drafting assistance you may be asked to provide will be limited to assisting with the Plan Document and employee booklets. This assistance will most

likely involve providing contract language and booklet wording for the plan selected by the County. The County will require assistance with the medical plans.

We have included a copy of the Medical Plan Document in Section K. It is your responsibility to thoroughly review these documents and explain in detail what areas of the plan that can and cannot be administered effectively by your organization. It is imperative for an administrator to clearly outline any and all deviations or their inability to administer the County's Plan's as written. The County will consider some alternative benefits given a valid reason for doing so, but the reasons must be clearly outlined in the proposal response. This is your one opportunity. If a proposer does not outline any deviations or alternatives, the County will assume acceptance to administer the plans as written and will hold the administrator responsible for any and all financial hardships that they may endure in changing the plan or finding another suitable administrator.

III. General Instructions

A. In developing your proposal, we have not identified a separate section for the development of claim forms, etc., at the onset of the plan. You will be expected, however, to assist and cooperate in the development of all claim and reporting forms appropriate for both your needs and County's needs.

B. Your proposal must be submitted as a flat monthly fee per enrolled employee per month. Payment will be remitted to you at the end of each month when the County has tallied the monthly participation.

While it is contemplated that the successful ASO proposer will enjoy a long-term relationship with the County, should the relationship be terminated, you will be required to settle all claims, your fee will be remitted on the claims you actually pay provided the County leaves run-out responsibility with you.

C. With your quotation please enclose samples of your present claim drafts and other related required forms. Also include a listing of information required for the operation of your present claims system.

IV. Assistance with COBRA requirements as to eligibility or termination dates is requested. Service is currently provided by United Healthcare.

Additional Information on New Plan:

A. Coordination of Benefits - (COB)

The provider will be expected to follow-up diligently on COB claims and report savings on a regular basis.

B. Take Over Provision

The provider will be expected to be responsible for claims on a **"no loss, no gain"** basis and full credit will be given for deductibles satisfied on the previous

contract.

1. If any special banking arrangements are required, you should so state.

2. If any one-time start-up costs, so state.

3. The administrator will be expected to work with the County staff to provide administrator with format for electronic transfer of eligibility data.

V. Performance Guarantee's

Implementation/Plan Building Total Fees at Risk $100,000

1. ID Cards- 100% of id cards delivered prior to the effective date accurately $50,000
2. Implementation- 100% client satisfaction with the implementation process. $25,000
3. Plan Building- 100% accuracy on plan building to clients SPD $25,000

PPO Network Guarantee Total Fees at Risk $100,000

We have supplied 3 months of raw claims data you must re-price the claims to calculate the network discount guarantee you are willing to offer. You must supply the re-priced claims as part of your proposal response in order for your response to be considered. The minimum risk free corridor the client is willing to accept is 2%. To receive this file email Eric Smith at eric.smith@smith-associates.com

Is your organization also willing to agree to the following performance standards? The percentage at risk will be negotiated at a later date.

	Yes	No
Claim Processing Accuracy (95%)	o	o
Claim Turnaround (90% - 10 days)	o	o
Financial Payment Accuracy (99.5%)	o	o
Financial Coding Accuracy (97%)	o	o
Implementation	o	o
Employee Satisfaction	o	o

Customer Service
Telephone response time of 95% of all calls answered in 90 seconds
Abandonment rate of less than 5% Yes o No o

Guaranteed dedicated contact to assist with the County's Health Benefits –

Refusal to adhere to this provision may directly result in your company not being awarded this contract.

Yes o No o

MINIMUM REQUIRED MANAGEMENT REPORTS

Monthly

- Experience reports of paid and incurred claims by benefit (service) for employee and dependents in an electronic format.
- Check register of checks issued for bank reconciliation and a tape to be sent to bank.
- A claims problem report or claims pending report showing claims pending for such reasons as coordination of benefits, reasonable and customary, lack of information, or any other such items.
- List billing with separate bills for all medical/dental plans.

Other financial reporting required by the County's finance department.

Quarterly

- Summation of monthly reports and claims experience.
- Savings reports on C.O.B., R.C., duplicate charges, deductibles, coinsurance or eligibility.
- Utilization reports showing total number of hospital days and the average duration of stay by diagnosis, the total number of hospital days, the average duration of stay, and diagnosis by hospital. Provider information such as in-patient versus outpatient services, surgical procedures, accidents and PPO usage by number of patients and dollars incurred vs. charged by facility.
- A claims payment report on the timeliness of claims being submitted and paid.
- Area or provider comparisons such as hospital, doctors, drugs and diagnosis.
- Physician data including diagnosis coding.
- A quarterly data dump to be utilized on alternate software for claims utilization and must be provided in the file layout determined by the County.

Annual Reports

- A claims report showing the number of claims by dollar breakout such as $500, $1,000, $2,000, $10,000, $15,000 and $25,000.
- A list of the top 25 claims.
- Summary reports on quarterly information.

It is understood that the format of reports will vary by systems. The above outline illustrates the type of information the County wishes to receive. The administrator should provide, as an attachment, the format utilized for similar reports that are part of their services and/or any other illustrations it considers pertinent.

The County does not wish to incur extraneous charges for report generation.

Due to the fact that it is the County's intention to enter into a multiple year relationship with the successful administrator, additional reports could become necessary in the future. The administrator shall provide the additional reports, if necessary on a timely basis provided the cost of additional programming is not cost prohibitive. Should the additional reports be obtainable from the proposer's system in a compatible format, the proposer shall not receive additional compensation. Should the nature of the additional reports warrant compensation beyond the bounds of this contract, the report shall be provided at a cost mutually agreeable between the County and the successful proposer.

MEDICAL ADMINISTRATION QUESTIONNAIRE

1. From what City will claims be administered?

2. Do you provide in-state and/or national 800 telephone service? What, if any, are the additional charges for this service? What hours is the service available? Can you offer a dedicated 800 number for the County?

3. Describe your company's performance standards with respect to:

    a. employee inquiries (both written and telephonic);
    b. claims turnaround; and
    c. claims accuracy – both financial and procedural.

    Please indicate the actual performance of the office indicated in item 1 above during 2010 and 2011 in attaining these standards.

4. Is your firm willing to incorporate guaranteed turnaround time, COB recovery and quality performance standards in its contract with the County?

5. Describe your company's quality assurance and/or internal audit procedures and programs. Are you willing to provide the client with quarterly audit reports on its claims? You will be required to allow an annual audit done by an external auditor; do you have any provisions surrounding audits that would in any way limit the County's ability to fully audit their claims?

6. Describe in detail your claims hardware and software systems, and in particular, your claims editing capabilities (code review). Specifically, address how it checks for procedural discrepancies based on diagnosis, diagnostic "creep", and procedural unbundling. What percent of claims are detected by these edits? What percent of dollars claimed? How do you treat claims detected as a result of these edits? Do you charge extra for this?

7. Please list the main contact and telephone number for your services.

8. What percentage of claims are currently auto-adjudicated by your system? Do you expect this percentage to increase or decrease over time?

9. What are normal business hours for participant questions or precertification?

10. Please describe the nature of the contract you would propose, indicating:

    a. the length of time of the contract;
    b. the length of time your fees are guaranteed beyond the required three years; and
    c. termination notices required.

    Note: Williamson County requests a minimum three year contract.

11. If your company is selected, describe in detail the steps and schedule that would need to occur to assume the claims payment functions effective November 1, 2012?

12. How do you propose to collect claims data from the prior carrier to accommodate a smooth transition?

13. How would you determine "Days per 1000" by plan? Please explain in detail.

14. Are you able to administer on-line, electronic transfer, and tape-to-tape eligibility transfers? How does this impact your cost proposal?

15. Do you have the capability for the County to have access to your claims and eligibility system through an on-line system? Any cost for such a system should be included in your PEPM costs.

16. Does your system incorporate scanning capability and if so, is it incorporated into claims adjudication automatically?

17. Do you have physician and patient profiling/reporting capabilities? If so, please describe the standard reports available and *ad hoc* capability. Provide sample reports.

18. How would your organization determine usual, reasonable and customary charges for medical, surgical and anesthesia procedures? Answer this question in specific detail for both PPO and indemnity claims including what data source you utilize (e.g. HIAA, etc.) and how often it is updated.

19. If claims exceed the individual attachment point, how often are updated claim reports sent to the stop-loss carrier? Do you provide both clinical evaluations as well as claim costs with your standard updates to carriers for stop-loss claims? What carriers do you currently work with? Are there any carriers or MGU's that you have difficulty working with?

20. Please submit a sample of your proposed claim and Explanation of Benefits forms. Would you be willing to customize the information contained in these forms? Would there be an additional cost?

21. Please provide a list of all data elements which will be captured off of the claim forms and stored in your claims adjudication system. Do you capture DRG classifications? What information is coded off of a hospital U.B. 92? All revenue codes? How many levels of diagnosis codes are captured?

22. Please state what records (including the participant and data processing documents) would; in fact, belong to the County upon contract termination.

23. In the event of contract termination, when would records which are property of the County be released to the party or organization designated by the County? Describe your termination notice requirement.

24. It is required that all reporting requirements be included in your per capita administrative fee. Do you agree with this provision? Please provide copies of your standard reports for

review by the County.

25. Are you willing to guarantee ASO fees beyond the initial term? If so, what are your proposed service renewal guarantees or terms?

26. Does your system, or can you, administer a program that identifies and coordinates deductibles/claims on a family basis for dual working spouses?

27. Please describe any insurance you carry for Fiduciary Liability and Errors and Omissions Insurance. Amount? Carrier?

28. Do you pay the printing of checks; E.O.B.'s, and claim forms? Do you process checks and/or EOB's in house or is this function outsourced?

29. Can you handle electronic transfer of prescription drug claims?

30. Please attach samples of standard reports or any special cost containment reports available. If there is a charge, please state.

31. What process do you have to ensure that claims are not paid after a termination of coverage, or if paid, recovery of payments?

32. Does the Administrator employ a full-time M.D. as a medical advisor? If not on a full-time basis, when are the advisors available?

33. Will you work with the County to design a tailor made claim form?

35. Is your system capable of tracking Unique Provider Identification Number (UPIN)?

36. Can your system track referrals made by the primary care physician? Is this information date sensitive to the change?

37. Can your system track and provide information by physician (PCP) as to all patients treated, any/all hospital admissions, any emergency treatment, laboratory and any/all physicians referred by PCP?

38. Can you guarantee the County that you will enter all ICD-9 and CPT codes to agreed upon number of digits? The County will insist upon complete and accurate coding entry.

39. Can your system track and process itemized hospital charges by code?

DENTAL ADMINISTRATION QUESTIONNAIRE

This proposal is for self insured Dental claims administration only. At this time, the County is not interested in receiving fully insured Dental PPO Plan quotes.

1. From what City will claims be administered?

2. Do you provide in-state and/or national 800 telephone service? What, if any, are the additional charges for this service? What hours is the service available?

3. Describe your company's performance standards with respect to:

   a. employee inquiries (both written and telephonic);
   b. claims turnaround;
   c. claims accuracy (statistical, payment, financial, technical);
   d. number of claims received monthly by plan type;
   e. number of claims processed monthly by plan type, and;
   f. current average processing time and current backlog in days.

   Please indicate the actual performance of the office indicated in item 1 above during 2010 and 2011 in attaining these standards.

4. Describe your company's quality assurance and/or internal audit procedures and programs. To who does your in-house audit/quality assurance person(s) report? What percentage of all claims processed are audited? Describe methodology used in computing processing time. Is the claim "receive date" the same for the claim and subsequent adjustments? Are you willing to provide the client with quarterly audit reports on its claims? Are you willing to allow an annual audit done by an external auditor?

5. Please list a contact and telephone number for your services.

6. Please list five references with names, titles, and telephone numbers. State number of employees covered.

7. What are normal business hours for participant questions or pre-determination?

8. Please describe the nature of the contract you would propose, indicating:

   a. the length of time of the contract;
   b. the length of time your fees are guaranteed beyond the required three years; and
   c. termination notices required.

   Note: The County requires a minimum three year contract.

9. If your company is selected, describe in detail the steps and schedule that would need to occur to assume the claims payment functions effective November 1, 2012.

10. Are you able to administer on-line, electronic transfer, and tape-to-tape eligibility transfers? How does this impact your cost proposal?

11. Do you have the capability for the County to have access to your claims and eligibility system through an on-line system? At what cost?

12. Please submit a sample of your proposed claim and Explanation of Benefits forms. Would you be willing to customize the information contained in these forms? Would there be an additional cost?

13. Please state what records (including the participant and data processing documents) would; in fact, belong to the County upon contract termination. Describe how and where claim records will be stored. Specify whether storage media is electronic or hard copy, on-site or off-site.

14. In the event of contract termination, when would records, which are property of the County, be released to the party or organization designated by the County? Describe your termination notice requirement. Are records stored in an easily retrievable manner?

15. Are you willing to guarantee ASO fees beyond the initial three-year term? If so, what are your proposed service renewal guarantees or terms?

16. Does your system, or can you, administer a program that identifies and coordinates deductibles/claims on a family basis for dual working spouses?

17. Please describe any insurance you carry for Fiduciary Liability and Errors and Omissions Insurance. Amount? Carrier?

18. Do you pay the printing of checks; E.O.B.'s, and claim forms?

19. What process do you have to ensure that claims are not paid after a termination of coverage, or if paid, recovery of payments?

21. Does the Administrator employ a full-time DDS as a dental advisor? If not on a full-time basis, when is the advisor available?

22. Are plan changes, discounts, fee schedules to be loaded into the computer system by Administrator employees or an outside support group? Are changes verified back to the County as to accuracy and implementation date?

23. Please explain in detail your refund process. How do you identify refunds? Are letters are sent out? If so, how many? Is this a manual or automated process? Is the provider ever contacted by any other means than by a letter?

24. Do you have an on-line enrollment system? If so, please explain in detail how it functions (i.e. ability to transmit data back to the County in an electronic format).

25. Please explain in detail how you will assist the County during open enrollment.

VISION PLAN ADMINISTRATION QUESTIONNAIRE

This proposal is for self insured Vision Claims Administration only. At this time, the County is not interested in receiving fully insured Vision Plan quotes.

1. From what City will claims be administered?

2. Do you provide in-state and/or national 800 telephone service? What, if any, are the additional charges for this service? What hours is the service available?

3. Describe your company's performance standards with respect to:

   a. employee inquiries (both written and telephonic);
   b. claims turnaround;
   c. claims accuracy (statistical, payment, financial, technical);
   d. number of claims received monthly by plan type;
   e. number of claims processed monthly by plan type, and;
   f. current average processing time and current backlog in days.

   Please indicate the actual performance of the office indicated in item 1 above during 2010 and 2011 in attaining these standards.

4. Describe your company's quality assurance and/or internal audit procedures and programs. To who does your in-house audit/quality assurance person(s) report? What percentage of all claims processed are audited? Describe methodology used in computing processing time. Is the claim "receive date" the same for the claim and subsequent adjustments? Are you willing to provide the client with quarterly audit reports on its claims? Are you willing to allow an annual audit done by an external auditor?

5. Please list a contact and telephone number for your services.

6. Please list five references with names, titles, and telephone numbers. State number of employees covered.

7. What are normal business hours for participant questions or pre-determination?

8. Please describe the nature of the contract you would propose, indicating:

   a. the length of time of the contract;
   b. the length of time your fees are guaranteed beyond the required three years; and
   c. termination notices required.

   Note: The County requires a minimum three year contract.

9. If your company is selected, describe in detail the steps and schedule that would need to occur to assume the claims payment functions effective November 1, 2012.

10. Are you able to administer on-line, electronic transfer, and tape-to-tape eligibility transfers? How does this impact your cost proposal?

11. Do you have the capability for the County to have access to your claims and eligibility system through an on-line system? At what cost?

12. Please submit a sample of your proposed claim and Explanation of Benefits forms. Would you be willing to customize the information contained in these forms? Would there be an additional cost?

13. Please state what records (including the participant and data processing documents) would; in fact, belong to the County upon contract termination. Describe how and where claim records will be stored. Specify whether storage media is electronic or hard copy, on-site or off-site.

14. In the event of contract termination, when would records, which are property of the County, be released to the party or organization designated by the County? Describe your termination notice requirement. Are records stored in an easily retrievable manner?

15. Are you willing to guarantee ASO fees beyond the initial three-year term? If so, what are your proposed service renewal guarantees or terms?

16. Does your system, or can you, administer a program that identifies and coordinates deductibles/claims on a family basis for dual working spouses?

17. Please describe any insurance you carry for Fiduciary Liability and Errors and Omissions Insurance. Amount? Carrier?

18. Do you pay the printing of checks; E.O.B.'s, and claim forms?

19. What process do you have to ensure that claims are not paid after a termination of coverage, or if paid, recovery of payments?

21. Does the Administrator employ a full-time Optometrist as a vision advisor? If not on a full-time basis, when is the advisor available?

23. Are plan changes, discounts, fee schedules to be loaded into the computer system by Administrator employees or an outside support group? Are changes verified back to the County as to accuracy and implementation date?

23. Please explain in detail your refund process. How do you identify refunds? Are letters are sent out? If so, how many? Is this a manual or automated process? Is the provider ever contacted by any other means than by a letter?

24. Do you have an on-line enrollment system? If so, please explain in detail how it functions (i.e. ability to transmit data back to the County in an electronic format).

25. Please explain in detail how you will assist the County during open enrollment.

Items to include in proposals:

- Exact specimen copy of your proposed service contract, including all limiting exclusions, amendments, and extensions;
- Political subdivisions references and/or list of representative clients;
- A description as to how your firm would like to structure the account and handle the monthly billings;
- Specify how and at what cost your firm would handle the enrollment and in the event of a discontinuance of your services, what actions would be necessary;
- Coverage must continue as long as an employee is payroll active;
- **Provide a GeoAccess Map of Network Providers in <u>Bastrop, Bell, Blanco, Burnett, Hays, Lee, Milam, Travis, and Williamson Counties</u>.**

SECTION E

PRESCRIPTION DRUG CARD
RETAIL & MAIL ORDER DRUGS

All proposers must clearly mark the cost proposal sections and place them at the front of the proposal.

SECTION E: PRESCRIPTION DRUG CARD RETAIL & MAIL ORDER DRUGS

Selection Criteria

To assist you in developing your response, we have summarized the criteria that will be used to evaluate your proposal. The successful organization will exhibit the following critical elements:

General Program Characteristics

- Ability to administer an electronically integrated POS retail and mail service program;
- Ability to provide dedicated service to the individual handling the County's Health Benefits;
- Proven experience in administering integrated managed prescription drugs and DUR programs;
- Ability and willingness to administer plan design exactly as specified;
- Ability to administer the County's health plans in the most cost effective manner;
- Ability to offer cost effective alternatives to today's changing healthcare environment;
- Ability to offer on-line access to transfer of eligibility information;
- Ability to interface with medical claims payers and utilization review organizations as necessary;
- Proactive, responsive, and effective account management;
- Professional, complete, and timely response to RFP; and
- Favorable input from client references.

Retail Network Considerations

- Access to retail network providers;
- Ability to provide on-line, electronic POS capability to:
  - Verify eligibility;
  - Verify plan design;
  - Submit and adjudicate claims;

- Perform concurrent DUR; and

- Collect cost and utilization data.

Mail Service Characteristics

- Acceptable level of dispensing accuracy;
- Acceptable prescription turnaround time;
- Ability to provide on-line, electronic POS capability to:
  - Verify eligibility;
  - Verify plan design;
  - Submit claims;
  - Perform concurrent DUR;
  - Collect cost and utilization data; and
- Acceptable plan for transition from current mail service provider (if necessary).

DUR Programs

- Timely integration of mail service and retail data;
- Ability to offer comprehensive concurrent and retrospective programs;
- Extensive evaluation criteria and frequent product enhancement;
- Ability to monitor concurrent and retrospective review outcomes; and
- Ability to provide measurable results.

Quality Assurance Measures

- Thorough retail network provider credentialing including:
  - Professional qualifications;
  - Appropriate state and federal licensure;
  - Adequate malpractice insurance;
  - Disciplinary history; and

- Recredentialing/contract renegotiation.

Customer/Client Services (Applicable to Both Retail and Mail Order Service)

- Access to Customer Service Representative (CSR);
- Favorable CSR responsiveness:
  - Average speed of answer;
  - Abandonment rate;
  - Inquiry/complaint resolution;
- Ability to monitor customer service performance measures on a client-specific basis;
- Access to registered pharmacist;
- Access to electronically integrated mail service and retail cost and utilization data (on line, real time);
- Extensive, flexible reporting capabilities;
- Ability to provide on-line access to claims database; and
- Assistance in developing a broad range of education/introductory program materials/services.

Financial Considerations

- Stability of organization;
- Competitive administrative costs;
- Significant provider discounts; and
- Ability to negotiate network pharmacy reimbursement based upon the lesser of the pharmacy's usual and customary retail price, the negotiated contract price or Maximum Allowable Cost (MAC) pricing.

Please be advised that other criteria may be employed during the course of the evaluation process. Consequently, your organization should feel free to address other issues that may be deemed crucial to the competitiveness of your proposal.

FEE FOR PRESCRIPTION DRUG/MAIL ORDER SERVICES

Administrative Service Fees

Please show your administrative service fees on the enclosed Rate/Fee Sheet assuming the existing benefit design for both the retail and mail service portions of the plan. Additionally, consider the following:

- Administrative fee quotations are to be provided on a per claim basis;
- Please note any additional administrative fees not accounted for in the quoted base rate (e.g., data integration, etc.); and
- Fees would be guaranteed for a minimum of three years. Please indicate if your guarantee will differ.
- The County is interested in for-going any Rebates in an effort to lower Administrative/Dispensing Fees. ***Please propose your fees with and without Rebates***.

Drug Costs

Please quote retail and mail service drug costs assuming existing benefit design. Additionally, assume:

- Lesser of U&C price, MAC price, or negotiated contract rate for reimbursement. MAC Pricing is not the preferred pricing model that the County wishes to enter into. Guaranteed discounted amount offerings will receive preferential treatment.
- A generic enforcement program whereby patients refusing a generic substitute when available and appropriate, will be required to pay the difference between brand and generic prices in addition to the applicable co-payment. This program will apply for both retail and mail service prescription purchases;
- Use of voluntary formulary program to help drive drug product selection;
- All claims incurred by eligible participants on or after November 1, 2012 will be covered under these arrangements; and

If you are unwilling to meet these requirements, please note variations and include them along with your quotation.

ALL PLANS
Prescription Benefits

	RETAIL (30 day supply)	**MAIL ORDER (90 day supply)**
	AFTER $50 DEDUCTIBLE	
Retail Rx Plan Year Maximum of $1,250		
Generic	30% up to $100 per Rx	$20.00 Co-Pay
Brand	30% up to $100 per Rx	$70.00 Co-Pay
Specialty Drug	$125 Co-Pay	

WILLIAMSON COUNTY PHARMACY BENEFIT MANAGER COST SHEET				
	Option 1 Retail	**Option 1 Mail Order**	**Option 2 Retail**	**Option 2 Mail Order**
Admin Fee Electronic				
Paper				
Dispensing Fee Brand				
Generic				
Discount Brand				
Generic				
Generic w/MAC				
Generic w/o MAC				
Rebate				
Start-Up Fees				
Rate Guarantee				
Min. Charge/Presc.				
Notes				

**** Please note: This form must be submitted within your proposal response to reflect the proposed fees.**

GENERAL INFORMATION FOR PRESCRIPTION DRUG/MAIL ORDER

1. Who owns your organization?

_____

a. If applicable, please describe the organizational relationship between your organization and its parent company.

_____

2. When did your organization begin administering:

a. POS retail programs?

_____

b. Mail service programs?

_____

c. Integrated POS retail/mail service pharmacy programs?

_____

3. Is the Quantity Level limits plans flexible or does the County have to abide by proposers set programs?

4. Please provide location for each of the following as they relate to the County's account:

State

Home Office _____

Regional Office _____

Claims Processing Facility _____

Mail Service Pharmacy _____

5. Is your organization authorized to do business in the state of Texas? What other states are you authorized to do business in?

_____

6. Are premium taxes included in any fee shown?

_____

7. Do the fees provided include any level of commissions?

_____

8. Does your organization agree that all records, member files, and miscellaneous data used in administration of this plan shall remain the property of the County?

_____

9. Please provide three (3) references consisting of both current and terminated clients.

Name	Company	Telephone #	# of EE Lives
Name	Company	Telephone #	# of EE Lives
Name	Company	Telephone #	# of EE Lives

SECTION F

PRECERTIFICATION/
LARGE CASE MANAGEMENT

SECTION F - PRECERTIFICATION/LARGE CASE MANAGEMENT

SERVICES TO BE PROVIDED

1. MEDICAL/SURGICAL UTILIZATION REVIEW

a. Pre-authorization of services
b. Pre-determination of physician fees
c. Admission review (all in-patient admissions)
d. Continued stay management
e. Discharge planning
f. In-patient behavioral case management
g. Second opinion coordination
h. Physician fee review
I. Referrals to preferred provider physicians and hospitals
j. Health information services via toll-free number (if necessary)
k. Out-patient surgery coordination
l. Home managed care
m. Hospice care management
n. Standard Activity Reports

2. PSYCHIATRIC AND CHEMICAL DEPENDENCY REVIEW

a. Specialized case management provided by professional staff with experience in the behavioral sciences.
b. Precertification and concurrent certification of services provided in a provider's office or facility based services.
c. Standard Activity Reports

3. CASE MANAGEMENT

TPA reviews the specific needs of patients whose conditions are indicative of long-term or high dollar medical care to ensure appropriate use of medical care facilities, to improve quality of care, to control or reduce costs, and to manage the individual's care, disability, and rehabilitation. Saving reports are available according to client request.

4. DISEASE MANAGEMENT

To manage the County's population using advanced disease state management criteria the proposer must state what experience they have with this type of management service and what disease states they currently are managing.

UTILIZATION MANAGEMENT QUESTIONNAIRE

This is to be filled out by any organization desiring to provide precertification, second opinion and concurrent review.

I. GENERAL

A. Basic Information About Your Firm

1. Name of Firm, Headquarters Address and Phone Number.

2. Executive contact, name and title.

3. How many locations does your firm have working within its Utilization Review Program?

4. Include primary contact, number of professionals by category (M.D., R.N., etc.) number of para-professionals and size of support staff. Identify the location which would provide review services.

5. How long has your firm been providing Utilization Review services?

6. What is the present number of employees working in Utilization Review?

7. Approximately how many groups and covered persons does your firm presently serve?

   Groups:_____ Covered Persons:_____

   What were these totals 12 months ago?

   Groups:_____ Covered Persons:_____

8. What types of services does your firm provide?

	YES	NO
• Pre-Admission	____	____
• Pre-Admission Employee Telephone Advisory	____	____

	YES	NO
• Concurrent Review	____	____
• Discharge Planning	____	____
• Retrospective Review	____	____
• Hospital Bill Audit	____	____
• Mental/Nervous and Alcohol/Drug Quality Review	____	____
• Second Surgical Opinion	____	____
• Medical Case Management	____	____
• Other (Answer this question on back side of this page)	____	____

9. Can the above services be purchased separately? ____ ____

10. Does your firm provide consulting advice or other services in regard to Wellness Programs? ____ ____

11. Does your firm have any geographic restrictions regarding where it may provide services? ____ ____

12. Please provide the most recent annual report for your firm. (Submit with your proposal.)

B. Client-Related Information

1. Please list 3 prominent Utilization Review clients. Please include addresses, the name of the contact person of each location, and the volume of employees for whom Utilization Review services are being provided.

2. Please list the client name, address and local or regional contact person for the largest two clients who have terminated your firm's services in the past twelve (12) months.

Utilization Review

1. Does your firm offer the following utilization control?

	Yes	No	Partially
a. Pre-admission Certification	o	o	o
b. Managed Mental Health Program	o	o	o
c. Large Case Management	o	o	o

d. Home Health Care management	o	o	o
e. Organ Transplant Network	o	o	o
f. Hospice Care	o	o	o
g. Second Surgical Opinion	o	o	o
h. Concurrent Review	o	o	o
i. Discharge Planning	o	o	o
j. Line Item Hospital Bill Audits	o	o	o

2. Are these services provided by

a. Your company	o	o	o
b. A company owned/subsidiary	o	o	o
c. A vendor	o	o	o

II. PROCEDURES FOR VARIOUS PROGRAMS

A. Pre-Admission Certification

1. Are all hospitalizations, regardless of diagnosis, included in Utilization Review?

Yes_____ No_____

2. For each of the following, what is the timetable for certification? (Period of elapsed time from first request to point of approval.)

		Number of Hours
a.	Emergency Admissions?	_____
b.	Urgent Admissions?	_____
c.	Elective Admissions?	_____
d.	Normal Childbirth?	_____
e.	Extended Stays?	_____

3. How is each party kept informed?

   - Patient?

   - Physician?

   - Employer?

4. Are certifications obtained by: Telephone _____
   Mail _____
   Both _____

5. What specific information is submitted in the initial request for certification? (Include sample form. Complete on the back side of this sheet.)

6. Are length of stay guidelines provided with initial admission approval?

   Yes_____ No_____

7. To what extent are nurses and/or physicians involved, step-by-step in the certification procedures? At what point is a physician called to review the nurse in the evaluation?

B. Concurrent Review and Discharge Planning

1. Are concurrent review and discharge planning normally included with your firm's pre-admission certification review?

   Yes_____ No_____

2. Are length of stay extensions typically administered within this part of the program?

3. What procedures does your firm believe belong with concurrent review and discharge planning?

4. Is this procedure handled by your firm or delegated?

   If delegated, do you contract with various Peer Review Organizations?

5. How are contracts made by your administrators with attending physicians to be certain estimated discharge dates are met?

C. Retrospective Review and Hospital Bill Audit

1. Does your firm regard these two efforts as one or separate services?

2. What is your procedure regarding retrospective review?

3. What is your procedure regarding hospital audits?

D. Medical Case Management Program

1. Does your firm provide a medical case management program?

2. Indicate how your program states its objectives in view of typical goals of (a) identifying alternate care, (b) recommending accelerated care, and (c) reduction of medical complications.

3. Most MCM programs concentrate on a group of illness and injury cases which have proved successful candidates for MCM.

   Has your firm identified a list of illnesses and injuries it considers best for MCM? If so, please list below:

4. If your firm were selected to administer the Utilization Review Program, do you believe your firm would be in a position to also administer the MCM program more efficiently than the primary claim administrator?
   Explain.

5. Indicate what levels of Disease Management your firm currently provides by disease state.

MEDICAL MANAGEMENT

1. Number of local full-time equivalent Medical Directors on staff_____ nurses_____. Average number of year's clinical experience and utilization review experience.

   Do you have on-line access to claim payment function?

   Do you handle both in-network and out-of-network claims?

2. How are cases identified for potential case management? Describe specialized handling of catastrophic illnesses.

3. What guidelines do you use for in-patient pre-admission certification and concurrent review? To what extent is concurrent review performed on-site at the hospital?

4. Complete the following:

	Current Year 2011	1st Previous 2010	2nd Previous 2009
Hospital days per 1,000 members:			
In-network	_____	_____	_____
Out-of-network	_____	_____	_____
Hospital admissions per 1,000 members:			
In-network	_____	_____	_____
Out-of-network	_____	_____	_____

5. How do you measure patient satisfaction?

6. Are you accredited by NCQA or any other accrediting organization? Please provide name of organizations and accreditation dates.

III. IMPLEMENTATION SCHEDULE

Based upon your firm's experience, what do you believe is typically a satisfactory lead time (stated in days) to implement a Utilization Review Program?

IV. COMMUNICATIONS

The employer recognizes the need for a comprehensive communication program for Utilization Review.

1. Will your firm be willing to provide a representative to attend meetings to explain your Utilization Review Program?

2. Please provide us with examples of your recent communication work, including:

   - Letters prepared for the employer to be sent to employees announcing the establishment of a pre-admission certification program.
   - Brochures outlining the goals of the program and the employee's role in the program.
   - Posters, payroll stuffers and other similar material.
   - Audio-Visual Aids

3. Does your firm issue ID cards or stickers to be used on existing ID cards?

4. Does your firm supply postage-paid envelopes for mail-in requests?

5. (a) How many hours per day and days per week are your firm's phone lines open?

   Hours per day_____ Days per week_____

   (b) Do you provide a toll-free number for use by covered members, providers, and the County?

   Yes_____ No_____

SECTION G

DISEASE MANAGEMENT

SECTION G: DISEASE MANAGEMENT QUESTIONNAIRE

Name of Organization:_____

Street Address:_____

City:_____ State:_____ Zip Code:_____

Telephone Number:_____Fax Number:_____

Name of Contact:_____Title:_____

GENERAL QUESTIONS

1. Please provide a *brief* description of your organization, including history, business philosophy, and target market?

2. Describe any unique qualifications that distinguish your company within the disease management industry.

3. How do you protect individual participant data? How are you addressing HIPAA-specific data privacy requirements? Are you up to date with HIPAA compliance with EDI and privacy requirements? Date first operational:

4. Describe service area:

ENROLLMENT PROFILE	NUMBER OF MEMBERS Most Recent Count (as of 01/01/2012)
Employee-Employer Groups	_____
Individual	_____
Medicare/Medicaid	_____
Other (specify)	_____
Total Number of Members	_____
Percent Growth over last 24 months	_____
Number of Employer Accounts	_____
Percent Growth over last 24 months	_____

Five largest employee-employer groups:

	Group Name	Current Number of Members
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____

Account Management/Implementation

1) Who are the individuals that would provide account management services to the County? What are their qualifications?

2) Provide a detailed description of the implementation process, including how you will work with the County, its plans and other programs.

3) How often will you meet in person with the County during implementation, including promotion and education of County beneficiaries regarding the availability of your program?

4) Once the program is implemented, how often will you meet with the County to provide feedback, updates and reports?

5) Describe your process to communicate the disease management program to employees.

6) Can communications materials be customized? If yes, identify what can be customized and if there would be any additional fees for customization.

7) Are multi-lingual materials available?

8) Please provide copies of all implementation AND communication materials.

9) List the diseases covered in your disease management programs and specify whether they are currently available or in development.

10) Do you use clinical practice guidelines? If yes, specify which guidelines are used and how they are applied.

11) Describe the types of interventions and methods of delivery used for the disease management programs you offer.

12) Explain how Disease Management interventions are targeted to individual participants' needs and motivation to change.

13) Do you use a readiness to change behavioral model in the delivery of your services? If so, describe.

14) How do you track and monitor patients over time?

15) Describe how you handle co-morbid conditions and provide a list of the co-morbid conditions you address.

16) Do you have an educational component to your program and educational materials?

17) What is the literacy level of your written materials?

18) What methods do you use to identify candidates for the disease management programs and the frequency of each method?

19) Describe your information technology infrastructure.

20) Describe the desktop system that is used in your Disease Management operations?

21) Do you any data mining software in your Disease Management?

22) Describe system security and back-up procedures.

23) Describe the process of Claims Data and Eligibility transfer from the Medical plan TPA.

24) How much data do you need initially?

25) What is the frequency of subsequent feeds?

26) Please provide the file feed format and any necessary specifications.

27) Enrollment

28) How does your organization encourage participation in Disease Management programs?

29) What is your program enrollment rate?

30) Do participants graduate from the program? If so, what is the graduation criteria?

31) How often are outbound calls made to participants?

32) Describe the makeup, qualifications, and experience of the Disease Management staff?

33) List the components that make up your staff training and indicate whether each component occurs during orientation or is ongoing.

34) Provide the hours of operation

35) Do you offer a 24-hour nurse line service?

36) This year the County instituted a Diabetic Plan administered by UHC and details of this plan are included in Section K. Describe in detail how your organization will implement the current plan and what services your organization can provide to assist the County in managing the Diabetic Plan.

37) Describe how your organization collaborates with an employer's other health care initiatives to deliver integrated disease/condition management services.

38) How do you identify the participants' physician and how are they incorporated within the care of participant?

39) How do you handle physicians that are non-compliant with the necessary protocol for the patient's disease state?

40) Describe all care management services available through your organization to large employers. Which services, if any are outsourced to third parties?

41) Describe how your organization retrieves & reviews paid claim data when analyzing a prospective client's needs.

42) Are reporting tools available to clients electronically?

43) Do you utilize any statistical methodology for early disease detection (e.g. predictive modeling)?

44) Indicate which measures you use to determine program impact and cost savings.

45) Please provide a sample of standard client reports.

46) What data elements are captured and tracked in your Disease Management programs and which ones can you report back to the client?

47) Describe the types of client reports available. How often are reports provided?

48) Will you provide comparative data from your book of business?

49) Please provide copies of standard client reports.

50) Are you capable and will you provide customized client reports?

51) What services are included in your fees? Describe all potential extra fees in providing services.

52) List all Disease Management programs and services you propose to provide to the County and indicate your proposed fees.

SECTION H

PREFERRED PROVIDER ORGANIZATION

All proposers must clearly mark cost proposal sections and place them at the front of the proposal.

SECTION H: PREFERRED PROVIDER NETWORK CONTRACTS

It is the County's intent to implement performance guarantees for PPO provider discounts. In order to best analyze the appropriateness of a given network for discounts and for provider coverage all proposer must re-price the claims file that will be sent to all interested proposers. To receive a copy of the claims file please email Mr. Eric Smith at eric.smith@smith-associates.com. In order to simplify the County's analysis, the re-priced claims file should include clear indication of whether a provider is in or out of network, allowed amount, and discount amount. In order to comply with the Texas Open R ecords Act any information deemed as proprietary must be clearly marked as such with clear explanation of how that information should be handled in case the County receives a request for this information. All proposers must be prepared to clearly state the performance guarantee for their provider discounts and any outliers that may apply.

NETWORK EVALUATION QUESTIONNAIRE

Name of Organization:_____

Street Address:_____

City:_____State:_____Zip Code:_____

Telephone Number:_____Fax Number:_____

Name of Contact:_____Title:_____

GENERAL QUESTIONS

1. Describe ownership and history of organization:

2. Date first operational:

3. Describe service area:

ENROLLMENT PROFILE

	NUMBER OF MEMBERS Most Recent Count **(as of 01/01/2012)**
Employee-Employer Groups	_____
Individual	_____
Medicare/Medicaid	_____
Other (specify)	_____
Total Number of Members	_____
Percent Growth over last 24 months	_____
Number of Employer Accounts	_____
Percent Growth over last 24 months	_____

Five largest employee-employer groups:

	Group Name	Current Number of Members
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____

HOSPITAL INFORMATION

1. Where do you provide the following tertiary care? What types of contracts do you have with these facilities (none, case to case, or blanket)?

   Premature infants: _____

   Cardiovascular care: _____

   Burns: _____

   Organ transplants: _____

   Severe trauma: _____

   Other tertiary: _____

2. Are hospital reimbursements at the lesser of billed charges or contracted price? Please complete the following chart.

HOSPITAL REIMBURSEMENT CHART
NOTE: PER DIEM OR % DISCOUNT

In-Patient	Round Rock Medical Center	St. David's Georgetown Hospital	Seton Medical Center Round Rock	Dell Children's Medical Center Of Central Texas	Scott & White Memorial Hospital	Cedar Park Regional Medical Center	St. David's Medical Center Austin
Medical							
Surgical							
ICU/CCU/NICU							
Obstetrics Vaginal Delivery First Day							
Subsequent Days							
C-Section Delivery First Day							
Subsequent Days							
Progressive Care Unit							
Telemetry Unit							
Nursery Level I							
Level II							
Level III							
Out-Patient Surgery							

Medicare Category 1.							
2.							
3.							
4.							
5.							
6.							
Any Other Out-Patient Discounts							
Stop-Loss Point & % discount							
Exclusions:							

PHYSICIAN INFORMATION

	Primary Care	Specialists
1. What is the number of physicians? participating in your Network in the Austin / Georgetown area?	_____	_____

2. Are you able to track out-of-network charges? ____Yes ____No
If yes, what percentage of the physician charges reimbursed within medical plans you sponsor/administer are paid to participating physicians? _____%

3. Describe your reimbursement arrangement (e.g., McGraw-Hill M.D.R. - HIAA, R&C, etc.) and provide the following CPT code allowable:

CPT Code	Description	Allowable
99202	Office/outp; new 20 min.	
99203	Office/outp; new 30 min.	
99204	Office/outp; new 45 min.	
99211	Office/outp; est. 5 min	
99212	Office/outp; est. 10 min.	
99213	Office/outp; est. 15 min.	
99214	Office/outp; est. 25 min.	
99215	Office/outp; est. 40 min.	
99233	Subsequent hospital visit	
99284	Emergency Visit	
99395	Office visit preventive	

4. Are participating primary care physicians required to accept new patients?

5. Do primary care physicians have "gatekeeper" responsibilities within your system?
_____Yes _____No

If not, how are specialty utilization and out-of-network referral costs controlled?

Are PCPs required to refer to network specialists? _____

What information/assistance for referrals does the Network provide PCPs?

6. Do physicians have risk-sharing arrangements (e.g., risk pools, withholds)?
_____Yes _____No If yes, please describe:

7. Describe your physician selection and termination criteria. Describe your credentialing requirements for physicians. Are these requirements made prior to or after acceptance into the network? Who performs the credentials review and how often are physicians recredentialed? This may be provided elsewhere on proposal.

8. How many physicians have been added and dropped out of the network over the last three years?_____ Describe and quantify reasons:

9. **Provide a GeoAccess Map of Network Physicians and Hospitals in Bastrop, Bell, Blanco, Burnet, Hays, Milam, Lee, Travis and Williamson Counties. For an exact zip code match, a file is available in electronic format. Please email your request to eric.smith@smith-associates.com**

10. Please describe in detail the process utilized to re-price the Sample Claims File (i.e. actual contracts or estimated based upon your Williamson County area contracts).

11. Clearly outline your proposed PPO Discount Performance Guarantee to include any claims which may be excluded and all caveats to above mentioned guarantee.

MEDICAL MANAGEMENT

1. Number of local full-time equivalent Medical Directors on staff_____ and nurses_____.

   Average number of years in clinical experience and utilization review experience.

   Do you have on-line access to claim payment function?

   Do you handle both in-network and out-of-network claims?

2. How are cases identified for potential case management? Describe specialized handling of catastrophic illnesses.

3. What guidelines do you use for in-patient pre-admission certification and concurrent review? To what extent is concurrent review performed on-site at the hospital?

4. Complete the following:

	Current Year 2011	1st Previous 2010	2nd Previous 2009
Hospital days per 1,000 members:			
In-network	_____	_____	_____
Out-of-network	_____	_____	_____
Hospital admissions per 1,000 members:			
In-network	_____	_____	_____
Out-of-network	_____	_____	_____

5. How do you measure patient satisfaction?

6. Are you accredited by the National Council for Quality Assurance (NCQA) or any other accrediting organization? Please provide name of organizations and accreditation dates.

7. Describe your quality assurance program and provide a copy of any guidelines utilized.

8. What data and education do you provide to providers? Do you have a provider "report cards" system (e.g., specialist referral rate, in-patient statistics) member feedback, comparisons to standards and peers? If so, describe.

9. Does a technology assessment process exist?

10. How are medical necessity guidelines developed and modified?

11. How are guidelines communicated to network providers?

12. Does network perform clinical outcome studies? _____ If so, describe:

13. Is a portion of physician compensation directly based on individual quality results?

14. What percentage of your statewide network is owned by you and what percentage is leased?

15. If you are utilizing a lease network, please list the areas of the state by county that you access via the lease network.

MISCELLANEOUS

1. Describe work flow. Does the network re-price claims prior to submission to payer? Is this data captured? (Please provide reports.)

2. What data is available and in what format?

   What census data, membership demographics is available?

   What frequency of service data is maintained and how often are reports run and reviewed?

   What charge data is captured and how often are reports run summarizing the results?

   What provider data is captured and how often are reports run summarizing the results?

3. How is hospital reimbursement calculated and who does it? The network or a third party?_____ Is payment accuracy verified?____ If so, how?

4. How is physician reimbursement calculated and who does it? The network or a third party?_____ Is payment accuracy verified?____ If so, how?

5. Is payment accuracy verified and if so, how?

6. Does network credential all participating providers and facilities?____ If not, which are?

   What hospital credentialing and recredentialing criteria are required?

   How often are facilities recredentialed?

7. What percent of physicians are credentialed? _____ What documentation is kept in network files?

Is the function delegated to a third party credentialler (e.g., IPA or hospital)? _____ If so, to whom?_____

Is each physician credentialed before being accepted into network?

8. What percent of your participating physicians are board certified?

   Primary Care Physicians? _____

   Specialists? _____

9. Do you contract with any entities such as prescription drug organizations, mental, nervous and chemical dependency companies, etc. which perform their functions at discounted and/or capitated rates? _____Yes _____No Please describe these arrangements, the associated reimbursement contract, the utilization reporting capabilities and the generic substitution rate (for prescription drug arrangements).

FEES

1. What is your fee for accessing the network? What services are included in the fee?

2. What other services are available, and at what cost?

DOCUMENTATION

Please include copies of the following:

1.	Financial statement or annual report	__Attached
2.	Current organizational chart	__Attached
3.	Background and profile of your management personnel	__Attached
4.	Sample hospital contract and reimbursement arrangement	__Attached
5.	Sample physician contract and reimbursement arrangement	__Attached
6.	Copies of standard data reports (especially reports that demonstrate medical management capabilities and/or savings achieved)	__Attached
7.	Austin area provider directory	__Attached

SELF INSURED PREFERRED PROVIDER ORGANIZATION FEE QUOTATIONS

Give costs in your normal fashion. State clearly attachment points, reserves, guarantees if provided and retention and insurance costs. Show your cost separately for each category of service assuming (a) that the full range of administrative services is taken and (b) that each category may not be purchased. All carrier/administrators should assume that they will be responsible for claims that arrive after November 1, 2012.

Please state the length of time your fees are guaranteed beyond the required three years _____.

Your Charge per Participation per Month

	First Year	Second Year Cap
	$_____	$_____
	$_____	$_____

I.	Start-Up Costs	$_____
II.	Provider Directories	$_____
III.	Additional Charges	$_____
IV.	Percentage of Savings	$_____
TOTAL		$_____

SECTION I

EMPLOYEE ASSISTANCE PROGRAM/ MANAGED MENTAL HEALTH

All proposers must clearly mark cost proposal sections and place them at the front of the proposal.

SECTION I: EMPLOYEE ASSISTANCE PROGRAM

MENTAL HEALTH/CHEMICAL DEPENDENCY MANAGED CARE SERVICES

Williamson County currently offers an EAP through Professional Assistance of Central Texas.

The current Plan Design includes a 6 visit EAP per occurrence, for all family members. The selected vendor will offer regular EAP services for employees and dependants along with Critical Incident Debriefings, Management Referrals, and assist with Behavioral Modifications Classes in conjunction with the County's Wellness Program. Please price the Behavioral Modifications Classes as a separate fee.

EAP QUESTIONNAIRE

. Maximum of three (3) or six (6) sessions per employee and dependent per incident every 12 months.
. Training for both employee and supervisors.
. Reports upon request.

1. Do you provide a toll free number for customer service?

2. What are your business hours?

3. Do you provide an afterhour's call-in system? How does it work?

4. What is the average return call time?

5. Briefly summarize the history of your organization and identify the owner.

6. List the academic and professional experience of your staff.

7. List areas of counseling (individual and family) you are prepared to offer.

8. How does your organization handle client confidentiality?

9. Are you equipped to stagger the scheduling of employees in order to maintain their confidentiality? Please explain.

10. How do you provide comprehensive follow-up care?

11. Explain your referral process.

12. What are your liability insurance levels?

13. Provide addresses of locations where counseling will be available.

14. Has your organization ever worked with an employee group that has a PPO? If so, describe how you interact with a PPO system.

15. Will your organization provide educational materials to the County for employees? Is there an extra cost for materials provided?

16. What are your procedures for management and employee training? How much training is provided?

17. Do you have a provider network? If so, state your financial interest, if any, in the network.

18. What reports are provided and how often are they available? What are your fees for additional reports?

19. Are you able, if requested, to provide seminars or assistance to management in how to confront troubled employees for possible referral to the program? Is this an extra charge?

20. Provide a list of companies/references and a contact name for each that utilize your services.

21. Provide one company/reference that has terminated your services in the last six months.

22. Explain in detail your claims reprocessing procedures and how you will work with the County's current Third Party Administrator.

23. Basic Program EAP only:

	3 Visit	6 Visit
Annual Cost	$_____	$_____
Monthly Cost Per Employee	$_____	$_____
Start Up Cost	$_____	$_____
PPO Access Fee (if any)	$_____	$_____
Behavioral Modification Classes	$_____	$_____

25. How long will your fee remain firm?

26. Other comments:

PSYCHIATRIC CASE MANAGEMENT/
UTILIZATION REVIEW QUESTIONNAIRE

1. List providers available within your PPO network.

2. What do the savings average within your PPO?

3. Do you do in-patient and out-patient precertification?

4. How do you handle precertification with a PPO provider that is not within your own network?

5. What types of services does your firm provide?

6. How long has your firm been in business?

7. Include primary contact, number of professionals by category (PHD, LPC, etc.) number of para-professionals and size of support staff. Identify the location which would provide review services.

1. Are length of stay guidelines for chemical dependency provided with initial admission approval?

9. To what extent are nurses and/or physicians involved, step-by-step in the certification procedures? At what point is a physician called to review the nurse in the evaluation?

10. Are certifications obtained by:
    Telephone ____
    Mail ____
    Both ____

11. What specific information is submitted in the initial request for certification? (Include sample form.)

12. What is the timetable for certification? (Period of elapsed time from first request to point of approval.)

13. Please list 3 prominent Psychiatric Review clients. Please include addresses, the name of the contact person of each location, and the volume of employees for whom Psychiatric Review services are being provided.

14. Please list the client name, address, and local or regional contact person for the largest two clients who have terminated your firm's services in the past twelve (12) months.

15. Reports (Please provide examples)

    Monthly Reports: _____
    Quarterly Reports: _____
    Annual Reports: _____

    List any additional costs associated with reports:

16. State your financial interest, if any, in your PPO Network.

17. Describe your Basic Program Services.

18. Optional Services:

SECTION J

SECTION 125
CLAIMS ADMINISTRATION

All proposers must clearly mark cost proposal sections and place them at the front of the proposal.

SECTION J: SECTION 125 CLAIMS ADMINISTRATION

QUESTIONNAIRE

- Name, address, city, state, zip code and telephone number of home office of firm. Branch office location(s), if any.

- Is your company a wholly-owned subsidiary or a division of another company? If so, please identify the company name and address. In addition, please list all owners (if not publicly owned), and all affiliated companies.

- Have any principals of the firm ever been named in a lawsuit dealing with the management/administration of a Section 125 Cafeteria Plan?

- How many clients are currently served? Please provide the largest group, the smallest group and the number of employees covered.

- What is the maximum processing time that will occur between receipt of claims and reimbursements to the members?

- What guarantee will you provide to the County that this function will be completed within this time frame?

- What is the size of your staff?

- List staff experience of the employees that will be handling the County's account.

- List the office location intended to service the County.

- Is there a toll free number for employees and/or the County to speak to a customer service representative? If so, what are the hours?

- Does your firm perform discrimination studies as to eligibility, contributions and benefits under the plan? If so, how frequently?

- Does your company offer debit card services? If so, please explain in detail.

ADMINISTRATION

- Describe the computerized system used to collect, assimilate and integrate the data of the program.

- Provide a sample of your Administrative Service Agreement.

- Provide a sample of your Plan Document.

- Describe your capabilities for Direct Deposit.

- Provide samples of worksheets and/or any materials that will be provided to the County for educational purposes.

- Describe your process for entering enrollment information into your system.

- What electronic or Web-based services does your company offer? Can claims be filed via fax or through other electronic means? Do you charge additional fees for this service?

- Does your firm provide monthly, quarterly or annual account statements directly to the participating employees? If so, please explain in detail the process and if there are any additional fees associated with Employee Account Status statements.

- Provide a sample of Section 125 reports generated for employees and the County. Provide a sample of any other reports that you believe may be useful to the County on a regular basis. Please provide sample reports that would be utilized for bank reconciliation.

ORGANIZATION STRUCTURE

- Any Administrator must have filed and be approved with the State of Texas. If a TPA is later rejected by the State, it will be considered grounds for dismissal.

- Is your organization for profit or non-profit?

- Are you an affiliate of an insurance carrier or independently owned and managed?

- If you are a multiple site organization, are certain services delegated to specific locations or are all services available at any location?

LIABILITY PROTECTION & BANKING REFERENCE

- Please disclose the amount of liability insurance protection currently in force. The selected Administrator must provide confirmation of coverage.

- Is the company and all employees bonded? If so, please provide details.

- Are employees covered by workers compensation insurance while performing services on site at the County?

  { }Yes { }No

PRICES/FEES

- Provide schedules of fees for each Plan. Indicate whether fees or services are contingent upon the sale of any products to the County and the conditions under which the products would be sold.

- Are the fees due payable on the first of the month, quarterly, annually or combination of these?

- Is a fee structure available that incorporates various levels of participation?

- Do you intend to receive any commissions from the vendors servicing the County?

- Explain any methods to be utilized to control expense.

- **Provide a fee for administering the Medical and Dependent Care Spending Accounts with and without a Debit Card option.**

HISTORY

- Briefly explain the development of your organization and your corporate business objectives.

- Explain how long you have been in business and how long you have been providing Section 125 Administration services.

UNIQUE CHARACTERISTICS

- What do you feel is unique about your firm that will offer the best value to the County for Section 125 Administration services?

- Please comment on any other characteristics of your organization that are considered unique in the industry.

REFERENCES

- Provide the names, addresses, telephone numbers and contact names for five of your clients. For each client listed, provide the number of employees covered (on your capacity as a Section 125 Administrator). Also state whether or not any of the Section 125 Administration Agreements with these firms are on a fee for services rendered basis.

- Please include a resume of the contact person responsible for this case.

Any Third Party Administrator must have filed and have been approved with the State of Texas. If a TPA is later rejected by the State, it will be considered grounds for dismissal and termination of any contract.

SECTION K

CLAIM EXPERIENCE
CURRENT PLAN DESIGNS
AND
SAMPLE CONTRACT

CLAIMS REPRICING FILE

FOR A COPY OF THE "CLAIMS REPRICING FILE" PLEASE EMAIL YOUR REQUEST TO ERIC.SMITH@SMITH-ASSOCIATES.COM.

WILLIAMSON COUNTY

Medical Claims History

October 2011

	Core Plan			Deductible Plan			EPO Plan		
	2008/09	**2009/10**	**2010/11**	**2008/09**	**2009/10**	**2010/11**	**2008/09**	**2009/10**	**2010/11**
November	$314,062	$582,512	$507,422	$3,802	$7,063	$80,528	$787,078	$378,790	$363,857
December	$322,415	$387,904	$281,548	$6,830	$8,863	$172,741	$496,378	$306,750	$155,770
January	$344,723	$422,746	$465,460	$2,913	$7,704	$277,755	$984,580	$521,853	$192,469
February	$391,577	$286,097	$265,777	$4,441	$11,863	$270,997	$357,984	$334,454	$147,491
March	$461,236	$306,713	$425,581	$5,072	$10,003	$279,161	$620,299	$454,686	$75,412
April	$316,342	$670,388	$445,806	$6,458	$22,826	$327,356	$429,804	$553,704	$171,842
May	$390,704	$1,018,117	$420,531	$17,575	$29,623	$326,684	$446,812	$357,351	$241,700
June	$488,618	$583,110	$663,736	$3,991	$23,675	$416,025	$494,474	$302,570	$129,618
July	$409,566	$321,586	$373,920	$8,092	$15,797	$307,148	$459,010	$229,337	$72,494
August	$329,763	$727,547	$311,024	$9,301	$32,547	$697,271	$394,701	$548,684	$146,482
September	$337,621	$1,521,623	$205,548	$5,529	$24,468	$309,364	$331,622	$394,569	$134,691
October	$542,921	$530,260	$212,989	$11,277	$26,689	$374,759	$458,650	$481,861	$116,782
TOTALS:	$4,649,548	$7,358,603	$4,579,342	$85,281	$221,121	$3,839,789	$6,261,392	$4,864,609	$1,948,608

WILLIAMSON COUNTY

Claims History

October 2011

PHARMACY

	Core Plan			Deductible Plan			EPO Plan		
	2008/09	2009/10	2010/11	2008/09	2009/10	2010/11	2008/09	2009/10	2010/11
November	$82,847	$81,920	$79,405	$388	$4,479	$29,168	$51,227	$58,119	$75,048
December	$223,133	$151,339	$60,752	$1,279	$6,779	$72,799	$90,201	$109,641	$45,414
January	$100,503	$64,118	$81,450	$1,437	$3,792	$109,888	$73,385	$74,963	$72,708
February	$100,983	$88,093	$98,752	$1,342	$5,005	$76,806	$55,216	$79,087	$55,059
March	$82,993	$88,529	$50,166	$465	$4,579	$69,312	$73,196	$107,404	$48,175
April	$66,020	$98,398	$74,401	$835	$6,319	$80,390	$67,361	$96,215	$44,668
May	$73,843	$101,474	$69,697	$2,112	$7,083	$71,633	$69,134	$105,624	$42,149
June	$86,191	$90,911	$96,099	$672	$4,512	$121,699	$62,909	$94,055	$80,934
July	$107,271	$165,807	$72,452	$1,055	$7,964	$74,325	$94,256	$144,198	$33,666
August	$69,887	$95,408	$69,754	$1,061	$4,324	$74,058	$62,025	$102,685	$47,710
September	$103,579	$101,152	$78,178	$1,366	$4,256	$93,481	$66,713	$96,086	$43,193
October	$83,194	$96,389	$76,859	$2,237	$7,333	$77,022	$73,546	$83,270	$47,282
TOTALS:	$1,180,444	$1,223,538	$907,965	$14,249	$66,425	$950,581	$839,169	$1,151,347	$636,006

WILLIAMSON COUNTY

Claims History

October 2011

	DENTAL						VISION		
	HIGH PLAN			LOW PLAN					
	2008/09	2009/10	2010/11	2008/09	2009/10	2010/11	2008/09	2009/10	2010/11
November	$51,364	$57,497	$69,373	$5,711	$3,904	$7,984	$16,774	$19,994	$30,315
December	$50,937	$30,815	$70,242	$5,685	$4,331	$3,415	$18,191	$22,058	$26,173
January	$82,881	$103,018	$83,628	$4,816	$9,965	$8,860	$35,699	$26,986	$29,878
February	$65,908	$70,374	$75,684	$4,698	$7,491	$9,364	$20,991	$30,214	$20,533
March	$73,191	$64,474	$80,338	$6,477	$9,144	$5,886	$22,206	$24,561	$21,133
April	$73,523	$66,192	$65,352	$7,879	$7,953	$5,845	$31,809	$25,991	$17,126
May	$54,135	$58,728	$67,636	$6,189	$4,982	$6,922	$19,891	$17,389	$23,709
June	$72,887	$64,055	$73,934	$7,769	$7,442	$7,568	$19,868	$18,381	$29,319
July	$69,415	$72,230	$54,630	$3,945	$7,652	$6,351	$20,468	$23,417	$23,063
August	$58,552	$74,350	$76,458	$5,010	$8,788	$9,322	$16,998	$25,903	$21,355
September	$63,293	$59,334	$51,675	$7,629	$5,780	$8,747	$23,851	$30,712	$32,129
October	$47,898	$72,595	$81,380	$5,472	$7,305	$8,936	$32,177	$32,285	$28,987
TOTALS:	$763,984	$793,662	$850,330	$71,280	$84,737	$89,200	$278,924	$297,890	$303,720

Williamson County EAP
Annual Report Oct 07-Sept 08

	Oct-Dec	Jan-March	April-June	July-Sept	Yearly Total
Total Clients Seen	61	58	55	55	229
Total Sessions	135	139	140	143	557
Average Length	2.2	2.4	2.5	2.6	2.4
Type Of Clients					
Employee	52	46	45	48	191
Spouse	13	13	15	11	52
Dependent	14	12	09	10	45
Referral Type					
Self-Referral	39	41	40	40	160
Mngt Suggested	15	14	11	13	53
Mngt Required	07	03	04	02	16
Tx Focus					
Chemical Dep	11	07	03	06	27
Mental Health	43	46	39	36	164
Family	21	15	19	11	66
Marital	24	18	14	19	75
Occupational	08	07	10	07	32
Critical Incident	05	02	04	04	15
Mngt Consults	13	11	08	10	44
CI Debriefs	02	01	00	02	05

Williamson County EAP
Annual Report Oct 08-Sept 09

	Oct-Dec	Jan-March	April-June	July-Sept	Yearly Total
Total Clients Seen	66	61	59	63	249
Total Sessions	154	129	144	151	574
Average Length	2.4	2.1	2.4	2.4	2.3
Type Of Clients					
Employee	53	49	48	54	204
Spouse	11	16	13	14	27
Dependent	15	14	18	18	29
Referral Type					
Self-Referral	51	48	50	53	202
Mngt Suggested	09	08	05	06	28
Mngt Required	06	05	04	04	19
Tx Focus					
Chemical Dep	09	06	07	06	28
Mental Health	53	50	48	54	205
Family	25	26	20	24	95
Marital	24	19	18	18	79
Occupational	16	12	10	13	51
Critical Incident	05	04	04	03	16
Mngt Consults	13	10	10	14	47
CI Debriefs	04	02	02	02	10

Williamson County EAP
Annual Report Oct 09-Sept 10

	Oct-Dec	Jan-March	April-June	July-Sept	Yearly Total
Total Clients Seen	68	66	70	62	266
Total Sessions	159	155	154	148	616
Average Length	2.3	2.3	2.2	2.4	2.3
Type Of Clients					
Employee	54	50	55	49	208
Spouse	12	12	15	14	53
Dependent	16	15	18	12	61
Referral Type					
Self-Referral	53	54	59	52	218
Mngt Suggested	10	07	08	06	31
Mngt Required	05	05	03	04	17
Tx Focus					
Chemical Dep	07	05	09	07	28
Mental Health	56	50	59	51	216
Family	21	19	25	17	82
Marital	23	22	24	20	89
Occupational	13	13	14	17	57
Critical Incident	04	03	06	03	16
Mngt Consults	13	09	10	11	43
CI Debriefs	02	01	00	01	04

Williamson County EAP
Annual Report Oct 010-Sept 11

	Oct-Dec	Jan-March	April-June	July-Sept	Yearly Total
Total Clients Seen	61	62	65	59	247
Total Sessions	134	149	146	150	579
Average Length	2.2	2.4	2.2	2.5	2.3
Type Of Clients					
Employee	47	50	52	48	197
Spouse	13	14	12	10	49
Dependent	13	17	14	15	59
Referral Type					
Self-Referral	53	54	55	53	215
Mngt Suggested	06	05	05	04	20
Mngt Required	02	03	05	02	12
Tx Focus					
Chemical Dep	07	05	09	11	32
Mental Health	55	52	58	51	116
Family	20	17	20	16	73
Marital	21	22	20	18	81
Occupational	15	14	17	15	61
Critical Incident	02	02	05	03	12
Mngt Consults	11	08	12	10	41
CI Debriefs	01	00	02	03	06

HEALTH PLAN DOCUMENT

Williamson County (the "County"), through its Risk Pool, has approved the Williamson County Employee Health Benefit Plan (the "Plan") as a benefit to its eligible Employees. All Employees should read this Plan document carefully.

The benefits hereinafter described are available to eligible Employees of the County during the continuance of the Plan, but such benefits are subject to modification or termination at any time with respect to expenses or treatments (including those already in process) not yet incurred.

The County also reserves the right to charge Employees for employee or dependant coverage and to change such charges at any time. The County will inform the Employee of such charges, or changes herein, prior to their effective date.

Eligible Employees may choose from three (3) medical plans. Each plan has a different level of benefits, but all are subject to the terms, provisions, and conditions recited on the following pages. The Plan is not intended to cover all procedures, treatments, or programs.

The Contract Administrator has adopted guidelines which further describe and may limit the benefits applied hereunder. Each eligible Employee may review those guidelines upon request to the Contract Administrator. The Claims Administrator shall decide any disputes or questions with respect to the Plan.

As a governmental plan, the Williamson County Employee Health Benefit Plan is not required to comply with the Health Insurance Portability and Accountability Act (HIPAA), the Mental Health Parity Act (MHPA), the Newborns and Mothers Health Protection Act (NMHPA), and the Women's Health and Cancer Right Act (WHCRA). However, effective November 1, 1989, the Plan has been voluntarily amended to substantially comply with the requirements of HIPAA, NMHPA, and WHCRA. Effective November 1, 2010 the plan has opted out of all requirements of the Mental Health Parity Act (MHPA).

The Plan is to take effect as of 12:01 A.M., standard time, on November 1, 2011, in Williamson County, Texas.

TABLE OF CONTENTS

SCHEDULE OF BENEFITS
EPO PLAN MEDICAL

DEDUCTIBLES	**Network Benefits/Copayment - Coinsurance Amounts/Your Responsibility**
Individual/per plan year	$300
Family/per plan year	$900
Retail Prescription, individual/plan year	$50
OUT-OF-POCKET EXPENSES[1]	
Individual/plan year	$3,500[1]
Family/plan year	$6,000[1]
Retail Prescription Annual Maximum	$1,250
LIFETIME MAXIMUM	Unlimited
PLAN PAYS	
Primary Care Physician (Family Practice, General Practice, Internal Medicine, OB/Gyn, Pediatrician) No copayment applies to Physician office visits for prenatal care after the first visit. No-copayment applies when a Physicians fee is not accessed, deductible and co-insurance will apply.	After $25 co-pay per visit plan pays 100%
Specialist	After $40 co-pay per visit plan pays 100%
Urgent Care	After $40 co-pay per visit plan pays 100%
Preventive Care Including: well baby care, well woman visit, family planning, routine physicals and immunizations, maternity pre and postnatal.	100% no deductible
Hospital Services	
In-Patient	90% after deductible
Out-Patient	90% after deductible
Emergency Room	$225 co-pay per visit
Ambulance – Emergency Only	
Ground Transport	90% after deductible
Air Transport	90% after deductible
Outpatient Diagnostic Service (Lab and Radiology/X-ray)	100%, no deductible applies
Outpatient Diagnostic/Therapeutic Services (CT Scans, Pet Scans, MRI and Nuclear Medicine)	90% after deductible
Outpatient Therapeutic Treatments (Dialysis, Intravenous Chemotherapy or other Intravenous Infusion Therapy and other treatments not listed.)	90% after deductible

Prescriptions Retail (maximum 30-day supply) Mail Order (maximum 90-day supply) Specialty Drugs Diabetic (If approved for Diabetic Plan)	 Generic: 70% / Brand: 70% After a $50 deductible Member co-pay Generic: $20 / Brand $70 Member co-pay $125 After a $50 deductible 100%
Diabetes Management (if approved for Diabetic Plan) Diabetic or Pre-Diabetic Office Visits Must have primary diagnosis code of diabetic or pre-diabetic: Hospital – Inpatient Stay: Outpatient Surgery: Outpatient Diagnostic/Therapeutic Services – CT Scans, Pet Scans, MRI and Nuclear Medicine: Professional Fees for Surgical and Medical Services: Prosthetic/Orthotic Devices: *Prior notification is required when the cost is more than $1,000. Nutritional Counseling PCP Specialists	*Contact the Human Resources Department for information regarding the Diabetes Program. 3 visits per year covered at 100% of Eligible Expenses 90% of Eligible Expenses after Deductible 90% of Eligible Expenses after Deductible Covered at 100% of Eligible Expenses 90% of Eligible Expenses after Deductible 90% of Eligible Expenses after Deductible After $25 co-pay per visit plan pays 100% After $40 co-pay per visit plan pays 100%
Spinal Treatment Limited to 1 visit and 1 treatment per day. (20 visits maximum annual benefit)	90% after deductible
Prosthetic Devices Prior Notification is required when the cost is more than $1,000.	90% after deductible
Home Health Care (60 visits maximum annual benefit)	Covered at 100%, no deductible applies
Hospice Care	Covered at 100%, no deductible applies
Allergy Injections	90% after deductible
Durable Medical Equipment Prior Notification is required when the cost is more than $1,000.	90% after deductible
Orthotic Devices (only with a Diabetes Diagnosis) Prior Notification is required when the cost is more than $1,000.	90% after deductible

Rehabilitation Therapy Benefits are limited to 100 visit annual maximum for physical therapy; occupational therapy; speech therapy; pulmonary rehabilitation; and cardiac rehabilitation.	After $25 co-pay per visit plan pays 100%
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services (90 days maximum annual benefit)	100%, no deductible applies
Transplantation Services	90% after deductible
Dental Services (Accidental only) Limited to $3,000 max per year. $900 max per tooth. Prior notification is required before follow-up treatment begins.	90% after deductible
Mental Health and Substance Abuse Services – Outpatient Must receive prior authorization through Mental Health /Substance Abuse Designee. Maximum annual benefit of 20 visits.	90% after deductible
Mental Health and Substance Abuse Services – Inpatient and Intermediate Must receive prior authorization through the Mental Health/Substance Abuse Designee. Maximum annual benefit of 30 days. Chemical Dependency limited to 3 series of treatment per lifetime.	90% after deductible
Temporomandibular Joint Services Coverage is to be provided for medically necessary treatment resulting from: An accident, trauma, congenital defect, developmental defect, pathology.	90% after deductible
Hearing Aids	90% after deductible
Radial Keratotomy or Lasik (Lifetime Maximum benefit $1,500)	50% after deductible

[1] The following expenses do not count towards satisfying the out-of-pocket amount: deductibles, co-payment, charges which exceed Plan Maximum, charges paid at a reduced percentage because of non-compliance with Care Coordination, and the charge or portion of any charges which exceeds reasonable and customary guidelines.

All benefits are subject to Reasonable, and Customary guidelines.

Specific excluded, limited, and covered items are addressed in the following pages of this Plan booklet.

All annual limitations are applied on a plan year basis unless expressly stated otherwise.

Note: Care Coordination must be notified for the following services.

Skilled Nursing/Inpatient Rehab Facilities
Home Health Care Services
Hospice Care
Maternity (inpatient stays greater than 48/96 hours)
Transplant services
Non-Network Inpatient Hospital Stay
Non-Network Durable Medical Equipment

Non-Network Reconstructive Procedures

The phone number to call for notification is 1-800-842-3920.

Notification Requirements: Prior notification is required before you receive certain Covered Health Services; In general, network providers are responsible for notifying the Claims Administrator before they provide these services to you. There are some Network Benefits, however, for which you are responsible for notifying the Claims Administrator.

Please remember that for Non-Network Benefits you must notify the Claims Administrator five business days before receiving services. If you don't notify the Claims Administrator, Benefits will be reduced by $500 of eligible expenses; however the reduction in Benefits will not exceed Eligible Expenses for the Covered Health Service.

A Healthy Pregnancy Program is available to you from United Healthcare Services, Inc. (UHC). It is completely voluntary and there is no extra cost for participating in the program. To sign up, you should notify UHC AT 1-800-411-7984 or visit www.healthy-pregnancy.com.

Please see the Care Management section in this booklet for details.

SCHEDULE OF BENEFITS
PPO CORE MEDICAL PLAN

DEDUCTIBLES	**NETWORK**	**NON-NETWORK**
Individual/plan year	$0	
Family/plan year	$0	
Retail Prescriptions, individual/plan year	$50	
OUT-OF-POCKET EXPENSES[1]		
Individual/plan year	$3,500[1]	Unlimited
Family/plan year	$6,000[1]	Unlimited
Retail Prescription Annual Maximum	$1,250	Unlimited
LIFETIME MAXIMUM	Unlimited	
PLAN PAYS		
Primary Care Physician (Family Practice, General Practice, Internal Medicine, OB/Gyn, Pediatrician)	70%	50%
Specialists	70%	50%
Urgent Care	70%	70%
Preventive Care Including: well baby care, well woman visit, family planning, routine physicals and immunizations, maternity pre and postnatal.	100%	Not Covered
Hospital Services In-Patient Out-Patient Emergency Room	 90% 90% 70%	 50% 50% 70% Notification required if results in an in-patient stay.
Ambulance – Emergency Only		
Ground Transport	90%	90%
Air Transport	90%	90%
Outpatient Diagnostic Service (Lab and Radiology)	100%	50%
Outpatient Diagnostic/Therapeutic Services (CT Scans, Pet Scans, MRI and Nuclear Medicine)	70%	50%
Outpatient Therapeutic Treatments (Dialysis, Intravenous Chemotherapy or other Intravenous Infusion Therapy and other treatments not listed.)	70%	50%

PLAN PAYS	**NETWORK**	**NON-NETWORK**
Prescriptions	After a $50 deductible	
Retail (maximum 30-day supply) Mail Order (maximum 90-day supply) Specialty Drugs Diabetic (If approved for Diabetic Plan)	Generic: 70% / Brand70% Member co-pay Generic; $20 / Brand $70 Member co-pay $125 100%	
Diabetes Management (if approved for Diabetic Plan)		
Diabetic or Pre-Diabetic Office Visits *Must have primary diagnosis code of diabetic or pre-diabetic.*	3 visits per year covered at 100% of Eligible Expenses	50% of Eligible Expenses
Hospital-Inpatient Stay:	90% of Eligible Expenses	*Contact the Human Resources Department for information regarding the Diabetes Program.
Outpatient Surgery:	90% of Eligible Expenses	
Outpatient Diagnostic For Lab and Radiology /X-Ray:	Covered at 100% of Eligible Expenses	
Outpatient Diagnostic/Therapeutic Services-CT Scans, Pet Scans, MRI and Nuclear Medicine:	70% of Eligible Expenses	
Professional Fees for Surgical and Medical Services:	70% of Eligible Expenses	
Prosthetic/Orthotic Devices: *Prior notification is required when the cost is more than $1,000.	70% of Eligible Expenses	
Nutritional Counseling	70% of Eligible Expenses	
Spinal Treatment Limited to 1 visit and 1treatment per day. (20 visit maximum annual benefit)	70%	50%
Prosthetic Devices Prior notification is required when the cost exceeds $1,000.	70%	50%
Orthotic Devices (only with a Diabetes Diagnosis) Prior Notification is required when the cost is more than $1,000.	70%	50%
Home Health Care (60 visit maximum annual benefit)	100%	50%
Hospice Care	100%	100%
Allergy Injections	70%	50%

Durable Medical Equipment Ordered or provided by a Physician for outpatient use, used for medical purposes, not consumable or disposable, and not of use to a person in the absence of a disease or disability. Prior notification is required when the cost is more than $1,000.	70%	50%
Rehabilitation Therapy Network and Non-network Benefits are limited to 100 visits per calendar year for physical therapy; occupational therapy; speech therapy; pulmonary rehabilitation; and cardiac rehabilitation.	70%	50%
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services (90 days maximum annual benefit)	100%	50%
Transplantation Services	70%	50%
Dental Services (Accidental only) Limited to $3,000 max per year. $900 max per tooth. Prior notification is required before follow-up treatment begins.	70%	50%
Mental Health and Substance Abuse Services – Outpatient Must receive prior authorization through the Mental Health/Substance Abuse Designee. Maximum annual benefit 30 visits per calendar year.	70%	50%
Mental Health and Substance Abuse Service – Inpatient Facility charges only All other services Must receive prior authorization through the Mental Health/Substance Abuse Designee. Maximum annual benefit of 30 days. Substance Abuse Treatment limited to 3 series of treatment per lifetime.	 90% 70%	 50% 50%
Mental Health Services for Serious Mental Illness – Outpatient	70%	70%
Mental Health Services for Serious Mental illness – Inpatient Facility charges only All other services	 90% 70%	 50% 50%
Temporomandibular Joint Services Coverage is to be provided for medically necessary treatment resulting from: An accident, trauma, congenital defect, developmental defect, pathology.	70%	50%
Hearing Aids	70%	50%
Radial Keratotomy or Laski Benefit (Lifetime Maximum benefit $1,500)	50%	50%

[1] The following expenses do not count towards satisfying the out-of-pocket amount: deductibles, co-payments, charges which exceed Plan Maximum, charges paid at a reduced percentage because of non-compliance with Care Coordination, and the charge or portion of any charges which exceeds reasonable and customary guidelines.

All benefits are subject to Reasonable, and Customary guidelines.

Specific excluded, limited, and covered items are addressed in the following pages of this Plan booklet.

All annual limitations are applied on a plan year basis unless expressly stated otherwise.

Note: Care Coordination must be notified for the following services.

Skilled Nursing/Inpatient Rehab Facilities
Home Health Care Services
Hospice Care
Maternity (inpatient stays greater than 48/96 hours)
Transplant services
Non-Network Inpatient Hospital Stay
Non-Network Durable Medical Equipment
Non-Network Reconstructive Procedures

The phone number to call for notification is 1-800-842-3920.

Notification Requirements: Prior notification is required before you receive certain Covered Health Services; In general, network providers are responsible for notifying the Claims Administrator before they provide these services to you. There are some Network Benefits, however, for which you are responsible for notifying the Claims Administrator.

Please remember that for Non-Network Benefits you must notify the Claims Administrator five business days before receiving services. If you don't notify the Claims Administrator, Benefits will be reduced by $500 of eligible expenses; however the reduction in Benefits will not exceed Eligible Expenses for the Covered Health Service.

A Healthy Pregnancy Program is available to you from United Healthcare Services, Inc. (UHC). It is completely voluntary and there is no extra cost for participating in the program. To sign up, you should notify UHC AT 1-800-411-7984 or visit www.healthy-pregnancy.com.

Please see the Care Management section in this booklet for details.

SCHEDULE OF BENEFITS
PPO DEDUCTIBLE MEDICAL PLAN

DEDUCTIBLES	**NETWORK**	**NON-NETWORK**
Individual/plan year	$1,250	$2,500
Family/plan year	$3,750	$7,500
Retail Prescriptions, individual/plan year	$50	$50
OUT-OF-POCKET EXPENSES[1]		
Individual/plan year	$3,000[1]	Unlimited
Family/plan year	$9,000[1]	Unlimited
LIFETIME MAXIMUM	Unlimited	
PLAN PAYS		
Primary Care Physician (Family Practice, General Practice, Internal Medicine, OB/Gyn, Pediatrician)	After $25 co-pay per visit plan pays 100% No copayment applies when a Physician charge is not assessed	60% after deductible
Specialists	After $40 co-pay per visit plan pays 100% No copayment applies when a Physician charge is not assessed	60% after deductible
Urgent Care	After $40 co-pay per visit plan pays 100%	
Preventive Care Including: well baby care, well woman visit, family planning, routine physicals and immunizations, maternity pre and postnatal.	100% No deductible applies	Not Covered
Hospital Services		
In-Patient	80% after deductible	60% after deductible
Out-Patient	80% after deductible	60% after deductible
Emergency Room	After $225 co-pay per visit, plan pays 100%	After $225 co-pay per visit, plan pays 80%
Ambulance – Emergency Only		
Ground Transport	80% after deductible	80% after deductible
Air Transport	80% after deductible	80% after deductible
Outpatient Diagnostic Service (Lab and Radiology)	100% No deductible applies	60% after deductible
Outpatient Diagnostic/Therapeutic Services (CT Scans, Pet Scans, MRI and Nuclear Medicine)	80% after deductible	60% after deductible
Outpatient Therapeutic Treatments (Dialysis, Intravenous Chemotherapy or other Intravenous Infusion Therapy and other treatments not listed.)	80% after deductible	60% after deductible

Prescriptions	After a $50 deductible	
Retail (maximum 30-day supply) Mail Order (maximum 90-day supply) Specialty Drugs Diabetic (If approved for Diabetic Plan)	Generic: 70% / Brand70% Member co-pay Generic; $20 / Brand $70 Member co-pay $125 100%	
Diabetes Management (If approved for Diabetic Plan) Diabetic or Pre-Diabetic Office Visits: *Must have primary diagnosis code of diabetic or pre-diabetic.* Hospital-Inpatient Stay: Outpatient Surgery: Outpatient Diagnostic For Lab and Radiology /X-Ray: Outpatient Diagnostic/Therapeutic Services-CT Scans, Pet Scans, MRI and Nuclear Medicine: Professional Fees for Surgical and Medical Services: Prosthetic/Orthotic Devices: *Prior notification is required when the cost is more than $1,000. Nutritional Counseling	3 visits per year covered at 100% of Eligible Expenses 80% of Eligible Expenses after Deductible 80% of Eligible Expenses after Deductible Covered at 100% of Eligible Expenses 80% of Eligible Expenses after Deductible 80% of Eligible Expenses after Deductible 80% of Eligible Expenses after Deductible 80% of Eligible Expenses	40% of Eligible Expenses after Deductible *Contact the Human Resources Department for information regarding the Diabetes Program.
Spinal Treatment Limited to 1 visit and 1treatment per day. (20 visit maximum annual benefit)	80% after deductible	60% after deductible
Prosthetic Devices Prior notification is required when the cost is more than $1,000.	80% after deductible	60% after deductible
Orthotic Devices (only with a Diabetes Diagnosis) Prior Notification is required when the cost is more than $1,000.	80% after deductible	60% after deductible
Home Health Care (60 visit maximum annual benefit)	100% no deductible applies	60% after deductible

Hospice Care	100% no deductible applies	100% after deductible
Allergy Injections	80% after deductible	60% after deductible
Durable Medical Equipment Ordered or provided by a Physician for outpatient use, used for medical purposes, not consumable or disposable, and not of use to a person in the absence of a disease or disability. Prior notification is required when the cost is more than $1,000.	80% after deductible	60% after deductible
Rehabilitation Therapy Network and Non-network Benefits are limited to 100 visit maximum per calendar year for physical therapy; occupational therapy; speech therapy; pulmonary rehabilitation; and cardiac rehabilitation.	After $25 co-pay per visit plan pays 100%	60% after deductible
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services (90 day maximum annual benefit)	100% no deductible applies	60% after deductible
Transplantation Services	80% after deductible	60% after deductible
Dental Services (Accidental only) Limited to $3,000 max per year. $900 max per tooth. Prior notification is required before follow-up treatment begins.	80% after deductible	60% after deductible
Mental Health and Substance Abuse Services – Outpatient Must receive prior authorization through the Mental Health/Substance Abuse Designee. Maximum annual benefit 30 visits.	80% after deductible	60% after deductible
Mental Health and Substance Abuse Service – Inpatient and Intermediate Must receive prior authorization through the Mental Health/Substance Abuse Designee. Maximum annual benefit of 30 days. Substance Abuse Treatment limited to 3 series of treatment per lifetime.	80% after deductible	60% after deductible
Mental Health Services for Serious Mental Illness – Outpatient (Maximum annual benefit 60 visits)	80% after deductible	60% after deductible
Mental Health Services for Serious Mental illness – Inpatient (Maximum annual benefit 45 days)	80% after deductible	60% after deductible
Temporomandibular Joint Services Coverage is to be provided for medically necessary treatment resulting from: An accident, trauma, congenital defect, developmental defect, pathology.	80% after deductible	60% after deductible

Hearing Aids	80% after deductible	60% after deductible
Radial Keratotomy or Lasik Benefit (Lifetime Maximum benefit $1,500)	50% after deductible	50% after deductible

[1] The following expenses do not count towards satisfying the out-of-pocket amount: deductibles, co-payment, charges which exceed Plan Maximum, charges paid at a reduced percentage because of non-compliance with Care Coordination, and the charge or portion of any charges which exceeds reasonable and customary guidelines.

All benefits are subject to Reasonable, and Customary guidelines.

Specific excluded, limited, and covered items are addressed in the following pages of this Plan booklet.

All annual limitations are applied on a plan year basis unless expressly stated otherwise.

Note: Care Coordination must be notified for the following services.

Skilled Nursing/Inpatient Rehab Facilities
Home Health Care Services
Hospice Care
Maternity (inpatient stays greater than 48/96 hours)
Transplant services
Non-Network Inpatient Hospital Stay
Non-Network Durable Medical Equipment
Non-Network Reconstructive Procedures

The phone number to call for notification is 1-800-842-3920.

Notification Requirements: Prior notification is required before you receive certain Covered Health Services; In general, network providers are responsible for notifying the Claims Administrator before they provide these services to you. There are some Network Benefits, however, for which you are responsible for notifying the Claims Administrator.

Please remember that for Non-Network Benefits you must notify the Claims Administrator five business days before receiving services. If you don't notify the Claims Administrator, Benefits will be reduced by $500 of eligible expenses; however the reduction in Benefits will not exceed Eligible Expenses for the Covered Health Service.

A Healthy Pregnancy Program is available to you from United Healthcare Services, Inc. (UHC). It is completely voluntary and there is no extra cost for participating in the program. To sign up, you should notify UHC AT 1-800-411-7984 or visit www.healthy-pregnancy.com.

Please see the Care Management section in this booklet for details.

DEFINITIONS

The following definitions shall apply for purposes of the Plan. Terms as used herein shall be deemed to define words that may be used in the wording of the Plan document. These definitions shall not be construed to provide coverage under any benefit unless specifically provided.

A. GENERAL DEFINITIONS

1. Accident is a traumatic bodily injury definite as to time and place sustained independently of all other causes, by outside event, or due to exposure to the elements.

2. Amendment is a formal written document changing the provisions of the Plan which is approved by the Employer. Amendments apply to all Covered Persons with respect to all expenses incurred after the effective date thereof, including those persons who are covered, and those treatments that are initiated or contemplated, before the amendment becomes effective, unless otherwise specified.

3. Care Coordination and Care Management are programs which reviews the specific needs of those patients whose conditions are indicative of long-term or high dollar medical care. The goal is to provide the necessary care in the most cost effective manner possible. Each case requires a treatment plan specifically designed to meet the patient's individual needs and situation. It is the responsibility of the care manager to ascertain the specific needs of the cases, to assist the patient in obtaining quality services, and to ensure that these services are rendered in the most appropriate and cost effective setting for covered expenses. Services authorized by medical care management are deemed a covered expense.

4. Certificate of Creditable Coverage is notice provided by an employer-sponsored plan, insured individual policy, or state or federal governmental plan showing a Covered Person's length of coverage under that plan.

5. Change in Status is one of the following events, as further defined in the Flexible Benefit Plan, *provided* the event results in the Employee or one or more of the Employee's family members gaining or losing eligibility for health coverage under the Plan or a health plan of the eligible family member's employer. Change in status events include: 1) events that change an Employee's legal marital status (including marriage, death of spouse, divorce, legal separation, or annulment); 2) events that change an Employee's number of dependants (including birth, adoption, placement for adoption, or death of a dependant); 3) a termination or commencement of employment by the Employee or one or more of the Employee's family members; 4) a reduction or increase in hours of employment by the Employee or one or more of the Employee's family members (including a switch between part-time and full-time employment, a strike or lock-out, or the commencement or return from an unpaid leave of absence or from leave under the Family Medical Leave Act (if coverage was revoked during such leave)); 5) an event that causes an Employee's dependant to satisfy or cease to satisfy the requirements for coverage due to attainment of age, student status, or any similar circumstance as provided in the Plan; 6) the Employee or the Employee's family member who is enrolled as a dependant under the Plan becomes enrolled under Part A or Part B of Medicare or under Medicaid; 7) a significant change in the health coverage or the cost of health coverage of the Employee or the Employee's family member under the Plan or a health plan in which the Employee's family member participates.

6. Claims Administrator means the person or firm employed by the Risk Pool who is responsible for the processing of claims and payment of benefits, administration, accounting, reporting, and other services contracted for by the Risk Pool.

7. Co-insurance or co-payment is the amount of eligible expenses not payable by the Plan that is the responsibility of the Employee (exclusive of any applicable deductible).

8. Contract Administrator means the Employer, Williamson County, maintaining an employee benefit plan. The Contract Administrator may employee any persons or firms to process claims and perform other Plan-connected services. The Contract Administrator has the sole authority to determine plan benefit eligibility, define the plan terms, and manage the plan assets disposition.

9. Custodial Care includes care to meet personal needs and daily living activity needs of an individual that could be provided by persons without professional skills or training.

10. Deductible means the amount of covered expense that must be incurred by a Covered Person before benefits subject to the deductible become payable by the Plan.

11. Dental Services accident only includes treatment when necessary because of accidental damage and services are received from a Doctor of Dental Surgery (D.D.S.) or Doctor of Medical Dentistry (D.M.D). Limited to $3,000 max per year. $900 max per tooth.

12. Durable Medical Equipment is rental equipment that is used for the therapeutic treatment of an illness or injury. Should the rental cost exceed purchase price, the durable medical equipment may be purchased. Durable medical equipment is normally found in a hospital setting and cannot be considered as a household item for use by other family members or for the comfort and convenience of the patient or family.

13. Eligible Benefit - Care which is: 1) the appropriate therapeutic procedure, service, or supply used in the medical treatment of illness or injury; 2) in accordance with generally accepted standards of medical practice; 3) not primarily for the convenience of the Covered Person, physician or another provider; or 4) the most appropriate supply or level which can be provided (for in-patient stays, this means acute care is necessary due to the kinds of services the Covered Person is receiving or the severity of the Covered Person's condition and that safe adequate care cannot be received on an outpatient basis).

14. Eligible Expenses means only the fees and prices regularly and customarily charged for medical services and supplies generally furnished for cases of comparable nature and severity in the particular geographical area concerned. Any agreement as to fees or charges made between the individual and the doctor shall not bind the Plan in determining its liability with respect to expenses incurred. An expense or charge is deemed to be incurred on the date on which the service or supply which gives rise to the expense or charge is rendered or obtained.

15. Emergency Services are services that are received due to 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 life or health.

16. Emergency Transportation is professional ambulance service as follows: a) ground transportation when used locally to or from the nearest hospital qualified to render treatment; b) air ambulance where air transportation is medically indicated to transport a Covered Person to the nearest facility qualified to render treatment; and c) “CARE” and “LIFE” flights in a life-threatening situation.

17. Employer means Williamson County.

18. Exclusions are those charges for which benefits are not provided. Such charges are those which are listed in General Exclusions or Limitations; or those which are not specifically listed as covered expenses.

19. Experimental or Investigational Services - medical, surgical, diagnostic, psychiatric, substance abuse or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time a determination is made regarding coverage in a particular case, are determined to be any of the following:

a. Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use.

b. Subject to review and approval by any institutional review board for the proposed use.

c. The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trials set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

20. Eye Examination includes services received from a health care provider in the provider's office for medical diagnosis only.

21. Hearing Aids includes benefits for hearing aids, evaluation and fitting.

22. Hormonal Disorder is the abnormal, inadequate, or impaired function of the reproductive organs not including diagnoses of menopausal conditions.

23. Illness shall mean bodily sickness or disease, psychiatric disorders, or congenital abnormalities of the newborn child. Illness must be medically diagnosed and treatment given by a physician.

24. Incident (in relation to the Employee Assistance Program) may include child/parent or family member conflicts; job-related or legal and financial stress; teen problems; illness or death of a family member; depression; marital conflicts; dual career problems; eating disorders; interpersonal problems; alcohol or drug addiction.

25. Injury is a condition which results independently of sickness and all other causes and is a result of an externally violent force.

26. Maintenance Care - All services, equipment, and supplies which are provided solely to maintain a patient's condition at the level to which it is restored or stabilized and from which no practical improvement can be expected.

27. Medical Emergency means a severe condition whose symptoms occur suddenly and which requires immediate medical care at the most accessible facility equipped to furnish such care to prevent death or serious impairment to health. Examples of medical emergencies include, but are not limited to: suspected poisoning, acute appendicitis, heat prostration, convulsions, and other acute conditions which are determined to be medical emergencies by broadly accepted medical standards.

28. Medicare is the Health Insurance for the Aged and Disabled program under Title XVIII of the United States Social Security Act, as amended.

29. Mental Health Services are health care services and supplies for the diagnosis and treatment of mental illness, whether or not the illness has a physiological origin.

30. 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 the Diagnostic and Statistical Manual of Mental Disorders-IV (DSM-IV) published by the American Psychiatric Association. The fact that a condition is listed in the DSM-IV does not mean that treatment of the condition is covered under the Plan.

31. Occupational Therapy is therapy provided by an occupational therapist directed at improving impaired muscle strength, range of motion, physical endurance, concentration attention span, thought organization problem

solving, visual-spatial relationships, eye-motor coordination and sensory integration, or any combination of the above.

32. Out-of-Pocket Maximum - Once an Employee accumulates personal payments on a Covered Person for eligible expenses in the amount stated in the Schedule of Benefits (***excluding*** deductibles, prescription co-payments), charges which exceed Plan Maximum, charges paid at a reduced percentage because of non-compliance with Care Coordination, charges from any non-network provider, and the charge or portion of any charges which exceeds reasonable, and customary guidelines), the Plan will pay 100% of eligible expenses thereafter in the plan year unless otherwise stated.

33. Out-patient Care is treatment including services, supplies, and medicines provided and used at a hospital under the direction of a physician to a person not admitted as a registered bed patient; or services rendered in a physician's office, laboratory or x-ray facility, an ambulatory surgical center, or the patient's home.

34. Period of Disability as it applies to an individual means all periods of disability arising from the same causes, including any and all complications there from, except that if the individual completely recovers or returns to active full-time employment, any subsequent period of disability from the same cause shall be considered a new disability.

    a. For Covered Dependants, the term period of disability, as it applies, means all periods of disability arising from the same cause including any and all complications there from, except that if the dependant recovers for a period of six months and throughout such period is capable of resuming the normal activities of a person in good health and of the same age and sex, any subsequent period of disability from the same cause shall be considered a new period of disability.

35. Physical Therapy is therapy directed for treatment of disease or injury by physical agents and methods to assist in rehabilitation and restoration of normal bodily functions, that have been significantly impaired due to an acute illness, injury, or congenital defect for which surgery has been performed.

36. Plan means the Williamson County Employee Health Benefit Plan and is the provisions for coverage and payment of benefits as described herein.

37. Plan Sponsor means the Risk Pool.

38. Plan Year is a period of one (1) year beginning November 1st.

39. Pre-existing Condition is an injury or sickness or a related injury or sickness, except pregnancy, for which a Covered Person has consulted with a physician, or for which advice, treatment, or diagnosis was received or recommended, including prescription drugs, within the six (6) month period immediately preceding the effective date of his/her coverage under the Plan.

40. Pregnancy includes: 1) all pregnancies except extra-uterine which are considered to be genito-urinary conditions; 2) childbirth; 3) miscarriage; 4) any complications arising wholly from these conditions; or 5) any pregnancy complications arising from any trauma.

41. Prior Medical Plan means any medical plan(s) offered by the Employer which have been terminated or amended.

42. Prior Notification is required before you receive certain Covered Health Services; In general, network providers are responsible for notifying the Claims Administrator before they provide these services.

43. Psychiatric Conditions are those conditions or illnesses, regardless of whether the cause is organic, that are classified as a Mental Disorder in the current edition of International Classification of Disease, 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 Disorder, published by the American Psychiatric Association.

44. Reasonable, and Customary a reasonable, and customary charge is based on a percentile of MDR (Medical Data Research) as determined by the Claims Administrator; The charge is the most consistent charge by a physician or provider of service to patients for a given service;

    a. A charge is reasonable when it meets the usual and customary criteria as determined by the Plan; or it may be reasonable, if upon review, it merits special consideration based on the nature and extent of treatment of the particular case;
    b. A charge is customary when it is within the range of usual charges for a given service billed by most physicians or providers of services with similar training and experience;
    c. A reasonable and customary charge for a surgical procedure includes the total amount allowable as an eligible expense under the Plan for the surgery, hospital visits, and post-operative visits following the surgical procedure by the doctor performing the surgery and/or any associates, partners, or affiliated physicians;
    d. A reasonable and customary charge is based on the geographical area in which services were provided; geographical area is a county or greater area as necessary to establish a representative cross-section of persons or other entities regularly furnishing the services.

45. Risk Pool is a legal entity established to provide health and accident coverage for the eligible employees of the Williamson County and the eligible dependants of such employees.

46. Serious Mental Illness means the following (as defined by the American Psychiatric Association in the Diagnostic and Statistical Manual (DSM) III-R and by Texas House Bill #1173 on Serious Mental Illness):

    a. Schizophrenia
    b. Paranoid and other psychotic disorders
    c. Bipolar disorders (hypomanic, manic, depressive, and mixed)
    d. Major depressive disorders (single episode or recurrent)
    e. Schizo-affective disorders (bipolar or depressive)
    f. Pervasive developmental disorders
    g. Obsessive-compulsive disorders
    h. Depression in childhood and adolescence

47. Special Enrollment Event means the opportunity to enroll the Employee and/or the Employee's eligible dependants for medical and/or dental coverage during the year if the Employee or one of the Employee's eligible family members loses other coverage due to certain circumstances.

48. Substance Related Disorders Services are services and supplies for the diagnosis and treatment of alcoholism and chemical dependency disorders which are listed in the Diagnostic and Statistical Manual-IV (DSM-IV). The fact that a disorder is listed in the DSM-IV does not mean that treatment of the disorder is covered under the Plan.

49. Terminally Ill means a life expectancy of six (6) months or less.

50. Total Disability or Totally Disabled means that the Covered Employee is prevented, solely because of a non-occupational injury or non-occupational disease, from engaging in his regular or customary occupation, even with reasonable accommodations and is performing no work of any kind for compensation or profit, or if a Covered Dependant is incapable of self-sustaining employment by reason of mental retardation (but not mental illness), or physical handicap, and continues to be dependent upon the Covered Employee for support and maintenance.

51. Treatment means any specific procedure which is an eligible expense and used for the cure or improvement of an illness, disorder, or injury.

52. Treatment Episode (in relation to substance related disorders benefits) may include in-patient hospitalization, intensive out-patient care, and other follow-up care through resolution and discharge as approved by the Mental Health Substance Abuse Designee.

53. Well Care includes a limited screening exam with no symptoms, treatment, prescriptions, or referrals. It is designed to identify potential undiagnosed health problems and high-risk behaviors. It may also include vaccinations for disease prevention, lab tests or x-rays. Well Care is not intended to replace a complete evaluation to treat existing conditions.

B. **PROVIDER DEFINITIONS**

1. Choice Plus PPO is a group of providers who, as a group or individually, agree to specified fee schedules and cost containment procedures in the delivery of health care and are named by the Plan Sponsor as participating in the Plan.

2. Dentist means a person who is a Doctor of Dental Surgery (D.D.S.) or Doctor of Dental Medicine (D.M.D.) and who is a member of his state Dental Association or eligible for membership in such association and shall also include a person who is a physician as defined above.

3. Extended Care Facility (skilled nursing facility) means an institution (or a distinct part of an institution), other than an institution which is primarily for custodial care, which:

   a. is primarily engaged in providing for inpatient skilled nursing care and related services for patients who require medical or nursing care, or rehabilitation service for the rehabilitation of injured or sick persons;

   b. has policies which are developed with the advice of (and with provision of review of such policies from time to time by) a group of professional personnel, including one or more physicians and one or more registered professional nurses, to govern the skilled nursing care and related medical or other services it provides;

   c. has a physician, a registered professional nurse, or a medical staff responsible for the execution of such policies;

   d. has a requirement that the health care of every patient must be under the supervision of a physician, and provides for having a physician available to furnish necessary medical care in case of emergency;

   e. maintains clinical records on all patients;

   f. provides 24-hour nursing service which is sufficient to meet nursing needs in accordance with the policies developed as provided in sub-paragraph (b) above, and has at least one registered professional nurse employed full-time, and one or more Registered Nurses (R.N.), Licensed Vocational Nurses (L.V.N.), or Licensed Practical Nurses (L.P.N.) on duty at all times;

   g. provides appropriate methods and procedures for the dispensing and administering of drugs and biologicals;

   h. has, in effect, Care Coordination which provides for the review of admissions to the institution, the duration of stays therein, and the professional services furnished with respect to an eligible benefit, and for the purpose of promoting the most efficient use of available health facilities and services; and with such review to be made by either a staff committee of the institution composed of two or more physicians

or a group similarly composed which is established by the local medical society and some or all of the hospitals and convalescent nursing homes in the locality; and which review provides for prompt notification to the nursing home, the individual, and his attending physician of any finding by the committee or group that any further stay in the nursing home is an eligible benefit;

i. is licensed pursuant to any applicable state or local law or is approved by the appropriate state or local agency as meeting the standards established for such licensing.

4. Surgical Facility means a public or private institution, including private offices or clinics of physicians, which meets the official surgical facility requirements of the State Department of Health or, which in the absence of such requirements:

a. has established, equipped, and operated for the purpose of performing surgical procedures by a physician;

b. has a permanent plant, equipment, and supplies not usually available in the physician's office for surgical procedures not requiring inpatient confinement;

c. has at least two operating rooms and: 1) has at least one post-anesthesia recovery room; 2) is equipped to perform diagnostic x-ray laboratory examinations required in connection with any surgery performed; and 3) has a blood bank or other blood supply;

d. has full-time services of Registered Nurses (R.N.) for patient care in the operating and post-anesthesia recovery rooms;

e. has a written agreement with one or more hospitals in the area for immediate acceptance of patients who develop complications or require post-operative confinement;

f. has an organized medical staff supervising its operation in accordance with established policy, and maintains adequate medical records for each patient.

5. Home Health Care Agency means a public or private agency or organization:

a. licensed by the state in which it is located; or

b. accredited by the Joint Commission on the Accreditation of Hospitals or the National League for Nursing/American Public Health Association; or

c. approved by Medicare.

6. Home Health Care Plan means a program for continued care and treatment of the Covered Person:

a. established and approved in writing by the attending physician; and

b. certified by the attending physician that the proper treatment of the disability would require continued confinement as an inpatient in a hospital in the absence of the services and supplies provided as part of the home health care plan.

7. Hospice Home Care Program means a coordinated, interdisciplinary program providing palliative and supportive medical, nursing, and other health care services approved by the terminally ill individual's attending physician and the medical director of a hospice, for meeting the special physical, psychological, and social needs of:

a. a terminally ill individual;

b. the immediate family of such individual; and

A hospice home care program may be extended for an additional period of six (6) months if approved by:

a. the terminally ill individual's attending physician; and

b. the medical director of a hospice.

8. Hospice Home Care Services means:

a. Medical treatment given by a physician;

b. Intermittent nursing care by a registered professional;

c. Part-time or intermittent home health aide services for patient care;

d. Physical therapy;

e. Drugs and medicines lawfully obtainable only upon the written prescription of a physician;

f. Blood transfusions and blood which is not donated nor replaced;

g. Oxygen and other gases and their administration;

h. Dressings;

i. Rental of durable medical equipment;

j. Medical social services provided by a social worker licensed or certified by a governmental entity for the immediate family prior to the death of the terminally ill individual for:

1) assessment of the social, psychological, and family problems related to or arising out of the terminally ill individual's illness and treatment;
2) appropriate action and utilization of community resources to assist in resolving such problems; and
3) participation in the development of treatment for the terminally ill individual.

9. Hospital means only an institution constituted and operated pursuant to law, engaged in providing on an inpatient basis, at the patient's expense, diagnostic and therapeutic facilities for the surgical and medical diagnosis, treatment, and care of injured and sick individuals by or under the supervision of licensed physicians and surgeons and continuously provides 24-hour a day services by registered nurses. A birthing center that has an obstetrician consultant and certified Nurse-Midwives on its staff will be considered as a hospital. The term hospital shall not include an institution or any part thereof, which is other than incidentally a place for rest, a place for the aged, a place for alcoholics or drug addicts, a nursing home or convalescent hospital or hotel. However, an institution specializing in the care and treatment of mentally ill, and/or chemically dependent, patients and licensed as an acute care facility or residential treatment facility, which would qualify under this definition as a hospital, except solely for the fact that it lacks organized facilities on its premises for major surgery, shall nevertheless be deemed a hospital under the Plan.

10. Intensive Care Unit is a section, ward, or wing within a hospital which is operated exclusively for critically ill patients and provides special supplies, equipment, and constant observation and care by registered graduate nurses or other highly trained hospital personnel, excluding however, any hospital facility maintained for the purpose of providing normal postoperative recovery treatment or service.

11. Nurse means a Registered Graduate Nurse (R.N.), a Licensed Vocational Nurse (L.V.N.), an Advanced Practice Nurse (A.P.N.), a Licensed Practical Nurse (L.P.N.), or a Nurse Practitioner (N.P.).

12. Nurse Midwife means a licensed Registered Nurse who is certified as a Nurse Midwife by the American College of Nurse-Midwives and is authorized to practice as a Nurse Midwife under state regulations.

13. Out-patient means a Covered Person who is treated at a hospital and confined less than twenty-four (24) consecutive hours.

14. Physician means only a person acting within the scope of his license and holding the degree of Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S.), Doctor of Podiatry (D.P.M.), Doctor of Optometry (O.D.), Doctor of Chiropractic (D.C.), or a licensed Psychiatrist (M.D. or D.O.), Psychologist (Ph.D.), and Master's Level Psychotherapists who hold an LPC (Licensed Professional Counselor) or LCSW (Licensed Clinical Social Worker) and are eligible for memberships in his/her respective society or association.

15. Room and Board includes bed, linens, meals, special diets, standard nursing services, social services, dietary services, including dietary instructions, use of hospital equipment, transportation within the hospital, and any other services regularly furnished by the hospital as a condition of being hospitalized.

16. Semi-Private Accommodation is two or more beds per room in a Hospital, Skilled Nursing Facility, or other approved health care facility or program. The semi-private accommodation charge is the maximum allowable toward private room accommodation charge. Charges for a private room will be paid at a higher level only if the facility does not provide semi-private room accommodations, subject to verification from the facility.

C. **PARTICIPANT DEFINITIONS**

1. Persons eligible for coverage:

   a. Employee: a person in a permanent status (as defined by the Employer) and regularly scheduled to work at least 30 hours per week. In addition, for purposes of the three (3) medical plans only, Employee includes a person in a permanent status (as defined by the Employer) regularly scheduled to work at least 30 hours per week. If an individual is on approved leave status under the Employer's leave policies and was in permanent status immediately prior to or coincident with beginning the leave status, he or she will be deemed to have the same permanent status and to be scheduled to work the same number of hours as prior to or coincident with the beginning of such approved leave status.

   b. Part-Time Employee: A person who works 20-29 hours per week. Part Time Employees are not eligible for Employer Contributions for any coverages and must pay 100% of the costs.

   c. Dependants:
      1. The legal spouse of a Covered Employee (including a common law spouse).

      2. An eligible child of a Covered Employee. The term child shall include a natural child, legally-adopted child, foster child, stepchild, or grandchild. A child to be acquired by adoption is considered an eligible child upon proof of physical placement in the Covered Employee's home.

   An eligible child may be covered from birth to the end of the calendar month in which he/she reaches age 26.
   An eligible child may be covered past age 26 provided the child is totally disabled as defined herein. Proof of this criteria must be furnished to the Plan within 60 days of the child's 26th birthday or when requested at any time thereafter.

Excluded as dependants are:

- any person(s) legally separated or divorced from a Covered Person; or
- any person(s) on active military duty for any country, except to the extent required by applicable law; or
- any person(s) who fails to meet any of the eligibility criteria.

d. Retirees:
Williamson County employees are eligible to continue their current health plan benefits as a retiree if:

1. The employee retires under the Texas County and District Retirement System service retirement guidelines upon terminating employment with Williamson County and begins receiving monthly TCDRS retirement benefit payments
2. The employee is under age 65 at the time of retirement

Medical, Dental, and Vision may be continued until age 65.

- Dependant coverage is available until one of the following occurs:
    1. Dependant reaches age 65 (dependant loses coverage)
    2. Retiree reaches age 65 (both retiree and dependant(s) loses coverage)

Upon reaching the age of 65, Retirees and/or Dependants should contact the Social Security Administration to sign up for Medicare coverage. Medicare penalties may be assessed if Medicare coverage is delayed after reaching age 65. Medicare coverage eligibility begins at age 65 even though eligibility for Social Security benefit payments may begin after age 65.

2. Actively at Work - An Employee will be considered actively at work with the Employer on a day which is one of the Employer's scheduled work days if he is performing in the customary manner all of the regular duties of his employment with the Employer on that day, either at one of the Employer's business establishments or at some location to which the Employer's business requires him to travel. An Employee will be considered actively at work on a day which is not one of the Employer's scheduled work days if he was performing in the customary manner all of the regular duties of his employment on the preceding scheduled work day.

   An Employee will be considered actively at work on any day when on approved leave status under the Family Medical Leave Act, Temporary Disability, or any other Employer leave policies.

3. COBRA Participant is an individual who was covered under the Plan as an active Employee or Dependant and who was affected by a qualifying event when coverage would normally end, but elected continuation of coverage~~,~~ in accordance with the provisions of COBRA and the terms of the Plan.

4. Contribution means the amount payable by the Employer, the amount payable by the Employee or the amount payable by the Employer/Employee jointly for participation in the benefits of the Plan.

5. Covered Dependant is a dependant who is eligible for coverage and who has enrolled in the Plan.

6. Covered Employee is an Employee who is eligible for coverage and who has enrolled in the Plan.

7. Covered Person is a Covered Employee or Covered Dependant.

8. Enroll is to make written application for coverage on the prescribed forms. Enrollment is not completed until such forms are received by the Employer and any required contribution has been made.

ELIGIBILITY AND CHANGE OF COVERAGE

The date of eligibility is the first day of the month following the completion of a 60 day waiting period.

EFFECTIVE DATES PROVISIONS

A person may become a Covered Person subject to the following:

All eligible Employees may be Covered Employees provided they are Actively at Work as defined herein on the date of eligibility.

An eligible dependant may become a Covered Dependant simultaneously with the related Employee becoming a Covered Employee provided the dependant is not confined in a hospital, extended care facility; surgical facility, custodial care facility, or similar institution on the date coverage would otherwise begin. If on the date of eligibility a dependant is so confined, the date of eligibility shall be delayed until the dependant is released from such facility or institution by his physician.

The Employee and/or dependants' coverage is effective on the date of eligibility provided that enrollment is made and received by the Insurance Department of the Employer on or before the date of eligibility.

No person will be eligible for coverage under this Plan simultaneously as both a Covered Employee and a dependant or as a Covered Dependant of more than one Employee. If husband and wife are both eligible to have dependants covered, a dependent child or dependent children otherwise eligible for coverage may be covered as dependants of the husband or dependants of the wife, but not both.

All eligible Employees may select one of three medical plans at the time of enrollment: EPO Plan, Core PPO Plan, and a Deductible PPO Plan option. Employee plan changes are effective on November 1st, provided a change form has been completed and returned to the Human Resource Department of the Employer in advance of such date and in accordance with guidelines established by the Employer.

An Employee may change from anyone of the medical plans to another medical, or change the number of dependants covered by a particular medical or dental option, during the plan year only as a result of a Change in Status or special enrollment event, and application for such change must be made within thirty-one (31) days after the Change in Status or special enrollment event. Otherwise, the change cannot be made until the next enrollment period as determined by the Employer. Election changes due to a Change in Status are permitted only to the extent the election change is permitted under the Flexible Benefit Plan.

Any change made to an Employee's coverage due to change in status or special enrollment event will be effective the first of the month following the change in status or special enrollment event except in the case of newborn or newly-adopted children (as explained herein), the death of a Covered Person or termination by cause.

Newborn children are covered at birth if the Covered Employee enrolls the child within thirty-one (31) days from the date of birth. A child who is adopted or placed for adoption will be covered as of the date of adoption or placement for adoption if the Covered Employee enrolls the child within thirty-one (31) days after the adoption or placement for adoption. Newborn and adopted children meeting these requirements who are not enrolled within 31 days from date of birth or adoption may become covered on the first day of the month subject to the deadlines for enrolling after a change in status or special enrollment event, unless the child is recognized under a Qualified Medical Child Support Order (QMCSO) according to Omnibus Budget Reconciliation Act of 1993. A child may be enrolled during the plan year to the extent required by a child support order (QMCSO) according to Omnibus Budget Reconciliation Act of 1993. A child who does not qualify as an eligible dependant cannot be enrolled under the Plan.

A claim for maternity or newborn expenses is not considered as enrollment for coverage of a newborn child.

If additional dependants are born, adopted or otherwise become dependants while the Employee is covering dependant(s) under the Plan and such additional dependant coverage does not require an increase in the Employee's contribution, such dependant will not become covered until completion of an enrollment form for such dependant and until the effective date.

A special enrollment event occurs if the Employee and/or the Employee's eligible dependants (1) are eligible for coverage under the coverage rather than medical plan coverage because the Employee and/or the Employee's eligible dependants have other coverage and (2) subsequently lose that other medical coverage. The Employee and/or the Employee's eligible dependants may enroll in the Plan as a result of a special enrollment event if either of the following conditions is satisfied: (i) when the Employee declined enrollment in one of the medical options for the Employee or the Employee's eligible dependant, the Employee or the Employee's eligible dependant had COBRA continuation coverage under another plan and that COBRA continuation coverage has since been exhausted, or (ii) when the Employee declined enrollment in one of the medical options for the Employee or the Employee's eligible dependant, the Employee or the Employee's eligible dependant had coverage other than COBRA continuation coverage and either the other coverage has terminated as a result of a loss of eligibility or employer contributions toward that coverage have been terminated. Loss of eligibility includes a loss of coverage as a result of legal separation, divorce, death, termination of employment, or reduction in hours of employment. Loss of eligibility does not include a loss of coverage due to a failure to timely pay premiums or the termination of coverage for cause (such as a termination of coverage for making a fraudulent claim).

If a person becomes an eligible dependant through marriage, birth, adoption, or placement for adoption, the new dependant may be enrolled in the Plan after the occurrence of such event, subject to the deadlines for enrolling after a Change in Status or special enrollment event. If the Employee is eligible for enrollment but not enrolled, he/she must also enroll to enroll the new dependant. In the case of the birth, adoption, or placement for adoption of a child, the Employee's legal spouse may also be enrolled as a dependant during such period if such spouse is otherwise eligible for coverage but not already enrolled.

If the Employee re-applies for coverage on eligible dependants after coverage on such dependants has been terminated by action of the Employee, such person may not enroll in the Plan until the next annual enrollment period, unless affected by a Change in Status or special enrollment event, subject to the deadlines for enrolling after a Change in Status or special enrollment event.

Changes to benefit selections may only be made as a result of a Change in Status event or special enrollment event and must correspond with such event.

All other Plan changes must be made during the regular annual enrollment period as determined by the Employer.

TERMINATION AND CONTINUATION OF COVERAGE

A. The coverage of any Employee or dependant under any benefit shall automatically cease on:

1. The last day of the month in which the Employee's actively at work status ceases; or

2. The last day of the month in which the Employee ceases to be in a class of employees eligible for the coverage; or

3. The date the Employee fails to make any required contribution for coverage within thirty (30) days after the date such contribution was due; or

4. The last day of the month in which the Employee dies; or

5. The date the Plan is discontinued with respect to the Employer; or

6. The date the Plan is discontinued with respect to the class of Employees to which such Employee belongs; or

7. The last day of the month in which the Covered Person ceases to be eligible as defined herein; or

8. Except to the extent required by applicable law, the date the Covered Person becomes an active member of the Armed Forces of any country or state or international organization or becomes a member of any civilian force auxiliary to any military force; or

9. The date the Employee elects to waive or terminate coverage for the Employee and/or the Employee's Covered Dependants in connection with a Change in Status or leave under the Family Medical Leave Act; or

10. The date the Plan is amended to terminate coverage.

B. The Employer reserves the right to terminate the Plan or change any of its benefits at any time.

COBRA Continuation of Coverage

Coverage may be continued for a Covered Employee and any dependants covered at the time of cessation of coverage as outlined in Termination or Change of Coverage, Section A above, under the following provisions:

A. As long as the Employee is on an approved temporary leave as determined by the Employer and makes a contribution as determined by the Employer. Under no circumstances will benefits during the continuation of coverage period be greater than those benefits provided prior to such continuation of coverage period.

B. COBRA continuation coverage will be made available according to the rights of Employees and dependants, and after payment of required amounts, as outlined in Title XXII of the Public Health Services Act which was a result of the Consolidated Omnibus Budget Reconciliation Act (COBRA). Any continuation of benefits under COBRA will run concurrently with any other continuation of benefits in the Plan. Under no circumstances will benefits during the continuation of coverage period be greater than those benefits provided prior to such continuation of coverage period. Continuation of coverage under COBRA will not apply if the Employer ceases to maintain any group health plan for any employee.

During the enrollment period determined by the Employer, COBRA participants may exercise the same rights as active Employees in making changes in their coverage.

The following does not fully describe all rights under the Plan and is only a summary of rights of eligible Covered Persons to temporarily continue coverage in accordance with COBRA. The following is informational only and where in conflict or differing from the requirements of COBRA, the provisions of COBRA shall govern.

The Plan does not provide for continuation coverage except as required by law. Therefore, the following provisions will be construed and applied to provide continuation coverage only to the minimum extent required by law.

COBRA Continuation Coverage

The right to COBRA continuation coverage was created by federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). This section generally explains COBRA continuation coverage, when it may become available to a Covered Person, and what a Covered Person must do to protect the right to receive it.

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a "qualifying event." Specific qualifying events are listed later in this section. 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.

A Covered Employee will become a qualified beneficiary if he or she will lose coverage under the Plan because either one of the following qualifying events happens:

1. his or her hours of employment are reduced, or
2. his or her employment ends for any reason other than his or her gross misconduct.

A Covered Spouse will become a qualified beneficiary if he or she will lose coverage under the Plan because any of the following qualifying events happens:

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

Covered 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 "dependent child" as defined in the Plan Document.

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Williamson County Insurance Department has been notified that a qualifying event has occurred. When the qualifying event is the end of employment, reduction of hours of employment, or death of the employee, the HR Services Department will notify the Insurance Department of the qualifying event within 30 days following the date coverage will end.

For the other qualifying events {divorce or legal separation of the employee and spouse, a dependant child's losing eligibility for coverage as a dependent child, or enrollment of the employee in Medicare (Part A, Part B, or both)}, a Covered Person is required to notify the Insurance Department within 60 days after the qualifying event occurs. The notice must specify the type and date of the qualifying event; the name and social security number of the covered Employee; the names, dates of birth, and social security numbers of affected qualified beneficiaries; and such other information as is required by UHC DirectBill. This initial notice to the Insurance Department may be done in writing, in person, or by telephone, and may be provided by a Covered Employee or Covered Dependant. The Insurance Department will provide a form for the Covered Employee's signature and will inform him or her of the documentation required to process the qualifying event. **If the required notice is not provided to the Insurance Department within in the 60-day period described above, COBRA continuation coverage will not be available**. Special notice timing rules apply in the case of second qualifying events. These rules are described later in this section.

Once UHC DirectBill 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 on the date that Plan coverage would otherwise have been lost.

Length of COBRA Continuation Coverage

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), divorce or legal separation, or a dependent child losing eligibility for coverage as a dependent child, COBRA continuation coverage may last 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 may last 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 COBRA continuation coverage: If any qualified beneficiary is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage and the Insurance Department is notified within 60 days of the date of the determination and before the end of the initial 18-month period, all qualified beneficiaries can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. This notice should be sent in writing to the Insurance Department.

Second qualifying event extension of 18-month period of COBRA continuation coverage: If another qualifying event occurs while receiving COBRA continuation coverage, the Covered Spouse and Dependent Children can get additional months of COBRA continuation coverage, up to a total maximum of 36 months. This extension is available to the Covered Spouse and Dependent Children if the former employee dies, enrolls in Medicare (Part A, Part B, or both), or gets divorced or legally separated. The extension is also available to a Covered Dependent Child when that child stops being eligible under the Plan as a dependent child. In all of these cases, the Insurance Department must be notified of the second qualifying event within 60 days of the second qualifying event and within the original 18- or 29-month COBRA continuation period. **If the required notice is not provided to the Insurance Department within the required period, COBRA continuation coverage will not be extended**.

Election of COBRA Continuation Coverage

Continuation coverage must be elected within an election period of 60 days. The 60-day period starts on the later of:

1. the date coverage would otherwise terminate because of a qualifying event; or
2. the date the Employer furnishes notice of the right to elect continuation coverage.

Notice mailed to the last known address which the Employer has on record for a qualified Covered Person will start the 60-day election period. Notice will be deemed provided to each dependent child of a Covered Employee if a single notice is provided to the Covered Employee or the Covered Employee's spouse and if, on the basis of the most recent information available to the Plan, the dependent child resides at the same location as the individual to whom such notice is provided. Notice will be deemed provided to a Covered Employee and the Covered Employee's spouse by furnishing a single notice addressed to both the Covered Employee and the Covered Employee's spouse, if, on the basis of the most recent information available to the Plan, the Covered Employee and the Covered Employee's spouse reside at the same location.

Election of continuation coverage by any qualified Covered Person shall be deemed to include an election of continuation on behalf of any other qualified Covered Persons whose health coverage under this Plan would otherwise terminate by reason of the same Qualifying Event unless specified otherwise on the COBRA enrollment form. However, each qualified beneficiary has an independent right to elect continuation coverage. If the Employee rejects any coverage, a dependant may elect to retain any rejected coverage.

Payment for COBRA Continuation Coverage

The full contribution must be paid to the Employer. This includes any portion of the contribution which was previously paid by the Employer and a 2% administrative fee. Except as provided below, all payments must be made via personal check, money order, or cashier's check. When making premium payments, write the name of the qualified beneficiary and "COBRA" in the memo portion of the check or money order. Make checks and money orders payable to Williamson County. All payments must be mailed via U.S. first class mail to:

UnitedHealthcare Benefit Services
P O Box 713082
Cincinnati, OH 45271-3082

First payment: The first payment must be made within 45 days of election of COBRA continuation coverage. If this first payment is not made within those 45 days, all rights to COBRA continuation coverage under the Plan will be lost. The first payment must cover the cost of the continuation coverage from the time coverage under the Plan would have otherwise ended, up to the time of the first payment. Any claims submitted for expenses incurred after the qualifying event may be denied until all premiums which are due have been paid.

Subsequent payments: Payments are required for each subsequent month of COBRA continuation coverage. Under the Plan, these payments are due on the first day of each month. Although subsequent payments are due on the first day of each month, there is a 30-day grace period to make each payment. COBRA 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, a subsequent payment made later than its due date but during its grace period may result in your coverage under the Plan being suspended as of the due date and then retroactively reinstated (going back to the due date) when the payment is made. This means that any claim submitted for benefits while coverage is suspended may be denied and may have to be resubmitted once coverage is reinstated.

Failure to make payment before the end of a grace period for that payment will result in cancellation of coverage and loss of all rights to COBRA continuation coverage under the Plan.

Termination of COBRA Continuation Coverage

If elected, COBRA continuation coverage can continue until the earliest of the following:

1. the Covered Person's failure to pay the required contribution in a timely fashion; or

2. the date a Covered Person becomes covered under any other group health plan as an employee or otherwise, unless such plan contains an exclusion or limitation provision with respect to any pre-existing condition of the Covered Person until such time the exclusion or limitation is no longer applicable to such condition. Any benefits will be subject to the coordination of benefits provision of this Plan; or

3. the expiration of 18 months from the date of the Qualifying Event if the event is termination or reduction of the Employee's employment. However, continuation may be extended an additional 11 months if:
    a. a Covered Person is determined under Titles II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of continuation coverage; and
    b. notice is furnished to the Insurance Department within 60 days of the date of such determination and prior to the end of the original 18-month period of continuation coverage (the notice must include a copy of the Social Security Administration disability determination, a written request by a qualified beneficiary to extend coverage, the names of the affected qualified beneficiaries, and such other information as is required by the Insurance Department); and
    c. the appropriate additional contribution is paid for all months after the 18th.

4. the date on which it is determined that the Covered Person is no longer disabled under Titles II or XVI of the Social Security Act if the person's Qualifying Event was termination or reduction of hours of the Employee's employment and if continuation has been extended beyond 18 months. Notification should be made to the Insurance Department within 30 days of any final determination that the person is no longer disabled under Titles II or XVI of the Social Security Act; or

5. the expiration of 36 months from the date of the original Qualifying Event if the event was:
    a. Employee's death; or
    b. divorce or legal separation; or
    c. dependants' loss of coverage because the Employee became covered for Medicare benefits; or
    d. a dependent child ceasing to be a dependant as defined herein; or

6. the date of the Employee's death, if the Qualifying Event was the Plan Sponsor's filing of bankruptcy; or the death of the Employee's spouse, if the Employee died before the bankruptcy. Upon the Employee's death, dependent children are entitled to 36 months of continuation of coverage; or

7. the date on which a Covered Person becomes entitled to Medicare; or

8. the date on which the Plan is terminated in its entirety; or

9. the Covered Person's request to terminate coverage; or

10. any reason the Plan would terminate coverage of a participant or beneficiary not receiving COBRA continuation coverage.

Required Notices to the Plan

A COBRA participant must notify the Williamson County Insurance Department of the following events. Notice to the Insurance Department may be done in writing, in person, or by telephone, and may be provided by a Covered Employee or Covered Dependant. The Insurance Department will provide a form for the Covered Employee's signature and will

inform him or her of the documentation required to process the qualifying event. **If the required notice is not provided to the Insurance Department within the required period described below, COBRA continuation coverage will not be available**.

Notify the Plan within 30 days:

- A newborn or newly-adopted child that is to be added to COBRA continuation coverage under the Plan. (Notification within 30 days ensures that coverage will begin on the date of birth, date of adoption, or date of placement for adoption.)

Notify the Plan within 60 days:

- A change in marital status that would result in addition or deletion of family members from your coverage.
- A covered child no longer being eligible as a dependent child under the Plan.
- Death of a qualified beneficiary.
- A determination by the Social Security Administration that a qualified beneficiary is disabled. (Notification within 60 days and before the end of the initial 18-month period will protect the qualified beneficiaries' rights to an extension of continuation coverage.) Please note: A qualified beneficiary must also notify the Plan within 30 days if the Social Security Administration later determines that the qualified beneficiary is no longer disabled.
- The former employee's enrollment in Medicare.
- A qualified beneficiary becoming covered by another group health plan.
- A second qualifying event as described in this notice.
- Any name or address changes.

Notice mailed to the latest address which the Employer has on record for a qualified Covered Person will constitute required notice. Notice to the Employee's spouse will be deemed notice to all other qualified Covered Dependants residing with such spouse on the date the notice is furnished.

For More Information

More information about COBRA continuation coverage and your rights under the Plan is available by contacting the Williamson County Insurance Department, or by contacting the nearest Regional or County Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Address and phone numbers of Regional and County EBSA Offices are available through EBSA's web site at www.dol.gov/ebsa.

The name, address, and phone number of the Williamson County Insurance Department and the Claims Administrator are set forth below.

Williamson County Insurance Department
301 SE Inner Loop, Suite 108
Georgetown, Texas 78626
(512) 943-1531

COMPREHENSIVE MEDICAL EXPENSE BENEFIT

A. BENEFIT PROVISION

Upon receipt of due proof, satisfactory to the Plan, that a Covered Person has an expense incurred for treatment of a covered illness or a covered injury, the Plan will pay the percentage payable indicated in the Schedule of Benefits, which are usual, reasonable, and customary. Home health care and durable medical equipment charges are subject to fee guidelines established by the Plan.

The benefits payable, for all covered conditions, shall not exceed the maximum lifetime benefit or any separate maximum lifetime benefits applicable to specific expenses and are subject to the deductible amount(s) specified herein and are subject to all limitations and conditions of the Plan.

B. DEDUCTIBLE AMOUNT

1. Individual Deductible is the amount of eligible expenses under the Plan for each Covered Person (as shown in the Schedule of Benefits) which the Employee first pays before benefits are payable from the Plan. For plan year deductibles, satisfaction of the deductible is determined taking into account only those eligible expenses incurred during the same plan year.

2. Family Deductible - When the covered members of a family unit have collectively satisfied the maximum deductible per family in a plan year, no further cash deductible need be satisfied in that plan year. Satisfaction of the deductible is determined taking into account only those eligible expenses incurred during the same plan year.

C. AMOUNT PAYABLE

1. Percentage Payable shall mean the percentage payable by the Plan for the covered expenses as shown in the Schedule of Benefits.

2. Out-of-Pocket Maximum - Once an Employee accumulates personal payments on a Covered Person for eligible expenses in the amount stated in the Schedule of Benefits (excluding deductibles, prescription co-payments, charges which exceed Plan maximum, charges paid at a reduced percentage because of non-compliance with Care Coordination, charges from any non-network provider, and the charge or portion of any charges which exceeds, reasonable, and customary guidelines), the Plan will pay 100% of eligible in-network expenses thereafter in the plan year unless otherwise stated.

D. MAXIMUM BENEFIT

1. The maximum benefit, as shown in the Schedule of Benefits, is the lifetime maximum amount of benefit reimbursement available for any Covered Person. The lifetime maximum is cumulative and is not reduced or reinstated by an interruption of coverage or by a transfer from one medical or dental option to another.

2. If at any time the Employer transfers from one insurance policy to another or from one Claims Administrator to another, the amount payable for maximum benefits will not be reduced or reinstated by such exchange.

E. **COVERED MEDICAL EXPENSES**

Covered medical expenses shall include, subject to the General Exclusions or Limitations and Schedule of Benefits, only the reasonable and customary charges for services and supplies which are prescribed and recommended by a physician for an eligible expense or treatment of an injury or illness and which are incurred by a Covered Person as follows:

1. Hospital care in a hospital as defined herein, for room, board, and other hospital services required for purposes of treatment.

   In the event a Covered Person incurs hospital expenses in a non- network hospital as a result of an emergency and such choice of hospital is beyond the control of the Covered Person, such expenses will be paid as if incurred in a Choice Plus PPO hospital;

2. Professional services by:

   a. A physician as defined herein;

   b. A nurse providing non-custodial services;

   c. An anesthetist or anesthesiologist;

   d. A licensed physical therapist for restoration or rehabilitative physical therapy for loss or impairment of function due to an illness or trauma, or congenital defects for which surgery has been performed; subject to established administrative guidelines;

   e. A certified nurse midwife;

   f. A licensed speech therapist for restoratory or rehabilitory speech therapy for speech loss or impairment due to an illness or trauma, or congenital defects for which surgery has been performed provided such loss or impairment is not due to a functional nervous disorder; and

   g. A licensed occupational therapist for restoratory or rehabilitory occupational therapy for loss or impairment of function of an upper extremity due to an **acute** illness or trauma, or congenital defects for which surgery has been performed;

3. Chiropractic services rendered by a Doctor of Chiropractic for the detection and correction by manual or mechanical means (including x-rays incidental thereto) of structural imbalance, distortion or subluxation in the human body for the removal of nerve interference where such interference is the result of or related to distortion misalignment or subluxation of or in the vertebral column;

4. Drugs and medicines on an outpatient basis through Medco Health;

5. Diagnostic x-ray and laboratory service;

6. Oxygen and/or rental of equipment required for its administration;

7. X-ray, radium and radioactive isotope therapy, cobalt and chemotherapy;

8. Rental of durable medical equipment up to the purchase price required for temporary therapeutic use. Purchase of durable medical equipment is limited to the initial purchase only and must be approved by the Claims Administrator;

9. Rental of Orthotic Devices (only with a Diabetes Diagnosis) up to the purchase price required for temporary therapeutic use. Purchase of Orthotic Devices is limited to the initial purchase only and must be approved by the Claims Administrator;

10. Crutches, casts, and splints as prescribed by or dispensed by a physician;

11. Braces required for the mobilization and restoration of an impaired function;

12. External Prosthetic devices that replace a limb or an external body part, limited to:
    a) Artificial arms, legs, feet and hands
    b) Artificial eyes, ears and noses
    c) Breast prosthesis as required by the Women's Health and Cancer Rights Act of 1998. Benefits include mastectomy bras and lymphedema stockings for the arm.

    If more than one prosthetic device can meet your functional needs, Benefits are available only for the most cost-effective prosthetic device.

    The prosthetic device must be ordered or provided by, or under the direction of a Physician. Except for items required by the Women's Health and Cancer Rights Act of 1998, Benefits for prosthetic devices are limited to a single purchase of each type of prosthetic device every three calendar years. Initial artificial limbs, eyes or other prosthetic appliance if prescribed by an M.D. or D.O. to replace lost physical organs or parts if the loss occurred while covered under this Plan; replacement of prosthetic appliance if necessitated by bodily change, or rendered non-functional due to normal use but to include charges for repair or maintenance.

13. Wigs (if prescribed by an M.D. or D.O. as a result of hair loss due to chemotherapy or radiation;

14. For Emergency Transportation (as defined herein) of the Covered Person to the nearest hospital where care and treatment of the injury or illness can be given, or other medical institution for necessary special treatment not locally obtainable and is considered an Eligible Benefit;

15. Blood or other fluid actually injected into the circulatory system unless donated or replaced;

16. Initial contact lenses or glasses if required following cataract surgery;

17. Mental health expenses which may include
    a. crisis intervention for psychiatric conditions that are determined to be unresponsive to short-term therapy;
    b. in-patient and structured out-patient acute care treatment through a covered psychiatric hospital or the psychiatric/substance related disorders unit of a covered general medical hospital.
       Subacute care treatment may mean residential treatment, day treatment/partial hospitalization, or intensive out-patient care. (NOTE: Two (2) subacute treatment days are equal to one (1) in-patient care day in regards to the Schedule of Benefit maximums.);
    c. emergency care in response to an acute episode triggered by chronic organic brain syndrome;
    d. marriage counseling when directly related to mental illness;
    e. chronic pain treated through psychotherapy if such pain has a psychological origin; and
    f. services of licensed psychologists, psychiatrists or social workers for the treatment of specifically diagnosed mental health conditions;

18. Dental charges (including inpatient hospital facility expense when an eligible expense) for the extraction of impacted wisdom teeth (including related anesthesia), treatment of a fractured or

dislocated jaw, or injury to sound natural teeth including replacement of such teeth within six (6) months (or when medically feasible) after the date of the accident provided that such accident occurs while covered under the Plan ("sound" means undiseased, undamaged natural teeth or natural teeth restored to function);

19. Treatment of temporomandibular joint dysfunction, according to the Schedule of Benefits, as follows:

    a. Diagnostic exam and x-rays except full mouth series, panoramic x-rays, and cephalogram.

    b. Physical medicine including ultrasound, diathermy, high voltage galvanic stimulation, and transcutaneous nerve stimulation;

    c. Prescribed medication and injections;

    d. Appliance therapy including occlusal splints; and

    e. Surgical procedures;

    Expenses related to other methods of treatment will not be covered under the medical plan including orthodontics;

20. Extended care facility services and supplies as listed below, when furnished to a Covered Person for his use during confinement in the facility, and by means of a transfer from a hospital in which he was confined for at least five (5) consecutive days or confined within seven (7) days after hospital discharge, and is for continued care of the same condition(s) which resulted in that hospital confinement.

    The following are extended care facility services and supplies:

    a. Room and board;

    b. Routine nursing care, but not including the services of a private-duty nurse or other private-duty attendant;

    c. Physical therapy, occupational therapy and speech therapy provided by the extended care facility or by others under arrangements with such facility;

    d. Medical social services;

    e. Such biologicals, supplies, appliances, and equipment as are ordinarily provided by the extended care facility for the care and treatment of its inpatients;

    f. Diagnostic and therapeutic services furnished to inpatients of the extended care facility by a hospital; and

    g. Such other services necessary to the health of patients as are generally provided by extended care facilities (excluding, however, any item or service which would not be provided to an inpatient of a hospital);

21. Ambulatory surgical center services rendered within twenty-four (24) hours from, and in connection with, a surgical procedure, or within seven (7) consecutive days before the procedure in the case of diagnostic procedures;

22. For hospice home care services provided in accordance with a hospice home care program:

    a. To a terminally ill individual who is a Covered Person; and

    b. To members of the immediate family of the terminally ill Covered Person while the terminally ill individual is not confined in a hospital or hospice facility and the attending physician has certified that the hospice care is an alternative to hospitalization.
    The term immediate family means any person eligible to be covered under the Plan;

23. For services or supplies furnished by a home health care agency for the sole purpose of treating a disabling illness or injury in accordance with a home care plan.

    a. Part-time or intermittent nursing care by a registered professional nurse (R.N.) or by a licensed practical nurse under the supervision of a registered nurse;

    b. Physical therapy, occupational therapy and speech therapy provided by the home health care agency; and

    c. Medical supplies, drugs, and medications prescribed by a physician, and laboratory services by or on behalf of a hospital, to the extent such items would have been covered under this benefit if the Covered Person had been confined in the hospital;

24. For rhinoplasties and blepharoplasties, to correct an accidental injury; or a congenital anomaly

25. Physician's charges for birth control injections or devices, their insertion and removal, including but not limited to Nor-Plant and Depo-Provera;

26. Birth control pills obtained only through Medco Health;

27. Charges for elective sterilization;

28. Childhood immunizations which include immunization against diphtheria, haemophilus influenza type b, hepatitis B, measles, mumps, pertussis, polio, rubella, tetanus, varicella and any other immunization required by law for a child prior to the date the child attains age nineteen (19). Such childhood immunizations are not subject to any deductible, copayment, or coinsurance requirement.

29. In compliance with the Newborns and Mothers Health Protection Act (NMHPA), benefits for any hospital length of stay in connection with childbirth for the mother or newborn child will not be restricted to less than 48 hours following an uncomplicated vaginal delivery or less than 96 hours following an uncomplicated caesarean section delivery. Provider authorization from the Plan for prescribing a length of stay not in excess of the above periods is not required. Newborn children are covered at birth if the Covered Employee enrolls the child within thirty (31) days from the date of birth;

30. Circumcision whether performed inpatient or outpatient;

31. Health services and supplies which are an Eligible Benefit during the benefit period for the Covered Person which are related to transplantation and approved by the Plan prior to the delivery of any services. Such services shall include, but are not limited to, inpatient and outpatient hospital charges, physician's charges for pre-transplant evaluation, pre-transplant stabilization, the transplant itself and follow-up care. **This shall not include any expenses for transplantation specifically excluded herein, except autologous bone marrow transplants and/or stem cell rescue with high**

dose chemotherapy for the treatment of tumorous cancer. All transplant services must be coordinated through the Claims Administrator's Care Coordination department prior to receiving any services, including evaluation with any transplant provider, in order for maximum benefits to be payable. For Network Benefits, you or your Physician must notify Care Coordination as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center).

32. The Plan covers expenses for travel, lodging and meals for the patient, provided he or she is not covered by Medicare, and a companion as follows:

a. transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the cancer-related treatment, or the transplant for the purposes of an evaluation, the procedure or necessary post-discharge follow-up;

b. eligible expenses for lodging and meals for the patient (while not a Hospital inpatient) and one companion. Benefits are paid at a per diem (per day) rate of up to $50 per day for the patient or up to $100 per day for the patient plus one companion; or

c. if the patient is an enrolled Dependant minor child, the transportation expenses of two companions will be covered and lodging and meal expenses will be reimbursed at a per diem rate up to $100 per day.

Travel and lodging expenses are only available if the recipient lives more than 50 miles from the Designated Facility (for CRS and transplantation) or the CHD facility. United Healthcare Services, Inc. must receive valid receipts for such charges before you will be reimbursed. Examples of travel expenses may include:

a. airfare at coach rate;

b. taxi or grand transportation; or

c. mileage reimbursement at the IRS rate for the most direct route between the patient's home and the Designated Facility.

Travel and lodging will be provided up to a $10,000 lifetime limit and may be applied to travel for Transplant, Cancer or Heart URN Center.

33. A. Charges in connection with cosmetic surgery are covered only:

1) For treatment within twelve (12) months after and as the result of an injury sustained while covered under this Plan; or

2) For the correction of a birth defect, provided the Covered Person was covered under the Plan from birth; or

3) For replacement of diseased tissue surgically removed while covered under this Plan.

B. Charges in connection with reconstructive surgery are covered only if due to:

1) An injury that occurred while covered under this Plan; or

2) A birth defect, provided the Covered Person was covered under the Plan from birth;

however, if the surgery has been delayed until the covered person reaches a specific age or growth level, or if illness at birth delayed the surgery, or if the condition was undetected at birth, it would not be necessary that the Covered Person be covered under the Plan from birth;

34. The examination for the prescription when an injury to the internal ear or illness results in permanent hearing loss and which occurred while covered under the Plan and (b) a screening test for hearing loss from the birth of a Covered Dependant child through the date the child is 30 days old and any necessary diagnostic follow-up care relating to the screening test from birth through the date the child attains age two. Such infant hearing loss coverage is not subject to any deductible or dollar limit on covered benefits;

35. Treatment for sleep disorders subject to the maximum stated on the Schedule of Benefits. Charges for surgical treatment of this disorder or a C-Pap machine are only covered if the surgery or purchase/rental of a C-Pap machine were preceded by sleep studies rendered by a certified sleep lab;

36. Education for management and control of diabetes subject to the maximum stated on the Schedule of Benefits.

37. An annual medically recognized diagnostic examination for the detection of prostate cancer, including a physical examination for the detection of prostate cancer and a prostate-specific antigen test.

38. Hearing Aid Benefits including evaluation and fitting and subject to the provisions in the Schedule of Benefits.

39. Eye Examinations received from a health care provider in the provider's office for medical diagnosis only. Please note that Benefits are not available for charges connected to the purchase of fitting of eyeglasses or contact lenses. In the case of Glaucoma or Diabetes the plan will pay for replacements lenses only.

40. Diabetic foot care services.

41. Speech Therapy, except when required for treatment of a speech impediment or speech dysfunction that results from injury, stroke, cancer, or a Congenital Anomaly.

PRE-EXISTING CONDITIONS LIMITATIONS

Covered Persons will not be entitled to reimbursement for eligible medical expenses that are incurred as the result of an injury or sickness or a related injury or sickness, except pregnancy, for which the Covered Person has consulted with a physician, or for which advice, treatment, or diagnosis was received or recommended, including prescription drugs within the six (6) month period immediately preceding the earlier of 1) the first day of the waiting period following the Employee's date of employment by the Employer and 2) the effective date of his or her coverage, until the first of one of the following events occurs:

A. Twelve (12) consecutive months after the date the Covered Person became enrolled in the Plan or the first day of any applicable waiting period, whichever is earlier.

The 12-month period described above is reduced by one day for each day of creditable coverage of the Covered Person, not including creditable coverage that occurs before a significant break in coverage.

"Creditable coverage" is coverage under another health plan, whether provided by an employer, an insurance contract (group or individual), or a governmental entity. Creditable coverage does not include limited coverage of "excepted benefits" as defined by HIPAA.

A "significant break in coverage" is a period of 63 days, not including waiting periods, during which the Covered Person does not have creditable coverage.

The Employee has the right to demonstrate creditable coverage for him and eligible dependants by providing a certificate of creditable coverage from his/her previous health plan to the Plan Administrator. The Employer and the Plan Administrator will assist you in obtaining a certificate of creditable coverage from a previous health plan.

A newborn child or an unmarried child under age 19 who is adopted or placed for adoption will not be subject to the pre-existing condition limitation if the child is enrolled in the Plan within 31 days after the birth, adoption, or placement for adoption. In addition, such a child will not be subject to the pre-existing condition limitation if the child has creditable coverage within 31 days of birth, adoption, or placement for adoption and does not incur a significant break in coverage before enrolling in the Plan.

GENERAL EXCLUSIONS OR LIMITATIONS
(To All Plans)

No benefits shall be payable under any part of this Plan with respect to any charges:

A. Alternative Treatments

1. Acupressure and acupuncture.
2. Aroma therapy.
3. Hypnotism.
4. Massage Therapy.
5. Rolfing.
6. Other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.

B. Comfort or Convenience

1. Television.
2. Telephone.
3. Beauty/Barber service.
4. Guest service.
5. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include:
   - Air conditioners.
   - Air purifiers and filters.
   - Batteries and battery chargers.
   - Dehumidifiers.
   - Humidifiers.
6. Devices and computers to assist in communication and speech.

C. Dental

1. Dental care except as described under Covered Benefits under the heading *Dental Services - Accident Only*.
2. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include all of the following:
   - Extraction, restoration and replacement of teeth.
   - Medical or surgical treatments of dental conditions.
   - Services to improve dental clinical outcomes.
3. Dental implants.
4. Dental braces.
5. Dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia. The only exceptions to this are for any of the following:
   - Transplant preparation.
   - Initiation of immunosuppressives.
   - The direct treatment of acute traumatic Injury, cancer or cleft palate.
6. Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a Congenital Anomaly.

D. Drugs

1. Prescription drug products for outpatient use that are filled by a prescription order or refill.
2. Self-injectable medications.
3. Non-injectable medications given in a Physician's office except as required in an Emergency.
4. Over the counter drugs and treatments.

E. Experimental, Investigational or Unproven Services

Experimental, Investigational and Unproven Services are excluded. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition

will not result in Benefits if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.

F. Foot Care

1. Routine foot care (including the cutting or removal of corns and calluses), except for diabetic foot care that is prescribed by a Physician.
2 Nail trimming, cutting, or debriding.
3. Hygienic and preventive maintenance foot care. Examples include the following:
   - Cleaning and soaking the feet.
   - Applying skin creams in order to maintain skin tone.
   - Other services that are performed when there is not a localized illness, Injury or symptom involving the foot.
4. Treatment of flat feet.
5. Treatment of subluxation of the foot.

G. Medical Supplies and Appliances

1. Devices used specifically as safety items or to affect performance in sports-related activities.
2. Prescribed or non-prescribed medical supplies and disposable supplies. Examples include:
   - Elastic stockings.
   - Ace bandages.
   - Gauze and dressings.
3. Orthotic appliances that straighten or re-shape a body part (including cranial banding and some types of braces).
4. Tubings and masks are not covered except when used with Durable Medical Equipment as described under Covered Benefits.

H. Mental Health/Substance Abuse

1. Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.
2. Mental Health Services and Substance Abuse Services that extend beyond the period necessary for short-term evaluation, diagnosis, treatment or crisis intervention.
3. Mental Health Services as treatment for insomnia and other sleep disorders, neurological disorders and other disorders with a known physical basis.
4. Treatment for conduct and impulse control disorders, personality disorders, paraphilias and other Mental Illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to prevailing national standards of clinical practice, as reasonably determined by the Mental Health/Substance Abuse Designee.
5. Services utilizing methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents.
6. Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements, unless authorized by the Mental Health/Substance Abuse Designee.
7. Residential treatment services.
8. Services or supplies for the diagnosis or treatment of Mental Illness, alcoholism or substance abuse disorders that, in the reasonable judgment of the Mental Health/Substance Abuse Designee, are any of the following:
   - Not consistent with prevailing national standards of clinical practice for the treatment of such conditions.
   - Not consistent with prevailing professional research demonstrating that the services or supplies will have a measurable and beneficial health outcome.
   - Typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective.
   - Not consistent with the Mental Health/Substance Abuse Designee's level of care guidelines or best practices as modified from time to time.

The Mental Health/Substance Abuse Designee may consult with professional clinical consultants, peer review committees or other appropriate sources for recommendations and information regarding whether a service or supply meets any of these criteria.

I. Nutrition

1. Megavitamin and nutrition based therapy.
2. Enteral feedings and other nutritional and electrolyte supplements, including infant formula and donor breast milk.

J. Physical Appearance

1. Cosmetic Procedures. See the definition in Defined Terms. Examples include:
   - Pharmacological regimens, nutritional procedures or treatments.
   - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
   - Skin abrasion procedures performed as a treatment for acne.
2. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. **Note:** Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy.
3. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation.
4. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.
5. Wigs regardless of the reason for the hair loss.

K. Providers

1. Services performed by a provider who is a family member by birth or marriage, including spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself.
2. Services performed by a provider with your same legal residence.
3. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services that have been self-directed to a free-standing or Hospital-based diagnostic facility. Services ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider:
   - Has not been actively involved in your medical care prior to ordering the service, or
   - Is not actively involved in your medical care after the service is received.
   - This exclusion does not apply to mammography testing.

L. Reproduction

1. Health services and associated expenses for infertility treatments.
2. Surrogate parenting.
3. The reversal of voluntary sterilization.
4. Health services and associated expenses for elective abortion.
5. Fetal reduction surgery.
6. Health services associated with the use of non-surgical or drug-induced Pregnancy termination.

M. Services Provided under another Plan

1. Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. This includes, but is not limited to, coverage required by workers' compensation, no-fault auto insurance, or similar legislation.

   If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Sickness or Mental Illness that would have been covered under workers' compensation or similar legislation had that coverage been elected.
2. Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you.

3. Health services while on active military duty.
4. Services, supplies or other care for injury or illness for which there is non-group insurance (except individual health insurance policies) providing medical payments or medical expense coverage, such as automobile no fault or medical payment insurance, regardless of whether the other coverage is primary, excess or contingent to this certificate. If benefits subject to this provision are paid or provided by the County, the County reserves all rights to recover the reasonable value of such benefits as provided in the section of this certificate entitled "**RIGHTS OF REIMBURSEMENT DUE TO ACTS OF OTHER PARTIES".**

N. Transplants

1. Health services for organ and tissue transplants, except those described under Covered Benefits (unless the Claims Administrator determines the transplant to be appropriate according to the Claims Administrator's transplant guidelines).
2. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs for removal are payable for a transplant through the organ recipient's Benefits under the Plan).
3. Health services for transplants involving mechanical or animal organs.
4. Any solid organ transplant that is performed as a treatment for cancer.
5. Any multiple organ transplant not listed as a Covered Health Service under the heading *Transplantation Health Services* under Covered Benefits.

O. Travel

1. Health services provided in a foreign country, unless required as Emergency Health Services.
2. Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to covered transplantation services may be reimbursed at our discretion.

P. Vision and Hearing

1. Eye exercise therapy.
2. Surgery that is intended to allow you to see better without glasses or other vision correction or refractive eye surgery, except radial keratotomy and lasik corrective eye treatments which are covered at 50% of eligible expenses after satisfying any applicable deductibles and co-payments, up to a lifetime maximum of $1,500.

Q. All Other Exclusions

1. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in Defined Terms.
2. Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.
3. Health services received after the date your coverage under the Plan ends, including health services for medical conditions arising before the date your coverage under the Plan ends.
4. Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Plan.
5. In the event that a non-Network provider waives Copayments and/or the Annual Deductible for a particular health service, no Benefits are provided for the health service for which the Copayments and/or Annual Deductible are waived.
6. Charges in excess of Eligible Expenses or in excess of any specified limitation.
7. Non-surgical treatment of obesity, including morbid obesity.
8. Surgical treatment of obesity including severe morbid obesity (with a BMI greater than 35).
9. Growth hormone therapy.
10. Sex transformation operations.
11. Custodial Care.
12. Domiciliary care.
13. Private duty nursing.
14. Respite care.
15. Rest cures.
16. Psychosurgery.

17. Treatment of benign gynecomastia (abnormal breast enlargement in males).
18. Medical and surgical treatment of excessive sweating (hyperhidrosis).
19. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.
20. Oral appliances for snoring.
21. Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, or a Congenital Anomaly.
22. Any charges for missed appointments, room or facility reservations, completion of claim forms or record processing.
23. Any charge for services, supplies or equipment advertised by the provider as free.
24. Any charges prohibited by federal anti-kickback or self-referral statutes.

CARE COORDINATION PROVISIONS

A. SECOND SURGICAL OPINION BENEFITS

When a physician recommends surgery that could be performed by such physician and is within the field of his or her current practice, then such recommendation is considered a "surgical opinion" for purposes under the Plan.

An additional surgical opinion will be considered a "second surgical opinion" only when the physician providing such opinion is not associated with other physician(s) rendering an opinion for the proposed surgery.

Second surgical opinions are not mandatory unless specified elsewhere in this document.

1. Second Surgical Opinion Consultation Expenses
   The expenses incurred as a result of a second surgical opinion, including charges for necessary x-ray and laboratory examination, are covered according to the Schedule of Benefits. In the event the recommendations in the first and second surgical opinions differ, expenses for a third surgical opinion are considered an eligible expense under this provision.

   Expenses under this provision are eligible whether or not actual surgery is performed.

2. Benefits Not Payable
   The following expenses are not payable under this provision:

   a. Any consultation required by a hospital;

   b. Any surgical procedure or operation which would not require the use of a hospital's major operating room or qualified surgical center;

   c. Any consultation in connection with a surgical procedure which would not be covered under any other terms of the Plan.

B. OUT-PATIENT SURGERY

Outpatient surgery is surgery that is performed without the necessity of the patient being confined in a hospital or clinic on an overnight basis and the patient is returned to the home setting the same day the surgical procedure is performed.

C. HOSPITAL ADMISSION ON FRIDAY OR SATURDAY

Regular benefits are payable for expenses incurred on a Friday and/or Saturday when confinement commences on Friday or Saturday if such confinement on a Friday and/or Saturday is necessary so as not to endanger the health and safety of the patient as certified by the attending physician.

D. GENERAL OVERVIEW

The Claims Administrator will review the hospital confinement with the physician; however, in all cases, the necessity of hospital confinement and the length of stay is determined by the Covered Person and the physician, not the Claims Administrator or the Plan.

In order for the Claims Administrator to review a hospital confinement with the physician, the Claims Administrator must be advised of such confinement. Notification of such confinement in accordance with the rules described below is considered "compliance" and will vary based on different types of confinements as

described later.

Benefits under the Plan will be more favorable if a Covered Person complies with Care Coordination. The Schedules of Benefits outline the differences in payment between compliance with Care Coordination and non-compliance.

E. **DEFINITIONS**

1. Care Coordination is the review of a hospital confinement by the Plan (through the Claims Administrator) prior to the date of such confinement and/or during such confinement. The purpose is to possibly avoid unnecessary hospital confinements and/or reduce the length of some confinements without affecting the quality of treatment.

2. Notification Requirements: Prior notification is required before you receive certain Covered Health Services; In general, network providers are responsible for notifying the Claims Administrator before they provide these services to you. There are some Network Benefits, however, for which you are responsible for notifying the Claims Administrator.

   Please remember that for Non-Network Benefits you must notify the Claims Administrator five business days before receiving services. If you don't notify the Claims Administrator there will be a $250 penalty.

   Note: Care Coordination must be notified for the following services.

   Skilled Nursing/Inpatient Rehab Facilities
   Home Health Care Services
   Hospice Care
   Maternity (inpatient stays greater than 48/96 hours)
   Transplant services
   Non-Network Inpatient Hospital Stay
   Non-Network Durable Medical Equipment
   Non-Network Reconstructive Procedures

   The phone number to call for notification is 1-800-842-3920.

3. Emergency Admission is a hospital admission that may not be scheduled at the convenience of the physician and the patient without endangering the patient's life or bodily functions.

4. Urgent Admission is a hospital admission that is not an emergency admission, but is necessary within at least 72 hours from the time a physician recommends such hospital confinement.

5. Scheduled Admission is a hospital admission that a physician has recommended that is neither an emergency nor urgent admission.

6. Working Day is any day Monday through Friday, excluding national legal holidays.

7. Prior-Notification is the formal approval of a treatment or treatment program via the Care Management process.

F. **TYPES OF REVIEW**

1. Pre-admission Review - Review is performed prior to admission for scheduled procedures.

2. Concurrent Review - Review is performed for scheduled and non-scheduled admissions during confinement.

3. Discharge Planning - Where appropriate arrangements are made to facilitate the earliest possible discharge.

4. Care Management - Alternate treatment plans are developed which meet the medical needs of the Covered Person and are more cost-effective than standard treatment forms.

5. Mental Health, Substance Related Disorders and Serious Mental Illness Case Management - Pre-admission review, Concurrent review, Alternate treatment plans, and Discharge plans for mental health/substance related disorders services are performed by the Mental Health Substance Abuse Designee to meet the medical needs of the Covered Person.

Hospital expenses will not be certified as eligible for hospital confinements that collectively total more than thirty (30) days for a patient who either has stabilized and does not require an acute level of care or is not progressing in rehabilitation. Expenses for such hospital confinements could be covered if a specific plan for transfer to the appropriate level of care is in progress and is pre-approved by the Claims Administrator's care management department.

G. **COMPLIANCE GUIDELINES**

EMPLOYEE'S FAILURE TO COMPLY WITH THESE STEPS WILL RESULT IN NON-COMPLIANCE WITH PLAN PROVISIONS AND LIMITED BENEFITS WILL BE PAID ACCORDING TO THE SCHEDULE OF BENEFITS.

Care Coordination must be notified for the following services.

Skilled Nursing/Inpatient Rehab Facilities
Home Health Care Services
Hospice Care
Maternity (inpatient stays greater than 48/96 hours)
Transplant services
Non-Network Inpatient Hospital Stay
Non-Network Durable Medical Equipment
Non-Network Reconstructive Procedures

The phone number to call for notification is 1-800-842-3920.

Notification Requirements: Prior notification is required before you receive certain Covered Health Services; In general, network providers are responsible for notifying the Claims Administrator before they provide these services to you. There are some Network Benefits, however, for which you are responsible for notifying the Claims Administrator.

Please remember that for Non-Network Benefits you must notify the Claims Administrator five business days before receiving services. If you don't notify the Claims Administrator there will be a $500 penalty.

A Healthy Pregnancy Program is available to you from United Healthcare Services, Inc. (UHC). It is completely voluntary and there is no extra cost for participating in the program. To sign up, you should notify UHC AT 1-800-411-7984 or visit www.healthy-pregnancy.com.

1. Once the Employee/Physician has complied with these provisions, the Claims Administrator will proceed to work with the physician and hospital on the Employee's behalf for necessary medical care in compliance with the physician's recommendations.

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

If there is a potential conflict with the Claims Administrator or Care Coordination, the physician's instructions should be followed; however, coverage of such treatment is subject to the Plan provisions. The Plan only reimburses or pays for a portion of the cost of eligible health care expenses and does not directly provide health care to any person.

CARE MANAGEMENT

Care Management is a cost management program administered by United Healthcare Services, Inc. to provide a timely, coordinated referral to alternative care facilities to a Covered Person who suffers a catastrophic sickness or injury while covered under this Plan. Care Management for a Covered Person who requires out-patient treatment for psychiatric conditions, mental health conditions and/or substance related disorders while covered under this Plan is administered by United Behavioral Health.

Note: Care Coordination must be notified for the following services.

Skilled Nursing/Inpatient Rehab Facilities
Home Health Care Services
Hospice Care
Maternity (inpatient stays greater than 48/96 hours)
Transplant services
Non-Network Inpatient Hospital Stay
Non-Network Durable Medical Equipment
Non-Network Reconstructive Procedures

The phone number to call for notification is 1-800-842-3920.

When United Healthcare Services, Inc. is notified of one of the above services the care manager will consult with the attending physician to develop a written plan of treatment outlining all medical services and supplies to be utilized, as well as the most appropriate treatment setting. The treatment plan may be modified intermittently as the Covered Person's condition changes, with the mutual agreement of the United Healthcare Services, Inc. doctor, the care manager, the patient, and the attending physician.

All services and supplies authorized by the treatment plan will be considered covered expenses. The benefit level for alternative treatment settings may be the same as the hospital benefit level, in the absence of the Care Management program. For all other services and supplies, the benefit level will be the same as the benefit for out-patient medical treatment, in the absence of the program.

Any deviation from the treatment plan without the care manager's prior approval will negate the treatment plan, and all charges will be subject to the regular provisions of this Plan.

If there is a potential conflict with the treatment plan, the physician's instructions should be followed; however, coverage of such treatment is subject to the Plan provisions. The Plan only reimburses or pays for a portion of the cost of eligible health care expenses and does not directly provide health care to any person.

MENTAL HEALTH/SUBSTANCE RELATED DISORDERS/ EMPLOYEE ASSISTANCE PROGRAM

The mental health and substance related disorders coverage is a two-part program offering Employees and their dependant's service and counseling in two ways:

- Counseling or information service through the Employee Assistance Program (EAP); and
- Coverage for mental health and substance related disorders treatment.

Employee Assistance Program (EAP)

The EAP provides confidential access to skilled counselors and expert clinical care.

The EAP should be the first step in accessing mental health and substance related disorders services. The EAP is a confidential counseling and information service provided as a benefit to Covered Employees and their dependants and serves as an outside source for Covered Employees and dependants to call upon for consultation in dealing with issues of mental health and substance related disorders. For each incident as defined herein, up to six (6) visits to an EAP professional are free for every Covered Employee and their dependants.

Professional Assistance of Central Texas
(800) 842-5658

Managed Mental Health and Substance Related Disorders

Mental health and substance related disorders benefits are available through a network of providers. The Employee may choose to receive services from a network or non-network provider. Use of a non-network provider will result in decreased reimbursement as described in the Schedules of Benefits.

PRESCRIPTION BENEFITS

A. **GUIDELINES**

1. Prescription drugs are covered through Medco Health for eligible options and plans. Retail prescriptions can be up to a 30-day Mail-order non-injectable drugs are covered for greater than a 30-day supply to a 90-day supply maximum.

2. Refer to the schedule of benefits for co-payment rates.

B. **DRUGS COVERED**

1. Benefits for Outpatient Prescription Drug Products: Benefits for outpatient Prescription Drug Products are available when the outpatient Prescription Drug Product meets the definition of a Covered Health Service or is prescribed to prevent conception.

2. When a Brand Name Drug becomes available as a Generic: You will either pay the Generic Copayment, if you choose to receive the Generic drug, or you may pay the higher Copayment for a Brand-name Prescription Drug if you choose to continue receiving the Brand-name or if your Physician determines that you should continue receiving the Brand-name.

   The terms "generic" and "brand-name" are used in the health care industry in many different ways. To be sure that you know whether a drug is classified as Brand-name or Generic by use, please review the definitions contained at the end of this Section.

3. Supply Limits: Benefits for Prescription Drug Products are subject to the supply limits that are stated in the "Description of Pharmacy Type and Supply Limits" of the Schedule of Benefits information table. For a single Copayment, you may receive a Prescription Drug Product up to the stated supply limit.

   Note: Some products are subject to additional supply limits based on criteria that the Claims Administrator has developed. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply.

   You may obtain a current list of Prescription Drug Products that have been assigned maximum quantity levels for dispensing through the Internet at www.myuhc.com or www.365wellst.com or by calling the telephone number on your ID card. This list is subject to periodic review and modification.

4. Any other drug which under applicable state law may only be dispensed upon the written prescription of a physician or other lawful prescriber.

C. **EXCLUSIONS**

1. Coverage for Prescription Drug Products for the amount dispensed (days supply or quantity limit) which exceeds the supply limit.

2. Drugs which are prescribed dispensed or intended for use while you are inpatient in a Hospital, Skilled Nursing Facility, or Alternate Facility.

3. Experimental or Investigational Services or Unproven Services and medications; medications used for experimental indications and/or dosage regimens determined by us to be experimental.

4. Prescription Drug Products furnished by the local, state or federal government. Any Prescription Drug

Product to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law.

5. Prescription Drug Products for any condition, injury, sickness or mental illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment of benefits are received.

6. Any product dispensed for the purpose of appetite suppression and other weight loss products.

7. A specialty medication Prescription Drug Product (such as immunizations and allergy serum) which, due to its characteristics as determined by us, must typically be administered or supervised by a qualified provider or licensed/certified health professional in an outpatient setting. This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.

8. Durable Medical Equipment. Prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered.

9. General vitamins, except the following which require a Prescription Order or Refill: prenatal vitamins, vitamins with fluoride, and single entity vitamins.

10. Unit dose packaging of Prescription Drug Products.

11. Medications used for cosmetic purposes.

12. Prescription Drug Products, including New Prescription Drug Products or new dosage forms that are determined to not be a Covered Health Service.

13. Prescription Drug Products as a replacement for a previously dispensed Prescription Drug that was lost, stolen or broken or destroyed.

14. Prescription Drug Products when prescribed to treat infertility.

15. Prescription Drug Products for smoking cessation.

16. Compounded drugs that do not contain at least one ingredient that requires a Prescription Order or Refill.

17. Drugs available over-the-counter which do not require a Prescription Order or Refill by federal or state law before being dispensed. Any Prescription Drug Product that is therapeutically equivalent to an over-the-counter drug. Prescription Drug Products that are comprised of components which are available in over-the-counter form or equivalent.

RIGHTS OF REIMBURSEMENT DUE TO ACTS OF OTHER PARTIES

Subrogation and Reimbursement

The Plan has a right to subrogation and reimbursement.

Subrogation applies when we have paid Benefits on your behalf for a Sickness or Injury for which a third party is considered responsible. The right to subrogation means that we are substituted to and shall succeed to any and all legal claims that you may be entitled to pursue against any third party for the Benefits that we have paid that are related to the Sickness or Injury for which a third party is considered responsible.

The right to reimbursement means that if a third party causes a Sickness or Injury for which you receive a settlement, judgment, or other recovery from any third party; you must use those proceeds to fully return to us 100% of any Benefits you received for that Sickness or Injury.

The following persons and entities are considered third parties:

- A person or entity alleged to have caused you to suffer a Sickness, Injury or damages, or who is legally responsible for the Sickness, Injury or damages.
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Sickness, Injury or damages.
- The Plan Sponsor.
- Any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.
- Any person or entity that is liable for payment to you on any equitable or legal liability theory.

You agree as follows:

- You will cooperate with us in protecting our legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:
  - Notifying us, in writing, of any potential legal claim(s) you may have against any third party for acts which caused Benefits to be paid or become payable.
  - Providing any relevant information requested by us.
  - Signing and/or delivering such documents as we or our agents reasonably request to secure the subrogation and reimbursement claim.
  - Responding to requests for information about any accident or injuries.
  - Making court appearances.
  - Obtaining our consent or our agents' consent before releasing any party from liability or payment of medical expenses.
  - Complying with the terms of this section.

  Your failure to cooperate with us is considered a breach of contract. As such, we have the right to terminate your Benefits, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits we have paid relating to any Sickness or Injury caused by any third party to the extent not recovered by the Plan due to you or your representative not cooperating with us. If we incur attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, we have the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.
- We have a first priority right to receive payment on any claim against a third party before you receive payment from that third party. Further, our first priority right to payment is superior to any and all claims, debts or liens asserted by any medical providers, including but not limited to hospitals or emergency treatment facilities, that assert a right to payment from funds you recover from a third party.

- The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries and is no amount of associated costs, including attorneys' fees, shall be deducted from our recovery without the Plan's express written consent. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.

- Regardless of whether you have been fully compensated or made whole, we may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which we may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule or any "Made-Whole Doctrine" or "Make-Whole Doctrine" shall limit our subrogation and reimbursement rights.

- Benefits paid by us may also be considered to be benefits advanced.

- If you receive any payment from any party as a result of Sickness or Injury, and we allege some or all of those funds are due and owed to us, you shall hold those funds in trust, either in a separate bank account in your name or in your attorney's trust account. You agree that you will serve as a trustee over those funds to the extent of the Benefits the Plan has paid.

- The Plan's rights to recovery will not be reduced due to your own negligence.

- Upon our request, you will assign to us all rights of recovery against third parties, to the extent of the Benefits we have paid for the Sickness or Injury.

- We may, at our option, take necessary and appropriate action to preserve our rights under these subrogation provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party and filing suit in your name, which does not obligate us in any way to pay you part of any recovery we might obtain.

- You may not accept any settlement that does not fully reimburse the Plan, without its written approval.

- We have the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.

- In the case of your wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries.

- No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse the Plan for 100% of its interest unless the Plan provides written consent to the allocation.

- The provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by a third party. If a parent or guardian may bring a claim for damages arising out of a minor's Sickness or Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.

- If a third party causes you to suffer a Sickness or Injury while you are covered under this Plan, the provisions of this section continue to apply, even after you are no longer covered.

- The Plan and all Administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

COORDINATION OF BENEFITS

The amount of benefits payable under this Plan and any other group plan or no-fault auto insurance will be coordinated so that the combined benefits paid by both plans will never exceed the total of all eligible expenses. However, benefits payable under this Plan will never exceed the amount which would have been paid if there were no other plans involved.

If a Covered Spouse or Child(ren) under this Plan have primary coverage with an HMO, any expenses incurred by the Covered Spouse or Child(ren) outside the HMO's required network of providers are not eligible under this Plan.

This Plan will have a right of recovery for any expenses paid under the Plan where recovery is made due to a cause of action for these expenses. This right of subrogation in no way obligates the patient to reimbursement of legal expenses unless agreed to by the Plan.

A. DEFINITIONS APPLICABLE TO THIS PROVISION

1. Plan - The term plan includes the following plans under which a person is entitled to receive or received benefits or services for or by reason of medical and dental treatment:

    a. Group plans, insured or non-insured; group, blanket, or franchise insurance coverage; group hospital or medical service plans, and other group pre-payment coverage; any coverage under labor management trusteed plans, union welfare plans, employer organization plans, or employee benefit organization plans;

    b. Any coverage required or provided by any statute, including any no-fault automobile insurance provided or required by statute; or

    c. Any plan sponsored by or provided through a school or other educational institution.

2. Primary - The plan that makes the first payment as if no other coverage existed except that plan.

3. Secondary - The plan that makes the payment after the primary plan has made the maximum payment allowable on such eligible expense. A secondary carrier calculates benefits as though there was no other coverage, then pays the lesser of either the calculated amount or the balance the primary carrier has submitted, subject to eligible expenses.

4. Eligible expense - Means any necessary item of expense, reasonable and customary in amount, at least a portion of which is covered under at least one of the plans insuring the individual for whom claim is made. When a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be considered to be both an eligible expense and a benefit paid.

5. Claim determination period - The term claim determination period means a period commencing with any November 1st, and ending at twelve o'clock (12:00) midnight on the next succeeding October 31st.

B. ORDER OF BENEFIT DETERMINATION

- If you are covered by two or more plans, the benefit payment follows the rules below in this order:
- This Plan will always be secondary to medical payment coverage or personal injury protection coverage under any auto liability or no-fault insurance policy.

- When you have coverage under two or more medical plans and only one has COB provisions, the plan without COB provisions, the plan without COB provisions will pay benefits first;

- A plan that covers a person as an employee pays benefits before a plan that covers the person as a dependant;
- If you are receiving COBRA continuation coverage under another employer plan, this Plan will pay benefits first;
- You dependent children will receive primary coverage from the parent whose birth date occurs first in the calendar year. If both parents have the same birth date, the plan that pays benefits first is the one that has been in effect the longest. This birthday rule applies only if:
    - The parents are married or living together whether or not they have ever been married and not legally separated; or
    - A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage;
- If two or more plans cover a dependent child of divorced or separated parents and if there is no court decree stating that one parent is responsible for health care, the child will be covered under the plan of;
    - The parent with custody of the child; then
    - The Spouse of the parent with custody of the child; then
    - The parent not having custody of the child; then
    - The spouse of the parent not having custody of the child;
- plans for active employees pay before plans covering laid-off or retired employees;
- the plan that has covered the individual claimant the longest will pay first. The expenses must be covered in part under at least one of the plans; and
- Finally, if none of the above rules determines which plan is primary or secondary, the allowable expenses shall be shared equally between the plans meeting the definition of the Plan. In addition, this Plan will not pay more than it would have paid had it been the primary Plan.

The following examples illustrate how the Plan determines which plan pays first and which plan pays second.

Determining Primary and Secondary Plan – Examples

1) Let's say you and your Spouse both have family medical coverage through your respective employers. You are unwell and go to see a Physician. Since you're covered as an Employee under this Plan, and as a dependant under your Spouse's plan, this plan will pay Benefits for the Physician's office visit first.
2) Again let's say you and your spouse both have family medical coverage through your respective employers. You take your Dependant child to see a Physician. This Plan will look at your birthday and your Spouse's birthday, to determine which plan pays first. If you were born on June 11 and your Spouse was born on May 30, your Spouse's plan will pay first.

WHEN THIS PLAN IS SECONDARY

If this Plan is secondary, it determines the amount it will pay for a Covered Health Service by following the steps below. The Plan determines the amount it would have paid had it been the only plan involved.

The Plan pays the entire difference between the allowable expense and the amount paid by the primary plan – as long as this amount is not more than the Plan would have paid had it been the only plan involved.

The maximum combined payment you may receive from all plans cannot exceed 100% of the total allowable expense. See the textbox below for the definition of allowable expense.

Determining the Allowable Expense when this plan is Secondary

When this plan is secondary, the allowable expense is the primary plan's Network rate. If the primary plan bases its reimbursement on reasonable and customary charges, the allowable expense is the primary plan's reasonable the customary charge. If both the primary plan and this Plan do not have a contracted rate, the allowable expense will be the greater of the two plans' reasonable and customary charges.

What is an allowable expense?
For purposes of COB, an allowable expense is a health care expense that is covered at least in part by one of the health benefits plans covering you.

C. **ORDER OF FILING A CLAIM**

Since the secondary payer cannot make a calculation of payment until they are aware of the amount paid by the primary payer, it is important that the primary payer be sent all allowable expenses. After the primary payer has made payment, the secondary payer must receive the Explanation of Benefits of the primary payer along with the allowable expenses.

D. **RELEASE OF INFORMATION**

The purpose of determining the applicability of and implementing the terms of the above provisions of this Plan or any similar provision of another plan, the Plan may, without the consent of or notice to any individual, release to or obtain from any other insurance company or other organization or individual any information, concerning any individual, which the Plan considers to be necessary for those purposes. Any individual claiming benefits under this Plan will furnish the information that may be necessary to implement the above provisions.

Right to receive and Release Needed Information:

Certain facts about healthcare coverage and services are needed to apply these rules and to determine benefits payable under this Plan. The Plan Administrator may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determine benefits payable under this Plan and other Plans covering the person claiming benefits.

The Plan Administrator need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give us any facts needed to apply these rules and determine benefits payable. If you do not provide the necessary information we need to apply these rules and determine the Benefits payable, your claim for benefits will be denied.

E. **PAYMENTS**

Whenever payments, which should have been made under this Plan in accordance with the above provisions, have been made under any other plans, the Plan will have the right, exercisable alone and in its sole discretion, to pay to any organization making those payments any amounts it determines to be warranted in order to satisfy the intent of the above provisions. Amounts paid in this manner will be considered to be benefits paid under this Plan and to the extent of these payments; the plan will be fully discharged from liability under this Plan.

F. **RECOVERY**

Whenever payments have been made by the Plan, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of the above provisions, the Plan will have the right to recover these payments, to the extent of the excess, from among one or more of the following, as the Plan will determine: any individuals to or for or with respect to whom these payments were made, any other insurance companies, or other organizations.

TREATMENT OF MEDICARE BENEFITS

Covered Persons are encouraged to enroll in Medicare when eligible and should be aware of penalties for late enrollment (premium penalties and limited enrollment periods each year). According to federal law, the group plan is primary to Medicare coverage for all active Employees and their dependants.

CLAIM FILING PROCEDURE

If you receive covered health services from a Network Provider, we pay Network Providers directly for your covered health services. If a Network provider bills you for any covered Health Service, contact the Claims Administrator. However, you are responsible for meeting the Annual Deductible and for paying Copayments to a Network Provider at the time of service, or when you receive a bill from the provider.

When you receive covered health services from a non-Network Provider, you are responsible for requesting payment from us through the Claims Administrator. You must file the claim in a format that contains all of the information required, as described below.

You must submit a request for payment of Benefits within 90 days after the date of service. If you don't provide this information to the Claims Administrator within one year of the date of service, Benefits for that health service will be denied or reduced, at the Claims Administrator's discretion. This time limit does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

Required information when you request payment of Benefits, you must provide all of the following information:

1.) Participant's name and address.
2.) The patient's name, age and relationship to the Participant.
3.) The member number stated on your ID Card.
4.) An itemized bill from your provider that includes the following:
    a. Patient diagnosis
    b. Date of Service
    c. Procedure code(s) and description of service(s) rendered.
    d. Provider of Service (Name, Address, and Tax Identification Number.
5.) The date of Injury or Sickness began.
6.) A Statement of indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name of the other carrier(s).

PAYMENT OF BENEFITS

A. Subject to proof of loss, the Claims Administrator will determine if benefits are payable according to Plan provisions and administrative guidelines. Benefits will be paid or denied within 30 days upon receipt of due written proof unless additional information is required to determine amounts payable.

B. Benefits are payable to the Covered Employee whose injury or sickness or whose dependant's injury or sickness is the basis of claim under this Plan.

C. If, in the opinion of the Claims Administrator, a Covered Person by or for whom a claim has been made is incapable of furnishing a valid receipt for any payment due him and in the absence of written evidence to the Plan of the qualification of a guardian for his estate, the Plan may, in its sole discretion, make any and all such payments to the individual or institution which is providing the care and support of such Employee.

D. If a Covered Person dies before all amounts payable to him have been paid, the Plan will pay such amounts to his executors or administrators, provided that the Plan may, in its sole discretion, pay all or part of such amounts to the spouse of such Employee, if living, otherwise to his surviving children equally, or if there is no surviving child, to the Employee's parents, or to the survivor of them.

E. Subject to any written direction of the Covered Person in any application or otherwise, all or a portion of any benefits provided by the Plan on account of hospital, nursing, medical, or surgical service may, at the Plan's option, and unless the Covered Person requests otherwise in writing not later than the time for filing proof of such loss, be paid directly to the hospital or person rendering such services, but it is not required that the services be rendered by a particular hospital or person.

F. Any payment made by the Plan in accordance with this section will fully discharge the Plan's liability to the extent of such payment.

G. At the option of the Contract Administrator, payments may be made directly to providers of service when in the Claim Administrator's opinion an assignment of benefits may exist. Payments to Choice Plus PPO providers may, in the Contract Administrator's opinion, be made as if an assignment of benefits exists.

DENIAL, INQUIRY AND REVIEW OF A CLAIM

A. DENIAL

In the event a claim is denied, in whole or in part, by the Claims Administrator, the denial shall be in writing, delivered to the claimant, and shall set forth the reasons for denial based on either Plan provisions or administrative guidelines. The written notification is generally in the form of an explanation of benefits form (EOB) sent by the Claims Administrator.

If additional information is necessary to process a claim as to what amount is payable, the claim may be denied subject to receipt of any additional material or information needed.

B. CLAIM INQUIRY PROCEDURE

The Claims Administrator will address an inquiry concerning a denial. This procedure, whether in writing or by telephone, is considered an informal inquiry. The Covered Employee, or his/her duly authorized representative, may submit additional information that the Claims Administrator will review for reconsideration.

C. CLAIM REVIEW PROCEDURE

The procedures described below apply to all claims for benefits under the Plan, but are subject to the additional claims procedures described herein, any insurance contracts or other documents which constitute governing Plan documents, and/or any separate Dental PPO summary plan description. In the event of any conflict or inconsistency between such claims procedures, the Plan Sponsor will resolve such inconsistency or conflict.

1. Claim Determination Authority. The Plan Sponsor or its authorized delegate (including the Claims Administrator) has the final authority to determine whether and the extent to which a particular benefit claim or appeal will be approved or denied. In making benefit claim and appeal determinations, the Claims Administrator has the complete discretion and authority to make factual findings regarding the claim or appeal, to interpret the terms of the Plan as they apply to the claim or appeal, and to make all other decisions and determinations regarding the claim or appeal. In any case, a Covered Person will receive only those benefits under the applicable Plan that the Claims Administrator in its sole discretion determines the Covered Person is entitled to receive.

2. Types of Benefit Claims.

   a. *Emergency Medical Benefit Claim*—An emergency medical benefit claim is any pre-service medical benefit claim with respect to which the lack of expedited processing of the claim could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function or, in the opinion of the treating physician (a physician with knowledge of the claimant's medical condition), would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. If the treating physician determines that a claim is an emergency medical benefit claim then it will be treated as such under the applicable Plans.

   b. *Concurrent Medical Benefit Claim*—A concurrent medical benefit claim is a claim for an extension of the duration or number of treatments provided through a previously-approved claim under any of the Plans providing medical care benefits. If possible, this type of claim must be filed at least 24 hours before the expiration of any course of treatment for which an extension is being sought.

   c. *Pre-Service Medical Benefit Claim*—A pre-service medical benefit claim is a claim for medical benefits under any of the Plans providing medical care benefits with respect to which

the terms of the Plan require approval of the benefit in advance of obtaining medical care (the approval process may be referred to as Care Coordination or prior notification).

d. *Post-Service Medical Benefit Claim*—A "post-service medical benefit claim" is a claim for a medical benefit under any of the Plans providing medical care benefits that is not a pre-service medical benefit claim.

e. *Disability Benefit Claim*—A "disability benefit claim" is a claim for disability benefits (if any such benefits are provided under the Plan).

f. *Other Benefit Claim*—An "other benefit claim" is any claim for Plan benefits other than a concurrent medical benefit claim, a pre-service medical benefit claim (including an urgent medical benefit claim), a post-service medical benefit claim, or a disability benefit claim.

3. Filing a Claim for Benefits. The Covered Person or his authorized representative must file any claim for benefits with the Claims Administrator for the applicable Plan or Plan component.

a. *Designating an Authorized Representative*—The Claims Administrator may impose reasonable procedures (including requiring written designation of an authorized representative on a form approved by the Claims Administrator) for determining whether an individual has been authorized to act on behalf of a claimant with respect to a claim for benefits. However, in the case of an emergency medical benefit claim the claimant's treating physician (as defined above) will automatically be considered an authorized representative of the claimant. In addition, the Employee may automatically be considered the authorized representative of the Employee's covered family members. A mere assignment of benefits by a claimant does not make the assignee the authorized representative of the claimant. If the claimant designates (or is considered to designate) an authorized representative with respect to a claim, (1) all information and notifications required to be provided to the claimant with respect to that claim will be provided to the claimant's authorized representative (except to the extent the claimant notifies the Claims Administrator, as applicable, in writing that information and notifications should not be provided to the authorized representative) and (2) references in these procedures to the claimant generally include the authorized representative.

b. *Submitting Claim Forms and Required Information*—Claims must be filed on the written form(s) authorized by the Claims Administrator or in such other manner as is provided in governing Plan document. Claims may be submitted by U.S. Mail or such other methods as are approved by the Claims Administrator. The claim form(s) and the governing Plan documents contain specific instructions for submitting claims for the applicable Plan.

c. *Deadline for Submitting Claims*—The deadlines for filing claims for benefits under a Plan are set forth in the section of this booklet describing that Plan (or in the Dental PPO Summary Plan Description, if applicable). Claims filed after the applicable deadline will be denied. However, a claim will not be denied solely for failure to obtain timely prior approval under circumstances in which obtaining such prior approval would be impossible or if application of the prior approval process could seriously jeopardize the life or health of the claimant. In such a case, the claim must be submitted as soon as possible.

d. *Incomplete Claims*— Claim submissions must include all information required by the form(s) and the terms of the governing Plan documents. Failure to include all required information with a claim may result in denial of all or a portion of the claim.

4. Initial Claim Determinations.

a. *Urgent Medical Benefit Claims*—The Claims Administrator will notify the claimant of its decision, whether adverse or not, as soon as possible, but in any event within 72 hours after receiving the claim. If the claim does not include sufficient information for the Claims Administrator to make an intelligent decision, the claimant will be notified within 24 hours after receipt of the claim of the specific additional information required to consider the claim. Such notice will specify a reasonable period of time (at least 48 hours) to respond to the notice. The Claims Administrator will notify the claimant of its decision within 48 hours after it receives the requested additional information or, if the claimant does not provide the requested information within the period specified in the notice, after the end of such period.

b. *Concurrent Medical Benefit Claims*—The Claims Administrator will notify the claimant of its decision, whether adverse or not, as soon as possible, but in any event within 24 hours after receiving the claim (provided the claim was filed at least 24 hours prior to the expiration of the course of treatment). Notice of any early reduction or termination of a previously approved course of treatment (other than by Plan amendment or termination) will be provide sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a determination on review before the early reduction or termination occurs.

c. *Pre-Service Medical Benefit Claims*—The Claims Administrator will notify the claimant of its decision, whether adverse or not, within a reasonable period of time appropriate to the medical circumstances, but in any event within 15 days after receiving the claim. This 15-day period may be (but is not required to be) extended by the Claims Administrator for an additional 15 days if the extension is due to matters beyond the Claims Administrator's control (such as the claimant's failure to provide all required information) and if the claimant is notified of the extension within the original 15-day period. If an extension is due to the claimant's failure to provide all required information, the notice of extension will describe the required information and designate a time period (at least 45 days) within which such information must be provided by the claimant. The period within which the Claims Administrator must make its decision will be suspended during the time period for providing the requested information.

d. *Post-Service Medical Benefit Claim*—The Claims Administrator will notify the claimant of its decision only if the claim is denied in whole or in part. Such notice will be provided within 30 days after the Claims Administrator receives the claim. This 30-day period may be (but is not required to be) extended by the Claims Administrator for an additional 15 days if the extension is due to matters beyond the Claims Administrator's control (such as the claimant's failure to provide all required information) and if the claimant is notified of the extension within the original 30-day period. If an extension is due to the claimant's failure to provide all required information, the notice of extension will describe the required information and designate a time period (at least 45 days) within which such information must be provided by the claimant. The period within which the Claims Administrator must make its decision will be suspended during the time period for providing the requested information.

e. *Other Benefit Claims*—The Claims Administrator will notify the claimant of its decision only if the claim is denied in whole or in part. Such notice will be provided within 90 days after the Claims Administrator receives the claim. This 90-day period may be (but is not required to be) extended by the Claims Administrator for an additional 90 days if the Claims Administrator determines that special circumstances require the extension and if the claimant is notified of the extension within the original 90-day period. The notice of extension will describe the circumstances requiring the extension and specify the date the Claims Administrator expects to make a decision.

5. Notice of Initial Claim Determination**.** The notice of initial claim determination will be provided in writing or in approved electronic form. However, an adverse initial determination of an urgent medical benefit claim may be provided orally. In that case, a written or electronic notice will be provided within 3 days after the oral notice. The notice of initial claim determination will contain the following information:

   a. the specific reason or reasons for the adverse determination;

   b. reference to the specific Plan provisions on which the determination is based;

   c. a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;

   d. a description of the Plan's review procedures and the time limits applicable to such procedures;

   e. in the case of an adverse determination under a Plan that provides medical care or disability benefits, if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the determination, either the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request;

   f. if the adverse determination is based on an Eligible Benefit or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and

   g. in the case of an adverse determination of an urgent medical benefit claim, a description of the expedited review process applicable to such claims.

6. Appealing an Initial Claim Denial. A claimant may appeal an adverse initial claim determination by submitting an appeal to the applicable Claims Administrator. Such appeal must be filed within 60 days (180 days in the case of a claim for benefits under a Plan providing medical care benefits) after notice of the adverse determination was provided to the claimant. The appeal request must be in writing unless it is for an urgent medical benefit claim, in which case the request may be made orally and all information necessary to decide the appeal may be transmitted by telephone or fax between the claimant and the Claims Administrator. Depending on the Plan or Plan component involved, a claimant may be required to go through two levels of appeal before exhausting the administrative appeals process.

   In connection with the appeal, the claimant may submit written comments, documents, records, or any other information relating to the claim. Upon written request by the claimant, the claimant will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim, including the identity of medical or vocational experts whose advise was obtained on behalf of the Plan in connection with an adverse determination (regardless of whether such advice was relied upon in making the determination).

   The Claims Administrator's review of the claim on appeal will take into account all comments, documents, records, and other information submitted by the claimant and relating to the claim, regardless of whether such information was submitted or considered in the initial benefit determination. If the appeal relates to a disability claim or a claim under a Plan providing medical care benefits, the review will not give deference to the initial determination and will be conducted by

an individual who is neither the individual who made the initial determination being appealed or the subordinate of such individual. In addition, if such an appeal is of an initial claim denial based on a medical judgment, the Claims Administrator will consult with a health care professional retained by the Plan. Such health care professional will not be an individual who was consulted with on the decision being appealed or a subordinate of such individual.

7. Decision on Appeal.

a. *Urgent Medical Benefit Claims*— The Claims Administrator will notify the claimant of its decision on appeal as soon as possible, but in any event within 72 hours after receiving the claim.

b. *Pre-Service Medical Benefit Claims*—The Claims Administrator will notify the claimant of its decision on appeal within a reasonable period of time appropriate to the medical circumstances, but in any event within 30 days after receiving the appeal (15 days if the Plan requires two levels of appeal).

c. *Post-Service Medical Benefit Claims*— The Claims Administrator will notify the claimant of its decision on appeal within a reasonable period of time not to exceed 60 days after receipt of the appeal (30 days if the Plan requires two levels of appeal).

d. *Other Benefit Claims*—The Claims Administrator will notify the claimant of its decision on appeal within a reasonable period of time not to exceed 60 days after receipt of the appeal. If special circumstances require an extension (such as the need to hold a hearing), the Claims Administrator may approve an extension of up to an additional 60 days if written notice of the extension (including a description of the special circumstances and the date by which the Claims Administrator expects to make a decision) is provided to the claimant prior to the expiration of the original 60-day period. If an extension is due to a claimant's failure to provide information necessary to decide the appeal, the period for making the determination is suspended until the date the claimant responds to the request for additional information.

8. Notice of Appeal Determination. The notice of appeal determination will be provided in writing or in approved electronic form and will contain the following information:

a. the specific reason or reasons for the adverse determination;

b. reference to the specific Plan provisions on which the determination is based;

c. a statement that the claimant is entitled to receive without charge reasonable access to any document (1) that was relied on in making the determination, (2) that was submitted, considered or generated in the course of making the benefit determination, (3) that demonstrates compliance with the administrative processes and safeguards required in making the determination, or (4) in the case of a Plan providing medical care or disability benefits, that constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether the statement was relied on in making the determination;

d. in the case of a Plan providing medical care or disability benefits, if the adverse determination is based on an Eligible Benefit or experimental treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment, applying the terms of the Plan to the claimant's medical condition, or a statement that such an explanation will be provided without charge on request;

e. in the case of a Plan providing disability or medical care benefits, if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, or similar criterion or a statement that such rule, guideline, or similar criterion was relied upon in making the determination and that a copy of such information will be provided to the claimant free of charge upon request; and

f. A statement that the claimant and the Plan may have other voluntary alternative dispute resolution options, such as mediation.

9. Filing of a claim appeal to Williamson County Benefits Committee

Should the claimant not agree with the first or second level of appeal determination, the appeal may be elevated to a third level. A third written appeal may be sent to Williamson County Benefits Committee within sixty (60) days of receipt of the second appeal determination. The decision by the Benefits Committee will be final.

D. **LIMITATION ON ACTIONS**

No action at law or in equity shall be brought to recover on the Plan prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirement of the Plan and all appeal rights pursuant to the Plan have been exhausted. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

GENERAL PROVISIONS

A. ENTIRE PLAN DOCUMENT - NO CONTRACT

The Plan document constitutes the entire Plan. The Plan shall not be deemed to constitute a contract of employment, or contract for benefits, or give any employee the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge any employee. Nothing in the Plan shall be construed as creating any vested rights to benefits in favor of any Covered Person or any other person except with respect to claims that have actually been incurred by any such person that would otherwise be eligible for payment under the Plans, as in effect at the time the claim or expense was incurred.

No term, condition, or provision of the Plan shall be deemed waived, and there shall be no estoppel against enforcing any provision of the Plan, except through a writing of the party to be charged by the waiver or estoppel. No such written waiver shall be deemed a continuing waiver unless explicitly made so, and it shall operate only with regard to the specific term or condition waived, and shall not be deemed to waive such term or condition in the future, or as to any act other than as specifically waived. No person other than as named or described by class in the waiver shall be entitled to rely on the waiver for any purpose.

If any provision of any Plan shall be held invalid or illegal for any reason, any invalidity or illegality shall not affect the remaining parts of the Plan, but the Plan shall be construed and enforced as if the invalid or illegal provision had never been inserted. The Employer shall have the privilege and opportunity to correct and remedy those questions of invalidity or illegality by amendment as provided in the Plan.

B. AMENDMENTS TO OR TERMINATION OF PLAN

The Plan may be amended, canceled, or discontinued at any time by the Employer without the consent of, or notice to, any Covered Person or beneficiary. In the event of a material amendment of the Plan, information describing the change will be distributed within a reasonable period of time after the later of the date the amendment is adopted or effective; provided that the failure to provide such information shall not make or be construed to make the amendment ineffective. All treatment received by a Covered Person is subject to the benefits in effect on the date of treatment, regardless of whether or not such treatment was covered when the illness or injury was diagnosed or earlier treated.

C. ASSIGNMENT

Benefits under the Plan may not be assigned, transferred, or in any way made over to another party by any person without the written consent of the Employer, Risk Pool, or Claims Administrator. Notwithstanding anything in the Plan to the contrary, the Plan shall not be construed to make the Employer, Risk Pool, or Plan liable to any third-party to whom a Covered Person, beneficiary, or other person is liable for care, treatment, services, or otherwise. The interest of any person under the Plan is not subject to the claims of such person's creditors (other than the Plan/Risk Pool) and may not be voluntarily or involuntarily transferred, assigned, alienated, or encumbered (other than to or by the Plan/Risk Pool) without the specific written consent of the Employer, Risk Pool, or Claims Administrator.

D. OPERATION AND ADMINISTRATION OF THE PLAN

The Risk Pool has the authority to control and manage operation and administration of the Plan.

1. General administration - The general administration of the Plan is vested in the Plan Sponsor. The Plan Sponsor shall have all powers and duties necessary or proper, as determined in its discretion, to administer the Plan and to discharge its duties under the Plan.

2. Discretion to interpret - The Plan Sponsor shall have absolute discretion to construe and interpret any

and all terms and provisions of the Plan, including, but not limited to, the discretion to resolve ambiguities, inconsistencies, or omissions conclusively, provided, however, that all such discretionary interpretations and decisions shall be applied in a uniform and nondiscriminatory manner to all Covered Persons similarly situated.

3. Right to delegate - The Plan Sponsor may from time to time allocate to one or more of the Employer's officers, employees, or agents, and may delegate to the Claims Administrator or any other person or organization, any of its powers, duties, and responsibilities with respect to the operation and administration of the Plan, including, without limitation, the administration of claims, the authority to authorize payment of benefits, the review of denied or modified claims, the determination of reasonable, customary, and eligible medical expenses and procedures, the discretion to decide matters of fact and interpret Plan provisions and may employ and authorize any person to whom any of its responsibilities have been delegated to employ persons to render advice with regard to any responsibility held hereunder.

E. PROCEDURE FOR FUNDING THE BENEFITS

The Employer and eligible Employees will contribute to the Plan the amount determined by the Employer to be appropriate for the benefits to be provided under the Plan. Such amount is subject to change at any time during the Plan year. By electing to participate in the Plan and/or receiving benefits under the Plan, each Covered Employee and Covered Dependant and any beneficiaries thereof agree to the deduction of required contributions from the wages otherwise payable to the Covered Employee and/or from any benefits payable under the Plan.

F. MISSTATEMENT OF AGE

If the age of a Covered Person has been misstated and if the amount of contribution is based on age, an adjustment of contributions shall be made based on the Covered Person's true age. If age is a factor in determining eligibility or amount of coverage and there has been misstatement of age, the coverages or amount of benefits, or both, for which the person is covered shall be adjusted in accordance with the Covered Person's true age. Any such misstatement of age shall neither continue coverage otherwise validly terminated, nor terminate coverage otherwise validly in force. Contributions and benefits will be adjusted on the contribution due date next following the date of discovery of such misstatement.

G. MISSTATEMENT OF MEDICAL FEES

Any misstatement of fees by a medical provider which are known to the Employee at the time and result in overpayment become the responsibility of the Employee.

H. MISSTATEMENT OF DIAGNOSIS

If diagnosis is a factor in determining eligibility or amount of coverage and there has been a misstatement of diagnosis, the coverages or amount of benefits, or both, for which the person is covered will be adjusted in accordance with the Covered Person's true diagnosis.

I. OVERPAYMENT OF BENEFITS

Any misstatement of diagnosis by a medical provider or Covered Person which results in an overpayment becomes the responsibility of the Employee and/or Covered Person. The Plan reserves the right to recover any overpayment of plan benefits from that provider if the Plan made direct payments to such providers.

J. **FACILITY OF PAYMENT**

If, in the opinion of the Claims Administrator, a valid release cannot be rendered for the payment of any benefit payable under this Plan, the Claims Administrator may, at its option, make such payment directly to health care provider, or to the guardian or conservator, or the parents of minor child, or an individual or individuals as have, in the Claims Administrator's discretion to that person having the custody, the care and principal support of the Covered Person.

In the event of the death of the Covered Person, the payment shall be made to the personal representative of the Covered Person's estate. Any payment made by the Claims Administrator in good faith pursuant to this provision, shall fully discharge the Plan and/or the Claims Administrator to the extent of such payment.

K. **ADMINISTRATIVE GUIDELINES**

The Plan document cannot include complete explanation of all claims payment procedures; therefore, administrative guidelines are prepared and used by the Claims Administrator for clarification. A Covered Person may review this reference material upon request, before or after an expense is incurred.

L. **GENDER**

As used herein the singular form of any word shall include the plural wherever necessary for the proper interpretation of this Plan, and wherever used herein a pronoun in the masculine gender shall be considered as including the feminine gender unless the context clearly indicates otherwise.

COMPLIANCE WITH TEXAS LOCAL GOVERNMENT CODE CHAPTER 172

A. GENERAL OVERVIEW

Chapter 172 of the Texas Local Government Code allows Texas political subdivision to provide employees group health coverage provided by either a risk pool established under Chapter 172 of the Texas Local Government Code ("Chapter 172") or a policy of insurance or group contract. The Employer has chosen to make such coverage available under a risk pool. The purpose of this section is to ensure compliance with Chapter 172, as amended.

B. RISK POOL

1. The Employer does hereby establish a Risk Pool to provide health coverage for its eligible employees and their dependants as set forth in the Plan. Employer may provide workers' compensation and other coverages through the Risk Pool to the extent permitted by law.

2. Contributions paid by the Employer's employees for coverage shall be deposited to the credit of the Risk Pool's fund and used as provided by rules of the Risk Pool and the Plan.

3. The Risk Pool by contract may purchase insurance coverage for persons who are covered by the Risk Pool from an insurance company authorized to do business in Texas.

4. The Risk Pool or its' agents may not represent to persons who apply for coverage or who are covered by the Risk Pool that the coverage being provided is insurance.

5. The Risk Pool is a legal entity that may contract with an insurer licensed to do business in Texas to assume any excess of loss of a benefit contract. Notwithstanding any provision of the Texas Insurance Code or any other law governing insurance in Texas, an insurer authorized to do business in Texas may assume the excess of loss of a benefit contract.

C. SUPERVISION AND ADMINISTRATION OF THE RISK POOL

1. The Employer shall select Trustees to supervise the operation of the Risk Pool.

2. The Risk Pool may be administered by a staff employed by the Risk Pool, an entity created by the Employer, or a third party administrator known as a claims administrator.

3. Before entering into a contract with a person to be a claims administrator of the Risk Pool, the Trustees shall require that person to submit information necessary for the Trustees to evaluate the background, experience, and financial qualifications and solvency of that person. The information submitted by a prospective claims administrator other than an insurance company must disclose:

   a. any ownership interest that the prospective Claims administrator has in an insurance company, group hospital service corporation, health maintenance organization, or other provider of health care indemnity; and

   b. any commission or other benefit that the prospective administrator will receive for purchasing services or coverage for the Risk Pool.

4. An attorney employed by a claims administrator, provider of excess loss coverage, or reinsurer may not be simultaneously employed by the Risk Pool unless, before the attorney is employed by the Risk Pool, the claims administrator, provider of excess loss coverage, reinsurer, or attorney discloses to the Risk Pool's Board of Trustees that the attorney is employed by the claims administrator, provider, or

reinsurer.

5. If the State of Texas enacts a law providing for the licensing or registration of claims administrators, the Risk Pool in contracting for administrative services may only contract for services of a claims administrator licensed or registered under the law.

D. TRUSTEE TRAINING

1. Trustees who act as fiduciaries for the Risk Pool must have at least 16 hours of combined professional instruction with four hours of instruction in each of the following areas:

   a. law governing the establishment and operation of risk pools by political subdivisions;

   b. principles of self-insurance and risk pools, including actuarial and underwriting principles and investment principles;

   c. principles relating to reading and understanding financial statements; and

   d. the general fiduciary duties of trustees.

2. A trustee must complete the required training no later than the 180th day after the date of selection as Trustee.

E. EXCESS LOSS COVERAGE AND REINSURANCE

1. The Risk Pool may purchase excess loss coverage or reinsurance to insure the Risk Pool against financial losses that the Risk Pool determines might place the solvency of the Risk Pool in financial jeopardy.

2. If the Risk Pool does not purchase excess loss coverage or reinsurance, the Administrator shall give written notice to each person who applies for coverage from the Risk Pool that the Risk Pool does not maintain excess loss coverage or reinsurance. The Administrator shall provide the notice before coverage is issued to an applicant and shall give the applicant the opportunity to decline the coverage.

3. If the Risk Pool cancels or does not renew excess loss coverage or reinsurance, the Administrator shall give notice to each Covered Person that the coverage has been canceled or has not been renewed and shall give each an opportunity to cancel coverage. The Administrator must give the notice and opportunity to cancel coverage not later than the 30th day after the date on which the Risk Pool cancels or does not renew the excess loss coverage of reinsurance.

F. INVESTMENTS

1. The Trustees shall invest the Risk Pool's money in accordance with the Public Funds Investment Act of 1987 (Article 842a-2, Vernon's Texas Civil Statutes) to the extent of that law can be made applicable.

2. In addition to investments authorized under the Public Funds Investment Act of 1987, the Trustees of the Risk Pool may invest the Risk Pool's money in any investment authorized by the Texas Trust Code (Subtitle B, Title 9, Property Code).

G. AUDITS

1. The Trustees shall have the fiscal accounts and records of the Risk Pool audited annually by an independent auditor.

2. The person who performs the audit must be a certified public accountant or public accountant licensed by the Texas State Board of Public Accountancy.

3. The independent audit shall cover the Risk Pool's fiscal year.

4. The Trustees shall file annually with the State Board of Insurance a copy of the audit report. A person may request the State Board of Insurance to provide copies of any item included in an audit report on payment of the cost of providing the copies.

H. INSOLVENCY

1. The Trustees shall declare the Risk Pool insolvent if the Trustees determine that the Risk Pool is unable to pay valid claims within 60 days after the date the claims are verified.

2. If the Risk Pool is declared insolvent by the Trustees, the Risk Pool shall cease operation on the day of the declaration, and the Trustees shall provide for the disposition of the Risk Pool's assets, debts, obligations, losses, and other liabilities.

3. A Covered Person may institute proceedings to have the Risk Pool declared insolvent by petitioning a County court in Travis County to declare the Risk Pool insolvent. If the County court, after notice and hearing, determines that the Risk Pool is insolvent, the court shall appoint a receiver to take charge of and dispose of the Risk Pool's assets, debts, obligations, losses and other liabilities.

4. After a receiver takes charge of the assets and determines outstanding debts, obligations, losses, and other liabilities, the receiver shall give notice of his determination to all Covered Persons.

I. PAYMENT OF CONTRIBUTIONS AND PREMIUMS

1. The Employer may pay all or part of the contributions for coverage from local funds, including federal grant or contract pass-through funds, which are not dedicated by law to some other purpose.

2. The Employer also may pay all or part of the contributions for coverage for eligible employees, retirees, and dependants.

3. On written approval of an employee, the Employer may deduct from the employee's compensation an amount necessary to pay that person's and his or her dependant's contributions.

4. State funds, except federal grant or contract fund passed through the state to the Employer or other state funds as permitted by Articles 3.50-7 and 3.50-8 of the Texas Insurance Code, may not be used to purchase coverage or to pay contributions.

J. APPLICATION OF CERTAIN LAWS

The Risk Pool is not insurance or an insurer under the Insurance Code and other laws of this state, and the State Board of Insurance does not have jurisdiction over the Risk Pool.

K. SUBROGATION

The Risk Pool shall have a right of reimbursement and be subrogated to any and all recoveries and rights of recovery of a Covered Person for personal injuries or illness from any and all sources. The Risk Pool's right of reimbursement and subrogation is described in more detail herein under the section entitled "Rights of Reimbursement Due to Acts of Other Parties."

L. AMENDMENT

The County Commissioner's of the Employer may amend the provisions of this Risk Pool at any time and from time to time pursuant to the amendment provision of the Plan or in accordance with applicable law.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

A. SCOPE

The following provisions regarding protected health information and electronic protected health information apply solely to the extent the Plan (or any relevant portion thereof) is a "health plan" covered by the privacy regulations under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Sections B. and C. below are generally effective as of April 14, 2003, or such later effective date as is permitted or required by such regulations. Section D. below is generally effective as of April 20, 2005, or such later effective date as is permitted or required by such regulations. For purposes of this Section, the terms "protected health information" and "electronic protected health information" shall have the meaning specified by the privacy and security regulations under HIPAA.

The following provisions are intended to comply with the privacy regulations under HIPAA and shall be construed solely for that purpose. Such provisions shall not be construed to provide or mean that the Plan is a health care provider, practices medicine, or makes medical treatment decisions. The Plan reimburses or pays for a portion of the cost of eligible health care expenses and does not directly provide health care or practice medicine.

B. PERMITTED USES AND DISCLOSURES

The Plan may use protected health information to the extent of and in accordance with the uses and disclosures permitted by HIPAA and the privacy regulations there under. Without limiting the foregoing, the Plan may use and disclose protected health information for "payment," "treatment," and "health care operations" purposes as such terms are defined by the HIPAA privacy regulations.

"Payment" includes activities undertaken by the Plan to obtain premiums or determine or fulfill the Plan's responsibility for coverage and provision of benefits under the terms of the Plan or to provide reimbursement for the provision of health care. Such activities include, but are not limited to, determinations of eligibility and/or coverage, adjudication and/or subrogation of claims, billing, claims management, collection activities, health care data processing, review of an Eligible Benefit and/or coverage, review of appropriateness of care and/or justification of charges, utilization review activities (including prior notification of services and concurrent and retrospective review of services), and certain disclosures to consumer reporting agencies.

"Treatment" includes, but is not limited to, the provision, coordination, or management of health care and related services by one or more health care providers, including the referral of a patient for health care from one health care provider to another.

"Health Care Operations" include, but are not limited to, conducting quality assessment and improvement activities, case management and care coordination, contacting health care providers and patients with information about treatment alternatives, related functions that do not include treatment, reviewing and evaluating qualifications and/or health plan performance, securing contracts for reinsurance, conducting or arranging for medical review or auditing functions (including fraud and abuse detection), and business planning and development (including methods of payment or coverage policies).

In addition to using protected health information for the purposes described above, protected health information may be disclosed by the Plan to the Employer, and the Employer may use and disclose protected health information, for plan administration purposes, for enrollment purposes, and for any other purposes consistent with an individual's authorization or permitted by the HIPAA privacy regulations. In addition, "summary health information" may be disclosed by the Plan to the Employer and may be used and disclosed by the Employer for purposes of obtaining premium bids for health insurance coverage under the Plan or modifying, amending, or terminating the Plan.

C. EMPLOYER CERTIFICATION

1. The Plan will not disclose protected health information to the Employer for plan administration purposes unless the Plan receives from the Employer a certification that the applicable Plan documents have been amended to incorporate the following provisions. Therefore, the Employer certifies and agrees that it will:

   - not use or further disclose protected health information other than as permitted or required by the Plan documents or as required by law;

   - 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 Employer with respect to such information;

   - not use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer (unless authorized by the individual and/or permitted by the HIPAA privacy regulations);

   - report to the Plan any use or disclosure of the protected health information that is inconsistent with the uses or disclosures provided for and of which it becomes aware;

   - make available protected health information to the affected individual in accordance with section 164.524 of the HIPAA privacy regulations;

   - make available protected health information for amendment at the request of the affected individual and incorporate any amendments to protected health information in accordance with section 164.526 of the HIPAA privacy regulations;

   - make available the information required to provide an accounting of disclosures to an affected individual in accordance with section 164.528 of the HIPAA privacy regulations;

   - make its internal practices, books, and records relating to the use and disclosure of protected health information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the applicable requirements of the HIPAA privacy regulations;

   - if feasible, return or destroy all protected health information received from the Plan that the Employer still maintains in any form and retain no copies of such information when no longer needed for the purpose for which 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 infeasible; and

   - ensure that the adequate separation described below is established.

2. With respect to protected health information disclosed by the Plan to the Employer for use and/or disclosure by the Employer for plan administration purposes:

   - such information may be disclosed to employees in the Insurance Department or other departments and positions with oversight responsibility for the Plans, including employees with oversight responsibility for claims payment and third party claims administration;

- such information may be used by the persons described above only for purposes of the plan administration functions that the Employer performs for the Plan; and

- compliance with the provisions above relating to disclosure for plan administration purposes shall be monitored and enforced by the Plan Sponsor. The Plan Sponsor shall establish rules for effectively resolving any instances of noncompliance. Such rules are incorporated herein by this reference.

D. SECURITY REQUIREMENTS

The following provisions of this Section D. do not apply to the extent the only electronic protected health information disclosed to the Employer for plan administration purposes (1) is disclosed pursuant to an individual's authorization; (2) is summary health information disclosed for the purpose of obtaining premium bids or modifying, amending, or terminating the Plan; or (3) is enrollment, disenrollment, or participation information.

The Plan Sponsor or its delegate (including, if applicable, the Employer) will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that the Employer creates, receives, maintains, or transmits on behalf of the Plan for plan administration purposes.

With respect to electronic protected health information, the Plan Sponsor will ensure that the requirements of Section C.2 above are supported by reasonable and appropriate security measures.

With respect to electronic protected health information that the Employer creates, receives, maintains, or transmits on behalf of the Plan for plan administration purposes, the Plan Sponsor will ensure that any agent, including a subcontractor, to whom the Employer provides such information, agrees to implement reasonable and appropriate security measures to protect the information.

The Plan Sponsor and the Employer will report to the Plan any "security incident" (as such term is defined by the HIPAA security regulations) of which it becomes aware with respect to electronic protected health information that the Employer creates, receives, maintains, or transmits on behalf of the Plan for plan administration purposes.

INDEX

SAMPLE
ADMINISTRATIVE SERVICES AGREEMENT

THIS Administrative Services Agreement (hereinafter "Agreement"), effective _____, 2012, and ending _____, 20___, and continuing thereafter, for a maximum of ___ additional twelve (12) month periods, as provided by this Agreement, is entered into by Williamson County, a political subdivision of the State of Texas, (hereinafter referred to as the ("County and/or Plan Sponsor"), and _____, a corporation duly organized and existing under the laws of the State of _____ (hereinafter referred to as the "TPA").

WHEREAS, the Plan Sponsor sponsors a self-funded employee welfare benefit plan (the "Plan");

WHEREAS, the Plan Sponsor desires to make available a program of health care benefits under the Plan;

WHEREAS, the Plan Sponsor wishes to contract with an independent third party administrator to perform certain administrative services with respect to the Plan as described herein;

WHEREAS, the TPA desires to contract with the Plan Sponsor to perform certain administrative services with respect to the Plan as described herein; and

THEREFORE, in consideration of the promises and mutual covenants contained herein, the Plan Sponsor and the TPA enter into this Agreement for administrative services for the Plan.

ARTICLE I: DEFINITIONS

For the purposes of this Agreement, the following words and phrases have the meanings set forth below, unless the context clearly indicates otherwise and, wherever appropriate, the singular shall include the plural and the plural shall include the singular.

1.1 "Claim" means each bill, invoice, claim form or other document representing a request for payment for medical, dental or vision services, which is received by the TPA. Each such document will be considered to be one "claim", regardless of the number of itemized lines on the document and regardless of whether the document is a duplicate of previous documents or whether the services indicated on the document are eligible for coverage under the applicable Plan.

1.2 "Claimant" means a Covered Person or entity on behalf of a Covered Person, submitting expenses for payment or reimbursement from the Plan.

1.3 "Claims Payment Account" means an account utilized by the Plan Sponsor for payment or reimbursement for Covered Services, which account balances shall constitute assets of the Plan Sponsor and not the Plan.

1.4 "COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985 or the Public Health Service Act, as amended, together with all regulations applicable thereto.

1.5 "COBRA Participant" means any person who is properly enrolled for and entitled to benefits from the Plan policy, pursuant to COBRA continuation coverage.

1.6 "Complete Claim" means a claim for benefits for a Covered Person that has been submitted by a licensed Health Care Provider or the Covered Person, void of any omissions of pertinent information, coordination of benefits or liability issues, in a form satisfactory to TPA and with sufficient documentation to substantiate the claim for benefits under the Plan that is necessary or required according to industry standards or requirements in order for the TPA to make a determination of benefits under the Plan.

1.7 "Covered Person" is a person who is properly enrolled and entitled to benefits from the Plan.

1.8 "Covered Services" means the care, treatments, services or supplies described in the Plan Document as eligible for payment or reimbursement from the Plan.

1.9 "Creditable Coverage" means health or medical coverage under which a Covered Person was covered prior to enrollment under this Plan which prior coverage was under any of the following:

(a) A group health plan;
(b) Health Insurance coverage;
(c) Part A, Part B or Part C of Title XVIII of the Social Security Act (Medicare);
(d) Title XIX of the Social Security Act, other than coverage consisting solely of benefits under §1928 (Medicaid);
(e) Chapter 55 of Title 10, United States Code (active military and CHAMPUS);
(f) A medical care program of the Indian Health Service or a tribal organization;
(g) A state health benefits risk pool;
(h) A health plan offered under Chapter 89 of Title 5, United States Code (Federal Employee Health Benefits);
(i) A public health plan; or
(j) A health benefit plan under §5(e) of the Peace Corps Act.
(k) A state Children's Health Insurance Program (CHIP)

1.10 "Employer" means the Plan Sponsor and any successor organization or affiliate of such Employer which assumes the obligations of the Plan and this Agreement.

1.11 "ERISA" means the Employee Retirement Income Security Act of 1974, as amended, together with all regulations applicable thereto.

1.12 "Fee Schedule" means the listing of fees or charges for services provided under this Agreement. This Fee Schedule may be modified from time to time in writing by the mutual agreement of the parties. The Fee Schedule is contained in Appendix A and is a part of this Agreement.

1.13 "Health Care Providers" means physicians, dentists, hospitals, or other health care practitioners or health care facilities that are duly licensed and authorized to receive payment or reimbursement for Covered Services in accordance with the terms of the Plan.

1.14 "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended, together with all applicable regulations thereto.

1.15 "Paid Claims" means claims for benefits under the Plan that have been processed for payment by the TPA, have been funded in U.S. Dollars by the Plan or the Plan Sponsor, and for which payment or electronic payment has been issued and transmitted to the Claimant or assignee.

1.16 "Plan" means the self-funded health and welfare benefit plan which is the subject of this Agreement and which the Plan Sponsor has established pursuant to the Plan Document.

1.17 "Plan Administrator" means the person or entity, including an insurance company, designated by the Plan Sponsor to manage the Plan and make all discretionary decisions regarding Plan terms and managing Plan assets.

1.18 "Plan Document" means the instrument or instruments that set forth and govern the duties of the Plan Sponsor and eligibility and benefit provisions of the Plan, which provide for the payment or reimbursement of Covered Services.

1.19 "Plan Participant" is any employee, retiree or COBRA beneficiary who is properly enrolled and eligible for benefits under the Plan.

1.20 "Plan Year" means the twelve-month period of time beginning with the effective date of the Plan as specified in the Plan Document.

1.21 "Qualified Beneficiary" means a Covered Person under the Plan Sponsor's Plan, who is eligible to continue coverage under the Plan policy in accordance with the applicable provisions of Title X of COBRA or §609(a) of ERISA regarding Qualified Medical Child Support Orders, or in accordance with any similar applicable state law. Qualified Beneficiary also means a child born to, adopted or placed for adoption with a Participant or former Participant, who is a COBRA participant, at any time during active COBRA continuation coverage of that Participant or former Participant.

1.22 "Qualifying Event" means:

(a) With respect to an eligible Participant:

1. The termination (other than by reason of gross misconduct) of the covered Participant's employment; or
2. The reduction in hours of the covered Participant's employment causing the Participant to become ineligible for coverage.

(b) With respect to covered Dependents:

1. Death of the covered Participant;
2. Termination of the covered Participant's employment;
3. Reduction in hours of the covered Participant's employment causing the Participant to become ineligible for coverage;
4. The divorce or legal separation of the covered Participant from his or her spouse;
5. The covered Participant's entitlement to Medicare; or
6. A covered Dependent child ceases to be a Dependent as defined by the Plan.

(c) Qualifying Events for retired Participants, for purposes of this section, are:

1. Bankruptcy, if the covered Participant retired on or before the date of any substantial elimination of group health coverage due to bankruptcy.

(d) Qualifying Events for the Dependents of retired covered Participants, for purposes of this section, are:

1. Bankruptcy, if the Dependent was a covered Dependent of a covered retiree on or before the day before the bankruptcy Qualifying Event.

1.23 "Stop Loss or Excess Loss Insurance" means an insurance policy obtained by the Plan or the Plan Sponsor to provide coverage for individual claims at a specified stop loss limit and/or group claims at an aggregate stop loss limit that are incurred and paid during a defined period of time by the insurance policy.

1.24 "Summary Plan Description" means the document that describes the terms and conditions under which the Plan operates.

1.25 "Utilization Management" means the evaluation of medical necessity and appropriateness of the use of health care services, procedures, and facilities utilized by a Covered Person under the terms of the Plan.

1.26 "Working Days" shall mean a regular business day, which is not a recognized federal or banking holiday, and specifically excluding any Saturday or Sunday.

ARTICLE II. RELATIONSHIP OF THE PARTIES

2.1 The Plan Sponsor acknowledges that the TPA is an independent contractor for purposes of this Agreement. As such, the TPA is not an agent or employee of the Plan Sponsor and does not assume any liability or responsibility for any breach of duty or act of omission by the Plan Sponsor. The Plan Sponsor delegates to the TPA only non-discretionary authority with respect to assisting Plan Sponsor in the development, maintenance and administration of the Plan as specifically described in this Agreement. Any function not specifically delegated by Plan Sponsor to, and

agreed to be assumed by the TPA in writing pursuant to this Agreement shall remain the sole responsibility of the Plan Sponsor. The Plan Sponsor shall retain all discretionary authority, control and responsibility for the operation and administration of the Plan.

2.2 The parties acknowledge that:

(a) This is a contract for administrative services only as specifically set forth herein;

(b) The TPA shall not be obligated to disburse more in payment for Claims or other obligations arising under the Plan than the Plan Sponsor shall have made available in the Claims Payment Account;

(c) This Agreement shall not be deemed a contract of insurance under any laws or regulations. The TPA does not insure, guarantee or underwrite the liability of the Plan Sponsor under the Plan. The TPA has no responsibility and the Plan Sponsor has total responsibility for payment of Claims under the Plan and all expenses incidental to the Plan; and

(d) The TPA is not the plan administrator, plan sponsor or plan fiduciary and the Plan Sponsor will not identify the TPA or any of its affiliates as such. The Plan Sponsor acknowledges and agrees that it is the plan sponsor; plan administrator and named fiduciary as such terms are defined by ERISA.

2.3 Except as specifically set forth herein, this Agreement shall inure to the benefit of and be binding upon the parties hereto and their respective legal successors provided, however, that neither party may assign this Agreement without the prior written consent of the other, which consent shall not be unreasonably withheld.

2.4 It is agreed by the parties to this Agreement that any cause of action brought by either party to this contract must be made within four (4) years of the date of occurrence of any alleged breach, infraction or dispute, or within four (4) years of the termination date of this Agreement, whichever occurs first.

2.5 The Plan Sponsor acknowledges and agrees that the TPA will not be deemed to be a legal or tax advisor for the Plan or the Plan Sponsor as a result of the performance of its duties under this Agreement. The TPA makes no representation to the Plan Sponsor concerning federal, state, or local laws, rules or regulations applicable to the Plan. Company must seek its own counsel for legal advice and guidance. **In no event shall the TPA be liable for special or consequential damages, even if the TPA was advised of the possibility of such damages.**

2.6 The TPA may secure the services of actuaries, computer software companies, computer service firms, insurance consultants and producers, legal counsel, accountants, utilization management consultants, pharmacy benefit management companies, preferred provider organizations, claims negotiation companies, subrogation firms, and any other entities that it deems necessary in the performance of its obligations under this Agreement. At the discretion of the TPA, such services may be performed directly by the TPA, wholly or in part, through a subsidiary or affiliate of TPA or under an agreement with an organization, agent, advisor or other person of its choosing. Any such services resulting in a fee not agreed to in the Fee Schedule, Appendix A, must first be authorized in writing by the Plan Sponsor.

2.7 The TPA agrees to be duly licensed as a Third Party Administrator to the extent required under applicable law and agrees to maintain such licensure throughout the term of this Agreement.

2.8 The TPA will possess through the term of this Agreement an in-force fidelity bond or other insurance as may be required by state and federal laws for the protection of its clients. Additionally, the TPA agrees to comply with any state or federal statutes or regulations regarding its operations.

2.9 The TPA shall be entitled to rely upon, without investigation or inquiry, any written or oral information or communication of the Plan Sponsor or agents, including but not limited to consultants, actuaries, attorneys, accountants, auditors, managed care organizations, preferred provider organizations, pharmacy benefit management companies, mental health care management companies or brokers retained by the Plan Sponsor.

2.10 THE TPA WILL INDEMNIFY, DEFEND, SAVE AND HOLD THE PLAN SPONSOR HARMLESS FROM AND AGAINST ANY AND ALL CLAIMS, SUITS, LIABILITIES, LOSSES, PENALTIES OR DAMAGES INCLUDING COURT COSTS AND ATTORNEYS' FEES WITH RESPECT TO THE PLAN WHICH DIRECTLY RESULT FROM OR ARISE OUT OF THE DISHONEST, FRAUDULENT, GROSSLY NEGLIGENT OR CRIMINAL ACTS OF THE TPA OR ITS EMPLOYEES, EXCEPT FOR ANY ACTS TAKEN AT THE SPECIFIC DIRECTION OF THE PLAN SPONSOR.

2.11 The Plan Sponsor accepts all legal and financial liability for its own actions or inactions as well as the actions or inactions of its authorized representatives. The Plan Sponsor shall ensure that no such legal or financial liabilities shall be borne by the TPA.

ARTICLE III. THE TPA'S RESPONSIBILITIES

The TPA will provide the following Plan Administrative services for the Plan Sponsor:

3.1 Maintain Plan records based on eligibility information submitted by the Plan Sponsor as to the dates on which a Covered Person's coverage commences and terminates.

Maintain Plan records of Plan coverage applicable to each Covered Person based on information submitted by the Plan Sponsor.

Maintain Plan records regarding payment of Claims, denial of Claims, and Claims pended.

3.2 Administer enrollment of Covered Persons, create and distribute enrollment forms and answer inquiries, create and maintain enrollment records for Covered Persons, and distribute identification cards to the Plan Sponsor in

accordance with Appendix A, the Fee Schedule.

3.3 Process Complete Claims submitted by Covered Persons or Health Care Providers according to the terms of the Plan Document as construed by the Plan Sponsor. These Claims will be processed in accordance with prevailing industry practices and the TPA will use an industry-recognized method of determining usual, customary, and reasonable charges or the prevailing fee allowance as determined by the Plan Sponsor in the Plan.

The TPA will not be required by the Plan Sponsor to alter its standard claims processes, procedures or regular mail dates to manipulate the Paid Claims date for any purpose.

The TPA will process claims received on a basis consistent with prevailing industry practice for timeliness and accuracy, in accordance with the terms of the Plan Document as construed by the Plan Sponsor, and consistent medical information forms, pre-existing conditions requirements, disability determinations and coordination of benefits situations. Unless specifically agreed by the parties in writing, the TPA's duties with respect to subrogation situations shall be limited to informing the Plan Sponsor that subrogation rights may exist. The terms, conditions and fees for any additional agreement regarding subrogation are as stated in the attached Subrogation Services Appendix, if applicable.

The TPA will process Claims or request additional information in order to be able to process a Complete Claim within an average of fourteen (14) Working Days from the date the Complete Claim is received by the TPA.
If additional information is needed for a Complete Claim, the TPA will send through the U.S. Mail to the appropriate persons (with a copy to the Plan Participant) a follow-up request for the required information for a Complete Claim requesting a response to the request for additional information for a Complete Claim within a maximum of forty-five (45) days. The follow-up request will indicate that no additional requests for information will be sent and the file will be closed, and the initial incomplete claim will be denied, if the requested information is not provided within the specified time.

When all necessary documents and Claim information have been received to constitute a Complete Claim and the Complete Claim has been approved, a Claim check or draft will be remitted on the next Paid Claims batch disbursal date provided that the Plan Sponsor has provided funds for such Complete Claims or advance funding has been provided by the Stop Loss or Excess Loss insurance company. All Complete Claims will remain in a processed but pended status until funded by the Plan Sponsor or its Stop Loss or Excess Loss insurance company. The Plan Sponsor must provide funding of all Complete Claims within five (5) Working Days of receipt of request for funding from the TPA.

Customer Service Representatives of the TPA will inform any Plan Participant or Health Care Provider who inquires about any Claim which is pended for lack of funds that such Claim has been received and processed and is pending receipt of funds. No further explanation will be required of the TPA by the Plan Sponsor under such circumstances.

Unless otherwise advised by the Plan Sponsor, the Plan Sponsor agrees that the order of claims payment by TPA of new claims submitted under the Plan shall be based on processing first the oldest claims with complete medical, repricing/discount, and other necessary information with permitted exceptions for those claims identified with excess loss insurance reimbursement potential or which face loss of any available discounts for the medical services so rendered. Any payment by TPA is contingent upon the availability adequate funding by the Plan Sponsor. If the funds provided by the Plan Sponsor are insufficient to pay all adjudicated claims, then, at the specific direction of Plan Sponsor, the funds will be applied to pay claims as noted above to the extent funds are available except that large claims that cannot be funded by the then available funding will be skipped in favor of more recent claims that can be covered with then available funding. Further, all claims for a participant and his or her covered dependents subsequent to the first claim that cannot be funded due to insufficient funding from the Plan Sponsor shall be skipped in favor of more recent claims from other participants and/or their dependents if the Plan Sponsor funding is not sufficient to cover all adjudicated claims for the participant and/or his or her dependent.

3.4 After a preliminary review to determine that the Claim was correctly processed, the TPA will refer any doubtful, disputed or appealed Claims to the Plan Sponsor for a final decision. The TPA will provide initial claims adjudication and assist the Plan Administrator with appeals. The Plan will pay the actual cost of any expert medical consultation required to determine claims eligibility under the Plan as a claims cost.

3.5 Process, issue and distribute Claims checks, drafts or electronic funds transfer, as instructed by the Plan Sponsor to Plan Participants, Health Care Providers, or others as may be applicable.

Every week the TPA will notify the Plan Sponsor of the Claims batch amount required to be prospectively deposited to the Claims Payment Account to pay the Claims liability after these Claims are processed for payment.

The TPA shall establish and maintain customary investigative benefit and Claims review procedures within the prevailing standard of care in the TPA industry. The TPA will notify the Plan Sponsor of the discontinuance of such procedures or any significant or material changes therein. The TPA shall take reasonable measures and precautions to prevent the allowance and payment of improper benefits and Claims. The TPA shall not be liable for fraud by any Health Care Provider or Covered Person or for errors in Claim payment made to Covered Persons or designated assignees in good faith. The TPA shall not be liable for any loss of discount or increase in charges arising from a Claim due to a delay in the payment of a Claim. If a Claim payment error is discovered, the Health Care Provider or Covered Person will be notified and requested to refund payment. In the event that the Covered Person or his/her assignee does not respond to the refund request or refuses payment, the Plan Sponsor will be notified. The Plan Sponsor shall have the right to bring action against any employee or provider of service who does not voluntarily

agree to repay the Plan for payments made in error. The TPA shall not be liable for misrepresentations, inflated charges, omissions, errors or fraud by any Health Care Provider or Covered Person which may result in any ineligible or excessive Claim payments.

3.6 Notify Covered Persons in writing through the U.S. Mail of ineligible Claims received. The computerized Explanation of Benefits form (EOB) shall indicate the general reason why such Claim is ineligible for payment. The EOB shall also contain notice of the written Claims review and appeal procedure in the Plan. This notification will be made within an average of fourteen (14) Working Days of the date the TPA receives the Complete Claim documentation and any Plan interpretations by the Plan Sponsor.

3.7 Respond to Claims inquiries by a Covered Person, the estate of a Covered Person, an authorized member of a Covered Person's family unit, the Covered Person's authorized legal representative or an authorized Health Care Provider.

3.8 Maintain local telephone service and toll-free telephone lines during regular business hours for inquiries made by Covered Persons regarding the status of their Claims. Such telephone lines may be recorded by the TPA.

3.9 Maintain an Internet Inquiry site for Paid Claims, processed claims and related information. Maintain an interactive voice response system and fax back service for the convenience of Covered Persons and Health Care Providers for Claim or coverage inquiries.

3.10 Maintain information that identifies a Covered Person in a confidential manner. The TPA agrees to take all reasonable precautions to prevent disclosure or use of Claims information for a purpose unrelated to the administration of the Plan. TPA shall not be liable for fraud, deceit, misrepresentation or any other false, misleading or erroneous representations made by the Plan Sponsor, any Covered Person, any Health Care Provider or any other person pertaining to any confidential, personal or protected health information or claim request. The TPA will only release non-protected health or Claims information for certificate of need reviews; for medical necessity determinations; to set uniform data standards; to update relative values scales; to use in claims analysis; to further cost containment programs; to verify eligibility; to comply with federal, state or local laws; for coordination of benefits; for subrogation; in response to a civil or criminal action upon issuance of a subpoena, or with the written consent of the Covered Person or his or her legal representative.

3.11 Provide and maintain a specimen Plan Document and Summary Plan Description in a format acceptable to the TPA for review and final approval by the Plan Sponsor and the Plan Sponsor's legal counsel. Upon approval of the Plan Document from the Plan Sponsor, the TPA will forward copies of plan document and amendments, if any, to the Stop Loss or Excess Loss insurance company.

The TPA will furnish a master Summary Plan Description to the Plan Sponsor, either electronically (PDF format), or in printed form, and Summary Plan Description booklets in TPA's format for the fees stated in Appendix A.

The TPA will maintain an electronic Claims file on every Claim reported to it by the Covered Persons. The TPA shall retain such files and all Plan-related information for a period of six (6) years. Copies of such records shall be made available to the Plan Sponsor for inspection during a regularly scheduled Working Day at the office of the TPA for consultation, review and audit upon advance notice of a minimum of fourteen (14) Working Days.

The Plan Sponsor shall pay for any audit made at its request.

In the event this Agreement is terminated, the Plan Sponsor shall have a continuing obligation and liability to pay the TPA for all costs and professional, executive, managerial and clerical time expended by the TPA and its employees for any audit conducted by the Plan Sponsor or its Stop Loss or Excess Loss insurance company, and this obligation and liability shall survive and continue beyond the termination of this Agreement. The Plan Sponsor shall pay an advance retainer to the TPA for any audit assistance at any time the TPA receives notice from the Plan Sponsor or its Stop Loss or Excess Loss insurance company of an audit to be conducted after the termination date of this Agreement. The advance retainer shall be in an amount to be determined by the TPA in estimation of the extra time required for the scope of the audit that is requested. In no event shall the audit retainer fee be less than Two Thousand Five Hundred and no/100 Dollars ($2,500.00). The TPA will not be required by the Plan Sponsor to provide access to its records, nor will any of the TPA's employees provide assistance to any auditor until receipt by the TPA of the required audit retainer fee.

Any audit shall be conducted by an auditor mutually acceptable to the Plan Sponsor and the TPA and the audit shall include, but not necessarily be limited to, producing photocopies of Claims and funding information in the TPA's existing format(s), a review of procedural controls, a review of system controls, a review of Plan provisions, a review of sampled Claims, and comparison of results to TPA industry performances standards or any statistical models previously agreed to by the Plan Sponsor and the TPA in writing.

Nothing in this Agreement, expressed or implied, shall require the TPA disclose any proprietary information, including, but not limited, file layout or record formats of its Claims processing system or procedures. Further, except for those reports and data extracts agreed to separately in writing, nothing in this Agreement, expressed or implied shall require TPA to provide records or information in a format not in use by the TPA, or to create unique information formats solely for the use of the auditor(s), consultant(s), agent(s) or broker(s) for the Plan Sponsor without mutual agreement or without payment of fees at the normal hourly rate changed for such services as noted in Appendix A.

3.12 Upon request of the Plan Sponsor, provide COBRA continuation coverage services through a related corporation, _____ COBRA Services, Inc. (ACSI). A separate fee will be charged for COBRA continuation services, which fee is set out in a COBRA Services Agreement. If the Plan Sponsor does not request COBRA continuation services from

ACSI, all responsibility and liability for administration of COBRA continuation shall remain with the Plan Sponsor, and neither the TPA nor ACSI will have any obligation or responsibility for providing such services or consultation regarding such services.

3.13 Provide the following reports:

(a) monthly summary of benefits paid analysis by type of Claim and total dollar amounts;
(b) monthly check register;
(c) monthly cumulative aggregate deductible to paid Claims report;
(d) annual summary management report within sixty (60) days after the close of the Plan Year;
(e) annual loss analysis report; and
(f) special reports requested by the Plan Sponsor which the TPA agrees to produce, and subject to a fee addressed in Appendix A.

3.15 If applicable:

(a) Notify the Stop Loss or Excess Loss insurance company of any potential large Claims, which may become a Claim under the Stop Loss or Excess Loss coverage.
(b) On behalf of the Plan Sponsor, the TPA will file with the insurance company or its designee any Complete Claims for consideration for reimbursement under the Stop Loss or Excess Loss policies.
(c) Promptly forward to the Plan Sponsor any premium, claim reimbursement, Stop Loss or Excess Loss or other notices received from the Stop Loss or Excess Loss insurance carrier concerning the policy.

3.16 If applicable, conduct utilization review for the Plan, including pre-certification of hospital stays, concurrent review of hospital stays, discharge planning, preliminary review for potential hospital bill audits, large case management or any other managed care programs as agreed to between the Plan Sponsor and the TPA. A separate fee will be charged for these services as stated in Appendix A.

3.17 Maintain working relationships with networks of Health Care Providers through Preferred Provider Organizations (PPO) contracted by the Plan Sponsor or arranged by the TPA. The TPA shall be entitled to rely upon any and all representations made by Health Care Providers/PPO regarding their qualifications as Health Care Providers, and shall have no obligation or liability to obtain, verify or monitor such qualifications or credentials.

If applicable, a separate fee will be charged for PPO network services, TPA coordination and system maintenance for PPO networks, as stated in Fee Schedule, Appendix A.

The TPA will not be responsible for any services provided (or any failure to provide services) by a participating PPO or Health Care Providers and specifically makes no representation, warranty or guarantee whatsoever regarding any such PPO, Health Care Providers, or their representations, qualifications or credentials.

3.18 If checked as an included service in Appendix A, the TPA will provide coordination of services for wellness and health assessment through a third party vendor, Behavioral Health Care Options, Inc.

3.19 Provide, within thirty (30) days after termination of this Agreement, a summary paid Claim report of all Claims paid twenty-four (24) months prior to the date of termination, copies of any governmental reports, and other plan documentation to the Plan Sponsor. Until that time, these records will be maintained at the TPA's principal administrative office. Claim files will be kept in secure storage facilities or electronic media for at least six (6) years following the termination of the Plan Year. Copies of any materials in storage will be available to the Plan Sponsor for a copy fee of fifteen ($.15) cents per page copied plus a retrieval fee of Ten Dollars ($10.00) per box or electronic media access. At the end of the six (6) year period or termination of this Agreement, if earlier, the TPA shall notify the Plan Sponsor that these records will be destroyed.

Upon termination of this Agreement, provide all notices and documents to the Plan Sponsor and to the Texas Department of Insurance as are required under Applicable Texas statutes and regulations.

3.20 Provide Certificates of Creditable Coverage and other Creditable Coverage services as required by HIPAA for employees of the Plan Sponsor and their eligible dependents.

3.21 Provide Medicare, MSP, and §111 reporting services.

3.22 Provide non-proprietary information and documents as requested by the Plan Sponsor to representatives designated by the Plan Sponsor. However, if the Plan Sponsor has entered into an agreement with any new representative, and the TPA has notice of the same, the TPA shall not be required to provide any information or documentation to other representatives unless or until the Plan Sponsor has terminated the original representative agreement and notified the original representative of the termination. The TPA shall have the express right to contact any representative to verify the representative agreement has been terminated. A separate fee will be charged for this service as stated in Appendix A.

3.23 For Plan Sponsors which have designated subsidiaries, divisions, or which are a Multiple Employer Welfare Arrangement (MEWA): when any designated subsidiary, division or member employer of a MEWA terminates coverage under the plan that is the subject of this Agreement, the TPA will automatically perform run-out services for a period of three (3) months after the date of such termination for such designated subsidiary, division or member employer, unless directed not to do so by the Plan Sponsor in writing. The fee for each month of run-out services will be equal to the claims processing fee(s) stated in Appendix A, based upon the designated subsidiary's, division's or MEWA member employer's number of enrolled Plan Participants for the month immediately prior to the date of termination of coverage. Plan Sponsor will also pay the TPA run-out services fees for any enrolled Plan Participants who were laid-off or otherwise terminated from the rolls of the Plan during the term of this Agreement if the total number of such laid-off or terminated Plan Participants exceeds five (5%) percent of

the total number of enrolled Plan Participants during the first month of this Agreement. Final reconciliation of run-out services fees will be made within ninety (90) days of the end of this Agreement.

3.24 Fees for the services described in Article III are set out in Appendix A hereto. Such fees are fixed for the initial term of this Agreement except that upon sixty (60) days prior notice to Plan Sponsor, the fees are subject to change under the following conditions:

(a) if the Plan Sponsor's census of enrolled employees increases or decreases by more than ten (10%) percent from the number of employees that were enrolled on the commence of this Agreement;
(b) if the Plan Sponsor significantly alters the design or complexity of its health benefit plan; or
(c) regularly requesting and obtaining extra-contractual services from the TPA.

3.25 The TPA will comply with the applicable laws and rules for the storage, transmission and release of any "protected health information" (used herein as such defined in HIPAA). Notwithstanding any other provision of this Agreement, the TPA shall not be required to do any act which in its judgment violates the HIPAA Administrative Simplification or Hi Tech Security rules.

3.26 The TPA will provide consolidated billing services if checked as an included service in Appendix A. Specifically, the TPA will bill fees and premiums for other employee benefits including, but not limited to, group life, group AD&D and/or group short term and long term disability to the Plan Sponsor, and will remit the premium collected to the applicable carrier.

ARTICLE IV: THE PLAN SPONSOR'S RESPONSIBILITIES

The Plan Sponsor or Employer will:

4.1 Establish the Plan together with a framework of policies, interpretations and rules, which shall be the basis for the TPA's performance of its duties under this Agreement.

Maintain current and accurate Plan eligibility and coverage records, verify Covered Person eligibility and submit eligibility and coverage information monthly, or more often if requested by the TPA, to the TPA at its designated electronic or postal address.

This information shall be provided in a format acceptable to the TPA and shall include the following for each Covered Person: name and address, Social Security number, date of birth, type of coverage, sex, relationship to employee, changes in coverage, date coverage begins or ends, and any other information as necessary to determine eligibility and coverage under the Plan.

The Plan Sponsor assumes the responsibility for and will hold the TPA harmless from the erroneous disbursement of benefits by the TPA in the event of error or neglect by the Plan Sponsor or Employer in providing eligibility and coverage information to the TPA, including, but not limited to, failure to give timely notification if ineligibility or termination of a former Covered Person, or fraudulent enrollment and/or continuation of coverage.

4.2 The TPA shall make recommendations regarding Claims determinations. The Sponsor shall have the sole authority to resolve all Plan ambiguities and interpretations, questions and disputes relating to the Plan eligibility of a Covered Person, Plan coverage and denied Claims.

The Plan Sponsor shall have the sole authority to make determinations regarding appeal of denied Claims. The Plan Sponsor will respond to any written request for information made by the TPA within ten (10) Working Days of receipt of the request.

Resolve all Plan ambiguities, questions and disputes relating to the Plan eligibility of a Covered Person, Plan coverage, denial of Claims or decisions regarding appeal or denial of Claims, or any other Plan interpretation questions. The Plan Sponsor will respond to any written request made by the TPA within ten (10) Working Days of receipt of the request.

The TPA will administer and process Claims in accordance with Article III if the Plan Document and Summary Plan description are clear and unambiguous as to the validity of the Claims and the Covered Person's eligibility for coverage under the Plan. The TPA will have no discretionary authority to interpret the Plan or adjudicate Claims. If processing a benefit Claim requires interpretation of ambiguous Plan language, and the Plan Sponsor has not previously indicated to the TPA the proper interpretation of the language, then the Plan Sponsor will be responsible for resolving the ambiguity or any other dispute.

In any event, the TPA shall rely upon the Plan Sponsor's decision as to any Claim (whether or not it involves a Plan ambiguity or other dispute) and such decision by the Plan Sponsor shall be final and binding unless modified or reversed by a court or regulatory agency having jurisdiction over such Claim matter.

4.3 Fully fund the Claims Payment Account every week based upon the Claims batch report provided by the TPA.

4.4 Set funding levels for the Plan at a minimum level necessary to cover the expected Claims costs, administrative expenses and incurred but not reported Claims liability and fund the Plan at such level.

4.5 Not request or require the TPA, under any circumstances, to issue Claims drafts for Claims, stop loss or excess loss insurance premiums, or any other costs arising out of the subject matter of this Agreement, unless the Plan Sponsor has so authorized and has previously deposited sufficient funds to cover such Complete Claims or other Plan expense obligations and payment(s).

4.6 Provide the TPA with copies of any and all revisions or changes to the Plan at least five (5) Working Days prior to the effective date of the changes. Failure to provide timely notice may result in additional claims processing fees as set forth in Appendix A.

4.7 Provide, and timely distribute, all notices and information required to be given to Covered Persons, including Summary Annual Reports. Maintain and operate the Plan in accordance with applicable law. Maintain all recordkeeping and file all forms relative thereto pursuant to any federal, state or local law, unless this Agreement specifically assigns such duties to the TPA.

4.8 Acknowledge that it is the Plan Sponsor, Plan Administrator, and Named Fiduciary. As such, the Plan Sponsor retains full discretionary control and authority and discretionary responsibility in the operation and administration of the Plan.

4.9 Pay any taxes, assessments for fees arising solely out of the operations of the Plan or the services provided under this Agreement that are levied against the Plan or against the TPA by any governmental entity whether federal, state or local, or any political subdivisions or instrumentality thereof. Taxes based on TPA's net income or licenses TPA is required to maintain to provide the services under this Agreement shall be the sole responsibility of TPA.

4.10 The Plan Sponsor understands and agrees that the TPA and its affiliates are not obligated to share proprietary and confidential information. Nevertheless, in the event TPA or its affiliates agree to provide proprietary and confidential information, the Plan Sponsor understands and acknowledges that that TPA or its affiliate will assert, in a brief to the Texas Attorney General, that the proprietary an confidential information would be exempt from public disclosure under the Texas Public Information Act codified at Chapter 552 of the Texas Government Code, and that such information should not be released to a requestor under the Texas Public Information Act without the prior written consent of the TPA or its affiliate. The Plan Sponsor hereby agrees to notify the TPA, in writing, within ten (10) business days of Plan Sponsor's receipt of any such public information request for the proprietary and confidential information. Failure to provide such notice to the TPA shall constitute a material breach of this Agreement

4.11 Pay, in accordance with the Fee Schedule, Appendix A, the TPA's fees for services rendered under this Agreement. The TPA is expressly directed by the Plan Sponsor to pay any excess loss insurance premiums (where applicable), fee, cost or charge then due to the TPA prior to application of funds to payment of Claims or any other costs arising out of the Plan or subject matter of this Agreement. The Plan Sponsor specifically directs that all funds provided to TPA under this Agreement will be disbursed in the following order: First to pay excess loss insurance premiums where applicable, claims administration fees, costs and related expenses incurred by TPA and second, to pay benefit claims arising under the Plan.

4.12 Maintain any fidelity bond or other insurance as may be requested by state or federal law for the protection of the Plan and Covered Persons.

4.13 Notify the TPA if the Plan Sponsor ceases to maintain Stop Loss or Excess Loss insurance with an admitted insurance company in the amount set forth in the Fee Schedule, Appendix A.

4.14 Promptly notify the TPA of any termination notice, expiration lapse, or modification of Stop Loss or Excess Loss insurance, life insurance, disability insurance, conversion insurance or any other insurance purchased in conjunction with the Plan.

4.15 Ensure that there is adequate release and authorization from each participant and/or beneficiary under the Plan permitting Health Care Providers to share with TPA and TPA to share with Health Care Providers and other service providers to the Plan any and all information, whether protected or individually identifiable, which may be necessary to perform the services anticipated by this Agreement and any Appendices hereto. TPA may in its sole discretion, require participants and/or beneficiaries of the Plan to execute additional releases and authorizations for the use and disclosure of such information. TPA may refuse to release protected or other individually identifiable health care information to Plan Sponsor, its agents and designees if such authorizations and/or releases are not provided.

4.16 Have the sole responsibility for reporting and disclosure, including but not limited to plan documents, summary plan descriptions, summaries of material modifications, participant communications, pre-retirement counseling to participants, bonding filings or other compliance required of, by or for the Plan, their participants and beneficiaries, or the Plan Sponsor by ERISA, the Internal Revenue Code, or any other related and/or applicable federal, state or local laws, rules or regulations.

4.17 Shall be solely responsible for paying all fees, expenses, or costs attributable to any legal action or proceeding brought to recover a claim for benefits under the Plan. TPA shall, however, make available to the Plan Sponsor and its counsel, such evidence which relates to or is relevant to such action or proceeding as TPA may have as a result of the performance of the services set forth in this Agreement. TPA shall promptly notify the Plan Sponsor in writing of any legal actions of which it becomes aware that involve the Plan or the Plan Sponsor. The TPA will be responsible for its own attorney's fees and costs but only to the extent that the TPA is found to be liable for such fees and costs.

4.18 Provide timely, accurate and complete information required by TPA to provide the services that TPA has agreed to perform under this Agreement. TPA shall have the right to rely on such information. Such information shall include but not be limited to all necessary eligibility enrollment and participant data; and copies of all governing documents of the Plan and any amendments thereto, including any written policies, interpretations, rules, practices or procedure concerning same. Such information shall be provided upon execution of this Agreement and immediately following modification or amendment. TPA shall have the right to assume that all such information is accurate and complete and TPA shall be under no duty to question such information. Plan Sponsor shall reimburse TPA at its standard hourly rates for TPA's costs incurred for efforts expended to remedy data or information inaccuracies as were provide by the Plan Sponsor.

ARTICLE V: DURATION OF AGREEMENT

5.1 This Agreement shall commence and end on the dates first written above, unless terminated earlier in accordance with this Article. This Agreement shall automatically renew for a maximum of ____ additional 12 month periods (November 1, 20__ through October 30, 20___ and November 1, 20___ through October 31, 20___) upon the terms and for these stated in the Fee Appendix hereto, unless terminated as otherwise stated in this Article.

5.2 At any time during the term of this Agreement, either the Plan Sponsor or the TPA may amend or change the provisions of this Agreement. These amendments or changes must be agreed upon in advance in writing by both the Plan Sponsor and the TPA. If any such amendment increases the anticipated Claims experience under the Plan or the TPA's cost of administering the Plan, the Plan Sponsor agrees to pay any increase in Claims expenses, as well as increases in administrative fees or other costs which the TPA reasonably expects to incur as a result of such modification.

Any amendment which affects only the Fee Schedule, Appendix A, may be made, in writing, signed by all parties, and without other formal amendment of this Agreement. All fee quotes accepted by the Plan Sponsor for renewals of this Agreement will be incorporated into this Agreement as amendments to the Fee Schedule, Appendix A.

5.3 Plan Sponsor may terminate this Agreement for convenience and without cause or further liability upon sixty (60) days written notice to TPA. In the event of such termination for convenience by Plan Sponsor, it is understood and agreed that only the amounts due to TPA for services provided and expenses incurred to and including the date of termination; and fees and liquidated damages set forth under this Article V, will be due and payable.

5.4 The TPA may, at its sole option, terminate this Agreement with thirty (30) days written notice upon the occurrence of any one or more of the following events pertaining to the Plan Sponsor:

(a) The Plan Sponsor fails to fund the Claims Payment account;
(b) The Plan Sponsor fails to pay administration fees or other fees for the TPA's services upon presentation for payment and in accordance with the Fee Schedule, Appendix A;
(c) The Plan Sponsor fails to comply with any federal, state or other government statute, rule or regulation;
(d) The Plan Sponsor, through its acts, practices, or operations, exposes the TPA to any existing or potential investigation or litigation.
(e) The Plan Sponsor permits its stop loss or excess loss insurance to lapse, whether by failure to pay premiums or otherwise;
(f) The Plan Sponsor loses its licensure or certification, if required by law, to continue the Plan;
(g) Insolvency of the Plan;
(h) Court appointment of a permanent receiver for substantially all of the Plan Sponsor's assets;
(i) A general assignment for the benefit of creditors by the Plan Sponsor; or
(j) The filing of a voluntary or involuntary petition of bankruptcy, if such petition is not dismissed within forty-five (45) days of the date of filing, provided that an order for relief from automatic stay has been obtained, or with respect to a Chapter 11 proceeding, that the bankrupt or Bankruptcy Trustee fails to reaffirm this Agreement and provide adequate assurances pursuant to 11 USC 365.

During the thirty-day notice period TPA's obligations under this Agreement and any performance guarantees related thereto shall be suspended.

5.5 The Plan Sponsor may, at its option, terminate this Agreement with thirty (30) days written notice upon the occurrence of any one or more of the following events pertaining to the TPA:

(a) Court appointment of a permanent receiver for all or substantially all of the TPA's assets;
(b) A general assignment for the benefit of creditors by the TPA;
(c) The filing of a voluntary or involuntary petition of bankruptcy, if such petition is not dismissed within forty-five (45) days of the date of filing, provided that an order for relief from automatic stay has been obtained, or with respect to a Chapter 11 proceeding, that the bankrupt or Bankruptcy Trustee fails to reaffirm this Agreement and provide adequate assurances pursuant to 11 USC 365;
(d) The TPA loses its licensure or certification required by law to continue its business or continue as third party administrator; or
(e) The TPA fails to comply with any federal, state or other governmental statute, rule or regulations.
(f) The TPA, through its acts, practices, or operations, exposes the TPA to any existing or potential investigation or litigation.

During the thirty-day notice period TPA's obligations under this Agreement and any performance guarantees related thereto shall be suspended.

5.6 At the written request of the Plan Sponsor and subject to the Plan Sponsor's continuing obligation to fund the Claims Payment Account, and to timely pay any outstanding amounts due and payable to the TPA under the terms of this Agreement, the TPA may, at its sole discretion, agree to process incurred but not reported Claims after the termination of this Agreement (Run-Out Services). The written request of the Plan Sponsor must be received simultaneously with the notice of termination required by subsection 5.3 of this Agreement. Such agreement (Run-Out Services Agreement), if any, shall be in writing and a separate fee will be charged for this service. TPA will not refuse to provide Run-out Services except if the Plan Sponsor has materially breached this Agreement, the Plan Sponsor terminates this Agreement without proper notice, or if this Agreement is terminated as a result of any of the events set out in paragraphs 5.4 or 5.5 of this Agreement. Additionally, if the Plan Sponsor terminates this agreement early, there shall be additional fees for run out services as stated in Appendix A hereto.

5.7 If this Agreement terminates for any reason and no Run-Out Service Agreement is requested, or if the TPA declines to

provide Run-Out Services, the TPA shall have no obligation to:

(a) Complete the processing of any claim requests that were pending or otherwise not Complete Claims or complete the processing of any Complete Claims if the Plan Sponsor has failed to provide funds for the payments of any benefits due;
(b) Accept or process requests for claim payments presented to it after termination of this Agreement irrespective of when such claim was incurred;
(c) Issue claims checks after the termination date of this Agreement for any request for claims payments relative to conditions existing before, on or after such a date.
(d) Provide ongoing customer service to Plan Participants or Health Care Providers; or
(e) Perform any other task or requirement of this Agreement, except for those requirements that specifically survive termination of this Agreement.

5.8 If the Plan Sponsor terminates this Agreement on or before the expressed expiration date of this Agreement, but after such termination date becomes entitled to any reimbursement(s) pursuant to the provisions of the Plan Sponsor's Stop Loss or Excess Loss insurance policy aggregate or specific loss reimbursement provisions, and no separate Run-Out Services Agreement is executed, the Plan Sponsor shall pay to the TPA an hourly fee of One Hundred and no/100 Dollars ($100.00) per hour for all services rendered by the TPA after termination of this Agreement regarding such reimbursement(s) request made to or claims paid by a Stop Loss or Excess Loss insurance company.

5.9 In the event this Agreement is terminated for any reason and Plan Sponsor cannot be located following reasonable efforts by TPA, TPA shall charge a $50.00 per check administrative charge for its efforts to return any stale dated funds (defined as a check with an original issue date greater than 180 days) belonging to Plan Sponsor or belonging to a plan participant who, likewise, cannot be located. The administrative charge may be paid from any funds of the Plan Sponsor held by TPA, or billed directly to the Plan Sponsor. This provision shall survive termination of this Agreement.

5.10 The Plan Sponsor specifically acknowledges that the TPA incurs ongoing costs for staffing, long term planning, maintenance of customer service support and other costs connected with providing services to Plan Sponsor's Plan, and that the notice of termination and terminate date provisions of this Agreement provide adequate notice to the TPA so that unnecessary costs are not incurred by the TPA if the Plan Sponsor terminates this Agreement. In that regard, it is specifically agreed by the Plan Sponsor that in the event that the Plan Sponsor either fails to provide the advance notice for termination required by this Agreement, or terminates this Agreement other than on its express expiration date, the Plan Sponsor shall pay to the TPA a fee equal to two times the amount of Plan Sponsor's administrative fees payable to the TPA for the month immediately prior to the date notice of termination is received. The amount payable under this provision shall be as liquidated damages incurred by the TPA for the costs recited in this subsection, in lieu of specific calculation of the same, and not as a penalty. The liquidated damages will be in addition to any other fees required under this Agreement or any subsequent Run-Out Services Agreement between the parties.

ARTICLE VI: MISCELLANEOUS

6.1 This Agreement, together with all addenda, exhibits and appendices, supersedes any and all prior representations, conditions, warranties, understandings, proposals or other agreements between the Plan Sponsor and the TPA hereto, oral or written, in relation to the services and systems of the TPA, which are rendered or are to be rendered in connection with its assistance to the Plan Sponsor in the administration of the Plan.

6.2 This Agreement, together with the aforesaid addenda, exhibits, and appendices, constitutes the entire Administrative Services Agreement of whatsoever kind or nature existing between or among the parties.

6.3 The parties hereto, having read and understood this entire Agreement, acknowledge and agree that there are no other representations, conditions, promises, agreements, understandings or warranties that exist outside this Agreement which have been made by either of the parties hereto, which have induced either party or have led to the execution of this Agreement by either party. Any statements, proposals, representations, conditions, warranties, understandings or agreements which may have been heretofore made by either of the parties hereto, and which are not expressly contained or incorporated by reference herein, are void and of no effect.

6.4 Except as provided in Article V, no changes in or additions to this Agreement shall be recognized unless and until made in writing and signed by all parties hereto.

6.5 In the event any provision of this Agreement is held to be invalid, illegal or unenforceable for any reason and in any respect, such invalidity, illegality or unenforceability shall in no event affect, prejudice or disturb the validity of the remainder of this Agreement, which shall remain in accordance with its terms.

6.6 The parties hereto will each notify the other, within ten (10) Working Days of any inquiry made by any Covered Person or authorized representative of any Covered Person related to Plan Documents, Plan Records, Claims, Claims Appeals, Claims Disputes, threatened litigation, lawsuits pertaining to the Plan or any inquiry made by federal or state authority regarding the Plan.

6.7 In the event that either party is unable to perform any of its obligations under this Agreement because of natural disaster, fire, flood, wind storm, power outage, labor unrest, civil disobedience, acts of war (declared or undeclared), or actions or decrees of governmental bodies or any event which is referred to as a "Force Majeure Event", the party who has been so affected shall immediately notify the other party and shall do everything possible to resume performance.

Upon receipt of such notice, all obligations under this Agreement shall be immediately suspended. If the period of non-performance exceeds fourteen (14) Working Days from the receipt of notice of the Force Majeure Event, the party

whose ability to perform has not been so affected may terminate this Agreement by giving thirty (30) calendar days' written notice.

6.8 All notices required to be given to either party by this Agreement shall, unless otherwise specified in writing, be deemed to have been given three (3) days after deposit in the U.S. Mail, first class postage prepaid, certified mail, return receipt requested.

Any official notice to the TPA will be mailed to the attention of: _____, _____, _____, __ _____.

Any official notice to the Plan Sponsor will be mailed to the attention of:

Lisa Zirkle
Sr. Director of Human Resources
Williamson County
301 SE Inner Loop, Suite 108
Georgetown, TX 78626

6.9 The TPA has adopted an Affirmative Action Policy which is in compliance with §_____, _____ Code Annotated.

Employees hired by the TPA are hired on the basis of merit and qualifications, and there is no discrimination on the basis of race, color, religious creed, political ideas, sex, age, marital status, physical handicap, national origin or ancestry by persons performing this Agreement. Qualifications mean such abilities as are genuinely related to competent performance of the particular occupational task.

6.10 This Agreement shall be interpreted and construed in accordance with the laws of the state of Texas except to the extent superseded by federal law. Any litigation related to the interpretation or performance of this agreement shall be conducted in a Texas state or federal court with jurisdiction, in Williamson County, Texas.

6.11 The parties agree to use and disclose protected health information about a Covered Person in accordance with the terms of a separately provided Business Associate Agreement.

6.12 The TPA shall comply with the _____ Workers' Compensation Act while performing its obligations under this Agreement in accordance with §§_____, _____ Code Annotated. Proof of compliance shall be in the form of workers' compensation insurance, an independent contractor's exemption or documentation of corporate officer status. Such insurance/exemption shall be valid and in force for the duration of this Agreement. The TPA shall also comply with the worker's compensation laws or other similar laws of any other state that may apply.

6.13 The TPA may enter into arrangements with a Health Care Provider or group of Health Care Providers to obtain discounts in charges for Covered Services. TPA makes no representations that such discounts will continue for any period of time or will apply in any particular factual context. In no event will TPA be responsible for the loss of any such discounts except in the sole event that such loss is directly cause by commissions or omissions of TPA which constitute gross negligence.

6.14 No forbearance or neglect on the part of either party to enforce or insist upon any of the provisions of this Agreement shall be construed as a waiver, alteration or modification of the Agreement.

6.15 Should TPA's performance of its duties under this Agreement be made materially more burdensome or expensive due to an increase in US Postal Service rates or due to a change in federal, state or local laws or imposition of fees there under, any such additional fees shall be paid by Plan Sponsor. The TPA will notify the City and get their approval before any increase in fees associated with this section.

6.16 The TPA and the Plan Sponsor specifically state, acknowledge and agree that it is their intent that no other parties including, but not limited to, all persons eligible for benefits under the Plan, all covered employees, and their assignees shall be third party beneficiaries of this Agreement. The parties further agree that nothing herein shall be deemed to impose on the TPA any obligation to any other party including, but not limited to, all persons eligible for benefits under the Plan, all covered employees, and their assignees.

6.17 The Plan Sponsor acknowledges that the TPA shall have no responsibility or liability for any fines or penalties assessed the Internal Revenue Service as a result of the issuance of annual 1099 forms to medical service providers so long as the TPA has issued the 1099 to the same name, address and TIN as billed by the medical services provider at the point of claim submission.

6.18 The obligations of the Plan Sponsor under this Agreement do not constitute a general obligation or indebtedness of Plan Sponsor for which Plan Sponsor is obligated to levy, pledge, or collect any form of taxation. It is understood and agreed that Plan Sponsor shall have the right to terminate this Agreement at the end of any fiscal year if the governing body of Plan Sponsor does not appropriate sufficient funds as determined by Plan Sponsor's budget for the fiscal year in question. Plan Sponsor may effect such termination by giving written notice of termination at the end of its then-current fiscal year.

6.19 Plan Sponsor's payment for goods and services shall be governed by chapter 2251 of the Texas Government Code. Invoices shall be paid by plan sponsor within thirty (30) days from the date of the Williamson County Auditor's receipt of an invoice. Interest charges for any late payments shall be paid by Plan Sponsor in accordance with Texas Government Code Section 2251.025. More specifically, the rate of interest that shall accrue on a late payment is the rate in effect on September 1 of Plan Sponsor's fiscal year in which the payment becomes due. The said rate in effect on September 1 shall be equal to the sum of one percent (1%) and (2) the prime rate published in the Wall Street Journal on the first day of July of the preceding fiscal year that does not fall on a Saturday or Sunday. In the event that a discrepancy arises in relation to an invoice, such as an incorrect amount on an invoice or a lack of documentation that is required to be attached to an invoice to evidence the amount claimed to be due, Plan Sponsor shall notify TPA of the discrepancy. Following Plan Sponsor's notification of any discrepancy as

to an invoice, TPA must resolve the discrepancy and resubmit a corrected or revised invoice, which includes all required support documentation, to the Williamson County Auditor. Plan Sponsor shall pay the invoice within thirty (30) days from the date of the Williamson County Auditor's receipt of the corrected or revised invoice. Plan Sponsor's payment of any invoice that contains a discrepancy shall not be considered late, nor shall any interest begin to accrue until the thirty-first (31st) day following the Williamson County Auditor's receipt of the corrected or revised invoice.

IN WITNESS WHEREOF, the parties have caused this Agreement to be executed on their behalf by their duly authorized representatives' signatures, effective as of the date first written above.

WILLIAMSON COUNTY, TEXAS **_____**

By: _____ (Name/Title)

By: _____ (Signature)

Date: _____

By: _____ (Name/Title)

By: _____ (Signature)

Date: _____

APPENDIX A

FEE SCHEDULE AND FINANCIAL ARRANGEMENT

I
Fee Schedule

The Plan Sponsor and the TPA hereby agree to the compensation schedules set forth below as being the sole compensation to the TPA for the performance of its obligations under this Agreement. Monthly fees are based upon Plan Participant enrollment as of the beginning of each month. Except as otherwise provided in this Agreement, the fees of the TPA stated in this Fee Schedule are guaranteed for the initial ____ year term of this Agreement (November 1, 2012 through October 31, 20__). This Agreement may be renewed after the initial term for a maximum of ___ successive 12 month periods. For each such 12 month renewal period, TPA's fees stated below will increase ____% for each 12 month period.

A. Administration fee of $_____ per Plan Participant per month, which fee shall include services for production and maintenance of Plan Documents/Summary Plan Description, plan building, amendment production, plan document compliance, and HIPAA compliance, ERISA compliance (if applicable) and production and mailing via bulk mail to the Plan Sponsor of health plan identification cards, and all of the following services that are checked:

____ Medical Claims
____ Dental Claims
____ Vision Claims
____ Consolidated Billing
____ PPO Management and Provider Network Coordination
____ Predictive Modeling Services
____ Behavioral Healthcare Options
____ World Doc online wellness program
____ On-line Wellness/health risk assessment program
___ COBRA services and HIPAA Certificates of Creditable Coverage, provided by _____ COBRA Services, Inc. pursuant to the COBRA Administrative Services and Certification of Creditable Coverage Agreement attached hereto. (In addition to this fee, the TPA will also retain two (2) percent of all COBRA premiums as fees for COBRA services.)
____ pre-certification, outpatient surgery pre-treatment review, continued stay review, concurrent utilization review, or coordination of large case management referrals.
___ any administrative fees charged by the Pharmacy Benefit Management (PBM) company that is utilized by the Plan pursuant to written agreement with the Plan, the PBM and the TPA. Certain drug manufacturers may have rebate agreements for certain drugs with the PBM. Rebates from drug manufacturers are not guaranteed to the PBM and may be subject to change during the term of this Agreement. Rebates received by the TPA, if any, from the PBM under any master contract between the TPA and the PBM that is accessed by the Plan or Plan Sponsor pursuant to this Agreement will be allocated on a prorated basis to all participating Plans under such PBM agreement with the TPA. In addition to the Administration Fee stated above, rebates equal to $_____ per Plan Participant per month for the period covered by the rebate will be retained by the TPA to offset costs and expenses incurred by the TPA for regular eligibility maintenance, file maintenance, ID card production, reporting customer service assistance and other services performed by the TPA in connection with the PBM agreement for and on behalf of the participating Plan, provided, however, that if the Plan's pro rata share of the rebate, in total, is insufficient to equal $____per Plan Participant per month for the period covered by the rebate, the TPA will accept the amount of the rebate as full payment for these services.

Distribution of plan materials will be delivered to the Plan Sponsor. An additional postage and handling fee will be paid to the TPA for mailing materials to individual Plan Participants.

In the event that the Plan Sponsor terminates this agreement early, the Run Out fees shall be $_____ per Plan Participant per month of Run Out Services.

B. A onetime fee of $_____ for plan set up and programming.

C. Hourly fee of $_____ for welfare plan consulting. Such services must be agreed to in advance by the Plan Sponsor.

D. Hourly fee of $_____ for stop-loss reimbursement services, audit assistance services and any other services provided by the TPA after termination of this Agreement and in the absence of a separate Run-Out Services Agreement.

E. Hourly fee of $_____ for special programming requests or research including production of any special claims history reports. Such services must be agreed to in advance by the Plan Sponsor.

F. Special Reports requested by the Plan Sponsor and produced by the TPA upon prior agreement as to report(s) and fee(s).

G. A fee of $_____ per employee per month for Large Case Management.

H. Final fee of $_____ for forwarding magnet diskette of eligibility/enrollment file in DBC or ASCII format to the Plan Sponsor (if requested).

I. Final fee of $_____ for forwarding magnetic diskette of Claims history file in DBC or ASCII format to the Plan Sponsor (if requested).

J. Check customization, customized printed material, special statistical reports other than those enumerated in this contract, special medical underwriting, new taxes assessed against the Plan, or other services mutually agreed upon will be billed separately at the rate of $_____ per hour for such services. Such services must be agreed to in advance by the Plan Sponsor.

K. The TPA will furnish a master Summary Plan Description to the Plan Sponsor either electronically (PDF format), or in printed form and will provide printed SPDs for a fee equal to the actual costs for printing a Summary Plan Description Booklet, together with costs of shipping for each booklet.

L. A fee of $_____ per hour for time expended producing and providing information in addition to those reports and/or data extracts mutually agreed upon to representatives for whom the Plan Sponsor requests Plan information be provided, together with any postage, shipping and copying costs. Paper copies will be billed at _____ per copy and electronic copies shall be billed at $_____ per disk in DBC or ASCII format only.

M. PPO access fees for any PPO organization or claim negotiation company that assesses a per Plan Participant fee, a per Claim fee, or a percentage of claims savings fees not to exceed _____ percent of the actual savings amount between the charges billed by the Health Care Provider and the discounted amount agreed to between the PPO or Claims Negotiation Company and the Health Care Provider. The amount charged under this Agreement shall be equal to the amount charged by the PPO or Claims Negotiation Company. The TPA, its parents or its affiliates, may be paid a service fee by the PPO for claim repricing or other administrative services associated with the claims discount or negotiation. The Plan Sponsor will receive a report that outlines the total billed charges, the total discounts obtained, the net claims cost and the total claim savings to the Plan. Any additional fee in excess of this amount must be approved in advance by the Plan Sponsor. The TPA may be paid a fee not to exceed _____ percent of net savings payable to TPA, its parent or its affiliates, realized as a result of any negotiation or reduction in the amount of claims paid or any recovered funds obtained by TPA

through employment of cost containment companies. Specific fees at the inception of this contract for which a per Participant per month rate is charged are:

$_____ per Plan Participant per month for _____.

N. Funds held in accounts by TPA, until paid out for benefits, may accrue interest. The interest accrued will be retained by TPA as reasonable compensation and fees for fees assessed on the accounts, for paper, printing and postage, record keeping and account reconciliation, bank service fees, trust tax return preparation; and SAS 70 and related trust activities audit fees.

II

Funding and Fee Payment Terms

_____, will establish and maintain a zero balance Claims Payment Account for payment and reimbursement of Covered Services.

TPA will notify Plan Sponsor or its designee on a weekly basis of amount required to be deposited to the Claims Payment Account to pay claims after they have been processed for payment. Notification of the amount required to be deposited will take place as follows:

On Monday of each week (Tuesday, if Monday coincides with a recognized Federal holiday), an electronic notification will be provided to Plan Sponsor that the weekly report of claims processed for payment is available on TPA's secured website.

Upon approval from Plan Sponsor, TPA will affect an electronic withdrawal of funds from an account designated by Plan Sponsor on a Debit Authorization form, a copy of which is attached.

TPA will generate a monthly bill for fees. Payment of monthly billing will be as follows:

On or about the _____of each month, TPA will provide an electronic notification to Plan Sponsor that the monthly bill is available on TPA's secured website.

Upon approval from Plan Sponsor, TPA will affect an electronic withdrawal of funds from an account designated by Plan Sponsor on the Debit Authorization Form.