



WILLIAMSON COUNTY
PURCHASING DEPARTMENT
901 S. Austin Ave.
GEORGETOWN, TEXAS 78626

<http://wilco-online.org/es/s.aspx>

REQUEST FOR PROPOSAL (RFP)

HEALTH RELATED SERVICES FOR WILLIAMSON COUNTY EMPLOYMENT BENEFIT ADMINISTRATION

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

PROPOSAL NUMBER: 15RFP101

PROPOSALS MUST BE RECEIVED ON OR BEFORE: February 25, 2014 – 2:00 PM

PROPOSALS WILL BE PUBLICLY OPENED: February 25, 2014 – 2:00 PM

**NON-MANDATORY PRE-PROPOSAL CONFERENCE: Tuesday, February 11, 2014
AT 1:30PM**

**At the Williamson County Human Resources Department Training Room, 301
SE Inner Loop, Suite 108, Georgetown, Texas 78626. Respondents interested
in attending the meeting via phone conference, please RSVP by sending an
email to Khancock@wilco.org by 5pm on Friday, February 7, 2014.**

PROPOSAL SUBMISSION

Notice is hereby given that sealed Proposals will be accepted by the Williamson County Purchasing Department for RFP# 15RFP101 Health Related Services For Williamson County Employment Benefit Administration Self-Insured Medical, Dental and Vision Claims Administration, Disease Management, Precertification Management, Large Case Management, Biometric/Wellness Program Management, Prescription Drug Card/Mail Order, Preferred Provider Network, And Section 125 Claims Administration. Specifications for this RFP may be obtained from <http://wilco-online.org/ebids/bids.aspx>.

Proposals should be addressed to the Williamson County Purchasing Agent with the RFP number and RFP name marked on the outside of the envelope. Respondents should forward **one (1) original, nine (9) paper copies and one (1) CD** copy of their Proposal to the address shown below. Late Proposals will be rejected as non-responsive. Proposals will be publicly opened in the Williamson County Purchasing Department at the time and date indicated above. Proposals shall be opened in a manner that avoids disclosure of the contents to competing Respondents and maintains the confidentiality of the Proposals during negotiations. Proposals will be open for public inspection after the Contract Award. Respondents are invited to attend the sealed Proposal opening.

PROPOSAL NAME: Health Related Services For Williamson County Employment Benefit Administration Health Related Services For Williamson County Employment Benefit Administration Self-Insured Medical, Dental and Vision Claims Administration, Disease Management, Precertification Management, Large Case Management, Biometric/Wellness Program Management, Prescription Drug Card/Mail Order, Preferred Provider Network, And Section 125 Claims Administration

PROPOSAL NO: 15RFP101
DUE DATE/TIME: February 25, 2014 ON OR BEFORE 2:00 PM
MAIL OR DELIVER TO: Williamson County Purchasing Department
901 S. Austin Ave.

Georgetown, TX 78626

All Respondents interested in submitting a Proposal are encouraged to attend the NON-MANDATORY pre-Proposal conference on February 11, 2014 at 1:30 PM at the Williamson County Human Resources Training Room, 301 SE Inner Loop, Suite 108, Georgetown, TX 78626. Respondents interested in attending the meeting via phone conference, please RSVP by sending an email to Khancock@wilco.org by 5PM on February 7, 2014.

Any questions, clarifications or requests for general information should be directed in writing to the contact listed below:

Assistant Purchasing Agent
RFP# 15RFP101
901 S. Austin Ave.
Georgetown, TX 78626
purchase@wilco.org

Any questions, clarifications or requests of technical nature should be directed in writing to the contact listed below:

Consultant Contact:
Nick Long
Gallagher Benefits
nick_long@ajg.com

Technical Contact (Secondary):
Williamson County Benefits Administrator
Shelly Loughrey
Sloughrey@wilco.org

Question submittals must be made via email, and are due by 5PM CST on February 20, 2014. Every effort will be made to answer questions within 24 hours of receiving them, with an email response.

All submitted questions with their answers will be posted and updated on a daily basis to the Williamson County portal, <http://wilco-online.org/ebids/bids.aspx>

It is the Respondent's responsibility to check with the Williamson County Purchasing Department prior to submitting your Proposal to ensure that you have a complete, up-to-date package. The Williamson County Purchasing Department takes no responsibility to ensure any interested Respondent has obtained any outstanding addenda or additional information. Any addenda and/or other information relevant to the RFP will be posted on the Williamson County vendor portal at the following link:

<http://wilco-online.org/ebids/bids.aspx>

All interested Respondents are invited to submit a Proposal in accordance with the Instructions and General Requirements, Response Format, Proposal Specifications, and Definitions, Terms and Conditions stated in this Request for Proposal. No negotiations or modifications to the Proposals received will be allowed except from the finalist (s) during negotiations.

**RESPONDENTS ARE STRONGLY ENCOURAGED TO CAREFULLY
READ THE ENTIRE RFP.**

**Health Related Services For Williamson County Employment Benefit
Administration Health Related Services For Williamson County Employment
Benefit Administration Health Related Services For Williamson County
Employment Benefit Administration Self-Insured Medical, Dental and Vision
Claims Administration, Disease Management, Precertification Management, Large
Case Management, Biometric/Wellness Program Management, Prescription Drug
Card/Mail Order, Preferred Provider Network, And Section 125 Claims
Administration
PROPOSAL NUMBER: 15RFP101**

There is no expressed or implied obligation for Williamson County (sometimes referred to herein as the "County") to reimburse Respondents for any expense incurred in preparing a Proposal in response to this RFP and Williamson County will not reimburse Respondents for these expenses.

All Proposals must be received in the Williamson County Purchasing Department before the opening, which will be on the date and at the time set forth on Page 1. Proposals received after the submittal deadline will be considered void and unacceptable and returned to the Respondent unopened. Williamson County is not responsible for lateness or non-delivery of mail, carrier, etc. The date and time stamp of the Williamson County Purchasing Department shall be the official date and time of receipt.

FACSIMILE TRANSMITTALS WILL NOT BE ACCEPTED.

The **Respondent's Proposal and all RFP requirements and Submittal Checklist** should be completed prior to submission. Failure to fully complete forms/affidavits and return the documentation required by this RFP may, at Williamson County's sole discretion, render your Proposal null and void. Proposals will be opened and the names of Respondents read aloud in the Williamson County Purchasing Department, 901 S. Austin Ave., Georgetown, Texas 78626.

**HOURS FOR THE WILLIAMSON COUNTY PURCHASING DEPARTMENT ARE 8:00 AM – 12:00 PM
AND 1:00 PM – 5:00 PM CENTRAL TIME (PURCHASING DEPARTMENT IS CLOSED DURING
LUNCH FROM 12:00PM – 1:00PM), MONDAY – FRIDAY, EXCLUDING COUNTY HOLIDAYS**

Tentative Schedule of Events

Issuance of RFP	January 28, 2014
Pre-Proposal Meeting	February 11, 2014 at 1:30PM
Deadline to Submit Questions	February 20, 2014 at 5:00PM
Proposal Submission Deadline (Late Proposals will not be considered)	February 25, 2014 at 2:00 PM
Conduct Interview/Best and Final Offer/Short List (optional)	March 12-14, 2014
Recommendation to Commissioner's Court	April 22, 2014
Effective Date	November 1, 2014

PRE-PROPOSAL INSPECTION

To the extent necessary and prior to the submittal, Respondents are strongly encouraged to visually inspect and be familiar with all goods and/or services for which they intend to submit a Proposal. If in the Pre-Proposal inspection the Respondent determines any discrepancies, he/she/it should inform the Williamson County Purchasing Department.

1. INTRODUCTION TO RESPONDENTS

This RFP is to receive Proposals from qualified Respondents regarding the goods and/or services which Williamson County seeks to procure under this RFP.

2. DEFINITIONS, TERMS AND CONDITIONS

2.1 DEFINITIONS

- a. "Addenda" – Means any written or graphic instruments issued by Williamson County prior to the consideration of Proposals which modify or interpret the Proposal Documents by additions, deletions, clarifications, or corrections.
- b. "Agreement" – The Successful Respondent may be required by Williamson County to sign an additional Agreement containing terms necessary to ensure compliance with the RFP and Respondent's Proposal. Such ensuing Agreement shall contain the Proposal Specifications, Terms and Conditions that are derived from the RFP.
- c. "Contract" – This RFP and the Proposal of the Successful Respondent shall become a contract between the Successful Respondent and Williamson County once the Successful Respondent's Proposal is properly accepted by the Williamson County Commissioners Court (sometimes referred to herein as the "Commissioners Court").
- d. "Proposal Documents" – The Legal Notice, RFP including attachments, and any Addenda issued by Williamson County prior to the consideration of any Proposals.
- e. "Proposal" – Is a complete, properly signed Proposal submitted in accordance with this RFP which is irrevocable during the specified period for evaluation and acceptance of Proposals.
- f. "Respondent" – A person or entity who submits a Proposal in response to this RFP.
- g. "RFP" – Refers to this document, together with the attachments thereto and any future addenda issued by Williamson County.
- h. "Successful Respondent" – The responsible Respondent who, in Williamson County's sole opinion, submits the Proposal which is in the best interest of Williamson County, taking into account factors identified herein and to whom Williamson County intends to award the Contract. The Successful Respondent is sometimes referred to herein as the "selected administrator", "successful administrator" or the "administrator".

2.2 TERMS AND CONDITIONS

2.2.1 Venue and Governing Law

Respondent hereby agrees and acknowledges that venue and jurisdiction of any suit, right, or cause of action arising out of or in connection with this RFP, the Contract and any ensuing Agreement shall lie exclusively in either Williamson County, Texas or in the Austin Division of the Western Federal District of Texas, and the parties hereto expressly consent and submit to such jurisdiction. Furthermore, except to the extent that this RFP, the Contract and any ensuing Agreement is governed by the laws of the United States, this RFP, the Contract and any ensuing Agreement shall be governed by and construed in accordance with the laws of the State of Texas, excluding, however, its choice of law rules.

2.2.2 Incorporation by Reference and Precedence

The Contract shall be derived from (1) the RFP and its Addenda; and (2) the Respondent's Proposal. In the event of a dispute under the Contract, applicable documents will be referred to for the purpose of clarification or for additional detail in the following order of precedence: (1) the RFP and its Addenda; and (2) the Respondent's Proposal.

In the event Williamson County requires that an ensuing Agreement be executed following award and a dispute arises between (1) terms and conditions of the ensuing Agreement, (2) the RFP,

and its Addenda; and (3) the Respondent's Proposal, applicable documents will be referred to for the purpose of clarification or for additional detail in the following order of precedence: (1) terms and conditions of the ensuing Agreement and its Addenda, (2) the RFP and its Addenda; and (3) the Respondent's Proposal.

2.23 Ownership of Proposal

Each Proposal shall become the property of Williamson County upon submittal and will not be returned to Respondents unless received after the submittal deadline.

2.2.4 Disqualification of Respondent

Upon signing and submittal of the Proposal, a Respondent offering to sell supplies, materials, services, or equipment to Williamson County certifies that the Respondent has not violated the antitrust laws of this state codified in Section 15.01, et seq, Business & Commerce Code, or the Federal Antitrust Laws, and has not communicated directly or indirectly the offer made to any competitor or any other person engaged in such line of business. Any or all Proposals may be rejected if Williamson County believes that collusion exists among the Respondents.

2.2.5 Funding

County intends to budget and make sufficient funds available and authorize funds for expenditure to finance the costs of the Contract. Respondents understand and agree that the County's payment of amounts under the 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 the Contract.

2.2.6 Assignment, Successors and Assigns

The Successful Respondent may not assign, sell, or otherwise transfer the Contract or any other rights or interests obtained under the Contract without written permission of the Williamson County Commissioners Court. The Contract and any ensuing Agreement shall be binding upon and inure to the benefit of the contracting parties and their respective successors and permitted assigns.

2.2.7 Implied Requirements

Products and services not specifically described or required in the RFP, but which are necessary to provide the functional capabilities described by the Respondent, shall be deemed to be implied and included in the Proposal.

2.2.8 Termination

- a. **Termination for Cause:** Williamson County reserves the right to terminate the Contract and/or any ensuing Agreement for default if the Successful Respondent breaches any of the RFP Specifications, Terms and Conditions, including warranties of Respondent, if any, or if the Successful Respondent becomes insolvent or commits acts of bankruptcy. Such right of termination is in addition to and not in lieu of any other remedies Williamson County may have at law or in equity or as may otherwise be provided herein. Default may be construed as, but not limited to, failure to deliver the proper goods and/or services within the proper amount of time, and/or to properly perform any and all other requirements to Williamson County's satisfaction, and/or to meet all other obligations and requirements.
- b. **Termination for Convenience:** Williamson County may terminate the Contract and/or any ensuing Agreement for convenience and without cause or further liability, upon thirty (30) calendar days written notice to Successful Respondent. In the event Williamson County exercises its right to terminate without cause, it is understood and agreed that only the amounts due to the Successful Respondent 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.

2.2.9 Non-Performance

It is the objective of Williamson County to obtain complete and satisfactory performance of the requirements set forth herein. In addition to any other remedies available at law, in equity or that may be set out herein, failure to perform may result in a deduction of payment equal to the amount of the goods and/or services that were not provided and/or performed to the County's satisfaction. In the event of such non-performance, the County shall have the right, but shall not be obligated, to complete the services itself or by others and/or purchase the goods from other sources. If the County elects to acquire the goods or perform the services itself or by others, pursuant to the foregoing, the Successful Respondent shall reimburse the County, within ten (10) calendar days of demand, for all costs incurred by the County (including, without limitation, applicable, general, and administrative expenses, and field overhead, and the cost of necessary equipment, materials, and field labor) in correcting the nonperformance which the Successful Respondent fails to meet pursuant to the requirements set out herein. In the event the Successful Respondent refuses to reimburse the County as set out in this provision, County shall have the right to deduct such reimbursement amounts from any amounts that may be then owing or that may become owing in the future to the Successful Respondent.

2.2.10 Proprietary Information and Texas Public Information Act

All material submitted to the County shall become public property and subject to the Texas Public Information Act upon receipt. If a Respondent does not desire proprietary information in the Proposal to be disclosed, each page must be clearly identified and marked proprietary at time of submittal or, more preferably, all proprietary information may be placed in a folder or appendix and be clearly identified and marked as being proprietary. The County will, to the extent allowed by law, endeavor to protect from public disclosure the information that has been identified and marked as proprietary. The final decision as to what information must be

disclosed, however, lies with the Texas Attorney General. Failure to clearly identify and mark information as being proprietary as set forth under this provision will result in all unmarked information being deemed non-proprietary and available to the public. For all information that has not been clearly identified and marked as proprietary by the Respondent, the County may choose to place such information on the County's website and/or a similar public database without obtaining any type of prior consent from the Respondent.

To the extent, if any, that any provision in this RFP or in the Respondent's Proposal is in conflict with Tex. Gov't Code 552.001 et seq., as amended (the "Public Information Act"), the same shall be of no force or effect. Furthermore, it is expressly understood and agreed that Williamson County, its officers and employees may request advice, decisions and opinions of the Attorney General of the State of Texas in regard to the application of the Public Information Act to any items or data furnished to Williamson County as to whether or not the same are available to the public. It is further understood that Williamson County's officers and employees shall have the right to rely on the advice, decisions and opinions of the Attorney General, and that Williamson County, its officers and employees shall have no liability or obligation to any party hereto for the disclosure to the public, or to any person or persons, of any items or data furnished to Williamson County by a party hereto, in reliance of any advice, decision or opinion of the Attorney General of the State of Texas.

2.2.11 Right to Audit

Successful Respondent agrees that Williamson County or its duly authorized representatives shall, until the expiration of three (3) years after termination or expiration of the Contract and/or the ensuing Agreement, have access to and the right to examine and photocopy any and all books, documents, papers and records of Successful Respondent, which are directly pertinent to the services to be performed or goods to be delivered for the purposes of making audits, examinations, excerpts and transcriptions. Successful Respondent agrees that Williamson County shall have access during normal working hours to all necessary facilities and shall be provided adequate and appropriate work space in order to conduct audits in compliance with the provisions of this section. Williamson County shall give Successful Respondent reasonable advance notice of intended audits (please refer to section B; paragraph 13 under Proposal specifications for additional information relative to audits)

2.2.12 Proposal Preparation Cost

Cost of developing Proposals is entirely the responsibility of Respondents and shall not be charged to Williamson County. There is no expressed or implied obligation for Williamson County to reimburse Respondents for any expense incurred in preparing a Proposal in response to this RFP and Williamson County will not reimburse Respondents for such expenses.

2.2.13 INDEMNIFICATION

SUCCESSFUL RESPONDENT SHALL INDEMNIFY, DEFEND AND SAVE HARMLESS WILLIAMSON COUNTY, ITS OFFICIALS, EMPLOYEES, AGENTS AND AGENTS' EMPLOYEES FROM AND AGAINST ALL CLAIMS, LIABILITY, AND EXPENSES, INCLUDING REASONABLE ATTORNEYS' FEES, ARISING FROM ACTIVITIES OF RESPONDENT, ITS AGENTS, SERVANTS OR EMPLOYEES, PERFORMED HEREUNDER THAT RESULT FROM THE NEGLIGENT ACT, ERROR, OR OMISSION OF RESPONDENT OR ANY OF RESPONDENT'S AGENTS, SERVANTS OR EMPLOYEES, AS WELL AS ALL CLAIMS OF LOSS OR DAMAGE TO THE RESPONDENT'S AND WILLIAMSON COUNTY'S PROPERTY, EQUIPMENT, AND/OR SUPPLIES.

FURTHERMORE, WILLIAMSON COUNTY, ITS OFFICIALS, EMPLOYEES, AGENTS AND AGENTS' EMPLOYEES SHALL NOT BE LIABLE FOR DAMAGES TO THE SUCCESSFUL RESPONDENT ARISING FROM ANY ACT OF ANY THIRD PARTY, INCLUDING, BUT NOT BEING LIMITED TO THEFT. SUCCESSFUL RESPONDENT FURTHER AGREES TO INDEMNIFY, DEFEND AND SAVE HARMLESS WILLIAMSON COUNTY FROM, ITS OFFICIALS, EMPLOYEES, AGENTS AND AGENTS' EMPLOYEES AGAINST ALL CLAIMS OF WHATEVER NATURE ARISING FROM ANY ACCIDENT, INJURY, OR DAMAGE WHATSOEVER CAUSED TO ANY PERSON OR TO THE PROPERTY OF ANY PERSON OCCURRING IN RELATION TO SUCCESSFUL RESPONDENT'S PERFORMANCE OF ANY SERVICES REQUESTED HEREUNDER DURING THE TERM OF THE CONTRACT AND/OR ANY ENSUING AGREEMENT.

SUCCESSFUL RESPONDENT SHALL TIMELY REPORT ALL CLAIMS, DEMANDS, SUITS, ACTIONS, PROCEEDINGS, LIENS OR JUDGMENTS TO WILLIAMSON COUNTY AND SHALL, UPON THE RECEIPT OF ANY CLAIM, DEMAND, SUIT, ACTION, PROCEEDING, LIEN OR JUDGMENT, NOT LATER THAN THE FIFTEENTH (15TH) DAY OF EACH MONTH; PROVIDE WILLIAMSON COUNTY WITH A WRITTEN REPORT ON EACH SUCH MATTER, SETTING FORTH THE STATUS OF EACH MATTER, THE SCHEDULE OR PLANNED PROCEEDINGS WITH RESPECT TO EACH MATTER AND THE COOPERATION OR ASSISTANCE, IF ANY, OF WILLIAMSON COUNTY REQUIRED BY SUCCESSFUL RESPONDENT IN THE DEFENSE OF EACH MATTER. SUCCESSFUL RESPONDENT'S DUTY TO DEFEND, INDEMNIFY AND HOLD WILLIAMSON COUNTY HARMLESS SHALL BE ABSOLUTE. IT SHALL NOT ABATE OR END BY REASON OF THE EXPIRATION OR TERMINATION OF THE CONTRACT AND/OR ANY ENSUING AGREEMENT UNLESS OTHERWISE AGREED BY WILLIAMSON COUNTY IN WRITING. THE PROVISIONS OF THIS SECTION SHALL SURVIVE THE TERMINATION OF THE CONTRACT AND SHALL REMAIN IN FULL FORCE AND EFFECT WITH RESPECT TO ALL SUCH MATTERS NO MATTER WHEN THEY ARISE.

IN THE EVENT OF ANY DISPUTE BETWEEN THE PARTIES AS TO WHETHER A CLAIM, DEMAND, SUIT, ACTION, PROCEEDING, LIEN OR JUDGMENT APPEARS TO HAVE BEEN CAUSED BY OR APPEARS TO HAVE ARISEN OUT OF OR IN CONNECTION WITH ACTS OR OMISSIONS OF WILLIAMSON COUNTY, RESPONDENT SHALL NEVER-THE-LESS FULLY DEFEND SUCH CLAIM, DEMAND, SUIT, ACTION, PROCEEDING, LIEN OR JUDGMENT UNTIL AND UNLESS THERE IS A DETERMINATION BY A COURT OF COMPETENT JURISDICTION THAT THE ACTS AND OMISSIONS OF RESPONDENT ARE NOT AT ISSUE IN THE MATTER.

Successful Respondent's indemnification shall cover, and Successful Respondent agrees to indemnify Williamson County, in the event Williamson County is found to have been negligent for having selected Successful Respondent to perform the work described in this request. The provision by Successful Respondent of insurance shall not limit the liability of Successful Respondent under the Contract and/or any ensuing Agreement.

2.2.14 Waiver of Subrogation

Successful Respondent and Successful Respondent's insurance carrier waive any and all rights whatsoever with regard to subrogation against Williamson County as an indirect party to any suit arising out of personal or property damages resulting from the Respondent's performance under this Contract and any ensuing Agreement.

2.2.15 Relationship of the Parties

The Successful Respondent shall be an independent contractor and shall assume all of the rights, obligations, liabilities, applicable to it as such independent contractor hereunder and any provisions herein which may appear to give County the right to direct the Successful Respondent as to details of doing work herein covered or to exercise a measure of control over the work shall be deemed to mean that the Successful Respondent shall follow the desires of County in the results of the work only. County shall not retain or have the right to control the Successful Respondent's means, methods or details pertaining to the Successful Respondent's performance

of the work. County and the Successful Respondent hereby agree and declare that the Successful Respondent is an independent contractor and as such meets the qualifications of an "Independent Contractor" under Texas Workers Compensation Act, Texas Labor Code, Section 406.141, that the Successful Respondent is not an employee of County, and that the Successful Respondent and its employees, agents and sub-contractors shall not be entitled to workers compensation coverage or any other type of insurance coverage held by County.

2.2.16 Sole Provider

The Successful Respondent agrees and acknowledges that it shall not be considered a sole provider of the goods and/or services described herein and that Williamson County may contract with other providers of such goods and/or services if Williamson County deems, at its sole discretion, that multiple providers of the same goods and/or services will serve the best interest of Williamson County.

2.2.17 Force Majeure

If the party obligated to perform is prevented from performance by an act of war, order of legal authority, act of God, or other unavoidable cause not attributable to the fault or negligence of said party, the other party shall grant such party relief from the performance. The burden of proof for the need of such relief shall rest upon the party obligated to perform. To obtain release based on force majeure, the party obligated to perform shall file a written request with the other party.

2.2.18 Severability

If any provision of this RFP, the Contract or any ensuing Agreement shall be held invalid or unenforceable by any court of competent jurisdiction, such holding shall not invalidate or render unenforceable any other provision thereof, but rather the entire RFP, Contract or any ensuing Agreement will be construed as if not containing the particular invalid or unenforceable provision or provisions, and the rights and obligation of the parties shall be construed and enforced in accordance therewith. The parties acknowledge that if any provision of this RFP, the Contract or any ensuing Agreement is determined to be invalid or unenforceable, it is the desire and intention of each that such provision be reformed and construed in such a manner that it will, to the maximum extent practicable, give effect to the intent of this RFP, the Contract or any ensuing Agreement and be deemed to be validated and enforceable.

2.2.19 Equal Opportunity

Neither party shall discriminate against any employee or applicant for employment because of race, color, religion, sex, or national origin.

2.2.20 Notice

Any notice to be given shall be in writing and may be affected by personal delivery or by registered or certified mail, return receipt requested, addressed to the proper party, at the following address:

Williamson County Purchasing Department
Bob Space, Purchasing Agent (or successor)
901 S. Austin Ave.,
Georgetown, Texas 78626

Respondent:

Address set out in Respondent's Transmittal Letter

Notices given in accordance with this provision shall be effective upon (i) receipt by the party to which notice is given, or (ii) on the third (3rd) calendar day following mailing, whichever occurs first.

2.2.21 Sales and Use Tax Exemption

Williamson County is a body corporate and politic under the laws of the State of Texas and claims exemption from sales and use taxes under Texas Tax Code Ann. § 151.309, as amended, and the services and/or goods subject hereof are being secured for use by Williamson County. However, the total bid 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 Respondent whether or not the Proposal is taxable to the county. The Respondent through the Respondent's attorney or tax consultant must make such determination. Bills submitted for taxes after the Proposals are awarded will not be honored.

2.2.22 Compliance with Laws

Williamson County and Successful Respondent shall comply with all federal, state, and local laws, statutes, ordinances, rules and regulations, and the orders and decrees of any courts or administrative bodies or tribunals in any matter affecting the performance of the Contract and any ensuing Agreement, including, without limitation, Workers' Compensation laws, salary and wage statutes and regulations, licensing laws and regulations. When required, the Successful Respondent shall furnish the County with certification of compliance with said laws, statutes, ordinances, rules, regulations, orders, and decrees above specified.

2.2.23 Incorporation of Exhibits, Appendices and Attachments

All of the Exhibits, Appendices and Attachments referred to herein are incorporated by reference as if set forth verbatim herein.

2.2.24 No Waiver of Immunities

Nothing herein shall be deemed to waive, modify or amend any legal defense available at law or in equity to Williamson County, its past or present officers, employees, or agents, nor to create any legal rights or claim on behalf of any third party. Williamson County does not waive, modify, or alter to any extent whatsoever the availability of the defense of governmental immunity under the laws of the State of Texas and of the United States.

2.2.25 No Waiver

The failure or delay of any party to enforce at any time or any period of time any of the provisions of this RFP, the Contract or any ensuing Agreement shall not constitute a present or future waiver of such provisions nor the right of either party to enforce each and every provision. Furthermore, no term or provision shall be deemed waived and no breach excused unless such waiver or consent shall be in writing and signed by the party claimed to have waived or consented. Any

consent by any party to, or waiver of, a breach by the other, whether expressed or implied, shall not constitute a consent to, waiver of or excuse for any other, different or subsequent breach.

2.2.26 Current Revenues

The obligations of the parties under the Contract and any ensuing Agreement do not constitute a general obligation or indebtedness for which County is obligated to levy, pledge, or collect any form of taxation. It is understood and agreed that Williamson County shall have the right to terminate the Contract and any ensuing Agreement at the end of any Williamson County fiscal year if the governing body of Williamson County does not appropriate sufficient funds as determined by Williamson County's budget for the fiscal year in question. Williamson County may effect such termination by giving written notice of termination to the Successful Respondent at the end of its then-current fiscal year.

2.2.27 INTENTIONALLY DELETED

2.2.28 Binding Effect

This Contract and any ensuing Agreement shall be binding upon and inure to the benefit of the parties and their respective permitted assigns and successors.

2.2.29 Assignment

The Successful Respondent's interest and duties hereunder may not be assigned or delegated to a third party without the express written consent of Williamson County.

2.2.30 Safety

Successful Respondent is responsible for initiating, maintaining, and supervising all safety precautions and programs in connection with any services to be provided hereunder. The safety program shall comply with all applicable requirements of the current federal Occupational Safety and Health Act and all other applicable federal, state and local laws and regulations.

2.2.32 General Obligations and Reliance

Successful Respondent shall perform all services and/or provide all goods, as well as those reasonably inferable and necessary for completion and provision of the services and goods required hereunder. The Successful Respondent shall keep the County informed of the progress and quality of the services and/or goods to be provided. Successful Respondent agrees and acknowledges that County is relying on Successful Respondent's represented expertise and ability to provide the goods and/or services described herein. Successful Respondent agrees to use its best efforts, skill, judgment, and abilities to perform its obligations in accordance with the highest standards used in the profession and to further the interests of County in accordance with County's requirements and procedures. Successful Respondent's duties as set forth herein shall at no time be in any way diminished by reason of any approval by the County nor shall the Successful Respondent be released from any liability by reason of such approval by the County, it being understood that the County at all times is ultimately relying upon the Successful

Respondent's skill and knowledge in performing the services and providing any goods required hereunder.

2.2.33 Estimated Quantities

To the extent applicable to this RFP, the estimated quantity of each item listed in this RFP 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.

2.2.34 Contractual Development

The Williamson County Commissioners Court may award the Contract on the basis of the initial Proposals received, without any further or additional discussions. Therefore, each initial Proposal should contain the Respondent's best terms and offer. The contents of the RFP and the selected Proposal will become an integral part of the Contract, but may be modified, at Williamson County's sole discretion, by provisions of an ensuing Agreement. Therefore, the Respondent must agree to inclusion in an ensuing Agreement of the Proposal Specifications, Terms and Conditions of this RFP. Williamson County may, at its discretion, opt to conduct further discussions with responsible offerors and request the highest ranked firm's Best and Final Offer.

2.2.35 Entire Agreement

The Contract and any ensuing Agreement shall supersede all prior Agreements, written or oral between the Successful Respondent and County and shall constitute the entire Agreement and understanding between the parties with respect to the services and/or goods to be provided. Each of the provisions herein shall be binding upon the parties and may not be waived, modified amended or altered except by writing signed by the Successful Respondent and County.

2.2.36 Survivability

All applicable agreements that were entered into between Respondent and Williamson County under the terms and conditions of the Contract and/or any ensuing Agreement shall survive the expiration or termination thereof for ninety (90) days unless a new contract has been awarded.

2.2.37 Air Quality

In determining the overall best Proposal, the County may, to the extent applicable, exercise the following option granted to local governments under the Texas Local Government Code.

Option – TLGC § 271.907. This option allows the County to evaluate Proposals and give preference to goods and/or services of a Respondent that demonstrates that the Respondent meets or exceeds any and all state or federal environmental standards, including voluntary standards, relating to air quality. If the Proposal being submitted will have an effect on air quality for Williamson County (as it relates to any state, federal, or voluntary air quality standard), then the Respondent is encouraged to provide information in narrative form indicating the anticipated air quality impact. Respondents are expected to meet all mandated state and federal air quality standards.

2.2.38 Payment

Unless specified otherwise in this RFP or an ensuing Agreement, the following provision shall control the County's method of payment:

County's payment for goods and services shall be governed by Chapter 2251 of the Texas Government Code. An invoice shall be deemed overdue the 31st day after the later of (1) the date County receives the goods under the Contract; (2) the date the performance of the service under the Contract is completed; or (3) the date the Williamson County Auditor receives an invoice for the goods or services. Interest charges for any overdue payments shall be paid by County 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 County'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 an error appears in an invoice submitted by Successful Respondent, County shall notify Successful Respondent of the error not later than the twenty first (21st) day after the date County receives the invoice. If the error is resolved in favor of Successful Respondent, Successful Respondent shall be entitled to receive interest on the unpaid balance of the invoice submitted by Successful Respondent beginning on the date that the payment for the invoice became overdue. If the error is resolved in favor of the County, Successful Respondent shall submit a corrected invoice that must be paid in accordance within the time set forth above. The unpaid balance accrues interest as provided by Chapter 2251 of the Texas Government Code if the corrected invoice is not paid by the appropriate date.

As a minimum, invoices shall include:

- (1) Name, address, and telephone number of Successful Respondent 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 Williamson County Auditor's Office, Accounts Payable Department: accountspayable@wilco.org 512-943-1500

2.2.39 Contractual Formation and Ensuing Agreement

The RFP and the Respond's Proposal, when properly accepted by the Williamson County Commissioners Court, shall constitute a contract equally binding between the Successful Respondent and Williamson County.

The Successful Respondent will be required by Williamson County to sign an ensuing Agreement containing terms necessary to ensure compliance with the RFP and Respondent's Proposal.

A sample administrative services agreement with approved language is included in Section J. All Respondents must supply the County with what they feel is an executable contract based upon the language and form of the sample agreement. Failure to do so may affect a Respondent's selection.

2.2.40 Initial Contract Term

The Successful Respondent shall provide the goods and/or services described herein for an initial term of thirty-six (36) months, beginning November 1, 2014 and ending October 31, 2017.

2.2.41 Contract Extensions

At the end of the Initial Contract Term, the Commissioners Court reserves the right to extend the Initial Contract Term, 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. Any 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 the 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 Respondent may elect to terminate the contract, with no additional liability to the County. The County and the Respondent agree that termination shall be the Respondent's sole remedy under this circumstance.

3. INSTRUCTIONS AND GENERAL REQUIREMENTS

Read this document carefully. Follow all instructions and requirements. You are responsible for fulfilling all requirements and specifications. Be sure you have a clear understanding of this RFP.

General requirements apply to all advertised RFPs; however, these may be superseded, in whole or in part, by the **Proposal Specifications, Addenda issued as a part of this RFP and Modifications issued as a part of this RFP**. Be sure your Proposal package is complete.

3.1 Ambiguity, Conflict, or other Errors in the RFP

If Respondent discovers any ambiguity, conflict, discrepancy, omission or other error in this RFP, Respondent shall immediately notify Williamson County Purchasing Department of such error in writing and request modification or clarification of the document. Modifications will be made by issuing Addenda. If the Respondent fails to notify Williamson County prior to the date and time fixed for submission of Proposals of an error or ambiguity in the RFP known to Respondent, or an error or ambiguity that reasonably should have been known to Respondent, then Respondent shall be deemed to have waived the error or ambiguity or its later resolution.

Williamson County may also modify the RFP, no later than 48 hours prior to the date and time fixed for submission of Proposals, by issuance of an Addendum. All addenda will be numbered consecutively, beginning with 1.

3.2 Notification of Most Current Address

Respondents in receipt of this RFP shall notify the Williamson County Purchasing Department of any address changes, contact person changes, and/or telephone number changes no later than 48 hours prior to the date and time fixed for submission of Proposals.

3.3 Proposal Preparation Cost

Cost of developing Proposals is entirely the responsibility of Respondents and shall not be charged to Williamson County.

3.4 Signature of Respondent

A Transmittal Letter, which shall be considered an integral part of the Proposal, shall be signed by an individual who is authorized to bind the Respondent contractually.

If the Respondent is a Corporation or Limited Liability Company, the legal name of the Corporation or Limited Liability Company shall be provided together with the signature of the officer or officers authorized to sign on behalf of such entity.

If the Respondent is a General Partnership, the true name of the firm shall be provided with the signature of each partner authorized to sign.

If the Respondent is a Limited Partnership, the name of the Limited Partner's General Partner shall be provided with the signature of the officer authorized to sign on behalf of the General Partner.

If the Respondent is a Sole Proprietor(s) (individual), each Sole Proprietor(s) shall sign.

If signature is by an agent, other than the Sole Proprietor(s) or an officer of a Corporation, Limited Liability Company, General Partner or a member of a General Partnership, a power of attorney or equivalent document must be submitted to the Williamson County Purchasing Department prior to contract award.

3.5 Assumed Business Name

If the Respondent operates business under an Assumed Business Name, the Respondent must have on file with the Williamson County Clerk a current Assumed Name Certificate and provide a file marked copy of same **prior to contract award.**

3.6 Economy of Presentation

Proposals should not contain promotional or display materials, except as they may directly answer in whole or in part questions contained in the RFP. Such exhibits shall be clearly marked with the applicable reference number of the question in the RFP. Proposals must address the technical requirements as specified in the RFP. All questions posed by the RFP must be answered concisely and clearly. Proposals that do not address each criterion may be, at the sole discretion of Williamson County, rejected and not considered.

3.7 Proposal Obligation

The contents of the RFP, Proposal and any clarification thereof submitted by the Successful Respondent shall become part of the contractual obligation and incorporated by reference into the Contract and any ensuing Agreement.

3.8 Compliance with RFP Specifications

It is intended that this RFP describe the requirements and the response format in sufficient detail to secure comparable Proposals. Failure to comply with all provisions of the RFP may, at the sole discretion of Williamson County, result in disqualification.

3.9 Evaluation

Williamson County reserves the right to use all pertinent information (also learned from sources other than disclosed in the RFP process) that might affect Williamson County's judgment as to the appropriateness of an award to the best evaluated Respondent. This information may be appended to the Proposal evaluation process results. Information on a Respondent from reliable sources, and not within the Respondent's Proposal, may also be noted and made part of the evaluation file. Williamson County shall have sole discretion for determining the reliability of the source. Williamson County reserves the right to conduct written and/or oral discussions/interviews after the Proposal opening. The purpose of such discussions/interviews is to provide clarification and/or additional information to make an award that is in the best interest of Williamson County.

3.10 Withdrawal of Proposal

The Respondent may withdraw its Proposal by submitting a written request over the signature of an authorized individual, as described herein above, to the Williamson County Purchasing Department any time prior to the submission deadline. The Respondent may thereafter submit a new Proposal prior to the deadline. Withdrawal of a Proposal after the deadline will be subject to written approval of the Williamson County Purchasing Agent.

3.11 Responsibility

It is expected that a Respondent will be able to affirmatively demonstrate Respondent's responsibility. A Respondent 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; and
- d) be otherwise qualified and eligible to receive an award.

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

3.12 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. Respondent must submit a firm price that must be good from the date of Proposal opening for the fixed period of time set out in this RFP. Unless the RFP 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 best Proposal.

3.13 Purchase Orders

If required by the Williamson County Purchasing Department, a purchase order(s) may be generated to the Successful Respondent for goods and/or services. If a purchase order is issued, the purchase order number must appear on all itemized invoices and/or requests for payment.

3.14 Silence of Specifications

The apparent silence of any RFP 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.

3.15 References

Williamson County may require Respondent to supply a list of at least three (3) references where like services and/or goods have been supplied by Respondent.

4. RESPONSE FORMAT AND SUBMISSION

4.1 Introduction

Each Proposal submitted in response to this RFP should clearly reference those numbered sections of this RFP that require a response. Failure to arrange the Proposal as requested may result in the disqualification of the Proposal.

Though there is not a page limit for Proposals, to save natural resources including paper, and to allow Williamson County staff to efficiently evaluate all submitted Proposals, Williamson County requests that Proposals be orderly, concise, but comprehensive in providing the requested information. Conciseness and clarity of content are emphasized and encouraged. Please limit additional, non-requested information.

Please provide your Proposal response using:

- 8 ½" x 11" pages, inclusive of any cover letter or supporting materials
- The least amount of plastic/laminate or other non-recyclable binding materials
- Single-sided printing

Vague and general Proposals will be considered non-responsive, and may, at County's sole discretion, result in disqualification. Proposals must be legible and complete. Failure to provide the required information may result in the disqualification of the Proposal. All pages of the Proposal should be numbered and the Proposal should contain an organized, paginated table of contents corresponding to the sections and pages of the Proposal.

4.2 Organization of Proposal Contents and Table of Contents

Each Proposal should be submitted with a table of contents that clearly identifies and denotes the location of each title and subtitle of the Proposal. Additionally, the table of contents should clearly identify and denote the location of all enclosures of the Proposal. The table of contents should follow the RFP's structure as much as is practical.

Each Proposal should be organized in the manner described below:

- a. Transmittal Letter (Appendix A of RFP)
- b. Table of Contents
- c. Executive Summary
- d. Fee Proposals (Appendix B of RFP)
- e. Statement of Compliance (Appendix C of RFP)
- f. Felony Conviction Notice (Appendix D of RFP)
- g. References: Identification of three (3) references for which the Respondent is providing or has provided the services and/or goods of the type requested, including the name, position, and telephone number of a contact person at each entity (Appendix E of RFP)
- h. Conflict of Interest Questionnaire (Appendix F of RFP)
- i. Proposal Affidavit (Appendix G of RFP)
- j. Signature Page (Appendix H of RFP)

4.3 Transmittal Letter

The Respondent should submit a Transmittal Letter that provides the following:

1. Name and address of individual or business entity submitting the Proposal;
2. Respondent's type of business entity (i.e., Corporation, General Partnership, Limited Partnership, LLC, etc.);

3. Place of incorporation or organization, if applicable;
4. Name and location of major offices and other facilities that relate to the Respondent's performance under the terms of this RFP;
5. Name, address, business and fax number of the Respondent's principal contact person regarding all contractual matters relating to this RFP;
6. The Respondent's Federal Employer Identification Number;
7. A commitment by the Respondent to provide the services required by Williamson County;
8. A statement that the Proposal is valid for ninety (90) calendar days from the deadline for submittal of Proposals to Williamson County (Any Proposal containing a term of less than ninety (90) calendar days for acceptance, may at Williamson County's sole discretion, be rejected as non-responsive.);
9. If the Proposal being submitted will have an effect on air quality for Williamson County (as it relates to any state, federal, or voluntary air quality standard), then the Respondent is encouraged to provide information in narrative form indicating the anticipated air quality impact.

The Transmittal Letter should be signed by a person legally authorized to bind the Respondent to the representations in the Transmittal Letter and Proposal. In the case of a joint Proposal, each party must sign the Transmittal Letter.

4.4 Executive Summary

The Respondent should provide an Executive Summary of its Proposal that asserts that the Respondent is providing in its response all of the requirements of this RFP. The Executive Summary must represent a full and concise summary of the contents of the Proposal

The Executive Summary must not include any information concerning the cost of the Proposal.

The Respondent must identify any services and/or goods that are provided beyond those specifically requested. If the Respondent is providing services and/or goods that do not meet the specific requirements of this RFP, but in the opinion of the Respondent are equivalent or superior to those specifically requested, any such differences must be noted in the Executive Summary. However, the Respondent must realize that failure to provide the services specifically required may, at Williamson County's sole discretion, result in disqualification of the Proposal.

The Respondent also should indicate why it believes that it is the most qualified Respondent to provide the services described in this RFP. The Successful Respondent must demonstrate extensive experience in and understanding required in order to carry out the intent of this project. The Respondent must describe in detail the current and historical experience the Respondent and its subcontractors have that would be relevant to completing the project. References should contain the name of key contacts and a telephone number. The Respondent should briefly state why it believes its proposed services and/or goods best meet Williamson County's needs and RFP requirements, and the Respondent also should concisely describe any additional features, aspects, or advantages of its services and/or goods in any relevant area not covered elsewhere in its Proposal.

4.5 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 amended.

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

<http://www.wilco.org/CountyDepartments/Purchasing/ConflictofInterestDisclosure/tabid/689/language/en-US/Default.aspx>

Each Respondent must disclose any existing or potential conflict of interest relative to the performance of the requirements of this RFP. Examples of potential conflicts may include an existing business or personal relationship between the Respondent, its principal, or any affiliate or subcontractor, with Williamson County or any other entity or person involved in any way in the project that is the subject of this RFP. Similarly, any personal or business relationship between the Respondent, the principals, or any affiliate or subcontractor, with any employee or official of Williamson County or its suppliers must be disclosed. Any such relationship that might be perceived or represented as a conflict must be disclosed. Failure to disclose any such relationship or reveal personal relationships with Williamson County employees or officials may be cause for termination. Williamson County will decide if an actual or perceived conflict should result in Proposal disqualification.

By submitting a Proposal in response to this RFP, all Respondents affirm that they have not given, nor intend to give, at any time hereafter any economic opportunity, future employment, gift, loan, gratuity, special discount, trip, favor, or service to a Williamson County public servant or any employee, official or representative of same, in connection with this procurement.

Each Respondent must provide a Conflict of Interest Statement. The Conflict of Interest Statement is attached as an appendix to this RFP and must be completed, signed, and submitted prior to contract award.

4.6 Ethics

The Respondent 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.

4.7 Proposal Submittal

The Proposal is due no later than the submittal date and time set forth on Page 1 of this RFP, and should include each item identified on the Proposal Submittal Checklist page of this RFP.

4.8 Delivery of Proposals

All Proposals are to be delivered on or before the submittal deadline, as noted on Page 1 of this RFP, to:

Williamson County Purchasing Department
Attn: RFP# 15RFP101
901 S. Austin Ave.
Georgetown, Texas 78626

Williamson County will not accept any Proposals received after the submittal deadline, and shall return such Proposals unopened to the Respondent.

Williamson County will not accept any responsibility for Proposals being delivered by third party carriers.

Respondent should submit **one (1) original, nine (9) paper copies and one (1) CD** copy of the Proposal. Proposals will be opened publicly in a manner to avoid public disclosure of contents; however, names of Respondents will be read aloud.

Respondents should list the Proposal Number on the outside of the box or envelope and note "Sealed Proposal Enclosed."

FAILURE BY RESPONDENT TO INCLUDE ALL LISTED ITEMS MAY, AT THE SOLE DISCRETION OF WILLIAMSON COUNTY, RESULT IN THE REJECTION OF ITS PROPOSAL.

5. PROPOSAL SPECIFICATIONS

Proposal Requirements

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 Respondent whether or not the Proposal is taxable to the County. The Respondent through the Respondent's attorney or tax consultant must make such determination. Bills submitted for taxes after the Proposals are awarded will not be honored.

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 7.3.3 Weighted Evaluation Factors. 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 is conducting enrollment through an on-line enrollment system. It is preferred that the selected carrier be able to accept electronic eligibility files from an outside vendor.

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

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Section B	General Carrier/ Administrator Requirements
Section C	Medical, Dental & Vision Claims Administration Questionnaires
Section D	Prescription Drug Card & Mail Order Drugs
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Section H	Section 125 Claims Administration
Section I	Biometric/Wellness Program Mgmt
Section J	Sample Administrative Services Agreement
Section K	Williamson County Medical Plan Documents

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 Allegiance TPA that differ by deductible and coinsurance amounts. This year the County instituted a Diabetic Plan administered by Allegiance TPA and details of this plan are included in Section K. As of December 2013, there are approximately, 1378 employees, 91 Retirees, and 3 Cobra Participants enrolled in the three medical plans and 154 active employees enrolled in the HM Plan and 29 Retirees enrolled in the Diabetic Plan. The County is currently using Cigna's PPO Network. The county offers a self-funded PPO Dental Plan with two (2) Plan Options to choose from with 1179 employees, 83 retirees participating and 5 Cobra participants, and a Vision Program with 858 employees and 73 retirees and 2 cobra participants which are both administered by Allegiance TPA. The County offers Basic Life Insurance, AD&D Voluntary Term Life, Long Term Disability and Self-Funded Short Term Disability with Cigna Life Insurance Company of North America currently administering these programs.

Allegiance TPA is currently administering the Section 125 Cafeteria Plan. The maximum an employee can elect to contribute for the Health Care Reimbursement Account is \$2,500 and \$5,000 for the Dependent Care Account.

The bulk of this RFP is for differing types of administration. Respondents may submit Proposals for all or selected services. The services are:

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

To include Technology Access Online enrollment platform and Standard File Feed upload capabilities.

Please note that your inability to quote all 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 Respondent will be responsible for having qualified personnel and computerized systems capable of handling a case of this size and their plan of benefits. The Respondent must provide references and proof of the provider's ability to satisfactorily serve the County. **All Respondents 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 Cigna's 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 Proposals 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 County's benefits consultant and the County. Any deviations from this request are to be discussed with the County's benefits consultant in advance of the due date. After a commitment has been made by the County, the Respondent 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, 2014.

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 September.

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 Proposal to the RFP 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 ensuing Agreement must be negotiated and executed by the selected vendor prior to being presented to the Commissioner's Court for approval. A sample administrative services agreement with approved language is included in Section J. All Respondents must supply the County with what they feel is an executable contract based upon the language and form of the sample agreement. Failure to do so may affect a Respondent's 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, 2014.

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 Respondent. If the selected Respondent does not have a 95% procedural accuracy as a result of the Post Implementation Audit, the new Respondent **will incur the cost of a focused claims audit at 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, Allegiance TPA and Cigna. It has been gathered and coordinated by the County's benefits 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 eligibility 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 County's benefits consultant at least quarterly but not more frequently than once per month. All costs associated with this process must be included in the Respondent'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 Respondent 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 Respondent will be based upon responses to questions outlined in these specifications and an estimate of the quality and effectiveness of each Respondent's services. The evaluation criteria is outlined in Section 7.3.3 of this RFP.

- 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

**MEDICAL, DENTAL AND VISION
CLAIMS ADMINISTRATION**

SECTION C: 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 Respondent must consider this as a minimum level of service and must provide a cost estimate that is all-inclusive of the minimum services.

The selected 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 Benefits Committee 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 COUNTY'S BENEFITS 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/Respondents 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 90% as determined by the County.
14. Annual renewal prices will not exceed the percentage increase specified in the Proposal. All Proposals/Respondents must sign and agree to this stipulation in order to be considered.
15. All Proposals/Respondents 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. Please complete the chart in the Workbook about how the certain procedures are addressed.

- | | | | |
|-----|---|-----|----|
| 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, on the EOB, the applicable procedure code? o o
- q. to show, on the EOB, the percentage of payment? o o
- r. to show, on the EOB, 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 an 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 Respondent 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 Respondent 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 Allegiance TPA.

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

<u>Implementation/Plan Building</u>	<u>Total Fees at Risk \$100,000</u>
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

<u>PPO Network Guarantee</u>	<u>Total Fees at Risk</u>	<u>\$100,000</u>
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The maximum risk free corridor the client is willing to accept is 2% for all PPO Network Guarantees.

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%)	<input type="radio"/>	<input type="radio"/>
Claim Turnaround (90% - 10 days)	<input type="radio"/>	<input type="radio"/>
Financial Payment Accuracy (99.5%)	<input type="radio"/>	<input type="radio"/>
Financial Coding Accuracy (97%)	<input type="radio"/>	<input type="radio"/>
Implementation	<input type="radio"/>	<input type="radio"/>
Employee Satisfaction	<input type="radio"/>	<input type="radio"/>

Customer Service

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

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 No

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/vision plans.

- High claims report
- 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.
- Top 100 provider list with TIN, Zip Code, Billed Amount, Paid Amount

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 Respondent's system in a compatible format, the Respondent 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 Respondent.

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.
 - d. claims process with time frames for review

Please indicate the actual performance of the office indicated in item 1 above during 2012 and 2013 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. Please describe the implementation process in detail. Provide a sample timeline assuming award is made April 15 and plan is effective November 1, 2014.

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

DENTAL 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?
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 2012 and 2013 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, 2014.
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

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 2012 and 2013 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, 2014.
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 Bastrop, Bell, Blanco, Burnett, Hays, Lee, Milam, Travis, and Williamson Counties.**

SECTION D

PRESCRIPTION DRUG CARD RETAIL & MAIL ORDER DRUGS

SECTION D: PRESCRIPTION DRUG CARD **RETAIL & MAIL ORDER DRUGS**

Selection Criteria

To assist you in developing your Proposal, we have summarized the criteria that will be used to evaluate your Proposal. The Successful Respondent 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.

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 Respondents 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
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Name	Company	Telephone #	# of EE Lives
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Name	Company	Telephone #	# of EE Lives
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SECTION E

PRECERTIFICATION/ LARGE CASE MANAGEMENT

SECTION E - 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 Respondent 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. Please complete the Large Case Management service chart in the Workbook.
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. Please complete UR Service Chart in the Workbook
2. Are these services provided by
 - a. Your company
 - b. A company owned/subsidiary
 - c. A vendor

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.)

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

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 2013	1st Previous 2012	2nd Previous 2011
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 F
DISEASE MANAGEMENT

SECTION F: 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 01/01/2014)

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 Public groups in Texas:

	<u>Group Name</u>	<u>Current Number of Members</u>
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____

Account Management/Implementation

- Who are the individuals that would provide account management services to the County? What are their qualifications?
- Provide a detailed description of the implementation process, including how you will work with the County, its plans and other programs.
- 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?
- Once the program is implemented, how often will you meet with the County to provide feedback, updates and reports?
- Describe your process to communicate the disease management program to employees.
- Can communications materials be customized? If yes, identify what can be customized and if there would be any additional fees for customization.
- Are multi-lingual materials available?
- Please provide copies of all implementation AND communication materials.
- List the diseases covered in your disease management programs and specify whether they are currently available or in development.
- Do you use clinical practice guidelines? If yes, specify which guidelines are used and how they are applied.
- Describe the types of interventions and methods of delivery used for the disease management programs you offer.
- Explain how Disease Management interventions are targeted to individual participants' needs and motivation to change.

- Do you use a readiness to change behavioral model in the delivery of your services? If so, describe.
- How do you track and monitor patients over time?
- Describe how you handle co-morbid conditions and provide a list of the co-morbid conditions you address.
- Do you have an educational component to your program and educational materials?
- What is the literacy level of your written materials?
- What methods do you use to identify candidates for the disease management programs and the frequency of each method?
- Describe your information technology infrastructure.
- Describe the desktop system that is used in your Disease Management operations?
- Do you any data mining software in your Disease Management?
- Describe system security and back-up procedures.
- Describe the process of Claims Data and Eligibility transfer from the Medical plan TPA.
- How much data do you need initially?
- What is the frequency of subsequent feeds?
- Please provide the file feed format and any necessary specifications.
- Enrollment
- How does your organization encourage participation in Disease Management programs?
- What is your program enrollment rate?
- Do participants graduate from the program? If so, what is the graduation criteria?
- How often are outbound calls made to participants?
- Describe the makeup, qualifications, and experience of the Disease Management staff?
- List the components that make up your staff training and indicate whether each component occurs during orientation or is ongoing.
- Provide the hours of operation
- Do you offer a 24-hour nurse line service?

- 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.
- Describe how your organization collaborates with an employer's other health care initiatives to deliver integrated disease/condition management services.
- How do you identify the participants' physician and how are they incorporated within the care of participant?
- How do you handle physicians that are non-compliant with the necessary protocol for the patient's disease state?
- Describe all care management services available through your organization to large employers. Which services, if any are outsourced to third parties?
- Describe how your organization retrieves & reviews paid claim data when analyzing a prospective client's needs.
- Are reporting tools available to clients electronically?
- Do you utilize any statistical methodology for early disease detection (e.g. predictive modeling)?
- Indicate which measures you use to determine program impact and cost savings.
- Please provide a sample of standard client reports.
- What data elements are captured and tracked in your Disease Management programs and which ones can you report back to the client?
- Describe the types of client reports available. How often are reports provided?
- Will you provide comparative data from your book of business?
- Please provide copies of standard client reports.
- Are you capable and will you provide customized client reports?
- What services are included in your fees? Describe all potential extra fees in providing services.
- List all Disease Management programs and services you propose to provide to the County and indicate your proposed fees.

SECTION G

PREFERRED PROVIDER ORGANIZATION

SECTION G: 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 Respondent must complete the attached Workbook. In order to simplify the County's analysis, the 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 Records 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 Respondents 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 01/01/2014)**

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 Public groups in Texas:

	<u>Group Name</u>	<u>Current Number of Members</u>
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 chart in the Workbook.

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 CPT code allowable chart in the Workbook.

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 recertified? 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.**

10. 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 2013	1st Previous 2012	2nd Previous 2011
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 recredialed?

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).

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 __Attached
(especially reports that demonstrate medical management capabilities and/or savings achieved)
7. Austin area provider directory __Attached

SECTION H

**SECTION 125
CLAIMS ADMINISTRATION**

SECTION H: 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

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 I

Biometrics and Wellness

The current required tests for the wellness program are listed below but each Respondent is expected to outline their process and if it includes more tests than those required by the County, please explain in detail.

Required Tests:

- Body Mass Index (BMI)
- HDL
- LDL
- Blood Glucose
- Diastolic
- Systolic
- Cotinine Level
- Waist Measurement

Approach and Goals

Describe the multi-faced approaches of awareness, education and management that will be provided to the membership during the course of their plan year. Identify the expected goals for the wellness program to achieve. Please highlight management of claim information and education regarding medical care consumerism, and healthy lifestyle choice.

Review the County's membership and ensure services may be provided on-site to each member.

Please address the following:

- Services provided on-site
- Screenings and/or preventative tests
- Prevention/Intervention Programs/Web-sites/Teleconferences/Telecommunication
 - Website availability
 - Internet question/answer service regarding health care
- Educational materials
 - Reminder letters for wellness services to be conducted
 - Education on targeted health management information
 - Education regarding community support services
 - Newsletter availability and frequency
 - Resource availability of Health Promotion
 - Reminder Letters for Wellness Services to be Rendered
- Seminar Prevention Sessions
- Reporting to the County so integration between wellness participation, claims overview and disease management may occur

Return on Investment Calculation

Please address the following

- Age/Gender Breakdown

- ❑ Claim Cost Assessment on Wellness
- ❑ Comorbidity identification due to Wellness Services
- ❑ Progression of disease states with implementation to Wellness Services
- ❑ Lifestyle Risk Factor Assessment (Provide information on Lifestyle Risk Factors and assessment protocol)
 - Physical Activity
 - Tobacco Use
 - Nutrition
 - Alcohol Use
 - Stress
 - Others
- ❑ Medical Risk Factor Assessment (Provide information on Medical Risk Factors)
 - Blood Pressure
 - TC:HDL³
 - Triglycerides
 - Blood Glucose
 - Weight
 - Others
- ❑ Psychometric Assessments
- ❑ Physiological Assessments

WELLNESS PROGRAM QUESTIONNAIRE

1. What is the full name of your organization, address, and telephone number for the person responsible for this bid/Proposal?
2. Please provide a brief history of your organization.
3. What is the general structure of your organization? Please provide an organizational chart, which indicates major divisions and reporting relationships.
4. Please provide the names of three references that we may call (including number of employees, location, contact, and telephone number) that are similar in size and composition to the County.
5. Are there any plans for major capital investment, sale, or divestment during the next 12 months?
6. What is the name and title of the person who would be responsible for the County's account? Where is that person headquartered? Who would be the back-up to this person? Please provide a description of each person's qualifications and experience.
7. What certifications and licensures does your organization currently hold that permits the activities associated with wellness promotion? In what states are you licensed and certified?
8. What steps is your organization taking to remain in compliance with new regulatory requirements concerning privacy and security?
9. Provide a copy of your written Exposure Control Plan.
10. Please describe the clinical background and experience that is required for your healthcare wellness staff. Is your wellness staff full-time employees or subcontracted personnel?
11. Please describe the level of training that is required for the staff administering and reviewing test results. What types of continuing education and ongoing training is

required for your wellness employees?

12. Will someone on the Healthcare Screening Team be CPR or Advanced CPR Certified?

13. How is the entire wellness process managed from start to finish?

14. What communications support do you provide prior to health screening programs?
Please provide samples of educational material that will be available to the County.

15. How was your Health Risk Assessment developed? Is it proprietary?

16. Describe how the Health Risk Assessment is administered. ***Please provide a copy of your questionnaire for review.***

17. How and when do health care screening participants receive their results?

18. Please describe the type and frequency of the communication tools your firm uses to follow-up with health screening participants.

19. What is the ratio of the number of employees per hour that you can screen?

20. What is the average participation rate for your clients?

21. Is your screening time arranged on a first-come, first-served basis or by appointment? If by appointment, do you have the ability for on-line scheduling?

22. What web-based online services are available to wellness participants?

23. How are travel costs calculated into the overall program for staff who perform your services?

24. What flexibility does your program have to administer in multiple locations?

25. What is your proficiency testing percentage for Lipid Profile Cholesterol?
26. Has your lab ever had any sanctions imposed on it by any certifying or accrediting organization?
27. What is your protocol for follow-up with critical lab values derived from a health screening?
28. Attach sample reports that you will provide the County and the employees as part of your standard reporting package that is included in your fee quote.
29. Please explain your risk stratification protocol and how this information is disseminated to the employer.
30. What predictive modeling tools do you incorporate into your data analysis?
31. Who will conduct the Medical Review of pertinent data? What are the training or degree requirements?
32. How does your organization work with a participant's physician practitioner?
33. How do you communicate patient rights and responsibilities? How are the results for specialty test communicated to the physician and or member?
34. How do you measure program efficiency?
35. Do you have Return on Investment (ROI) information and, if so, what time period does the data cover? Please explain in detail your method of calculating a baseline for the County and reporting the information back to the County.
36. What disease management alternatives does your company offer?
37. How will disease management components be integrated into your wellness program?

38. What is your company's overall philosophy to view wellness and chronic disease management (CDM) as part of the overall health care benefits program continuum? What roles do you see wellness and CDM playing in lowering health care costs in general?
39. Describe the information that your firm would need and the time line needed to complete the scope of work in this RFP.
40. Provide a detailed description of the implementation process, including how you will work with the County, its plans and other programs.
42. Please define how local community providers will be utilized in the delivery of services?

On-Site
Education
Follow-Up
Referrals

Williamson County Wellness Campaign

The premise of this plan is that 80 percent of our health costs are spent on 20 percent of our employees/retirees/COBRA participants/spouses who have chronic conditions. We want to reach out to those people and really make a difference in their lives and the lives of their family members.

Also, the Williamson County Wellness Program should be a core business strategy and sustainability program. If our healthy employees/retirees/COBRA participants/spouses are costing taxpayers substantially less than the cost of our unhealthy employees/retirees/COBRA participants/spouses, we then have a business case for the goals/objectives and strategies outlined below for this program.

The adoption of a strategic plan for the Williamson County Wellness Program will serve as a guide to the Benefits Committee and Wellness Subcommittee and as a communications tool for the participants in the Self-funded Health Plan.

We acknowledge that at least 50% of an organization's health care costs are driven by the lifestyle related behaviors of employees and spouses such as:

- smoking,
- poor diet and
- lack of exercise.

Case studies show that Wellness coaching is the most effective influence in changing behavior. We must take the actions necessary to implement a workplace wellness culture if we are going to positively impact

these lifestyle related risks. Studies also show that the greatest cost impact occurs in years 3 and 4 following the implementation of a strategic Wellness Program.

To reward those employees/spouses, retirees/spouses and COBRA/spouses who participate, this plan ultimately allows participants to meet certain participation requirements and earn premium incentives beginning November 2012.

The open enrollment process would reflect the individual participant's certified responses and biometric screening status provided through the HRA premium incentives applied based upon this information. The certified responses would also include the reasonable alternative options and would eliminate the current affidavit processes entirely.

Comprehensive Goals / Objectives:

- 1) "Bend the Trend" - We will not accept the industry standard of 8-10% annual increases in healthcare claims costs and will limit the aggregate trend for annual increases to 5% or less
- 2) Annual reduction of the average participating members claims costs vs. average non-participating members
- 3) Provide all health plan participants the resources and opportunity to influence and encourage healthy lifestyle changes to improve and sustain their health and the health of their family members.
- 4) Minimize the need for annual employee/retiree/ and county rate contribution increases.

Five Year Strategy:

FY 2012: Annual Goal - 80% of eligible employees/spouses retirees/spouses and COBRA/spouses participate in Biometric Screening / HRA and 50% meet healthy metrics

- Discontinue all points related wellness activities beginning November 2011
- Discontinue the continue testing processes described in the 2011 tobacco free affidavits
- RFP for Biometric Screenings / HRA / Reporting vendor in February 2012
 - Capability to access on-line appointment scheduling for biometric screenings beginning May 2012
 - Collection of screening data from employees/spouses; retirees/spouses and COBRA/spouses (aggregate data is "owned" by Williamson County)
 - Load screening data into HRA
 - Add Link to Wilco HR External Website to facilitate access for both employees/spouses
 - Optional Quote for "Wellness Center" offering:
 - Biometric Screening and reporting
 - Wellness Coaching for diet / exercise / stress management / tobacco cessation
 - Fitness Center Equipment and Monitoring for high risk employees/spouses, retirees/spouses and COBRA/spouses
 - Immunizations / Flu Shots
- Cost for Biometric Screenings / HRA / Reporting to be paid from Wellness Program budget
- Implement Web-based Open Enrollment Process that allows for external access by both employee/spouse, retiree/spouse and COBRA/spouse participants and accepts upload by color code status of participants;
- "Know Your Numbers" Campaign beginning in May 2012 - Collect and report data via Biometric Screenings and cross with key employee variables (some of which are obtained via

HRA) which are:

- Wellness Program Participant levels based upon last two years of Wellness data -
 - Light (once and done);
 - moderate;
 - high;
 - non-participant
- Age/Gender - this can determine the most effective communications strategies
- County Department - this can identify which departments encourage and support participation
- Health Risk Stratification -
 - HDL
 - LDL
 - Blood Glucose
 - Diastolic
 - Systolic
 - Cotinine level
 - Waist Measurement
- Employee/Spouse, Retiree/Spouse, COBRA/Spouse Coaching Status -
 - Currently receiving coaching
 - Not receiving coaching
- Lifestyle Habits that contribute to chronic disease prevention -
 - Physical Activity / Exercise
 - Eating Habits / Healthy Diet
 - Non-Tobacco Use
 - Stress Management
 - Limited Alcohol Use
- Analyze annual results - raw data is analyzed and translated into information that can be communicated in the form of a concise, layman's terms report to employees and to the public

FY 2013: Annual Goal - 85% of eligible employees/spouses, retirees/spouses and COBRA/spouses participate in Biometric Screening / HRA and 55% meet healthy metrics

- Begin offering "Get Fit, Get Healthy, Get Movin' (G3)", "America on the Move" and "Healthy Eating Every Day (HEED)" programs to assist with weight loss and healthy diet awareness
- Consider departmental challenges and competitions for Walk Across Texas, ToughCookies.com and possibly average weight loss
- Offer on-line access to free tracking and monitoring websites with healthy lifestyle information, tips and communications
- Add links to "5 minute cubical exercises" to encourage and increase physical activity and exercise in the workplace
- Offer weekly / monthly blood pressure checks, blood glucose screenings and weight/waist measurements
- "Know Your Numbers" Campaign continues in May - Collect and report data via Biometric Screenings and cross with key employee variables
- Determine whether healthy metrics have improved and total health plan claims costs per participant per year have reduced over last year
- Set annual goals for participation and determine activities that will result in continuous improvement year to year and reflect a positive trend.
- Survey employees for comments / suggestions on wellness activities with positive results
- Analyze annual results - raw data is analyzed and translated into information that can be communicated in the form of a concise, layman's terms report to employees and to the public

FY 2014: Annual Goal - 90% of eligible employees/spouses, retirees/spouses and COBRA/spouses participate in Biometric Screening / HRA and 60% meet healthy metrics. This year's activities below are consistent with last years' activities unless re-programming is necessary to meet annual goals.

- "Know Your Numbers" Campaign continues in May - Collect and report data via Biometric Screenings and cross with key employee variables
- Determine whether healthy metrics have improved and total health plan claims costs per participant per year have reduced over last year
- Set annual goals for participation and determine activities that will result in continuous improvement year to year and reflect a positive trend.
- Survey employees for comments / suggestions on wellness activities with positive results
- Analyze annual results - raw data is analyzed and translated into information that can be communicated in the form of a concise, layman's terms report to employees and to the public

FY 2015: Annual Goal - 95% of eligible employees/spouses, retirees/spouses and COBRA/spouses participate in Biometric Screening / HRA and 65% meet healthy metrics. This year's activities below are consistent with last years' activities unless re-programming is necessary to meet annual goals.

- "Know Your Numbers" Campaign continues in May - Collect and report data via Biometric Screenings and cross with key employee variables
- Determine whether healthy metrics have improved and total health plan claims costs per participant per year have reduced over last year
- Set annual goals for participation and determine activities that will result in continuous improvement year to year and reflect a positive trend.
- Survey employees for comments / suggestions on wellness activities with positive results
- Analyze annual results - raw data is analyzed and translated into information that can be communicated in the form of a concise, layman's terms report to employees and to the public

FY 2016: Annual Goal - 100% of eligible employees/spouses, retirees/spouses and COBRA/spouses participate in Biometric Screening / HRA and 70% meet healthy metrics. This year's activities below are consistent with last years' activities unless re-programming is necessary to meet annual goals.

- "Know Your Numbers" Campaign continues in May - Collect and report data via Biometric Screenings and cross with key employee variables
- Determine whether healthy metrics have improved and total health plan claims costs per participant per year have reduced over last year
- Set annual goals for participation and determine activities that will result in continuous improvement year to year and reflect a positive trend.
- Survey employees for comments / suggestions on wellness activities with positive results
- Analyze annual results - raw data is analyzed and translated into information that can be communicated in the form of a concise, layman's terms report to employees and to the public

SECTION J

SAMPLE ADMINISTRATIVE AGREEMENT

SAMPLE

ADMINISTRATIVE SERVICES AGREEMENT

THIS Administrative Services Agreement (hereinafter "Agreement"), effective _____, 2014, 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 pending.
- 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 disbursement 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 charged 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 and 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.

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.

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,

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, 2014 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.

SECTION K

WILLIAMSON COUNTY

MEDICAL PLAN DOCUMENT

PLAN DOCUMENT/SUMMARY PLAN DESCRIPTION

WILLIAMSON COUNTY
EMPLOYEE HEALTH BENEFIT PLAN

PLAN DOCUMENT GENERAL EFFECTIVE DATE:
November 1, 2013

GROUP NUMBER
2001025

COVER/SIGNATURE PAGE

Effective November 1, 2013 and as otherwise specified herein, Williamson County (the "County") revised its self-funded Health Care Plan for the benefit of eligible Employees, Retirees and their eligible Dependents entitled, **WILLIAMSON COUNTY EMPLOYEE HEALTH BENEFIT PLAN** (the "Plan").

The purpose of this Plan is to provide reimbursement for Expenses Incurred for covered services, treatment or supplies as a result of Medically Necessary treatment for Illness or Injury of the County's eligible Employees, Retirees and their eligible Dependents. The County, in conjunction with any required contributions by its Employees and Retirees, agrees to make payments through its Risk Pool to the Plan's Trust in order for payments to be made for covered services, treatments or supplies as provided by this Plan.

The County has caused this instrument to be executed on this ____ day of _____, 2013, effective as specified above.

WILLIAMSON COUNTY

BY: _____

TITLE: _____

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INTRODUCTION

Effective November 1, 2013 and as otherwise specified herein, Williamson County, hereinafter referred to as the "County", through its Risk Pool revises this Plan for eligible participating Employees, referred to as "Participants;" Retirees; and the eligible Dependents of such Participants and Retirees.

Certain terms are capitalized and defined in the General Definitions section of this booklet (a term defined in that section has the specified meaning even if the word is not capitalized in this booklet). The headings in the Plan are inserted for convenience of reference only and are not to be construed or used to interpret any of the provisions of the Plan.

Williamson County (the Plan Sponsor) has retained the services of an independent Claims Supervisor, experienced in claims processing, to handle health claims. The Claims Supervisor for the Plan is:

Allegiance Benefit Plan Management, Inc.
P.O. Box 3018
Missoula, MT 59806-3018

We recommend that you read this booklet and any amendments carefully before incurring any medical expenses. If you wish, you may call or write to Allegiance Benefit Plan Management, Inc. regarding any detailed questions you may have concerning the Plan.

This Plan is not intended to, and cannot be used as workers compensation coverage for any employee or any covered dependent of an employee. Therefore, this plan generally excludes claims related to any activity engaged in for wage or profit including, but not limited to, farming, ranching, part-time and seasonal activities. See Plan Exclusions for specific information.

The information contained in this Plan Document/Summary Plan Description is only a general statement regarding FMLA, COBRA, USERRA, and QMCSO's. It is not intended to be and should not be relied upon as complete legal information about those subjects. Covered Persons and Employers should consult their own legal counsel regarding these matters.

Pre-Treatment Review or Pre-certification is required for certain services. Refer to Pre-Treatment Review or Hospital Admission Certification sections for further details.

HIPAA EXEMPTION ELECTION

As a governmental plan, the Williamson County Employee Health Benefit Plan is not required to comply with the Mental Health Parity Act (MHPA), the Newborns and Mothers Health Protection Act (NMHPA), and the Women's Health and Cancer Rights Act (WHCRA). However, the Plan has been voluntarily amended to substantially comply with the requirements of the NMHPA and WHCRA.

COMPLIANCE WITH TEXAS LOCAL GOVERNMENT CODE CHAPTER 172

GENERAL OVERVIEW

The County has elected to provide Employees and Retirees group health coverage under a Risk Pool established under Chapter 172 of the Texas Local Government Code ("Chapter 172"). The purpose of this section is to ensure compliance with Chapter 172.

RISK POOL

1. The Employer does hereby establish a Risk Pool to provide health coverage for its eligible Employees, Retirees, and their dependents 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 or Retirees 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.

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 Supervisor.
3. Before entering into a contract with a person to be a Claims Supervisor 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 Supervisor other than an insurance company must disclose:
 - A. any ownership interest that the prospective Claims Supervisor 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 Supervisor, 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 Supervisor, 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 Supervisor, provider, or reinsurer.

5. If the State of Texas enacts a law providing for the licensing or registration of Claims Supervisors, the Risk Pool in contracting for administrative services may only contract for services of a Claims Supervisor licensed or registered under the law.

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.

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.

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).

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.

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.

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, that are not dedicated by law to some other purpose.
2. The Employer in its discretion may pay all, part, or none of the contributions for coverage for Participants, Retirees, and Dependents.
3. The Employer shall in its discretion determine the share of contributions required to be paid by a Covered Person for that person's (and his or her Dependent's) coverage. The required contribution may differ for different Covered Persons or classes of Covered Persons, such as Retirees and Participants. The Employer may deduct from any compensation or benefits otherwise payable to a Covered Person an amount necessary to pay that person's (and his or her Dependent's) share of the contributions required for coverage. Contributions not deducted from compensation or other benefits shall be paid by a Covered Person in the manner determined by the Employer.
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.

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.

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."

AMENDMENT

The Board of Trustees 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.

NETWORK BENEFIT

This Plan provides benefits through a group of contracted providers (Network Providers). A Network Provider means using a Physician or other Licensed Health Care Provider who is part of a group of contracted providers. Using Network Providers offers cost-savings advantages because a Covered Person pays only a percentage of the scheduled fee for services provided.

To determine if a provider qualifies as an eligible Network Provider under this Plan, please consult Allegiance's website at www.askallegiance.com/wilco to access links for directories of Network Providers.

The Benefit Percentages for Medical Benefits may vary depending on the type of service and provider rendering the service or treatment. Non-Network Provider means a provider who is not a Network Provider. If a Non-Network Provider is chosen over a Network Provider, the Benefit Percentage will be lower (as stated in the following Schedule of Medical Benefits), unless one of the "Non-Network Benefit Exceptions stated below applies.

NON-NETWORK BENEFIT EXCEPTION

When a covered service is rendered by a Non-Network Provider, charges will be paid as if the service were rendered by a Network Provider only under the following circumstances:

1. Charges for an Emergency as defined by this Plan, limited to only those emergency medical procedures necessary to treat and stabilize an eligible injury or illness and then only to the extent that the same are necessary in order for the Covered Person to be transported, at the earliest medically appropriate time to a Network Hospital, clinic or other facility, or discharged.
2. Charges which are incurred as a result of and related to confinement in or use of a Network Hospital, clinic or other facility only for Non-Network services and providers over whom or which the Covered Person does not have any choice in or ability to select.
3. A Network Provider is not reasonably available within 50 miles (using Googlemaps.com) who can provide the service needed. **To obtain this exception, the Covered Person must request the exception in writing indicating the name and address of the patient, the Participant's name, identification number and group number, type of treatment, service or supply for which exception is needed. Requests for exceptions can be sent to Allegiance. If this exception is granted by the Plan, charges made by the Non-Network Provider will be paid at the Network benefit level. This exception will not be granted until written approval is received from the Plan.**
4. A Network Provider refers the patient to a Non-Network Provider. Medical documentation from the Network Provider stating the reason for referring the patient to a Non-Network Provider must be submitted to the Plan for review. **To obtain this exception, the Network Provider must request the exception in writing indicating the name and address of the patient, the Participant's name, identification number and group number, type of treatment, service or supply for which exception is needed including medical documentation stating the reasons for referring the patient to a Non-Network Provider. Requests for exceptions can be sent to Allegiance. If this exception is granted by the Plan, charges made by the Non-Network Provider will be paid at the Network benefit level. This exception will not be granted until written approval is received from the Plan.**

**SCHEDULE OF MEDICAL BENEFITS - EPO MEDICAL OPTION
FOR
ELIGIBLE PARTICIPANTS AND DEPENDENTS**

ALL BENEFITS PAYABLE UNDER THIS PLAN ARE SUBJECT TO THE APPLICABLE PLAN EXCLUSIONS AND THE USUAL, CUSTOMARY AND REASONABLE LIMITS OF THE PLAN

**THE BENEFIT PERIOD IS A TWELVE MONTH PERIOD
COMMENCING ON NOVEMBER 1ST AND ENDING ON OCTOBER 31ST OF EACH YEAR**

COST SHARING PROVISIONS	NETWORK BENEFITS
<u>ANNUAL DEDUCTIBLE</u>	
Per Covered Person per Benefit Period	\$300
Per Family per Benefit Period (three individual deductibles must be met in order to satisfy the Family Deductible)	\$900
<u>BENEFIT PERCENTAGE (After Deductible is satisfied)</u> (Applies to all benefits unless specifically stated otherwise)	
	90%
<u>OFFICE VISIT COPAYMENT</u>	
Primary Care Physician (PCP) Copayment per Visit	\$25
Specialist Physician (SP) Copayment per Visit	\$40
Urgent Care Copayment per Visit (Professional & Facility charges)	\$40
Benefit Percentage after Copayment	100%
<p>The Office Visit Copayment applies to all services performed in the office, by the same provider, on the same day as the office visit. Copayments do not apply towards the Out-of-Pocket maximum and will continue to apply after satisfaction of the Annual Deductible. No Copayment applies to Physician office visits for prenatal care after the first visit. No Copayment applies when an office visit charge is not assessed and the Deductible and Benefit Percentage will apply.</p> <p>“Primary Care Physician” includes Family Practice, General Practice, Internal Medicine, OB/Gyn (obstetrics/gynecology), Pediatrician, licensed nurse practitioner or Physician Assistant.</p> <p>“Specialist Physician” includes any Physician who is practicing any branch of medicine or medical specialty other than Family Practice, General Practice, Internal Medicine, OB/Gyn (obstetrics/gynecology), general pediatrics, licensed nurse practitioner or Physician Assistant.</p>	
<u>OUT-OF-POCKET MAXIMUM</u>	
Per Covered Person per Benefit Period	\$3,500
Per Family per Benefit Period	\$6,000
<p>Eligible Expenses in excess of the Out-of-Pocket Maximum will be paid at 100% for the remainder of the Benefit Period. The following expenses do not accrue towards the Out-of-Pocket Maximum: Deductible, Copayments, charges for any non-network provider, charges which exceed benefit maximums, charges paid at a reduced percentage because of non-compliance with Pre-Certification or Pre-Treatment review and the charge or portion of any charges which exceeds Usual, Customary and Reasonable guidelines.</p>	
LIFETIME MAXIMUM FOR ALL CAUSES	Unlimited

ENHANCED BENEFITS THROUGH THE DIABETES CARE PLAN
<p>The following services related to diabetes or pre-diabetes and are payable at 100% when rendered by a Network Provider:</p> <ul style="list-style-type: none"> ◆ Office visits related to diabetes or pre-diabetes, limited to three (3) visits per Benefit Period. ◆ Dilated Retinal Exam, limited to one exam per Benefit Period ◆ Hemoglobin A1C test, limited to 2 per Benefit Period ◆ Cholesterol test, limited to 1 per Benefit Period ◆ Creatine or Microalbumin, limited to 1 per Benefit Period ◆ PSA for men age 50 years or older, limited to 1 every 2 Benefit Periods ◆ Mammogram for women over 40 years, limited to 1 every 2 Benefit Periods <p>The above enhanced benefits through the Diabetes Care Plan are available only to a Covered Person who is enrolled in the Diabetes Care Plan through this plan. Services rendered must have primary diagnosis code of diabetes or pre-diabetes. The Deductible and Copayment are waived for the above services and are payable at 100% if provided by a Network Provider. Charges exceeding limits may be considered under the Medical Benefits of this Plan.</p> <p>Please contact Williamson County Human Resources Department for further details.</p>

BENEFITS / LIMITATIONS	NETWORK
PHYSICIAN SERVICES	
Office Setting charges Deductible Waived, Benefit Percentage	100% after PCP or SP Copayment
Non-Office Setting Charges Deductible Applies, Benefit Percentage	90%
ALLERGY INJECTIONS	
Deductible Applies, Benefit Percentage	90%
PREVENTIVE CARE (See Medical Benefits for further details)	
Deductible Waived, Benefit Percentage	100%
DIABETES EDUCATION AND COUNSELING	
Deductible Applies, Benefit Percentage	90%
HOSPITAL & OTHER FACILITY SERVICES (Inpatient and Outpatient)	
Inpatient Deductible Applies, Benefit Percentage Room and Board limited to average semi-private room Intensive Care Unit limited to the UCR	90%
Pre-certification is required. If Pre-certification is not obtained, benefits will be reduced by \$250.	
Outpatient Deductible Applies, Benefit Percentage	90%

BENEFITS / LIMITATIONS	NETWORK
EMERGENCY ROOM SERVICES	
Hospital Services for True Emergency (as defined by Plan) Copayment Applies, Deductible Waived, Benefit Percentage	100% after \$225 Copayment
Physician Services for True Emergency (as defined by Plan) Deductible Waived, Benefit Percentage	100%
Hospital and Physician services related to Non-Emergency	Not Covered
URGENT CARE - Professional and Facility services	
Copayment Applies, Deductible Waived, Benefit Percentage	100% after \$40 Copayment
AMBULANCE SERVICES (Ground transport or Air)	
Deductible Applies, Benefit Percentage	90%
OUTPATIENT DIAGNOSTIC SERVICE (Lab and Radiology/X-ray)	
Deductible Waived, Benefit Percentage	100%
OUTPATIENT DIAGNOSTIC/THERAPEUTIC SERVICES (CT Scans, PET Scans, MRI and Nuclear Medicine)	
Deductible Applies, Benefit Percentage	90%
OUTPATIENT THERAPEUTIC TREATMENTS (Dialysis, Intravenous Chemotherapy or other Intravenous Infusion Therapy and other treatments not listed)	
Deductible Applies, Benefit Percentage	90%
SPINAL TREATMENT/CHIROPRACTIC CARE	
Deductible Applies, Benefit Percentage Maximum of 1 visit and 1 treatment per day Max. number of visits and treatments per Benefit Period / 20	90%
DURABLE MEDICAL EQUIPMENT, PROSTHETIC DEVICE, ORTHOPEDIC APPLIANCES	
Deductible Applies, Benefit Percentage	90%
Prior notification is required when charges are expected to exceed \$1,000	
ORTHOTIC DEVICES (Only with a Diabetes Diagnosis)	
Deductible Applies, Benefit Percentage	90%
HOME HEALTH CARE	
Deductible Waived, Benefit Percentage Maximum Visits per Benefit Period / 60	100%
HOSPICE CARE	
Deductible Waived, Benefit Percentage	100%
SHORT-TERM REHABILITATIVE THERAPY OUTPATIENT SERVICES (Includes Physical Therapy,	

BENEFITS / LIMITATIONS	NETWORK
Occupational Therapy, Speech Therapy, Cardiac Therapy and Pulmonary Rehabilitation)	
Deductible Waived, Benefit Percentage Maximum Days per Benefit Period / 100	100% after \$25 Copayment

SKILLED NURSING FACILITY/INPATIENT REHABILITATION FACILITY	
Deductible Waived, Benefit Percentage Maximum Number of Days per Benefit Period / 90	100%
Pre-certification is required. If Pre-certification is not obtained, benefits will be reduced by \$250.	

ORGAN OR TISSUE TRANSPLANT SERVICES Services must be performed at a Preferred Transplant Center*	
Deductible Applies, Benefit Percentage	90%
**"Preferred Transplant Center" means a medical facility for which the Plan, either directly or through the Claims Supervisor, has obtained special billing discounts for the Covered Person and the Plan and for which the Plan or Claims Supervisor has ascertained based upon objective criteria that the facility and its Physicians have a superior degree of expertise for the transplant services provided, and the facility's positive patient outcomes are significantly higher than other comparable facilities.	

TRAVEL, LODGING AND MEALS BENEFIT Only when transplant services are performed at a Preferred Transplant Center*	
Deductible Waived, Benefit Percentage Maximum Benefit Per Benefit Period / \$10,000 . Lodging and meals are payable at 100% 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. See Medical Benefits for further details.	100%
**"Preferred Transplant or Cancer Center" means a medical facility for which the Plan, either directly or through the Claims Supervisor, has obtained special billing discounts for the Covered Person and the Plan and for which the Plan or Claims Supervisor has ascertained based upon objective criteria that the facility and its Physicians have a superior degree of expertise for the cancer or transplant services provided, and the facility's positive patient outcomes are significantly higher than other comparable facilities.	

DENTAL SERVICES	
Deductible Applies, Benefit Percentage Maximum Benefit per Benefit period / \$3,000* Maximum Benefit per tooth / \$900*	90%
*Maximum Benefit applies to Accidental Injury only. Expenses must be incurred within 6 months from date of Injury.	

OUTPATIENT MENTAL ILLNESS AND SUBSTANCE ABUSE/CHEMICAL DEPENDENCY	
Deductible Applies, Benefit Percentage Maximum number of visits per Benefit Period / 30	90%

BENEFITS / LIMITATIONS	NETWORK
INPATIENT MENTAL ILLNESS AND SUBSTANCE ABUSE/CHEMICAL DEPENDENCY	
Deductible Applies, Benefit Percentage	90%
Maximum number of Days per Benefit Period / 30 Maximum Lifetime Benefit for Substance Abuse or Chemical Dependency / 3 treatment episodes which may include Inpatient hospitalization, intensive Outpatient care, and other follow-up care through resolution and discharge as approved by StarPoint, the utilization management company. Pre-certification is required. If Pre-certification is not obtained, benefits will be reduced by \$250.	
SERIOUS MENTAL ILLNESS (as defined by Plan)	
Deductible Applies, Benefit Percentage	90%
TMJ (Temporomandibular Joint Dysfunction)	
Office Setting charges Deductible Waived, Benefit Percentage Non-Office Setting charges Deductible Applies, Benefit Percentage	100% after PCP or SP Copay 90%
HEARING AIDS	
Deductible Applies, Benefit Percentage	90%
RADIAL KERATOTOMY OR LASIK PROCEDURE	
Deductible Applies, Benefit Percentage Maximum Lifetime Benefit / \$1,500	50%
NEWBORN INPATIENT CARE	
Deductible Applies, Benefit Percentage	90%
WIG (when prescribed by M.D. or D.O. as a result of hair loss due to chemotherapy or radiation)	
Deductible Applies, Benefit Percentage Maximum Lifetime Benefit / 1	90%

**SCHEDULE OF MEDICAL BENEFITS - CORE MEDICAL OPTION
FOR
ELIGIBLE PARTICIPANTS AND DEPENDENTS**

ALL BENEFITS PAYABLE UNDER THIS PLAN ARE SUBJECT TO THE APPLICABLE PLAN EXCLUSIONS AND THE USUAL, CUSTOMARY AND REASONABLE LIMITS OF THE PLAN

**THE BENEFIT PERIOD IS A TWELVE MONTH PERIOD
COMMENCING ON NOVEMBER 1ST AND ENDING ON OCTOBER 31ST OF EACH YEAR**

COST SHARING PROVISIONS	NETWORK	NON-NETWORK
<u>ANNUAL DEDUCTIBLE</u>		
Per Covered Person per Benefit Period		\$0
Per Family per Benefit Period		\$0
<u>BENEFIT PERCENTAGE</u> (Applies to all benefits unless specifically stated otherwise)	70%	50%
<u>OUT-OF-POCKET MAXIMUM</u>		
Per Covered Person per Benefit Period	\$3,500	Unlimited
Per Family per Benefit Period	\$6,000	Unlimited
Network Eligible Expenses in excess of the Out-of-Pocket Maximum will be paid at 100% for the remainder of the Benefit Period. The following expenses do not accrue towards the Out-of-Pocket Maximum: Pharmacy Copayments, charges for any non-network provider, charges which exceed benefit maximums, charges paid at a reduced percentage because of non-compliance with Pre-Certification or Pre-Treatment review and the charge or portion of any charges which exceeds Usual, Customary and Reasonable guidelines.		
LIFETIME MAXIMUM FOR ALL CAUSES	Unlimited	

ENHANCED BENEFITS THROUGH THE DIABETES CARE PLAN
<p>The following services related to diabetes or pre-diabetes are payable at 100% when rendered by a Network Provider:</p> <ul style="list-style-type: none"> ◆ Office visits related to diabetes or pre-diabetes, limited to three (3) visits per Benefit Period. ◆ Dilated Retinal Exam, limited to one exam per Benefit Period ◆ Hemoglobin A1C test, limited to 2 per Benefit Period ◆ Cholesterol test, limited to 1 per Benefit Period ◆ Creatine or Microalbumin, limited to 1 per Benefit Period ◆ PSA for men age 50 years or older, limited to 1 every 2 Benefit Periods ◆ Mammogram for women over 40 years, limited to 1 every 2 Benefit Periods <p>The above enhanced benefits through the Diabetes Care Plan are available only to a Covered Person who is enrolled in the Diabetes Care Plan through this plan. Services rendered must have primary diagnosis code of diabetes or pre-diabetes. The Deductible and Copayment are waived for the above services and are payable at 100% if provided by a Network Provider. Charges exceeding limits or rendered by a Non-Network Provider may be considered under the Medical Benefits of this Plan.</p> <p>Please contact Williamson County Human Resources Department for further details.</p>

BENEFITS / LIMITATIONS	NETWORK	NON-NETWORK
Benefit maximums are combined for services received from Network and Non-Network providers.		
PHYSICIAN SERVICES		
Benefit Percentage	70%	50%
ALLERGY INJECTIONS		
Benefit Percentage	70%	50%
PREVENTIVE CARE (See Medical Benefits for further details)		
Benefit Percentage	100%	Not Covered
DIABETES EDUCATION AND COUNSELING		
Benefit Percentage	70%	70%
HOSPITAL & OTHER FACILITY SERVICES (Inpatient and Outpatient)		
Inpatient Benefit Percentage Room and Board limited to average semi-private room Intensive Care Unit limited to the UCR	90%	50%
Pre-certification is required. If Pre-certification is not obtained, benefits will be reduced by \$250.		
Outpatient Benefit Percentage	90%	50%
EMERGENCY ROOM SERVICES		
Hospital Services for True Emergency (as defined by Plan) Benefit Percentage	70%	70%
Physician Services for True Emergency (as defined by Plan) Benefit Percentage	70%	70%
Hospital and Physician services related to Non-Emergency	Not Covered	
URGENT CARE - Professional and Facility services		
Benefit Percentage	70%	70%
AMBULANCE SERVICES (Group transport or Air)		
Benefit Percentage	90%	90%
OUTPATIENT DIAGNOSTIC SERVICE (Lab and Radiology/X-ray)		
Benefit Percentage	100%	50%
OUTPATIENT DIAGNOSTIC/THERAPEUTIC SERVICES (CT Scans, PET Scans, MRI and Nuclear Medicine)		
Benefit Percentage	70%	50%

BENEFITS / LIMITATIONS	NETWORK	NON-NETWORK
Benefit maximums are combined for services received from Network and Non-Network providers.		

OUTPATIENT THERAPEUTIC TREATMENTS (Dialysis, Intravenous Chemotherapy or other Intravenous Infusion Therapy and other treatments not listed)

Benefit Percentage	70%	50%
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SPINAL TREATMENT/CHIROPRACTIC CARE

Benefit Percentage Maximum of 1 visit and 1 treatment per day Max. number of visits and treatments per Benefit Period / 20	70%	50%
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DURABLE MEDICAL EQUIPMENT, PROSTHETIC DEVICE, ORTHOPEDIC APPLIANCES

Benefit Percentage	70%	50%
Prior notification is required when charges are expected to exceed \$1,000		

ORTHOTIC DEVICES (Only with a Diabetes Diagnosis)

Benefit Percentage	70%	50%
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HOME HEALTH CARE

Benefit Percentage Maximum Visits per Benefit Period / 60	100%	50%
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HOSPICE CARE

Benefit Percentage	100%	100%
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SHORT-TERM REHABILITATIVE THERAPY OUTPATIENT SERVICES (Includes Physical Therapy, Occupational Therapy, Speech Therapy, Cardiac Therapy and Pulmonary Rehabilitation)

Benefit Percentage Maximum Days per Benefit Period / 100	70%	50%
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SKILLED NURSING FACILITY/INPATIENT REHABILITATION FACILITY

Benefit Percentage Maximum Number of Days per Benefit Period / 90	100%	50%
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Pre-certification is required. If Pre-certification is not obtained, benefits will be reduced by \$250.

ORGAN OR TISSUE TRANSPLANT SERVICES

Services must be performed at a Preferred Transplant Center*

Benefit Percentage	70%	50%
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**"Preferred Transplant Center" means a medical facility for which the Plan, either directly or through the Claims Supervisor, has obtained special billing discounts for the Covered Person and the Plan and for which the Plan or Claims Supervisor has ascertained based upon objective criteria that the facility and its Physicians have a superior degree of expertise for the transplant services provided, and the facility's positive patient outcomes are significantly higher than other comparable facilities.

BENEFITS / LIMITATIONS	NETWORK	NON-NETWORK
Benefit maximums are combined for services received from Network and Non-Network providers.		

TRAVEL, LODGING AND MEALS BENEFIT

Only when transplant services are performed at a Preferred Transplant Center*

Benefit Percentage Maximum Benefit Per Benefit Period / \$10,000 . Lodging and meals are payable at 100% 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. See Medical Benefits for further details.	100%	
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*"Preferred Transplant or Cancer Center" means a medical facility for which the Plan, either directly or through the Claims Supervisor, has obtained special billing discounts for the Covered Person and the Plan and for which the Plan or Claims Supervisor has ascertained based upon objective criteria that the facility and its Physicians have a superior degree of expertise for the cancer or transplant services provided, and the facility's positive patient outcomes are significantly higher than other comparable facilities.

DENTAL SERVICES

Benefit Percentage Maximum Benefit per Benefit period / \$3,000* Maximum Benefit per tooth / \$900*	70%	70%
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*Maximum Benefit applies to Accidental Injury only. Expenses must be incurred within 6 months from date of Injury.

OUTPATIENT MENTAL ILLNESS AND SUBSTANCE ABUSE/CHEMICAL DEPENDENCY

Benefit Percentage Maximum number of visits per Benefit Period / 30	70%	50%
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INPATIENT MENTAL ILLNESS AND SUBSTANCE ABUSE/CHEMICAL DEPENDENCY

Facility charges: Benefit Percentage All other services: Benefit Percentage	90% 70%	50% 50%
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Maximum number of Days per Benefit Period / **30**
Maximum Lifetime Benefit for Substance Abuse or Chemical Dependency / **3 treatment episodes which may include Inpatient hospitalization, intensive Outpatient care, and other follow-up care through resolution and discharge as approved by StarPoint, the utilization management company. Pre-certification is required. If Pre-certification is not obtained, benefits will be reduced by \$250.**

SERIOUS MENTAL ILLNESS (as defined by Plan)

Outpatient Services Benefit Percentage	70%	70%
Inpatient Services Facility charges only Benefit Percentage All other services Benefit Percentage	90% 70%	50% 50%

TMJ (Temporomandibular Joint Dysfunction)

BENEFITS / LIMITATIONS	NETWORK	NON-NETWORK
Benefit maximums are combined for services received from Network and Non-Network providers.		
Benefit Percentage	70%	50%
HEARING AIDS		
Benefit Percentage	70%	50%
RADIAL KERATOTOMY OR LASIK PROCEDURE		
Benefit Percentage Maximum Lifetime Benefit / \$1,500	50%	50%
NEWBORN INPATIENT CARE		
Benefit Percentage	70%	50%
WIG (when prescribed by M.D. or D.O. as a result of hair loss due to chemotherapy or radiation)		
Benefit Percentage Maximum Lifetime Benefit / 1	70%	70%

**SCHEDULE OF MEDICAL BENEFITS - DEDUCTIBLE MEDICAL OPTION
FOR
ELIGIBLE PARTICIPANTS AND DEPENDENTS**

ALL BENEFITS PAYABLE UNDER THIS PLAN ARE SUBJECT TO THE APPLICABLE PLAN EXCLUSIONS AND THE USUAL, CUSTOMARY AND REASONABLE LIMITS OF THE PLAN

**THE BENEFIT PERIOD IS A TWELVE MONTH PERIOD
COMMENCING ON NOVEMBER 1ST AND ENDING ON OCTOBER 31ST OF EACH YEAR**

COST SHARING PROVISIONS	NETWORK	NON-NETWORK
<u>ANNUAL DEDUCTIBLE</u>		
Per Covered Person per Benefit Period	\$1,250	\$2,500
Per Family per Benefit Period (three individual deductibles must be met in order to satisfy the Family Deductible)	\$3,750	\$7,500
Network charges apply only toward the Network Deductible and Non-Network charges apply only toward the Non-Network Deductible.		
<u>BENEFIT PERCENTAGE (After Deductible is satisfied)</u> (Applies to all benefits unless specifically stated otherwise)		
	80%	60%
<u>OFFICE VISIT FOR COPAYMENT</u>		
Primary Care Physician (PCP) Copayment per Visit	\$25	---
Specialist Physician (SP) Copayment per Visit	\$40	---
Urgent Care Copayment per Visit (Professional & Facility charges)	\$40	\$40
Benefit Percentage after Copayment for Network Providers	100%	---
Benefit Percentage after Deductible for Non-Network	---	60%
The Office Visit Copayment applies to all services performed in the office, by the same provider, on the same day as the office visit. Copayments do not apply towards the Out-of-Pocket maximum and will continue to apply after satisfaction of the Annual Deductible. No Copayment applies when an office visit charge is not assessed and the Deductible and Benefit Percentage will apply.		
“Primary Care Physician” includes Family Practice, General Practice, Internal Medicine, OB/Gyn (obstetrics/gynecology), Pediatrician, licensed nurse practitioner or Physician Assistant.		
“Specialist” includes any Physician who is practicing any branch of medicine or medical specialty other than Family Practice, General Practice, Internal Medicine, OB/Gyn (obstetrics/gynecology), general pediatrics, licensed nurse practitioner or Physician Assistant.		
<u>OUT-OF-POCKET MAXIMUM</u>		
Per Covered Person per Benefit Period	\$3,000	Unlimited
Per Family per Benefit Period	\$9,000	Unlimited
Network Eligible Expenses in excess of the Out-of-Pocket Maximum will be paid at 100% for the remainder of the Benefit Period. The following expenses do not accrue towards the Out-of-Pocket Maximum: Deductible, Copayments, charges for any non-network provider, charges which exceed benefit maximums, charges paid at a reduced percentage because of non-compliance with Pre-Certification or Pre-Treatment review and the charge or portion of any charges which exceeds Usual, Customary and Reasonable guidelines.		
<u>LIFETIME MAXIMUM FOR ALL CAUSES</u>		Unlimited

ENHANCED BENEFITS THROUGH THE DIABETES CARE PLAN
<p>The following services related to diabetes or pre-diabetes are payable at 100% when rendered by a Network Provider:</p> <ul style="list-style-type: none"> ◆ Office visits related to diabetes or pre-diabetes, limited to three (3) visits per Benefit Period. ◆ Dilated Retinal Exam, limited to one exam per Benefit Period ◆ Hemoglobin A1C test, limited to 2 per Benefit Period ◆ Cholesterol test, limited to 1 per Benefit Period ◆ Creatine or Microalbumin, limited to 1 per Benefit Period ◆ PSA for men age 50 years or older, limited to 1 every 2 Benefit Periods ◆ Mammogram for women over 40 years, limited to 1 every 2 Benefit Periods <p>The above enhanced benefits through the Diabetes Care Plan are available only to a Covered Person who is enrolled in the Diabetes Care Plan through this plan. Services rendered must have primary diagnosis code of diabetes or pre-diabetes. The Deductible and Copayment are waived for the above services and are payable at 100% if provided by a Network Provider. Charges exceeding limits or rendered by a Non-Network Provider may be considered under the Medical Benefits of this Plan.</p> <p>Please contact Williamson County Human Resources Department for further details.</p>

BENEFITS / LIMITATIONS	NETWORK	NON-NETWORK
Benefit maximums are combined for services received from Network and Non-Network providers.		

PHYSICIAN SERVICES

<p>Network Office setting charges Deductible Waived, Benefit Percentage</p>	100% after \$25 PCP Copayment or \$40 SP Copayment	---
<p>Non-Network Office setting charges Deductible Applies, Benefit Percentage</p>	---	60%
<p>Network and Non-Network non-office setting charges Deductible Applies, Benefit Percentage</p>	80%	60%

ALLERGY INJECTIONS

Deductible Applies, Benefit Percentage	80%	60%
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PREVENTIVE CARE (See Medical Benefits for further details)

Deductible Waived, Benefit Percentage	100%	Not Covered
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DIABETES EDUCATION AND COUNSELING

Deductible Applies, Benefit Percentage	80%	80%
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HOSPITAL & OTHER FACILITY SERVICES (Inpatient and Outpatient)

<p>Inpatient Deductible Applies, Benefit Percentage Room and Board limited to average semi-private room Intensive Care Unit limited to the UCR</p>	80%	60%
Pre-certification is required. If Pre-certification is not obtained, benefits will be reduced by \$250.		

BENEFITS / LIMITATIONS	NETWORK	NON-NETWORK
Benefit maximums are combined for services received from Network and Non-Network providers.		
Outpatient Deductible Applies, Benefit Percentage	80%	60%

EMERGENCY ROOM SERVICES

Hospital Services for True Emergency (as defined by Plan) Copayment Applies, Deductible Waived, Benefit Percentage	100% after \$225 Copayment	100% after \$225 Copayment
Physician Services for True Emergency (as defined by Plan) Deductible Applies, Benefit Percentage	100%	100%
Hospital and Physician services related to Non-Emergency	Not Covered	

URGENT CARE - Professional and Facility services

Deductible Waived, Benefit Percentage	100% after \$40 Copayment	100% after \$40 Copayment
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AMBULANCE SERVICES (Group transport or Air)

Deductible Applies, Benefit Percentage	80%	80%
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OUTPATIENT DIAGNOSTIC SERVICE (Lab and Radiology/X-ray)

Deductible Waived, Benefit Percentage	100%	60%
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OUTPATIENT DIAGNOSTIC/THERAPEUTIC SERVICES (CT Scans, PET Scans, MRI and Nuclear Medicine)

Deductible Applies, Benefit Percentage	80%	60%
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OUTPATIENT THERAPEUTIC TREATMENTS (Dialysis, Intravenous Chemotherapy or other Intravenous Infusion Therapy and other treatments not listed)

Deductible Applies, Benefit Percentage	80%	60%
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SPINAL TREATMENT/CHIROPRACTIC CARE

Deductible Applies, Benefit Percentage Maximum of 1 visit and 1 treatment per day Max. number of visits and treatments per Benefit Period / 20	80%	60%
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DURABLE MEDICAL EQUIPMENT, PROSTHETIC DEVICE, ORTHOPEDIC APPLIANCES

Deductible Applies, Benefit Percentage	80%	60%
Prior notification is required when charges are expected to exceed \$1,000		

ORTHOTIC DEVICES (Only with a Diabetes Diagnosis)

Deductible Applies, Benefit Percentage	80%	60%
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HOME HEALTH CARE

Deductible Waived for Network Only, Benefit Percentage	100%	60%
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BENEFITS / LIMITATIONS	NETWORK	NON-NETWORK
Benefit maximums are combined for services received from Network and Non-Network providers.		

Maximum Visits per Benefit Period / 60		
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HOSPICE CARE

Deductible Waived for Network Only, Benefit Percentage	100%	100%
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SHORT-TERM REHABILITATIVE THERAPY OUTPATIENT SERVICES (Includes Physical Therapy, Occupational Therapy, Speech Therapy, Cardiac Therapy and Pulmonary Rehabilitation)

Deductible Waived, Benefit Percentage Maximum Days per Benefit Period / 100	100% after \$25 Copayment per visit	60%
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SKILLED NURSING FACILITY/INPATIENT REHABILITATION FACILITY

Deductible Waived, Benefit Percentage Maximum Number of Days per Benefit Period / 90	100%	60%
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Pre-certification is required. If Pre-certification is not obtained, benefits will be reduced by \$250.

ORGAN OR TISSUE TRANSPLANT SERVICES

Services must be performed at a Preferred Transplant Center*

Deductible Applies, Benefit Percentage	80%	60%
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*"Preferred Transplant Center" means a medical facility for which the Plan, either directly or through the Claims Supervisor, has obtained special billing discounts for the Covered Person and the Plan and for which the Plan or Claims Supervisor has ascertained based upon objective criteria that the facility and its Physicians have a superior degree of expertise for the transplant services provided, and the facility's positive patient outcomes are significantly higher than other comparable facilities.

TRAVEL, LODGING AND MEALS BENEFIT

Deductible Waived, Benefit Percentage Maximum Benefit Per Benefit Period / \$10,000 . Lodging and meals are payable at 100% 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. See Medical Benefits for further details.	100%
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"Preferred Transplant or Cancer Center" means a medical facility for which the Plan, either directly or through the Claims Supervisor, has obtained special billing discounts for the Covered Person and the Plan and for which the Plan or Claims Supervisor has ascertained based upon objective criteria that the facility and its Physicians have a superior degree of expertise for the cancer or transplant services provided, and the facility's positive patient outcomes are significantly higher than other comparable facilities.

DENTAL SERVICES

Deductible Applies, Benefit Percentage Maximum Benefit per Benefit period / \$3,000* Maximum Benefit per tooth / \$900*	80%	80%
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BENEFITS / LIMITATIONS	NETWORK	NON-NETWORK
Benefit maximums are combined for services received from Network and Non-Network providers.		
*Maximum Benefit applies to Accidental Injury only. Expenses must be incurred within 6 months from date of Injury.		

OUTPATIENT MENTAL ILLNESS AND SUBSTANCE ABUSE/CHEMICAL DEPENDENCY

Deductible Applies, Benefit Percentage Maximum number of visits per Benefit Period / 30	80%	60%
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INPATIENT MENTAL ILLNESS AND SUBSTANCE ABUSE/CHEMICAL DEPENDENCY

Facility charges: Deductible Applies, Benefit Percentage	80%	60%
All other services: Deductible Applies, Benefit Percentage	80%	60%
Maximum number of Days per Benefit Period / 30 Maximum Lifetime Benefit for Substance Abuse or Chemical Dependency / 3 treatment episodes which may include Inpatient hospitalization, intensive Outpatient care, and other follow-up care through resolution and discharge as approved by StarPoint, the utilization management company. Pre-certification is required. If Pre-certification is not obtained, benefits will be reduced by \$250.		

SERIOUS MENTAL ILLNESS (as defined by Plan)

Deductible Applies, Benefit Percentage	80%	60%
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TMJ (Temporomandibular Joint Dysfunction)

Office Setting charges Deductible Waived, Benefit Percentage	100% after PCP or SP Copay	60%
Non-Office Setting charges Deductible Applies, Benefit Percentage	80%	60%

HEARING AIDS

Deductible Applies, Benefit Percentage	80%	60%
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RADIAL KERATOTOMY OR LASIK PROCEDURE

Deductible Applies, Benefit Percentage Maximum Lifetime Benefit / \$1,500	50%	50%
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NEWBORN INPATIENT CARE

Deductible Applies, Benefit Percentage	80%	60%
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WIG (when prescribed by M.D. or D.O. as a result of hair loss due to chemotherapy or radiation)

Deductible Applies, Benefit Percentage Maximum Lifetime Benefit / 1	80%	60%
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PHARMACY BENEFIT

Prescription drug charges are payable only through the Plan’s Pharmacy Benefit Management (PBM) program, which program is sponsored in conjunction with and is an integral part of this Plan. **The Pharmacy Benefit Manager (PBM) will provide separate information for details regarding pharmacies and Specialty Drugs upon enrollment for coverage under this Plan.**

Generics preferred - Physician choice (DAW2) - If the Physician does not prescribe “Dispense as Written”, and there is a generic alternative for the prescription drug, and the Covered Person chooses a brand name instead, the Covered Person must pay the difference in cost between the generic and brand name medication plus the applicable brand copayment amount. **This amount sometimes referred to as the ancillary charge will not apply towards the Pharmacy Out-of-Pocket Maximum and will continue to apply after satisfying the Pharmacy Out-of-Pocket Maximum.**

If the Physician prescribes a brand name drug and communicates on the prescription “Dispense as Written” (DAW), the Covered Person will pay the brand name copayment only.

There is no coordination of benefits for Pharmacy Benefits.

COST SHARING PROVISIONS - ALL MEDICAL OPTIONS

Pharmacy Deductible - Applies to all prescriptions, except as specifically waived
Per Covered Person per Benefit Period..... \$50

Pharmacy Out-of-Pocket Maximum - Applies to all prescriptions, except as specifically waived
Per Covered Person per Benefit Period.....\$1,250*

*Does not include the Pharmacy Deductible

The Pharmacy Out-of-Pocket Maximum applies to all Pharmacy charges. After satisfaction of the Pharmacy Out-of-Pocket Maximum per Covered Person in any Benefit Period, the Copayment will be \$0 for the remainder of the Benefit Period.

Copayment per Prescription				
Drug Type	Retail (31-day supply)	Member Submit* (31-day supply)	Mail Order 90-day supply	Specialty Drug per 31-day supply
Generic	30% up to \$100 max	30% up to \$100 max	\$20	\$125
Brand	30% up to \$100 max	30% up to \$100 max	\$70	\$125
The Deductible and Copayment are waived and the following are payable at 100%:				
<ol style="list-style-type: none"> 1. Prescribed generic contraceptives or brand if generic is unavailable. 2. Smoking cessation products prescribed by a Physician or Licensed Health Care Provider. 3. Over-the-counter (OTC) medications only with a written prescription by a Physician or Licensed Health Care Provider as follows: FDA approved OTC female contraceptives, aspirin to prevent cardiovascular disease (CVD) for men and women, oral fluoride supplementation, iron supplementation in children and supplementation with folic acid for all women capable of pregnancy (daily supplement). 4. Diabetic drugs only if 18 years of age or older and enrolled in Diabetes Care Plan. 				
Mail Order Copay applies to Retail prescriptions (32-90 day supply) obtained at CVS pharmacies only.				
*For Member Submit prescriptions, the PBM will reimburse the contract cost of the prescription drug, less the applicable Copayment per Prescription. Contract cost is the PBM's discounted cost of the prescription drug.				

COVERAGE

Coverage for prescription drugs will include only those drugs requiring a written prescription of a Physician or Licensed Health Care Provider, if within the scope of practice of the Licensed Health Care Provider, and that are Medically Necessary for the treatment of an Illness or Injury.

Coverage also includes prescription drugs or supplies that require a written prescription of a Physician or Licensed Health Care Provider, if within the scope of practice of the Licensed Health Care Provider, as follows:

1. Self-administered contraceptives and over-the-counter FDA approved female contraceptives with a written prescription by a Physician or Licensed Health Care Provider., Deductible and Copay are waived.
2. Legend vitamins (oral only): Prenatal agents used in pregnancy; therapeutic agents used for specific deficiencies and conditions; and hemopoetic agents used to treat anemia.
3. Legend fluoride products (oral only): Dental or pediatric.
4. Diabetic supplies, including syringes, needles, swabs, blood test strips (glucose or ketone), blood glucose calibration solutions, urine tests, lancets and lancet devices.
5. Impotency drugs (injectable, oral, suppository, kits): Quantity limited to 8 units per 25 days.
6. Nutritional supplements for PKU.
7. Tobacco cessation products, Deductible and Copay are waived.

8. Growth hormone.
9. The following over-the-counter medications are payable at 100%, deductible and coinsurance are waived, only with a written prescription by a Physician as specifically covered as Recommended Preventive Services:
 - A. Aspirin to prevent cardiovascular disease (CVD) for men and women.
 - B. Oral fluoride supplementation.
 - C. Iron supplementation in children.
 - D. Supplementation with folic acid for all women capable of pregnancy (daily supplement).

SERVICE OPTIONS

The Program includes the following Service Options for obtaining prescriptions under the Pharmacy Benefit:

Retail Prescriptions: Available only through a retail pharmacy. The pharmacy will bill the Plan directly for that part of the prescription cost that exceeds the Copayment (Copayment amount must be paid to pharmacy at time of purchase). **The prescription identification card is required for this option.**

Member Submit Prescriptions: Available only if the prescription identification card cannot be used or is not used at a retail pharmacy. **Prescriptions must be paid for at the point of purchase and the prescription drug receipt must be submitted to the Pharmacy Benefit Manager (PBM), along with a reimbursement form (Direct Reimbursement). The PBM will reimburse the contract cost of the prescription drug, less the applicable Copayment per Prescription. Contract cost is the PBM's discounted cost of the prescription drug.**

Mail Order Prescriptions: Available only through a licensed pharmacy that fills prescriptions and delivers them to Covered Persons through the United States Postal Service, United Parcel Service or other delivery service. **The pharmacy will bill the Plan directly for prescription costs that exceed the Copayment.**

Specialty Drug(s): These medications are generic or non-generic drugs classified by the Plan and listed by the PBM as Specialty Drugs and require special handling (e.g., most injectable drugs other than insulin). Specialty drugs must be obtained from a CVS Caremark Specialty Pharmacy. **After two (2) refills are obtained at retail pharmacy, all subsequent refills must be obtained through a CVS Caremark Pharmacy.**

DRUG OPTIONS

The drug options available are:

Generic: Those drugs and supplies listed in the most current edition of the Physicians Desk Reference or by the PBM Program as generic drugs.

Brand: Copyrighted or patented brand name drugs (Non-Generic).

COPAYMENT

"Copayment" means a dollar amount fixed as either a percentage or a specific dollar amount per prescription payable to the pharmacy at the time of service. Copayments are specifically stated in this section and apply towards the Pharmacy Out-of-Pocket Maximum. Copayments are not payable by the Plan and do not serve to satisfy the Medical Benefits Annual Deductible or Out-of-Pocket Maximum.

SUPPLY LIMITS

Supply is limited to a maximum of 90 days for Retail Prescriptions and Member Submit, 31 days for Specialty Drug, and 90-day supply for Mail Order Prescriptions.

Prescription drug refills are not allowed until 75% of the prescribed day supply is used.

PRIOR AUTHORIZATION

Certain drugs require approval before the drug can be dispensed. A current list of drugs that require prior authorization can be obtained by contacting the PBM at the number listed on your identification card.

EXCLUSIONS

Prescription drugs or supplies in the following categories are specifically excluded:

1. Cosmetic only indications, including but not limited to, photo-aged skin products (Renova); Hair Growth Agents (Propecia, Vaniqa); and Injectable cosmetics (botox cosmetic).
2. Dermatology: Tretinoin agents used in the treatment of acne and/or for cosmetic purposes (Retin A) for Covered Persons 30 years or older subject to medical review or depigmentation products used for skin conditions requiring a bleaching agent.
3. Legend homeopathic drugs.
4. Fertility agents, oral, vaginal and injectable.
5. Weight management.
6. Allergen injectables.
7. Serums, toxoids and vaccines*.
8. Over-the-counter equivalents and non-legend medications (OTC), except as covered under the Preventive Care Benefit.
9. Blood monitors and kits (glucose or ketone)*.
10. Durable Medical Equipment*.
11. Experimental or Investigational drugs.
12. Abortifacient drugs.

*Eligible for coverage under the Medical Benefits, subject to all provisions and limitations of this Plan.

MEDICAL BENEFIT DETERMINATION REQUIREMENTS

ELIGIBLE SERVICES, TREATMENTS AND SUPPLIES

Services, treatments or supplies are eligible for coverage if they meet all of the following requirements:

1. They are administered, ordered or provided by a Physician or other eligible Licensed Health Care Provider; and
2. They are Medically Necessary for the diagnosis and treatment of an Illness or Injury or they are specifically included as a benefit if not Medically Necessary; and
3. Charges do not exceed the Usual, Customary and Reasonable limits of the Plan; and
4. They are not excluded under any provision or section of this Plan.

Treatments, services or supplies excluded by this Plan may be reimbursable if such charges are approved by the Contract Administrator prior to beginning such treatment. Prior approval is limited to medically accepted non-experimental or investigational treatments, services, or supplies, which, in the opinion of the Contract Administrator, are more cost effective than a covered treatment, service or supply for the same Illness or Injury, and which benefit the Covered Person.

DEDUCTIBLE - EPO AND DEDUCTIBLE MEDICAL OPTIONS

The Deductible applies to Expenses Incurred during each Benefit Period, unless specifically waived, but it applies only once for each Covered Person within a Benefit Period. Also, if at least three members of a Family have satisfied individual Deductible amounts as stated in the Schedule of Medical Benefits, during the same Benefit Period, no further Deductible will apply to any member of that Family during that Benefit Period. **An individual Covered Person cannot receive credit toward the Family Deductible for more than the Individual Annual Deductible as stated in the Schedule of Medical Benefits.**

DEDUCTIBLE - CORE MEDICAL OPTION

This option is not subject to a Deductible for Medical Benefits.

BENEFIT PERCENTAGE

The Benefit Percentage is stated in the Schedule of Medical Benefits. The Plan will pay the Benefit Percentage of the Eligible Expense indicated.

OUT-OF-POCKET MAXIMUM

The Out-of-Pocket Maximum, per Covered Person or Family, whichever is applicable, is stated in the Schedule of Medical Benefits and includes amounts in excess of the Benefit Percentage paid by the Plan.

The Out-of-Pocket Maximum does not include: Deductibles and Copayments (EPO and Deductible Medical Options), charges which exceed benefit maximums, charges paid at a reduced percentage because of non-compliance with Pre-Certification or Pre-Treatment review, charges for any non-network provider, and the charge or portion of any charges which exceeds Usual, Customary and Reasonable guidelines. Expenses Incurred in a single Benefit Period after satisfaction of the Out-of-Pocket Maximum per Covered Person or per Family, whichever is applicable, will be paid at 100% of the Eligible Expense for the remainder of the Benefit Period. **An individual Covered Person cannot receive credit toward**

the Family Out-of-Pocket Maximum for more than the Individual Out-of-Pocket Maximum as stated in the Schedule of Medical Benefits.

COPAYMENT

The amount of Eligible Expense not payable by the Plan that is the responsibility of the Covered Person exclusive of any applicable Deductible.

MAXIMUM BENEFIT

The amount payable by the Plan will not exceed any Maximum Benefit or Maximum Lifetime Benefit as stated in the Schedule of Medical Benefits, for any reason.

APPLICATION OF DEDUCTIBLE AND ORDER OF BENEFIT PAYMENT

Deductibles will be applied to Expenses Incurred in the chronological order in which they are adjudicated by the Plan. Expenses Incurred will be paid by the Plan in the chronological order in which they are adjudicated by the Plan. The manner in which the Deductible is applied and Expenses Incurred are paid by the Plan will be conclusive and binding on all Covered Persons and their assignees.

CHANGES IN COVERAGE CLASSIFICATION

A change in coverage that decreases a benefit of this Plan will become effective on the stated effective date of such change with regard to all Covered Persons to whom it applies.

MEDICAL BENEFITS

Medical Benefits that are incurred by a Covered Person for the following are payable as stated in the Schedule of Medical Benefits, subject to all terms and conditions of this Plan:

1. Hospital services for:

A. Daily Room and Board in a Semi-Private Room (or private room if no Semi-Private room is available or when confinement in a private room is Medically Necessary) and general nursing services, or confinement in an Intensive Care Unit, not to exceed the applicable limits shown in the Schedule of Medical Benefits.

B. Medically Necessary Hospital Miscellaneous Expenses other than Room and Board furnished by the Hospital, including Inpatient miscellaneous service and supplies, Outpatient Hospital treatments for chronic conditions and emergency room use for an Emergency only, Physical Therapy treatments, hemodialysis, and x-ray.

C. Nursery neonatal units, general nursing services, including Hospital Miscellaneous Expenses for services and supplies, Physical Therapy, hemodialysis and x-ray, care or treatment of Injury or Illness, congenital defects, birth abnormalities or premature delivery incurred by a Newborn Dependent.

D. Therapy which has been prescribed by a speech pathologist or Physician and includes a written treatment plan with estimated length of time for therapy.

2. Ambulatory Surgical Center services when treatment has been 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.

“Ambulatory Surgical Center” (also called same-day surgery center or Outpatient surgery center) means a licensed establishment with an organized staff of Physicians and permanent facilities, either freestanding or as a part of a Hospital, equipped and operated primarily for the purpose of performing surgical procedures and which a patient is admitted to and discharged from within a twenty-four (24) hour period. Such facilities must provide continuous Physician and registered nursing services whenever a patient is in the facility. An Ambulatory Surgical Center must meet any requirements for certification or licensing for ambulatory surgery centers in the state in which the facility is located.

“Ambulatory Surgical Center” does not include an office or clinic maintained by a Dentist or Physician for the practice of dentistry or medicine, a Hospital emergency room or trauma center.

3. Urgent Care Facility services when treatment has been rendered.

“Urgent Care Facility” means a free-standing facility which is engaged primarily in diagnosing and treating Illness or Injury for unscheduled, ambulatory Covered Persons seeking immediate medical attention. A clinic or office located in or in conjunction with or in any way made a part of a Hospital will be excluded from the terms of this definition.

4. Services and supplies furnished by a Birthing Center.

5. Hospice care services provided in accordance with a Hospice health care program within any one Hospice Benefit Period for:

A. Room and Board, including any charges made by the facility as a condition of occupancy, or on a regular daily or weekly basis such as general nursing services. If private room accommodations are used, the daily Room and Board charge allowed will not exceed the facility's average Semi-Private charges or an average Semi-Private rate made by a representative cross section of similar institutions in the area.

B. Nursing care by a Registered Nurse (R.N.), a Licensed Practical Nurse (L.P.N.), a public health nurse who is under the direct supervision of a Registered Nurse.

C. Physical Therapy when rendered by a licensed therapist.

D. Medical supplies, including drugs and biologicals and the use of medical appliances.

E. Physician's services.

F. Services, supplies, and treatments deemed Medically Necessary and ordered by a licensed Physician.

G. Nutritional guidance given by a registered nutritionist.

H. Hospice services provided 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.

I. 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.

"Hospice Benefit Period" means a specified amount of time during which the Covered Person undergoes treatment by a Hospice. Such time period begins on the date the attending Physician of a Covered Person certifies a diagnosis of terminal illness, and the Covered Person is accepted into a Hospice program. The period will end the earliest of six months from this date or at the death of the Covered Person. A new Hospice Benefit Period may begin if the attending Physician certifies that the patient is still terminally ill; however, additional proof will be required by the Contract Administrator before a new Hospice Benefit Period can begin.

6. Services of a licensed Physician or Licensed Health Care Provider for medical care and/or treatments, including office, home visits, Hospital Inpatient care, Hospital Outpatient visits/exams, clinic care, and surgical opinion consultations.

Also eligible are drugs intended for use in a physicians' office or settings other than home use that are billed during the course of an evaluation or management encounter.

7. Pregnancy, including charges for prenatal care, childbirth, miscarriage, and any medical complications arising out of or resulting from Pregnancy.

8. Surgical Procedures.

For Non-Network Providers, when two or more Surgical Procedures occur during the same operative session, charges will be considered as follows:

A. When multiple or bilateral Surgical Procedures are performed that increase the time and amount of patient care, 100% of the Eligible Expense will be considered for the Major Procedure; and 50% of the Eligible Expense will be considered for each of the lesser procedures, except for contracted or negotiated services. Contracted or negotiated services will be reimbursed at the contracted or negotiated rate.

B. When an incidental procedure is performed through the same incision, only the Eligible Expense for the Major Procedure will be considered. Examples of incidental procedures are: excision of a scar, appendectomy at the time of other abdominal surgery, lysis of adhesions, etc.

When an assisting Physician is required to render technical assistance during a Surgical Procedure, the charges for such services will be limited to 25% of the primary surgeon's Eligible Expense for the Surgical Procedure. When an assisting non-physician is required to render technical assistance during an operation, charges for such services will be limited to 10% of the surgeon's Eligible Expense for the Surgical Procedure.

For Network Providers payment will be made pursuant to the provider contract.

9. Charges for Registered Nurses (R.N.'s) or Licensed Practical Nurses (L.P.N.'s) for private duty nursing.

10. Services of a Certified Nurse Midwife (CNM). Nurse Midwife is a licensed Registered Nurse (R.N.) 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.

11. Home infusion services ordered by a Physician and provided by a home infusion therapy organization licensed and approved within the state in which the services are provided. A home infusion therapy organization is a health care facility that provides home infusion therapy services and skilled nursing services. Home infusion therapy services include the preparation, administration, or furnishing of parenteral medications, or parenteral or enteral nutritional services to a Covered Person by a home infusion therapy organization. Services also include education for the Covered Person, the Covered Person's care giver, or a family member. Home infusion therapy services include pharmacy, supplies, equipment and skilled nursing services when billed by a home infusion therapy organization.

Skilled nursing services billed by a home health agency are covered under the Home Health Care Benefit.

12. Chiropractic services rendered by a Doctor of Chiropractic (D.C.) 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. **Benefit limits apply as stated in the Schedule of Medical Benefits.**

13. Ambulance Service to the nearest facility where Emergency care or treatment can be rendered; or from one facility to another for care; or from a facility to the patient's home when Medically Necessary.

14. Drugs requiring the written prescription of a Physician or a Licensed Health Care Provider and Medically Necessary for the treatment of an Illness or Injury. Coverage also includes prescription contraceptive drugs and over-the-counter FDA approved female contraceptives with a written prescription by a Physician or Licensed Health Care Provider regardless of Medical Necessity.

Conditions of coverage for outpatient prescription drugs and supplies available through the Pharmacy Benefit are as stated in the Pharmacy Benefit section of the Plan.

15. X-rays, CAT scans, MRIs, microscopic tests, and laboratory tests.

16. Radiation therapy or treatment and chemotherapy.

17. Blood transfusions, blood processing costs, blood transport charges, blood handling charges, administration charges, and the cost of blood, plasma and blood derivatives. Any credit allowable for replacement of blood plasma by donor or blood insurance will be deducted from the total Eligible Expense.

18. Oxygen and other gases and their administration.

19. Electrocardiograms, electroencephalograms, pneumoencephalograms, basal metabolism tests, or similar well-established diagnostic tests generally accepted by Physicians throughout the United States.

20. The cost and administration of an anesthetic.

21. Services provided by a Physician or Licensed Health Care Provider for dressings, sutures, casts, splints, trusses, crutches, braces, adhesive tape, bandages, antiseptics, ostomy supplies or other Medically Necessary medical supplies.

Diabetic supplies are eligible for coverage under the Pharmacy Benefit of this Plan, including insulin, needles, syringes and test strips.

22. Adhesive tape, bandages, antiseptics or other over-the-counter first aid supplies only upon prior approval of the Plan. **Approval will be based on guidelines of cost effectiveness and Medically Necessary treatment of an Illness or Injury as determined by the Contract Administrator.**

23. Durable Medical Equipment, Orthopedic Appliances, or Prosthetic Devices as follows:

A. Rental of, up to the purchase price of, a wheelchair, Hospital bed, respirator or other Durable Medical Equipment required for therapeutic use, or the purchase of this equipment if economically justified, whichever is less. If the purchase is not medically feasible, rental charges will be paid without limitation based upon purchase price.

B. Initial purchase of Orthopedic Appliances or Prosthetic Devices, including but not limited to artificial limbs, eyes, larynx if prescribed by an M.D. or D.O. Benefits for Prosthetic Devices are limited to a single purchase of each type of Prosthetic Device every three (3) Benefit Periods, except as required by the Women's Health and Cancer Rights Act of 1988.

C. Replacement or repair of Durable Medical Equipment, Orthopedic Appliances, Prosthetic Devices if necessitated by bodily change, or rendered non-functional due to normal use but not to include charges for repair or maintenance.

Pre-treatment Review of charges for Durable Medical Equipment, Orthopedic Appliances or Prosthetic Devices that may exceed \$1,000 is required. Refer to Pre-Treatment Review section for further details.

24. Wigs (up to one (1) per lifetime) if prescribed by an M.D. or D.O. as a result of hair loss due to chemotherapy or radiation.
 25. Initial purchase of contact lenses or glasses if required following cataract surgery.
 26. Charges for vasectomy.
 27. Reasonable charges for producing medical records only if incurred for the purpose of utilization review, audits or investigating a claim for benefits if requested and approved by the Plan. Charges that exceed limits for such charges imposed by applicable law will not be deemed to be reasonable.
 28. Contraceptive Management, regardless of Medical Necessity. "Contraceptive Management" means Physician fees related to a prescriptive contraceptive device, obtaining a prescription for contraceptives, purchasing, fitting, injecting, implantation, placement or removal of any contraceptive device.
 29. Dental services (including Inpatient Hospital facility expense when an Eligible Expense) for treatment of a fractured or dislocated jaw, or Injury to natural teeth including replacement of such teeth within six (6) months (or when medically feasible) after the date of the accident. **Benefit limits apply to Accidental Injuries as stated in the Schedule of Medical Benefits.**
 30. Treatment of temporomandibular joint dysfunction as follows:
 - A. Diagnostic exam and x-rays except full mount 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.
31. For rhinoplasties and blepharoplasties to correct a functional condition or in the case of a rhinoplasty, to correct an Accidental Injury, or a congenital anomaly.
 32. Circumcision whether performed Inpatient or Outpatient.
 33. 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 cesarean 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 according to the Special Enrollment Period.
 34. Treatment for sleep disorders. 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.

35. Diabetes self-management training and nutrition counseling and instructions on the proper use of diabetes equipment and supplies for a Covered Person who has been diagnosed with diabetes or caretaker of the Covered Person with diabetes. Diabetes self-management training must be a program recognized by the American Diabetes Association and must be provided by a Physician or Licensed Health Care Provider who is licensed, registered or certified in the state where services will be rendered and acting within the scope of practice authorized by the license, registration or certification.
36. Custom-molded orthotics only when prescribed by a Physician and required for a Covered Person who is diagnosed with diabetes.
37. Hearing aid benefits include evaluation and fitting payable as stated in the Schedule of Medical Benefits.
38. Diabetic foot care services only when prescribed by a Physician and required for a Covered Person who is diagnosed with diabetes.
39. Surgical, medical or Hospital services and/or supplies rendered in connection with radial keratotomy, LASIK or any other procedure designed to correct farsightedness, nearsightedness or astigmatism. **Benefit limits apply as stated in the Schedule of Medical Benefits.**
40. Eye examination received from a Licensed 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, the Plan will pay for replacement lenses only.
41. Charges for treatment under the supervision of Physician for inborn errors of metabolism that involve amino acid, carbohydrate and fat metabolism, and for which medically standard methods of diagnosis, treatment and monitoring exist. Benefits include expenses of diagnosing, monitoring and controlling the disorders by nutritional and medical assessment, including but not limited to clinical services, biochemical analysis, medical supplies, prescription drugs, corrective lenses for conditions related to the inborn error of metabolism, nutritional management, and Medical Foods used in treatment to compensate for the metabolic abnormality and to maintain adequate nutritional status.

"Medical Foods" means any nutritional substances in any form that are:

- A. Formulated to be consumed or administered internally under supervision of a Physician;
- B. Specifically processed or formulated to be distinct in one or more nutrients present in natural food;
- C. Intended for the medical and nutritional management of patients with limited capacity to metabolize ordinary foodstuffs or certain nutrients contained in ordinary foodstuffs or who have other specific nutrient requirements as established by medical evaluation; and
- D. Essential to optimize growth, health, and metabolic homeostasis.

HOME HEALTH CARE BENEFIT

Benefit limits apply as stated in the Schedule of Medical Benefits.

Coverage under this benefit includes charges made by a Home Health Care Agency for care in accordance with a Home Health Care Plan for the following services:

1. Part-time or intermittent nursing care by a Registered Nurse (R.N.) or by a Licensed Practical Nurse (L.P.N.), a vocational nurse, or public health nurse who is under the direct supervision of a Registered Nurse;

2. Home health aides;
3. Medical supplies, drugs and medicines prescribed by a Physician, and laboratory services provided by or on behalf of a Hospital.

“Home Health Care Agency” means an organization that provides skilled nursing services and therapeutic services (home health aide services, physical therapy, occupational therapy, speech therapy, medical social services) on a visiting basis, in a place of residence used as the Covered Person’s home. The organization must be Medicare certified and licensed within the state in which home health care services are provided.

“Home Health Care Plan” means a program for continued care and treatment administered by a Medicare certified and licensed Home Health Care Agency, for the Covered Person who may otherwise have been confined as an Inpatient in a Hospital or Skilled Nursing Facility or following termination of a Hospital confinement as an Inpatient and is the result of the same related condition for which the Covered Person was hospitalized and is approved in writing by the Covered Person's attending Physician.

Home Health Care specifically excludes the following:

1. Services and supplies not included in the approved Home Health Care Plan.
2. Services of a person who ordinarily resides in the home of the Covered Person, or who is a Close Relative of the Covered Person who does not regularly charge the Covered Person for services.
3. Services of any social worker.
4. Transportation services.
5. Housekeeping services.
6. Custodial Care.

MENTAL ILLNESS

Benefit limits apply as stated in the Schedule of Medical Benefits:

Coverage under this benefit includes the following services:

1. Physician or Licensed Health Care Provider charges for diagnosis and Medically Necessary Psychiatric Care and treatment.
2. Charges for well-established medically accepted diagnostic testing generally accepted by Physicians in the United States.
3. Charges for Inpatient hospitalization, for Medically Necessary treatment, for the same services as are covered for hospitalization for physical Illness or Injury by this Plan.
4. Charges for Medically Necessary treatment at a Psychiatric Facility or Residential Treatment Facility licensed by the state in which the facility operates that is primarily for the treatment of Mental Illness if it meets these requirements:
 - A. Has a Physician in regular attendance;
 - B. Continuously provides twenty-four (24) hour a day nursing service on site or on call by a Registered Nurse (RN) or Licensed Practical Nurse (LPN);

- C. Has a full-time Psychiatrist or Psychologist on staff; and
 - D. Is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of Mental Illness.
5. Charges for Inpatient Mental Illness benefits: One day of Inpatient hospitalization may be exchanged for two days of Partial Hospitalization. **Partial Hospitalization is considered Inpatient hospitalization for purposes of benefit adjudication under this Plan.**

“Partial Hospitalization” means care in a day care or night care facility for a minimum of six (6) hours and a maximum of twelve (12) hours per day, during which therapeutic clinical treatment is provided.

ORGAN OR TISSUE TRANSPLANT PROCEDURES

Coverage under this benefit includes charges for health services and supplies related to non-Experimental or non-Investigational organ or tissue transplant procedures. Such services 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. Benefits are subject to the following conditions:

1. A second opinion is recommended prior to undergoing any transplant procedure. This second opinion should concur with the attending Physician's findings regarding the Medical Necessity of such procedure. The Physician rendering this second opinion must be qualified to render such a service either through experience, specialist training or education, or such similar criteria, and must not be affiliated in any way with the Physician who will be performing the actual surgery.
2. If the donor is covered under this Plan, expenses Incurred by the donor will be considered for benefits to the extent that such expenses are not payable by the recipient’s plan.
3. If the recipient is covered under this Plan, expenses Incurred by the recipient will be considered for benefits. Expenses Incurred by the donor, who is not ordinarily covered under this Plan according to eligibility requirements, will be considered for payment to the extent that such expenses are not payable by the donor's plan. In no event will benefits be payable in excess of the benefit still available to the recipient.
4. If both the donor and the recipient are covered under this Plan, Expenses Incurred by each person will be treated separately for each person.
5. The Eligible Expense of securing an organ from a cadaver or tissue bank, including the surgeon's charge for removal of the organ and a Hospital's charge for storage or transportation of the organ, will be considered for payment.

TRAVEL, LODGING AND MEALS BENEFIT

Benefit limits apply as stated in the Schedule of Medical Benefits.

Coverage under this benefit includes travel, lodging and meals for the Covered Person who is the patient, and a companion for cancer or transplant services as follows:

1. 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;

2. 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

3. If the patient is a covered Dependent 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, lodging and meal expenses are only available if the recipient lives more than fifty (50) miles from the Preferred Transplant or Cancer Center. Valid receipts are required for reimbursement to be made by the Plan. Examples of travel expenses may include:

1. Airfare at coach rate;

2. Taxi or ground transportation; or

3. Mileage reimbursement at the IRS rate for the most direct route between the patient's home and the facility.

"Preferred Transplant or Cancer Center" means a medical facility for which the Plan, either directly or through the Claims Supervisor, has obtained special billing discounts for the Covered Person and the Plan and for which the Plan or Claims Supervisor has ascertained based upon objective criteria that the facility and its Physicians have a superior degree of expertise for the cancer or transplant services provided, and the facility's positive patient outcomes are significantly higher than other comparable facilities.

PREVENTIVE CARE

"Preventive Care" means routine treatment or examination provided when there is no objective indication or outward manifestation of impairment of normal health or normal bodily function, which is not provided as a result of any Injury or Illness.

Coverage under this benefit includes the following routine services, subject to the following limitations:

1. Routine Wellness care for children and adults for the following:

A. Routine physical examinations by a Physician or Licensed Health Care Provider, which will include a medical history, physical examination, developmental assessment, and anticipatory guidance as directed by a Physician or Licensed Health Care Provider and associated routine testing provided or ordered at the time of the examination; and

B. Routine immunizations according to the schedule of immunizations which is recommended by the Advisory Committee on Immunization Practices (ACIP) that have been adopted by the Director of the Centers for Disease Control and Prevention.

2. Annual routine examination for the detection of prostate cancer, including a prostate-specific antigen test.

3. Recommended preventive services as set forth in the recommendations of the United States Preventive Services Task Force (Grade A and B rating), the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, and the guidelines supported by the Health Resources and Services Administration. The complete list of recommendations and guidelines can be viewed at:

<http://www.healthcare.gov/center/regulations/prevention/recommendations.html>.

4. Office visit charges only if the primary purpose of the office visit is to obtain a recommended Preventive Care service identified above.

5. Women's Preventive Care for the following:
 - A. Well-women annual visits for women 18 years of age and older to obtain the recommended preventive services that are age and developmentally appropriate, including preconception and prenatal care, and additional visits as medically appropriate.
 - B. Screening for gestational diabetes for pregnant women between 24 and 28 weeks of gestation and at the first prenatal visit for pregnant women identified to be at high risk for diabetes.
 - C. Human papillomavirus (HPV) DNA testing beginning at thirty (30) years of age, limited to once every three (3) years.
 - D. Annual counseling on sexually transmitted infections (STI's) and human immune-deficiency virus (HIV) screening for all sexually active women.
 - E. All Food and Drug Administration approved prescription contraceptives and female over-the-counter contraceptives with a written prescription by a Physician or Licensed HealthCare Provider, sterilization procedures, and patient education and counseling for all women with reproductive capacity. This does not include abortifacient drugs. Self-administered contraceptives are available only through the Pharmacy Benefit as outlined in the Pharmacy Benefit section of this Plan.
 - F. Breast feeding support, supplies, and counseling, including comprehensive lactation support and counseling by a trained provider during pregnancy and/or in the postpartum period, and costs for breast feeding equipment and related supplies.
 - G. Annual screening and counseling for interpersonal and domestic violence.

Expenses payable under this Preventive Care benefit will not be subject to the Medical Necessity provisions of this Plan. "Charges for Preventive care that involve excessive, unnecessary or duplicate tests are specifically excluded."

Charges for treatment of an active Illness or Injury are subject to the plan provisions, limitations and exclusions and are not eligible in any manner under Preventive Care.

RECONSTRUCTIVE BREAST SURGERY/NON-SURGICAL AFTER CARE BENEFIT

Coverage includes charges for reconstructive breast surgery subsequent to any Medically Necessary mastectomy, limited to charges for the following:

1. Reconstruction of the breast(s) upon which the mastectomy was performed, including implants;
2. Surgical procedures and reconstruction of the non-affected breast to produce a symmetrical appearance, including implants;
3. Non-surgical treatment of lymphedemas and other physical complications of mastectomy, including non-surgical prostheses and implants for producing symmetry.

Specifically excluded from this benefit are expenses for the following:

1. Solely Cosmetic procedures unrelated to producing a symmetrical appearance;
2. Breast augmentation procedures unrelated to producing a symmetrical appearance;
3. Implants for the non-affected breast unrelated to producing a symmetrical appearance;

4. Non-surgical prostheses or any other procedure unrelated to producing a symmetrical appearance.

SHORT-TERM REHABILITATIVE THERAPY OUTPATIENT SERVICES

Benefits limits apply as stated in the Schedule of Medical Benefits.

Coverage under this benefit includes the following Outpatient therapy services:

1. Professional services by 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.
2. Professional services by a licensed occupational therapist for restoration or rehabilitative 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. Professional services by a licensed speech therapist for restoration or rehabilitative Speech Therapy for speech loss or impairment due to an illness or trauma, (includes treatment for autism) or congenital defects for which surgery has been performed, provided such loss or impairment is not due to a functional nervous disorder. Speech therapy is excluded except when required for treatment of a speech impediment or speech dysfunction that results from injury, stroke, cancer, or a congenital anomaly.
4. Cardiac therapy, which is the process of restoring optimal function status after a cardiac event, including an ECG-monitored exercise component.
5. Pulmonary rehabilitation.

SKILLED NURSING/INPATIENT REHABILITATION FACILITY

Benefit limits apply as stated in the Schedule of Medical Benefits.

Coverage includes charges for Skilled Nursing Facility or Inpatient Rehabilitation Facility for the following services and supplies furnished by the facility. Only charges in connection with convalescence from the illness or injury for which the Covered Person was Hospital-confined will be eligible for benefits. These expenses include:

1. Room and Board, including any charges made by the facility as a condition of occupancy, or on a regular daily or weekly basis such as general nursing services. If private room accommodations are used, the daily Room and Board charge allowed will not exceed the facility's average Semi-Private charges or an average Semi-Private rate made by a representative cross section of similar institutions in the area.
2. Medical services customarily provided by the Skilled Nursing Facility or Inpatient Rehabilitation Facility, with the exception of private duty or special nursing services and Physicians' fees.
3. Drugs, biologicals, solutions, dressings and casts, but no other supplies.

SUBSTANCE ABUSE AND/OR CHEMICAL DEPENDENCY

Benefit limits apply as stated in the Schedule of Medical Benefits.

Coverage under this benefit includes the following services:

1. Physician or Licensed Health Care Provider charges for diagnosis and Medically Necessary treatment, including but not limited to group therapy.
2. Charges for well-established medically accepted diagnostic testing generally accepted by Physicians in the United States.
3. Charges for Inpatient hospitalization, for Medically Necessary treatment, for the same services as are covered for hospitalization for physical Illness or Injury by this Plan.
4. Charges for Medically Necessary treatment, including aftercare, at a Substance Abuse and/or Chemical Dependency Treatment Facility or Residential Treatment Facility licensed by the state in which the facility operates that is primarily for the treatment of Substance Abuse or Chemical Dependency if it meets these requirements:
 - A. Has a Physician in regular attendance;
 - B. Continuously provides twenty-four (24) hour a day nursing service on site or on call by a Registered Nurse (RN) or Licensed Practical Nurse (LPN);
 - C. Has a full-time Psychiatrist or Psychologist on staff; and
 - D. Is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of Substance Abuse or Chemical Dependency.
5. Charges for Inpatient Substance Abuse and/or Chemical Dependency benefits: One day of Inpatient hospitalization may be exchanged for two days of Partial Hospitalization. **Partial Hospitalization is considered Inpatient hospitalization for purposes of benefit adjudication under this Plan.**

“Partial Hospitalization” means care in a day care or night care facility for a minimum of six (6) hours and a maximum of twelve (12) hours per day, during which therapeutic clinical treatment is provided.

EMPLOYEE ASSISTANCE PROGRAM

The Mental Illness and Substance Abuse coverage is a two-part program offering Employees and their Dependents service and counseling in two ways:

1. Counseling or information service through the Employee Assistance Program (EAP); and
2. Coverage for Mental Illness and Substance Abuse 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 Illness and Substance Abuse related disorders services. The EAP is a confidential counseling and information service provided as a benefit to Covered Employees and their Dependents and serves as an outside source for Covered Employees and Dependents to call upon for consultation in dealing with issues of Mental Illness and Substance Abuse 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 Dependents.

All benefits can be accessed by calling Alliance Work Partners at 1-800-343-3822 or go to www.AllianceWP.com.

MANAGED MENTAL ILLNESS AND SUBSTANCE ABUSE DISORDERS

Mental Illness and Substance Abuse related disorders benefits are available through a network of providers. The Employee may choose to receive services from a Network Provider or Non-Network provider. Use of a Non-Network provider will result in decreased reimbursement as described in the Schedule of Benefits.

HOSPITAL ADMISSION CERTIFICATION

Pre-certification is required for Inpatient hospital admissions. **If Pre-certification is not obtained, benefits will be reduced by \$250.**

Pre-certification, Plan notification and case management are designed to:

1. Provide information regarding coverage before you receive treatment, services, or supplies;
2. Provide information about benefits regarding proposed procedures or alternate treatment plans;
3. Assist in determining out-of-pocket expenses and identify possible ways to reduce them;
4. Help avoid reductions in benefits which may occur if the services are not medically necessary or the setting is not appropriate; and
5. If appropriate, assign a case manager to work with you and your providers to design a treatment plan.

A benefit determination on a claim will be rendered only after the claim has been submitted to adjudicate whether it is eligible for coverage under the terms and conditions of the Plan. If it is determined not to be eligible, the Covered Person will be responsible to pay for all charges that are determined to be ineligible.

PRE-ADMISSION CERTIFICATION REVIEW

Prior to admission for any non-emergency illness or injury, and within seventy-two (72) hours after admission for any emergency illness or injury, the Covered Person or the Covered Person's attending physician must call the designated utilization management company, retained by the Plan Sponsor in connection with this Plan, for a pre-admission certification review.

To pre-certify, call the utilization management company at 1-800-342-6510 for pre-admission certification review.

Most certifications occur over the phone. Once a final decision is made regarding the request for certification, a notice of pre-certification will be sent to the physician, to the Covered Person, to the Claims Supervisor and to the hospital.

NOTE: PRE-CERTIFICATION OF BENEFITS IS NOT A GUARANTEE OF PAYMENT OF THE CLAIM(S). ELIGIBILITY FOR CLAIM PAYMENTS IS DETERMINED AT THE TIME CLAIMS ARE ADJUDICATED SINCE THE AMOUNT OF BENEFIT COVERAGE, IF ANY, IS SUBJECT TO ALL PLAN PROVISIONS INCLUDING, BUT NOT LIMITED TO, MEDICAL NECESSITY, PATIENT ELIGIBILITY, DEDUCTIBLES, CO-PAYMENTS AND ANY PLAN LIMITATIONS OR MAXIMUMS IN EFFECT WHEN THE SERVICES ARE PROVIDED. PROVIDERS AND COVERED PERSONS ARE INFORMED AT THE TIME CLAIMS ARE PRE-CERTIFIED THAT PRE-CERTIFICATION OF A COURSE OF TREATMENT BY THE PLAN DOES NOT GUARANTEE PAYMENT OF CLAIMS FOR THE SAME.

CONTINUED STAY CERTIFICATION

Charges for inpatient hospital services for days in excess of any days previously certified by the cost containment company are subject to all terms, conditions and exclusions of the Plan, and should be certified by the Plan's utilization management company.

Certification for additional days should be obtained in the same manner as the pre-admission certification.

EMERGENCY NOTIFICATION/CERTIFICATION

The Covered Person, or his or her representative, should notify the utilization management company for the Plan regarding any Emergency Hospital Admission within seventy-two (72) hours immediately following admission.

To notify the Plan of an emergency admission, call the utilization management company at 1-800-342-6510 for emergency admission certification.

MATERNITY NOTIFICATION

The Covered Person or her representative should notify the utilization management company at **1-877-792-7827** when pregnancy is diagnosed or as soon after as possible, in order to participate in the Plan's Star Baby Maternity Program. Notification is encouraged within the first trimester.

PRE-TREATMENT REVIEW

Pre-treatment Review is the process of verifying the eligibility of services to determine if reimbursement is available under Plan Provisions. Pre-treatment Review is required for the following services or treatment:

1. Outpatient Rehabilitative Care (Benefits in excess of \$2,000 per Benefit Period).
2. Surgery that could be considered cosmetic under some circumstances.
3. Any procedure or service that could possibly be considered Experimental or Investigational.
4. Surgical treatment of TMJ.
5. Durable Medical Equipment that costs more than \$1,000
6. Home Health Care services.
7. Organ or Tissue Transplant.
8. Dental Treatment for Accidental Injury.
9. Commercial or Private Automobile Transportation.
10. Residential Treatment Facility.

To obtain Pre-treatment Review from the Plan, submit the following to the Claims Supervisor at P.O. Box 3018, Missoula, MT 59806-3018:

1. A complete description of the procedure(s) or treatment(s) for which review is requested;
2. A complete diagnosis and all medical records regarding the condition that supports the requested procedure(s) or treatment(s), including, but not limited to, informed consent form(s), all lab and/or x-rays, or diagnostic studies;
3. An itemized statement of the cost of such procedure(s) or treatment(s) with corresponding CPT or HCPCS codes;
4. The attending Physician's prescription, if applicable;
5. A Physician's referral letter, if applicable;
6. A letter of medical necessity;
7. A written treatment plan; and
8. Any other information deemed necessary to evaluate the request for Pre-Treatment Review.

Upon receipt of all required information, the Plan will provide a written response to the written request for Pre-Treatment Review of services. **If Pre-Treatment Review is not obtained, benefits will be reduced by \$250.**

THE BENEFITS QUOTED ARE NOT A GUARANTEE OF PAYMENT. FINAL DETERMINATION AS TO BENEFITS PAID WILL BE MADE AT THE TIME THE CLAIM IS SUBMITTED FOR PAYMENT WITH REVIEW OF NECESSARY MEDICAL RECORDS AND OTHER INFORMATION.

PRE-EXISTING CONDITION EXCLUSIONS

Pre-existing Condition Exclusions apply to all Covered Persons except for anyone who is enrolled for coverage under the EPO Medical Option of this Plan.

Expenses Incurred resulting from treatment of Pre-existing Conditions are excluded from coverage under the Plan for a period of twelve (12)-consecutive months from the Enrollment Date.

All Pre-existing Condition exclusionary periods will commence on the Enrollment Date.

All Pre-existing Condition exclusionary periods set out in this Plan will be reduced on a day-for-day basis for any period(s) of Creditable Coverage that occurred prior to a Covered Person's Enrollment Date, provided there has been no break in the Creditable Coverage exceeding sixty-three (63)-consecutive days prior to the Covered Person's Enrollment Date. The Waiting Period imposed by this Plan will not be considered to be a break in Creditable Coverage.

Pre-existing Condition Exclusions will not apply to any of the following:

1. Pregnancy related expenses.
2. A Covered Person who is less than nineteen (19) years of age.
3. A genetic predisposition to a disease or condition without a diagnosis of a condition related to the genetic information.

GENERAL PLAN EXCLUSIONS AND LIMITATIONS

No benefits are payable under any part of this Plan with respect any charges for the following services:

1. Charges for routine medical examinations, routine health check-ups or preventive immunizations not necessary for the treatment of an Injury or Illness, except as specifically listed as a Covered Benefit.
2. Services in connection with the care or treatment of, surgery performed for, or as the result of, a Cosmetic procedure. **This exclusion will not apply when such treatment is rendered to correct a condition resulting from an Accidental Injury or an Illness, or when rendered to correct a congenital anomaly for a Covered Person.**
3. Services, supplies or treatments or procedures, surgical or otherwise, not recognized as generally accepted and Medically Necessary for the diagnosis and/or treatment of an active Illness or Injury, or which are Experimental or Investigational, except as specifically stated as a Covered Benefit of this Plan.
4. Health services and associated expenses for elective abortions.
5. Charges for hospitalization when such confinement occurs primarily for physiotherapy, hydrotherapy, convalescent or rest care, or any routine physical examinations, tests or treatments not connected with the actual Illness or Injury.
6. Domiciliary care, which is supervised living arrangement in a home-like environment for adults who are unable to live alone because of age-related impairments or physical, mental or visual disabilities.
7. Charges for Physicians' fees for any treatment which is not rendered by or in the physical presence of a Physician.
8. Charges for Licensed Health Care Providers' fees for any treatment which is not rendered by or in the physical presence of a Licensed Health Care Provider.
9. Special duty nursing services are excluded:
 - A. Which would ordinarily be provided by the Hospital staff or its Intensive Care Unit (the Hospital benefit of the Plan pays for general nursing services by Hospital staff); or
 - B. When private duty nurse is employed solely for the convenience of the patient or the patient's Family or for services which would consist primarily of bathing, feeding, exercising, homemaking, moving the patient, giving medication or acting as a companion, sitter or when otherwise deemed not Medically Necessary as requiring skilled nursing care.
10. Charges in connection with eye exercise therapy, eye refractions, the purchase or fitting of eyeglasses, or contact lenses, except for the initial purchase of eyeglasses or contact lenses following cataract surgery.
11. Dental treatment on or to the teeth, the nerves or roots of the teeth, gingival tissue or alveolar processes, except as specifically listed as a covered expense. See Dental Services under the Medical Benefits.
12. Services related to or in connection with fertility studies, sterility studies, procedures to restore or enhance fertility, artificial insemination, or in-vitro fertilization, or any other assisted reproductive technique. Also excluded is surrogate parenting, fetal reduction surgery and health services associated with the use of non-surgical or drug induced Pregnancy termination.

13. Family counseling, recreational counseling or milieu therapy.
14. Group therapy, except for the treatment of Alcoholism and/or Chemical Dependency.
15. Services resulting from or in connection with the reversal of a voluntary sterilization procedure.
16. 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.

17. Services or supplies provided for the treatment of obesity and weight reduction, including bariatric surgery or any other related bariatric procedure, weight loss programs for medical reasons and physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation.

18. Services related acupuncture, acupuncture, aroma therapy, hypnotism, massage therapy, naturopathy, holistic medical procedures or rolfing or other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health. Also excluded is chiropractic treatment which is not related to an actual illness or injury or which exceed the maximum benefit as stated in the Schedule of Medical Benefits.

19. Hair transplant procedures or drugs which are prescribed to promote hair growth. Wigs and artificial hairpieces are excluded except as specifically listed as a covered expense.

20. Services, care or treatment for trans-sexualism, gender dysphoria or sexual reassignment.

21. Services, care or treatment for sexual dysfunction, including related drugs, medications, surgery, medical or Psychiatric Care or treatment.

22. Charges related to Custodial Care.

23. Artificial organ implant procedures or any solid organ transplant that is performed as a treatment for cancer.

24. Charges for non-prescription supplies or devices, except as covered under the Preventive Care Benefit.

25. Services of a direct-entry midwife or lay midwife or the practice of direct-entry midwifery. A Direct-entry midwife is one practicing midwifery and licensed, but not as a certified nurse midwife.

“Direct-entry midwife” means a person who advises, attends, or assists a woman during pregnancy, labor, natural childbirth, or the postpartum period and who is not a licensed Certified Nurse Midwife.

26. Complications that directly result from acting against medical advice, non-compliance with specific physician’s orders or leaving an inpatient facility against medical advice.

27. Equipment, including, but not limited to, motorized wheelchairs or beds, that exceeds the patient’s needs for every day living activities as defined by the Americans with Disabilities Act as amended from time to time, unless Medically Necessary by independent review and not primarily for personal convenience.

28. Specialized computer equipment, including, but not limited to, Braille keyboards and voice recognition software, unless determined to be Medically Necessary by independent review, and not primarily for personal convenience.

29. Detoxification services or outpatient therapy under court order or as condition of parole.
30. Immunizations, medications and other preventive treatments that are recommended because of increased risk due to your type of employer or travel, including, but not limited to, immunizations, medications and/or other preventive treatments for malaria and yellow fever.
31. Examinations for employment, licensing, insurance, school camp, sports or adoption purposes.
32. Court-ordered examinations or treatment.
33. Expenses for examinations and treatment conducted for the purpose of medical research.
34. FAA and DOT Physicals.
35. Charges for the following (known as a "Never Event") when the condition is a result of patient confinement or surgery:
 - A. Removal of an object left in the body during surgery;
 - B. Catheter-associated urinary tract infection;
 - C. Pressure ulcers;
 - D. Vascular catheter-associated infection;
 - E. Infection inside the chest after coronary artery bypass graft surgery;
 - F. Hospital acquired injuries such as fractures, dislocations, intracranial injuries, crushing injuries and burns;
 - G. Treatment, amputation or removal of the wrong body part or organ.
36. Enteral feedings and other nutritional and electrolyte supplements, including infant formula and donor breast milk, except as specifically covered under the Medical Benefits for Home Infusion services or oral nutritional therapy prescribed by a Physician for treatment of in-born errors of metabolism.
37. Routine foot care, including the cutting or removal of corns and calluses, except for diabetic foot care that is prescribed by a Physician. Also excluded is nail trimming, cutting, or debriding, hygienic and preventive maintenance foot care, treatment of flat feet or treatment of subluxation of the foot.
38. Medical supplies and appliances or devices used specifically as safety items or to affect performance in sports-related activities.
39. Prescribed or non-prescribed medical supplies and disposable supplies, including but not limited to, elastic stockings, ace bandages, gauze and dressings.
40. Orthotic appliances that straighten or re-shape a body part (including cranial banding and some types of braces), unless as a result of a congenital anomaly.
41. Tubings and masks except when used with Durable Medical Equipment as specifically described under Medical Benefits.

42. Mental Illness or Substance Abuse/Chemical Dependency as follows:
- A. Services performed in conjunction with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.
 - B. Services that extend beyond the period necessary for short-term evaluation, diagnosis, treatment or crisis intervention.
 - C. Services as treatment for insomnia and other sleep disorders, neurological disorders and other disorders with a known physical basis.
 - D. 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.
 - E. Services utilizing methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents.
 - F. 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.
 - G. 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:
 - 1) Not consistent with prevailing national standards of clinical practice for the treatment of such conditions.
 - 2) Not consistent with prevailing professional research demonstrating that the services or supplies will have a measurable and beneficial health outcome.
 - 3) Typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective.
 - 4) Not consistent with the Mental Health/Substance Abuse Designee's level of care guidelines or best practices as modified from time to time.
43. Growth hormone therapy.
44. Respite care, which is services provided by a health care agency that permit primary caregiver temporary relief from caring for an ill individual.
45. Psychosurgery, which involves severing or otherwise disabling areas of the brain to treat a personality disorder, behavior disorder, or other Mental Illness.
46. Treatment of benign gynecomastia (abnormal breast enlargement in males).
47. Medical and surgical treatment of excessive sweating (hyperhidrosis).
48. Medical and surgical treatment for snoring, except when provided as part of treatment for documented obstructive sleep apnea.
49. Oral appliances for snoring, including but not limited to mouth guards.

50. Speech therapy except when required for treatment of a speech impediment or speech dysfunction that results from injury, stroke, cancer, or a congenital anomaly.
51. Charges for missed appointments, room or facility reservations, completion of claim forms or record processing.
52. Any charge for services, supplies or equipment advertised by the provider as free.
53. Any charges prohibited by federal anti-kickback or self-referral statutes.
54. Charges for services rendered or started, or supplies furnished prior to the effective date of coverage under the Plan, or after coverage is terminated under the Plan, except as specifically provided for in the Plan provisions.
55. Charges which are caused by or arising out of war or act of war, (whether declared or undeclared), civil unrest, armed invasion or aggression, or caused during service in the armed forces of any country.
56. Charges by the Covered Person for all services and supplies resulting from any Illness or Injury which occurs in the course of employment for wage or profit, or in the course of any volunteer work when the organization, for whom the Covered Person is volunteering, has elected or is required by law to obtain coverage for such volunteer work under state or federal workers' compensation laws or other legislation, including Employees' compensation or liability laws of the United States (collectively called "Workers' Compensation"). This exclusion applies to all such services and supplies resulting from a work-related Illness or Injury even though:
 - A. Coverage for the Covered Person under Workers' Compensation provides benefits for only a portion of the services Incurred;
 - B. The Covered Person's employer/volunteer organization has failed to obtain such coverage required by law;
 - C. The Covered Person waived his/her rights to such coverage or benefits;
 - D. The Covered Person fails to file a claim within the filing period allowed by law for such benefits;
 - E. The Covered Person fails to comply with any other provision of the law to obtain such coverage or benefits;
 - F. The Covered Person is permitted to elect not to be covered by Workers' Compensation but failed to properly make such election effective; or
 - G. The Covered Person is permitted to elect not to be covered by Workers' Compensation and has affirmatively made that election.

This exclusion will not apply to household and domestic employment, employment not in the usual course of the trade, business, profession or occupation of the Covered Person or employer, or employment of a Dependent member of an employer's family for whom an exemption may be claimed by the Employer under the Internal Revenue Code.

57. Health services for which the Covered Person is not, in the absence of this coverage, legally obligated to pay, or for which a charge would not ordinarily be made in the absence of this coverage.

58. Services provided under another Plan, including:
- A. For any services or supplies to the extent that benefits are otherwise provided under this Plan, or under any other plan of group benefits that the Participant's Employer contributes to or sponsors.
 - B. To the extent that the Covered Person could have obtained payment, in whole or in part, if he or she had applied for coverage or obtained treatment under any federal, state or other governmental program or in a treatment facility operated by a government agency, except where required by law, such as for cases of medical emergencies or for coverage provided by Medicaid.
59. Charges for services or supplies used primarily for personal comfort, convenience, beautification items, television or telephone use that are not related to treatment of a medical condition.
60. Services, treatments or supplies that may be useful to persons in the absence of Illness or Injury such as air conditioners, purifiers, humidifiers, special furniture, bicycles, whirlpools, dehumidifiers, exercise equipment, health club memberships, etc., whether or not they have been prescribed or recommended by a Physician.
61. Charges for non-medical expenses such as training, education, instructions or educational materials, even if they are performed, provided or prescribed by a Physician.
62. Expenses Incurred by persons other than the Covered Person receiving treatment.
63. Charges in excess of the Usual, Customary and Reasonable limits of the Plan.
64. Services rendered by a Physician or Licensed Health Care Provider who is a Close Relative of the Covered Person, or resides in the same household of the Covered Person and who does not regularly charge the Covered Person for services.
65. 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:
- A. Has not been actively involved in the patient's medical care prior to ordering the service, or
 - B. Is not actively involved in the patient's medical care after the service is received.
 - C. This exclusion does not apply to mammography testing.
66. Health services provided outside of the United States if the Covered Person traveled to such a location for the purpose of obtaining treatment, services, drugs, or supplies.
67. Charges for professional services on an Outpatient basis in connection with disorders of any type or cause, that can be credited towards earning a degree or furtherance of the education or training of a Covered Person regardless of the diagnosis.
68. Charges for services, treatment or supplies not considered legal in the United States.
69. Travel Expenses Incurred by any person for any reason, except as specifically covered under the Non Ambulance Travel Benefit.
70. Charges in connection with any operation or treatment for temporomandibular joint dysfunction or any related diagnosis or treatment of any nature, except as specifically listed as covered under Medical Benefits.

71. Charges for preparation of reports or itemized bills in connection with claims, unless specifically requested and approved by the Plan.
72. Charges for services or supplies that are not specifically listed as a Covered Benefit of this Plan.
73. Charges for incidental supplies or common first-aid supplies, such as, but not limited to, adhesive tape, bandages, antiseptics, analgesics, etc., except as specifically listed as a Covered Benefit.
74. Charges for dental braces or corrective shoes.
75. Charges for the following treatments, services or supplies:
 - A. Charges related to or connected with treatments, services or supplies that are excluded under this Plan.
 - B. Charges that are the result of any medical complication resulting from a treatment, service or supply which is, or was at the time the charge was incurred, excluded from coverage under this Plan.
76. Charges for treatment, services or supplies not actually rendered to or received and used by the Covered Person.
77. Charges for cryotherapy.

COORDINATION OF BENEFITS

The Coordination of Benefits provision prevents the payment of benefits which exceed the Allowable Expense. It applies when the Participant or Dependent who is covered by this Plan is or may also be covered by any other plan(s). This Plan will always pay either its benefits in full or a reduced amount which, when added to the benefits payable by the other plan(s), will not exceed 100% of the Allowable Expense. Only the amount paid by this Plan will be charged against the Plan maximums.

If a covered Dependent spouse or Dependent children under this Plan have primary coverage with an HMO, any expenses incurred by the Covered Dependent spouse or Dependent children outside the HMO's required network of providers are not eligible under this Plan.

In the event of a motor vehicle or premises accident; or an act of violence with the intent to disrupt electronic, communications, or any other business system, this Plan will be secondary to any auto "no fault" and traditional auto "fault" type contracts, homeowners, commercial general liability insurance and any other medical benefits coverage.

The Coordination of Benefits provision applies whether or not a claim is filed under the other plan or plans. If needed, authorization is hereby given this Plan to obtain information as to benefits or services available from the other plan or plans, or to recover overpayments.

All benefits contained in the Plan Document are subject to this provision.

DEFINITIONS

"Allowable Expense" as used herein means:

1. If the claim as applied to the primary plan is subject to a contracted or negotiated rate, Allowable Expense will be equal to that contracted or negotiated amount.
2. If the claim as applied to the primary plan is not subject to a contracted or negotiated rate, but the claim as applied to the secondary plan is subject to a contracted or negotiated rate, the Allowable Expense will be equal to that contracted or negotiated amount of the secondary plan.
3. If the claim as applied to the primary plan and the secondary plan is not subject to a contracted or negotiated rate, then the Allowable Expense will be equal to the secondary plan's chosen limits for non-contracted providers.

"Plan" as used herein means any Plan providing benefits or services for or by reason of medical, dental or vision treatment, and such benefits or services are provided by:

1. Group insurance or any other arrangement for coverage for Covered Persons in a group whether on an insured or uninsured basis, including but not limited to:
 - A. Hospital indemnity benefits; and
 - B. Hospital reimbursement-type plans which permit the Covered Person to elect indemnity at the time of claims; or
2. Hospital or medical service organizations on a group basis, group practice and other group pre-payment plans; or
3. Hospital or medical service organizations on an individual basis having a provision similar in effect to this provision; or

4. A licensed Health Maintenance Organization (H.M.O.); or
5. Any coverage for students which is sponsored by, or provided through a school or other educational institution; or
6. Any coverage under a Governmental program, and any coverage required or provided by any statute; or
7. Automobile insurance; or
8. Individual automobile insurance coverage on an automobile leased or owned by the County or any responsible third-party tortfeasor; or
9. Individual automobile insurance coverage based upon the principles of "No-Fault" coverage; or
10. Homeowner or premise liability insurance, individual or commercial.

"Plan" will be construed separately with respect to each policy, contract, or other arrangement for benefits or services, and separately with respect to that portion of any such policy, contract, or other arrangement which reserves the right to take the benefits or services of other Plans into consideration in determining its benefits and that portion which does not.

ORDER OF BENEFIT DETERMINATION

1. Non-Dependent/Dependent

The plan that covers the person as other than a dependent, (e.g., as an employee, member, subscriber, retiree) is primary and the plan that covers the person as a dependent is secondary.

2. Child Covered Under More Than One Plan

A. The primary plan is the plan of the parent whose birthday is earlier in the year if:

- 1) The parents are married;
- 2) The parents are not separated (whether or not they have ever been married), or
- 3) A court decree awards joint custody without specifying that one parent has the responsibility to provide health care coverage.

B. If both parents have the same birthday, the plan that has covered either of the parents longer is primary.

C. If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with financial responsibility has no coverage for the child's health care services or expenses, but that parent's spouse does, the spouse's plan is primary. This subparagraph will not apply with respect to any claim determination period, Benefit Period or Plan Year during which benefits are paid or provided before the entity has actual knowledge.

D. If the parents are not married or are separated (whether or not they were ever married) or are divorced, and there is no court decree allocating responsibility for the child's health care services or expenses, the order of benefit determination among the plans of the parents and the parents' spouses (if any) is:

- 1) The plan of the custodial parent.
- 2) The plan of the spouse of the custodial parent.
- 3) The plan of the non-custodial parent.
- 4) The plan of the spouse of the non-custodial parent.

3. Active or Inactive Employee

The Plan that covers a person as an employee who is neither laid-off nor retired (or as that employee's dependent) is primary. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule will not be followed.

4. Longer or Shorter Length of Coverage

If the preceding rules do not determine the order of benefits, the plan that has covered the person for the longer period of time is primary.

A. To determine the length of time a person has been covered under a plan, two plans will be treated as one if the Covered Person was eligible under the second within 24 hours after the first ended.

B. The start of a new plan does not include:

- 1) A change in the amount or scope of a plan's benefits;
- 2) A change in the entity that pays, provides, or administers the plan's benefits; or
- 3) A change from one type of plan to another (such as from a single employer plan to that of a multiple-employer plan).

C. A person's length of time covered under a plan is measured from the person's first date of coverage under that plan. If that date is not readily available for a group plan, the date the person first became a member of the group will be used as the date from which to determine the length of time the person's coverage under the present plan has been in force.

5. No Rules Apply

If none of these preceding rules determines the primary plan, the Allowable Expense will be determined equally between the plans.

COORDINATION WITH MEDICARE

Medicare Part A and Part B will be considered a plan for the purposes of coordination of benefits. This Plan will coordinate benefits with Medicare whether or not the Covered Person is actually receiving Medicare Benefits. This means that the plan will only pay the amount that Medicare would not have covered, even if the Covered Person does not elect to be covered under Medicare. Also, failure to enroll in Medicare Part B when a person is initially eligible may result in the person being assessed a significant surcharge by Medicare for late enrollment in Part B.

1. For Working Aged

A covered Employee who is eligible for Medicare Part A or Part B as a result of age may be covered under this Plan and be covered under Medicare, in which case this Plan will pay primary. A covered Employee, eligible for Medicare Part A or Part B as a result of age, may elect not to be covered under this Plan. If such election is made, coverage under this Plan will terminate.

A covered Dependent, eligible for Medicare Part A or Part B as a result of age, of a covered Employee may also be covered under this Plan and be covered under Medicare, in which case the Plan again will pay primary. A covered Dependent, eligible for Medicare Part A or Part B as a result of age, may elect not to be covered under this Plan. If such election is made, coverage under this Plan will terminate.

2. For Retired Persons

Medicare is primary and the Plan will be secondary for the covered Retiree if he/she is an individual who is enrolled in Medicare Part A or Part B as a result of age and retired.

Medicare is primary and the Plan will be secondary for the covered Retiree's Dependent who is enrolled in Medicare Part A or B if both the covered Retiree and his/her covered Dependent are enrolled in Medicare Part A or Part B as a result of age and retired.

Medicare is primary for the Retiree's Dependent when the Retiree is not enrolled for Medicare Part A or Part B as a result of age and the Retiree's Dependent is enrolled in Medicare Part A or Part B as a result of age.

3. For Covered Persons who are Disabled

The Plan is primary and Medicare will be secondary for the covered Employee or any covered Dependent who is eligible for Medicare by reason of disability, if the Employee is actively employed by the Employer.

The Plan is secondary and Medicare will be primary for the covered Employee or any covered Dependent who is eligible for Medicare by reason of disability if the Employee is retired or otherwise not actively working for the Employer.

4. For Covered Persons with End Stage Renal Disease

Except as stated below*, for Employees or Retirees and their Dependents, if Medicare eligibility is due solely to End Stage Renal Disease (ESRD), this Plan will be primary only during the first thirty (30) months of Medicare coverage. Thereafter, this Plan will be secondary with respect to Medicare coverage, unless after the thirty-month period described above, the Covered Person has no dialysis for a period of twelve (12) consecutive months and:

A. Then resumes dialysis, at which time the Plan will again become primary for a period of thirty (30) months; or

B. The Covered Person undergoes a kidney transplant, at which time the Plan will again become primary for a period of thirty (30) months.

*If a Covered Person is covered by Medicare as a result of disability, and Medicare is primary for that reason on the date the Covered Person becomes eligible for Medicare as a result of End Stage Renal Disease, Medicare will continue to be primary and the Plan will be secondary.

COORDINATION WITH MEDICAID

If a Covered Person is also entitled to and covered by Medicaid, the Plan will always be primary and Medicaid will always be secondary coverage.

COORDINATION WITH TRICARE/CHAMPVA

If a Covered Person is also entitled to and covered under TRICARE/CHAMPVA, the Plan will always be primary and TRICARE/CHAMPVA will always be secondary coverage. TRICARE coverage will include programs established under its authority, known as TRICARE Standard, TRICARE Extra and TRICARE Prime.

If the Covered Person is eligible for Medicare and entitled to veterans benefits through the Department of Veterans Affairs (VA), the Plan will always be primary and the VA will always be secondary for non-service connected medical claims. For these claims, the Plan will make payment to the VA as though the Plan was making payment secondary to Medicare.

PROCEDURES FOR CLAIMING BENEFITS

Claims must be submitted to the Plan within twelve (12) months after the date services or treatments are received or completed. Non-electronic claims may be submitted on any approved claim form, available from the provider. The claim must be completed in full with all the requested information. A complete claim must include the following information:

- Date of service;
- Name of the Participant;
- Name and date of birth of the patient receiving the treatment or service and his/her relationship to the Participant;
- Diagnosis code of the condition being treated;
- Treatment or service code performed;
- Amount charged by the provider for the treatment or service; and
- Sufficient documentation, in the sole determination of the Contract Administrator, to support the medical necessity of the treatment or service being provided and sufficient to enable the Claims Supervisor to adjudicate the claim pursuant to the terms and conditions of the Plan.

When completed, the claim must be sent to the Claims Supervisor, Allegiance Benefit Plan Management, Inc., at P.O. Box 3018, Missoula, Montana 59806-3018, 1-855-333-1009 or through any electronic claims submission system or clearinghouse to which Allegiance Benefit Plan Management, Inc. has access.

A claim will not, under any circumstances, be considered for payment of benefits if initially submitted to the Plan more than twelve (12) months from the date that services were incurred.

Upon termination of the Plan, final claims must be received within three (3) months of the date of termination, unless otherwise established by the Contract Administrator.

CLAIMS WILL NOT BE DEEMED SUBMITTED UNTIL RECEIVED BY THE CLAIMS SUPERVISOR.

The Plan will have the right, in its sole discretion and at its own expense, to require a claimant to undergo a medical examination, when and as often as may be reasonable, and to require the claimant to submit, or cause to be submitted, any and all medical and other relevant records it deems necessary to properly adjudicate the claim.

CLAIM DECISIONS ON CLAIMS AND ELIGIBILITY

Claims will be considered for payment according to the Plan's terms and conditions, industry-standard claims processing guidelines and administrative practices not inconsistent with the terms of the Plan. The Plan may, when appropriate or when required by law, consult with relevant health care professionals and access professional industry resources in making decisions about claims that involve specialized medical knowledge or judgment. Initial eligibility and claims decisions will be made within the time periods stated below. For purposes of this section, "Covered Person" will include the claimant and the claimant's authorized representative; "Covered Person" does not include a health care provider or other assignee, and said health care provider or assignee does not have an independent right to appeal an Adverse Benefit Determination simply by virtue of the assignment of benefits.

INFORMATION REGARDING URGENT CARE CLAIMS IS PROVIDED TO YOU UNDER THE DISCLOSURE REQUIREMENTS OF APPLICABLE LAW; THE PLAN DOES NOT MAKE TREATMENT DECISIONS. ANY DECISION TO RECEIVE TREATMENT MUST BE MADE BETWEEN THE PATIENT AND HIS OR HER HEALTHCARE PROVIDER; HOWEVER, THE PLAN WILL ONLY PAY BENEFITS ACCORDING TO THE TERMS, CONDITIONS, LIMITATIONS AND EXCLUSIONS OF THIS PLAN.

1. **Urgent Care Claims** - An Urgent Care Claim is any claim for medical care or treatment with respect to which:

A. In the judgment of a prudent layperson possessing an average knowledge of health and medicine could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function; or

B. In the opinion of 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.

There are no Urgent Care requirements under this Plan and therefore, there are no rights to appeal a pre-service Urgent Care claim denial.

2. **Pre-Service Claims** - Pre-Service Claims must be submitted to the Plan before the Covered Person receives medical treatment or service. A Pre-Service Claim is any claim for a medical benefit which the Plan terms condition the Covered Person's receipt of the benefit, in whole or in part, on approval of the benefit before obtaining treatment. Pre-Service Claims are procedures stated in the Plan Document which, the Plan recommends be utilized before a Covered Person obtains medical care.

3. **Post-Service Claims** - A Post-Service Claim is any claim for a medical benefit under the Plan with respect to which the terms of the Plan do not condition the Covered Person's receipt of the benefit, or any part thereof, on approval of the benefit prior to obtaining medical care, and for which medical treatment has been obtained prior to submission of the claim(s).

In most cases, initial claims decisions on Post-Service Claims will be made within thirty (30) days of the Plan's receipt of the claim. The Plan will provide timely notice of the initial determination once sufficient information is received to make an initial determination, but no later than thirty (30) days after receiving the claim.

4. **Concurrent Care Review** - For patients who face early termination or reduction of benefits for a course of treatment previously certified by the Plan, a decision by the Plan to reduce or terminate benefits for ongoing care is considered an Adverse Benefit Determination. (Note: Exhaustion of the Plan's benefit maximums is not an Adverse Benefit Determination.) The Plan will notify the Covered Person sufficiently in advance to allow an appeal for uninterrupted continuing care before the benefit is reduced or terminated. Any request to extend an Urgent Care course of treatment beyond the initially prescribed period of time must be decided within twenty-four (24) hours of the Plan's receipt of the request. The appeal for ongoing care or treatment must be made to the Plan at least twenty-four (24) hours prior to the expiration of the initially-prescribed period.

APPEALING AN UN-REIMBURSED PRE-SERVICE CLAIM

If a claim is denied in whole or in part, the Covered Person will receive written notification of the Adverse Benefit Determination. A claim denial will be provided by the Plan showing:

1. The reason the claim was denied;
2. Reference(s) to the specific plan provision(s) or rule(s) upon which the decision was based which resulted in the Adverse Benefit Determination;
3. Any additional information needed to perfect the claim and why such information is needed; and
4. An explanation of the Covered Person's right to appeal the Adverse Benefit Determination for a full and fair review and the right to bring a civil action following an Adverse Benefit Determination on appeal.

If a Covered Person does not understand the reason for any Adverse Benefit Determination, he or she should contact the Claims Supervisor at the address or telephone number shown on the claim denial.

The Covered Person must appeal the Adverse Benefit Determination before the Covered Person may exercise his or her right to bring a civil action. This Plan provides two (2) levels of benefit determination review and the Covered Person must exercise both levels of review before bringing a civil action.

To initiate the first level of benefit review, the Covered Person must submit in writing an appeal or a request for review of the Adverse Benefit Determination to the Plan within one hundred eighty (180) days after the Adverse Benefit Determination. The Covered Person should include any additional information supporting the appeal or the information required by the Plan which was not initially provided and forward it to the Claims Supervisor within the 180-day time period. Failure to appeal the Adverse Benefit Determination within the 180-day time period will render the determination final. Any appeal received after the 180-day time period has expired will receive no further consideration.

Appeals or requests for review of Adverse Benefit Determinations must be submitted to the Plan in writing to P.O. Box 1269, Missoula, MT 59806-1269. Supporting materials may be submitted via mail, electronic claims submission process, facsimile (fax) or electronic mail (e-mail).

1. First Level of Benefit Determination Review

The first level of benefit determination review is done by the Claims Supervisor. The Claims Supervisor will research the information initially received and determine if the initial determination was appropriate based on the terms and conditions of the Plan and other relevant information. Notice of the decision on the first level of review will be sent to the Covered Person within fifteen (15) days following the date the Claims Supervisor receives the request for reconsideration.

If, based on the Claims Supervisor's review, the initial Adverse Benefit Determination remains the same and the Covered Person does not agree with that benefit determination, the Covered Person must initiate the second level of benefit review. The Covered Person must request the second review in writing and send it to the Claims Supervisor, not later than sixty (60) days after receipt of the Claims Supervisor's decision from the first level of review. Failure to initiate the second level of benefit review within the 60-day time period will render the determination final.

2. Second Level of Benefit Determination Review

The Employee Benefits Committee will review the claim in question along with the additional information submitted by the Covered Person. The Plan will conduct a full and fair review of the claim by the Employee Benefits Committee who is neither the original decisionmaker nor the decisionmaker's subordinate. The Employee Benefits Committee cannot give deference to the initial benefit determination. The Employee Benefits Committee may, when appropriate or if required by law, consult with relevant health care professionals in making decisions about appeals that involve specialized medical judgment. Where the appeal involves issues of medical necessity or experimental treatment, the Employee Benefits Committee will consult with a health care professional with appropriate training who was neither the medical professional consulted in the initial determination or his or her subordinate.

After a full and fair review of the Covered Person's appeal, the Plan will provide a written or electronic notice of the final benefit determination, which contains the same information as notices for the initial determination, within fifteen (15) days.

APPEALING AN UN-REIMBURSED POST-SERVICE CLAIM

If a claim is denied in whole or in part, the Covered Person will receive written notification of the Adverse Benefit Determination. A claim Explanation of Benefits (EOB) will be provided by the Plan showing:

1. The reason the claim was denied;
2. Reference(s) to the specific plan provision(s) or rule(s) upon which the decision was based which resulted in the Adverse Benefit Determination;
3. Any additional information needed to perfect the claim and why such information is needed; and
4. An explanation of the Covered Person's right to appeal the Adverse Benefit Determination for a full and fair review and the right to bring a civil action following an Adverse Benefit Determination on appeal.

If a Covered Person does not understand the reason for any Adverse Benefit Determination, he or she should contact the Claims Supervisor at the address or telephone number shown on the EOB form.

The Covered Person must appeal the Adverse Benefit Determination before the Covered Person may exercise his or her right to bring a civil action. This Plan provides two (2) levels of benefit determination review and the Covered Person must exercise both levels of review before bringing a civil action.

To initiate the first level of benefit review, the Covered Person must submit in writing an appeal or a request for review of the Adverse Benefit Determination to the Plan within one hundred eighty (180) days after the Adverse Benefit Determination. The Covered Person should include any additional information supporting the appeal or the information required by the Plan which was not initially provided and forward it to the Claims Supervisor within the 180-day time period. Failure to appeal the Adverse Benefit Determination within the 180-day time period will render the determination final. Any appeal received after the 180-day time period has expired will receive no further consideration.

Appeals or requests for review of Adverse Benefit Determinations must be submitted to the Plan in writing to P.O. Box 1269, Missoula, MT 59806-1269. Supporting materials may be submitted via mail, electronic claims submission process, facsimile (fax) or electronic mail (e-mail).

1. First Level of Benefit Determination Review

The first level of benefit determination review is done by the Claims Supervisor. The Claims Supervisor will research the information initially received and determine if the initial determination was appropriate based on the terms and conditions of the Plan and other relevant information. Notice of the decision on the first level of review will be sent to the Covered Person within thirty (30) days following the date the Claims Supervisor receives the request for reconsideration.

If, based on the Claims Supervisor's review, the initial Adverse Benefit Determination remains the same and the Covered Person does not agree with that benefit determination, the Covered Person must initiate the second level of benefit review. The Covered Person must request the second review in writing and send it to the Claims Supervisor, not later than sixty (60) days after receipt of the Claims Supervisor's decision from the first level of review. Failure to initiate the second level of benefit review within the 60-day time period will render the determination final.

2. Second Level of Benefit Determination Review

The Employee Benefits Committee will review the claim in question along with the additional information submitted by the Covered Person. The Plan will conduct a full and fair review of the claim by the Employee Benefits Committee who is neither the original decisionmaker nor the decisionmaker's subordinate. The Employee Benefits Committee cannot give deference to the initial benefit determination. The Employee Benefits Committee may, when appropriate or if required by law, consult with relevant health care professionals in making decisions about appeals that involve specialized medical judgment. Where the appeal involves issues of medical necessity or experimental treatment, the Employee Benefits Committee will consult with a health care professional with appropriate training who was neither the medical professional consulted in the initial determination or his or her subordinate.

After a full and fair review of the Covered Person's appeal, the Plan will provide a written or electronic notice of the final benefit determination within a reasonable time, but no later than thirty (30) days from the date the appeal is received by the Plan at each level of review.

All claim payments are based upon the terms contained in the Plan Document, on file with the Contract Administrator and the Claims Supervisor. The Covered Person may request, free of charge, more detailed information, names of any medical professionals consulted and copies of relevant documents, as defined in and required by law, which were used by the Plan to adjudicate the claim.

INDEPENDENT EXTERNAL REVIEW

After exhaustion of all appeal rights stated above, a Covered Person may also request a final independent external review of any Adverse Benefit Determination involving a question of Medical Necessity, or other issue requiring medical expertise for resolution.

To assert this right to independent external medical review, the Covered Person must request such review in writing within one hundred twenty (120) days after a decision is made upon the second level benefit determination above.

If an independent external review is requested, the Claims Supervisor will forward the entire record on appeal, within ten (10) days, to an independent external review organization (IRO) selected randomly. The IRO will notify the Covered Person of its procedures to submit further information.

The IRO will issue a final decision within forty-five (45) days after receipt of all necessary information.

The decision of the IRO will be final and binding except that the Covered Person shall have an additional right to appeal the matter to a court with jurisdiction.

ELIGIBILITY PROVISIONS

If both the husband and wife are employed by the County, and both are eligible for Dependent Coverage, either the husband or wife, but not both, may elect Dependent Coverage for their eligible Dependents. No one can be covered under this Plan as both an Employee and a Dependent. No one can be covered under this Plan as a Dependent by more than one Participant.

EMPLOYEE ELIGIBILITY

An eligible Employee under this Plan includes only a person who in a permanent status (as defined by the Employer) and regularly scheduled to work at least thirty (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.

An Employee is not eligible while on active military duty if that duty exceeds a period of thirty-one (31) consecutive days.

WAITING PERIOD

With respect to a person covered by a previous plan or previous group health insurance of the Employer on the effective date of this Plan, the effective date of coverage under this Plan will be the effective date of the Plan.

With respect to an eligible employee, coverage under the Plan will not start until the Employee completes a Waiting Period. The Plan's Waiting Period is the period of time commencing on the Enrollment Date which is the date the Employee becomes an Eligible Employee and meets the requirements stated above, to the first day of the month following sixty (60) days from the Enrollment Date.

No Waiting Period will be considered a break in coverage for purposes of applying Creditable Coverage even if an eligible person maintains no Creditable Coverage during said Waiting Period.

DEPENDENT ELIGIBILITY

An eligible Dependent includes any person who is a citizen, resident alien, or is otherwise legally present in the United States or in any other jurisdiction that the related Participant or Retiree has been assigned by the Employer, and who is either:

1. The Participant's or Retiree's legal spouse of the opposite sex, according to the marriage laws of the state where the marriage was first solemnized or established.

An eligible Dependent does not include a spouse who is legally separated or divorced from the Participant or a Retiree and has a court order or decree stating such from a court of competent jurisdiction.

2. The Participant's Dependent child who meets all of the following "Required Eligibility Conditions":
 - A. Is a natural child; step-child; legally adopted child; a child who has been Placed with the Participant or Retiree for adoption and for whom as part of such Placement the Participant or Retiree has a legal obligation for the partial or full support of such child, including providing coverage under the Plan pursuant to a written agreement; a person for whom the Participant or Retiree has been appointed the legal guardian by a court of competent jurisdiction prior to the person attaining nineteen (19) years of age; or a grandchild; and

B. Is less than twenty-six (26) years of age. This requirement is waived if the Participant's or Retiree's child is mentally handicapped/challenged or physically handicapped/challenged, provided that the child is incapable of self-supporting employment and is chiefly dependent upon the Participant or Retiree for support and maintenance. Proof of incapacity must be furnished to the Contract Administrator upon request, and additional proof may be required from time to time; and

An eligible Dependent does not include a spouse of the Dependent child or a child of the Dependent child (other than an eligible grandchild of the Participant or Retiree as specified above).

PARTICIPANT ELIGIBILITY FOR DEPENDENT COVERAGE

Each Employee will become eligible for Dependent Coverage on the latest of: 1) the date the Employee becomes eligible for Participant coverage; or 2) the date on which the Employee first acquires a Dependent.

RETIREE ELIGIBILITY

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 applies to begin receiving monthly TCDRS retirement benefit payments.
2. The Employee is not eligible for Medicare as a result of age at the time of retirement. (A Retiree who is eligible for Medicare as a result of age may be eligible for a "Medigap" policy offered by the Employer. Contact: United Healthcare at 1-866-327-1593 for more information.

An Employee who continues coverage as a Retiree may also continue the coverage of his or her eligible Dependents at the time of retirement who are not eligible for Medicare as a result of age.

Prior to reaching sixty-five (65) years of age, Retirees and/or Dependents should contact the Social Security Administration to sign up for Medicare coverage. Medicare penalties may be assessed if Medicare coverage is delayed after reaching sixty-five (65) years of age. Medicare coverage begins at the age of sixty-five (65) even though eligibility for Social Security benefit payments may begin after sixty-five (65) years of age. Plan coverage ends upon attainment of Medicare eligibility age even if a Retiree or Dependent does not apply for or does not elect to receive Medicare. A Retiree who is eligible for Medicare as a result of age may be eligible for a "Medigap" policy offered by the Employer. Contact: United Healthcare at 1-866-327-1593 for more information

EFFECTIVE DATE OF COVERAGE

All coverage under the Plan will commence at 12:01 A.M. in the time zone in which the Covered Person permanently resides, on the date such coverage becomes effective.

All eligible Employees may elect one of three medical plans at the time of enrollment: EPO Medical Option, Core Medical Option or the Deductible Medical Option. Employees plan changes are effective on November 1st, provided the change has been completed electronically in the Online Enrollment System in advance of such date and in accordance with guidelines established by the Employer.

PARTICIPANT COVERAGE

Participant coverage under the Plan will become effective on the date the Employee satisfies the applicable eligibility requirements and Waiting Period, provided the change has been completed electronically in the Online Enrollment System within thirty-one (31) days of the Enrollment Date.

An eligible Employee who declines Participant coverage under the Plan during the Initial Enrollment Period will be able to become covered later during an Open Enrollment Period, or as a result of a Change in Status or Special Enrollment Period outlined below.

PARTICIPANT'S DEPENDENT COVERAGE

Each Participant who requests Dependent Coverage on the Plan's online enrollment platform will become covered for Dependent Coverage as follows:

1. On the Participant's effective date of coverage, if application for Dependent Coverage is made on the Plan's via the online enrollment platform along with the Employee during the Initial Enrollment Period. This subsection applies only to Dependents who are eligible on the Participant's effective date of coverage.
2. In the event a Dependent is acquired after the Participant's effective date of coverage as a result of a legal guardianship or in the event that a Participant is required to provide coverage as a result of a valid court order, or if the Dependent is acquired as a result of operation of law, Dependent Coverage will begin on the first day of the month following the Plan's receipt of a status change form and copy of said court order, if applicable.

RETIREE COVERAGE

Retiree coverage under the Plan will become effective on the day after the eligible Retiree's last day on the Employer's payroll as an Employee provided the change has been completed electronically in the Online Enrollment System within thirty-one (31) days of such Enrollment Date for Retiree coverage.

An eligible Retiree who declines Retiree coverage under the Plan during the Initial Enrollment Period for Retiree coverage will NOT be eligible to become covered later during an Open Enrollment Period or as a result of a Change in Status or Special Enrollment Period. The Plan does not provide any other opportunity to add Retiree coverage after the Initial Enrollment Period for such coverage that occurs at the time of retirement. This means that a Retiree who declines Retiree coverage for himself and/or his Dependents during the Initial Enrollment Period for such coverage will NOT be able to later enroll for Retiree coverage under the Plan. Retirees will be able to elect to move from one medical or dental plan to another during an Open Enrollment Period as long as they previously elected medical or dental coverage during the Initial Enrollment Period.

RETIREE'S DEPENDENT COVERAGE

Eligible Dependents of a Retiree who requests Dependent Coverage in accordance with the enrollment procedures specified by the Contract Administrator will become covered for Dependent Coverage on the Retiree's effective date of Retiree coverage, if application for Dependent Coverage is made in accordance with the enrollment procedures specified by the Contract Administrator along with the Retiree during the Initial Enrollment Period for Retiree coverage. This subsection applies only to Dependents who are eligible on the Retiree's effective date of Retiree coverage. Dependents acquired by the Retiree after the Initial Enrollment Period for Retiree coverage or otherwise not enrolled during the Initial Enrollment Period are not eligible for coverage under the Plan.

The Plan does not allow Retirees or Dependents of Retirees to add coverage pursuant to the Special Enrollment (including Change in Status) rules described below with the exception of enrolling in the Diabetic Plans offered by Williamson County. Therefore, a Retiree who does not elect to receive Retiree coverage during the Initial Enrollment Period for such coverage will not be able to add such coverage later for himself or his Dependents. Dependents acquired after the Initial Enrollment Period for Retiree coverage are not eligible for coverage under the Plan.

A Retiree who retired prior to 2013 and who has maintained some coverage under the Plan will have a one-time opportunity to add coverage for himself and his Dependents during the Open Enrollment Period for the Plan Year beginning November 1, 2013. A pre-2013 Retiree who does not add coverage during this Open Enrollment Period may **not** later add coverage under the Plan during any subsequent Open Enrollment Period and may **not** add coverage as a result of any subsequent Special Enrollment or Change in Status event with the exception of enrolling in the Diabetic Plans offered by Williamson County. **Except for this special one-time opportunity to add coverage, the Plan no longer allows Retirees or Dependents of Retirees to add coverage pursuant to the Special Enrollment (including Change in Status) rules described below with the exception of enrolling in the Diabetic Plans offered by Williamson County.**

OPEN ENROLLMENT PERIOD

The Open Enrollment Period will be during the month of September of each year, or such other time as determined by the Contract Administrator, during which an Employee and the Employee's eligible Dependents, who are not covered under this plan, may request Participant or Dependent coverage. Employees may also change plan options during the Open Enrollment Period. A person who enrolls during an Open Enrollment Period will be considered a Late Enrollee, except for individuals eligible for the first time or whose initial eligibility coincides with the Open Enrollment Period.

Coverage requested during any Open Enrollment Period will begin on November 1st following the Open Enrollment Period.

SPECIAL ENROLLMENT PERIOD

In addition to other enrollment times allowed by this Plan, certain persons may enroll during the Special Enrollment Periods described below. An eligible person who makes a special enrollment request during any such applicable Special Enrollment Period will not be considered a Late Enrollee.

Retirees and Dependents of Retirees are not eligible to enroll for coverage due to Special Enrollment (including a Change in Status) with the exception of enrolling in the Diabetic Plans offered by Williamson County. A Retiree may voluntarily drop coverage for himself and/or his Dependents at any time by providing written notice to the Contract Administrator. Coverage will be dropped as of the last day of the month in which the notice is received.

"Special Enrollment Period" means a period of time allowed under this Plan, other than the eligible person's Initial Enrollment Period or an Open Enrollment Period, during which an eligible person can request coverage under this Plan as a result of certain events that create special enrollment rights.

Coverage will become effective on the date of the event if the Employee makes a special enrollment request, verbally or in writing, within thirty (30) days of any special enrollment event and application for such coverage is made on the Plan's enrollment form within sixty (60) days of the event.

1. An eligible Employee who is not enrolled and eligible Dependents, including step children, who are acquired under the following specific events may enroll and become covered:

- A. Marriage;
- B. Birth of the Employee's child; or
- C. Adoption of a child by the Employee, provided the child is under the age of 19; or
- D. Placement for Adoption with the Employee, provided such Employee has a legal obligation for the partial or full support of such child, including providing coverage under the Plan pursuant to a written agreement and the child is under the age of 19.

2. A Participant may enroll eligible Dependents, including step children, who are acquired under the following specific events:

- A. Marriage to the Participant;
- B. Birth of the Participant's child; or
- C. Adoption of a child by the Participant, provided the child is under the age of 19; or
- D. Placement for Adoption with the Employee, provided such Employee has a legal obligation for the partial or full support of such child, including providing coverage under the Plan pursuant to a written agreement and the child is under the age of 19.

3. The spouse of a Participant, may enroll and will become covered on the date of the following specific events:

- A. Marriage to the Participant;
- B. Birth of the Participant's child; or
- C. Adoption of a child by the Participant provided the child is under the age of 19; or
- D. Placement for Adoption with the Employee, provided such Employee has a legal obligation for the partial or full support of such child, including providing coverage under the Plan pursuant to a written agreement and the child is under the age of 19.

4. The following individuals may enroll and become covered when coverage under another health care plan or health insurance is terminated due to loss of eligibility or if employer contributions to the other coverage have been terminated (Loss of Coverage), subject to the following:

- A. If the eligible Employee loses coverage, the eligible Employee who lost coverage and any eligible Dependents of the eligible Employee may enroll and become covered.
- B. If an eligible Dependent loses coverage, the eligible Dependent who lost coverage and the eligible Employee may enroll and become covered.

Further, Loss of Coverage means only one of the following:

- A. COBRA Continuation Coverage under another plan and the maximum period of COBRA Continuation Coverage under that other plan has been exhausted; or
- B. Group or insurance health coverage that has been terminated as a result of termination of employer contributions* towards that other coverage; or
- C. Group or insurance health coverage (includes other coverage that is Medicare) that has been terminated only as a result of a loss of eligibility for coverage for any of the following:
 - 1) Legal separation or divorce of the eligible Employee;
 - 2) Cessation of Dependent status;
 - 3) Death of the eligible Employee;
 - 4) Termination of employment of the eligible Dependent;
 - 5) Reduction in the number of hours of employment of the eligible Dependent;
 - 6) Termination of the eligible Dependent's employer's plan; or
 - 7) Any loss of eligibility after a period that is measured by reference to any of the foregoing; or
 - 8) Any loss of eligibility for individual or group coverage because the eligible Employee or Dependent no longer resides, lives or works in the service area of the HMO or other such plan.

*Employer contributions include contributions by any current or former employer that was contributing to the other non-COBRA coverage.

A loss of eligibility for coverage does not occur if coverage was terminated due to a failure of the Employee or Dependent to pay premiums on a timely basis or coverage was terminated for cause.

5. Current Employees and their Dependents (as applicable) may enroll and become covered when coverage under Medicaid or any state children's insurance program recognized under the Children's Health Insurance Program Reauthorization Act of 2009 is terminated due to loss of eligibility, subject to the following:

- A. A request for enrollment must be made either verbally or in writing within sixty (60) days after this special enrollment event, and written application for such coverage must be made within ninety (90) days after such event.
- B. If the eligible Employee loses coverage, the eligible Employee who lost coverage and any eligible Dependents of the eligible Employee may enroll and become covered.
- C. If an eligible Dependent loses coverage, the eligible Dependent who lost coverage and the eligible Employee may enroll and become covered.

6. A current Employee and the Employee's Dependents (as applicable) who are eligible for coverage under this Plan may enroll and become covered on the date they become entitled to a Premium Assistance Subsidy authorized under the Children's Health Insurance Program Reauthorization Act of 2009. The date of entitlement shall be the date stated in the Premium Assistance Authorization entitlement notice issued by the applicable state agency (CHIP or Medicaid). A request for enrollment, either verbal or in writing, must be made within sixty (60) days after this special enrollment event, and written application for such coverage must be made in writing within ninety (90) days after such event.

For any Special Enrollment event, the Participant may also elect to change coverage options to any coverage option offered by the Plan. The Coverage Option for the Dependent must be the same as the Participant.

CHANGE IN STATUS

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 death of spouse, divorce, legal separation, or annulment); 2) events that change an Employee's number of Dependents (including birth, adoption, placement for adoption, or death of a Dependent); 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 Dependent to satisfy or cease to satisfy the requirements for coverage due to attainment of age, or any similar circumstance as provided in the Plan; 6) the Employee or the Employee's family member who is enrolled as a dependent 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.

If the event causes eligible Dependents not previously covered to become covered, the effective date of coverage will be the date of the Change In Status event, provided application for such coverage is made within thirty-one (31) days of the event.

If the event causes loss of eligibility under this Plan, coverage will terminate on the Participant's last day of the last work period in which the loss of eligibility occurs.

If the event is death of a spouse or death of a Dependent, coverage will terminate on the date of death.

EMPLOYMENT CLASSIFICATION CHANGE

If a Covered Dependent under this Plan becomes an eligible Employee of the County, he/she may continue his/her coverage as a Dependent and/or elect to be covered as a Participant.

If an eligible Employee who is covered as a Participant of this Plan ceases to be an Employee of the County, but is eligible to be covered as a Dependent under another Employee/Participant, he/she may elect to continue his/her coverage as a Dependent of such Employee/Participant.

Application for coverage due to an Employment Classification Change must be made on the Plan's enrollment form, within thirty-one (31) days immediately following the date the Employee becomes or ceases to be an eligible Employee. An Employment Classification Change will not be deemed to be a break or termination of coverage and will not operate to reduce or increase any coverage or accumulations toward satisfaction of the deductible and Out-of-Pocket Maximum to which the Covered Person was entitled prior to the Employment Classification Change.

QUALIFIED MEDICAL CHILD SUPPORT ORDER PROVISION

PURPOSE

Pursuant to Section 609(a) of ERISA, the Contract Administrator adopts the following procedures to determine whether Medical Child Support Orders are qualified in accordance with ERISA's requirements, to administer payments and other provisions under Qualified Medical Child Support Orders (QMCSOs), and to enforce these procedures as legally required. Employer adopts ERISA standards to comply with child support enforcement obligation of Part D of Title IV of the Social Security Act of 1975 as amended.

DEFINITIONS

For QMCSO requirements, the following definitions apply:

1. "Alternate Recipient" means any child of a Participant who is recognized under a Medical Child Support Order as having a right to enroll in this Plan with respect to the Participant.
2. "Medical Child Support Order" means any state or court judgment, decree or order (including approval of settlement agreement) issued by a court of competent jurisdiction, or issued through an administrative process established under State law and which has the same force and effect of law under applicable State law and:
 - A. Provides for child support for a child of a Participant under this Plan, or
 - B. Provides for health coverage for such a child under state domestic relations laws (including community property laws) and relates to benefits under this Plan; and
 - C. Is made pursuant to a law relating to medical child support described in Section 1908 of the Social Security Act.
3. "Plan" means this self-funded Employee Health Benefit Plan, including all supplements and amendments in effect.
4. "Qualified Medical Child Support Order" means a Medical Child Support Order which creates (including assignment of rights) or recognizes an Alternate Recipient's right to receive benefits to which a Participant or Qualified Beneficiary is eligible under this Plan, and has been determined by the Contract Administrator to meet the qualification requirements as outlined under "Procedures" of this provision.

CRITERIA FOR A QUALIFIED MEDICAL CHILD SUPPORT ORDER

To be qualified, a Medical Child Support Order must clearly:

1. Specify the name and the last known mailing address (if any) of the Participant and the name and mailing address of each Alternate Recipient covered by the order, except that, to the extent provided in the order, the name and mailing address of an official of a State or a political subdivision thereof may be substituted for the mailing address of any such Alternate Recipient; and
2. Include a reasonable description of the type of coverage to be provided by the Plan to each Alternate Recipient, or the manner in which such type of coverage is to be determined; and
3. Specify each period to which such order applies.

In order to be qualified, a Medical Child Support Order must not require the Plan to provide any type or form of benefits, or any option, not otherwise provided under the Plan except to the extent necessary to meet the requirements of Section 1908 of the Social Security Act (relating to enforcement of state laws regarding child support and reimbursement of Medicaid).

PROCEDURES FOR NOTIFICATIONS AND DETERMINATIONS

In the case of any Medical Child Support Order received by this Plan:

1. The Contract Administrator will promptly notify the Participant and each Alternate Recipient of the receipt of such order and the plan's procedures for determining whether Medical Child Support Orders are qualified orders; and
2. Within a reasonable period after receipt of such order, the Contract Administrator will determine whether such order is a Qualified Medical Child Support Order and notify the Participant and each Alternate Recipient of such determination.

NATIONAL MEDICAL SUPPORT NOTICE

If the Contract Administrator of a group health plan which is maintained by the Employer of a noncustodial parent of a child, or to which such an employer contributes, receives an appropriately completed National Medical Support Notice as described in Section 401(b) of the Child Support Performance and Incentive Act of 1998 in the case of such child, and the Notice meets the criteria shown above for a qualified order, the Notice will be deemed to be a Qualified Medical Child Support Order in the case of such child.

FAMILY AND MEDICAL LEAVE ACT OF 1993

The Family and Medical Leave Act (FMLA) requires Employers who are subject to FMLA to allow their “eligible” Employees to take unpaid, job-protected leave. The Employer may also require or allow the Employee to substitute appropriate paid leave, including, but not limited to, vacation and sick leave, if the Employee has earned or accrued it. The maximum leave required by FMLA is twelve (12) workweeks in any twelve (12) month period for certain family and medical reasons and a maximum combined total of twenty-six (26) workweeks during any twelve (12) month period for certain family and medical reasons and for a serious injury or illness of a member of the Armed Forces to allow the Employee, who is the spouse, son, daughter, parent, or next of kin to the member of the Armed Forces, to care for that member of the Armed Forces. In certain cases, this leave may be taken on an intermittent basis rather than all at once, or the Employee may work a part-time schedule.

DEFINITIONS

For these Family and Medical Leave Act of 1993 provisions only, the following definitions apply:

1. “Member of the Armed Forces” includes members of the National Guard or Reserves who are undergoing medical treatment, recuperation, or therapy.
2. “Next of Kin” means the nearest blood relative to the service member.
3. “Parent” means Employee’s biological parent or someone who has acted as Employee’s parent in place of Employee’s biological parent when Employee was a son or daughter.
4. “Serious health condition” means an illness, injury impairment, or physical or mental condition that involves:
 - A. Inpatient care in a hospital, hospice, or residential medical facility; or
 - B. Continuing treatment by a health care provider (a doctor of medicine or osteopathy who is authorized to practice medicine or surgery as appropriate, by the state in which the doctor practices or any other person determined by the Secretary of Labor to be capable of providing health care services).
5. “Serious injury or illness” means an injury or illness incurred in the line of duty that may render the member of the Armed Forces medically unfit to perform his or her military duties.
6. “Son or daughter” means Employee’s biological child, adopted child, stepchild, foster child, a child placed in Employee’s legal custody, or a child for which Employee is acting as the parent in place of the child’s natural blood related parent. The child must be:
 - A. Under the age of eighteen (18); or
 - B. Over the age of eighteen (18), but incapable of self-care because of a mental or physical disability.
7. “Spouse” means Employee’s husband or wife as defined or recognized under State law in the State where the Employee resides.

EMPLOYERS SUBJECT TO FMLA

In general, FMLA applies to any employer engaged in interstate commerce or in any industry or activity affecting interstate commerce who employs 50 or more Employees for each working day during each of 20 or more calendar work weeks in the current or preceding Calendar Year. FMLA also applies to those persons described in Section 3(d) of the Fair Labor Standards Act, 29 U.S.C. 203(d). The FMLA applies to government entities, including branches of the United States government, state governments and political subdivisions thereof.

ELIGIBLE EMPLOYEES

Generally, an Employee is eligible for FMLA leave only if the Employee satisfies all of the following requirements as of the date on which any requested FMLA leave is to commence: (1) has been employed by the Employer for a total of at least twelve months (whether consecutive or not); (2) the Employee has worked (as defined under the Fair Labor Standards Act) at least 1,250 hours during the twelve-(12) month period immediately preceding the date the requested leave is to commence; (3) the Employee is employed in any state of the United States, the District of Columbia or any Territories or possession of the United States; and (4) at the time the leave is requested, the Employee is employed at a work site where 50 or more Employees are employed by the Employer within 75 surface miles of the work site.

REASONS FOR TAKING LEAVE

FMLA leave must be granted (1) to care for the Employee's newborn child; (2) to care for a child placed with the Employee for adoption or foster care; (3) to care for the Employee's spouse, son, daughter, or parent, who has a serious health condition; (4) because the Employee's own serious health condition prevents the Employee from performing his or her job; or (5) because of a qualifying exigency, as determined by the Secretary of Labor, arising out of the fact that a spouse, son, daughter or parent of the Employee is on active duty or has been called to active duty in the Armed Forces in support of a contingency operation (i.e., a war or national emergency declared by the President or Congress).

ADVANCE NOTICE AND MEDICAL CERTIFICATION

Ordinarily, an Employee must provide thirty (30) days advance notice when the requested leave is "foreseeable." If the leave is not foreseeable, the Employee must notify the Employer as soon as is practicable, generally within one to two working days. An employer may require medical certification to substantiate a request for leave requested due to a serious health condition. If the leave is due to the Employee's serious health condition, the Employer may require second or third opinions, at the Employer's expense, and a certification of fitness to return to work prior to allowing the Employee to return to work.

PROTECTION OF JOB BENEFITS

For the duration of FMLA leave, the Employer must maintain the Employee's health coverage under any "group health plan" on the same conditions as coverage would have been provided if the Employee had been in Active Service during FMLA leave period. Taking FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an Employee's leave, unless the loss would have occurred even if the Employee had been in Active Service.

UNLAWFUL ACTS BY EMPLOYERS

Employers cannot interfere with, restrain or deny the exercise of any right provided under the FMLA or to manipulate circumstances to avoid responsibilities under the FMLA. Employers may not discharge, or discriminate against any person who opposes any practice made unlawful by the FMLA or who may be involved in a proceeding under or relating to the FMLA.

ENFORCEMENT

The U.S. Department of Labor is authorized to investigate and resolve complaints of FMLA violations. An eligible Employee may also bring a civil action against an employer for FMLA violations. The FMLA does not supersede any federal or state law prohibiting discrimination, and does not supersede any state or local law or collective bargaining agreement which provides greater family or medical leave rights. For additional information, contact the nearest office of Wage and Hour Division, listed in most telephone directories under U.S. Government, Department of Labor.

TERMINATION OF COVERAGE

PARTICIPANT TERMINATION

Participant coverage will automatically terminate immediately upon the earliest of the following dates, except as provided in any Continuation of Coverage Provision (including continuation coverage required by USERRA):

1. On the last day of the last work period in which the Participant's employment terminates; or
2. On the last day of the last work period in which the Participant ceases to be eligible for coverage; or
3. The date the Participant fails to make any required contribution for coverage, if contribution is not received within thirty (30) days after the date such contribution was due; or
4. The date the Plan is terminated; or
5. The date the County terminates the Participant's coverage; or
6. On the day in which the Participant dies; or
7. The date the Participant enters the armed forces of any country as a full-time member, if active duty is to exceed thirty-one (31) days. A Participant who loses coverage due to qualified uniformed service may be eligible to elect to continue coverage under the Plan for a limited period of time to the extent required by COBRA and/or USERRA.

A Participant whose Active Service ceases because of Illness or Injury or as a result of any other approved leave of absence may remain covered as an Employee in Active Service for a period of twelve (12) weeks, or such other length of time that is consistent with and stated in the County's current Employee Personnel Policy Manual or pursuant to the Family and Medical Leave Act. Coverage under this provision will be subject to all the provisions of FMLA if the leave is classified as FMLA leave.

A Participant whose Active Service ceases due to temporary layoff will be considered employed by the County for the purposes of his/her coverage under this Plan, and such coverage may continue until the end of the last day of the last work period in which the layoff began.

If a Participant's coverage is to be continued during disability, approved leave of absence or temporary lay off, the amount of his or her coverage will be the same as the Plan benefits in force for an active Employee, subject to the Plan's right to amend coverage and benefits.

An Employee whose coverage terminates by reason of termination of employment or reduction in hours and who again becomes eligible for coverage under the Plan will be treated as if initially hired for purposes of eligibility and coverage under this Plan.

DEPENDENT TERMINATION

For purposes of COBRA Continuation Coverage, each Covered Person, whether Participant or Dependent, is responsible for notifying the Contract Administrator, within sixty (60) days after loss of Dependent status due to death, divorce, legal separation or ceasing to be an eligible Dependent child. Failure to provide this notice may result in loss of eligibility for COBRA Continuation Coverage After Termination.

Coverage for a Dependent will automatically terminate immediately upon the earliest of the following dates, except as provided in any Continuation of Coverage Provision:

1. On the last day of the Participant's last work period in which the Dependent ceases to be an eligible Dependent as defined in the Plan; or

2. On the day in which the Participant's coverage terminates under the Plan; or
3. On the last day of the Participant's last work period in which the Participant ceases to be eligible for Dependent Coverage; or
4. The date the Participant fails to make any required contribution for Dependent Coverage, if contribution is not received within thirty (30) days after the date such contribution was due; or
5. The date the Plan is terminated; or
6. The date the County terminates the Dependent's coverage; or
7. In the event that a Participant should die, their Dependent coverage shall be extended ten (10) additional days following the death of such Participant, or until the last day of the work period in which the Participant died, whichever is later; or
8. The date the Employee elects to terminate coverage in connection with a Change in Status or leave under the Family and Medical Leave Act.

RETIREE TERMINATION

Retiree coverage will automatically terminate immediately upon the earliest of the following dates, except as provided in any Continuation of Coverage Provision:

1. The last day of the month in which the Retiree ceases to be eligible for coverage; or
2. The date the Retiree fails to make any required contribution for coverage, if contribution is not received within thirty (30) days after the date such contribution was due; or
3. The date the Plan is terminated; or
4. The date the County terminates the Retiree's coverage; or
5. The date the Retiree dies; or
6. The date the Retiree enters the armed forces of any country as a full-time member, if active duty is to exceed thirty-one (31) days; or
7. The last day of the month in which the Retiree voluntarily elects to terminate Retiree coverage; or
8. The date the Retiree becomes eligible for Medicare as a result of age.

Dependents of Retirees will automatically terminate immediately upon the earliest of the following dates, except as provided in any Continuation of Coverage provision:

1. The date the Retiree ceases to be eligible for coverage; or
2. The last day of the month in which the Dependent ceases to be an eligible Dependent as defined in the Plan; or
3. The date the Retiree fails to make any required contribution for coverage for Dependent coverage, if contribution is not received within thirty (30) days after the date such contribution was due; or
4. In the event that a Retiree should die, their Dependent coverage shall be extended ten (10) additional days following the death of such Retiree, or until the last day of the month in which the Retiree died, whichever is later; or

5. The date the Retiree's coverage terminates (including due to Medicare eligibility or a voluntary election to terminate coverage); or
6. The date the Dependent becomes eligible for Medicare as a result of age; or
7. The date the Plan is terminated; or
8. The date the County terminates the Dependent's coverage; or
9. The last day of the month in which the Retiree voluntarily elects to terminate coverage for the Dependent.

RESCISSION OF COVERAGE

Coverage for an Employee and/or Dependent may be rescinded if the Contract Administrator determines that the Employee or a Dependent engaged in fraud or intentional misrepresentation in order to obtain coverage and/or benefits under the Plan. In such case, the Participant will receive written notice at least thirty (30) days before the coverage is rescinded.

CONTINUATION COVERAGE AFTER TERMINATION

Under the Public Health Service Act, as amended, Employees and their enrolled Dependents may have the right to continue coverage beyond the time coverage would ordinarily have ended. The law applies to employers who normally employ twenty (20) or more Employees.

The Contract Administrator is Williamson County, Human Resources Department, 301 SE Inner Loop, Suite 108, Georgetown, Texas 78626; (510) 943-1533. COBRA Continuation Coverage for the Plan is administered by Allegiance COBRA Services, Inc.; P.O. Box 2097; Missoula, MT 59806, 406-721-2222.

COBRA Continuation Coverage is available to any Qualified Beneficiary whose coverage would otherwise terminate due to any Qualifying Event. COBRA Continuation Coverage under this provision will begin on the first day following the date the date coverage terminates.

1. Qualifying Events for Participants, for purposes of this section, are the following events, if such event results in a loss of coverage under this Plan:

- A. The termination (other than by reason of gross misconduct) of the Participant's employment.
- B. The reduction in hours of the Participant's employment.

2. Qualifying Events for covered Dependents, for purposes of this section are the following events, if such event results in a loss of coverage under this Plan:

- A. Death of the Participant or Retiree.
- B. Termination of the Participant's employment.
- C. Reduction in hours of the Participant's employment.
- D. The divorce or legal separation of the Participant or Retiree from his or her spouse.
- E. A covered Dependent child ceases to be a Dependent as defined by the Plan.

NOTIFICATION RESPONSIBILITIES

The Covered Person must notify the Human Resources Department of the Employer of the following Qualifying Events within sixty (60) days after the date the event occurs. The Employer must notify the Contract Administrator of any of the following:

- 1. Death of the Participant or Retiree.
- 2. The divorce or legal separation of the Participant or Retiree from his or her spouse.
- 3. A covered Dependent child ceases to be a Dependent as defined by the Plan.

The Human Resources Department of the Employer must notify the Contract Administrator of the following Qualifying Events within thirty (30) days after the date of the event occurs:

- 1. Termination (other than by reason of gross misconduct) of the Participant's employment.
- 2. Reduction in hours of the Participant's employment.

ELECTION OF COVERAGE

When the Contract Administrator is notified of a Qualifying Event, the Contract Administrator will notify the Qualified Beneficiary of the right to elect continuation of coverage. Notice of the right to COBRA Continuation Coverage will be sent by the Plan no later than fourteen (14) days after the Contract Administrator is notified of the Qualifying Event.

A Qualified Beneficiary has sixty (60) days from the date coverage would otherwise be lost or sixty (60) days from the date of notification from the Contract Administrator, whichever is later, to notify the Contract Administrator that he or she elects to continue coverage under the Plan. Failure to elect continuation within that period will cause coverage to end.

MONTHLY PREMIUM PAYMENTS

A Qualified Beneficiary is responsible for the full cost of continuation coverage. Monthly premium for continuation of coverage must be paid in advance to the Contract Administrator. The premium required under the provisions of COBRA is as follows:

1. For a Qualified Beneficiary: The premium is the same as applicable to any other similarly situated non-COBRA Participant plus an additional administrative expense of up to a maximum of two percent (2%).
2. Social Security Disability: For a Qualified Beneficiary continuing coverage beyond eighteen (18) months due to a documented finding of disability by the Social Security Administration within 60 days after becoming covered under COBRA, the premium may be up to a maximum of 150% of the premium applicable to any other similarly situated non-COBRA Participant.
3. For a Qualified Beneficiary with a qualifying Social Security Disability who experiences a second Qualifying Event:
 - A. If another Qualifying Event occurs during the initial eighteen (18) months of COBRA coverage, such as a death, divorce or legal separation, the monthly fee for qualified disabled person may be up to a maximum of one hundred and two percent (102%) of the applicable premium.
 - B. If the second Qualifying Event occurs during the nineteenth (19th) through the twenty-ninth (29th) month (the Disability Extension Period), the premium for a Qualified Beneficiary may be up to a maximum of one hundred fifty percent (150%) of the applicable premium.

Payment of claims while covered under this COBRA Continuation Coverage Provision will be contingent upon the receipt by the Employer of the applicable monthly premium for such coverage. The monthly premium for continuation coverage under this provision is due the first of the month for each month of coverage. A grace period of thirty (30) days from the first of the month will be allowed for payment. Payment will be made in a manner prescribed by the Employer.

DISABILITY EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If the Qualified Beneficiary who is covered under the Plan is determined by the Social Security Administration to be disabled at any time before the qualifying event or within sixty (60) days after the qualifying event, and the Contract Administrator is notified in a timely fashion, the Qualified Beneficiary covered under the Plan can receive up to an additional 11 months of COBRA Continuation Coverage, for a total maximum of 29 months. The Contract Administrator must be provided with a copy of the Social Security Administration's disability determination letter within sixty (60) days after the date of the determination and before the end of the original 18-month period of COBRA Continuation Coverage. This notice should be sent to: Allegiance COBRA Services, Inc.; P.O. Box 2097; Missoula, MT 59806.

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

If another qualifying event occurs while receiving COBRA Continuation Coverage, the spouse and dependent children of the Employee can get additional months of COBRA Continuation Coverage, up to a maximum of thirty-six (36) months. This extension is available to the spouse and dependent children if the former employee dies or becomes divorced or legally separated. The extension is also available to a dependent child when that child stops being eligible under the Plan as a dependent child. **In all of these cases, the Contract Administrator must be notified of the second qualifying event within sixty (60) days of the second qualifying event. This notice must be sent to: Allegiance COBRA Services, Inc.; P.O. Box 2097; Missoula, MT 59806. Failure to provide notice within the time required will result in loss of eligibility for COBRA Continuation Coverage.**

MEDICARE ENROLLMENT EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

The dependents of a former employee are eligible to elect COBRA Continuation Coverage if they lose coverage as a result of the former employee's enrollment in Part A, Part B or Part D of Medicare, whichever occurs earlier.

When the former employee enrolls in Medicare before the Qualifying Event of termination, or reduction in hours, of employment occurs, the maximum period for COBRA Continuation Coverage for the spouse and dependent children ends on the later of:

1. Eighteen (18) months after the Qualifying Event of termination of employment or reduction in hours of employment; or
2. Thirty-six (36) months after the former employee's enrollment in Medicare.

When the former employee enrolls in Medicare after the Qualifying Event of termination, or reduction in hours, of employment, the maximum period for COBRA Continuation Coverage for the spouse and dependent children ends eighteen (18) months after the Qualifying Event, unless a second Qualifying Event, as described above occurs within that eighteen (18) month period.

WHEN COBRA CONTINUATION COVERAGE ENDS

COBRA Continuation Coverage and any coverage under the Plan that has been elected with respect to any Qualified Beneficiary will cease on the earliest of the following:

1. On the date the Qualified Beneficiary becomes covered under another group health plan or health insurance, unless the other group health plan contains a provision excluding or limiting coverage for a Pre-existing Condition applicable to a condition of the Qualified Beneficiary under this Plan. However, if the exclusionary period does not apply due to prior Creditable Coverage, COBRA continuation coverage ends. Coverage will not be terminated as stated until the pre-existing exclusionary period of the other coverage is no longer applicable.

This exception applies to all Qualified Beneficiaries.

2. On the date, after the date of election for COBRA Continuation Coverage, that the Qualified Beneficiary becomes enrolled in Medicare (either Part A, B or D);
3. On the first date that timely payment of any premium required under the Plan with respect to COBRA Continuation Coverage for a Qualified Beneficiary is not made to the Contract Administrator.
4. On the date the Employer ceases to provide any group health plan coverage to any Employee.

5. On the date of receipt of written notice that the Qualified Beneficiary wishes to terminate COBRA Continuation Coverage.
6. On the date that the maximum coverage period for COBRA Continuation Coverage ends, as follows:
 - A. Eighteen (18) months for a former employee who is a Qualified Beneficiary as a result of termination, or reduction in hours, of employment;
 - B. Eighteen (18) months for a Dependent who is a Qualified Beneficiary unless a second Qualifying Event occurs within that eighteen month period entitling that Dependent to an additional eighteen (18) months;
 - C. For the Dependent who is a Qualified Beneficiary as a result of termination, or reduction in hours, of employment of the former employee if that former employee enrolled in Medicare before termination, or reduction in hours, of employment, the later of eighteen (18) months from the Qualifying Event, or thirty-six (36) months following the date of enrollment in Medicare.
 - D. On the first day of the month beginning thirty (30) days after a Qualified Beneficiary is determined to be no longer disabled by the Social Security Administration if the Qualified Beneficiary was found to be disabled on or within the first sixty (60) days of the date of the Qualifying Event and has received at least eighteen (18) months of COBRA Continuation Coverage. COBRA Continuation Coverage will also terminate on such date for all Dependents who are Qualified Beneficiaries as a result of the Qualifying Event unless that Dependent is entitled to a longer period of COBRA Continuation Coverage without regard to disability.
 - E. Twenty-nine (29) months for any Qualified Beneficiary if a Disability Extension Period of COBRA Continuation Coverage has been granted for such Qualified Beneficiary.
 - F. Thirty-six (36) months for all other Qualified Beneficiaries.
7. On the same basis that the Plan can terminate for cause the coverage of a similarly situated non-COBRA Participant.

QUESTIONS

Any questions about COBRA Continuation Coverage should be directed to Allegiance COBRA Services or contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

INFORM THE PLAN OF ADDRESS CHANGES

In order to protect the Employee's family's rights, the Employee should keep the Contract Administrator informed of any changes in the addresses of family members. The Employee should also keep a copy, for his/her records, of any notices sent to the Contract Administrator.

COVERAGE FOR A MILITARY RESERVIST

To the extent required by the Uniform Services Employment and Reemployment Rights Act (USERRA), the following provisions will apply:

1. If a Participant is absent from employment with Employer by reason of service in the uniformed services, the Participant may elect to continue coverage under this Plan for himself or herself and his or her eligible Dependents as provided in this subsection. The maximum period of coverage under such an election will be the lesser of:

A. The twenty-four (24) month period beginning on the date on which the Participant's absence begins; or

B. The period beginning on the date on which the Participant's absence begins and ending on the day after the date on which the Participant fails to apply for or return to a position of employment, as required by USERRA.

2. A Participant who elects to continue Plan coverage under this Section may be required to pay not more than one hundred two percent (102%) of the full premium under the Plan (determined in the same manner as the applicable premium under Section 4980B(f)(4) of the Internal Revenue Code of 1986) associated with such coverage for the Employer's other Employees, except that in the case of a person who performs service in the uniformed services for less than thirty-one (31) days, such person may not be required to pay more than the regular Employee share, if any, for such coverage.

3. In the case of a Participant whose coverage under the Plan is terminated by reason of service in the uniformed services, an exclusion or Waiting Period may not be imposed in connection with the reinstatement of such coverage upon reemployment if an exclusion or Waiting Period would not have been imposed under the Plan had coverage of such person by the Plan not been terminated as a result of such service. This paragraph applies to the Employee who notifies the Employer of his or her intent to return to employment in a timely manner as defined by USERRA, and is reemployed and to any Dependent who is covered by the Plan by reason of the reinstatement of the coverage of such Employee. **This provision will not apply to the coverage of any illness or injury determined by the Secretary of Veterans Affairs to have been caused by or aggravated during, performance of service in the uniformed services.**

FRAUD AND ABUSE

THIS PLAN IS SUBJECT TO FEDERAL LAW WHICH PERMITS CRIMINAL PENALTIES FOR FRAUDULENT ACTS COMMITTED AGAINST THE PLAN. STATE LAW MAY ALSO APPLY.

Anyone who knowingly defrauds or tries to defraud the Plan, or obtains Plan funds through false statements or fraudulent schemes, may be subject to criminal prosecution and penalties. The following may be considered fraudulent:

1. Falsifying eligibility criteria for a Dependent, including marital status or age, to get or continue coverage for that Dependent when not otherwise eligible for coverage;
2. Falsifying or withholding medical history or information required to calculate benefits or determine pre-existing conditions when no creditable coverage exists;
3. Falsifying or altering documents to get coverage or benefits;
4. Permitting a person not otherwise eligible for coverage to use a Plan ID card to get Plan benefits; or
5. Submitting a fraudulent claim or making untruthful statements to the Plan to get reimbursement from the Plan for services that may or may not have been provided to a Covered Person.

The Contract Administrator, in its sole discretion, may take additional action against the Participant or Covered Person, including, but not limited to terminating the Participant or Covered Person's coverage under the Plan.

MISSTATEMENT OF AGE

If the Covered Person's age was misstated on an enrollment form or claim, the Covered Person's eligibility or amount of benefits, or both, will be adjusted to reflect the Covered Person's true age. If the Covered Person was not eligible for coverage under the Plan or for the amount of benefits received, the Plan has a right to recover any benefits paid by the Plan. A misstatement of age will not continue coverage that was otherwise properly terminated or terminate coverage that is otherwise validly in force.

MISREPRESENTATION OF ELIGIBILITY

If a Participant misrepresents a Dependent's marital status, age, dependent child relationship or other eligibility criteria to get coverage for that Dependent, when he or she would not otherwise be eligible, coverage for that Dependent will terminate as though never effective.

MISUSE OF IDENTIFICATION CARD

If a Covered Person permits any person who is not otherwise eligible as a Covered Person to use an ID card, the Plan Sponsor may, at the Plan Sponsor's sole discretion, terminate the Covered Person's coverage.

REIMBURSEMENT TO PLAN

Payment of benefits by the Plan for any person who was not otherwise eligible for coverage under this Plan but for whom benefits were paid based upon fraud as defined in this section must be reimbursed to the Plan by the Participant. Failure to reimburse the Plan upon request may result in an interruption or a loss of benefits by the Participant and Dependents.

RESCISSION OF COVERAGE

Coverage for an Employee and/or Dependent may be rescinded if the Contract Administrator determines that the Employee or a Dependent engaged in fraud or intentional misrepresentation in order to obtain

coverage and/or benefits under the Plan. In such case, the Participant will receive written notice at least thirty (30) days before the coverage is rescinded.

RECOVERY/REIMBURSEMENT/SUBROGATION

By enrollment in this Plan, Covered Persons agree to the provisions of this section as a condition precedent to receiving benefits under this Plan. Failure of a Covered Person to comply with the requirements of this section may result in the Plan pending the payment of benefits.

RIGHT TO RECOVER BENEFITS PAID IN ERROR

If the Plan makes a payment in error to or on behalf of a Covered Person or an assignee of a Covered Person to which that Covered Person is not entitled, or if the Plan pays a claim that is not covered, the Plan has the right to recover the payment from the person paid or anyone else who benefitted from the payment. The Plan can deduct the amount paid from the Covered Person's future benefits, or from the benefits for any covered Family member even if the erroneous payment was not made on that Family member's behalf.

Payment of benefits by the Plan for Participants' spouses, ex-spouses, or children, who are not eligible for coverage under this Plan, but for whom benefits were paid based upon inaccurate, false information provided by, or information omitted by, the Employee will be reimbursed to the Plan by the Employee. The Employee's failure to reimburse the Plan after demand is made, may result in an interruption in or loss of benefits to the Employee, and could be reported to the appropriate governmental authorities for investigation of criminal fraud.

The Plan may recover such amount by any appropriate method that the Contract Administrator, in its sole discretion, will determine.

The provisions of this section apply to any Physician or Licensed Health Care Provider who receives an assignment of benefits or payment of benefits under this Plan. If a Physician or Licensed Health Care Provider fails to refund a payment of benefits, the Plan may refuse to recognize future assignments of benefits to that provider.

REIMBURSEMENT

The Plan's right to Reimbursement is separate from and in addition to the Plan's right of Subrogation. If the Plan pays benefits for medical expenses on a Covered Person's behalf, and another party was responsible or liable for payment of those medical expenses, the Plan has a right to be reimbursed by the Covered Person for the amounts the Plan paid.

Accordingly, if a Covered Person, or anyone on his or her behalf, settles, is reimbursed or recovers money from any person, corporation, entity, liability coverage, no-fault coverage, uninsured coverage, underinsured coverage, or other insurance policies or funds for any accident, Injury, condition or Illness for which benefits were provided by the Plan, the Covered Person agrees to hold the money received in trust for the benefit of the Plan. The Covered Person agrees to reimburse the Plan, in first priority, from any money recovered from a liable third party, for the amount of all money paid by the Plan to the Covered Person or on his or her behalf or that will be paid as a result of said accident, Injury, condition or Illness. Reimbursement to the Plan will be paid first, in its entirety, even if the Covered Person is not paid for all of his or her claim for damages and regardless of whether the settlement, judgment or payment he or she receives is for or specifically designates the recovery, or a portion thereof, as including health care, medical, disability or other expenses or damages.

SUBROGATION

The Plan's right to Subrogation is separate from and in addition to the Plan's right to Reimbursement. Subrogation is the right of the Plan to exercise the Covered Person's rights and remedies in order to recover from any third party who is liable to the Covered Person for a loss or benefits paid by the Plan. The Plan may proceed through litigation or settlement in the name of the Covered Person, with or without his or her consent, to recover benefits paid under the Plan.

The Covered Person agrees to subrogate to the Plan any and all claims, causes of action or rights that he or she has or that may arise against any entity who has or may have caused, contributed to or aggravated the accident, Injury, condition or Illness for which the Plan has paid benefits, and to subrogate any claims, causes of action or rights the Covered Person may have against any other coverage, including but not limited to liability coverage, no-fault coverage, uninsured motorist coverage, underinsured motorist coverage, or other insurance policies, coverage or funds.

In the event that a Covered Person decides not to pursue a claim against any third party or insurer, the Covered Person will notify the Plan, and specifically authorize the Plan, in its sole discretion, to sue for, compromise or settle any such claims in the Covered Person's name, to cooperate fully with the Plan in the prosecution of the claims, and to execute any and all documents necessary to pursue those claims.

The Following Paragraphs Apply to Both Reimbursement and Subrogation:

1. Under the terms of this Plan, the Claims Supervisor is not required to pay any claim where there is evidence of liability of a third party unless the Covered Person signs the Plan's Third-Party Reimbursement Agreement and follows the requirements of this section. However, the Plan, in its discretion, may instruct the Claims Supervisor not to withhold payment of benefits while the liability of a party other than the Covered Person is being legally determined. If a repayment agreement is requested to be signed, the Plan's right of recovery through Reimbursement and/or Subrogation remains in effect regardless of whether the repayment agreement is actually signed.
2. If the Plan makes a payment which the Covered Person, or any other party on the Covered Person's behalf, is or may be entitled to recover against any liable third party, this Plan has a right of recovery, through reimbursement or subrogation or both, to the extent of its payment.
3. The Covered Person will cooperate fully with the Contract Administrator, its agents, attorneys and assigns, regarding the recovery of any benefits paid by the Plan from any liable third party. This cooperation includes, but is not limited to, make full and complete disclosure in a timely manner of all material facts regarding the accident, Injury, condition or Illness to the Contract Administrator; report all efforts by any person to recover any such monies; provide the Contract Administrator with any and all requested documents, reports and other information in a timely manner, regarding any demand, litigation or settlement involving the recovery of benefits paid by the Plan; and notify the Contract Administrator of the amount and source of funds received from third parties as compensation or damages for any event from which the Plan may have a reimbursement or subrogation claim.
4. Covered Persons will respond within ten (10) days to all inquiries of the Plan regarding the status of any claim they may have against any third parties or insurers, including but not limited to liability, no-fault, uninsured and underinsured insurance coverage. The Covered Person will notify the Plan immediately of the name and address of any attorney whom the Covered Person engages to pursue any personal Injury claim on his or her behalf.
5. The Covered Person will not act, fail to act, or engage in any conduct directly, indirectly, personally or through third parties, either before or after payment by the Plan, the result of which may prejudice or interfere with the Plan's rights to recovery hereunder. The Covered Person will not conceal or attempt to conceal the fact that recovery has occurred or will occur.

6. The Plan will not pay or be responsible, without its written consent, for any fees or costs associated with a Covered Person pursuing a claim against any third party or coverage, including, but not limited to, attorney fees or costs of litigation. Monies paid by the Plan will be repaid in full, in first priority, notwithstanding any anti-subrogation, "made whole," "common fund" or similar statute, regulation, prior court decision or common law theory unless a reduction or compromise settlement is agreed to in writing or required pursuant to a court order.

RIGHT OF OFF-SET

The Plan has a right of off-set to satisfy reimbursement claims against Covered Persons for money received by the Covered Person from a third party, including any insurer. If the Covered Person fails or refuses to reimburse the Plan for funds paid for claims, the Plan may deny payment of future claims of the Covered Person, up to the full amount paid by the Plan and subject to reimbursement for such claims. This right of off-set applies to all reimbursement claims owing to the Plan whether or not formal demand is made by the Plan, and notwithstanding any anti-subrogation, "common fund," "made whole" or similar statutes, regulations, prior court decisions or common law theories.

PLAN ADMINISTRATION

PURPOSE

The purpose of the Plan Document is to set forth the provisions of the Plan which provide for the payment or reimbursement of all or a portion of the claim. The terms of this Plan are legally enforceable and the Plan is maintained for the exclusive benefit of eligible Employees, Retirees and their covered Dependents.

EFFECTIVE DATE

The effective date of the Plan is November 1, 2013.

PLAN YEAR

The Plan Year will commence November 1st of each year and end on the last day of October each succeeding year.

PLAN SPONSOR

The Plan Sponsor is Williamson County Benefits Risk Pool.

CLAIMS SUPERVISOR

The Supervisor of the Plan is Allegiance Benefit Plan Management, Inc.

OPERATION AND ADMINISTRATION OF THE PLAN

The Williamson County 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.

CONTRACT ADMINISTRATOR

The Contract Administrator is Williamson County, a political subdivision of the State of Texas who has the authority to control and manage the operation and administration of the Plan. The Contract Administrator may delegate responsibilities for the operation and administration of the Plan. The Contract Administrator will have the authority to amend the Plan, to determine its policies, to appoint and remove other service providers of the Plan, to fix their compensation (if any), and exercise general administrative authority over them and the Plan. The Administrator has the sole authority and responsibility to review and make final decisions on all claims to benefits hereunder.

CONTRIBUTIONS TO THE PLAN

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 Plan Year. By electing to participate in the Plan and/or receiving benefits under the Plan, each Covered Employee and Covered Dependent 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.

The County has the discretion to set premiums that may require participation in a Wellness Program. Please contact the Human Resources Department for additional information.

PLAN AMENDMENTS/MODIFICATION/TERMINATION

The Plan Document contains all the terms of the Plan and may be amended at any time by the Contract Administrator. Any changes will be binding on each Participant and on any other Covered Persons referred to in this Plan Document. The authority to amend the Plan is delegated by the Contract Administrator to the Commissioners Court. Any such amendment, modification, revocation or termination of the Plan will be authorized and signed by the County Judge. Written notification of any amendments, modifications, revocations or terminations will be given to Plan Participants within one-hundred and twenty (120) days of such decision, except for notices of reduction of benefits.

NOTICE OF REDUCTION OF BENEFITS

All changes or amendments to this Plan that directly or indirectly reduce any benefit or coverage under the Plan, including any increase in contribution for coverage required from a Participant, will be reported to all eligible Participants and Dependents within sixty (60) days of the date such change or amendment is adopted.

TERMINATION OF PLAN

The County reserves the right at any time to terminate the Plan by a written notice. All previous contributions by the County will continue to be issued for the purpose of paying benefits and fixed costs under provisions of this Plan with respect to claims arising before such termination, or will be used for the purpose of providing similar health benefits to Participants, until all contributions are exhausted.

SUMMARY PLAN DESCRIPTIONS

Each Participant covered under this Plan will be issued a Summary Plan Description (SPD) describing the benefits to which the Covered Persons are entitled, the required Plan procedures for eligibility and claiming benefits and the limitations and exclusions of the Plan.

CREDITABLE COVERAGE PROCEDURES

CERTIFICATE OF CREDITABLE COVERAGE

The Plan will provide Certificate of Creditable Coverage for coverage under this Plan as required by the United States Public Health Service to any Covered Person or the Covered Person's designated and authorized agent, guardian, conservator, health care plan or health insurance as follows:

1. At the time the Covered Person ceases to be covered under this Plan; and
2. At the time a Covered Person ceases to be covered by the COBRA Continuation Coverage provided by this Plan, if any; and
3. At any other time that a request is made on behalf of the Covered Person for such certification, but not later than twenty four (24) months after cessation of coverage as set out in subparagraphs 1 and 2 above, whichever is later.

CREDITABLE COVERAGE

An eligible Employee or Dependent under this Plan may submit to the Plan, Certificate of Creditable Coverage from any prior health insurance or health care plan under which said Employee or Dependent had coverage, for the purpose of reducing, on a day for day basis, any Pre-existing Condition Exclusion imposed by this Plan for which the eligible Employee or Dependent had applicable Creditable Coverage under any prior insurance or health care coverage.

An eligible Employee or Dependent has a right to request and receive a Certificate of Creditable Coverage from any insurance carrier or health care plan under which he/she had coverage on or after July 1, 1996.

In the event that the eligible Employee or Dependent is unable to obtain a Certificate of Creditable Coverage from a prior insurance carrier or health care plan, the Contract Administrator may provide assistance to obtain the same.

CREDITABLE COVERAGE REVIEW

Upon the Plan's receipt of a Certificate of Creditable Coverage regarding prior coverage by any enrollee for coverage under this Plan, the Plan acting on its own or through a firm contracted to provide services to the Plan, will send to such enrollee a written confirmation of the amount of prior Creditable Coverage, if any, to which the enrollee will be entitled against any Pre-existing Condition Exclusion period under this Plan. Such written confirmation will be provided to the enrollee within thirty (30) days of receipt of the certification by the Plan.

In the event that an enrollee disagrees with the Plan's calculation of any prior Creditable Coverage, the enrollee will send written notice of said disagreement to the Plan, together with a written request for review of the calculation, within fifteen (15) days of receipt of the Plan's written confirmation. Failure to submit a written notice of disagreement and request for review of the calculation within the time limit required in this section will be deemed a waiver of any further review.

Upon receipt by the Plan of a notice of disagreement and request for review, the Plan will review the calculations, and will either affirm those calculations or revise its calculation and determination of prior Creditable Coverage. The Contract Administrator will notify the enrollee, in writing, of its decision after review within thirty (30) days after receipt of the notice of disagreement and request for review. The Contract Administrator's decision regarding prior Creditable Coverage will be final and binding upon the Plan and any Covered Person under the Plan.

DETERMINATION OF PRIOR CREDITABLE COVERAGE WHEN A CERTIFICATION IS UNAVAILABLE

If an enrollee is unable to obtain a Certificate of Creditable Coverage, for prior coverage, after having exhausted all reasonable efforts to obtain the same, such an enrollee may request in writing that the Plan make a determination whether he or she is entitled to prior Creditable Coverage based upon other evidence and information. Said request must be submitted to and received by the Plan within sixty (60) days of the effective date of coverage of the person for whom the request is made.

Upon receipt by the Plan of a request to determine prior Creditable Coverage in the absence of a Certification, the Plan will require that the person for whom the request is made provide to the Plan all evidence in support of such request within sixty (60) days of the initial request. A longer period of time, up to an additional sixty (60) days, may be granted, to submit evidence, upon written request and good cause for the same. Evidence submitted will include in every case, a sworn affidavit by the person for whom the determination is to be made, or by that person's parent or guardian, if the person is a minor, or is incompetent or unable to execute such an affidavit. The affidavit will contain the following information:

1. The name of the prior insurance carrier(s), benefit plan(s) or other payor(s) of medical benefits under which prior Creditable Coverage is asserted to exist.
2. The date(s) that coverage commenced and ended under any such prior insurance, benefit plan or other payor.
3. The address, if known, of the insurance carrier(s), benefit plan(s) or other payor(s).
4. The nature of the coverage under the prior insurance, benefit plan(s) or other benefit payor(s).
5. A description of the efforts undertaken to obtain Certifications of prior Creditable Coverage, and the results of those efforts.
6. The names, and addresses or telephone numbers, of former employers, insurance agents, human resource personnel, third party administrators, HMO's or medical providers that may have knowledge of the asserted prior coverage.
7. Any other information that the affiant deems relevant.

The affidavit, together with any other documentation submitted, including, but not limited to Summary Plan Descriptions or Policies indicating prior coverage, pay stubs indicating deduction of premium amounts, Explanations of Benefits from prior coverage, written statements from persons with knowledge of prior coverage, and medical bills indicating payment by insurance or benefit plans, will be reviewed and considered by the Plan. Subsequent to such review, the Plan will provide a written determination of prior Creditable Coverage, if any, within thirty (30) days after the submission of the last item of evidence on behalf of the enrollee, or ninety (90) days from the enrollee's initial request for determination under this section, whichever occurs first. The Plan's determination will be final and binding upon the Plan and all Covered Persons under the Plan.

GENERAL PROVISIONS

EXAMINATION

The Plan will have the right and opportunity to have the Covered Person examined whenever Injury or Illness is the basis of a claim when and so often as it may reasonably require to adjudicate the claim. The Plan will also have the right to have an autopsy performed in case of death to the extent permitted by law.

PAYMENT OF CLAIMS

All Plan benefits are payable to a Participant, Qualified Beneficiary or Alternate Recipient, whichever is applicable. All or a portion of any benefits payable by the Plan may, at the Covered Person's option and unless the Covered Person requests otherwise in writing not later than the time of filing the claim, be paid directly to the health care provider rendering the service, if proper written assignment is provided to the Plan. No payments will be made to any provider of services unless the Covered Person is liable for such expenses.

If any benefits remain unpaid at the time of the Covered Person's death or if the Covered Person is a minor or is, in the opinion of the Plan, legally incapable of giving a valid receipt and discharge for any payment, the Plan may, at its option, pay such benefits to the Covered Person's legal representative or estate. The Plan, in its sole option, may require that an estate, guardianship or conservatorship be established by a court of competent jurisdiction prior to the payment of any benefit. Any payment made under this subsection will constitute a complete discharge of the Plan's obligation to the extent of such payment and the Plan will not be required to oversee the application of the money so paid.

LEGAL PROCEEDINGS

No action at law or equity will be brought to recover on the Plan prior to the expiration of sixty (60) days after proof of loss has been filed in accordance with the requirements of the Plan, nor will such action be brought at all unless brought within three (3) years from the expiration of the time within which proof of loss is required by the Plan.

NO WAIVER OR ESTOPPEL

No term, condition or provision of this Plan will be waived, and there will be no estoppel against the enforcement of any provision of this Plan, except by written instrument of the party charged with such waiver or estoppel. No such written waiver will be deemed a continuing waiver unless specifically stated therein, and each such waiver will operate only as to the specific term or condition waived and will not constitute a waiver of such term or condition for the future or as to any act other than that specifically waived.

VERBAL STATEMENTS

Verbal statements or representations of the Contract Administrator, its agents and Employees, or Covered Persons will not create any right by contract, estoppel, unjust enrichment, waiver or other legal theory regarding any matter related to the Plan, or its administration, except as specifically stated in this subsection. No statement or representation of the Contract Administrator, its agents and Employees, or Covered Persons will be binding upon the Plan or a Covered Person unless made in writing by a person with authority to issue such a statement. This subsection will not be construed in any manner to waive any claim, right or defense of the Plan or a Covered Person based upon fraud or intentional material misrepresentation of fact or law.

FREE CHOICE OF PHYSICIAN

The Covered Person will have free choice of any licensed Physician, Licensed Health Care Provider or surgeon and the patient-provider relationship will be maintained.

WORKERS' COMPENSATION NOT AFFECTED

This Plan is not in lieu of, supplemental to Workers' Compensation and does not affect any requirement for coverage by Workers' Compensation Insurance.

CONFORMITY WITH LAW

If any provision of this Plan is contrary to any law to which it is subject, such provision is hereby amended to conform to the minimum requirements of the applicable law. Only that provision which is contrary to applicable law will be amended to conform; all other parts of the Plan will remain in full force and effect.

MISCELLANEOUS

Section titles are for convenience of reference only, and are not to be considered in interpreting this Plan.

No failure to enforce any provision of this Plan will affect the right thereafter to enforce such provision, nor will such failure affect its right to enforce any other provision of the Plan.

FACILITY OF PAYMENT

Whenever payments which should have been made under this Plan in accordance with this provision have been made under any other plan or plans, the Plan will have the right, exercisable alone and in its sole discretion, to pay to any insurance company or other organization or person making such other payments any amounts it determines in order to satisfy the intent of this provision. Amounts so paid will be deemed to be benefits paid under this Plan and to the extent of such payments, the Plan will be fully discharged from liability under this Plan.

The benefits that are payable will be charged against any applicable maximum payment or benefit of this Plan rather than the amount payable in the absence of this provision.

PROTECTION AGAINST CREDITORS

No benefit payment under this Plan will be subject in any way to alienation, sale, transfer, pledge, attachment, garnishment, execution or encumbrance of any kind, and any attempt to accomplish the same will be void, except an assignment of payment to a provider of Covered Services. If the Contract Administrator finds that such an attempt has been made with respect to any payment due or which will become due to any Participant, the Contract Administrator, in its sole discretion, may terminate the interest of such Participant or former Participant in such payment. In such case, the Contract Administrator will apply the amount of such payment to or for the benefit of such Participant or covered Dependents or former Participant, as the Contract Administrator may determine. Any such application will be a complete discharge of all liability of the Plan with respect to such benefit payment.

PLAN IS NOT A CONTRACT

The Plan Document constitutes the primary authority for plan administration. The establishment, administration and maintenance of this Plan will not be deemed to constitute a contract of employment, give any Participant of the County the right to be retained in the service of the County, or to interfere with the right of the County to discharge or otherwise terminate the employment of any Participant.

GENERAL DEFINITIONS

Certain words and phrases in this Plan Document are defined below. If the defined term is not used in this document, the term does not apply to this Plan.

Masculine pronouns used in this Plan Document will include either the masculine or feminine gender unless the context indicates otherwise.

Any words used herein in the singular or plural will include the alternative as applicable.

ACCIDENTAL INJURY

“Accidental Injury” means an Injury sustained as a result of an external force or forces that is/are sudden, direct and unforeseen and is/are exact as to time and place. A hernia of any kind will only be considered as an Illness.

ACTIVE SERVICE

“Active Service” means that an Employee is in service with the County on a day which is one of the County's regularly scheduled work days and that the Employee is performing all of the regular duties of his/her employment with the County on a regular basis, either at one of the County's business establishments or at some location to which the County's business requires him/her to travel.

ADVERSE BENEFIT DETERMINATION

“Adverse Benefit Determination” means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment, in whole or in part, for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Participant's or beneficiary's eligibility to participate in the Plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment, in whole or in part, for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental or Investigational or not Medically Necessary or appropriate, or a rescission of coverage if the Contract Administrator determines that the Employee or a Dependent engaged in fraud or intentional misrepresentation in order to obtain coverage and/or benefits under the Plan. In such case, the Participant will receive written notice at least thirty (30) days before the coverage is rescinded.

ALCOHOLISM

“Alcoholism” means a morbid state caused by excessive and compulsive consumption of alcohol that interferes with the patient's health, social or economic functioning.

AMBULANCE SERVICE

“Ambulance Service” means an entity, its personnel and equipment, including, but not limited to, automobiles, airplanes, boats or helicopters, which are licensed to provide Emergency medical and Ambulance services in the state in which the services are rendered.

BENEFIT PERCENTAGE

“Benefit Percentage” means that portion of Eligible Expenses payable by the Plan, which is stated as a percentage in the Schedule of Benefits.

BENEFIT PERIOD

“Benefit Period” refers to a time period of one year, which is either a Calendar Year or other annual period, as shown in the Schedule of Benefits. Such Benefit Period will terminate on the earliest of the following dates:

1. The last day of the one year period so established; or
2. The day the Maximum Lifetime Benefit applicable to the Covered Person becomes paid; or
3. The date the Plan terminates.

BIRTHING CENTER

A “Birthing Center” means a freestanding or hospital based facility which provides obstetrical delivery services under the supervision of a Physician, and through an arrangement or an agreement with a Hospital.

CALENDAR YEAR

“Calendar Year” means a period of time commencing on January 1 and ending on December 31 of the same year.

CHEMICAL DEPENDENCY

“Chemical Dependency” means the physiological and psychological addiction to a controlled drug or substance, or to alcohol. Dependence upon tobacco, nicotine, caffeine or eating disorders are not included in this definition.

CLAIMS SUPERVISOR

“Claims Supervisor” means the person or firm employed by the Plan to provide consulting services to the Plan in connection with the operation of the Plan and any other functions, including the processing and payment of claims. The Claims Supervisor is Allegiance Benefit Plan Management, Inc. The Claims Supervisor provides ministerial duties only, exercises no discretion over plan assets and will not be considered a fiduciary as defined by State or Federal law or regulation.

CLOSE RELATIVE

“Close Relative” means the spouse, parent, brother, sister, child, or in-laws of the Covered Person.

COBRA

“COBRA” means Sections 2201 through 2208 of the Public Health Service Act [42 U.S.C. § 300bb-1 through § 300bb-8], which contains provisions similar to Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

COBRA CONTINUATION COVERAGE

“COBRA Continuation Coverage” means continuation coverage provided under the provisions of the Public Health Service Act referenced herein under the definition of “COBRA”.

CONTRACT ADMINISTRATOR

“Contract Administrator” means the Employer and/or its designee which is responsible for the day-to-day functions and management of the Plan. The Contract Administrator may employ persons or firms to process claims and perform other Plan-connected services. For the purposes of any applicable state legislation of a similar nature, the Employer will be deemed to be the Contract Administrator of the Plan unless the Employer designates an individual or committee to act as Contract Administrator of the Plan.

CONVALESCENT NURSING FACILITY

See “Skilled Nursing Facility”.

COSMETIC

“Cosmetic” means services or treatment ordered or performed solely to change a Covered Person's appearance rather than for the restoration of bodily function.

COVERED PERSON

“Covered Person” means any Participant, Retiree or Dependent of a Participant or Retiree meeting the eligibility requirements for coverage and properly enrolled for coverage as specified in the Plan.

CREDITABLE COVERAGE

“Creditable Coverage” means health or medical coverage under which a Covered Person was covered, prior to that Covered Person's Enrollment Date under this Plan, which prior coverage was under any of the following:

1. A group health plan.
2. Health insurance coverage.
3. Part A, Part B or Part C of Title XVIII of the Social Security Act (Medicare).
4. Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928 (program for distribution of pediatric vaccines).
5. Chapter 55 of Title 10, United States Code (TRICARE).
6. A medical care program of the Indian Health Service or a tribal organization.
7. A state health benefits risk pool.
8. The Federal Employee Health Benefits Program.
9. A public health plan, including any plan established or maintained by a State, the US Government, a foreign country or any political subdivision of the foregoing.
10. A health benefit plan under Section 5 (e) of the Peace Corps Act.
11. The State Children's Health Insurance Program.

CUSTODIAL CARE

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

DEDUCTIBLE

“Deductible” means a specified dollar amount that must be incurred before the Plan will pay any amount for any benefit during each Benefit Period.

DEPENDENT

“Dependent” means a person who is eligible for coverage under the Dependent Eligibility subsection of this Plan.

DEPENDENT COVERAGE

“Dependent Coverage” means eligibility for coverage under the terms of the Plan for benefits payable as a consequence of Eligible Incurred Expenses for an Illness or Injury of a Dependent.

DURABLE MEDICAL EQUIPMENT

“Durable Medical Equipment” means equipment which is:

1. Able to withstand repeated use, i.e., could normally be rented, and used by successive patients; and
2. Primarily and customarily used to serve a medical purpose; and
3. Not generally useful to a person in the absence of Illness or Injury.

ERISA

“ERISA” refers to the Employee Retirement Income Security Act of 1974, as amended.

ELIGIBLE EXPENSES

“Eligible Expenses” means the maximum amount of any charge for a covered service, treatment or supply that may be considered for payment by the Plan, including any portion of that charge that may be applied to the Deductible or used to satisfy the Out-of-Pocket Maximum. Eligible Expenses are equal to the actual billed charge or UCR, whichever is less or a contracted or negotiated rate, if applicable.

EMERGENCY

“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.

“Emergency Services” are services that are received due to a serious medical condition or symptom resulting from Injury or Illness which arises suddenly and in the judgment of a reasonable person,

requires immediate care and treatment, generally received within twenty-four (24) hours of onset, to avoid jeopardy to life or health.

EMPLOYEE

“Employee” means a person employed by the Employer on a continuing and regular basis who is a common-law Employee and who is on the Employer’s W-2 payroll.

Employee does not include any employee leased from another employer, including but not limited to those individuals defined in Internal Revenue Code Section 414(n), or an individual classified by the Employer as a contract worker, independent contractor, temporary, seasonal or casual employee, whether or not any such persons are on the Employer’s W-2 payroll, or any individual who performs services for the Employer but who is paid by a temporary or other employment agency such as “Kelly,” “Manpower,” etc.

EMPLOYER

“Employer” means the Williamson County or any affiliated agencies or boards that have adopted this Plan for its Employees.

ENROLLMENT DATE

“Enrollment Date” means the date a person becomes eligible for coverage under this Plan or the eligible person’s effective date of coverage under this Plan, whichever occurs first. For Late Enrollees, Enrollment Date will always be the effective date of coverage under this Plan.

EXPERIMENTAL/INVESTIGATIONAL

“Experimental/Investigational” means:

1. Any drug or device that cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or
2. Any drug, device, medical treatment or procedure for which the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility’s Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or
3. That the drug, device or medical treatment or procedure is under study, prior to or in the absence of any clinical trial, to determine its maximum tolerated dose, its toxicity, or its safety, or
4. That based upon Reliable Evidence, the drug, device, medical treatment or procedure is the subject of an on-going phase I or phase II clinical trial. (A Phase III clinical trial recognized by the National Institute of Health is not considered Experimental or Investigational.) For chemotherapy regimens, a Phase II clinical trial is not considered Experimental or Investigational when both of these criteria are met:
 - A. The regimen or protocol has been the subject of a completed and published Phase II clinical trial which demonstrates benefits equal to or greater than existing accepted treatment protocols, and
 - B. The regimen or protocol listed by the National Comprehensive Cancer Network is supported by level of evidence Phase I or Phase IIA only; or
5. Based upon Reliable Evidence, any drug, device, medical treatment or procedure that the prevailing opinion among experts is that further studies or clinical trial are necessary to determine the maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with generally medically accepted means of treatment or diagnosis; or

6. Any drug, device, medical treatment or procedure used in a manner outside the scope of use for which it was approved by the FDA or other applicable regulatory authority (U.S. Department of Health, The Centers for Medicare and Medicaid Services (CMS), American Dental Association, American Medical Association).

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

FAMILY

“Family” means a Participant and his or her eligible Dependents as defined herein.

FMLA

“FMLA” means Family and Medical Leave Act.

HIPAA

“HIPAA” means the Health Insurance Portability and Accountability Act of 1996, as amended.

HOSPICE

“Hospice” means a health care program providing a coordinated set of services rendered at home, in Outpatient settings or in institutional settings for Covered Persons suffering from a condition that has a terminal prognosis. A Hospice must have an interdisciplinary group of personnel which includes at least one Physician and one Registered Nurse (R.N.), and it must maintain central clinical records on all patients. A Hospice must meet the standards of the National Hospice Organization (NHO) and applicable state licensing requirements.

HOSPITAL

“Hospital” means an institution which meets all of the following conditions:

1. It is engaged primarily in providing medical care and treatment to ill and injured persons on an emergent or inpatient basis at the patient's expense; and
2. It is licensed as a hospital or a critical access hospital under the laws of the jurisdiction in which the facility is located; and
3. It maintains on its premises the facilities necessary to provide for the diagnosis and treatment of an Illness or an Injury or provides for the facilities through arrangement or agreement with another hospital; and
4. It provides treatment by or under the supervision of a physician or osteopathic physician with nursing services by registered nurses as required under the laws of the jurisdiction in which the facility is licensed; and
5. It is a provider of services under Medicare. This condition is waived for otherwise Eligible Incurred Expenses outside of the United States; and
6. It is not, other than incidentally, a place for rest, a place for the aged, a place for drug addicts, a place for alcoholics, or a nursing home.

HOSPITAL MISCELLANEOUS EXPENSES

“Hospital Miscellaneous Expenses” mean the actual charges made by a Hospital on its own behalf for services and supplies rendered to the Covered Person which are Medically Necessary for the treatment of such Covered Person. Hospital Miscellaneous Expenses do not include charges for Room and Board or for professional services, regardless of whether the services are rendered under the direction of the Hospital or otherwise.

ILLNESS

“Illness” means a bodily disorder, Pregnancy, disease, physical sickness, mental illness, or functional nervous disorder of a Covered Person.

INCURRED EXPENSES OR EXPENSES INCURRED

“Incurred Expenses” or “Expenses Incurred” means those services and supplies rendered to a Covered Person. Such expenses will be considered to have occurred at the time or date the treatment, service or supply is actually provided.

INITIAL ENROLLMENT PERIOD

“Initial Enrollment Period” means the time allowed by this Plan for enrollment when a person first becomes eligible for coverage.

INJURY

“Injury” means physical damage to the Covered Person's body which is not caused by disease or bodily infirmity.

INPATIENT

“Inpatient” means the classification of a Covered Person when that person is admitted to a Hospital, Hospice, or Skilled Nursing Facility for treatment, and charges are made for Room and Board to the Covered Person as a result of such treatment.

INPATIENT CONFINEMENT DAY

“Inpatient Confinement Day” means any day a person is classified as Inpatient. An Inpatient Confinement Day will commence at 12:01 A.M. and will be calculated using a calendar day.

INTENSIVE CARE UNIT

“Intensive Care Unit” means a section, ward, or wing within the Hospital which is separated from other facilities and:

1. Is operated exclusively for the purpose of providing professional medical treatment for critically ill patients;
2. It has special supplies and equipment necessary for such medical treatment available on a standby basis for immediate use; and
3. It provides constant observation and treatment by Registered Nurses (R.N.'s) or other highly-trained Hospital personnel.

LATE ENROLLMENT OR LATE ENROLLEE

“Late Enrollment” or “Late Enrollee” means an eligible person who makes application for Participant or Dependent Coverage under this Plan other than during the Initial Enrollment Period or a Special Enrollment Period.

LICENSED HEALTH CARE PROVIDER

“Licensed Health Care Provider” means any provider of health care services who is licensed or certified by any applicable governmental regulatory authority to the extent that services are within the scope of the license or certification and are not specifically excluded by this Plan.

LICENSED PRACTICAL NURSE

“Licensed Practical Nurse” means an individual who has received specialized nursing training and practical nursing experience, and is licensed to perform such nursing services by the state or regulatory agency responsible for such licensing in the state in which that individual performs such services.

LICENSED SOCIAL WORKER

“Licensed Social Worker” means a person holding a Masters Degree (M.S.W.) in social work and who is currently licensed as a social worker in the state in which services are rendered, and who provides counseling and treatment in a clinical setting for Mental Illnesses.

MAXIMUM LIFETIME BENEFIT

“Maximum Lifetime Benefit” means the maximum benefit payable while a person is covered under this Plan. The Maximum Lifetime Benefit will not be construed as providing lifetime coverage, or benefits for a person’s Illness or Injury after coverage terminates under this Plan.

MEDICAID

“Medicaid” means that program of medical care and coverage established and provided by Title XIX of the Social Security Act, as amended.

MEDICALLY NECESSARY

“Medically Necessary” means treatment, tests, services or supplies provided by a Hospital, Physician, or other Licensed Health Care Provider which are not excluded under this Plan and which meet all of the following criteria:

1. Are to treat or diagnose an Illness or Injury; and
2. Are ordered by a Physician or Licensed Health Care Provider and are consistent with the symptoms or diagnosis and treatment of the Illness or Injury; and
3. Are not primarily for the convenience of the Covered Person, Physician or other Licensed Health Care Provider; and
4. Are the standard or level of services most appropriate for good medical practice that can be safely provided to the Covered Person and are in accordance with the Plan’s Medical Policy; and
5. Are not of an Experimental/Investigational or solely educational nature; and
6. Are not provided primarily for medical or other research; and

7. Do not involve excessive, unnecessary or repeated tests; and
8. Are commonly and customarily recognized by the medical profession as appropriate in the treatment or diagnosis of the diagnosed condition; and
9. Are approved procedures or meet required guidelines or protocols of the Food and Drug Administration (FDA) or The Centers For Medicare/Medicaid Services (CMS), pursuant to that entity's program oversight authority based upon the medical treatment circumstances.

MEDICAL POLICY

"Medical Policy" means a policy adopted by the Plan which is created and updated by physicians and other medical providers and is used to determine whether health care services including medical and surgical procedures, medication, medical equipment and supplies, processes and technology meet the following nationally accepted criteria:

1. Final approval from the appropriate governmental regulatory agencies;
2. Scientific studies showing conclusive evidence of improved net health outcome; and
3. In accordance with any established standards of good medical practice.

MEDICARE

"Medicare" means the programs established under the "Health Insurance for the Aged Act," Public Law 89-97 under Title XVIII of the Federal Social Security Act, as amended, to pay for various medical expenses for qualified individuals, specifically those who are eligible for Medicare Part A, Part B or Part D as a result of age, those with end-stage renal disease, or with disabilities.

MENTAL ILLNESS

"Mental Illness" means a medically recognized psychological, physiological, nervous or behavioral condition, affecting the brain, which can be diagnosed and treated by medically recognized and accepted methods, **but will not include Substance Abuse, Chemical Dependency or other addictive behavior.** Conditions recognized by the Diagnostic Statistical Manual (the most current edition) will be included in this definition.

NEWBORN

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

OCCUPATIONAL THERAPY

"Occupational Therapy" means a program of care ordered by a Physician which is for the purpose of improving the physical, cognitive and perceptual disabilities that influence the Covered Person's ability to perform functional tasks related to normal life functions or occupations, and which is for the purpose of assisting the Covered Person in performing such functional tasks without assistance.

ORTHOPEDIC APPLIANCE

"Orthopedic Appliance" means a rigid or semi-rigid support used to restrict or eliminate motion in a diseased, injured, weak or deformed body member.

OUT-OF-POCKET MAXIMUM

“Out-of-Pocket Maximum” means the maximum dollar amount, as stated in the Schedule of Medical Benefits, that any Covered Person or Family will pay in any Benefit Period for covered services, treatments or supplies.

OUTPATIENT

“Outpatient” means a Covered Person who is receiving medical care, treatment, services or supplies at a clinic, a Physician's office, a Licensed Health Care Provider's office or at a Hospital if not a registered bedpatient at that Hospital, Psychiatric Facility or Alcoholism and/or Chemical Dependency Treatment Facility.

PARTIAL HOSPITALIZATION

“Partial Hospitalization” means care in a day care or night care facility for a minimum of six (6) hours and a maximum of twelve (12) hours per day, during which therapeutic clinical treatment is provided.

PARTICIPANT

“Participant” means an Employee of the Employer who is eligible and enrolled for coverage under this Plan.

PHYSICAL THERAPY

“Physical Therapy” means a plan of care ordered by a Physician and provided by a licensed physical therapist, to return the Covered Person to the highest level of motor functioning possible.

PHYSICIAN

“Physician” means a person holding the degree of Doctor of Medicine, Dentistry or Osteopathy, or Optometry who is legally licensed as such.

“Physician” does not include the Covered Person or any Close Relative of the Covered Person who does not regularly charge the Covered Person for services.

PLACEMENT OR BEING PLACED FOR ADOPTION

“Placement” or “Being Placed for Adoption” means the assumption and retention of a legal obligation for total or partial support of a child by a person with whom the child has been placed in anticipation of the child's adoption. The child's placement for adoption with such person ends upon the termination of such legal obligation.

PLAN

“Plan” means the Health Benefit Plan for Employees and Retirees of the County, the Plan Document and any other relevant documents pertinent to its operation and maintenance.

PRE-EXISTING CONDITION

“Pre-Existing Condition” means an Injury or Illness of a Covered Person, except for Pregnancy, for which the Covered Person has been under the care of a Physician or Licensed Health Care Provider, or has received medical advice, diagnosis, treatment, services or care, including prescription drugs, within the six (6) month period immediately preceding his/her Enrollment Date. Pregnancy will never be considered a Pre-Existing Condition for any reason.

PREGNANCY

“Pregnancy” means a physical condition commencing with conception, and ending with miscarriage or birth.

PREVENTIVE CARE

“Preventive Care” means routine examinations or services provided when there is no objective indication or outward manifestation of impairment of normal health or normal bodily function, which is not provided for treatment or diagnosis of any Injury or Illness.

PROSTHETIC APPLIANCE

“Prosthetic Appliance” means a device or appliance that is designed to replace a natural body part lost or damaged due to Illness or Injury, the purpose of which is to restore full or partial bodily function or appearance, or in the case of Covered Dental Benefit, means any device which replaces all or part of a missing tooth or teeth.

PSYCHIATRIC CARE

“Psychiatric Care,” also known as psychoanalytic care, means treatment for a Mental Illness or disorder, a functional nervous disorder, Alcoholism, Substance Abuse or drug addiction by a licensed psychiatrist, psychologist, Licensed Social Worker or licensed professional counselor acting within the scope and limitations of his/her respective license, provided that such treatment is Medically Necessary as defined by the Plan, and within recognized and accepted professional psychiatric and psychological standards and practices.

PSYCHIATRIC FACILITY

“Psychiatric Facility” means a licensed institution that provides Mental Illness treatment and which provides for a psychiatrist who has regularly scheduled hours in the facility, and who assumes the overall responsibility for coordinating the care of all patients.

PSYCHOLOGIST

“Psychologist” means a person currently licensed in the state in which services are rendered as a psychologist and acting within the scope of his/her license.

QMCSO

“QMCSO” means Qualified Medical Child Support Order as defined by Section 609(a) of ERISA, as amended.

QUALIFIED BENEFICIARY

“Qualified Beneficiary” means an Employee, former Employee or Dependent of an Employee or former Employee who is eligible to continue coverage under the Plan in accordance with applicable provisions of Title X of COBRA or Section 609(a) of ERISA in relation to QMCSO's.

“Qualified Beneficiary” will also include a child born to, adopted by or Placed for Adoption with an Employee or former Employee at any time during COBRA Continuation Coverage.

REGISTERED NURSE

“Registered Nurse” means an individual who has received specialized nursing training and is authorized to use the designation of “R.N.” and who is licensed by the state or regulatory agency in the state in which the individual performs such nursing services.

RESIDENTIAL TREATMENT FACILITY OR RTF

“Residential Treatment Facility” or “RTF” means a facility for purposes of evaluation and treatment or evaluation and referral of any individual with Substance Abuse/Chemical Dependency or Mental Illness. Treatment received in a Residential setting for Mental Illness or Substance Abuse/Chemical Dependency treatment that is provided in a less restrictive manner than are Inpatient services, but in a more intensive manner than are Outpatient services.

RETIREE

“Retiree” means a former covered Employee of the Employer who meets the Plan’s Retiree eligibility requirements and is enrolled for coverage under this Plan.

RISK POOL

“Risk Pool” is a legal entity established to provide health and accident coverage for the eligible Employees and Retirees of the Williamson County and the eligible Dependents of such Employees and Retirees.

ROOM AND BOARD

“Room and Board” refers to all charges which are made by a Hospital, Hospice, or Skilled Nursing Facility as a condition of occupancy. Such charges do not include the professional services of Physicians or intensive nursing care by whatever name called.

SEMI-PRIVATE

“Semi-Private” refers to the class of accommodations in a Hospital or Skilled Nursing Facility in which at least two patient beds are available per room.

SERIOUS MENTAL ILLNESS

“Serious Mental Illness” means the following (as defined by the America Psychiatric Association in the most current edition of the Diagnostic and Statistical Manual (DSM)).

SKILLED NURSING FACILITY

“Skilled Nursing Facility” means an institution, or distinct part thereof, which meets all of the following conditions:

1. It is currently licensed as a long-term care facility or skilled nursing facility in the state in which the facility is located;
2. It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mentally disabled persons, custodial or educational care, or care of mental disorders; and
3. It is certified by Medicare.

This term also applies to Incurred Expenses in an institution known as a Convalescent Nursing Facility, Extended Care Facility, Convalescent Nursing Home, or any such other similar nomenclature.

SPEECH THERAPY

“Speech Therapy” means a course of treatment, ordered by a Physician, to treat speech deficiencies or impediments.

SUBSTANCE ABUSE AND/OR CHEMICAL DEPENDENCY TREATMENT FACILITY

“Substance Abuse and/or Chemical Dependency Treatment Facility” means a licensed institution which provides a program for diagnosis, evaluation, and effective treatment of Alcoholism, Substance Abuse and/or Chemical Dependency; provides detoxification services needed with its effective treatment program; provides infirmity-level medical services or arranges with a Hospital in the area for any other medical services that may be required; is at all times supervised by a staff of Physicians; provides at all times skilled nursing care by licensed nurses who are directed by a full-time Registered Nurse (R.N.); prepares and maintains a written plan of treatment for each patient based on medical, psychological and social needs which is supervised by a Physician; and meets licensing standards.

TOTAL DISABILITY (TOTALLY DISABLED)

“Total Disability” means the physical state of a Covered Person resulting from an Illness or Injury which wholly prevents:

1. In the case of a Participant, the Covered Person from engaging in any business or occupation or from performing any work activity as a volunteer; and
2. In the case of a Dependent, the Covered Person from engaging in Major Life Functions associated with a similarly situated non-disabled person of like age and gender. Major Life Function, as used herein, refers to the definition of the same stated in the Americans with Disabilities Act, and court opinions pursuant to that Act which construe the term.

USERRA

“USERRA” means the Uniformed Services Employment and Reemployment Rights Act, as amended.

USUAL, CUSTOMARY AND REASONABLE (UCR)”

“Usual, Customary and Reasonable (UCR)” means the maximum amount considered for payment by this Plan for any covered treatment, service, or supply, subject however, to all Plan annual and lifetime maximum benefit limitations. The following will apply in the order below to determine the Usual, Customary, and Reasonable amount:

1. A contracted amount as established by a preferred provider or other discounting contract; or
2. An amount established through a nationally recognized, published Usual, Customary and Reasonable (UCR) data base utilized by the Claims Supervisor and adopted by the Contract Administrator using the 90th percentile of said database; or
3. The billed charge if less than A or B above.

HIPAA PRIVACY AND SECURITY STANDARDS

These standards are intended to comply with all requirements of the Privacy and Security Rules of the Administrative Simplification Rules of HIPAA as stated in 45 CFR Parts 160, 162 and 164, as amended from time to time.

DEFINITIONS

“Protected Health Information” (PHI) means information, including demographic information, that identifies an individual and is created or received by a health care provider, health plan, employer, or health care clearinghouse; and relates to the physical or mental health of an individual; health care that individual has received; or the payment for health care provided to that individual. PHI does not include employment records held by the Plan Sponsor in its role as an employer.

“Summary Health Information” means information summarizing claims history, expenses, or types of claims by individuals enrolled in a group health plan and has had the following identifiers removed: names; addresses, except for the first three digits of the zip code; dates related to the individual (ex: birth date); phone numbers; email addresses and related identifiers; social security numbers; medical record numbers; account or plan participant numbers; vehicle identifiers; and any photo or biometric identifier.

PRIVACY CERTIFICATION

The Plan Sponsor hereby certifies that the Plan Documents have been amended to comply with the privacy regulations by incorporation of the following provisions. The Plan Sponsor agrees to:

1. Not use or further disclose the information other than as permitted or required by the Plan Documents or as required by law. Such uses or disclosures may be for the purposes of plan administration, including but not limited to, the following:
 - A. Operational activities such as quality assurance and utilization management, credentialing, and certification or licensing activities; underwriting, premium rating or other activities related to creating, renewing or replacing health benefit contracts (including reinsurance or stop loss); compliance programs; business planning; responding to appeals, external reviews, arranging for medical reviews and auditing, and customer service activities. Plan administration can include management of carve-out plans, such as dental or vision coverage.
 - B. Payment activities such as determining eligibility or coverage, coordination of benefits, determination of cost-sharing amounts, adjudicating or subrogating claims, claims management and collection activities, obtaining payment under a contract for reinsurance or stop-loss coverage, and related data-processing activities; reviewing health care services for medical necessity, coverage or appropriateness of care, or justification of charges; or utilization review activities.
 - C. For purposes of this certification, plan administration does not include disclosing Summary Health Information to help the Plan Sponsor obtain premium bids; or to modify, amend or terminate group health plan coverage. Plan administration does not include disclosure of information to the Plan Sponsor as to whether the individual is a participant in; is an enrollee of or has disenrolled from the group health plan.
2. Ensure that any agents, including a subcontractor, to whom it provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;
3. Not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;

4. Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;
5. Make available PHI as required to allow the Covered Person a right of access to his or her PHI as required and permitted by the regulations;
6. Make available PHI for amendment and incorporate any amendments into PHI as required and permitted by the regulations;
7. Make available the PHI required to provide an accounting of disclosures as required by the regulations;
8. Make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to any applicable regulatory authority for purposes of determining the Plan's compliance with the law's requirements;
9. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which 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
10. Ensure that the adequate separation required between the Plan and the Plan Sponsor is established. To fulfill this requirement, the Plan Sponsor will restrict access to nonpublic personal information to the Contract Administrator(s) designated in this Plan Document or employees designated by the Contract Administrator(s) who need to know that information to perform plan administration and healthcare operations functions or assist eligible persons enrolling and disenrolling from the Plan. The Plan Sponsor will maintain physical, electronic, and procedural safeguards that comply with applicable federal and state regulations to guard such information and to provide the minimum PHI necessary for performance of healthcare operations duties. The Contract Administrator(s) and any employee so designated will be required to maintain the confidentiality of nonpublic personal information and to follow policies the Plan Sponsor establishes to secure such information.

When information is disclosed to entities that perform services or functions on the Plan's behalf, such entities are required to adhere to procedures and practices that maintain the confidentiality of the Covered Person's nonpublic personal information, to use the information only for the limited purpose for which it was shared, and to abide by all applicable privacy laws.

SECURITY CERTIFICATION

The Plan Sponsor hereby certifies that its Plan Documents have been amended to comply with the security regulations by incorporation of the following provisions. The Plan Sponsor agrees to:

1. Implement and follow all administrative, physical, and technical safeguards of the HIPAA Security Rules, as required by 45 CFR §§164.308, 310 and 312.
2. Implement and install adequate electronic firewalls and other electronic and physical safeguards and security measures to ensure that electronic PHI is used and disclosed only as stated in the Privacy Certification section above.
3. Ensure that when any electronic PHI is disclosed to any entity that performs services or functions on the Plan's behalf, that any such entity shall be required to adhere to and follow all of the requirements for security of electronic PHI found in 45 CFR §§164.308, 310, 312, 314 and 316.
4. Report to the Contract Administrator any attempted breach, or breach of security measures described in this certification, and any disclosure or attempted disclosure of electronic PHI of which the Plan Sponsor becomes aware.

**WILLIAMSON COUNTY EMPLOYEE HEALTH BENEFIT PLAN
PLAN SUMMARY**

The following information, together with the information contained in this booklet, form the Summary Plan Description.

1. PLAN

The name of the Plan is the WILLIAMSON COUNTY EMPLOYEE HEALTH BENEFIT PLAN, which Plan describes the benefits, terms, limitations and provisions for payment of benefits to or on behalf of eligible Participants.

2. PLAN BENEFITS

This Plan provides benefits for covered expenses incurred by eligible participants for:

Hospital, Surgical, Medical, Maternity, other eligible medically related, necessary expenses.

3. PLAN EFFECTIVE DATE

This Plan was established effective November 1, 2013.

4. PLAN SPONSOR

Name: Williamson County
Phone 301 SE Inner Loop, Suite 108
Address: Georgetown, Texas 78626
(510) 943-1533

5. CONTRACT ADMINISTRATOR

The Contract Administrator is the Plan Sponsor.

7. PLAN YEAR

The Plan year ends October 31st.

8. PLAN TERMINATION

The right is reserved by the Sponsor to terminate, suspend, withdraw, amend or modify the Plan in whole or in part at any time.

9. IDENTIFICATION NUMBER

Group Number: 2001025
Employer Identification Number: 74-6000978

10. CLAIMS SUPERVISOR

Name: Allegiance Benefit Plan Management, Inc.
Address: P.O. Box 3018
Missoula, MT 59806

11. ELIGIBILITY

Employees, Retirees and dependents of employees and Retirees of the Plan Sponsor may participate in the Plan based upon the eligibility requirements set forth by the Plan.

12. PLAN FUNDING

The Plan is funded by contributions from the employer and employees and retirees.

13. AGENT FOR SERVICE OF LEGAL PROCESS

The Contract Administrator is the agent for service of legal process.

Dental Plan and Vision Summary of Benefits

Dental Plan	Low Plan	High Plan
	Plan Design	Plan Design
Individual Deductible	\$50 per benefit plan year	\$50 per benefit plan year
Family Deductible	\$150 per benefit plan year	\$150 per benefit plan year
Maximum Per Person	\$750 per benefit plan year	\$1,500 per benefit plan year
Benefits and Limitations		
Type 1 Preventive		
Routine Exam / Cleaning (Maximum two per benefit plan year. Amount does not count towards the dollar maximum per person)	Covered 100% of eligible expenses	Covered 100% of eligible expenses
Full Mouth X-Rays (Maximum once every three years)	Covered 100% of eligible expenses	Covered 100% of eligible expenses
Bitewing X-Rays (Maximum once every plan year)	Covered 100% of eligible expenses	Covered 100% of eligible expenses
Flouride Treatments (Maximum once every plan year for children 18 and under)	Covered 100% of eligible expenses	Covered 100% of eligible expenses
Sealants (Maximum once every 3 years for children 16 and under)	Covered 100% of eligible expenses	Covered 100% of eligible expenses
Type 2 Basic Services		
Restorative Amalgams (filling)	10% after deductible	10% after deductible
Restorative Composites (filling)	10% after deductible	10% after deductible
Endodontics / Periodontics	10% after deductible	10% after deductible
Type 3 Major Services		
Crown / Crown Repair	Not covered	35% after deductible
Inlays / Onlays	Not covered	35% after deductible
Dental Implants	Not covered	35% after deductible
Orthodontia		
Orthodontia benefits for children 18 and under. Lifetime Maximum of \$2,000	Not covered	50% after deductible

Vision Plan	
Individual Deductible	\$0
Individual Deductible	\$0
Family Deductible	\$0
Maximum Per Person	\$300 per benefit plan year
Coverage 100% up to a maximum of \$300 per person, per plan year for routine exam and materials (frames, lenses, contact lenses)	
You may see any provider of your choice. To maximize your eye care benefit, we encourage you to compare prices and services at various eye care providers / centers in your area.	

Five (5) Year Claims History

Date	Allegiance	UHC	Total	#
2008-04	\$ -	\$ 751,907.00	\$ 751,907.00	1,239
2008-05	\$ -	\$ 1,018,915.00	\$ 1,018,915.00	1,236
2008-06	\$ -	\$ 879,614.00	\$ 879,614.00	1,232
2008-07	\$ -	\$ 1,233,832.00	\$ 1,233,832.00	1,234
2008-08	\$ -	\$ 872,470.00	\$ 872,470.00	1,224
2008-09	\$ -	\$ 695,835.00	\$ 695,835.00	1,236
2008-10	\$ -	\$ 887,363.00	\$ 887,363.00	1,244
2008-11	\$ -	\$ 1,236,716.00	\$ 1,236,716.00	1,257
2008-12	\$ -	\$ 1,132,213.00	\$ 1,132,213.00	1,262
2009-01	\$ -	\$ 1,508,252.00	\$ 1,508,252.00	1,270
2009-02	\$ -	\$ 890,830.00	\$ 890,830.00	1,273
2009-03	\$ -	\$ 1,191,028.00	\$ 1,191,028.00	1,279
2009-04	\$ -	\$ 885,395.00	\$ 885,395.00	1,275
2009-05	\$ -	\$ 967,564.00	\$ 967,564.00	1,290
2009-06	\$ -	\$ 1,136,765.00	\$ 1,136,765.00	1,291
2009-07	\$ -	\$ 1,082,455.00	\$ 1,082,455.00	1,287
2009-08	\$ -	\$ 860,864.00	\$ 860,864.00	1,286
2009-09	\$ -	\$ 832,594.00	\$ 832,594.00	1,296
2009-10	\$ -	\$ 1,128,647.00	\$ 1,128,647.00	1,300
2009-11	\$ -	\$ 1,079,068.00	\$ 1,079,068.00	1,310
2009-12	\$ -	\$ 985,854.00	\$ 985,854.00	1,312
2010-01	\$ -	\$ 1,090,257.00	\$ 1,090,257.00	1,322
2010-02	\$ -	\$ 809,973.00	\$ 809,973.00	1,332
2010-03	\$ -	\$ 927,330.00	\$ 927,330.00	1,332
2010-04	\$ -	\$ 1,408,614.00	\$ 1,408,614.00	1,333
2010-05	\$ -	\$ 1,580,470.00	\$ 1,580,470.00	1,341
2010-06	\$ -	\$ 1,055,062.00	\$ 1,055,062.00	1,336
2010-07	\$ -	\$ 856,316.00	\$ 856,316.00	1,328
2010-08	\$ -	\$ 1,444,352.00	\$ 1,444,352.00	1,321
2010-09	\$ -	\$ 2,083,595.00	\$ 2,083,595.00	1,324
2010-10	\$ -	\$ 1,202,575.00	\$ 1,202,575.00	1,312
2010-11	\$ -	\$ 1,043,618.00	\$ 1,043,618.00	1,310
2010-12	\$ -	\$ 760,864.00	\$ 760,864.00	1,318
2011-01	\$ -	\$ 1,106,406.00	\$ 1,106,406.00	1,318
2011-02	\$ -	\$ 847,897.00	\$ 847,897.00	1,312
2011-03	\$ -	\$ 880,849.00	\$ 880,849.00	1,314
2011-04	\$ -	\$ 1,084,155.00	\$ 1,084,155.00	1,320
2011-05	\$ -	\$ 1,087,030.00	\$ 1,087,030.00	1328
2011-06	\$ -	\$ 1,442,594.00	\$ 1,442,594.00	1329
2011-07	\$ -	\$ 892,728.00	\$ 892,728.00	1322
2011-08	\$ -	\$ 1,259,720.00	\$ 1,259,720.00	1317
2011-09	\$ -	\$ 854,395.00	\$ 854,395.00	1314
2011-10	\$ -	\$ 832,960.00	\$ 832,960.00	1305
2011-11	\$ -	\$ 793,502.00	\$ 793,502.00	1319
2011-12	\$ -	\$ 1,209,079.00	\$ 1,209,079.00	1314

2012-01	\$	-	\$ 830,861.00	\$ 830,861.00	1321
2012-02	\$	-	\$ 1,015,610.00	\$ 1,015,610.00	1311
2012-03	\$	-	\$ 1,235,807.00	\$ 1,235,807.00	1306
2012-04	\$	-	\$ 892,301.00	\$ 892,301.00	1299
2012-05	\$	-	\$ 1,125,302.00	\$ 1,125,302.00	1305
2012-06	\$	-	\$ 1,041,995.00	\$ 1,041,995.00	1310
2012-07	\$	-	\$ 860,611.00	\$ 860,611.00	1315
2012-08	\$	-	\$ 936,614.00	\$ 936,614.00	1307
2012-09	\$	-	\$ 903,971.00	\$ 903,971.00	1297
2012-10	\$	-	\$ 1,760,536.00	\$ 1,760,536.00	1297
2012-11	\$	107,829.52	\$ 653,915.00	\$ 761,744.52	1370
2012-12	\$	275,957.47	\$ 156,350.00	\$ 432,307.47	1377
2013-01	\$	582,288.62	\$ 103,743.00	\$ 686,031.62	1390
2013-02	\$	808,935.69	\$ 92,213.00	\$ 901,148.69	1370
2013-03	\$	1,546,670.95	\$ 8,326.00	\$ 1,554,996.95	1353
2013-04	\$	1,661,027.99	\$ 19,873.00	\$ 1,680,900.99	1365
2013-05	\$	1,163,767.94	\$ 8,289.00	\$ 1,172,056.94	1365
2013-06	\$	1,254,685.44	\$ 3,489.00	\$ 1,258,174.44	1365
2013-07	\$	1,263,973.01	\$ 586.00	\$ 1,264,559.01	1359
2013-08	\$	1,529,805.31	\$ 198.00	\$ 1,530,003.31	1346
2013-09	\$	958,108.32	\$ 2,821.00	\$ 960,929.32	1351
2013-10	\$	2,277,374.48	\$ 4,335.00	\$ 2,281,709.48	1356
2013-11	\$	762,386.66	\$ 38.00	\$ 762,424.66	1376
2013-12	\$	960,955.91	\$ -	\$ 960,955.91	1404

6. CONTRACT ADMINISTRATION

Lisa R. Zirkle, SPHR/CCP, Williamson County Human Resources Director, (or successor), 301 SE Inner Loop, Ste 108, Georgetown, TX 78626, shall serve as Williamson County's Contract Administrator with designated responsibility to ensure compliance with the requirements of the Contract and any ensuing Agreement, such as but not limited to, acceptance, inspection and delivery. The Contract Administrator will serve as liaison between the Williamson County Commissioners Court and the Successful Respondent.

7. PROPOSAL EVALUATION AND SELECTION PROCESS

7.1 Introduction

The Proposal evaluation and selection process is detailed in this section, as are other factors, and the format in which the Fee Proposal of each Proposal must be submitted.

7.2 Fee Proposal

The Respondent should utilize the form(s) provided in the Appendix below in its submission of a Fee Proposal in response to this RFP. The Fee Proposal must be included in each copy of the Proposal. Any reworked version of the Appendix that is intended to be a substitute and that is provided by a Respondent may be determined as non-responsive, and may, at Williamson County's sole discretion, result in the Respondent's disqualification.

7.3 Proposal Evaluation and Selection

7.3.1 Evaluation/Selection Criteria

All Proposals received by the designated date and time will be evaluated based on the Respondent's Proposal. Other information may be taken into consideration when that information potentially provides an additional benefit to Williamson County, and further helps Williamson County in receiving the services listed in the RFP.

7.3.2 Evaluation Committee and Selection Process

Proposals may be evaluated by a County appointed Evaluation Committee. The Evaluation Committee may be composed of County Staff that may have expertise, knowledge or experience with the services and/or goods being procured hereunder. Those Respondents meeting all requirements and deemed most qualified may receive further evaluation via telephone or in-person interviews with members of the Evaluation Committee. The County will select a Respondent determined best and most responsible Respondent meeting minimum specifications and qualifications.

Respondents are advised that the County, at its option, may recommend an award strictly on the basis of the initial RFP responses, or in addition, may have interviews with firms to determine its final recommendation. The recommendation will be presented to the Williamson County Commissioners Court for approval and award of contract.

Finalist shall be determined by the Respondent receiving the most points in relation to the following Evaluation Criteria and any further scoring that may be conducted based upon Respondent's presentation during the interview process:

Evaluation of the Proposals received will be based on the following criteria.

7.3.3. Weighted Evaluation Factors

The following weighted evaluation factors will be used to determine how well a Respondent(s) meet(s) the desired performance.

Evaluation Criteria for Self-Insured Medical, Dental and Vision Claims Administration, Disease Management, Precertification Management, Large Case Management, Prescription Drug Card/Mail Order, Preferred Provider Network, Section 125 Claims Administration

	Possible Points
1 Firm's Qualifications and Capabilities	25.0
Brief Description of firm	2.0
Identify legal entity	1.0
Identify submitter and all partners and % of interest	1.0
Organization approach and role of partner & consultant	4.0
Ability to integrate Wellness & plan admin	6.0
Ability to integrate dental, vision, etc.	6.0
Provide staff, material & assistance for open enrollment	5.0
2 Similar Project Related Experience & Reference	10.0
Brief description of at least 2 similar operations	2.5
Description & role of submitting entity	2.5
Current Status of operation	2.5
Include address & telephone # for each reference	2.5
3 Financial Stability	10.0
*Evidence has financial capability: provide Standard & Poor's, Moody & A.M Best Ratings	3.0
* *2 most recent annual financial statements	1.0
References	5.0
No Bankruptcy	1.0

4 Performance Standards/Guarantee	25.0
Resolve all appeals	2.5
Claims coded correctly, accurately	2.5
Claims paid accurately	7.5
Clean claims processed W/I 14 days	2.5
Provider discounts & network access	10.0

5 Cost	30.0
Fixed Cost	10.0
Cost Containment Programs	10.0
Discounts	10.0

Total Points **100.0**

*For evidence of Financial Stability of Insurance Company: Provide the following:

Rating Firm	Rating	Date of Rating
A.M. Best Co.	_____	_____
Moody's Investors Service, Inc.	_____	_____
Standard & Poor's Corp.	_____	_____
Licensed to do business in the State of Texas		Yes _____ No _____

****2 most recent annual financial statements are required prior to contract award. If these are not provided at the time of evaluation, no points will be given for this criteria which may affect the overall score of the Proposal.**

Evaluation Criteria for Biometric and Wellness

Possible
Points

1	Firm's Qualifications and Capabilities	25.0
	Brief Description of firm	2.0
	Identify legal entity	1.0
	Identify submitter and all partners and % of interest	1.0
	Organization approach and role of partner & consultant	4.0
	Ability to integrate Wellness & plan admin	6.0
	Provide staff, material & assistance for open enrollment	11.0
2	Similar Project Related Experience & Reference	10.0
	Brief description of at least 2 similar operations	2.5
	Description & role of submitting entity	2.5
	Current Status of operation	2.5
	Include address & telephone # for each reference	2.5
3	Financial Stability	10.0
	*Evidence has financial capability: provide Standard & Poor's, Moody & A.M Best Ratings	3.0
	**2 most recent annual financial statements	1.0
	References	5.0
	Bankruptcy	1.0
4	Performance Standards/Guarantee	35.0
	Guarantee with % of fees at risk	2.5
	Clinically based program	2.5
	ROI based guarantee	7.5
	Outgoing intervention calls	2.5
	Integration of testing results into disease mgmt & predictive modeling	10.0
	Integration of testing services into base medical plan	10.0

5	Cost	20.0
	Fixed Cost	5.0
	Variable Costs (Testing, calls, etc.)	5.0
	Total Cost	10.0

Total Points **100.0**

*For evidence of Financial Stability of Insurance Company: Provide the following:

Rating Firm	Rating	Date of Rating
A.M. Best Co.	_____	_____
Moody's Investors Service, Inc.	_____	_____
Standard & Poors Corp.	_____	_____
Licensed to do business in the State of Texas		Yes _____ No _____

****2 most recent annual financial statements are required prior to contract award. If these are not provided at the time of evaluation, no points will be given for this criteria which may affect the overall score of the Proposal.**

Williamson County reserves the right to award a contract for any or all areas of this RFP.

It is the responsibility of the Respondent to provide sufficient information/data in a convincing manner to the County to assure all of the terms, conditions and expectations for satisfactory performance of the services requested herein will be met.

All contact during the evaluation phase shall be through the Williamson County Purchasing Department or the technical contact only. Successful Respondent shall neither contact nor lobby evaluators during the evaluation process. Attempts by Successful Respondent to contact and/or influence members of the Evaluation Committee may result in disqualification of Proposal.

Proposal Submittal Checklist
RESPONDENT SHOULD COMPLETE AND RETURN THIS
“PROPOSAL SUBMITTAL CHECKLIST” WITH YOUR PROPOSAL.

The Respondent's attention is especially called to the items listed below (**return pages marked with red border**), which should be submitted in full as part of Respondent's Proposal. Failure to submit any of the documents listed below as a part of your Proposal, or failure to acknowledge any Addendum in writing with your Proposal, or submitting a Proposal on any condition, limitation, or provision not officially invited in this RFP may serve, at Williamson County's sole discretion, as cause for rejection of the Proposal. The County reserves the right to request that any Respondent clarify its Proposal or to supply any additional material deemed necessary to assist in the evaluation of the Proposal.

Respondent should check each box below indicating compliance.

- Transmittal Letter (Appendix A 2 pages) **If signature is by an agent, other than the Sole Proprietor(s) or an officer of a Corporation, Limited Liability Company, General Partner or a member of a General Partnership, a power of attorney or equivalent document must be submitted to the Williamson County Purchasing Department prior to being recommended for award of the Proposal.**
- Table of Contents of the Proposal
- Executive Summary of Respondent's Proposal
- Fee Proposal forms (Appendix B)
- Statement of Compliance (Appendix C)
- Felony Conviction Notice (Appendix D)
- References: Identification of three (3) references for which the Respondent is providing or has provided the services and/or goods of the type requested)
- Conflict of Interest Questionnaire (Appendix F 2 pages)
- Proposal Affidavit (Appendix G) **If signature is by an agent, other than the Sole Proprietor(s) or an officer of a Corporation, Limited Liability Company, General Partner or a member of a General Partnership, a power of attorney or equivalent document must be submitted to the Williamson County Purchasing Department prior to being recommended for award of the Proposal.**
- Signature Page (Appendix H) **If signature is by an agent, other than the Sole Proprietor(s) or an officer of a Corporation, Limited Liability Company, General Partner or a member of a General Partnership, a power of attorney or equivalent document must be submitted to the Williamson County Purchasing Department prior to being recommended for award of the Proposal.**
- If Respondent is operating under an assumed business name, a file marked copy of the Assumed Name Certificate that has been filed with the Williamson County Clerk has to be provided prior to being awarded
- One (1) original, nine (9) paper copies and one (1) CD** copy of the Proposal should be mailed to or delivered on or before the Proposal submittal deadline, to the Williamson County Purchasing Department, 901 S. Austin Ave., Georgetown, TX 78626.

RESPONDENT SHOULD RETURN THIS PAGE WITH ITS PROPOSAL

Company

Telephone Number

Address

Fax Number

Authorized Representative (Please print)

Title

Authorized Signature

Date

RESPONDENT MUST RETURN THIS PAGE WITH ITS PROPOSAL

APPENDIX A (CONTINUED)
TRANSMITTAL LETTER
(Refer to section 4.2 of this RFP)

(g) **Complete if applicable:** If Proposal being submitted will have an effect on air quality for Williamson County (as it relates to any state, federal or voluntary air quality standard), then Respondent is encouraged to provide information in narrative form indicating the anticipated air quality impact:

(h) I hereby commit to provide the services/products required by Williamson County in this Proposal.

(i) I further commit that this Proposal is valid for ninety (90) calendar days from the deadline for submittal of Proposal to Williamson County.

Print Name

Title

Authorized Signature

This Transmittal Letter must be signed by a person legally authorized to bind the Respondent to the representations in the Transmittal Letter and Proposal (refer to section 3.4 of this RFP). In the case of a joint Proposal, each party must sign the Transmittal Letter.

APPENDIX B

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, 2014.

Your Charge per
Participant per Month

I. Claims Settlement and Statistics	<u>First Year</u>	<u>Second Year Cap</u>
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/Packets	\$_____
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	<u>Employee</u>	<u>Dependents</u>
Installation Fee	\$_____	\$_____
Annual Service Fee	\$_____	\$_____
Enrollment Fee	\$_____	\$_____
Monthly Charge Per COBRA Participant	\$_____	\$_____

APPENDIX B (CONTINUED)
FEE QUOTATIONS – SELF INSURANCE

VI.	Utilization Review	<u>\$ Per Employee</u>
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	\$ _____

APPENDIX B (CONTINUED)
FEE QUOTATION 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, 2014 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

FEE QUOTATIONS – PHARMACY BENEFIT MANAGER

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

APPENDIX B (CONTINUED)
FEE QUOTATIONS –SELF-INSURED PREFERRED PROVIDER ORGANIZATION

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?

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, 2014.

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

Your Charge per
Participation per Month

<u>First Year</u>	<u>Second Year Cap</u>
\$ _____	\$ _____
\$ _____	\$ _____

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

APPENDIX B (CONTINUED)
FEE QUOTATIONS – SECTION 125 CLAIMS ADMINISTRATION

- 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.**

Additional Services	
Additional Charges	

APPENDIX B (CONTINUED)
FEE QUOTATIONS

The undersigned hereby certifies that he or she has read the terms of this RFP and understands that Williamson County reserves the right to waive any informality in or to reject any or all Proposals.

Respondent Name: _____

Address: _____

Telephone: _____ Fax: _____

Contact Name (please print): _____

Authorized Signature: _____

Title or Representative Capacity of Signer:

State of Incorporation/Organization or Primary Place of Business: _____

Company Name:	
Authorized Signature:	
Title:	

If signature is by an agent, other than the Sole Proprietor(s) or an officer of a Corporation, Limited Liability Company, General Partner or a member of a General Partnership, a power of attorney or equivalent document must be submitted to the Williamson County Purchasing Department prior to being recommended for award of the Proposal.

**APPENDIX C
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 Health Related Services For Williamson County Employment Benefit Administration - Self-Insured Medical, Dental And Vision Claims Administration, Disease Management, Precertification Management, Large Case Management, Biometric/Wellness Program Management, Prescription Drug Card/Mail Order, Preferred Provider Network, And Section 125 Claims Administration- Proposal Number: 15RFP101 (the "RPF") and certify that our Proposal conforms to the RFP except as detailed below:

If signature is by an agent, other than the Sole Proprietor(s) or an officer of a Corporation, Limited Liability Company, General Partner or a member of a General Partnership, a power of attorney or equivalent document must be submitted to the Williamson County Purchasing Department prior to contract award.

Organization

Signature

Date

Title

APPENDIX D
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.

RESPONDENT'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: _____

APPENDIX E RESPONDENT REFERENCES

Please list at least three (3) companies or governmental agencies where the same or similar products and/or services as contained in this specification package were recently provided.

REFERENCE ONE

Government/Company Name: _____

Address: _____

Contact Person and Title: _____

Phone: _____ Fax: _____

Contract Period: _____ Scope of Work: _____

REFERENCE TWO

Government/Company Name: _____

Address: _____

Contact Person and Title: _____

Phone: _____ Fax: _____

Contract Period: _____ Scope of Work: _____

REFERENCE THREE

Government/Company Name: _____

Address: _____

Contact Person and Title: _____

Phone: _____ Fax: _____

Contract Period: _____ Scope of Work: _____

APPENDIX F CONFLICT OF INTEREST QUESTIONNAIRE

For Respondent or other person doing business with local government entity

This questionnaire is being filed in accordance with chapter 176 of the Local Government Code by a person doing business with the governmental entity.

By law this questionnaire must be filed with the records administrator of the local government not later than the 7th business day after the date the person becomes aware of facts that require the statement to be filed. See Section 176.006 Local Government Code.

A person commits an offense if the person violates Section 176.0006, Local Government Code. An offense under this section is a Class C misdemeanor.

OFFICE USE ONLY

1. Name of person doing business with local governmental entity.

2. Check this box if you are filing an update to a previously filed questionnaire.

(The law requires that you file an updated completed questionnaire with the appropriate filing authority not later than September 1 of the year for which an activity described in Section 176.006(a), Local Government Code, is pending and not later than the 7th business day after the date the originally filed questionnaire becomes incomplete or inaccurate.)

3. Describe each affiliation or business relationship with an employee or contractor of the local government entity who makes recommendations to a local government officer of the local governmental entity with respect to expenditure of money.

4. Describe each affiliation or business relationship with a person who is a local government officer and who appoints or employs a local government officer of the local governmental entity that is the subject of this questionnaire.

APPENDIX F CONFLICT OF INTEREST QUESTIONNAIRE - CONTINUED

CONFLICT OF INTEREST QUESTIONNAIRE

FORM CIQ

Page 2

For Respondent or other person doing business with local government entity

5. Name of local government officer with whom filer has affiliation or business relationship. (Complete this section only if the answer to A, B, or C is YES.)

This section, item 5 including subparts A, B, C & D, must be completed for each officer with whom the filer has affiliation or business relationship. Attach additional pages to this Form CIQ as necessary.

A. Is the local government officer named in this section receiving or likely to receive taxable income from the filer of the questionnaire?

Yes No

B. Is the filer of the questionnaire receive or likely to receive taxable income from or at the direction of the local government officer named in this section AND the taxable income is not from the local government entity?

Yes No

C. Is the filer of the questionnaire affiliated with a Corporation or other business entity that the local government officer serves as an officer or director, or holds an ownership of 10 percent or more?

Yes No

D. Describe each affiliation or business relationship:

6. Describe any other affiliation or business relationship that might cause a conflict of interest.

Respondent
Name: _____

Authorized Signature: _____

Title or Representative Capacity of Signer:

Date: _____, 20____

APPENDIX G PROPOSAL AFFIDAVIT

The undersigned certifies that the RFP and the Respondent's Proposal have been carefully reviewed and are submitted as correct and final. Respondent further certifies and agrees to furnish any and/or all goods and/or services upon which prices are extended at the price Proposal, and upon the conditions contained in the RFP.

STATE OF _____ COUNTY OF _____

"I, _____ (*Name of Signer*) am a duly authorized officer of/agent for _____ (*Name of Respondent*) and have been duly authorized to execute the foregoing on behalf of the said _____ (*Name of Respondent*).

I hereby certify that the foregoing Proposal has not been prepared in collusion with any other Respondent or other person or persons engaged in the same line of business prior to the official opening of this Proposal. Further, I certify that the Respondent is not now, nor has been for the past six (6) months, directly or indirectly concerned in any pool or agreement or combination, to control the price of services/commodities proposed, or to influence any person or persons to submit a Proposal or not to submit a Proposal thereon."

Respondent
Name: _____

Authorized Signature: _____

Title or Representative Capacity of Signer: _____

Date: _____, 20____

SUBSCRIBED AND SWORN to before me by the above-named _____ on this
the _____ day of _____, 20____.

Notary Public in and for
the State of _____

APPENDIX H SIGNATURE PAGE

This Proposal shall remain in effect for ninety (90) calendar days from Proposal opening and shall be exclusive of federal excise and state and local sales tax (exempt).

The Respondent agrees, if this Proposal is accepted, to furnish any and all items upon which prices are offered, in accordance with the Specifications, Terms and Conditions contained in the RFP, and all other items made a part of this RFP.

The undersigned affirms that he or she is duly authorized to execute this Proposal and that by executing this Proposal, Respondent understands, acknowledges and agrees that the Respondent's Proposal, when properly accepted by the Williamson County Commissioners Court, shall constitute a contract equally binding between the Successful Respondent and Williamson County upon selection. Respondent represents to Williamson County that Respondent has not prepared this Proposal in collusion with any other Respondent, and that the contents of this Proposal as to prices, terms or conditions have not been communicated by the undersigned nor by any employee or agent to any other Respondent or to any other person(s) engaged in this type of business prior to the official opening of this Proposal. And further, that neither the Respondent nor their employees nor agents have been for the past six (6) months directly nor indirectly concerned in any pool or agreement or combination to control the price of goods or services on, nor to influence any person to submit a Proposal or not to submit a Proposal thereon.

Respondent (Entity Name)	Signature
Street & Mailing Address	Print Name
City, State & Zip	Date Signed
Telephone Number	Fax Number
E-mail Address	

If signature is by an agent, other than the Sole Proprietor(s) or an officer of a Corporation, Limited Liability Company, General Partner or a member of a General Partnership, a power of attorney or equivalent document must be submitted to the Williamson County Purchasing Department prior to contract award.

Williamson County Purchasing

Address:

901 S Austin Ave
Georgetown, TX 78626

Directions:

From South (Austin, Round Rock)
Take IH-35 Northbound
Exit 261
Take EXIT 261 toward TX-29/Burnet.
Take the 1st right onto W University Ave/TX-29
Turn left onto S Austin Ave
901 S AUSTIN AVE is on the right

From North (Jarrell, Georgetown)
Take IH-35 Southbound
Exit 261
Turn left onto TX-29/W University Ave
Turn left onto S Austin Ave
901 S AUSTIN AVE is on the right

