NOTICE TO THE PUBLIC
WILLIAMSON COUNTY COMMISSIONER'S COURT
SEPTEMBER 1ST, 2015
9:30 A.M.

The Commissioner's Court of Williamson County, Texas will meet in regular session in the Commissioner's Courtroom, 710 Main Street, in Georgetown, Texas to consider the following items:

1. Review and approval of minutes.

2. Consider noting in minutes any off right-of-way work on any County road done by Road & Bridge Division.

3. Hear County Auditor concerning invoices, bills, Quick Check Report, wire transfers and electronic payments submitted for payment and take appropriate action including, but not limited to approval for payment provided said items are found by the County Auditor to be legal obligations of the county.

4. Citizen comments. Except when public hearings are scheduled for later in the meeting, this will be the only opportunity for citizen input. The Court invites comments on any matter affecting the county, whether on the Agenda or not. Speakers should limit their comments to three minutes. Note that the members of the Court may not comment at the meeting about matters that are not on the agenda.

CONSENT AGENDA
The Consent Agenda includes non-controversial and routine items that the Court may act on with one single vote. The Judge or a Commissioner may pull any item from the consent agenda in order that the court discuss and act upon it individually as part of the Regular Agenda.
(Items 5 – 15)

5. Discuss, consider and take appropriate action on a line item transfer for the County Clerk's Office.

Fiscal Impact

From/To	Acct No.	Description	Amount
To	0100-0403-004212	Postage	500.00
From	0100-0403-004350	Printed Materials & Binding	500.00
To	0100-0404-004212	Postage	700.00
From	0100-0404-004350	Printed Materials & Binding	700.00

6. Discuss, consider and take appropriate action on a line item transfer for the Road and Bridge Division.

Fiscal Impact

From/To	Acct No.	Description	Amount
From	0200-0210-03544	Contract Hauling	$12,000.00
To	0200-0210-03597	Roadway Rehab	$12,000.00
From	0200-0210-03556	Aggregate/Rock Materials	$3,000.00

To	0200-0210-03001	Small Equipment & Tools	$2,000.00
To	0200-0210-03010	Computer Equipment < $5,000	$1,000.00

7. Discuss, consider, and take appropriate action on a line item transfer for Facilities.

Fiscal Impact

From/To	Acct No.	Description	Amount
From	0100-0509-004962	Janitorial Contract Service	8000
To	0100-0509-003001	Small Tools & Equipment	8000

8. Consider recommendation from Williamson County Conservation Foundation and take appropriate action to confirm Doug Fell and Karen Wind to board positions ending April 2016 and April 2017 respectively.

9. Discuss, consider and take appropriate action on authorizing the disposal of county Vehicles through auction including, (1) 2011 Ford Crown Vic, (1) 2010 Ford Crown Vic, (2) 2009 Ford Crown Vic, (2) 2008 Ford Crown Vic, (1) 2007 Ford F150, (1) 2006 Ford Crown Vic, (complete list attached) pursuant to Tex. Local Gov't Code §263.152.

10. Discuss, consider and take appropriate action on authorizing the disposal of various county assets through auction including, (2) Printer, (1) Keyboard, (1) Mouse, (1) Keyboard/Mouse Combo (complete list attached), pursuant to Tex. Local Gov't Code §26.152.

11. Receive and acknowledge Supplemental Work Authorization No. 1 under Williamson County Contract for utility services between Cobb Fendley & Associates, Inc. and Williamson County dated February 10, 2015 for on call utility coordination and relocation services for Williamson County Road and Bridge.

12. Discuss, consider and take appropriate action on approval of the final plat for the Angel Oaks subdivision - Pct 1.

13. Discuss, consider and take appropriate action on approval of the revised preliminary plat for the Paloma Lake subdivision - Pct 4.

14. Discuss, consider and take appropriate action on approval of the final plat for the Paloma Lake Section 12 subdivision - Pct 4.

15. Discuss, consider and take appropriate action on approval of the revised preliminary plat for the Santa Rita Ranch South subdivision - Pct 2.

REGULAR AGENDA

16. Discuss, consider and take appropriate action on the Department of Infrastructure projects and issues update.

17. Discuss, consider and take appropriate action on a Supplemental #1 to Professional Service Agreement for the CR 258 (Sunset Ridge to Ronald Reagan Blvd) project between Williamson County and Don Durden, Inc., dba Civil Engineering Consultants relating to the 2006 Road Bond program.

18. Discuss, consider and take appropriate action on Supplemental #1 to a Professional Services Agreeement for the On-Call engineering services for Lakeline Right-Turn-Lane project between Williamson County and Kimley-Horn and Associates, Inc. relating to the 2006 Road Bond program.

19. Discuss, consider, and take appropriate action regarding Change Order No. 4 in the amount of -$46,859.57 for CR 108, a Road Bond Project in the Commissioner Pct. 4.

20. Discuss, consider, and take appropriate action regarding Change Order No. 2 in the amount of $18,766.35 for Lakeline Blvd Phase 2, a Road Bond Project in the Commissioner Pct. 2.

21. Discuss, consider and take appropriate action on approving the transfer of $171,616.00 from 2006 GO Bond cash ending projects to South West Regional Park Pavilion (P320) and $33,344.00 to Champion Park Phase 2 (P321): Transfer $171,616.00 from 2006 GO Parks Non-Departmental (P164) to South West Regional Park Pavilion (P320), $22,585.59 from 2006 GO Parks Non-Departmental (P164) To Champion Park Phase 2 (P321), $8,298.52 from Lake Creek Trail to Champion Park Phase 2 (P321), $2,179.89 from Berry Springs Dam to Champion Park Phase 2 (P321), $280 from South West Regional Park Office (P204) to Champion Park Phase 2 (P321).

22. Discuss, consider, and take appropriate action regarding First Amended Services Agreement for Carpentry with Adam Heath Construction on the Sign Shop (Phase II) Project.

23. Discuss, consider and take appropriate action on new Professional Service Agreement with Kimley-Horn and Associates, Inc. to provide On Call Traffic Engineering Services for Williamson County Road & Bridge Division.

24. Discuss and take appropriate action on a Real Estate Contract with Dennis and Shelley Eberwein for ROW needed on CR 258. (PARCEL 25)

25. Discuss and take appropriate action on a Real Estate Contract with Robert & Joanne Pontius for ROW needed on CR 258. (PARCEL 17)

26. Discuss and take appropriate action on a Real Estate Contract with Ted and Amanda Nichols for ROW needed on CR 258. (PARCEL 9)

27. Discuss and take appropriate action on the Amendment No. 1 with the Upper Brushy Creek Water Contract and Improvement District for Cost Sharing Related to Study and Improve the Great Oaks Drive Bridge.

28. 10:00 Hold Public Hearing on 2015-2016 County Budget.

29. Discuss, consider and take appropriate action regarding budget for 2015-2016.

30. Discuss, consider and take appropriate action on the 2015-2016 General Fund County Budget.

31. Discuss, consider and take appropriate action on the 2015-2016 Road and Bridge Fund County Budget.

32. Discuss, consider and take appropriate action on the 2015-2016 Debt Service Fund County Budget.

33. 10:00 AM Public hearing on proposed 2015 tax rate for Williamson County.

34. Discuss, consider and take appropriate action on an Interlocal Agreement Between Williamson County and the City of Georgetown, Texas Regarding Emergency Medical Services; a Mutual Assistance Agreement for Emergency Medical Services Between City of Georgetown, Texas and Williamson County, Texas; and an Interlocal Agreement for Ambulance Services for the Williamson County Jail.

35. Discuss, consider and take appropriate action on approving the renewal of education affiliation agreements between Williamson County EMS and Leander Fire Department, Austin Community College, Laramie County Community College, Emergency Management Training and Services, Life Start Training and Consulting.

36. Discuss, consider and take appropriate action on the contract with the Williamson Museum for FY 16.

37. Discuss, consider and take any necessary action in regards to Status of Projects and Allocation of Funds in the 2013 Cash Ending Reduction Program, 2014 Cash Ending Reduction Program, and 2015 Cash Ending Reduction Program.

38. Discuss, consider and take any possible action regarding Fiscal Year 2016 Cash Ending Reduction Program.

39. Discuss, consider and take appropriate action on appointment of Kelley Masters to the place four position on the ESD #11 Board of Directors, for the remainder of the January 1, 2015 to December 31, 2016 term.

40. Discuss, consider and take appropriate action on appointment of Kelley Masters to Place 4 of the ESD #11 Board of Directors for the term of January 1, 2015 through December 31, 2016.

41. Discuss, consider and take appropriate action on resolution authorizing Williamson-Burnet County Opportunities to apply for grant funds from the Texas Department of Agriculture for Home-Delivered Meal Grant Program.

42. Discuss, consider, and take appropriate action regarding renewal of agreement with Texas Workforce Commission for Williamson County Constable, Precinct Two access to agency data for FY2016 to support county operations.

43. Discuss, consider, and take appropriate action on rejecting proposals received for RFP#1506-010, Specific and Aggregate Stop Loss Insurance, and authorizing Purchasing Agent to re-advertise and receive proposals for same under new RFP#1508-009.

44. Discuss, consider, and take appropriate action on authorizing the Purchasing Department to have Rene Bates Auctioneers hold on-line auctions for the sale of surplus county property on the following dates: October 7th through October 21st in 2015, January 13th through January 27th, April 6th through April 20th, and July 13th through July 27th in 2016. All auctions closing by 5pm CST on these dates.

45. Discuss, consider and take appropriate action on the FY15/16 Budget Order.

EXECUTIVE SESSION

"The Commissioners Court for Williamson County reserves the right to adjourn into executive session at any time during the course of this meeting to discuss any of the matters listed above, as authorized by Texas Government Code Sections 551.071 (Consultations with Attorney), 551.072 (Deliberations regarding Real Property), 551.073 (Deliberations regarding

Gifts and Donations), 551.074 (Personnel Matters), 551.076 (Deliberations regarding Security Devices) and 551.087 (Deliberations regarding Economic Development Negotiations)."

46. Discussion regarding economic development negotiations pursuant to Texas Government Code, Section 551.087:

a) Business prospect(s) that may locate or expand within Williamson County.
b) Discuss Pearson Road District.
c) Discuss North Woods Road District.
d) Discuss Kaufman Loop.

47. Discuss real estate matters (EXECUTIVE SESSION as per VTCA Govt. Code sec. 551.072 Deliberation Regarding Real Estate Property if deliberation in an open meeting would have a detrimental effect on the position of the governmental body in negotiations with third person.)

A. Real Estate Owned by Third Parties

1. Preliminary discussions relating to proposed or potential purchase or lease of property owned by third parties
a) Discuss proposed acquisition of property for right-of-way for SH 195
b) Discuss proposed acquisition of property for proposed SH 29 project.
c) Discuss proposed acquisition of property for SW 183 and SH 29 Loop.
d) Discuss possible acquisition of property with endangered species for mitigation purposes.
e) Discuss the acquisition of real property: Sneed Loop
f) Discuss the acquisition of real property: Neenah Blvd.
g) Discuss the acquisition of real property: CR 119
h) Discuss the acquisition of real property: Tradesman Park.
i) Discuss the acquisition of real property for proposed CR 110 project. (All sections)
j) Discuss the acquisition of real property: CR 258
k) Discuss the acquisition of real property: Kruger property exchange (3901 CR 130 Hutto, TX)
l) Discuss the acquisition of real property: Arterial H.
m) Discuss the acquisition of real property for County Facilities.
n) Discuss the acquisition of real property for the Williamson County Expo Center.
o) Discuss the acquisition of Easement interests on CR 240.
p) Discuss the acquisition of Easement interests for the Brushy Creek Trail Project.

B. Property or Real Estate owned by Williamson County

1. Preliminary discussions relating to proposed or potential sale or lease of property owned by the County
a) Discuss County owned real estate containing underground water rights and interests.
b) Discuss proposed sale of real estate on Inner Loop
c) Discuss proposed trade of real estate adjacent to Chandler Rd. and CR 130
d) Discuss proposed exchange of property with Mr. Kruger
e) Discuss real estate at 355 Texas Ave.

48. Discuss pending or contemplated litigation, settlement matters and other confidential attorney-client legal matters (EXECUTIVE SESSION as per VTCA Govt. Code sec. 551.071 consultation with attorney.), including the following:

a) Litigation or claims or potential litigation or claims against the County or by the County
b) Status Update-Pending Cases or Claims;
c) Cause No. 06-453-C277; Kerry Heckman et al. v. Williamson County, et al., In the District Court of Williamson County, Texas, 277th Judicial District
d) Civil Action No.1:13- CV- 505, Robert Lloyd v. Lisa Birkman, et al, In The United States District Court

for the Western District of Texas, Austin Division
e) Cause No. 13-0090-C26, Mathews v. Williamson County, In The District Court of Williamson County, Texas, 26th Judicial District.
f) Employee/personnel related matters
g) Other confidential attorney-client matters, including contracts and certain matters related to county defense issues in which the duty of the attorney to the governmental body within the attorney/client relationship clearly conflicts with Chapter 551 of the Texas Government Code.
h) Civil Action No. 1:11-cv-907, Sarah Doe et al. v. Jerald Neveleff et al., In the United States District Court for the Western District of Texas Austin Division
i) Mortgage Electronic Recording Systems (MERS) litigation.
j) Cause No. 12-0721-C277; W. Paul Reed et al. v. Williamson County et al.; In the District Court of Williamson County, Texas; 277th District Court
k) Cause No. 1:12-CV-011222LY; Lance Brown v. Williamson County, Williamson County Sheriff's Office, Sheriff James Wilson and Shawn Wilson in the United States District Court for the Western District of Texas, Austin Division
l) Cause No. 15-0064-C277, Gordon v. Dollahite et al, In The District Court of Williamson County, Texas, 277th District
m) Cause No. D-1-GN-14-003420; John Wesley Staten v. State Of Texas, et al.; In The District Court Of Travis County, Texas;
n) County Road 241 utility and Right-of-Way Issues and matters;
o) Cause No. D-1-GN-15-000875, Houston v. Bank of America et al, In The District Court of Travis County, Texas, 345th Judicial District
p) Civil Action No. 1:15-cv-431; Herman Crisp v. Williamson County, et al; In the USDC-WD-Austin Division
q) Cause No. 12-1226-C368; Williamson County, Texas v. James Broaddus d/b/a Broaddus & Associates, and Broaddus & Associates, Inc.; In the 368th Judicial District Court of Williamson County, Texas
r) Notice of Claim - In Re Jessica Palmer
s) Floodplain Regulation Issue
t) Carolyn Barnes v. Austin American Statesman, et al; Cause # D-1-GN-15-002626, in the 353rd Judicial District Court of Travis County, Texas
u) Carolyn Barnes, et al v. Texas Attorney General, et al; Cause # D-1-GN-15-000877, in the 419th Judicial District Court of Travis County
v) Civil Action No. 1:15-cv-00679-RP, OCA-Great Houston and Mallika Das v. State of Texas, Et Al., In the United States District Court for the Western District
w) Notice of Claim – In Re Ray Steven Rose
x) Appeal of IRS Proposed Worker Classification Changes and Proposed Tax Adjustments 2011 -2013; and Payment of Disputed Employment Taxes Pending Appeal
y) Utility damage claim that occurred on or about 02/19/2014 on CR 488 (Claim # TXPR141360)

49. Deliberate the appointment, employment, evaluation, reassignment, duties, discipline and/or dismissal of Williamson County officers, directors, employees and/or positions, including but not limited to conducting deliberation and discussion pertaining to annual reviews of department heads and appointed officials (Executive Session as per Tex. Gov. Code Section 551.074 – Personnel Matters).

REGULAR AGENDA (continued)

50. Discuss and take appropriate action regarding economic development.

51. Discuss and take appropriate action on real estate.

52. Discuss and take appropriate action on pending or contemplated litigation, settlement matters and other confidential attorney-client legal matters, including the following:

a) Litigation or claims or potential litigation or claims against the County or by the County
b) Status Update-Pending Cases or Claims;
c) Cause No. 06-453-C277; Kerry Heckman et al. v. Williamson County, et al., In the District Court of Williamson County, Texas, 277th Judicial District
d) Civil Action No.1:13- CV- 505, Robert Lloyd v. Lisa Birkman, et al, In The United States District Court for the Western District of Texas, Austin Division
e) Cause No. 13-0090-C26, Mathews v. Williamson County, In The District Court of Williamson County, Texas, 26th Judicial District.
f) Employee/personnel related matters
g) Other confidential attorney-client matters, including contracts and certain matters related to county defense issues in which the duty of the attorney to the governmental body within the attorney/client relationship clearly conflicts with Chapter 551 of the Texas Government Code.
h) Civil Action No. 1:11-cv-907, Sarah Doe et al. v. Jerald Neveleff et al., In the United States District Court for the Western District of Texas Austin Division
i) Mortgage Electronic Recording Systems (MERS) litigation.
j) Cause No. 12-0721-C277; W. Paul Reed et al. v. Williamson County et al.; In the District Court of Williamson County, Texas; 277th District Court
k) Cause No. 1:12-CV-011222LY; Lance Brown v. Williamson County, Williamson County Sheriff's Office, Sheriff James Wilson and Shawn Wilson in the United States District Court for the Western District of Texas, Austin Division
l) Cause No. 15-0064-C277, Gordon v. Dollahite et al, In The District Court of Williamson County, Texas, 277th District
m) Cause No. D-1-GN-14-003420; John Wesley Staten v. State Of Texas, et al.; In The District Court Of Travis County, Texas;
n) County Road 241 utility and Right-of-Way Issues and matters;
o) Cause No. D-1-GN-15-000875, Houston v. Bank of America et al, In The District Court of Travis County, Texas, 345th Judicial District
p) Civil Action No. 1:15-cv-431; Herman Crisp v. Williamson County, et al; In the USDC-WD-Austin Division
q) Cause No. 12-1226-C368; Williamson County, Texas v. James Broaddus d/b/a Broaddus & Associates, and Broaddus & Associates, Inc.; In the 368th Judicial District Court of Williamson County, Texas
r) Notice of Claim - In Re Jessica Palmer
s) Floodplain Regulation Issue
t) Carolyn Barnes v. Austin American Statesman, et al; Cause # D-1-GN-15-002626, in the 353rd Judicial District Court of Travis County, Texas
u) Carolyn Barnes, et al v. Texas Attorney General, et al; Cause # D-1-GN-15-000877, in the 419th Judicial District Court of Travis County
v) Civil Action No. 1:15-cv-00679-RP, OCA-Great Houston and Mallika Das v. State of Texas, Et Al., In the United States District Court for the Western District
w) Notice of Claim – In Re Ray Steven Rose
x) Discuss, consider and take appropriate action regarding possible appeal of IRS Proposed Worker Classification Changes and Proposed Tax Adjustments 2011 -2013; and approval of payment of disputed employment taxes pending appeal
y) Utility damage claim that occurred on or about 02/19/2014 on CR 488 (Claim # TXPR141360)

53. Discuss, consider and take appropriate action regarding the appointment, employment, evaluation, reassignment, duties, discipline and/or dismissal of Williamson County officers, directors or employees, including but not limited to any necessary action pertaining to conducting annual reviews of department heads and appointed officials.

54. Comments from Commissioners.

_____
Dan A. Gattis, County Judge

This notice of meeting was posted in the locked box located on the south side of the Williamson County Courthouse, a place readily accessible to the general public at all times, on the _____ day of _____, 2015 at _____ and remained posted for at least 72 continuous hours preceding the scheduled time of said meeting.

Commissioners Court - Regular Session **5.**

Meeting Date: 09/01/2015

Transfer money to postage

Submitted For: Nancy Rister **Submitted By:** Nancy Rister, County Clerk

Department: County Clerk

Agenda Category: Consent

Information

Agenda Item

Discuss, consider and take appropriate action on a line item transfer for the County Clerk's Office.

Background

Both accounts are running low on postage and will not make it through to the end of the month.

Fiscal Impact

From/To	Acct No.	Description	Amount
To	0100-0403-004212	Postage	500.00
From	0100-0403-004350	Printed Materials & Binding	500.00
To	0100-0404-004212	Postage	700.00
From	0100-0404-004350	Printed Materials & Binding	700.00

Attachments

No file(s) attached.

Form Review

Inbox	Reviewed By	Date
County Judge Exec Asst.	Wendy Coco	08/26/2015 03:54 PM
Budget Office	Ashlie Koenig	08/27/2015 10:16 AM
Form Started By: Nancy Rister		Started On: 08/26/2015 02:19 PM
Final Approval Date: 08/27/2015		

Commissioners Court - Regular Session **6.**

Meeting Date: 09/01/2015

Discuss, consider and take appropriate action on a line item transfer for Road and Bridge.

Submitted For: Terron Evertson **Submitted By:** Daribel Texidor, Unified Road System

Department: Unified Road System

Agenda Category: Consent

Information

Agenda Item

Discuss, consider and take appropriate action on a line item transfer for the Road and Bridge Division.

Background

These transfers are necessary to continue the ability to stabilize road bed materials, to purchase small tools for Road and Bridge projects, for wireless communication and internet access due to no signal inside the sign shop.

Fiscal Impact

From/To	Acct No.	Description	Amount
From	0200-0210-03544	Contract Hauling	$12,000.00
To	0200-0210-03597	Roadway Rehab	$12,000.00
From	0200-0210-03556	Aggregate/Rock Materials	$3,000.00
To	0200-0210-03001	Small Equipment & Tools	$2,000.00
To	0200-0210-03010	Computer Equipment < $5,000	$1,000.00

Attachments

No file(s) attached.

Form Review

Inbox	Reviewed By	Date
County Judge Exec Asst.	Wendy Coco	08/27/2015 09:15 AM
Budget Office	Ashlie Koenig	08/27/2015 10:17 AM
Form Started By: Daribel Texidor		Started On: 08/26/2015 04:28 PM
Final Approval Date: 08/27/2015		

Commissioners Court - Regular Session **7.**

Meeting Date: 09/01/2015

Line Item Transfer

Submitted By: Shirley Taylor, Facilities Maintenance

Department: Facilities Maintenance

Agenda Category: Consent

Information

Agenda Item

Discuss, consider, and take appropriate action on a line item transfer for Facilities.

Background

To purchase needed tools.

Fiscal Impact

From/To	Acct No.	Description	Amount
From	0100-0509-004962	Janitorial Contract Service	8000
To	0100-0509-003001	Small Tools & Equipment	8000

Attachments

No file(s) attached.

Form Review

Inbox	Reviewed By	Date
County Judge Exec Asst.	Wendy Coco	08/27/2015 10:06 AM
Budget Office	Ashlie Koenig	08/27/2015 10:17 AM
Form Started By: Shirley Taylor		Started On: 08/27/2015 09:56 AM
Final Approval Date: 08/27/2015		

Commissioners Court - Regular Session **8.**

Meeting Date: 09/01/2015

confirm appointment of members to WCCF board

Submitted For: Gary Boyd **Submitted By:** Gary Boyd, Parks

Department: Parks

Agenda Category: Consent

Information

Agenda Item

Consider recommendation from Williamson County Conservation Foundation and take appropriate action to confirm Doug Fell and Karen Wind to board positions ending April 2016 and April 2017 respectively.

Background

This action is to confirm the appointment of Doug Fell and Karen Wind to the WCCF Board for terms ending, respectively, as of the Foundation's April 2016 and April 2017 annual meeting. This action is based on recommendation from the WCCF board passed at its August 26 regular board meeting.

Mr. Fell is a resident of the Hutto area, a retired banker, landowner and rancher. After attending the University of Texas and following a 20+ year career in banking he has returned to Williamson County to oversee family agricultural interests. Among his activities he is on the Hutto Economic Development Corporation.

Ms. Wind is a resident of Cedar Park. She serves on the Cedar Park Economic Development Sales Tax Corporation (4A) Board. Karen has had a lifelong interest in conservation and natural resources management. She earned her law degree from Washington University in St. Louis, where she studied the Endangered Species Act in land use and environmental law classes.

Fiscal Impact

From/To	Acct No.	Description	Amount

Attachments

No file(s) attached.

Form Review

Inbox	Reviewed By	Date
County Judge Exec Asst.	Wendy Coco	08/27/2015 09:15 AM
Form Started By: Gary Boyd		Started On: 08/26/2015 11:32 AM
Final Approval Date: 08/27/2015		

Commissioners Court - Regular Session **9.**

Meeting Date: 09/01/2015

Vehicle Sale

Submitted By: Stacy Partridge, Purchasing

Department: Purchasing

Agenda Category: Consent

Information

Agenda Item

Discuss, consider and take appropriate action on authorizing the disposal of county Vehicles through auction including, (1) 2011 Ford Crown Vic, (1) 2010 Ford Crown Vic, (2) 2009 Ford Crown Vic, (2) 2008 Ford Crown Vic, (1) 2007 Ford F150, (1) 2006 Ford Crown Vic, (complete list attached) pursuant to Tex. Local Gov't Code §263.152.

Background

Fiscal Impact

From/To	Acct No.	Description	Amount

Attachments

Vehicle Sale

Form Review

Inbox	Reviewed By	Date
Purchasing (Originator)	Kerstin Hancock	08/26/2015 04:25 PM
County Judge Exec Asst.	Wendy Coco	08/26/2015 04:25 PM
Form Started By: Stacy Partridge		Started On: 08/26/2015 03:56 PM
Final Approval Date: 08/26/2015		

Williamson County
Vehicle Status Change Form

COPY

To be completed by **department** releasing vehicle:

1) Identify Vehicle:

2FABP7BV3BX182485	560	SA1167
Vehicle Identification Number	Department	Door Number

1131035	2011	FORD	CROWN VIC	BLACK
License Plate Number	Year	Make	Model	Color

2) Reason for Status Change:

☐ Accident

Received: 1. Williamson County Fleet Incident/Crash/Vandalism Report
2. The Official Accident Report
3. A Vehicle Insurance / Litigation Form

☒ High Mileage: List actual mileage 118,415

☒ Not mechanically sound transmission is bad

☐ Other: Explain

3) Elected Official/Department Head/Authorized Staff

Print Name L.C. "Tony" Marshall Signature [signature] Date 8-5-15

To be completed by **Fleet Services Manager:**

1) Method of Status Change: This vehicle is to be considered for: (Select one)

- ☒ SALE at the earliest auction
- ○ TRANSFER between county departments
- ○ SALVAGE for parts
- ○ TRADE-IN for new assets of same general type for the county
- ○ SALE to a government entity / civil or charitable organization in the county at fair market value
- ○ Other

Print Name R Rodgers Signature [signature] Date 8-5-15

To be completed by **Human Resources Analyst:**

All applicable accident paperwork has been received and there is no litigation pending on this unit. It has been cleared for retirement.

HR Release Authorization: [signature]

To be completed by **Budget Office** (only for transfers):

Transfer has been reviewed and approved:

Signature:

All forms must be routed to the County Auditor's Office once the final authorization and approval have been received.

Williamson County
Vehicle Status Change Form

COPY

To be completed by **department** releasing vehicle:

1) Identify Vehicle:

2FABP7BV3AX124326	560	SA1008
Vehicle Identification Number	Department	Door Number

1104077	2010	FORD	CROWN VIC	BLK/WHT
License Plate Number	Year	Make	Model	Color

2) Reason for Status Change:

☐ Accident

Received: 1. Williamson County Fleet Incident/Crash/Vandalism Report
2. The Official Accident Report
3. A Vehicle Insurance / Litigation Form

☒ High Mileage: List actual mileage 126,001

☐ Not mechanically sound

☒ Other: Explain Bad Transmission.

3) Elected Official/Department Head/Authorized Staff

Print Name L.C. "Tony" Marshall Signature [signature] Date 8-3-15

To be completed by **Fleet Services Manager:**

1) Method of Status Change: This vehicle is to be considered for: (Select one)

- ☒ SALE at the earliest auction
- ☐ SALVAGE for parts
- ☐ TRADE-IN for new assets of same general type for the county
- ☐ SALE to a government entity / civil or charitable organization in the county at fair market value
- ☐ Other
- ☐ TRANSFER between county departments

Print Name R Rodgers Signature [signature] Date 8-5-15

To be completed by **Human Resources Analyst:**

All applicable accident paperwork has been received and there is no litigation pending on this unit. It has been cleared for retirement.

HR Release Authorization: [signature]

To be completed by **Budget Office** (only for transfers):

Transfer has been reviewed and approved:

Signature:

All forms must be routed to the County Auditor's Office once the final authorization and approval have been received.

Williamson County
Vehicle Status Change Form

COPY

To be completed by **department** releasing vehicle:

1) Identify Vehicle:

2FAFP71V38X155735	560	SA0824
Vehicle Identification Number	Department	Door Number

FMS9196	2008	FORD	CROWN VIC	BLACK
License Plate Number	Year	Make	Model	Color

2) Reason for Status Change:

☐ Accident

Received: 1. Williamson County Fleet Incident/Crash/Vandalism Report
2. The Official Accident Report
3. A Vehicle Insurance / Litigation Form

7AUG15 4:46P

☒ High Mileage: List actual mileage 159,485

☐ Not mechanically sound

☐ Other: Explain

3) Elected Official/Department Head/Authorized Staff

Print Name L.C. "Tony" Marshall Signature [signature] Date 8-5-15

To be completed by **Fleet Services Manager:**

1) Method of Status Change: This vehicle is to be considered for: (Select one)

- ☒ SALE at the earliest auction
- ○ TRANSFER between county departments
- ○ SALVAGE for parts
- ○ TRADE-IN for new assets of same general type for the county
- ○ SALE to a government entity / civil or charitable organization in the county at fair market value
- ○ Other

Print Name R Rodgers Signature [signature] Date 8-5-15

To be completed by **Human Resources Analyst:**

All applicable accident paperwork has been received and there is no litigation pending on this unit. It has been cleared for retirement.

HR Release Authorization: [signature]

To be completed by **Budget Office** (only for transfers):

Transfer has been reviewed and approved:

Signature:

All forms must be routed to the County Auditor's Office once the final authorization and approval have been received.

Williamson County
Vehicle Status Change Form

COPY

To be completed by **department** releasing vehicle:

1) Identify Vehicle:

2FAFP71V38X161714	560	SA0858
Vehicle Identification Number	Department	Door Number

1059876	2008	FORD	CROWN VIC	BLK/WHT
License Plate Number	Year	Make	Model	Color

2) Reason for Status Change:

☐ Accident

Received: 1. Williamson County Fleet Incident/Crash/Vandalism Report
2. The Official Accident Report
3. A Vehicle Insurance / Litigation Form

☒ High Mileage: List actual mileage 114,970

☐ Not mechanically sound

☐ Other: Explain

3) Elected Official/Department Head/Authorized Staff

Print Name L.C. "Tony" Marshall Signature [signature] Date 8-3-15

To be completed by **Fleet Services Manager:**

1) Method of Status Change: This vehicle is to be considered for: (Select one)

- ☒ SALE at the earliest auction
- ☐ SALVAGE for parts
- ☐ TRADE-IN for new assets of same general type for the county
- ☐ SALE to a government entity / civil or charitable organization in the county at fair market value
- ☐ TRANSFER between county departments
- ☐ Other

Print Name R Rodgers Signature [signature] Date 8-5-15

To be completed by **Human Resources Analyst:**

All applicable accident paperwork has been received and there is no litigation pending on this unit. It has been cleared for retirement.

HR Release Authorization: [signature]

To be completed by **Budget Office** (only for transfers):

Transfer has been reviewed and approved:

Signature:

All forms must be routed to the County Auditor's Office once the final authorization and approval have been received.

Williamson County
Vehicle Status Change Form

COPY

To be completed by **department** releasing vehicle:

1) Identify Vehicle:

2FAHP71V29X118668	560	SA0902
Vehicle Identification Number	Department	Door Number

NLW677	2009	FORD	CROWN VIC	BRONZE
License Plate Number	Year	Make	Model	Color

2) Reason for Status Change:

☐ Accident

Received: 1. Williamson County Fleet Incident/Crash/Vandalism Report
2. The Official Accident Report
3. A Vehicle Insurance / Litigation Form

☒ High Mileage: List actual mileage 129,504

☐ Not mechanically sound

☐ Other: Explain

3) Elected Official/Department Head/Authorized Staff

Print Name L.C. "Tony" Marshall Signature [signature] Date 7-31-15

To be completed by **Fleet Services Manager:**

1) Method of Status Change: This vehicle is to be considered for: (Select one)

- ☒ SALE at the earliest auction
- ○ TRANSFER between county departments
- ○ SALVAGE for parts
- ○ TRADE-IN for new assets of same general type for the county
- ○ SALE to a government entity / civil or charitable organization in the county at fair market value
- ○ Other

Print Name J Rodgers Signature [signature] Date 8-5-15

To be completed by **Human Resources Analyst:**

All applicable accident paperwork has been received and there is no litigation pending on this unit. It has been cleared for retirement.

HR Release Authorization: [signature]

To be completed by **Budget Office** (only for transfers):

Transfer has been reviewed and approved:

Signature:

All forms must be routed to the County Auditor's Office once the final authorization and approval have been received.

Williamson County
Vehicle Status Change Form

COPY

To be completed by **department** releasing vehicle:

1) Identify Vehicle:

2FAHP71V29X143974	551	1A0904
Vehicle Identification Number	Department	Door Number

1082301	2009	FORD	CVP	BLK/WHT
License Plate Number	Year	Make	Model	Color

2) Reason for Status Change:

☐ Accident

Attach: 1. Williamson County Fleet Incident/Crash/Vandalism Report
2. The Official Accident Report
3. A Vehicle Insurance / Litigation Form

5 AUG 15 7:1

☒ High Mileage: List actual mileage 104240

☐ Not mechanically sound

☒ Other: Explain UNIT HAS REACHED ITS SERVICE LIFE

3) Elected Official/Department Head/Authorized Staff

Print Name Lt. Jack Abbott Signature Lt. Jack Abbott Date Jul 23, 2015

To be completed by **Fleet Services Manager:**

1) Method of Status Change: This vehicle is to be considered for: (Select one)

- (X) SALVAGE for parts / SALE at the earliest auction based on Fleet's recommendation
- ( ) TRADE-IN for new assets of same general type for the county
- ( ) SALE to a government entity / civil or charitable organization in the county at fair market value
- ( ) Other
- ( ) TRANSFER between county departments

Print Name R Rodgers Signature R Rodgers Date 7-30-15

To be completed by **Human Resources Analyst:**

All applicable accident paperwork has been received and there is no litigation pending on this unit. It has been cleared for retirement.

HR Release Authorization: Sara Rampy

To be completed by **Budget Office** (only for transfers):

Transfer has been reviewed and approved:

Signature:

All forms must be routed to the County Auditor's Office once the final authorization and approval have been received.

Williamson County
Vehicle Status Change Form

COPY

To be completed by **department** releasing vehicle:

1) Identify Vehicle:

1FTPW12V77KC29785	551	1B0702
Vehicle Identification Number	Department	Door Number

1110138	2007	FORD	F150 CREW CAB	WHITE
License Plate Number	Year	Make	Model	Color

2) Reason for Status Change:

☐ Accident

Attach: 1. Williamson County Fleet Incident/Crash/Vandalism Report
2. The Official Accident Report
3. A Vehicle Insurance / Litigation Form

SAUG 15 3:15P

☒ High Mileage: List actual mileage 97599

☐ Not mechanically sound

☒ Other: Explain UNIT HAS REACHED ITS SERVICEABLE LIFE

3) Elected Official/Department Head/Authorized Staff

Print Name Lt. Jack Abbott Signature Lt. Jack Abbott Date 07/23/15

To be completed by **Fleet Services Manager:**

1) Method of Status Change: This vehicle is to be considered for: (Select one)

- X SALVAGE for parts / SALE at the earliest auction based on Fleet's recommendation
- ○ TRADE-IN for new assets of same general type for the county
- ○ SALE to a government entity / civil or charitable organization in the county at fair market value
- ○ Other
- ○ TRANSFER between county departments

Print Name R Rodgers Signature R Rodgers Date 7-30-15

To be completed by **Human Resources Analyst:**

All applicable accident paperwork has been received and there is no litigation pending on this unit. It has been cleared for retirement.

HR Release Authorization: Sara Rayner

To be completed by **Budget Office** (only for transfers):

Transfer has been reviewed and approved:

Signature:

All forms must be routed to the County Auditor's Office once the final authorization and approval have been received.

Williamson County
Vehicle Status Change Form

COPY

To be completed by **department** releasing vehicle:

1) Identify Vehicle:

2FAFP71W26X125440	551 Const #1	1A0600
Vehicle Identification Number	Department	Door Number

1156665	2006	FORD	CVP	BLACK/WHITE
License Plate Number	Year	Make	Model	Color

2) Reason for Status Change:

☐ Accident

Attach: 1. Williamson County Fleet Incident/Crash/Vandalism Report
2. The Official Accident Report
3. A Vehicle Insurance / Litigation Form

4AUG15 10:44A

☒ High Mileage: List actual mileage 114874

☐ Not mechanically sound

☐ Other: Explain

3) Elected Official/Department Head/Authorized Staff

Print Name Lt. Jack Abbott Signature Lt. Jack Abbott Date 07/09/2015

To be completed by **Fleet Services Manager:**

1) Method of Status Change: This vehicle is to be considered for: (Select one)

- ☒ SALVAGE for parts / SALE at the earliest auction based on Fleet's recommendation
- ○ TRADE-IN for new assets of same general type for the county
- ○ SALE to a government entity / civil or charitable organization in the county at fair market value
- ○ Other
- ○ TRANSFER between county departments

RECEIVED
JUL 20 2015
AUDITOR'S OFFICE
WILLIAMSON COUNTY, TEXAS

Print Name R Rodgers Signature Date 7/20/15

To be completed by **Human Resources Analyst:**

All applicable accident paperwork has been received and there is no litigation pending on this unit. It has been cleared for retirement.

HR Release Authorization:

To be completed by **Budget Office** (only for transfers):

Transfer has been reviewed and approved:

Signature:

All forms must be routed to the County Auditor's Office once the final authorization and approval have been received.

Commissioners Court - Regular Session **10.**

Meeting Date: 09/01/2015

Asset Sale

Submitted By: Stacy Partridge, Purchasing

Department: Purchasing

Agenda Category: Consent

Information

Agenda Item

Discuss, consider and take appropriate action on authorizing the disposal of various county assets through auction including, (2) Printer, (1) Keyboard, (1) Mouse, (1) Keyboard/Mouse Combo (complete list attached), pursuant to Tex. Local Gov't Code §26.152.

Background

Fiscal Impact

From/To	Acct No.	Description	Amount

Attachments

Asset Sale

Form Review

Inbox	Reviewed By	Date
Purchasing (Originator)	Kerstin Hancock	08/26/2015 04:25 PM
County Judge Exec Asst.	Wendy Coco	08/26/2015 04:25 PM
Form Started By: Stacy Partridge		Started On: 08/26/2015 04:15 PM
Final Approval Date: 08/26/2015		

FrmAudASCF01 revision 07/2014

Williamson County
Asset Status Change Form

Print Form

The following asset(s) is(are) considered for: (select one)

- ○ TRANSFER bet ween county departments
- ◉ SALE at the earliest auction *
- ○ TRADE-IN for new assets of similar type for the county
- ○ DONATION to a non-county entity
- ○ DESTRUCTION due to Public Health / Safety
- ○ SALE to a government entity / civil or charitable organization in the county at fair market value

Asset List:

Quantity	Description (year, make, model, etc.)	Manufacturer ID# (serial, service tag, or VIN)	County Tag#	Condition of Assets (Working, Non-Working)
1	HP Laserjet 4250n	s/n: CNGXF95489	100406	Working
1	Gearhead keyboard			Non-Working
1	Logitech mouse M310			Non-Working
1	Logitech keyboard/mouse combo K750			Non-Working

Parties involved:

FROM (Transferor Department): County Attorney

AUG 20 2015

Transferor - Elected Official/Department Head/ Authorized Staff:

Dee Hobbs
Print Name

Signature

August 18, 2015
Date

Contact Person:

Stephanie Lloyd
Print Name

943-1116
Phone Number

TO (Transferee Department/Auction/Trade-in/Donee): Auction

Transferee - Elected Official/Department Head/ Authorized Staff OR Donee - Representative: (If being approved for Sale or Trade-in, no signature is necessary.)

Print Name

Signature

Date

Contact Person:

Print Name

Phone Number

* If the above asset(s) is (are) listed for sale at auction and no bids are made, the Purchasing Director may dispose of or donate this (these) asset(s). A list of the (these) asset(s) to be donated or disposed of will be sent to the Auditor's Office with a date of donation or disposal.

Forward to County Auditor's Office

This Change Status was approved as agenda item # _____ in Commissioner's Court on _____

If for Sale, the asset(s) was(were) delivered to warehouse on _____ by _____

FrmAudASCF01 revision 07/2014

Williamson County
Asset Status Change Form

Print Form

The following asset(s) is(are) considered for: (select one)

- ○ TRANSFER bet ween county departments
- ◉ SALE at the earliest auction *
- ○ TRADE-IN for new assets of similar type for the county
- ○ DONATION to a non-county entity
- ○ DESTRUCTION due to Public Health / Safety
- ○ SALE to a government entity / civil or charitable organization in the county at fair market value

Asset List:

Quantity	Description (year, make, model, etc.)	Manufacturer ID# (serial, service tag, or VIN)	County Tag#	Condition of Assets (Working, Non-Working)
1	HP Color Printer CP 2025		497-120	Non-Working

Parties involved:

FROM (Transferor Department): Treasurer Office

Transferor - Elected Official/Department Head/ Authorized Staff:

Jerri Jones
Print Name

Signature 8-17-15 Date

Contact Person:

Jerri Jones
Print Name

+1 (512) 943-1540
Phone Number

TO (Transferee Department/Auction/Trade-in/Donee): AucFin

Transferee - Elected Official/Department Head/ Authorized Staff OR Donee - Representative: (If being approved for Sale or Trade-in, no signature is necessary.)

Print Name

Signature Date

Contact Person:

Print Name

Phone Number

RECEIVED
AUG 17 2015
AUDITOR'S OFFICE
WILLIAMSON COUNTY, TEXAS

* If the above asset(s) is (are) listed for sale at auction and no bids are made, the Purchasing Director may dispose of or donate this (these) asset(s). A list of the (these) asset(s) to be donated or disposed of will be sent to the Auditor's Office with a date of donation or disposal.

Forward to County Auditor's Office

This Change Status was approved as agenda item # _____ in Commissioner's Court on _____

If for Sale, the asset(s) was(were) delivered to warehouse on _____ by _____

Commissioners Court - Regular Session **11.**

Meeting Date: 09/01/2015

Cobb Fendley Supplemental Work Authorization 1

Submitted For: Terron Evertson **Submitted By:** Sarah Ramos, Unified Road System

Department: Unified Road System

Agenda Category: Consent

Information

Agenda Item

Receive and acknowledge Supplemental Work Authorization No. 1 under Williamson County Contract for utility services between Cobb Fendley & Associates, Inc. and Williamson County dated February 10, 2015 for on call utility coordination and relocation services for Williamson County Road and Bridge.

Background

Fiscal Impact

From/To	Acct No.	Description	Amount

Attachments

Cobb Fendley Supplemental Work Authorization 1

Form Review

Inbox	Reviewed By	Date
County Judge Exec Asst.	Wendy Coco	08/26/2015 11:16 AM
Form Started By: Sarah Ramos		Started On: 08/25/2015 11:39 AM
Final Approval Date: 08/26/2015		

SUPPLEMENTAL WORK AUTHORIZATION NO. 1
TO
WORK AUTHORIZATION NO. 1

WILLIAMSON COUNTY ROAD BOND PROJECT:
On Call Utility Coordination and Relocation Services for Road & Bridge Division

This Supplemental Work Authorization No. 1 to Work Authorization No. 1 is made pursuant to the terms and conditions of the Williamson County Contract for Engineering Services, being dated February 10, 2015 ("Contract") and entered into by and between Williamson County, Texas, a political subdivision of the State of Texas, (the "County") and Cobb Fendley & Associates, Inc (the "Engineer").

WHEREAS, the County and the Engineer executed Work Authorization No. 1 dated effective March 4, 2015 (the "Work Authorization");

WHEREAS, pursuant to the Contract, amendments, changes and modifications to a fully executed Work Authorization shall be made in the form of a Supplemental Work Authorization; and

WHEREAS, it has become necessary to amend, change and modify the Work Authorization.

AGREEMENT

NOW, THEREFORE, premises considered, the County and the Engineer agree that the Work Authorization shall be amended, changed and modified as follows:

I. The above referenced Work Authorization termination date shall be modified to September 30, 2016. The Services to be Provided by the Engineer shall be fully completed on or before said date unless extended by an additional Supplemental Work Authorization. The revised Work Schedule is attached hereto as Attachment "C".

County believes it has sufficient funds currently available and authorized for expenditure to finance the costs of this Supplemental Work Authorization. Engineer understands and agrees that County's payment of amounts under this Supplemental Work Authorization is contingent on the County receiving appropriations or other expenditure authority sufficient to allow the County, in the exercise of reasonable administrative discretion, to continue to make payments under the Supplemental Work Authorization. It is further understood and agreed by Engineer that County shall have the right to terminate this Supplemental Work Authorization at the end of any County fiscal year if the governing body of County does not appropriate sufficient funds as determined by County's budget for the fiscal year in question. County may effect such termination by giving written notice of termination to Engineer.

Except as otherwise amended by prior or future Supplemental Work Authorizations, all other terms of the Work Authorization are unchanged and will remain in full force and effect.

This Supplemental Work Authorization does not waive the parties' responsibilities and obligations provided under the Contract.

IN WITNESS WHEREOF, the County and the Engineer have executed this Supplemental Work Authorization, in duplicate, to be effective as of the date of the last party's execution below.

ENGINEER:	COUNTY:
COBB FENDLEY & ASSOCIATES	Williamson County, Texas
By: _____ Signature	By: _____ Signature
Sandra Khoury, PE Printed Name	Dan A. Gattis Printed Name
Principal Title	County Judge Title

LIST OF ATTACHMENTS

Attachment A - Services to be Provided by County

Attachment B - Services to be Provided by Engineer

Attachment C - Work Schedule

Attachment D - Fee Schedule

Attachment A - Services to be Provided by County

Williamson County Road & Bridge Division personnel will provide project direction, review and oversight.

Attachment B - Services to be Provided by Engineer

Scope of Services provided by Cobb, Fendley & Associates, Inc. (the ***Engineer***), involves utility coordination/ relocation services in Williamson County, Texas, (the County) as described below.

This scope includes the following major tasks:

1. UTILITY PROGRAM MANAGEMENT
2. PROJECT MANAGEMENT AND COORDINATION
3. UTILITY ADJUSTMENT COORDINATION
4. SUBSURFACE UTILITY ENGINEERING (SUE)
5. UTILITY ENGINEERING AND DESIGN
6. UTILITY CONSTRUCTION MANAGEMENT AND OBSERVATION
7. RESEARCH – UTILITY DATA COLLECTION (PLANNING)
8. FIELD SURVEYING
9. RIGHT-OF-WAY (ROW) COORDINATION
10. MISCELLANEOUS

Attachment C - Work Schedule

Work schedules will be developed as work (on call utility coordination/relocation services) are dispatched.

Attachment D - Fee Schedule

Cobb, Fendley & Associates, Inc.

Effective August 2014

Classification	2014 Billing Rate
Senior Engineer / Project Principal	$225.00/HR
Project Manager	$165.00/HR
Project Engineer III	$150.00/HR
Project Engineer II	$125.00/HR
Project Engineer I	$105.00/HR
Senior Technician	$120.00/HR
Technician III	$105.00/HR
Technician II	$95.00/HR
Technician I	$75.00/HR
Licensed State Land Surveyor	$200.00/HR
Registered Professional Land Surveyor	$150.00/HR
4-Man Survey Crew	$165.00/HR
3-Man Survey Crew	$145.00/HR
2-Man Survey Crew	$125.00/HR
1-Man Survey Crew	$105.00/HR
Construction Manager	$165.00/HR
Senior Field Construction Observer	$105.00/HR
Field Construction Observer	$90.00/HR
Senior Utility Specialist	$135.00/HR
Utility Specialist	$120.00/HR
GIS Manager	$145.00/HR
GIS Analyst	$95.00/HR
Right-of-Way Agent	$125.00/HR
Clerical	$65.00/HR
GPS	$32.00/HR/Receiver

SUBSURFACE UTILITY ENGINEERING

Level C & D (Without Level B).....$0.45/Foot

Level B – Designation (Without Level C & D).....$1.47/Foot

Level A – Location (Non-Destructive Excavation):

Vertical Depth:

0 Ft.	–	5 Ft	$1,125/Hole
5 Ft.	–	8 Ft	$1,580/Hole
8 Ft.	–	13 Ft	$1,825/Hole
13 Ft.	–	20 Ft	$2,510/Hole
> 20 Ft			$3,600/Hole

Ground Penetrating Radar.....$250/HR

SUE Technician (With Equipment).....$100/HR

Vacuum Excavation Truck with 2 Technicians.....$250/HR

Closed Circuit Television (CCTV) with 2 Technicians.....$265/HR

Traffic Control Officer.....@ Cost

Traffic Control (Lane Closures, etc.).....To Be Negotiated

Permits (Local, State, etc.).....@ Cost

Designation & Traffic Control Vehicles.....$3.40/Mile

Location Vehicles.....$6.80/Mile

REIMBURSABLE EXPENSES

Consultant or Specialty Contractor (Outside Firm).....@ Cost

Courier, Special Equipment Rental.....@ Cost

Title Plant Charges.....@ Cost

Other Misc. Expenses Related to the Project.....@ Cost

In-House Reproduction:

Copies (Up to 11" x 17")	$0.15/Each
Color Prints (Up to 11" x 17")	$1.50/Each
Color Prints (Larger than 11" x 17")	$3.00/Sq. Ft.
Bond Prints (All Sizes)	$2.00/Each

Refer to Exhibit E – Williamson County Reimbursement Policy for all other allowable reimbursable expenses

Austin Spatial Technologies, LLC

Survey Services Standard Hourly Rate Schedule

Effective August 2014

Classification	2014 Billing Rate
Registered Land Surveyor	$120.00/HR
Project Manager	$95.00/HR
Sr. Cad Technician	$85.00/HR
Survey Tech GPS Specialist	$70.00/HR
3-Man Survey Crew	$160.00/HR
2-Man Survey Crew	$135.00/HR
All-terrain Vehicle	$200.00/day
Special Equipment Rental	@ Cost

Commissioners Court - Regular Session **12.**

Meeting Date: 09/01/2015

Discuss consider and take appropriate action on approval of the final plat for the Angel Oaks subdivision - Pct 1

Submitted For: Joe England **Submitted By:** Patrick Hughes, Unified Road System

Department: Unified Road System

Agenda Category: Consent

Information

Agenda Item

Discuss, consider and take appropriate action on approval of the final plat for the Angel Oaks subdivision - Pct 1.

Background

This is a simple split of a 5.2-acre parcel into two lots. There are no proposed roads. Final plat review fees have been paid. The preliminary plat was approved on May 5, 2015.

Fiscal Impact

From/To	Acct No.	Description	Amount

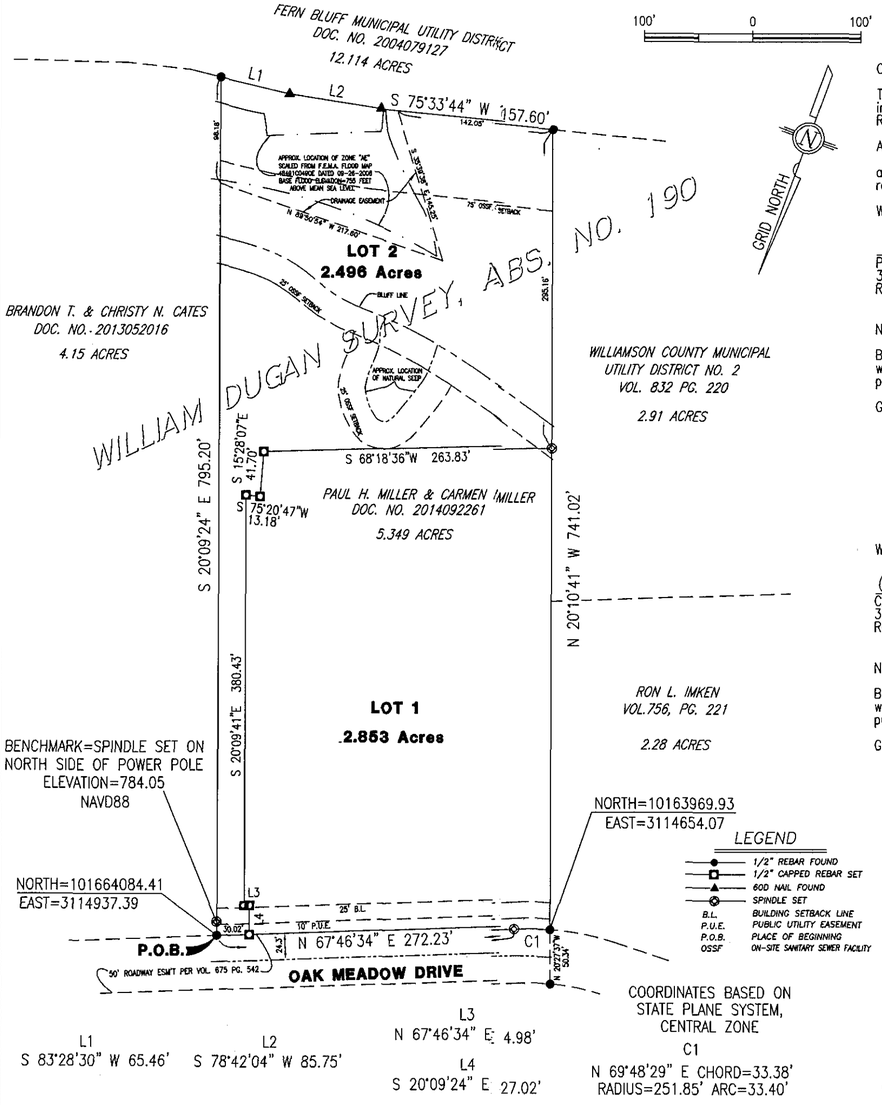
Attachments

Final Plat - Angel Oaks

Form Review

Inbox	Reviewed By	Date
County Judge Exec Asst.	Wendy Coco	08/26/2015 11:16 AM
Form Started By: Patrick Hughes		Started On: 08/25/2015 09:34 AM
Final Approval Date: 08/26/2015		

ANGEL OAKS



PERIMETER FIELD NOTE DESCRIPTION FOR 5.085 ACRES

Being a 5.349 acre tract of land out of the William Dugan Survey, Abstract No. 190, in Williamson County, Texas, same being that tract of land conveyed to Robert J. Jordan and Bette S. Jordan by warranty deed recorded in Volume 1527, Page 262 of the Official Records of Williamson County, and being more particularly described by metes and bounds as follows:

BEGINNING at a 1/2" iron rebar found on the south right of way line of Oak Meadow Drive, same being the northwest corner of a tract conveyed to Brandon and Christy Cates in Document No. 2013052016, Official Public Records, Williamson County, Texas for the northeast corner hereof;

THENCE along the west property line of the said Cates tract S 20°09'24" E, a distance of 795.20 feet to a 1/2" iron rebar found in the north line of a tract conveyed to Fern Bluff municipal Utility district in Document No. 2004079127, Official Public Records, Williamson County, Texas, for the southwest corner of the said Cates tract and the southeast corner hereof;

THENCE along the north line of the said Fern Bluff tract the following three courses:
1) S 83°28'30" W, a distance of 65.46 feet to a nail found for an angle point;
2) S 78°42'04" W, a distance of 85.75 feet to a nail found for an angle point;
3) S 75°33'44" W, a distance of 157.60 feet to a 1/2" iron rebar found for the southeast corner of a tract conveyed to Williamson County Municipal Utility District No. 2 in Volume 832, Page 220, Official Records, Williamson County, Texas, and the southwest corner hereof;

THENCE along the west line of the herein described tract N 20°10'41" W, a distance of 741.02 feet to a 1/2" iron rebar found in the south right of way line of said Oak Meadow Drive for the northeast corner of a tract conveyed to Ron L. Imken in Volume 756, Page 221, Official Records, Williamson County, Texas, and the northwest corner hereof;

THENCE along the south right of way line of said Oak Meadow Drive along a curve to the left having a radius of 251.85 feet, a chord bearing N 69°48'29" E, a chord distance of 33.38 feet to a spindle set in the south right of way line of said Oak Meadow Drive;

THENCE along the south right of way line of said Oak Meadow Drive N 67°46'34" E, a distance of 272.23 feet to the PLACE OF BEGINNING, containing 5.349 acres of land, more or less.

WILLIAMSON COUNTY AND CITIES HEALTH DISTRICT

Based upon the above representations of the engineer or surveyor whose seal is affixed hereto, and after review of the survey as represented by the said engineer or suveyor, I find that this blue line (survey) complies with the requirements of Edwards Aquifer Regulations for Williamson County and Williamson County On-Site Sewage Facility Regulations. This certification is made solely upon such representations and should not be relied upon for verification of the facts alleged. The Williamson County and Cities Health District (WCCHD) and Williamson County disclaim any responsibility to any member of the public for independent verification of the representations, factual or otherwise, contained in this blue line (survey) and the documents associated with it.

Deborah L. Marlow, R.S. Date: 7/27/2015
Deborah L. Marlow, RS, OS0029596
Assistant Deputy Director, Environmental Health Services, WCCHD

OWNER'S CONSENT

That PAUL H. MILLER and CARMEN MILLER, owners of 5.349 acres of land out of the William Dugan Survey, Abstract No. 190, in Williamson County, Texas, conveyed to us by instrument of record in Document Number 2014092261 of the Official Public Records of Williamson County, Texas, do hereby resubdivide said lots to be known as:

ANGEL OAKS

and do hereby dedicate to the public use of the streets and easements as shown thereon. Subject to any easements and restrictions heretofore granted and not released.

WITNESS MY HAND this the 17 day of August, 2015, A.D.

Paul H. Miller
PAUL H. MILLER
3703 OAK MEADOW DRIVE
ROUND ROCK, TEXAS 78681

NOTARY'S CERTIFICATE

Before me, the undersigned authority, on this day personally appeared PAUL H. MILLER, known by me to be the persons whose name is subscribed to the foregoing instrument and acknowledged to me that they executed the same for the purposes and considerations expressed therein.

GIVEN UNDER MY HAND AND SEAL OF OFFICE this the 17 day of August, 2015 A.D.

Jaclyn Guerra
Notary Public In and For the State of Texas
Jaclyn Guerra
Printed Name of Notary
My Commission Expires: 06-27-2016

JACLYN GUERRA
Notary Public
STATE OF TEXAS
My Comm. Exp. 06-27-16

WITNESS MY HAND this the 17 day of August, 2015, A.D.

Carmen Miller
CARMEN MILLER
3703 OAK MEADOW DRIVE
ROUND ROCK, TEXAS 78681

NOTARY'S CERTIFICATE

Before me, the undersigned authority, on this day personally appeared CARMEN MILLER, known by me to be the persons whose name is subscribed to the foregoing instrument and acknowledged to me that they executed the same for the purposes and considerations expressed therein.

GIVEN UNDER MY HAND AND SEAL OF OFFICE this the 17 day of August, 2015 A.D.

Jaclyn Guerra
Notary Public In and For the State of Texas
Jaclyn Guerra
Printed Name of Notary
My Commission Expires: 06-27-2016

JACLYN GUERRA
Notary Public
STATE OF TEXAS
My Comm. Exp. 06-27-16

This tract is located within the Edwards Aquifer Recharge Zone.

SURVEYOR'S CERTIFICATE

I, Victor M. Garza, am Registered in the State of Texas to practice the profession of land surveying, and do hereby certify that this plat complies with the rules and regulations of Williamson County, Texas, and that said plat was prepared from a physicall survey of the property under my direct supervision.

Date: 7/21/15
Victor M. Garza
Registered Professional Land Surveyor No.4740,
State of Texas
1404 West North Loop Blvd. Austin, Texas 78756
Phone (512) 458-6969 Fax (512) 458-9845

STATE OF TEXAS
REGISTERED
VICTOR M. GARZA
4740
PROFESSIONAL
LAND SURVEYOR

ROAD NAME AND 911 ADDRESSING

Road name and address assignments verified this the 24th day of August 2015 A.D.

Teresa Baker
Williamson County Addressing Coordinator

ENGINEER'S CERTIFICATION

I, Kurt M. Prossner, P.E., a licensed professional engineer, licensed in the State of Texas, hereby certify the the proper engineering considerations have been given to this lot and that it meets the requirements of Williamson County, Texas.

Kurt M. Prossner, P.E. No. 58191
Prossner and Associates, Inc.
13377 Pond Springs Road, Suite 104
Austin, Tx 78729
(512)918-3343 (512)918-2431(fax)
7/21/15 Date

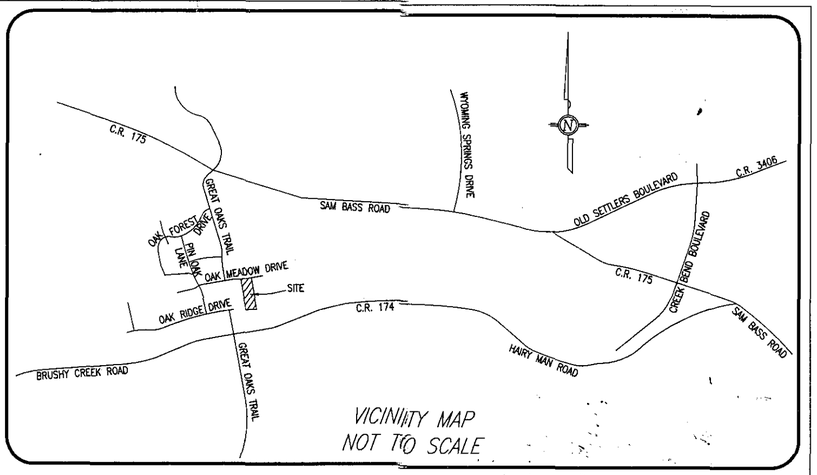
STATE OF TEXAS
KURT M. PROSSNER
58191
LICENSED
PROFESSIONAL ENGINEER

FLOODPLAIN CERTIFICATION

Part of the subject property lies within a floodplain or flood prone area or a flood way of any body of water per the Federal Emergency Management Agency Rate Map, Communlity F.I.R.M. map prepared for Williamson County, Dated *Effective September 26, 2008 as shown on Community Panel No. 481079 0490E. The 100 year floodplain will be* contained within the drainage easement shown hereon.

Kurt M. Prossner, P.E. No. 58191
Prossner and Associates, Inc.
13377 Pond Springs Road, Suite 104
Austin, Tx 78729
(512)918-3343 (512)918-2431(fax)
7/21/15 Date

STATE OF TEXAS
KURT M. PROSSNER
58191
LICENSED
PROFESSIONAL ENGINEER



NOTES

1. Water service for this subdivision will be provided by Aqua America. Sewer service for this subdivision will be provided by On-Site Sewage Facilities.
2. Wastewater service will be provided by on-site sewage facilities which must be designed by a Registered Professional Engineer or Registered Sanitarian. An on-site wastewater disposal system for each lot to be designed at site plan land use phase. Such system to be approved by Williamson County and Cities Health District. Upon availability of an organized sewage collection system each lot will be connected and abandon the on-site system.
3. Water and wastewater systems shall conform to the Texas Commission on Environmental Quality (TCEQ). The owner(s) understand and acknowledge that plat vacation or replatting may be required at owner(s) sole expense if plans to develop this subdivision do not comply with such codes and requirements.
4. No construction in the subdivision may begin until the Texas Commission on Environmental Quality (TCEQ) has approved the Water Pollution Abatement Plan (WPAP) in writing.
5. This certificate is valid until such time as FEMA revises or newly adopts floodplain boundaries in this area. A Floodplain Development Permit must be obtained from the Williamson County Flood Plain Administrator for Lot 2 prior to any construction or development.
6. If driveway culverts are required, the culvert must be designed and certified by a Registered Professional Engineer.
7. Rural mailboxes shall be set three feet from the edge of the pavement. Any mailbox that does not meet this requirement may be removed by Williamson County.
8. A de facto certificate of compliance is hereby issued for Lot 1 in this subdivision. No structure or land within this lot shall hereafter be located or altered without first obtaining a Development Permit from the williamson County Floodplain Administrator. The minimum lowest finished floor elevation shall be one foot higher than the highest spot elevation that is located within five feet outside the perimeter of the building, or 757 feet above Mean Sea Level, whichever is higher. The minimum finished first floor elevation for Lot 2 shown on this plat was determined by adding two (2) feet to the base flood elevation (BFE) as determined from the flood insurance study prepared by the Federal Emergency Management Agency (FEMA) dated September 26, 2008.
9. Lot 2 may not be further subdivided.

It is the responsibility of the owner, not the County, to assure compliance with the provisions of all applicable state, federal and local laws and regulations relating to the platting and development of this property.

The county assumes no reponsibility for the accuracy of representations by other parties in this plat. Floodplain data, in particular, may change.

STATE OF TEXAS §
KNOW ALL MEN BY THESE PRESENTS:
COUNTY OF WILLIAMSON §

I, Dan A. Gattis, County Judge of Williamson County, Texas, do hereby certify that this map or plat, that a dubdivision having been fully presented to the Commissioner's Court of Williamson County, Texas, and by the said Court duly considered, were on this day approved and plat is authorized to be registered and recorded in the proper records of the County Clerk of Williamson County, Texas.

Dan A. Gattis, County Judge Date
Williamson County, Texas

STATE OF TEXAS §
KNOW ALL MEN BY THESE PRESENTS:
COUNTY OF WILLIAMSON §

I, Nancy Rister, Clerk of the County Court of Williamson County, Texas, do hereby certify that he foregoing instrucment in writing, with its certificate of authentification was filed for record in my office on the _____ day of _____, 20___, A.D., at _____o'clock ___m., and duly recorded this the _____ day of _____, 20___, A.D., at _____o'clock, ___m. in the Plat Records of said county in Document Number _____.

WITNESS MY HAND AND SEAL OF OFFICE of the County Court of said County, this the ____ day of _____, 20___, A.D.

NANCY RISTER, CLERK COUNTY COURT, WILLIAMSON COUNTY., TEXAS

By: _____
Deputy

REVISED: 07/20/15
REVISED: 06/24/15
JOB #: B1208614_PLAT
DATE: 02/13/15
SCALE: 1"= 100'

B & G SURVEYING, LLC
FIRM REGISTRATION NO. 100363-00
WWW.BANDGSURVEY.COM
1404 West North Loop Blvd.
Austin, Texas 78756
Office 512*458-6969, Fax 512*458-9845

Commissioners Court - Regular Session **13.**

Meeting Date: 09/01/2015

Discuss consider and take appropriate action on approval of the revised preliminary plat for the Paloma Lake subdivision - Pct 4

Submitted For: Joe England **Submitted By:** Patrick Hughes, Unified Road System

Department: Unified Road System

Agenda Category: Consent

Information

Agenda Item

Discuss, consider and take appropriate action on approval of the revised preliminary plat for the Paloma Lake subdivision - Pct 4.

Background

The preliminary plat for Paloma Lake has been revised to eliminate a short, redundant piece of proposed road in Section 26, located immediately east of the planned Paloma Lake Boulevard. This change also required the slight reconfiguration of 23 lots in the immediate vicinity. The attached drawing shows the small road that was eliminated, and the 23 lots that were reconfigured.

Fiscal Impact

From/To	Acct No.	Description	Amount

Attachments

Revised Preliminary Plat - Paloma Lake

Proposed Prelim Plat Change - Paloma Lake

Form Review

Inbox	Reviewed By	Date
County Judge Exec Asst.	Wendy Coco	08/26/2015 11:16 AM
Form Started By: Patrick Hughes		Started On: 08/25/2015 12:04 PM
Final Approval Date: 08/26/2015		

REVISED PRELIMINARY PLAN OF

PALOMA LAKE

WILLIAMSON COUNTY, TEXAS

SCALE: 1"=200'

0 200' 400' 600' 800'



LOCATION MAP

LEGEND:

- ● = FOUND 1/2" IRON ROD
- ○ = SET 1/2" IRON ROD

PUE = PUBLIC UTILITY EASEMENT
DE = DRAINAGE AND STORM SEWER EASEMENT
WWE = WASTE WATER EASEMENT
ROW = RIGHT OF WAY

(XX) = BLOCK NUMBER
(X) = PHASE NUMBER
= PHASE LINE
= PORTIONS OF RIGHT-OF-WAY TO BE ABANDONED
= SECTIONS RECORDED, UNDER CONSTRUCTION OR UNDER DESIGN (NO CHANGES)

OPRWC = OFFICIAL PUBLIC RECORDS OF WILLIAMSON COUNTY, TEXAS

NOTES:

1. SIDEWALKS SHALL BE CONSTRUCTED IN ACCORDANCE WITH CHAPTER 36, SUBDIVISIONS, CITY OF ROUND ROCK CODE OF ORDINANCES, 2010 1995 EDITION, AS AMENDED AND WITH THE DESIGN AND CONSTRUCTION STANDARDS. SUBDIVISION DEED RESTRICTIONS SHALL INCLUDE THE REQUIREMENT THAT THE PROPERTY OWNERS OR THE HOMEOWNERS ASSOCIATION SHALL BE RESPONSIBLE FOR THE MAINTENANCE OF ALL SIDEWALKS WHICH ARE LOCATED ADJACENT TO THEIR PROPERTY LYING OUTSIDE THE ROUND ROCK CITY LIMITS.

2. NO OBSTRUCTIONS, INCLUDING BUT NOT LIMITED TO FENCING OR STORAGE, SHALL BE PERMITTED IN ANY DRAINAGE EASEMENTS SHOWN HEREON.

3. A PUBLIC UTILITY EASEMENT 10 FEET WIDE ABUTTING AND ALONG THE STREET SIDE PROPERTY LINE IS HEREBY DEDICATED FOR ALL STREET SIDE PROPERTY LOTS SHOWN HEREON.

4. SUBDIVISION WALLS SHALL BE LOCATED AND CONSTRUCTED IN ACCORDANCE WITH CHAPTER 36, SUBDIVISIONS, CITY OF ROUND ROCK CODE OF ORDINANCES, 2010 EDITION, AS AMENDED. MAINTENANCE SHALL BE PROVIDED BY THE HOA OR THE MUD.

5. THIS PLAN CONFORMS TO THE CONCEPT PLAN APPROVED BY THE PLANNING AND ZONING COMMISSION AUGUST 17, 2005.

6. FLOOD PLAIN NOTE: A PART OF THIS PLAT LIES WITHIN THE LIMITS OF THE 1% ANNUAL CHANCE FLOOD PLAIN ACCORDING TO FEMA MAP 48491C0515E EFFECTIVE SEPT. 2008.

7. SECTION 13 IS LIMITED TO A MAXIMUM 39 SINGLE FAMILY LOTS.

8. CONDITIONAL FINAL PLAT APPROVAL SHALL NOT BE GIVEN UNTIL ALL REQUIRED JURISDICTIONS HAVE APPROVED THE REMOVAL OF LOTS FROM THE 1% ANNUAL CHANCE FLOODPLAIN IN SECTIONS 25 AND 26.

9. PEDESTRIAN TRAILS SHALL BE PROVIDED IN ACCORDANCE WITH THE GAME PLAN 2020 TRAILS MASTER PLAN, ADOPTED IN 2009 AND RIGHTS OF PUBLIC ACCESS SHALL BE PROVIDED.

10. PRIOR TO FINAL PLAT APPROVAL OF ANY LOTS ADJACENT TO THE SEMINOLE PIPELINE, VERIFICATION OF COMPLIANCE SHALL BE IN ACCORDANCE WITH THE APPROPRIATE STATE AUTHORITY.

11. NO FENCES, STRUCTURES, STORAGE, OR FILL SHALL BE PLACED WITHIN THE LIMITS OF THE ULTIMATE 1% ANNUAL CHANCE FLOODPLAIN, UNLESS APPROVED BY THE CITY ENGINEER AND THE COUNTY ENGINEER. FILL MAY ONLY BE PERMITTED BY THE CITY ENGINEER AFTER APPROVAL OF THE PROPER ANALYSIS.

12. A LOT TABLE SPECIFYING LOT SIZE IN SQUARE FEET FOR ALL RESIDENTIAL LOTS HAS BEEN INCLUDED ON THE PREVIOUS RECORDED PLATS AND SHALL BE INCLUDED ON THE FINAL PLAT FOR EVERY SECTION.

13. LANDSCAPE LOTS, AMENITY LOTS AND OPEN SPACE LOTS / DRAINAGE LOTS SHALL BE CONVEYED TO AND MAINTAINED BY THE HOMEOWNERS ASSOCIATION OR THE APPROPRIATE MUNICIPAL UTILITY DISTRICT.

14. THE FOUR COMMERCIAL SECTIONS WILL BE PLATTED WITH ONE OR MORE UNIQUE PHASE NUMBERS, BUT AT THE TIME OF PRELIMINARY PLATTING, THE TIMING AND SEQUENCE CANNOT BE DETERMINED.

DEVELOPER:
BLAKE MAGEE COMPANY
ATTN: BLAKE MAGEE
1011 N. LAMAR
AUSTIN, TEXAS 78703
512-481-0303 FAX: 512-481-0333

PATENT SURVEYS:
WILLIS DONAHO, JR. SURVEY, ABSTRACT No. 173;
THOMAS GLASSCOCK SURVEY, ABSTRACT No. 255;
JOHN L. JUSTICE SURVEY, ABSTRACT No. 356;
HENRY MILLARD SURVEY, ABSTRACT No. 452;
WILLIAM DUNN SURVEY, ABSTRACT No. 186; AND
ROBERT McNUTT SURVEY, ABSTRACT No. 422

TOTAL AREA OF THIS PLAT: 757.47 ACRES

BENCH MARK:
BRASS DISK H.A.R.N MONUMENT ROUND ROCK 01-039
SET IN CONC - AT NW CORNER OF THIS PLAT
ELEVATION = 713.58' NAVD 88

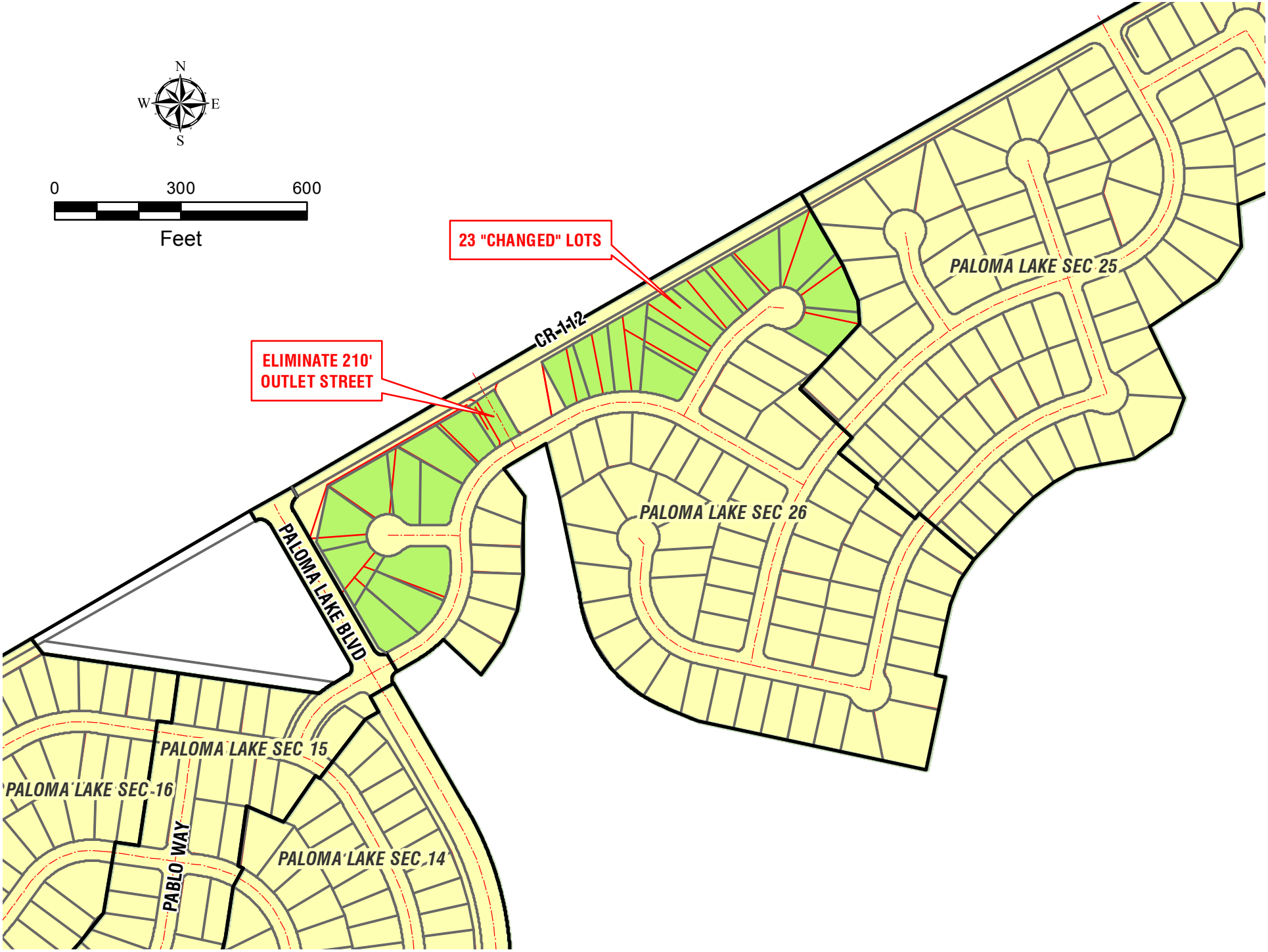
No.	DATE	DESCRIPTION	BY
2	6/16/15	REMOVE EXTENSION TO CR 112 FROM SECTION 26	DM
1	5/1/13	REMOVE EXTENSION TO CR 110 FROM SECTION 20B	DM

REVISIONS

DATE: JUNE 16, 2015 SCALE: 1" = 200'

RANDALL JONES & ASSOCIATES ENGINEERING, INC.
1212 E. BRAKER LANE, AUSTIN, TEXAS 78753
(512) 836-4793 FAX: (512) 836-4817 F-9784

RJ SURVEYING & ASSOCIATES, INC.
1212 E. BRAKER LANE, AUSTIN, TEXAS 78753
(512) 836-4793 FAX: (512) 836-4817 F-10015400


N
W
E
S
0
300
600
Feet
23 "CHANGED" LOTS
ELIMINATE 210' OUTLET STREET
CR-112
PALOMA LAKE SEC 25
PALOMA LAKE SEC 26
PALOMA LAKE BLVD
PALOMA LAKE SEC 15
PALOMA LAKE SEC 16
PABLO WAY
PALOMA LAKE SEC 14

Commissioners Court - Regular Session **14.**

Meeting Date: 09/01/2015

Discuss consider and take appropriate action on approval of the final plat for the Paloma Lake Section 12 subdivision - Pct 4

Submitted For: Joe England **Submitted By:** Patrick Hughes, Unified Road System

Department: Unified Road System

Agenda Category: Consent

Information

Agenda Item

Discuss, consider and take appropriate action on approval of the final plat for the Paloma Lake Section 12 subdivision - Pct 4.

Background

This is the next section of the Paloma Lake development. It consists of 68 single-family lots and 2,650 feet of new public roadway. Construction of this section is not yet complete, but a performance bond in the amount of $185,841.28 has been posted with the County to cover the cost of the remaining construction.

Fiscal Impact

From/To	Acct No.	Description	Amount

Attachments

Final Plat - Paloma Lake Sec 12

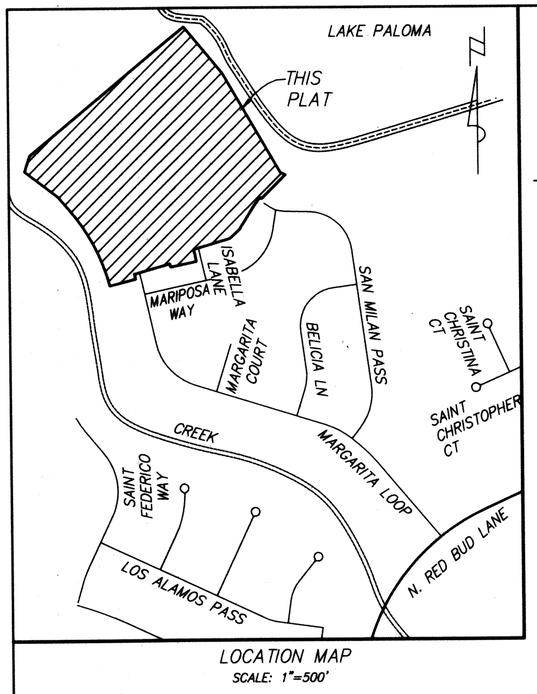
Form Review

Inbox	Reviewed By	Date
County Judge Exec Asst.	Wendy Coco	08/26/2015 11:16 AM
Form Started By: Patrick Hughes		Started On: 08/25/2015 01:14 PM
Final Approval Date: 08/26/2015		

PLAT OF
PALOMA LAKE SECTION 12
WILLIAMSON COUNTY, TEXAS

SCALE: 1"=100'

0 100' 200' 300' 400'



LOCATION MAP
SCALE: 1"=500'

LEGEND:
- o = SET 1/2" IRON ROD WITH RJ SURVEYING CAP
- DE = DRAINAGE AND STORM SEWER EASEMENT
- PUE = PUBLIC UTILITY EASEMENT
- PRWC = PLAT RECORDS OF WILLIAMSON COUNTY
- OPRWC = OFFICIAL PUBLIC RECORDS OF WILLIAMSON COUNTY, TEXAS
- (X) = BLOCK NAME
- ---------- = LIMITS OF FEMA ZONE A – 1% ANNUAL CHANCE FLOODPLAIN ACCORDING TO FLOOD INSURANCE RATE COMMUNITY PANEL NUMBER 48491C0515E EFFECTIVE SEPTEMBER 26, 2008 FOR WILLIAMSON COUNTY, TEXAS.

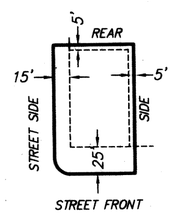
NEW STREETS:

NAME	LENGTH	DESIGN SPEED	ROW WIDTH
ISABELLA LANE	703	25	50
MARGARITA LOOP	1242	25	50
SAN MILAN PASS	705	25	50
TOTAL	2650		

EASEMENTS:
IN ADDITION TO THOSE EASEMENTS SHOWN HEREON
A PUBLIC UTILITY EASEMENT 10 FEET WIDE IS HEREBY DEDICATED ADJACENT TO ALL STREET RIGHTS-OF-WAY
A PUBLIC UTILITY EASEMENT 5 FEET WIDE IS HEREBY DEDICATED ALONG EACH SIDE OF ALL SIDE LOT LINES
A PUBLIC UTILITY EASEMENT 5 FEET WIDE IS HEREBY DEDICATED ALONG EACH SIDE OF ALL REAR LOT LINES

NOTES:

1. ALL PUBLIC ROADWAYS AND EASEMENTS AS SHOWN ON THIS PLAT ARE FREE OF LIENS.
2. THE BUILDING SLAB ELEVATION SHALL BE ONE (1) FOOT ABOVE ANY POINT ON THE LOT WITHIN FIVE (5) FEET OF THE PERIMETER OF THE BUILDING.
3. NO LOT IN THIS SUBDIVISION SHALL BE OCCUPIED UNTIL CONNECTION IS MADE TO AN APPROVED PUBLIC SEWER SYSTEM.
4. NO LOT IN THIS SUBDIVISION SHALL BE OCCUPIED UNTIL WATER SATISFACTORY FOR HUMAN CONSUMPTION IS AVAILABLE FROM A SOURCE IN ADEQUATE AND SUFFICIENT SUPPLY.
5. NO STRUCTURE OR LAND IN THIS PLAT SHALL HEREAFTER BE LOCATED OR ALTERED WITHOUT FIRST OBTAINING A CERTIFICATE OF COMPLIANCE FROM THE WILLIAMSON COUNTY FLOOD PLAIN ADMINISTRATOR.
6. ALL SIDEWALKS WITHIN THIS SUBDIVISION ARE TO BE MAINTAINED BY PALOMA LAKE M. U. D. No. 1. OR THE HOMEOWNERS ASSOCIATION.
7. RESIDENTIAL DRIVEWAYS ARE TO BE LOCATED NO CLOSER TO THE CORNER OF INTERSECTING RIGHTS-OF-WAY THAN 60 PERCENT OF PARCEL FRONTAGE OR 50 FEET, WHICHEVER IS LESS.
8. NO PORTION OF THIS TRACT IS ENCROACHED BY THE 1% ANNUAL CHANCE FLOODPLAIN AS IDENTIFIED BY THE U. S. FEDERAL EMERGENCY MANAGEMENT AGENCY BOUNDARY MAP (FLOOD INSURANCE RATE MAP) COMMUNITY PANEL NUMBER 48491C0515E, EFFECTIVE DATE SEPTEMBER 26, 2008, FOR WILLIAMSON COUNTY, TEXAS. NO SINGLE FAMILY LOT IS ENCROACHED BY THE 1% ANNUAL CHANCE FLOODPLAIN. NO PORTION OF THIS TRACT IS ENCROACHED BY THE ULTIMATE 1% ANNUAL CHANCE FLOODPLAIN.
9. WATER SERVICE WILL BE PROVIDED BY THE PALOMA LAKE M. U. D. No. 1.
10. SEWER SERVICE WILL BE PROVIDED BY THE PALOMA LAKE M. U. D. No. 1.
11. LOT 49, BLOCK X, IS FOR OPEN SPACE PURPOSES AND WILL BE MAINTAINED BY THE HOMEOWNERS ASSOCIATION. NO SINGLE FAMILY RESIDENCE IS PERMITTED ON THIS LOT.



SETBACKS

OWNER:
M/I HOMES OF AUSTIN, LLC, AN OHIO LIMITED LIABILITY COMPANY
WILLIAM G. PECKMAN, AUSTIN AREA PRESIDENT
1301 S. CAPITOL OF TEXAS HIGHWAY B-315
AUSTIN, TEXAS 78746

ACREAGE: 18.11 ACRES
68 SINGLE FAMILY LOTS
1 OPEN SPACE LOT
3 BLOCKS
WILLIS DONAHO SURVEY, ABSTRACT No. 173

PALOMA LAKE DEVELOPMENT, INC. REMAINDER OF 144.97 ACRES DOCUMENT No. 2007017059 OPRWC

LIMITS OF FEMA ZONE A – 1% ANNUAL CHANCE FLOODPLAIN ACCORDING TO FLOOD INSURANCE RATE COMMUNITY PANEL NUMBER 48491C0515E EFFECTIVE SEPTEMBER 26, 2008 FOR WILLIAMSON COUNTY, TEXAS.

LOT 54, BLOCK E PALOMA LAKE SECTION 6 CABINET GG, SLIDE 224 PRWC

PALOMA LAKE SECTION 11 DOC. No. 2014048966 OPRWC

SAN MILAN PASS

MARGARITA LOOP

ISABELLA LANE

MARIPOSA WAY

SAINT FEDERICO WAY

POINT OF BEGINNING

APPROXIMATELY N09°08'11"W 6865.01' TO SE CORNER OF WILLIS DONAHO SURVEY & NE CORNER OF JOSEPH MARSHALL SURVEY

LAKE PALOMA

DATE: OCT. 1, 2014 SCALE: 1" = 100'

RANDALL JONES & ASSOCIATES ENGINEERING, INC.
1212 E. BRAKER LANE, AUSTIN, TEXAS 78753
(512) 836-4793 FAX: (512) 836-4817 F-9784

RJ SURVEYING & ASSOCIATES, INC.
1212 E. BRAKER LANE, AUSTIN, TEXAS 78753
(512) 836-4793 FAX: (512) 836-4817 F-10015400

S:\LAND2251-2300\2260\dwg\2260-plat.dwg 10/1/2014 4:38:40 PM CDT

PLAT OF

PALOMA LAKE SECTION 12

WILLIAMSON COUNTY, TEXAS

CURVE TABLE					
CURVE	LENGTH	RADIUS	DELTA	CHORD BRNG.	CHORD
C1	416.62	884.00	27°00'11"	N27°54'33"W	412.78
C2	9.74	180.00	3°06'00"	N55°30'35"W	9.74
C3	23.73	300.00	4°31'53"	S14°27'24"E	23.72
C4	24.04	1009.00	1°21'53"	S15°05'24"E	24.03
C5	69.66	884.00	4°30'54"	N16°39'55"W	69.64
C6	73.81	884.00	4°47'03"	N21°18'54"W	73.79
C7	69.22	884.00	4°29'12"	N25°57'01"W	69.21
C8	69.12	884.00	4°28'49"	N30°26'02"W	69.11
C9	69.12	884.00	4°28'49"	N34°54'51"W	69.11
C10	65.68	884.00	4°15'24"	N39°16'57"W	65.66
C11	451.50	1009.00	25°38'18"	N28°35'30"W	447.74
C12	473.87	1059.00	25°38'18"	N28°35'30"W	469.93
C13	76.51	1009.00	4°20'41"	N16°45'02"W	76.49
C14	84.79	1009.00	4°48'54"	N21°19'49"W	84.77
C15	78.47	1009.00	4°27'21"	N25°57'57"W	78.45
C16	78.90	1009.00	4°28'49"	N30°26'02"W	78.88
C17	78.90	1009.00	4°28'49"	N34°54'51"W	78.88
C18	74.96	1009.00	4°15'24"	N39°16'57"W	74.95
C19	70.01	1059.00	3°47'17"	N17°39'59"W	70.00
C20	77.40	1059.00	4°11'16"	N21°39'15"W	77.38
C21	73.91	1059.00	3°59'56"	N25°44'51"W	73.90
C22	73.77	1059.00	3°59'29"	N29°44'34"W	73.76
C23	73.77	1059.00	3°59'29"	N33°44'03"W	73.76
C24	73.77	1059.00	3°59'29"	N37°43'32"W	73.76
C25	31.23	1059.00	1°41'22"	N40°33'58"W	31.23
C26	40.09	25.00	91°52'17"	N04°31'30"E	35.93
C27	21.03	25.00	48°11'23"	N65°30'20"W	20.41
C28	164.28	50.00	188°15'03"	N04°31'30"E	99.74
C29	41.19	50.00	47°11'43"	N66°00'11"W	40.03
C30	52.25	50.00	59°52'46"	N12°27'56"W	49.91
C31	58.77	50.00	67°20'44"	N51°08'49"E	55.44
C32	12.07	50.00	13°49'50"	N88°15'54"W	12.04
C33	21.03	25.00	48°11'23"	N74°33'20"E	20.41
C34	111.47	505.71	12°37'44"	N23°02'12"W	111.24
C35	79.25	505.71	8°58'45"	N21°12'43"W	79.17
C36	32.21	505.71	3°38'59"	N27°31'34"W	32.21
C37	122.49	555.71	12°37'44"	N23°02'12"W	122.24
C38	51.88	555.71	5°20'57"	N19°23'49"W	51.86
C39	62.01	555.71	6°23'36"	N25°16'05"W	61.98
C40	8.60	555.71	0°53'11"	N28°54'28"W	8.60
C41	86.32	1588.13	3°06'51"	N30°54'29"W	86.31
C42	10.50	1588.13	0°22'44"	N29°32'26"W	10.50
C43	65.45	1588.13	2°21'40"	N30°54'38"W	65.44
C44	10.37	1588.13	0°22'27"	N32°16'41"W	10.37
C45	89.03	1638.13	3°06'51"	N30°54'29"W	89.02
C46	27.41	1638.13	0°57'31"	N29°49'49"W	27.41
C47	61.63	1638.13	2°09'20"	N31°23'15"W	61.62
C48	54.39	440.55	7°04'27"	N36°00'08"W	54.36
C49	60.57	490.55	7°04'27"	N36°00'08"W	60.53
C50	23.56	15.00	90°00'00"	N84°32'22"W	21.21
C51	23.56	15.00	90°00'00"	N05°27'38"E	21.21
C52	98.79	230.00	24°36'31"	N41°39'20"W	98.03
C53	76.82	230.00	19°08'13"	N44°23'29"W	76.46
C54	21.97	230.00	5°28'19"	N32°05'13"W	21.96
C55	77.31	180.00	24°36'31"	N41°39'20"W	76.72
C56	40.27	180.00	12°49'04"	N50°39'03"W	40.18
C57	46.78	180.00	14°53'27"	N36°47'47"W	46.65
C58	124.35	2287.98	3°06'51"	N30°54'29"W	124.34
C59	76.53	2287.98	1°54'59"	N30°18'33"W	76.52
C60	47.83	2287.98	1°11'52"	N31°51'59"W	47.83
C61	127.07	2337.98	3°06'51"	N30°54'29"W	127.05
C62	65.80	2337.98	1°36'45"	N30°09'27"W	65.80
C63	61.27	2337.98	1°30'05"	N31°42'52"W	61.27
C64	42.36	25.00	97°04'27"	N81°00'08"W	37.47
C65	21.03	25.00	48°11'23"	N08°22'13"W	20.41
C66	168.82	50.00	193°27'13"	N81°00'08"W	99.31
C67	35.01	50.00	40°06'48"	N04°19'56"W	34.29
C68	58.98	50.00	67°35'06"	N58°10'53"W	55.62
C69	74.84	50.00	85°45'19"	N45°08'55"E	68.04
C70	21.03	25.00	48°11'23"	N26°21'57"E	20.41
C71	6.37	25.00	14°35'17"	N09°33'54"E	6.35
C72	14.66	25.00	33°36'06"	N33°39'35"E	14.45

A PARCEL OF LAND IN WILLIAMSON COUNTY, TEXAS, BEING A PART OF THE WILLIS DONAHO SURVEY, ABSTRACT No. 173, AND BEING A PART OF THAT 47.78-ACRE TRACT OF LAND CONVEYED TO M/I HOMES OF AUSTIN, LLC, BY DEED RECORDED IN DOCUMENT NO. 2013020779 OF THE OFFICIAL PUBLIC RECORDS OF WILLIAMSON COUNTY, TEXAS, AND BEING MORE PARTICULARLY DESCRIBED AS FOLLOWS:

BEGIN AT A 1/2" IRON ROD SET AT THE NORTHWEST CORNER OF LOT 19, BLOCK X, PALOMA LAKE SECTION 11, ACCORDING TO THE PLAT THEREOF RECORDED IN DOCUMENT No. 2014048968 OF THE OFFICIAL PUBLIC RECORDS OF WILLIAMSON COUNTY, TEXAS, IN THE NORTHEASTERLY LINE OF LOT 54, BLOCK E, PALOMA LAKE SECTION 6, ACCORDING TO THE PLAT THEREOF RECORDED IN CABINET GG, SLIDE 224 OF THE PLAT RECORDS OF WILLIAMSON COUNTY, TEXAS, AND IN THE WESTERLY LINE OF SAID 47.78 ACRE TRACT;

THENCE ALONG THE WESTERLY LINE OF SAID 47.78 ACRE TRACT THE FOLLOWING THREE COURSES:

1. NORTHWESTERLY ALONG THE ARC OF A CURVE TO THE LEFT A DISTANCE OF 416.62 FEET TO A 1/2" IRON ROD SET, SAID CURVE HAVING A RADIUS OF 884.00 FEET TO A 1/2" IRON ROD SET, A CENTRAL ANGLE OF 27°00'11", AND A CHORD BEARING N.27°54'34"W., 412.78 FEET TO A 1/2" IRON ROD SET TO A 1/2" IRON ROD SET;
2. N.41°24'39"W. A DISTANCE OF 69.50 FEET TO A 1/2" IRON ROD SET;
3. N.52°44'27"W. A DISTANCE OF 192.70 FEET TO A 1/2" IRON ROD SET;

THENCE ALONG THE NORTH LINE OF SAID 47.78 ACRE TRACT THE FOLLOWING TWO COURSES:

1. N.17°51'53"E. A DISTANCE OF 78.37 FEET TO A 1/2" IRON ROD SET;
2. THENCE N.50°27'38"E. A DISTANCE OF 935.58 FEET TO A 1/2" IRON ROD SET TO THE NORTHEAST CORNER OF SAID 47.78 ACRE TRACT;

THENCE ALONG THE EAST LINE OF SAID 47.78 ACRE TRACT THE FOLLOWING THREE COURSES:

1. S.39°32'22"E. A DISTANCE OF 279.05 FEET TO A 1/2" IRON ROD SET TO A 1/2" IRON ROD SET;
2. THENCE S.29°53'39"E. A DISTANCE OF 535.22 FEET TO A 1/2" IRON ROD SET;
3. THENCE S.64°41'57"E. A DISTANCE OF 26.96 FEET TO A 1/2" IRON ROD SET AT THE NORTHEAST CORNER OF LOT 58, BLOCK X, PALOMA LAKE SECTION 11;

THENCE ALONG THE NORTHERLY LINE OF SAID PLAT OF PALOMA LAKE SECTION 11 THE FOLLOWING 13 COURSES:

1. S.44°57'57"W. A DISTANCE OF 158.46 FEET TO A 1/2" IRON ROD SET AT A POINT ON A NON-TANGENT CURVE TO THE RIGHT
2. NORTHWESTERLY ALONG THE ARC OF SAID CURVE, A DISTANCE OF 9.74 FEET, SAID CURVE HAVING A RADIUS OF 180.00 FEET, A CENTRAL ANGLE OF 03°06'00" AND A CHORD BEARING N.55°30'35"W., 9.74 FEET TO A 1/2" IRON ROD SET;
3. S.36°02'25"W. A DISTANCE OF 50.00 FEET TO A 1/2" IRON ROD SET;
4. S.32°07'06"W. A DISTANCE OF 125.30 FEET TO A 1/2" IRON ROD SET;
5. S.46°24'17"W. A DISTANCE OF 61.55 FEET TO A 1/2" IRON ROD SET;
6. S.73°16'40"W. A DISTANCE OF 178.22 FEET TO A 1/2" IRON ROD SET AT A POINT ON A NON-TANGENT CURVE TO THE RIGHT;
7. SOUTHERLY ALONG THE ARC OF SAID CURVE, A DISTANCE OF 23.73 FEET, SAID CURVE HAVING A RADIUS OF 300.00 FEET, A CENTRAL ANGLE OF 04°31'53" AND A CHORD BEARING S.14°27'24"E., 23.72 FEET TO A 1/2" IRON ROD SET;
8. S.12°11'28"E. A DISTANCE OF 33.20 FEET TO A 1/2" IRON ROD SET;
9. S.77°48'32"W. A DISTANCE OF 121.78 FEET TO A 1/2" IRON ROD SET;
10. N.18°52'56"W. A DISTANCE OF 16.58 FEET TO A 1/2" IRON ROD SET;
11. S.74°13'39"W. A DISTANCE OF 170.61 FEET TO A 1/2" IRON ROD SET AT A POINT ON A NON-TANGENT CURVE TO THE RIGHT;
12. SOUTHERLY ALONG THE ARC OF SAID CURVE, A DISTANCE OF 24.03 FEET, SAID CURVE HAVING A RADIUS OF 1009.00 FEET A CENTRAL ANGLE OF 01°21'53" AND A CHORD BEARING S.15°05'25"E., 24.03 FEET TO A 1/2" IRON ROD SET;
13. S.75°35'32"W. A DISTANCE OF 125.00 FEET TO THE SAID POINT OF BEGINNING.

CONTAINING 18.11 ACRES

BEARINGS ARE BASED ON THE PLAT OF PALOMA LAKE SECTION 11

LINE TABLE		
LINE	LENGTH	BEARING
L1	50.00'	S36°02'25"W
L2	33.20'	S12°11'28"E
L3	16.58'	N18°52'56"W
L4	93.57'	N41°24'39"W
L5	3.68'	N41°24'39"W
L6	70.86'	N41°24'39"W
L7	19.03'	N41°24'39"W
L8	97.81'	N41°24'39"W
L9	43.60'	N41°24'39"W
L10	54.21'	N41°24'39"W
L11	116.68'	S50°27'38"W
L12	71.00'	N16°43'20"W
L13	11.00'	N16°43'20"W
L14	60.00'	N16°43'20"W
L15	71.00'	N16°43'20"W
L16	60.54'	N16°43'20"W
L17	10.46'	N16°43'20"W
L18	87.45'	N29°21'04"W
L19	37.95'	N29°21'04"W
L20	49.50'	N29°21'04"W
L21	87.45'	N29°21'04"W
L22	53.22'	N29°21'04"W
L23	34.24'	N29°21'04"W
L24	55.00'	N39°32'22"W
L25	55.00'	N39°32'22"W

LINE	LENGTH	BEARING
L26	41.67'	N13°32'52"W
L27	60.01'	N17°39'50"W
L28	35.04'	N17°39'50"W
L29	24.96'	N17°39'50"W
L30	63.47'	N21°55'18"W
L31	58.45'	N27°12'44"W
L32	60.01'	N28°33'55"W
L33	23.67'	N28°33'55"W
L34	36.34'	N28°33'55"W
L35	58.80'	N30°58'52"W
L36	45.95'	N30°58'52"W
L37	12.85'	N30°58'52"W
L38	60.00'	N33°04'17"W
L39	60.04'	N34°37'22"W
L40	9.47'	N34°37'22"W
L41	50.57'	N34°37'22"W
L42	60.03'	N34°24'59"W
L43	32.06'	N34°24'59"W
L44	27.97'	N34°24'59"W
L45	56.53'	N39°48'03"W
L46	46.53'	N39°48'03"W
L47	10.00'	N39°48'03"W
L48	70.01'	N40°32'16"W
L49	125.00'	N66°02'39"E
L50	124.97'	N66°02'39"E

LINE	LENGTH	BEARING
L51	124.81'	N66°02'39"E
L52	84.67'	N27°37'10"W
L53	64.29'	N27°37'10"W
L54	20.37'	N27°37'10"W
L55	74.12'	N29°21'04"W
L56	46.81'	N29°21'04"W
L57	27.31'	N29°21'04"W
L58	70.75'	N30°06'31"W
L59	39.72'	N30°06'31"W
L60	31.03'	N30°06'31"W
L61	70.80'	N32°15'06"W
L62	35.98'	N32°15'06"W
L63	34.82'	N32°15'06"W
L64	71.03'	N32°27'55"W
L65	32.26'	N32°27'55"W
L66	38.77'	N32°27'55"W
L67	71.64'	N32°27'55"W
L68	28.61'	N32°27'55"W
L69	43.03'	N32°27'55"W
L70	72.60'	N33°46'56"W
L71	24.84'	N33°46'56"W
L72	47.76'	N33°46'56"W
L73	82.76'	N35°32'50"W
L74	12.59'	N35°32'50"W
L75	70.17'	N35°32'50"W

DEDICATION

STATE OF TEXAS

KNOW ALL MEN BY THESE PRESENTS

COUNTY OF WILLIAMSON

THAT M/I HOMES OF AUSTIN, LLC, AN OHIO LIMITED LIABILITY COMPANY, AS THE OWNER OF THE CERTAIN 47.78 ACRE TRACT OF LAND RECORDED IN DOCUMENT NUMBER 2013020779 OF THE OFFICIAL PUBLIC RECORDS OF WILLIAMSON COUNTY, TEXAS; DOES HEREBY CERTIFY THAT THERE ARE NO LIEN HOLDERS AND DEDICATES TO THE PUBLIC FOREVER USE OF THE STREETS, EASEMENTS AND ALL OTHER LANDS INTENDED FOR PUBLIC DEDICATION AS SHOWN HEREON TO BE KNOWN AS PALOMA LAKE SECTION 12 AND FURTHER ACKNOWLEDGE THAT IT IS THE RESPONSIBILITY OF THE OWNER, NOT THE COUNTY, TO ASSURE COMPLIANCE WITH THE PROVISIONS OF ALL APPLICABLE STATE, FEDERAL AND LOCAL LAWS AND REGULATIONS RELATING TO THE ENVIRONMENT, INCLUDING (BUT NOT LIMITED TO) THE ENDANGERED SPECIES ACT, STATE AQUIFER REGULATIONS AND MUNICIPAL WATERSHED ORDINANCES.

M/I HOMES OF AUSTIN, LLC, AN OHIO LIMITED LIABILITY COMPANY

BY: _____

WILLIAM G. PECKMAN, AUSTIN AREA PRESIDENT

STATE OF TEXAS

COUNTY OF TRAVIS

THIS INSTRUMENT WAS ACKNOWLEDGED BEFORE ME ON THE 7th DAY OF August, 2015 BY WILLIAM G. PECKMAN, AS AUSTIN AREA PRESIDENT OF M/I HOMES OF AUSTIN. LLC, AN OHIO LIMITED LIABILITY COMPANY ON BEHALF OF SAID M/I HOMES, LLC.

_____

NOTARY PUBLIC SIGNATURE

Austin Wilcher

NOTARY PUBLIC PRINTED OR TYPED NAME

MY COMMISSION EXPIRES: July 16, 2017 SEAL

AUSTIN WILCHER
Notary Public, State of Texas
My Commission Expires
July 16, 2017

ENGINEER'S CERTIFICATION

THE 100-YEAR FLOOD PLAIN IS CONTAINED WITHIN THE DRAINAGE EASEMENTS AS SHOWN HEREON. NO PORTION OF THIS TRACT IS WITHIN THE 100 YEAR FLOOD PLAIN AS SHOWN ON FLOOD INSURANCE RATE COMMUNITY PANEL NUMBER 48491C0515E EFFECTIVE SEPTEMBER 26, 2008 FOR WILLIAMSON COUNTY, TEXAS.

I, R. BRENT JONES, DO HEREBY CERTIFY THAT THE INFORMATION CONTAINED ON THIS PLAT COMPLIES WITH THE SUBDIVISION ORDINANCES AND THE STORMWATER DRAINAGE POLICY ADOPTED BY WILLIAMSON COUNTY, TEXAS.

THIS TRACT IS NOT LOCATED IN THE EDWARDS AQUIFER RECHARGE ZONE

R.B _____ 8/5/15

R. BRENT JONES DATE

LICENSED PROFESSIONAL ENGINEER No. 92671

STATE OF TEXAS
R. BRENT JONES
92671
LICENSED
PROFESSIONAL ENGINEER

SURVEYOR'S CERTIFICATION

I, J. KENNETH WEIGAND, DO HEREBY CERTIFY THAT I PREPARED THIS PLAT FROM AN ACTUAL AND ON THE GROUND SURVEY OF THE LAND SHOWN HEREON AND THAT THE CORNER MONUMENTS SHOWN HEREON WERE PROPERLY PLACED UNDER MY SUPERVISION. THIS PLAT COMPLIES WITH THE REQUIREMENTS OF WILLIAMSON COUNTY. ALL EASEMENTS OF RECORD OF WHICH I HAVE KNOWLEDGE ARE SHOWN OR NOTED ON THE PLAT. THE FIELD NOTES HEREON MATHEMATICALLY CLOSE.

John K. Weigand Aug. 5, 2015

J. KENNETH WEIGAND DATE
R.P.L.S. NO. 5741
STATE OF TEXAS

STATE OF TEXAS
REGISTERED
JOHN KENNETH WEIGAND
5741
PROFESSIONAL
LAND SURVEYOR

IN APPROVING THIS PLAT BY THE COMMISSIONERS' COURT OF WILLIAMSON COUNTY, TEXAS, IT IS UNDERSTOOD THAT THE BUILDING OF ALL STREETS, ROADS, AND OTHER PUBLIC THOROUGHFARES AND ANY BRIDGES OR CULVERTS NECESSARY TO BE CONSTRUCTED OR PLACED IS THE RESPONSIBILITY OF THE OWNERS OF THE TRACT OF LAND COVERED BY THIS PLAT IN ACCORDANCE WITH THE PLANS AND SPECIFICATIONS PRESCRIBED BY THE COMMISSIONERS' COURT OF WILLIAMSON COUNTY, TEXAS. SAID COMMISSIONERS' COURT ASSUMES NO OBLIGATION TO BUILD ANY OF THE STREETS, ROADS, OR OTHER PUBLIC THOROUGHFARES SHOWN ON THIS PLAT OR OF CONSTRUCTING ANY OF THE BRIDGES OR DRAINAGE IMPROVEMENTS IN CONNECTION THEREWITH. THE COUNTY WILL ASSUME NO RESPONSIBILITY FOR DRAINAGE WAYS OR EASEMENTS IN THE SUBDIVISION, OTHER THAN THOSE DRAINING OR PROTECTING THE ROAD SYSTEM AND STREETS.

THE COUNTY ASSUMES NO RESPONSIBILITY FOR THE ACCURACY OF REPRESENTATIONS BY OTHER PARTIES IN THIS PLAT. FLOOD PLAIN DATA, IN PARTICULAR, MAY CHANGE DEPENDING ON SUBSEQUENT DEVELOPMENT. IT IS FURTHER UNDERSTOOD THAT THE OWNERS OF THE TRACT OF LAND COVERED BY THIS PLAT MUST INSTALL AT THEIR OWN EXPENSE ALL TRAFFIC CONTROL DEVICES AND SIGNAGE THAT MAY BE REQUIRED BEFORE THE STREETS IN THE SUBDIVISION HAVE FINALLY BEEN ACCEPTED FOR MAINTENANCE BY THE COUNTY.

STATE OF TEXAS
COUNTY OF WILLIAMSON

KNOW ALL MEN BY THESE PRESENTS;

I, DAN A. GATTIS, COUNTY JUDGE OF WILLIAMSON COUNTY, TEXAS, DO HEREBY CERTIFY THAT THIS MAP OR PLAT, WITH FIELD NOTES HEREON, THAT A SUBDIVISION HAVING BEEN FULLY PRESENTED TO THE COMMISSIONERS' COURT OF WILLIAMSON COUNTY, TEXAS, AND BY THE SAID COURT DULY CONSIDERED, WERE ON THIS DAY APPROVED AND PLAT IS AUTHORIZED TO BE REGISTERED AND RECORDED IN THE PROPER RECORDS OF THE COUNTY CLERK OF WILLIAMSON COUNTY, TEXAS.

_____ _____

DAN A. GATTIS, COUNTY JUDGE DATE
WILLIAMSON COUNTY, TEXAS

STATE OF TEXAS

COUNTY OF WILLIAMSON

I, NANCY RISTER, CLERK OF THE COUNTY COURT OF SAID COUNTY, DO HEREBY CERTIFY THAT THE FOREGOING INSTRUMENT IN WRITING, WITH ITS CERTIFICATION OF AUTHENTICATION, WAS FILED FOR RECORD IN MY OFFICE ON THE ___ DAY OF _____ A. D.. _____, AT ___ O'CLOCK __ M. AND DULY RECORDED ON THE ___ DAY OF _____, A. _____ AT ___ O'CLOCK __ M IN THE OFFICIAL PUBLIC RECORDS OF SAID COUNTY IN DOCUMENT No.

WITNESS MY HAND AND SEAL OF THE COUNTY COURT OF SAID COUNTY, AT OFFICE IN GEORGETOWN, TEXAS, THE DATE LAST WRITTEN ABOVE.

NANCY RISTER, CLERK,
COUNTY COURT WILLIAMSON COUNTY, TEXAS

BY: _____
DEPUTY

DATE: OCT. 1, 2014

RANDALL JONES & ASSOCIATES ENGINEERING, INC.
1212 E. BRAKER LANE, AUSTIN, TEXAS 78753
(512) 836-4793 FAX: (512) 836-4817 F-9784

RJ SURVEYING & ASSOCIATES, INC.
1212 E. BRAKER LANE, AUSTIN, TEXAS 78753
(512) 836-4793 FAX: (512) 836-4817

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Commissioners Court - Regular Session **15.**

Meeting Date: 09/01/2015

Discuss consider and take appropriate action on approval of the revised preliminary plat for the Santa Rita Ranch South subdivision - Pct 2

Submitted For: Joe England **Submitted By:** Patrick Hughes, Unified Road System

Department: Unified Road System

Agenda Category: Consent

Information

Agenda Item

Discuss, consider and take appropriate action on approval of the revised preliminary plat for the Santa Rita Ranch South subdivision - Pct 2.

Background

This preliminary plat is being revised to eliminate a short piece of proposed street located in Section 5A that previously provided a connection to properties to the west. Those adjacent parcels are better served by access from SH 29. This change also includes the reconfiguration of 110 lots in Sections 5A and 5B. The attached drawing shows the 155-foot piece of road that was eliminated, as well as the 110 lots that were reconfigured.

Fiscal Impact

From/To	Acct No.	Description	Amount

Attachments

Revised Prelim Plat - Santa Rita Ranch South

Prelim Plat Changes - Santa Rita Ranch South

Form Review

Inbox	Reviewed By	Date
County Judge Exec Asst.	Wendy Coco	08/26/2015 11:16 AM
Form Started By: Patrick Hughes		Started On: 08/25/2015 02:29 PM
Final Approval Date: 08/26/2015		

REVISED PRELIMINARY PLAN FOR

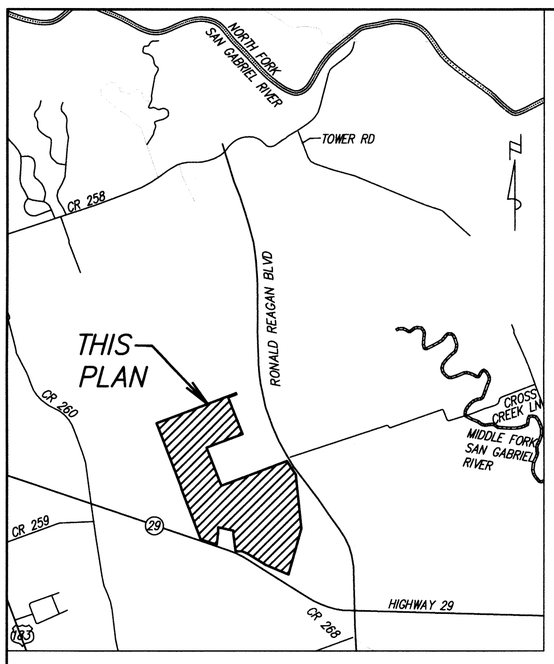
SANTA RITA RANCH SOUTH

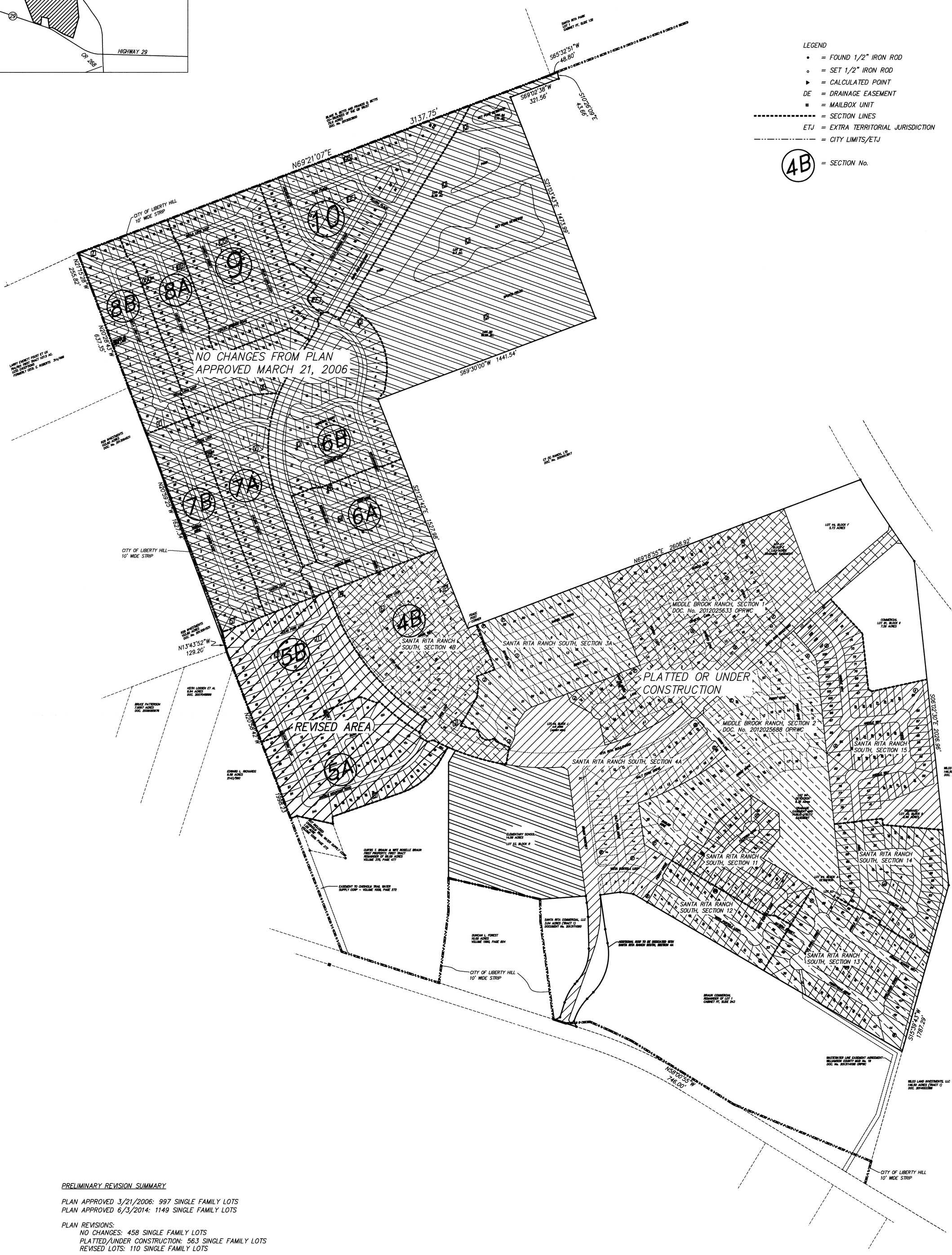
Formerly MIDDLEBROOK RANCH

WILLIAMSON COUNTY, TEXAS

SCALE: 1"=300'

0 300' 600' 900' 1200'





LEGEND

- • = FOUND 1/2" IRON ROD
- ○ = SET 1/2" IRON ROD
- ▶ = CALCULATED POINT
- DE = DRAINAGE EASEMENT
- ▣ = MAILBOX UNIT
- ---------- = SECTION LINES
- ETJ = EXTRA TERRITORIAL JURISDICTION
- —·—·—·— = CITY LIMITS/ETJ
- (4B) = SECTION No.

PRELIMINARY REVISION SUMMARY

PLAN APPROVED 3/21/2006: 997 SINGLE FAMILY LOTS
PLAN APPROVED 6/3/2014: 1149 SINGLE FAMILY LOTS

PLAN REVISIONS:
NO CHANGES: 458 SINGLE FAMILY LOTS
PLATTED/UNDER CONSTRUCTION: 563 SINGLE FAMILY LOTS
REVISED LOTS: 110 SINGLE FAMILY LOTS

TOTAL: 1131 SINGLE FAMILY LOTS

NOTES:

1. *NO LOT IN THIS SUBDIVISION IS ENCROACED BY ANY SPECIAL FLOOD HAZARD AREAS INUNDATED BY 100 YEAR FLOOD AS IDENTIFIED BY THE U.S. FEDERAL EMERGENCY MANAGEMENT AGENCY BOUNDARY MAP, (FLOOD INSURANCE RATE MAP), COMMUNITY PANEL No. 4849C0275E, EFFECTIVE DATE SEPTEMBER 29, 2008 FOR WILLIAMSON COUNTY, TEXAS.*
2. *WATER WILL BE PROVIDED BY: CHISHOLM TRAIL SUD*
3. *WASTEWATER SERVICE WILL BE PROVIDED BY: WILLIAMSON COUNTY MUD 19*
4. *A TEN FOOT (10') PUBLIC UTILITY EASEMENT WILL BE DEDICATED ALONG ALL PUBLIC RIGHT OF WAY.*
5. *A 25' BUILDING SETBACK FROM THE FRONT OF ALL LOTS AND A 15' STREET SIDE SETBACK WILL BE REQUIRED.*

SITE DATA:

AREA: 340.59 ACRES

SURVEYS: THE NOAH SMITHWICK SURVEY, ABSTRACT NO. 590 AND THE W.H. MONROE SURVEY, ABSTRACT NO. 453.

LOTS: 1131 SINGLE FAMILY LOTS

OWNERS:

SANTA RITA KC, LLC
3345 BEE CAVE ROAD
SUITE 203
AUSTIN, TEXAS 78746

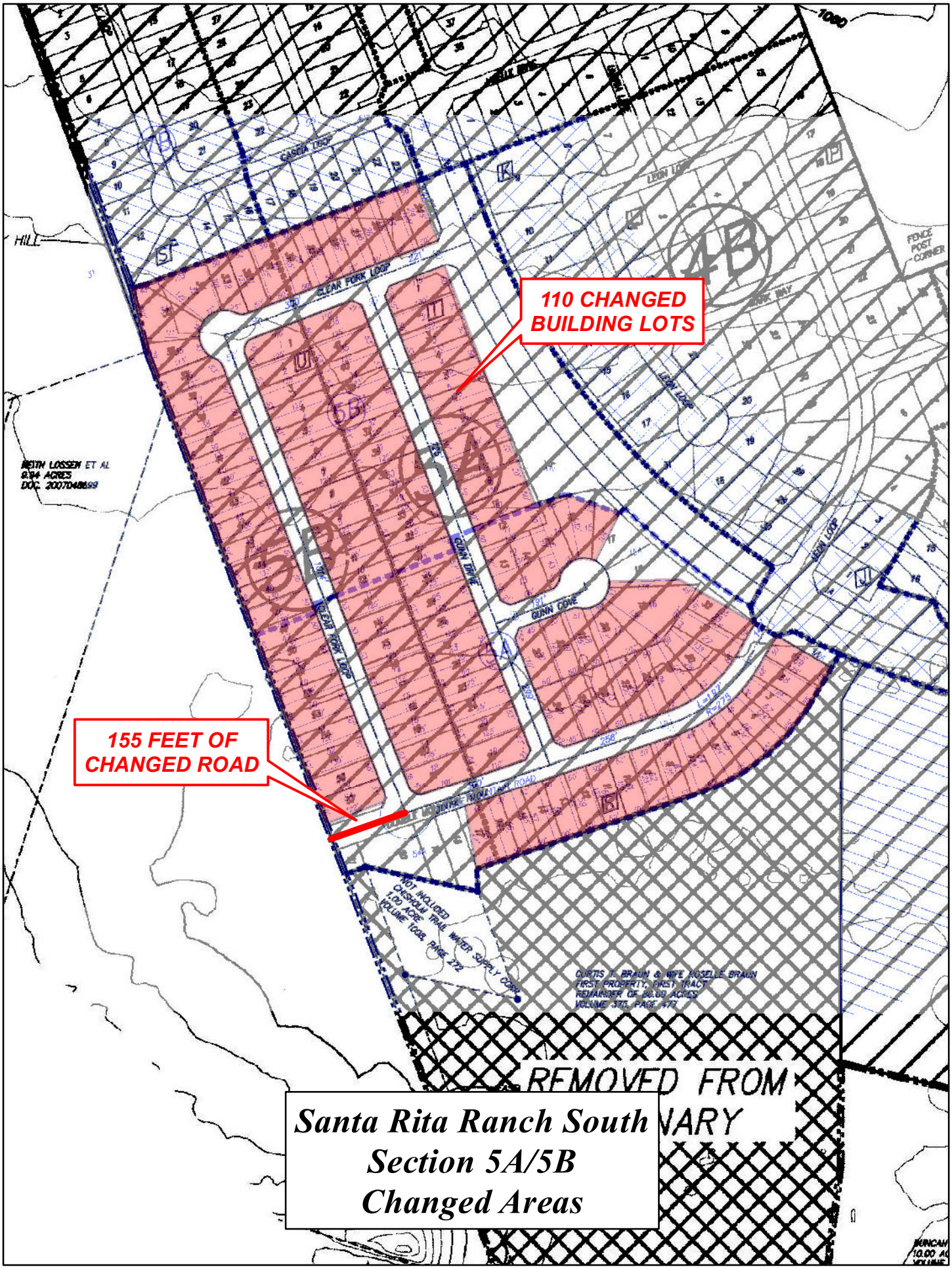
SANTA RITA COMMERCIAL, LLC
8200 NORTH MOPAC, SUITE 300
AUSTIN, TX 78759

DATE: JULY 8, 2015 *SCALE: 1" = 300'*

RANDALL JONES & ASSOCIATES ENGINEERING, INC.
1212 E. BRAKER LANE, AUSTIN, TEXAS 78753
(512) 836-4793 FAX: (512) 836-4817 F-9784

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S:\LAND\1300-1349\1348\dwg\1348-PREL.dwg 8/4/2015 3:39:33 PM CDT


110 CHANGED BUILDING LOTS
155 FEET OF CHANGED ROAD
CLEAR FORK LOOP
GUNN DRIVE
GUNN COVE
LEON LOOP
CASCIA LOOP
FENCE POST CORNER
BEGIN LOSSEN ET AL
8.94 ACRES
DOC. 2007048699
NOT INCLUDED CHISHOLM TRAIL WATER SUPPLY CORP.
1.00 ACRE
VOLUME 1008, PAGE 272
CURTIS T. BRAUN & WIFE HOSELLE BRAUN
FIRST PROPERTY, FIRST TRACT
REMAINDER OF 86.08 ACRES
VOLUME 375, PAGE 472
REMOVED FROM
NARY
Santa Rita Ranch South
Section 5A/5B
Changed Areas

Commissioners Court - Regular Session **16.**

Meeting Date: 09/01/2015

Discuss consider and take appropriate action on the Department of Infrastructure projects and issues update

Submitted For: Robert Daigh **Submitted By:** Lydia Linden, Unified Road System

Department: Unified Road System

Agenda Category: Regular Agenda Items

Information

Agenda Item

Discuss, consider and take appropriate action on the Department of Infrastructure projects and issues update.

Background

Fiscal Impact

From/To	Acct No.	Description	Amount

Attachments

No file(s) attached.

Form Review

Inbox	Reviewed By	Date
County Judge Exec Asst.	Rebecca Clemons	08/12/2015 02:57 PM
Form Started By: Lydia Linden		Started On: 08/11/2015 10:58 AM
Final Approval Date: 08/12/2015		

Commissioners Court - Regular Session **17.**

Meeting Date: 09/01/2015

Civil Engineering Consultants Supplemental 1 to CR 258 PSA

Submitted By: Marie Walters, Road Bond

Department: Road Bond

Agenda Category: Regular Agenda Items

Information

Agenda Item

Discuss, consider and take appropriate action on a Supplemental #1 to Professional Service Agreement for the CR 258 (Sunset Ridge to Ronald Reagan Blvd) project between Williamson County and Don Durden, Inc., dba Civil Engineering Consultants relating to the 2006 Road Bond program.

Background

This supplemental adds $100,000.00 to the contract compensation cap of $300,000.00 so that CEC may provide bid phase and construction phase services, modify roadway plans to incorporate profile change, and update/submit 95% PS&E to meet TxDOT 2014 specifications.

Fiscal Impact

From/To	Acct No.	Description	Amount

Attachments

CEC_CR258_Supp1PSA_08192015

CR 258

Form Review

Inbox	Reviewed By	Date
County Judge Exec Asst.	Wendy Coco	08/27/2015 11:57 AM
Form Started By: Marie Walters		Started On: 08/27/2015 11:43 AM
Final Approval Date: 08/27/2015		

RECEIVED
AUG 14 2015
BY: PST

CONTRACT FOR ENGINEERING SERVICES
SUPPLEMENTAL AGREEMENT NO. 1
TO THE PROFESSIONAL SERVICES AGREEMENT

STATE OF TEXAS §
COUNTY OF WILLIAMSON §

THIS SUPPLEMENTAL AGREEMENT to contract for engineering services is by and between Williamson County, Texas, a political subdivision of the State of Texas, *(the "County")* and Don Durden, Inc., dba Civil Engineering Consultants *(the "Engineer")* and becomes effective when fully executed by both parties.

WHEREAS, the *County* and the *Engineer* executed a contract on March 28, 2012;

WHEREAS, the not-to-exceed fee in Exhibit 1, Section 1, Item 1.1 limits the agreement to $264,896.00; and,

WHEREAS, the ***"Compensation Cap"*** in Exhibit 1, Section 4, Item 4.3 limits the maximum amount payable under the agreement to $300,000.00 and,

WHEREAS, the Hourly Rates in Exhibit II are limited to the rates noted; and,

WHEREAS, it has become necessary to amend the agreement.

AGREEMENT

NOW, THEREFORE, premises considered, the *County* and the *Engineer* agree that said contract is amended as follows:

I. The not-to-exceed fee in Exhibit 1, Section 1, Item 1.1 is hereby increased from $264,896.00 to $354,062.75.
II. The Compensation Cap in Exhibit 1, Section 4, Item 4.3 is hereby increased from $300,000.00 to $400,000.00.

All other provisions are unchanged and remain in full force and effect.

IN WITNESS WHEREOF, the ***County*** and the ***Engineer*** have executed this supplemental agreement in duplicate,

ENGINEER:
By:_____
Signature

Kyle A. Gass
Printed Name

Infrastructure Division Manager
Title

8/13/2015
Date

COUNTY:
By:_____
Signature

_____
Printed Name

_____
Title

_____
Date

OK
8/14/2015

ATTACHMENT A
SUPPLEMENTAL NO. 4 TO
WORK AUTHORIZATION NO. 1

This Work Authorization is made pursuant to the terms and conditions of the Agreement entered into by and between Williamson County, Texas, a political subdivision of the State of Texas, (***the "County"***) and Don Durden, Inc., dba Civil Engineering Consultants (***the "Engineer"***).

Part1. The ***Engineer*** will provide the following engineering services: Perform additional hydraulic analysis based on surveyed channel cross-sections, modify roadway plans to incorporate profile change, develop/submit 95% PS&E to meet TxDOT 2014 Standards, and provide bid phase services.

Part 2. The maximum amount payable for services under this Work Authorization without modification is hereby increased by $44,517.00 for a new maximum amount of $344,246.75.

Part 3. Payment to the ***Engineer*** for the services established under this Work Authorization shall be made in accordance with the Agreement.

Part 4. This Work Authorization shall become effective on the date of final acceptance of the parties hereto and shall terminate on 06/01/2016, unless extended by a Supplemental Work Authorization.

Part 5. This Work Authorization does not waive the parties' responsibilities and obligations provided under the Agreement.

ATTACHMENT A (con't.)

Part 6. This Work Authorization is hereby accepted and acknowledged below.

ENGINEER:	COUNTY:
Don Durden, Inc., dba Civil Engineering Consultants	Williamson County, Texas
By: _____ Signature	By: _____ Signature
Kyle A. Gass Printed Name	Dan A. Gattis Printed Name
Principal / Division Manager Title	County Judge Title
8/27/2015 Date	_____ Date

LIST OF EXHIBITS

Exhibit A - Services to be Provided by County

Exhibit B - Services to be Provided by Engineer

Exhibit C - Work Schedule

Exhibit D - Fee Schedule *(based on approved rates in PSA Exhibit II executed by Commissioners Court action; rates cannot be amended through a Supplemental to a Work Authorization)*

EXHIBIT B
SERVICES TO BE PROVIDED BY ENGINEER

Civil Engineering Consultants (Engineer) shall provide additional engineering services needed to update the current project design to conform to TxDOT 2014 Standard Specifications, address needs identified through recent coordination with property owners, and provide bid phase services. Services included are described below.

ENGINEERING SERVICES:

FC 110 PROJECT MANAGEMENT & ADMINISTRATION.

1. Provide ongoing coordination with County as required in the design and administration of this project in order to meet project objectives which include completing and delivering a bid ready set of construction plans and documents on schedule and within budget.

FC130 RIGHT-OF-WAY (ROW) & UTILITIES

1. Update project basemap based on resolved existing right-of-way as established by Walker Surveying;
2. Update property owner information in plans to reflect current ownership;
3. Incorporate plat/survey information provided by Mr. Eberwein and Mr. Mosner to reflect current/planned development of that lot.

FC160 ROADWAY DESIGN CONTROLS

1. Revise proposed profile between Sta 129+00 through Sta 141+50;
2. Update plans to include proposed driveways at Mr. Mosner's property;
3. Update plan and profile sheets, roadside ditches, project cross-sections, earthwork computations and quantities as needed to incorporate changes in proposed profile, design of new driveways, and revise ditches to reduce tree impacts.

FC 163 Traffic Control Plan and PS&E Submittals.

1. Prepare 95% milestone submittal to provide review of newly incorporated survey, design and plan changes; submittal at minimum will meet the 90% submittal requirements outlined in the Plan Checklists included in Chapter 7 of the Design Criteria Manual. 95% submittal to meet the TxDOT Standards Specifications adopted November 1, 2014.

BID PHASE SERVICES:

1. Prepare three (3) sets of the Project Manual and Plan Drawings for distribution per Chapter 7, Section 3.2.1 for use in the Advertisement of Project.
2. Attend Pre-Bid Meeting;.
3. Respond to Contractor Questions
4. Prepare and Distribute Necessary Addenda (2 max)
5. Attend Bid Opening;
6. Review Bids and prepare bid tabulation and provide recommendation to Program Manager.

EXHIBIT D - FEE PROPOSAL FOR ADDITIONAL SERVICES
Supplmental #4 to WA #1 (August 27, 2015)

Project: CR 258
Limits: From Sunset Ridge to Ronald Reagan Blvd, 1.74 Mi

Work Authorization # 1

CIVIL ENGINEERING CONSULTANTS

CEC STAFF CODES		032	017	052	002	023	007	029	003	005	050	033	014	015	049	009			
TASK DESCRIPTION	Sheets	SENIOR PROJECT MANAGER	PROJECT MANAGER	PROJECT ENGINEER	EIT	SENIOR ENGINEERING TECH	CADD OPERATOR	SENIOR RPLS	RPLS	SURVEYOR IN TRAINING	SURVEY TECH	ABSTRACTOR	3 PERSON SURVEY FIELD CREW	4 PERSON SURVEY FIELD CREW	SURVEY COORDINATOR	CLERICAL	TOTAL HOURS	HOURS PER SHEET	COST
Rates		$ 180.00	$148.00	$127.00	$93.00	$120.00	$87.00	$168.00	$150.00	$95.00	$95.00	$79.00	$165.00	$190.00	$95.00	$50.00			
ENGINEERING SERVICES:																			
FC 110 Client Coordination and Proj. Management																			
Update Project Design Schedule			2														2		$ 296.00
Project Administration and Invoicing			8													6	14		$ 1,484.00
FC 110 TOTAL			**10**													**6**	**16**		**$ 1,780.00**
FC 120 Social, Ec & Env Studies/ Public Involvement																			
Attend Stakeholder meetings (est @ 2 mtgs)																	-		$ -
Prepare Meeting Exhibits																	-		$ -
Assist Bond Program in addressing public comments/questions																	-		$ -
FC 120 TOTAL																			**$ -**
FC 130 Right-Of-Way (ROW) & Utilities																			
Update project basemap per resolved ROW (Walker Surveying)				1	2		4										-		$ 661.00
Update plans to reflect current property owner info				1	2		4										-		$ 661.00
Incorporate plat/survey info @ Eberwein				1	2		4										-		$ 661.00
FC 130 TOTAL				**3**	**6**		**12**												**$ 1,983.00**
FC 160 Roadway Design Controls																			
Modify vertical profile - Sta 129+00 to 141+50 (+/-)	4			2	4		8										14	3.5	$ 1,322.00
Modify design of roadside ditches (profile change & address public comment)			2	8	10		16										36		$ 3,634.00
Update Project Cross Sections	16			4	8		16										28	1.75	$ 2,644.00
Update Earthwork Computations & Summary Sheet				2	2		4										8		$ 788.00
Calculate Roadway Quantities & Update Summary Sheet				2	4		4										10		$ 974.00
Update Driveway Design along revised profile; design addtl driveways; update Driveway Summary Sheet				2	4		8										14	-	$ 1,322.00
QC/QA Reviews		2															2	-	$ 360.00
FC 160 TOTAL		**2**	**2**	**20**	**32**		**56**										**112**		**$ 11,044.00**
FC 161 Drainage																			
~~Refine/verify culvert #2 design per chl xsection using HEC-RAS v.4.1.0~~																		-	$ -
~~Update culvert layout and hydraulic computations (Q25 yr)~~																		-	$ -
~~Identify/develop channel stabilization immediately d/s of culvert~~																		-	$ -
~~QC/QA Reviews~~																		-	$ -
FC 161 TOTAL																			**$ -**
FC 163 Traffic Control Plan and PSE Submittals																			
95% PS&E Submittal:																		-	$ -
Update 90% PSE to Meet TxDOT 2014 Standards			2	12	24		8										46	-	$ 4,748.00
Update Construction Cost Estimate			2		4												6	-	$ 668.00
Update Construction Schedule		1															1	-	$ 180.00
Update Spl Provision Forms (ROW, Utility Relocates, Env Clearances)			2		4												6	-	$ 668.00
Prepare 95% plan submittal checklist			1														1	-	$ 148.00
Assemble & Submit 95% PS&E			1	2	4		8									4	19	-	$ 1,670.00
Attend 95% Review Meeting			6	6													12	-	$ 1,650.00
Prepare & distribute 95% review meeting minutes			1	3													4	-	$ 529.00
FC 162 TOTAL		**1**	**15**	**23**	**36**		**16**									**4**	**95**		**$ 10,261.00**

EXHIBIT D - FEE PROPOSAL FOR ADDITIONAL SERVICES
Supplmental #4 to WA #1 (August 27, 2015)

Project: CR 258
Limits: From Sunset Ridge to Ronald Reagan Blvd, 1.74 Mi

Work Authorization # 1

CIVIL ENGINEERING CONSULTANTS

CEC STAFF CODES		032	017	052	002	023	007	029	003	005	050	033	014	015	049	009			
TASK DESCRIPTION	Sheets	SENIOR PROJECT MANAGER	PROJECT MANAGER	PROJECT ENGINEER	EIT	SENIOR ENGINEERING TECH	CADD OPERATOR	SENIOR RPLS	RPLS	SURVEYOR IN TRAINING	SURVEY TECH	ABSTRACTOR	3 PERSON SURVEY FIELD CREW	4 PERSON SURVEY FIELD CREW	SURVEY COORDINATOR	CLERICAL	TOTAL HOURS	HOURS PER SHEET	COST
Rates		$ 180.00	$148.00	$127.00	$93.00	$120.00	$87.00	$168.00	$150.00	$95.00	$95.00	$79.00	$165.00	$190.00	$95.00	$50.00			
BID PHASE SERVICES:																			
FC 210 Bid Phase Services																			
Prep Package of Contract Docs for Advertisement of Project			0.5	2			4									8	14.5	-	$ 1,076.00
Attend Pre-Bid Meeting; Prepare & Distribute Meeting Minutes			8	8													16		$ 2,200.00
Respond to Contractor Questions (10 max)			10	10													20		$ 2,750.00
Prepare and Distribute Necessary Addenda (2 max)		2	4	8			12										26		$ 3,012.00
Attend Bid Opening			6	6													12		$ 1,650.00
Prepare Bid Tab and Provide Recommendation Program Manager		0.5	1		5												6.5		$ 703.00
																			$ -
FC 220 TOTAL		**2.5**	**29.5**	**34**	**5**		**16**									**8**	**95**	-	**$ 11,391.00**
																		SUBTOTAL SERVICES	**$ 36,459.00**
																		DIRECT COSTS	**$ 8,058.00**
																		TOTAL AMOUNT	**$ 44,517.00**

DIRECT COSTS	Total Units	Unit Cost	Total Cost
Copies, 8-1/2"x11" (per sheet)	1000	$ 0.12	$ 120.00
Copies, 11"x17" (per sheet)	3500	$ 0.14	$ 490.00
Overnight mail - oversized box	3	$ 40.00	$ 120.00
Mileage (meetings assumes 6 trips est @ 240 mi r/t)	1440	$ 0.58	$ 828.00
TCEQ Filing Fee	LS	$ 6,500.00	$ 6,500.00
Subtotal (Design Related)			**$ 8,058.00**
Survey related costs:			
Meals (per diem $30/person per day)		$ -	$ -
Hotel (2 rooms est @ $100/day)		$ -	$ -
Mileage (roundtrip plus local travel)		$ -	$ -
Subtotal (Survey Related)			$ -
TOTAL DIRECT COSTS			**$ 8,058.00**

COST SUMMARY BY FUNCTION CODE		Cost
ENGINEERING		
FC 110 Client Coordination and Proj. Management	$	1,780.00
FC 120 Social, Ec & Env Studies/ Public Involvement	$	-
FC 130 Right-Of-Way (ROW) & Utilities	$	1,983.00
FC 160 Roadway Design Controls	$	11,044.00
FC 161 Drainage	$	-
FC 163 Traffic Control Plan and PSE Submittals	$	10,261.00
BID PHASE SERVICES		
FC 210 Bid Phase Services	$	11,391.00
DIRECT COSTS	$	8,058.00
TOTAL SUPPLEMENTAL SERVICES	**$**	**44,517.00**

Commissioners Court - Regular Session **18.**

Meeting Date: 09/01/2015

Kimley-Horn On-Call services Lakeline RTL Supplemental No 1 to PSA

Submitted By: Marie Walters, Road Bond

Department: Road Bond

Agenda Category: Regular Agenda Items

Information

Agenda Item

Discuss, consider and take appropriate action on Supplemental #1 to a Professional Services Agreeement for the On-Call engineering services for Lakeline Right-Turn-Lane project between Williamson County and Kimley-Horn and Associates, Inc. relating to the 2006 Road Bond program.

Background

This supplemental adds $75,000.00 to the contract compensation cap of $300,000.00 so that Kimley-Horn may provide construction phase services and complete additional design work, submittal packages and environmental technical reports needed for the site plan approval process.

Fiscal Impact

From/To	Acct No.	Description	Amount

Attachments

KimleyHorn_On-Call_Supp1-PSA_08192015

KimleyHorn_LakelineRTL_Supp1WA6_08192015

Form Review

Inbox	Reviewed By	Date
County Judge Exec Asst.	Wendy Coco	08/27/2015 11:57 AM
Form Started By: Marie Walters		Started On: 08/27/2015 11:29 AM
Final Approval Date: 08/27/2015		

RECEIVED
AUG 13 2015
BY: PSI

CONTRACT FOR ENGINEERING SERVICES
SUPPLEMENTAL AGREEMENT NO. 1
TO THE PROFESSIONAL SERVICES AGREEMENT

STATE OF TEXAS §
COUNTY OF WILLIAMSON §

THIS SUPPLEMENTAL AGREEMENT to contract for engineering services is by and between Williamson County, Texas, a political subdivision of the State of Texas, *(the "County")* and Kimley-Horn and Associates *(the "Engineer")* and becomes effective when fully executed by both parties.

WHEREAS, the *County* and the *Engineer* executed a contract on July 12, 2011;

WHEREAS, the not-to-exceed fee in Exhibit 1, Section 1, Item 1.1 limits the agreement to $300,000.00 ; and,

WHEREAS, the "***Compensation Cap***" in Exhibit 1, Section 4, Item 4.3 limits the maximum amount payable under the agreement to $300,000.00; and,

WHEREAS, the Hourly Rates in Exhibit II are limited to the rates noted; and,

WHEREAS, it has become necessary to amend the agreement.

AGREEMENT

NOW, THEREFORE, premises considered, the *County* and the *Engineer* agree that said contract is amended as follows:

I. The not-to-exceed fee in Exhibit 1, Section 1, Item 1.1 is hereby increased from $300,000.00 to $375,000.00.
II. The Compensation Cap in Exhibit 1, Section 4, Item 4.3 is hereby increased from $300,000.00 to $375,000.00.

All other provisions are unchanged and remain in full force and effect.

IN WITNESS WHEREOF, the ***County*** and the ***Engineer*** have executed this supplemental agreement in duplicate,

ENGINEER:
By: Andrew W. Van Leeuwen
Signature

Andrew W. Van Leeuwen
Printed Name

SR Vice President
Title

8/17/2015
Date

COUNTY:
By: _____
Signature

_____
Printed Name

_____
Title

_____
Date

8/14/2015

RECEIVED
AUG 13 2015
BY: PST

ATTACHMENT A
SUPPLEMENTAL NO. 1 TO
WORK AUTHORIZATION NO. 6

This Work Authorization is made pursuant to the terms and conditions of the Agreement entered into by and between Williamson County, Texas, a political subdivision of the State of Texas, (***the "County"***) and Kimley-Horn and Associates (***the "Engineer"***).

Part1. The ***Engineer*** will provide the following engineering services:

See attached - Exhibit B

Part 2. The maximum amount payable for services under this Work Authorization without modification is hereby *increased* by $34,514.00 for a new maximum amount of $171,089.00.

Part 3. Payment to the ***Engineer*** for the services established under this Work Authorization shall be made in accordance with the Agreement.

Part 4. This Work Authorization shall become effective on the date of final acceptance of the parties hereto and shall terminate on February 29, 2016, unless extended by a Supplemental Work Authorization.

Part 5. This Work Authorization does not waive the parties' responsibilities and obligations provided under the Agreement.

ATTACHMENT A (con't.)

Part 6. This Work Authorization is hereby accepted and acknowledged below.

ENGINEER:

By: Andrea W. VanLeeuwen
Signature

Andrea W. VanLeeuwen
Printed Name

SR Vice President
Title

8/13/2015
Date

COUNTY:
Williamson County, Texas

By: _____
Signature

Dan A. Gattis
Printed Name

County Judge
Title

_____
Date

DF 8/14/2015

LIST OF EXHIBITS

Exhibit A - Services to be Provided by County

Exhibit B - Services to be Provided by Engineer

Exhibit C - Work Schedule

Exhibit D - Fee Schedule *(based on approved rates in PSA Exhibit II executed by Commissioners Court action; rates cannot be amended through a Supplemental to a Work Authorization)*

EXHIBIT A

Services to be Provided by the County

Location(s): **Lakeline Boulevard**
Project: **Final Design – Right Turn Lanes at Pecan Park, Apartment Driveway, and HEB Driveway**

SCOPE OF WORK OVERVIEW

This project involves the development of PS&E for right turn lanes on eastbound Lakeline Boulevard at the intersection with Pecan Park Blvd, Apartment Driveway, and HEB driveway (1st driveway east of Pecan Park) in Austin, Texas.

SERVICES TO BE PROVIDED BY THE COUNTY

A. Subsurface Utility Engineering and Utility Coordination
B. Title abstracts and/or commitments
C. Right-of-Way and easement acquisition
D. Updated ADT information (if available)
E. Assist the Engineer in obtaining information from various County resources and/ or departments.
F. Assist the Engineer in obtaining as-built information along the corridor.
G. Provide available copies of associated studies and coordination with ongoing related county projects.
H. Post and maintain project information on the County website.
I. Review and provide comments on all aspect of the design and PS&E preparation.
J. Provide decisions in a timely manner.
K. Process payment to Engineer in a timely manner.

EXHIBIT B

Services to be Provided by the Engineer

Location(s): **Lakeline Boulevard**
Project: **Final Design – Right Turn Lanes at Pecan Park, Apartment Driveway, and HEB Driveway**

SCOPE OF WORK OVERVIEW

This project involves the development of PS&E for right turn lanes on eastbound Lakeline Boulevard at the intersection with Pecan Park Blvd, Apartment Driveway, and HEB driveway (1st driveway east of Pecan Park) in Austin, Texas.

SERVICES TO BE PROVIDED BY THE ENGINEER

Task 1. Project Management

Project management spans the entire duration of the project and involves monitoring and coordination of services provided to the County to assure timely and efficient completion of the project. Included in this task are project coordination, project meetings, quality assurance and quality control, City of Austin verification submittal, City of Austin comment responses, and City of Austin final site plan submittal.

Task 2. PS&E

KHA will develop additional PS&E documents and necessary supporting documentation for City of Austin approval following the criteria set forth in the City of Austin Small Project – Transportation application for suburban watersheds. The additional items for the City submittal are listed below.

Environmental Site Plan Submittal Information

- Project Report
- Cover Sheet
- Erosion and Sedimentation Control and Tree Protection Plan
- Water Quality/Drainage Plan
- Water Quality Control Plan
- Landscape Plan
- Slope and Topographic Map
- Environmental Assessment Report
- Change to use City of Austin Standard Specifications
- Geological Assessment

KHA will revise the plans to replace TxDOT 2014 Standard Specification with City of Austin Standard Specifications where feasible.

The Geological Assessment required for the City of Austin Small Project – Transportation will include the following:

- Sampling and testing of the subsurface materials by drilling test borings and observing the groundwater conditions at the site, to depths that would significantly affect or be affected by the water quality control element;
- Identification of the physical and engineering characteristics of the subsurface materials encountered during the sampling and testing, including Atterberg Limits Determinations, Particle Size Distributions, and remolded permeability testing of the shallow native materials for suitability as a line material. Standard Proctor testing will also be performed on the materials representing the clay liner (if suitable) and subgrade;
- Providing recommendations for appropriate liner materials.
- Providing general design and construction considerations, as well as recommendations regarding materials testing during liner construction;
- Performing a stability analysis of the planned rain garden slopes given geometry from our client.

Field Exploration

Truck mounted drilling equipment will be used to drill and sample **two (2)** test borings to explore the soil and groundwater conditions at the subject site. The table below provides the proposed structure, quantity, and test boring depths. In addition to the test borings, bulk samples will be collected for permeability and Proctor testing.

Table 1 - Summary of Test Borings

Design Element	Quantity	Depth (ft) (each)	Total Depth (ft)
Rain Garden (Water Quality Control)	2	15	30
TOTAL	**2**	**---**	**30**

Upon completion of the drilling operations, the test borings will be backfilled with soil/rock cuttings. If rock is encountered, the test borings will be terminated at five (5) to 10 feet into rock, unless the specified depth has already been attained. Soils will be sampled continuously in the upper 10 feet and every five (5) feet thereafter. Final depths of the test borings may be extended or reduced dependent on encountered material. Groundwater observations will be made during and after the drilling operations. Upon request a 24 hour groundwater observation can be performed.

Laboratory Services

The geotechnical investigation will include laboratory testing of the samples obtained during the field exploration. This testing will be conducted to determine the soil classification and evaluate the plasticity, grain size, permeability and other characteristics of the subsurface materials encountered. PSI laboratories are equipped with modern soil testing apparatus; field exploration programs are conducted with modern drilling equipment. Field and laboratory testing is performed by trained, qualified technicians under the guidance and supervision of professional engineers.

Unless directed otherwise by the Client, portions of any samples that are not altered or consumed by laboratory testing will be retained for 60 days from the date shown on the report and will then be discarded.

Reporting Services

PSI's proposal covers the work needed to present our findings and recommendations in a report form may include:

- A review of surface topographical features, geologic features, and site conditions;
- Logs of test borings and a plan showing the locations of test borings;
- Estimated subsurface profiles and a review of subsurface stratigraphy with pertinent available physical properties and ground water conditions;
- Identification of the physical and engineering characteristics of the subsurface materials encountered during the sampling and testing, including Atterberg Limits Determinations, Particle Size Distributions, and remolded permeability testing of the shallow native materials for suitability as a line material. Standard Proctor testing will also be performed on the materials representing the clay liner (if suitable) and subgrade;
- Providing recommendations for appropriate liner materials.
- Providing general design and construction considerations, as well as recommendations regarding materials testing during liner construction;
- Performing a stability analysis of the planned rain garden slopes given geometry from our client.

A pdf report presenting the results of our field exploration and laboratory testing will be prepared and submitted by email and, if requested by the Client, three (3) hard copies will be mailed. The geotechnical report will include the results of the field exploration and laboratory tests and will be reviewed by a professional engineer.

ADDITIONAL SERVICES/CHANGE IN SERVICES

Since the Engineer's compensation is a not-to-exceed fee for Basic Services described in this Agreement, compensation to the Engineer for Additional Services will only be for substantial deviations from the scope of services described in this Agreement. The Engineer will submit a written estimate of fees to the County and obtain the County's authorization before initiating any additional services. The following services are not included in this Agreement at present and are specifically considered to be additional services:

a) Preparing for and attending public meetings, and/or appearing as an expert witness in any litigation for the County.

b) Work associated with outfalls outside the project ROW

c) Upgrading traffic signal at Pecan Park from span-wire design to a mast-arm design.

d) Developing photometric model for roadway illumination design.

e) Services after the award of the construction contract

f) Stormwater Hydrologic analysis of external drainage areas

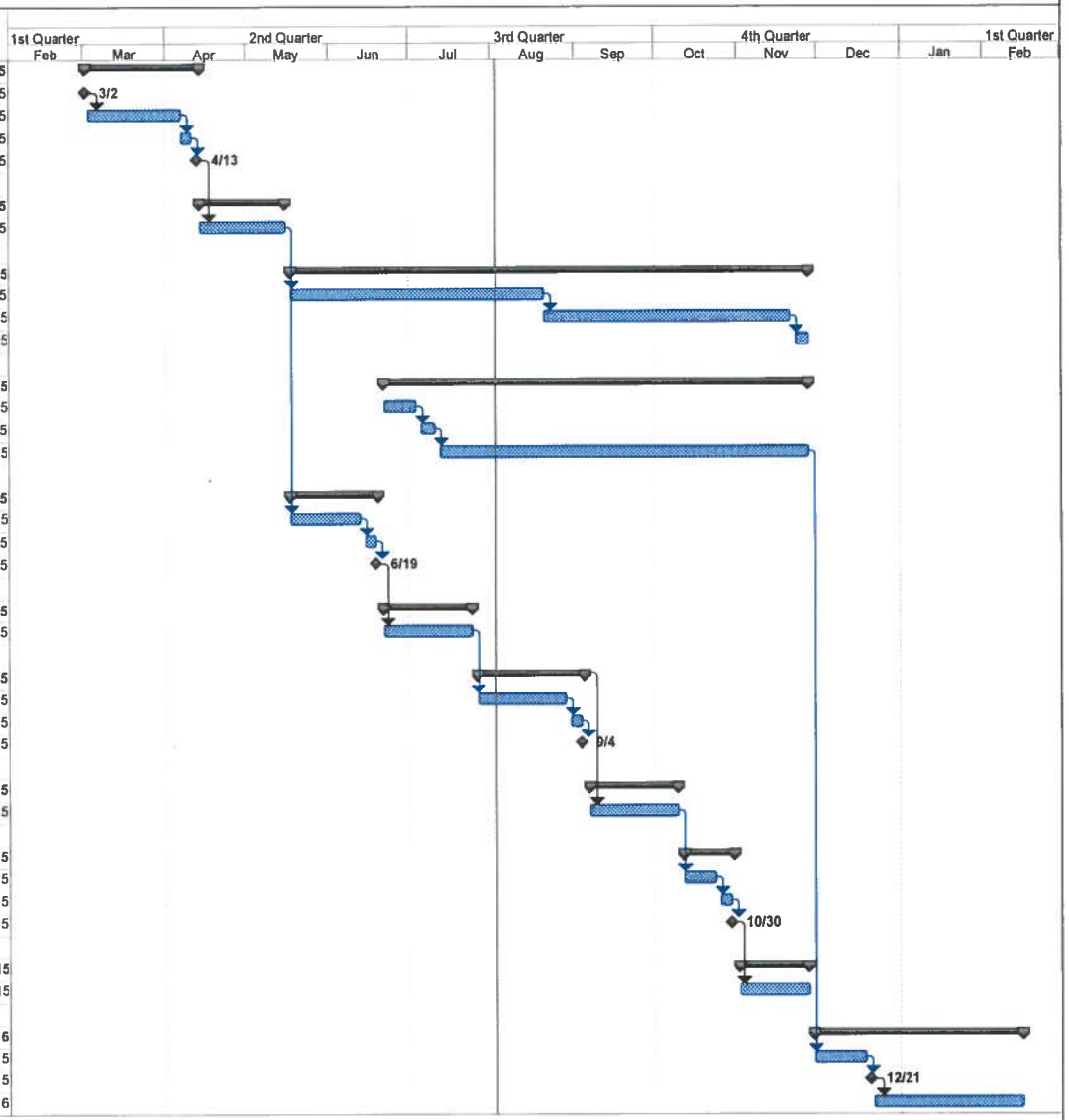
g) Stormwater detention analysis and design

h) Non-standard retaining wall design

i) Low Impact Development Design

Exhibit C - Williamson County - Lakeline Boulevard Right Turn Lanes PS&E

ID	Task Name	Duration	Start	Finish
1	**60% Design**	**31 days**	**Mon 3/2/15**	**Mon 4/13/15**
2	NTP	1 day	Mon 3/2/15	Mon 3/2/15
3	Prepare 60% Plans and OPCC	25 days	Tue 3/3/15	Mon 4/6/15
4	QC/QA and Assemble 60% Deliverables	4 days	Tue 4/7/15	Fri 4/10/15
5	Submit 60% Deliverables	1 day	Mon 4/13/15	Mon 4/13/15
6				
7	**Review - 60% Submittal**	**24 days**	**Tue 4/14/15**	**Fri 5/15/15**
8	City and County Review and Comments	24 days	Tue 4/14/15	Fri 5/15/15
9				
10	**Water Pollution Abatement Plan**	**140 days**	**Mon 5/18/15**	**Fri 11/27/15**
11	Prepare WPAP	69 days	Mon 5/18/15	Thu 8/20/15
12	TCEQ Review WPAP	66 days	Fri 8/21/15	Fri 11/20/15
13	WPAP Approval	5 days	Mon 11/23/15	Fri 11/27/15
14				
15	**ROW Documents**	**115 days**	**Mon 6/22/15**	**Fri 11/27/15**
16	Prepare ROW Documents	10 days	Mon 6/22/15	Fri 7/3/15
17	County Review of ROW Documents	5 days	Mon 7/6/15	Fri 7/10/15
18	ROW Acquisition	100 days	Mon 7/13/15	Fri 11/27/15
19				
20	**90% Submittal to County**	**25 days**	**Mon 5/18/15**	**Fri 6/19/15**
21	Prepare 90% Plans, Specs, and OPCC	20 days	Mon 5/18/15	Fri 6/12/15
22	QC/QA and Assemble 90% Deliverables	4 days	Mon 6/15/15	Thu 6/18/15
23	Submit 90% Deliverables	1 day	Fri 6/19/15	Fri 6/19/15
24				
25	**Review - 90% Submittal**	**25 days**	**Mon 6/22/15**	**Fri 7/24/15**
26	County Review and Comments	25 days	Mon 6/22/15	Fri 7/24/15
27				
28	**Permit Submittal to City**	**30 days**	**Mon 7/27/15**	**Fri 9/4/15**
29	Prepare Permit Plans, Specs, and Reports	25 days	Mon 7/27/15	Fri 8/28/15
30	QC/QA and Assemble Permit Deliverables	4 days	Mon 8/31/15	Thu 9/3/15
31	Submit Permit Deliverables	1 day	Fri 9/4/15	Fri 9/4/15
32				
33	**Review - Permit Submittal**	**25 days**	**Mon 9/7/15**	**Fri 10/9/15**
34	City Review and Comments	25 days	Mon 9/7/15	Fri 10/9/15
35				
36	**Final Design**	**15 days**	**Mon 10/12/15**	**Fri 10/30/15**
37	Address 90% Review Comments and Complete Plans	10 days	Mon 10/12/15	Fri 10/23/15
38	QC/QA and Assemble 100% Deliverables	4 days	Mon 10/26/15	Thu 10/29/15
39	Submit Final Plans, Specs and OPCC	1 day	Fri 10/30/15	Fri 10/30/15
40				
41	**Review - Final Submittal**	**20 days**	**Mon 11/2/15**	**Fri 11/27/15**
42	City and County Review and Comments	20 days	Mon 11/2/15	Fri 11/27/15
43				
44	**Bidding and Contract Execution**	**56 days**	**Mon 11/30/15**	**Mon 2/15/16**
45	Advertisement	15 days	Mon 11/30/15	Fri 12/18/15
46	Bid Opening	1 day	Mon 12/21/15	Mon 12/21/15
47	Contract Doc Finalization and Approvals	40 days	Tue 12/22/15	Mon 2/15/16



Williamson County - Lakeline Boulevard Right Turn LanesPS&E
Date: Mon 8/3/15

Task
Split
Milestone
Summary
Project Summary
External Tasks
External MileTask
Inactive Task
Inactive Milestone
Inactive Summary
Manual Task
Duration-only
Manual Summary Rollup
Manual Summary
Start-only
Finish-only
Progress
Split

WORK AUTHORIZATION 6

Exhibit D

Project Name: Lakeline Boulevard PS&E

Project Description: Right Turn Lanes at Pecan Park, HEB driveway, and apartment driveway

Prepared By: Kimley-Horn and Associates, Inc.

Task #	KHA Task Name	Direct Labor (Person-Hours)						Sub-Contractor and Expense ($)
		Senior Transportation Engineer $205.00	Senior Engineer 190.00	Project Engineer 120.00	Analyst 105.00	Secretary / Clerical 60.00	KHA Labor Total (hours)	
1	**Project Management**							
							0	
	City of Austin Small Transportation Project Permit						0	
	Project Coordiantion	2	10				12	
	Project Meetings (Assume 2 Meetings)	4	4				8	
	QA/QC	2	4				6	
	Verification Submittal		2	4	8	2	16	
	Site Plan Submittal		2	4	8	2	16	
	Commet Responses	2	4	4			10	
	Final Submittal		2	4	8	2	16	
							0	
	Task Total (Hours)	10	28	16	24	6	84	
	Task Total (Dollars)	$2,050	$5,320	$1,920	$2,520	$360	**$12,170**	**$0**

2	**PS&E**							
	City of Austin Small Transportation Project Permit						0	
	Environmental Site Plan Submittal Information						0	
	Project Report		2	8	16		26	
	Cover Sheet		1	2	4		7	
	Erosion and Sedimentation Control and Tree Protection Plan		1	4	8		13	
	Water Quality/Drainage Plan		1	2	6		9	
	Water Quality Control Plan		1	2	8		11	
	Landscape Plan		1	4	16		21	
	Slope and Topographic Map		1	4	8		13	
	Environmental Assessment Report		1	8	16		25	
	Change to use City of Austin Standard Specifications	1	1	2	16		20	
	Geological Assessment	See Attached for Hourly Rates					0	$4,945
	Task Total (Hours)	1	10	36	98	0	145	
	Task Total (Dollars)	$205	$1,900	$4,320	$10,290	$0	**$16,715**	**$4,945**
	DESIGN (1-2) TOTAL (Hours)	11	38	52	122	6	229	
	DESIGN (1-2) TOTAL (Fee)	**$2,255**	**$7,220**	**$6,240**	**$12,810**	**$360**	**$28,885**	**$4,945**

Project Summary

Expenses						
Subconsultants (Geotech)						**$4,945**
Mileage	60.0	Miles	x	$0.565	per mile	$34
11"x17" Plots	500.0	Plots	x	$0.20	per plot	$100
8-1/2"x11" Plots	500.0	Plots	x	$0.10	per plot	$50
TCEQ Recharge Zone Exceptiond Request	1.0	Each	x	$500.00	Each	$500
Total						**$5,629**
DESIGN (1-2) TOTAL						**$28,885**
GRAND TOTAL						**$34,514**

PSI - Lakeline Right Turn Lanes Exhibit D				
GEOTECHNICAL FIELD EXPLORATION	**QUANTITY**	**UNIT**	**RATE**	**TOTAL**
Staking/Coordinating	3	hours	$ 45.00	$135.00
Rig Mobilization/Demobilization	1	each	$ 450.00	$450.00
Drilling & Sampling - Soils	30	ft	$ 30.00	$900.00
GEOTECHNICAL LABORATORY TESTING				
Natural Moisture Content	15	ea	$ 6.00	$90.00
Particle Size Distribution, 5 sieves through No. 200	6	ea	$ 50.00	$300.00
Atterberg Limits	6	ea	$ 60.00	$360.00
Permeability Testing, Constant or Falling Head	2	ea	$ 255.00	$510.00
Total Field & Lab				**$2,745.00**
ENGINEERING/SECRETERIAL				
Project Manager	4	hours	$ 100.00	$400.00
Engineering Time	8	hours	$ 125.00	$1,000.00
Principle Consultant Review	4	hours	$ 175.00	$700.00
Secretarial/Drawings	2	hours	$ 50.00	$100.00
Total Engineering/Secreterial				**$2,200.00**
TOTAL EXPENSES				**$4,945.00**

Commissioners Court - Regular Session **19.**

Meeting Date: 09/01/2015

13IFB00118 CR 108 Change Order No. 4

Submitted By: Dawn Haggard, Road Bond

Department: Road Bond

Agenda Category: Regular Agenda Items

Information

Agenda Item

Discuss, consider, and take appropriate action regarding Change Order No. 4 in the amount of -$46,859.57 for CR 108, a Road Bond Project in the Commissioner Pct. 4.

Background

This Change Order provides for the final balancing of the overrun/underrun of Contract quantities for the project, as a result of addressing field conditions not accounted for in the original plan quantities.

Fiscal Impact

From/To	Acct No.	Description	Amount

Attachments

CR 108 CO No 4

Form Review

Inbox	Reviewed By	Date
County Judge Exec Asst.	Wendy Coco	08/27/2015 11:57 AM
Form Started By: Dawn Haggard		Started On: 08/27/2015 09:34 AM
Final Approval Date: 08/27/2015		

Received
AUG 05 2015
HNTB Corporation
Round Rock

Received
AUG 26 2015
HNTB Corporation
Round Rock

WILLIAMSON COUNTY, TEXAS

CHANGE ORDER NUMBER: 4

1. CONTRACTOR: **DNT Construction**

2. Change Order Work Limits: Sta. **0+78** to Sta. **79+00**

3. Type of Change(on federal-aid non-exempt projects): **Minor** (Major/Minor)

4. Reasons: **2E** (3 Max. - In order of importance - Primary first)

Project:	***13IFB00118***
Roadway:	***CR 108***
CSJ Number:	

5. Describe the work being revised:

2E: Differing Site Conditions (unforeseeable). Miscellaneous differences in site conditions (unforeseeable) (Item 9). Final balancing of the overrun/underrun of Contract quantities to meet field conditions.

6. Work to be performed in accordance with Items: **See Attached**

7. New or revised plan sheet(s) are attached and numbered: **N/A**

8. New Special Provisions/Specifications to the contract are attached: ☐ Yes ☑ No

9. New Special Provisions to Item N/A No. N/A, Special Specification Item N/A are attached.

Each signatory hereby warrants that each has the authority to execute this Change Order (CO).

The contractor must sign the Change Order and, by doing so, agrees to waive any and all claims for additional compensation due to any and all other expenses; additional changes for time, overhead and profit; or loss of compensation as a result of this change.

THE CONTRACTOR Date 8/4/15

By

Typed/Printed Name SETH JEWELL

Typed/Printed Title PROJECT MGR.

The following information must be provided

Time Ext. #: **N/A** Days added on this CO: **0**

Amount added by this change order: **($46,859.57)**

RECOMMENDED FOR EXECUTION:

James A. K... P.E. 8/5/15
Project Manager Date

N/A
Design Engineer Date

M. [illegible] 8/26/2015
Program Manager Date

Design Engineer's Seal:

N/A

County Commissioner Precinct 1 Date
☐ APPROVED ☐ REQUEST APPROVAL

County Commissioner Precinct 2 Date
☐ APPROVED ☐ REQUEST APPROVAL

County Commissioner Precinct 3 Date
☐ APPROVED ☐ REQUEST APPROVAL

County Commissioner Precinct 4 Date
☐ APPROVED ☐ REQUEST APPROVAL

County Judge Date
☐ APPROVED

WILLIAMSON COUNTY, TEXAS

CHANGE ORDER NUMBER: *4* ***Project #*** *13IFB00118*

TABLE A: Force Account Work and Materials Placed into Stock

	LABOR	HOURLY RATE			HOURLY RATE

TABLE B: Contract Items:

				ORIGINAL + PREVIOUSLY REVISED		ADD or (DEDUCT)	NEW		
ITEM	DESCRIPTION	UNIT	UNIT PRICE	QUANTITY	ITEM COST	QUANTITY	QUANTITY	ITEM COST	OVERRUN/ UNDERRUN
168-2001	VEGETATIVE WATERING	MG	$6.57	4,879.00	$32,055.03	(4,051.00)	828.00	$5,439.96	($26,615.07)
506-2001	ROCK FILTER DAMS (INSTALL) (TY 1)	LF	$13.11	382.00	$5,008.02	50.00	432.00	$5,663.52	$655.50
9999-018	TRAFFIC CONTROL DAILY LANE CLOSURE	DAY	$450.00	5.00	$2,250.00	(2.00)	3.00	$1,350.00	($900.00)
9999-025	FORCE ACCOUNT: WATER SEEPAGE INVESTIGATIONS	DOL	$1.00	20,000.00	$20,000.00	(20,000.00)	0.00	$0.00	($20,000.00)
TOTALS					$59,313.05			$12,453.48	($46,859.57)

CHANGE ORDER REASON(S) CODE CHART

1. Design Error or Omission	1A. Incorrect PS&E 1B. Other
2. Differing Site Conditions (unforeseeable)	2A. Dispute resolution (expense caused by conditions and/or resulting delay) 2B. Unavailable material 2C. New development (conditions changing after PS&E completed) 2D. Environmental remediation 2E. Miscellaneous difference in site conditions (unforeseeable)(Item 9) 2F. Site conditions altered by an act of nature 2G. Unadjusted utility (unforeseeable) 2H. Unacquired Right-of-Way (unforeseeable) 2I. Additional safety needs (unforeseeable) 2J. Other
3. County Convenience	3A. Dispute resolution (not resulting from error in plans or differing site conditions) 3B. Public relations improvement 3C. Implementation of a Value Engineering finding 3D. Achievement of an early project completion 3E. Reduction of future maintenance 3F. Additional work desired by the County 3G. Compliance requirements of new laws and/or policies 3H. Cost savings opportunity discovered during construction 3I. Implementation of improved technology or better process 3J. Price adjustment on finished work (price reduced in exchange for acceptance) 3K. Addition of stock account or material supplied by state provision 3L. Revising safety work/measures desired by the County 3M. Other
4. Third Party Accommodation	4A. Failure of a third party to meet commitment 4B. Third party requested work 4C. Compliance requirements of new laws and/or policies (impacting third party) 4D. Other
5. Contractor Convenience	5A. Contractor exercises option to change the traffic control plan 5B. Contractor requested change in the sequence and/or method of work 5C. Payment for Partnering workshop 5D. Additional safety work/measures desired by the contractor 5E. Other
6. Untimely ROW/Utilities	6A. Right-of-Way not clear (third party responsibility for ROW) 6B. Right-of-Way not clear (County responsibility for ROW) 6C. Utilities not clear 6D. Other

Williamson County Road Bond Program

CR 108
Williamson County Project No. 13IFB00118

Change Order No. 4

Reason for Change

This Change Order provides for the final balancing of the overrun/underrun of Contract quantities for the project as a result of addressing field conditions not accounted for in the original plan quantities.

No new items are required for this Change Order.

This Change Order results in a net decrease of $46,859.57 to the Contract amount, for an adjusted Contract total of $3,259,262.87. The original Contract amount was $3,187,303.97. As a result of this and all Change Orders to-date, $71,958.90 has been added to the Contract, resulting in a 2.3% net increase in the Contract cost. No additional days will be added to or deducted from the Contract as a result of this Change Order.

HNTB Corporation

James Klotz, P.E.

Commissioners Court - Regular Session **20.**

Meeting Date: 09/01/2015

14IFB00219 Lakeline Blvd Phase 2 Change Order No 2

Submitted By: Dawn Haggard, Road Bond

Department: Road Bond

Agenda Category: Regular Agenda Items

Information

Agenda Item

Discuss, consider, and take appropriate action regarding Change Order No. 2 in the amount of $18,766.35 for Lakeline Blvd Phase 2, a Road Bond Project in the Commissioner Pct. 2.

Background

This Change Order adds Contract Items to adjust the amount of compensation paid to the Contractor based on the quality of hot mix asphalt pavement produced and placed. Specific job control tests were run on the asphalt to monitor the quality of the asphalt mix. Using these results, in conjunction with formulas as outlined in the TxDOT specifications, the Contractor was either awarded a bonus or assessed a penalty. This Change Order also adds additional quantities and a new Contract Item to compensate the Contractor for installing additional small signs and object markers along the roadway. Twenty (20) days are being added for delays associated with the discovery and mitigation of a karst feature.

Fiscal Impact

From/To	Acct No.	Description	Amount

Attachments

Lakeline Blvd Ph 2 CO No 2

Form Review

Inbox	Reviewed By	Date
County Judge Exec Asst.	Wendy Coco	08/27/2015 10:30 AM
Form Started By: Dawn Haggard		Started On: 08/27/2015 09:48 AM
Final Approval Date: 08/27/2015		

Received
AUG 2 1 2015
HNTB Corporation
Round Rock

Received
AUG 2 6 2015
HNTB Corporation
Round Rock

WILLIAMSON COUNTY, TEXAS

CHANGE ORDER NUMBER: 2

Project:	*14IFB00219*
Roadway:	*Lakeline Blvd Phase 2*
CSJ Number:	

1. CONTRACTOR: **DNT Construction**

2. Change Order Work Limits: Sta. **1+13** to Sta. **70+00**

3. Type of Change(on federal-aid non-exempt projects): **Minor** (Major/Minor)

4. Reasons: **3M, 3F** (3 Max. - In order of importance - Primary first)

5. Describe the work being revised:

3M: County Convenience. Other. As required by Item 3268, this Change Order adds Contract items to adjust the amount of compensation to be paid to the Contractor in proportion to the quality of the asphalt pavement produced and placed on the project. **3F: County Convenience. Additional work desired by the County.** This Change Order also adds additional quantities and a new Contract item to compensate the contractor for installing additional small signs and object markers along the roadway. Twenty (20) days are being added for delays associated with the discovery and mitigation of a karst feature.

6. Work to be performed in accordance with Items: **See Attached**

7. New or revised plan sheet(s) are attached and numbered: **122A - 127A**

8. New Special Provisions/Specifications to the contract are attached: ☐ Yes ☑ No

9. New Special Provisions to Item N/A No. N/A, Special Specification Item N/A are attached.

Each signatory hereby warrants that each has the authority to execute this Change Order (CO).

The contractor must sign the Change Order and, by doing so, agrees to waive any and all claims for additional compensation due to any and all other expenses; additional changes for time, overhead and profit; or loss of compensation as a result of this change.

THE CONTRACTOR Date 8/13/15

By

Typed/Printed Name SETH SEWELL

Typed/Printed Title PROJ. MGR.

The following information must be provided

Time Ext. #: 1 Days added on this CO: 20

Amount added by this change order: **$18,766.35**

RECOMMENDED FOR EXECUTION:

P.E. 8/21/15
Project Manager Date

N/A
Design Engineer Date

08/26/2015
Program Manager Date

Design Engineer's Seal:

See Revised Plan Sheets

County Commissioner Precinct 1 Date
☐ APPROVED ☐ REQUEST APPROVAL

County Commissioner Precinct 2 Date
☐ APPROVED ☐ REQUEST APPROVAL

County Commissioner Precinct 3 Date
☐ APPROVED ☐ REQUEST APPROVAL

County Commissioner Precinct 4 Date
☐ APPROVED ☐ REQUEST APPROVAL

County Judge Date
☐ APPROVED

WILLIAMSON COUNTY, TEXAS

CHANGE ORDER NUMBER: ***2*** ***Project #*** ***14IFB00219***

TABLE A: Force Account Work and Materials Placed into Stock

	LABOR	HOURLY RATE			HOURLY RATE

TABLE B: Contract Items:

				ORIGINAL + PREVIOUSLY REVISED		ADD or (DEDUCT)	NEW		
ITEM	DESCRIPTION	UNIT	UNIT PRICE	QUANTITY	ITEM COST	QUANTITY	QUANTITY	ITEM COST	OVERRUN/ UNDERRUN
502-2001	BARRICADES, SIGNS, AND TRAF HANDLING	MO	$1,025.00	9.00	$9,225.00	1.00	10.00	$10,250.00	$1,025.00
644-2001	IN SM RD SN SUP & AM TY10BWG (1) SA (P)	EA	$425.00	16.00	$6,800.00	1.00	17.00	$7,225.00	$425.00
658-2329	INSTL DEL ASSM (D-SW) SZ 1 (FLX) GND	EA	$36.05	0.00	$0.00	74.00	74.00	$2,667.70	$2,667.70
3268-WC01	D-GR HMA (QC/QA) TY-B PG64-22 BONUS/PENALTY	LS	$5,219.35	0.00	$0.00	1.00	1.00	$5,219.35	$5,219.35
3268-WC02	D-GR HMA (QC/QA) TY-C SAC B PG70-22 BONUS/PENALTY	LS	$4,479.30	0.00	$0.00	1.00	1.00	$4,479.30	$4,479.30
9999-010	ADDITIONAL PROJECT SIGNS	LS	$4,950.00	0.00	$0.00	1.00	1.00	$4,950.00	$4,950.00
TOTALS					$16,025.00			$34,791.35	$18,766.35

CHANGE ORDER REASON(S) CODE CHART

1. Design Error or Omission	1A. Incorrect PS&E 1B. Other
2. Differing Site Conditions (unforeseeable)	2A. Dispute resolution (expense caused by conditions and/or resulting delay) 2B. Unavailable material 2C. New development (conditions changing after PS&E completed) 2D. Environmental remediation 2E. Miscellaneous difference in site conditions (unforeseeable)(Item 9) 2F. Site conditions altered by an act of nature 2G. Unadjusted utility (unforeseeable) 2H. Unacquired Right-of-Way (unforeseeable) 2I. Additional safety needs (unforeseeable) 2J. Other
3. County Convenience	3A. Dispute resolution (not resulting from error in plans or differing site conditions) 3B. Public relations improvement 3C. Implementation of a Value Engineering finding 3D. Achievement of an early project completion 3E. Reduction of future maintenance 3F. Additional work desired by the County 3G. Compliance requirements of new laws and/or policies 3H. Cost savings opportunity discovered during construction 3I. Implementation of improved technology or better process 3J. Price adjustment on finished work (price reduced in exchange for acceptance) 3K. Addition of stock account or material supplied by state provision 3L. Revising safety work/measures desired by the County 3M. Other
4. Third Party Accommodation	4A. Failure of a third party to meet commitment 4B. Third party requested work 4C. Compliance requirements of new laws and/or policies (impacting third party) 4D. Other
5. Contractor Convenience	5A. Contractor exercises option to change the traffic control plan 5B. Contractor requested change in the sequence and/or method of work 5C. Payment for Partnering workshop 5D. Additional safety work/measures desired by the contractor 5E. Other
6. Untimely ROW/Utilities	6A. Right-of-Way not clear (third party responsibility for ROW) 6B. Right-of-Way not clear (County responsibility for ROW) 6C. Utilities not clear 6D. Other

Williamson County Road Bond Program

Lakeline Blvd Phase 2
Williamson County Project No. 14IFB00219

Change Order No. 2

Reason for Change

As required by Contract Item 3268 Dense Graded Hot Mix Asphalt (QC/QA), this Change Order adds new Contract items to adjust the compensation paid to the Contractor based on the quality of the hot mix asphalt pavement produced and placed. Specific job control tests were run on the asphalt (see attached back-up documentation) to monitor the quality of the asphalt mix. Using the results of these tests, in conjunction with formulas as outlined in the TxDOT specification, the Contractor was either awarded a bonus or assessed a penalty. This Change Order also adds additional quantities and a new Contract item to compensate the contractor for installing additional small signs and object markers along the roadway. Twenty (20) days are being added for actual delays associated with the discovery and mitigation of the karst feature found on November 11, 2014. A force account item was added in Change Order No. 1, to pay for the costs of the mitigation. The karst feature was located in the bioswale area near Station 69+00 and impacted the completion of the bioswale.

Following is a summary of the new items required for this Change Order.

ITEM	DESCRIPTION	QTY	UNIT
658-2329	INSTL DEL ASSM (D-SW) SZ 1 (FLX) GND	74	EA
3268-WC01	D-GR HMA (QC/QA) TY-B PG64-22 BONUS/PENALTY	1	LS
3268-WC02	D-GR HMA (QC/QA) TY-C SAC B PG70-22 BONUS/PENALTY	1	LS
9999-010	ADDITIONAL PROJECT SIGNS	1	LS

This Change Order results in a net increase of $18,766.35 to the Contract amount, for an adjusted Contract amount of $2,782,275.37. The original Contract amount was $2,768,985.10. As a result of this and all Change Orders to-date, $13,290.27 has been added to the Contract resulting in a 0.5% increase in the Contract cost. Twenty (20) additional days will be added to the Contract as a result of this Change Order.

HNTB Corporation

James Klotz, P.E.

Lakeline Blvd Phase 2

Project: 14IFB00219

ITEM 3268 2008: D-GR HMA(QCQA) TY-B PG64-22
BONUS/PENALTY

PRODUCTION & PLACEMENT BONUS / PENALTY					
Lot #	**Production Bonus**	**Placement Bonus**	**Production Penalty**	**Placement Penalty**	**Total Bonus or Penalty**
1	$877.12	$0.00			$877.12
2	$1,664.39			-$462.33	$1,202.06
3	$1,246.10	$1,894.07			$3,140.17
Totals	**$3,787.61**	**$1,894.07**	**$0.00**	**-$462.33**	**$5,219.35**

TEXAS DEPARTMENT OF TRANSPORTATION

QC/QA PAY ADJUSTMENT

SAMPLE ID:	Lakeline Blvd Phase II	DATE LOT OPENED:	01-06-2015
LOT NUMBER:	1	LETTING DATE:	
SAMPLE STATUS:		CONTROLLING CSJ:	
COUNTY:	WILLIAMSON	SPEC YEAR:	2004
SAMPLED BY:	Juan Carlos Gutierrez #2255	SPEC ITEM:	
SAMPLE LOCATION:		SPECIAL PROVISION:	
MATERIAL CODE:	1.11610	MIX TYPE:	ITEM341_B_Fine_Base
MATERIAL NAME:	515-64B1010		
PRODUCER:	Industrial Asphalt - Florence		
AREA ENGINEER:		PROJECT MANAGER:	

COURSE\LIFT:	Non-Surface (<8 i	STATION:		DIST. FROM CL:	
Total Quantity Actually Placed, Tons:	~~1,086.97~~ 1063.7			Bid Price / Tons:	$75.00
Quantity Placed But No Air Void Testing Was Required, Tons:				First Lot?	Yes

LABORATORY MOLDED DENSITY

TxDOT Sublot:	1	2	3	4
Design Target Density:	97.0	97.0	97.0	97.0
Average Percent Density:	97.1	97.8	97.7	97.9
Absolute Deviation:	0.1	0.8	0.7	0.9
Auto 1.000 Pay Factor:				
Pay Factor:	1.050	1.013	1.019	1.006

Average Pay Factor:	1.022
Production Pay Factor:	1.022

IN PLACE AIR VOIDS

TxDOT Sublot:	1	2	3	4
Average Percent Air Voids:	3.0	2.7	4.4	3.8
Auto 1.000 Pay Factor:				
Pay Factor:	1.000	1.000	1.000	1.000

Average Pay Factor:	1.000
Placement Pay Factor:	1.000

PAYMENT FOR ITEM = P_I

P_I = Bid price x (Total quantity actually placed - Quantity left in place without payment)
P_I = Bid price x Quantity with payment
$P_I = BP \times Q_{PAY}$
P_I = $75.00 x 1,086.97
P_I = $81,522.75

PAY ADJUSTEMENT FOR PRODUCTION = P_{PR}

P_{PR} = [(Payment for item x Production pay factor) - Payment for item] / 2
$P_{PR} = [(P_I \times PF_{PR}) - P_I] / 2$
P_{PR} = [($81,522.75 x 1.022) - $81,522.75] / 2
P_{PR} = ~~$896.75~~ $ 877.12

PAY ADJUSTEMENT FOR PLACEMENT = P_{PL}

$P_{PL} = [(BP \times (Q_{PAY} - \text{Quantity without AV req}) \times \text{Placement pay factor}) - (BP \times (Q_{PAY} - \text{Quantity without AV req}))]/2$
$P_{PL} = [(BP \times (Q_{PAY} - Q_{MIS}) \times PF_{PL}) - (BP \times (Q_{PAY} - Q_{MIS}))] / 2$
P_{PL} = [($75.00 x (1,086.97 - 0.00) x 1.000) - ($75.00 x (1,086.97 - 0.00))] / 2
P_{PL} = $0.00

TOTAL PAY

Total Pay = Payment for item + Pay adjustment for production + Pay adjustment for placement
Total Pay = $P_I + P_{PR} + P_{PL}$
Total Pay = $81,522.75 + $896.75 + $0.00
Total Pay = $82,419.50

Signature of Contractor Representative

Signature of TX DOT Representative

QC/QA PAY ADJUSTMENT

Mix: Ty B

Lot: 1

Bid Price: $ 75.00

Quantity Actually Placed: 1063.17 tons

Quantity Reported: 1086.97 tons

Difference: 23.80 tons

* A load of hot mix was rejected due to a temperature that was above the specified limits.

Pay Adjustment Factor for Production: 1.022

Pay Adjustment Factor for Placement: 1.00

PRODUCTION BONUS/PENALTY

1063.17 tons x $75.00 x 1.000 = $79,737.75

1063.17 tons x $75.00 x 1.022 = $81,491.98

Difference: = $1754.23 /2

= $877.12

PLACEMENT BONUS/PENALTY

No change.

TEXAS DEPARTMENT OF TRANSPORTATION

QC/QA PAY ADJUSTMENT

SAMPLE ID:	Lakeline Blvd Phase II	DATE LOT OPENED:	01-16-2015
LOT NUMBER:	2	LETTING DATE:	
SAMPLE STATUS:		CONTROLLING CSJ:	
COUNTY:	WILLIAMSON	SPEC YEAR:	2004
SAMPLED BY:	Juan Carlos Gutierrez #2255	SPEC ITEM:	
SAMPLE LOCATION:		SPECIAL PROVISION:	
MATERIAL CODE:	1.11610	MIX TYPE:	ITEM341_B_Fine_Base
MATERIAL NAME:	515-64B1010		
PRODUCER:	Industrial Asphalt - Florence		
AREA ENGINEER:		PROJECT MANAGER:	

COURSE\LIFT:	Non-Surface (<8 i	STATION:		DIST. FROM CL:	

Total Quantity Actually Placed, Tons:	1,232.88	Bid Price / Tons:	$75.00
Quantity Placed But No Air Void Testing Was Required, Tons:		First Lot?	

LABORATORY MOLDED DENSITY

TxDOT Sublot:	1	2	3	4
Design Target Density:	97.0	97.0	97.0	97.0
Average Percent Density:	96.4	97.7	96.9	97.2
Absolute Deviation:	0.6	0.7	0.1	0.2
Auto 1.000 Pay Factor:				
Pay Factor:	1.025	1.019	1.050	1.050

Average Pay Factor:	1.036
Production Pay Factor:	1.036

IN PLACE AIR VOIDS

TxDOT Sublot:	1	2	3	4
Average Percent Air Voids:	4.7	4.2	4.6	4.9
Auto 1.000 Pay Factor:				
Pay Factor:	1.005	0.930	0.990	1.035

Average Pay Factor:	0.990
Placement Pay Factor:	0.990

PAYMENT FOR ITEM = P_I

P_I = Bid price x (Total quantity actually placed - Quantity left in place without payment)
P_I = Bid price x Quantity with payment
$P_I = BP \times Q_{PAY}$
P_I = $75.00 x 1,232.88
P_I = $92,466.00

PAY ADJUSTEMENT FOR PRODUCTION = P_{PR}

$P_{PR} = [(\text{Payment for item} \times \text{Production pay factor}) - \text{Payment for item}] / 2$
$P_{PR} = [(P_I \times PF_{PR}) - P_I] / 2$
P_{PR} = [($92,466.00 x 1.036) - $92,466.00] / 2
P_{PR} = $1,664.39

PAY ADJUSTEMENT FOR PLACEMENT = P_{PL}

$P_{PL} = [(BP \times (Q_{PAY} - \text{Quantity without AV req}) \times \text{Placement pay factor}) - (BP \times (Q_{PAY} - \text{Quantity without AV req}))]/2$
$P_{PL} = [(BP \times (Q_{PAY} - Q_{MS}) \times PF_{PL}) - (BP \times (Q_{PAY} - Q_{MS}))] / 2$
P_{PL} = [($75.00 x (1,232.88 - 0.00) x 0.990) - ($75.00 x (1,232.88 - 0.00))] / 2
P_{PL} = *($462.33)*

TOTAL PAY

Total Pay = Payment for item + Pay adjustment for production + Pay adjustment for placement
Total Pay = $P_I + P_{PR} + P_{PL}$
Total Pay = $92,466.00 + $1,664.39 + ($462.33)
Total Pay = $93,668.06

Signature of Contractor Representative

Signature of TX DOT Representative

TEXAS DEPARTMENT OF TRANSPORTATION

QC/QA PAY ADJUSTMENT

SAMPLE ID:	Lakeline Blvd Phase II	DATE LOT OPENED:	01-17-2015
LOT NUMBER:	3	LETTING DATE:	
SAMPLE STATUS:		CONTROLLING CSJ:	
COUNTY:	WILLIAMSON	SPEC YEAR:	2004
SAMPLED BY:	Juan Carlos Gutierrez #2255	SPEC ITEM:	
SAMPLE LOCATION:		SPECIAL PROVISION:	
MATERIAL CODE:	1.11610	MIX TYPE:	ITEM341_B_Fine_Base
MATERIAL NAME:	515-64B1010		
PRODUCER:	Industrial Asphalt - Florence		
AREA ENGINEER:		PROJECT MANAGER:	

COURSE\LIFT:	Non-Surface (<8 i	STATION:		DIST. FROM CL:	

Total Quantity Actually Placed, Tons:	1,329.17	Bid Price / Tons:	$75.00
Quantity Placed But No Air Void Testing Was Required, Tons:		First Lot?	

LABORATORY MOLDED DENSITY

TxDOT Sublot:	1	2	3	4
Design Target Density:	97.0	97.0	97.0	97.0
Average Percent Density:	96.5	96.0	96.3	97.2
Absolute Deviation:	0.5	1.0	0.7	0.2
Auto 1.000 Pay Factor:				
Pay Factor:	1.031	1.000	1.019	1.050

Average Pay Factor:	1.025
Production Pay Factor:	1.025

IN PLACE AIR VOIDS

TxDOT Sublot:	1	2	3	4
Average Percent Air Voids:	5.7	6.8	6.8	6.9
Auto 1.000 Pay Factor:				
Pay Factor:	1.050	1.034	1.034	1.032

Average Pay Factor:	1.038
Placement Pay Factor:	1.038

PAYMENT FOR ITEM = P_I

P_I = Bid price x (Total quantity actually placed - Quantity left in place without payment)
P_I = Bid price x Quantity with payment
$P_I = BP \times Q_{PAY}$
P_I = $75.00 x 1,329.17
P_I = $99,687.75

PAY ADJUSTEMENT FOR PRODUCTION = P_{PR}

P_{PR} = [(Payment for item x Production pay factor) - Payment for item] / 2
$P_{PR} = [(P_I \times PF_{PR}) - P_I] / 2$
P_{PR} = [($99,687.75 x 1.025) - $99,687.75] / 2
P_{PR} = $1,246.10

PAY ADJUSTEMENT FOR PLACEMENT = P_{PL}

P_{PL} = [(BP x (Q_{PAY} - Quantity without AV req) x Placement pay factor) - (BP x (Q_{PAY} - Quantily without AV req))]/2
$P_{PL} = [(BP \times (Q_{PAY} - Q_{MIS}) \times PF_{PL}) - (BP \times (Q_{PAY} - Q_{MIS}))] / 2$
P_{PL} = [($75.00 x (1,329.17 - 0.00) x 1.038) - ($75.00 x (1,329.17 - 0.00))] / 2
P_{PL} = $1,894.07

TOTAL PAY

Total Pay = Payment for item + Pay adjustment for production + Pay adjustment for placement
Total Pay = $P_I + P_{PR} + P_{PL}$
Total Pay = $99,687.75 + $1,246.10 + $1,894.07
Total Pay = $102,827.92

Signature of Contractor Representative

Signature of TX DOT Representative

Lakeline Blvd Phase 2

Project: 14IFB00219

ITEM 3268-2027: D-GR HMA(QCQA) TY-C SAC B PG70-22 BONUS/PENALTY

PRODUCTION & PLACEMENT BONUS / PENALTY					
Lot #	**Production Bonus**	**Placement Bonus**	**Production Penalty**	**Placement Penalty**	**Total Bonus or Penalty**
1	$2,608.20	$1,871.10			$4,479.30
2					$0.00
3					$0.00
					$0.00
Totals	**$2,608.20**	**$1,871.10**	**$0.00**	**$0.00**	**$4,479.30**

TEXAS DEPARTMENT OF TRANSPORTATION

QC/QA PAY ADJUSTMENT

SAMPLE ID:	Lakeline Blvd	DATE LOT OPENED:	04-01-2015
LOT NUMBER:	01	LETTING DATE:	
SAMPLE STATUS:		CONTROLLING CSJ:	
COUNTY:	Williamson	SPEC YEAR:	2004
SAMPLED BY:	Ana Cervantes	SPEC ITEM:	3228
SAMPLE LOCATION:	Plant to Truck	SPECIAL PROVISION:	
MATERIAL CODE:	1.1078	MIX TYPE:	SS3224_C_Coarse_Surface
MATERIAL NAME:	64NC1020-2		
PRODUCER:	Industrial Asphalt and Aggregates - Florence Plant		
AREA ENGINEER:		PROJECT MANAGER:	

COURSE\LIFT:	Surface	STATION:		DIST. FROM CL:	

Lot Opened:	4/1/2015	Total Quantity Actually Placed, Tons:	1,400.00	Bid Price / Tons:	$81.00
Quantity Placed But No Air Void Testing Was Required, Tons:				First Lot?	Yes

LABORATORY MOLDED DENSITY

TxDOT Sublot:	1	2	3	4
Design Target Density:	97.0	97.0	97.0	97.0
Average Percent Density:	96.7	97.1	96.6	96.8
Absolute Deviation:	0.3	0.1	0.4	0.2
Auto 1.000 Pay Factor:				
Pay Factor:	1.044	1.050	1.038	1.050

Average Pay Factor:	1.046
Production Pay Factor:	1.046

IN PLACE AIR VOIDS

TxDOT Sublot:	1	2	3	4
Average Percent Air Voids:	7.0	7.5	6.9	6.1
Auto 1.000 Pay Factor:				
Pay Factor:	1.030	1.020	1.032	1.048

Average Pay Factor:	1.033
Placement Pay Factor:	1.033

PAYMENT FOR ITEM = P_I

P_I = Bid price x (Total quantity actually placed - Quantity left in place without payment)
P_I = Bid price x Quantity with payment
$P_I = BP \times Q_{PAY}$
P_I = $81.00 x 1,400.00
P_I = $113,400.00

PAY ADJUSTMENT FOR PRODUCTION = P_{PR}

P_{PR} = [(Payment for item x Production pay factor) - Payment for item] / 2
$P_{PR} = [(P_I \times PF_{PR}) - P_I] / 2$
P_{PR} = [($113,400.00 x 1.046) - $113,400.00] / 2
P_{PR} = $2,608.20

PAY ADJUSTMENT FOR PLACEMENT = P_{PL}

$P_{PL} = [(BP \times (Q_{PAY} - \text{Quantity without AV req}) \times \text{Placement pay factor}) - (BP \times (Q_{PAY} - \text{Quantity without AV req}))]/2$
$P_{PL} = [(BP \times (Q_{PAY} - Q_{MIS}) \times PF_{PL}) - (BP \times (Q_{PAY} - Q_{MIS}))] / 2$
P_{PL} = [($81.00 x (1,400.00 - 0.00) x 1.033) - ($81.00 x (1,400.00 - 0.00))] / 2
P_{PL} = $1,871.10

TOTAL PAY

Total Pay = Payment for item + Pay adjustment for production + Pay adjustment for placement
Total Pay = $P_I + P_{PR} + P_{PL}$
Total Pay = $113,400.00 + $2,608.20 + $1,871.10
Total Pay = $117,879.30

Signature of Contractor Representative

Signature of TX DOT Representative

PROJECT: LAKELINE BLVD EXTENSTION PH 2
GENERAL CONTRACTOR : DNT CONSTRUCTION
ENGINEER: HNTB
DATE: 5/14/15

Change Order Proposal #6

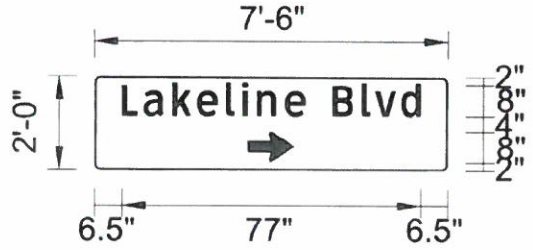
ITEM	QTY	UNIT	DESCRIPTION	UNIT PRICE	TOTAL	
1	74	EA	Object Markers	$36.05	$2,667.70	EXIST ITEM
2	1	EA	96" x 36" W1-7T Two Way Arrow Sign	$1,380.00	$1,380.00	LUMPSUM
3	2	EA	N. Lakeline Signs	$920.00	$1,840.00	
4	1	EA	R3-8 Signs (Lane Designation Arrow Sign)	$865.00	$865.00	
5	1	EA	W1-2R with W13-1P Sign	$865.00	$865.00	
6	12	EA	Additional Signs	$425.00	$5,100.00	EXIST ITEM
			TOTAL		$12,717.70	

Total Change Proposal $12,717.70

Note: Layout by HNTB

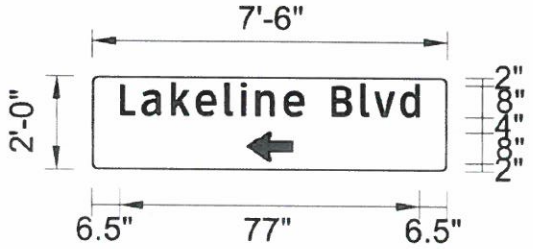
ITEM 9999-010 ADDITIONAL SIGNS LUMP SUM

$ 1380.00
1840.00
865.00
865.00
$ 4950.00



1.5" Radius, 1.0" Border, White on Green;
FONT: ClearviewHwy-3-W

Panel Style: Street name 8-6in.ssi
M.U.T.C.D.: 2009 Edition



1.5" Radius, 1.0" Border, White on Green;
FONT: ClearviewHwy-3-W

Panel Style: Street name 8-6in.ssi
M.U.T.C.D.: 2009 Edition

STATE OF TEXAS
ALEJANDRO REYNA JR.
101243
REGISTERED
PROFESSIONAL ENGINEER

5-8-15

LAKELINE BOULEVARD
SIGNS

SCALE:

HNTB The HNTB Companies Infrastructure Solutions

Texas Department of Transportation © 2013

DRAWING PREPARED BY: HNTB

STATE	DIST.	COUNTY
TEXAS	AUS	WILLIAMSON

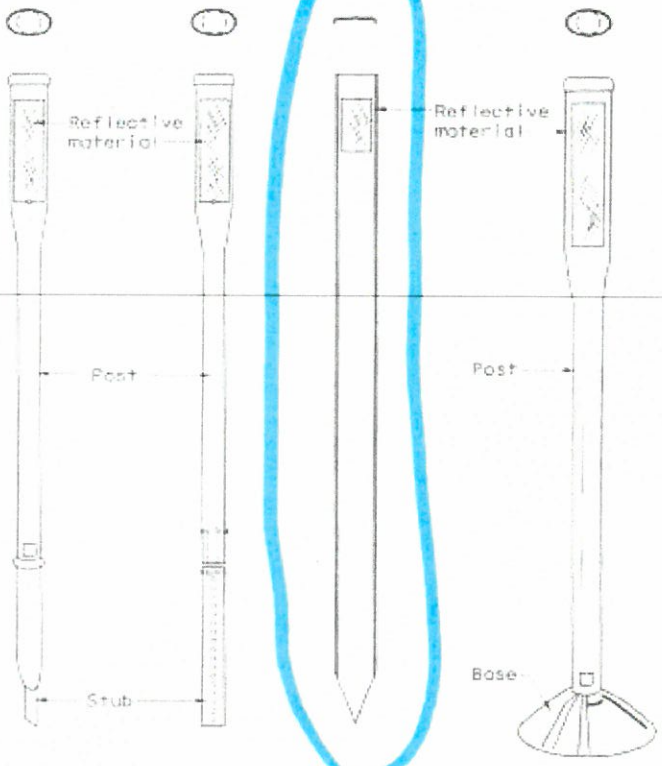
Pen Table:R:\1834+Phase+II\Project Development\Plan\SUP+11317 - Copy2.pen
Design Filename: C:\Users\AVolreyna\Desktop\gtfr+Bdr.dgn
Scale: 1:1
Plotted on: 08-MAY-2015 12:54

YPE 3

DELINEATORS

2. Yellow, White and Red: Conformable Reflective Sheeting as per OMS 8300.

BARRIER REFL



EMBEDDED

SURFACE MOUNT

658-2329 (D-SW) S2 1 (FLX) GND

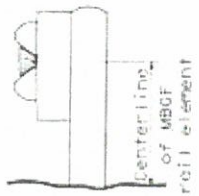
NOTES

1. See Material Producer List for approved devices.
2. Install to manufacturer's recommendations.

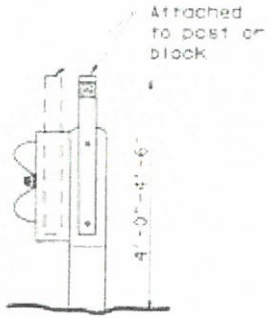
FLEXIBLE POSTS



CTB



GF1



GF2

BARRIER REFLECTORS

GENERAL NOTES

1. Place delineator the same distanc
2. Where a restrict placement from t affected object innermost edge o
3. When object mark from the edge of possible to main If this is the c as close to the
4. Install all deli barrier reflecto manufacturer's r

DEPARTMENTAL

FLEXIBLE DELINEATOR POSTS (EMBEDDED & S

SIGN FACE MATERIALS

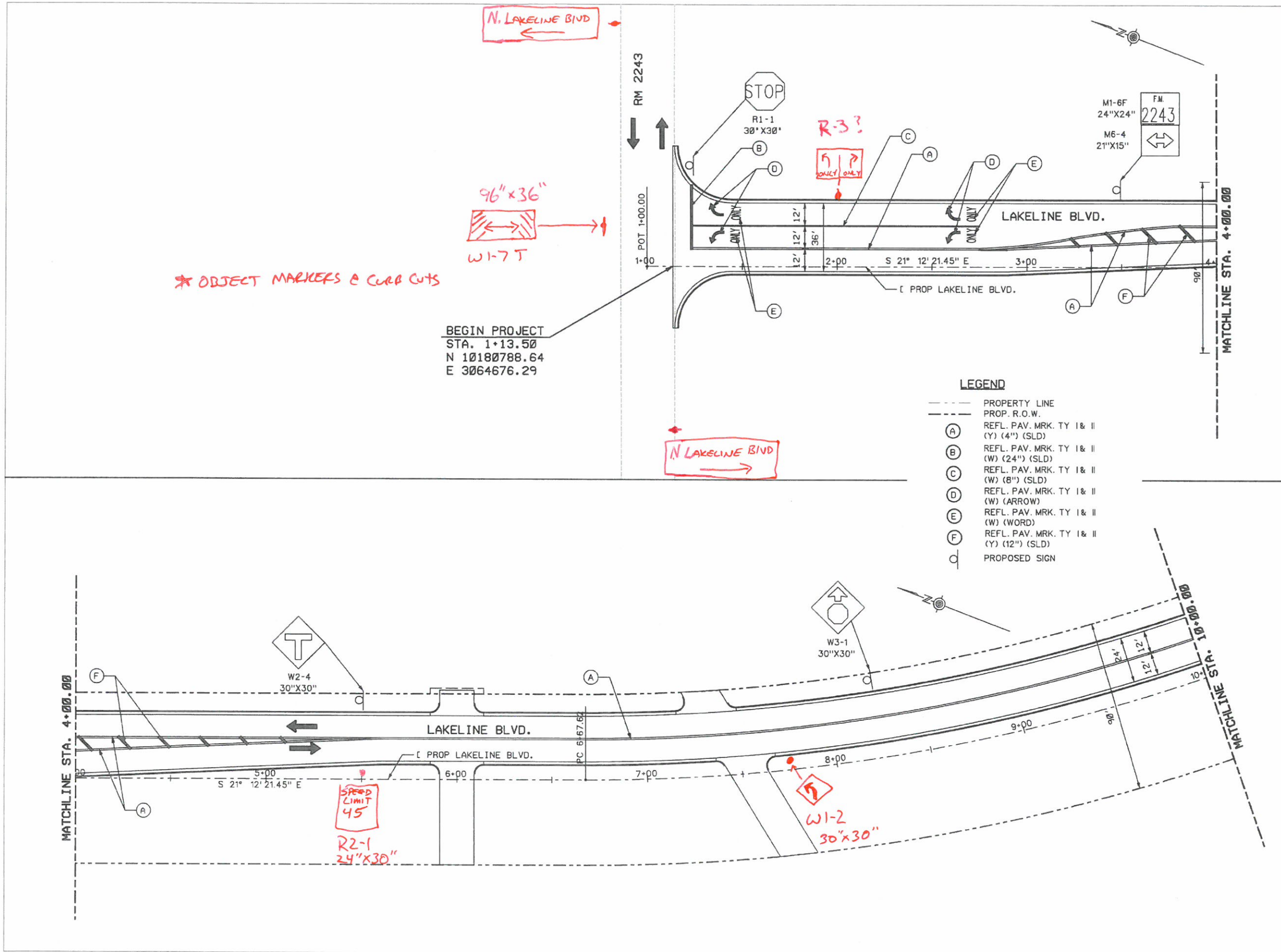
DELINEATORS AND OBJ

Texas D
Traff

DEL
OBJE
INSTA
MATERIA

REVISED August 2021

10-02



BAKER-AICKLEN & ASSOCIATES, INC.
Engineers • Surveyors • GIS • Planning
507 W. LIBERTY AVE.
ROUND ROCK, TX 78664
(512) 244-9620
ENGINEERING FIRM # F-45

0 25 50

SCALE: 1" = 50'

STATE OF TEXAS
KENNETH C. AICKLEN
47318
REGISTERED PROFESSIONAL ENGINEER
12/13/13

NOTES:
1. THE LOCATION AND ORIENTATION OF THE PROPOSED SIGNS, PAVEMENT MARKINGS, AND DELINEATORS SHALL BE IN ACCORDANCE WITH THE STANDARD DETAILS INCLUDED HEREIN AND THE TEXAS MUTCD.

WILLIAMSON COUNTY
1848

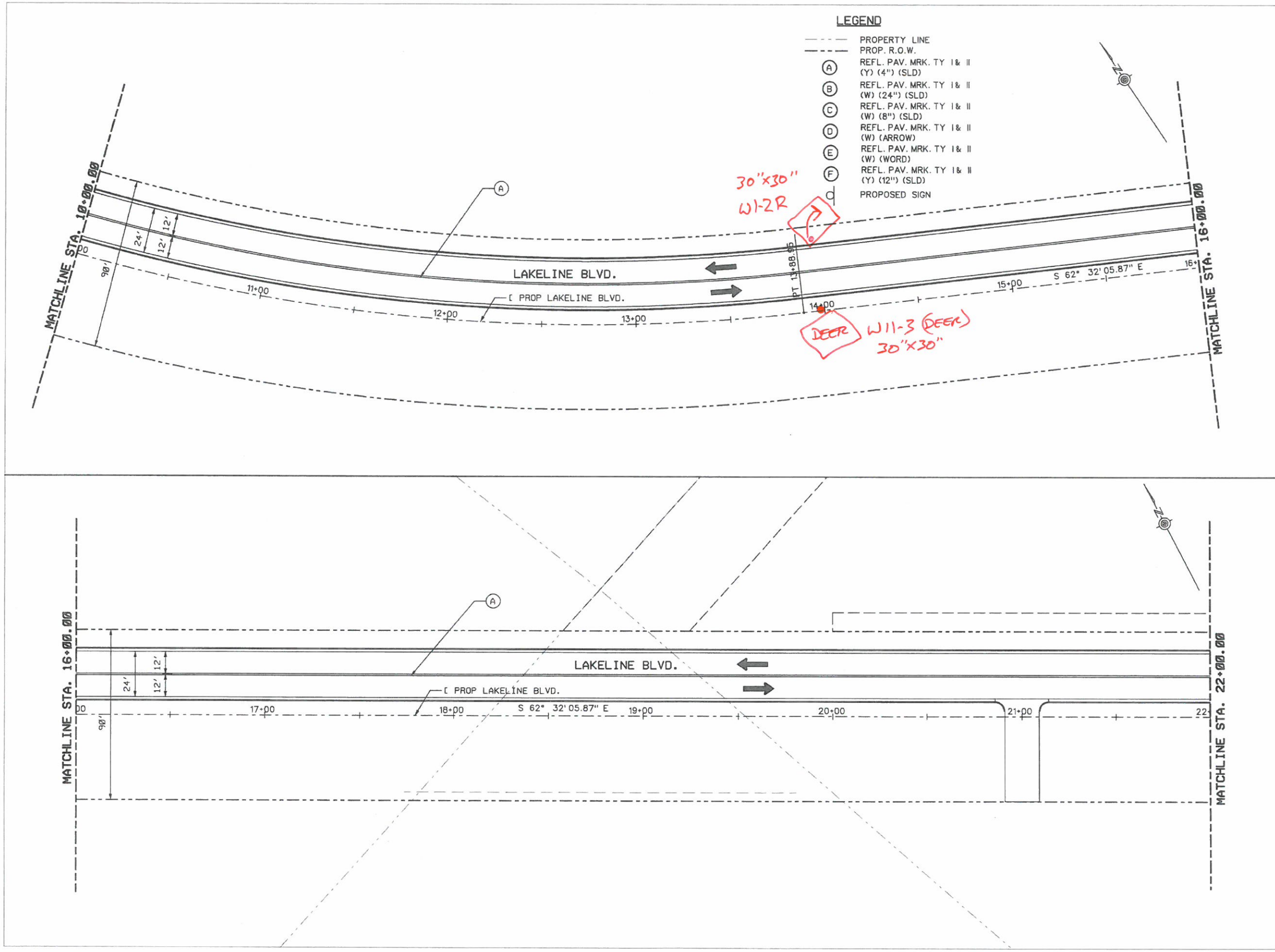
NO.	DATE	REVISIONS	RECOM'D

PROJECT
LAKELINE BLVD.

SHEET 1 OF 6

SIGNING AND PAVEMENT MARKING PLAN
STA. 1+00 - STA. 10+00

PROJECT NUMBER	DATE
	12/6/2013
DRAWN DESIGNED APPROVED	SHEET NO.
	122 A



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507 W. LIBERTY AVE.
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ENGINEERING FIRM # F-45

0 25 50

SCALE: 1" = 50'

STATE OF TEXAS
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NOTES:
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WILLIAMSON COUNTY
1848

NO.	DATE	REVISIONS	RECOM'D

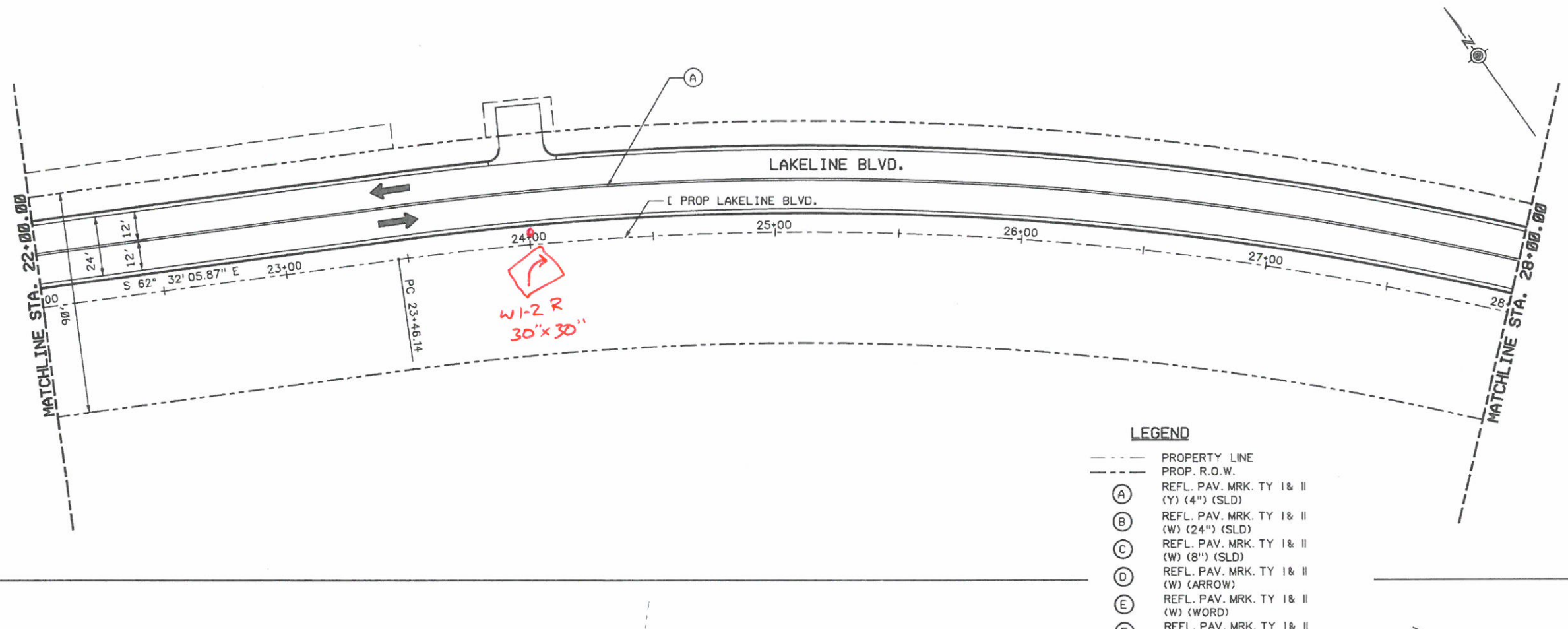
PROJECT

LAKELINE BLVD.

SHEET 2 OF 6

SIGNING AND
PAVEMENT MARKING PLAN
STA. 10+00 - STA. 22+00

PROJECT NUMBER	DATE
	12/6/2013
DRAWN DESIGNED APPROVED	SHEET NO.
	123 A



LEGEND

- PROPERTY LINE
- PROP. R.O.W.
- (A) REFL. PAV. MRK. TY I& II (Y) (4") (SLD)
- (B) REFL. PAV. MRK. TY I& II (W) (24") (SLD)
- (C) REFL. PAV. MRK. TY I& II (W) (8") (SLD)
- (D) REFL. PAV. MRK. TY I& II (W) (ARROW)
- (E) REFL. PAV. MRK. TY I& II (W) (WORD)
- (F) REFL. PAV. MRK. TY I& II (Y) (12") (SLD)
- PROPOSED SIGN

BAKER-AICKLEN & ASSOCIATES, INC.
Engineers • Surveyors • GIS • Planning
507 W. LIBERTY AVE.
ROUND ROCK, TX 78664
(512) 244-9620
ENGINEERING FIRM # F-45

0 25 50

SCALE: 1" = 50'

STATE OF TEXAS
KENNETH C. AICKLEN
47318
REGISTERED
PROFESSIONAL ENGINEER

NOTES:

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WILLIAMSON COUNTY
1848

NO.	DATE	REVISIONS	RECOM'D

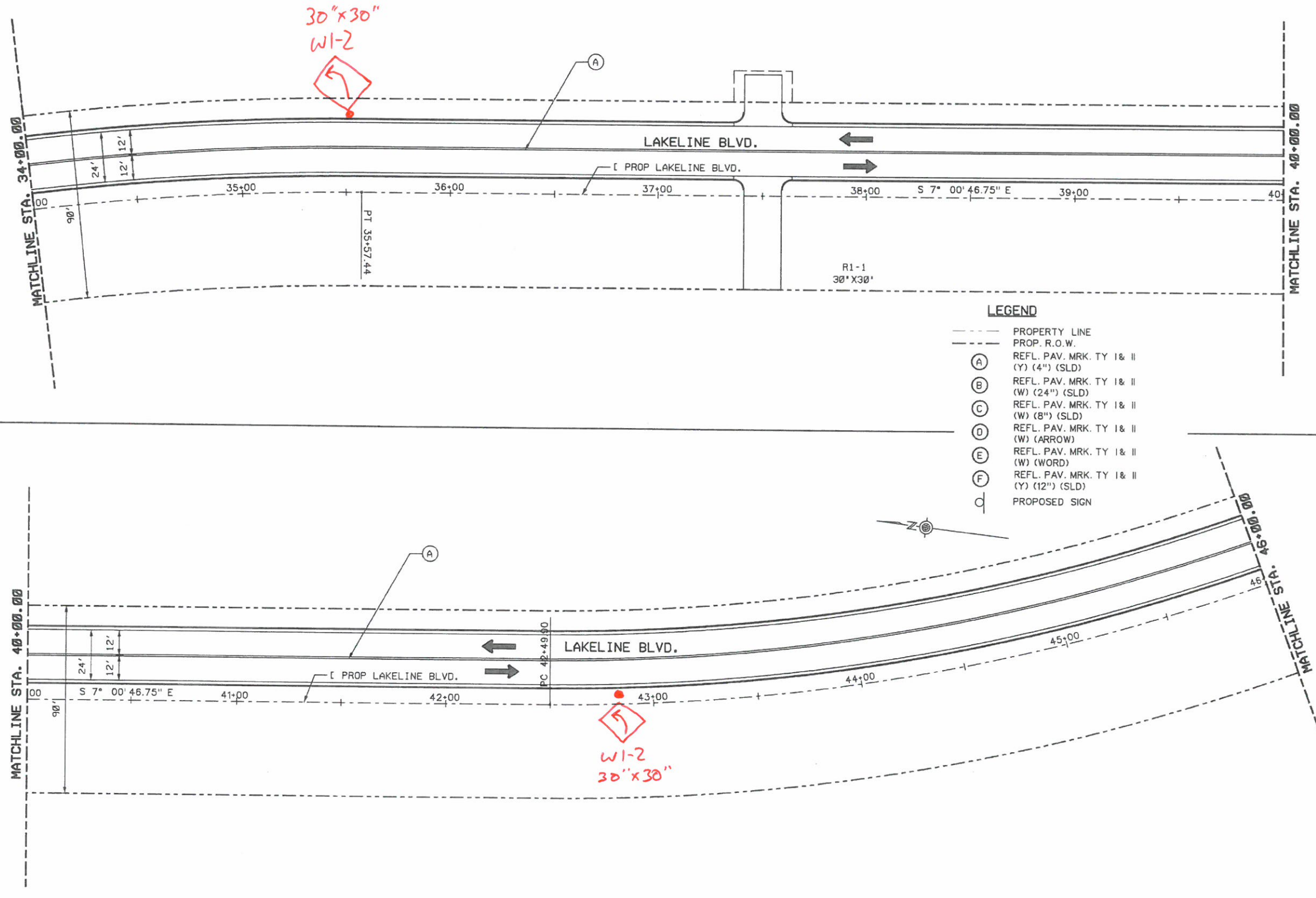
PROJECT

LAKELINE BLVD.

SHEET 3 OF 6

SIGNING AND PAVEMENT MARKING PLAN STA. 22+00 - STA. 34+00

PROJECT NUMBER	DATE
	12/6/2013
DRAWN DESIGNED APPROVED	SHEET NO.
	124 A



LEGEND

- PROPERTY LINE
- PROP. R.O.W.
- (A) REFL. PAV. MRK. TY I & II (Y) (4") (SLD)
- (B) REFL. PAV. MRK. TY I & II (W) (24") (SLD)
- (C) REFL. PAV. MRK. TY I & II (W) (8") (SLD)
- (D) REFL. PAV. MRK. TY I & II (W) (ARROW)
- (E) REFL. PAV. MRK. TY I & II (W) (WORD)
- (F) REFL. PAV. MRK. TY I & II (Y) (12") (SLD)
- PROPOSED SIGN

BAKER-AICKLEN & ASSOCIATES, INC.
Engineers • Surveyors • GIS • Planning
507 W. LIBERTY AVE.
ROUND ROCK, TX 78664
(512) 244-9620
ENGINEERING FIRM # F-45

0 25 50

SCALE: 1" = 50'

STATE OF TEXAS
KENNETH C. AICKLEN
47318
REGISTERED
PROFESSIONAL ENGINEER
12/13/13

NOTES:
1. THE LOCATION AND ORIENTATION OF THE PROPOSED SIGNS, PAVEMENT MARKINGS, AND DELINEATORS SHALL BE IN ACCORDANCE WITH THE STANDARD DETAILS INCLUDED HEREIN AND THE TEXAS MUTCD.

WILLIAMSON COUNTY
1848

NO.	DATE	REVISIONS	RECOM'D

PROJECT

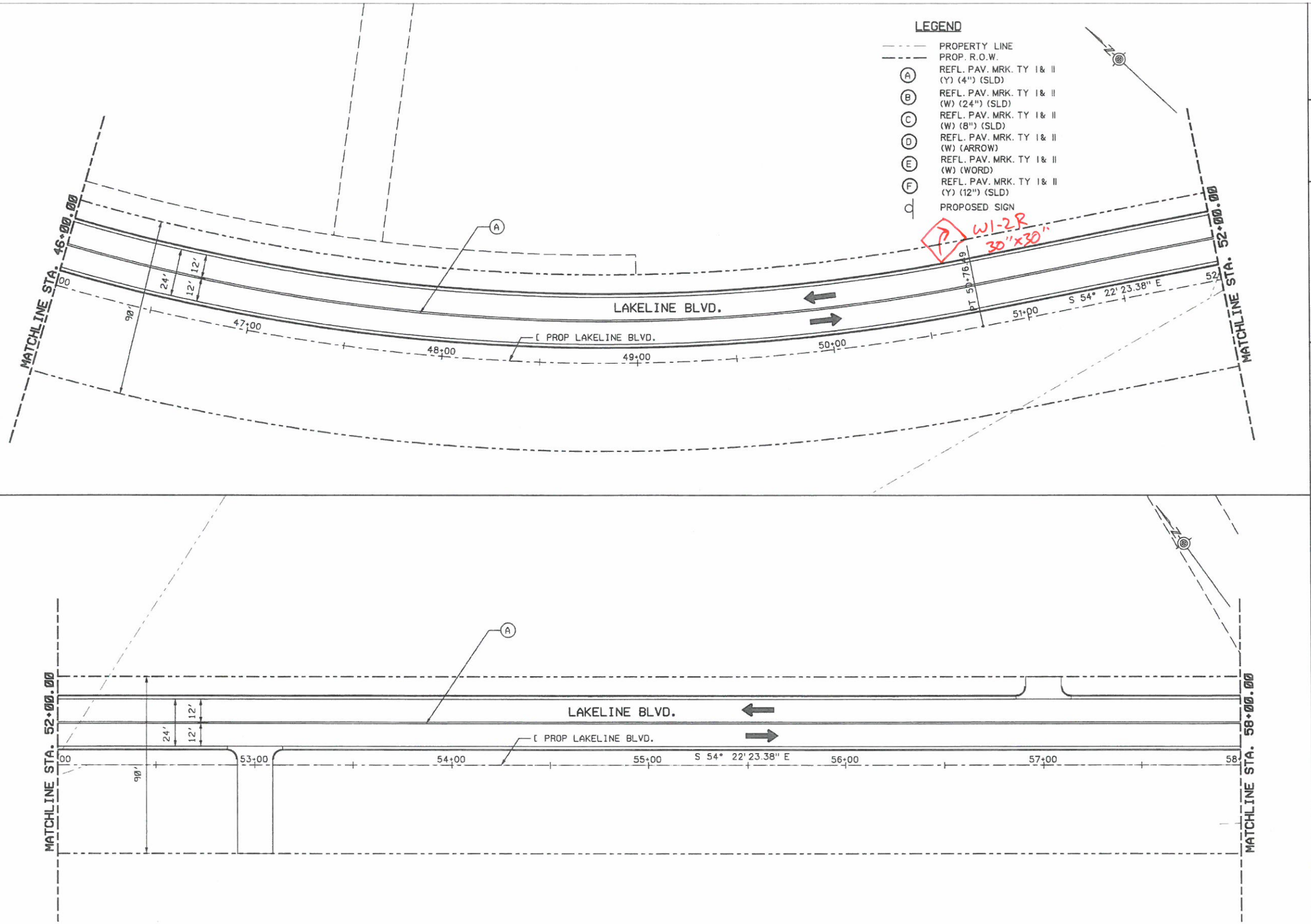
LAKELINE BLVD.

SHEET 4 OF 6

SIGNING AND PAVEMENT MARKING PLAN STA. 34+00 - STA. 46+00

PROJECT NUMBER	DATE
	12/6/2013

DRAWN	DESIGNED	APPROVED	SHEET NO.
			125 A



BAKER-AICKLEN & ASSOCIATES, INC.
Engineers • Surveyors • GIS • Planning

507 W. LIBERTY AVE.
ROUND ROCK, TX 78664
(512) 244-9620
ENGINEERING FIRM # F-45

0 25 50
SCALE: 1" = 50'

STATE OF TEXAS
KENNETH C. AICKLEN
47318
REGISTERED PROFESSIONAL ENGINEER
12/13/13

NOTES:
1. THE LOCATION AND ORIENTATION OF THE PROPOSED SIGNS, PAVEMENT MARKINGS, AND DELINEATORS SHALL BE IN ACCORDANCE WITH THE STANDARD DETAILS INCLUDED HEREIN AND THE TEXAS MUTCD.

WILLIAMSON COUNTY
1848

NO.	DATE	REVISIONS	RECOM'D

PROJECT

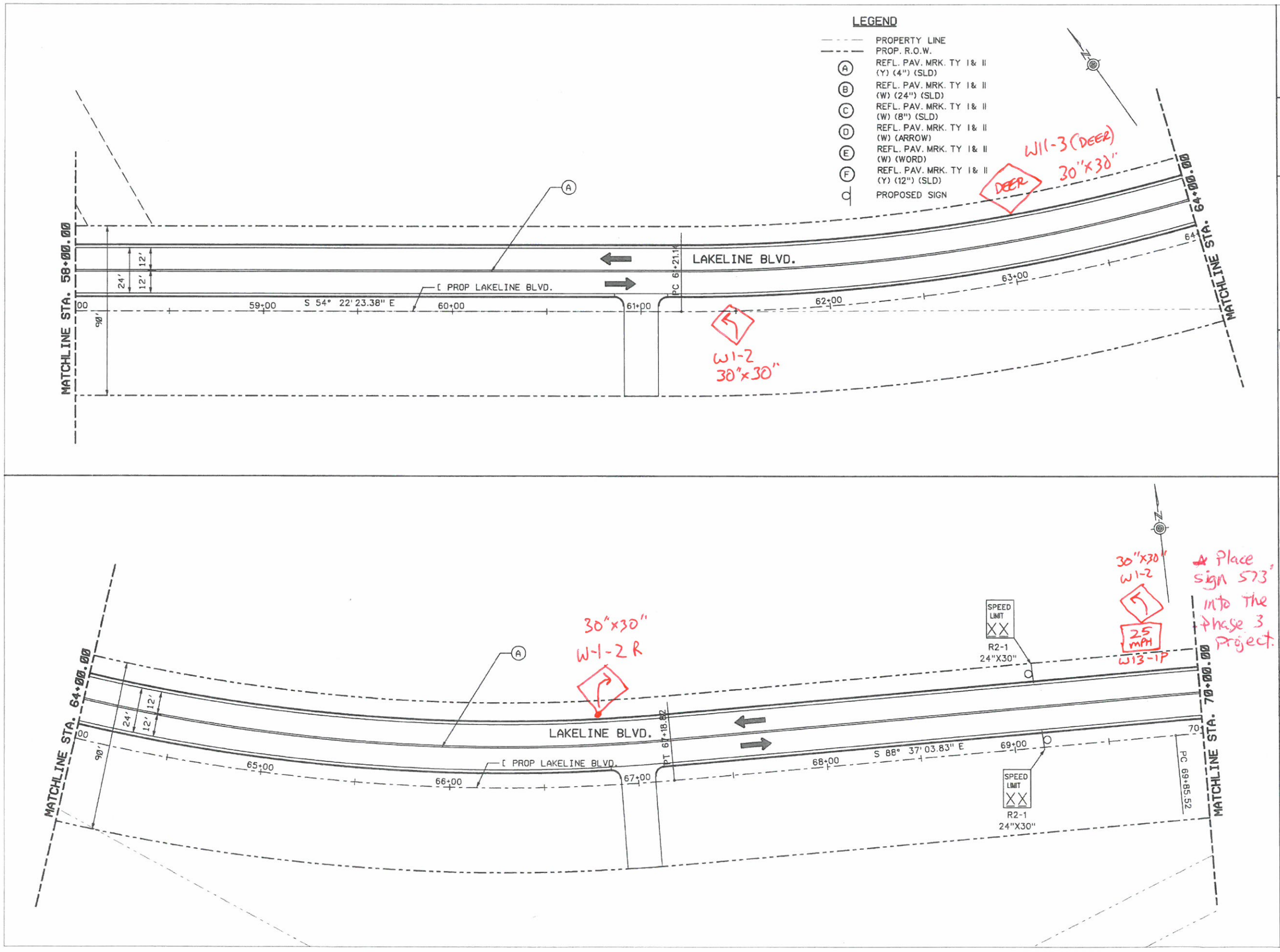
LAKELINE BLVD.

SHEET 5 OF 6

SIGNING AND
PAVEMENT MARKING PLAN
STA. 46+00 - STA. 58+00

PROJECT NUMBER	DATE
	12/6/2013

DRAWN	DESIGNED	APPROVED	SHEET NO.
			126 A



BAKER-AICKLEN & ASSOCIATES, INC.
Engineers • Surveyors • GIS • Planning
507 W. LIBERTY AVE.
ROUND ROCK, TX 78664
(512) 244-9620
ENGINEERING FIRM # F-45

0 25 50

SCALE: 1" = 50'

STATE OF TEXAS
KENNETH C. AICKLEN
47318
REGISTERED PROFESSIONAL ENGINEER
12/6/13

NOTES:
1. THE LOCATION AND ORIENTATION OF THE PROPOSED SIGNS, PAVEMENT MARKINGS, AND DELINEATORS SHALL BE IN ACCORDANCE WITH THE STANDARD DETAILS INCLUDED HEREIN AND THE TEXAS MUTCD.

WILLIAMSON COUNTY
1848

NO.	DATE	REVISIONS	RECOM'D

PROJECT

LAKELINE BLVD.

SHEET 6 OF 6

SIGNING AND PAVEMENT MARKING PLAN STA. 58+00 - STA. 70+00

PROJECT NUMBER	DATE
	12/6/2013

DRAWN	DESIGNED	APPROVED	SHEET NO.
			127A

Commissioners Court - Regular Session **21.**

Meeting Date: 09/01/2015

2006 GO Park Bond Allocations

Submitted For: Julie Kiley **Submitted By:** Jaime Aleman, County Auditor

Department: County Auditor

Agenda Category: Regular Agenda Items

Information

Agenda Item

Discuss, consider and take appropriate action on approving the transfer of $171,616.00 from 2006 GO Bond cash ending projects to South West Regional Park Pavilion (P320) and $33,344.00 to Champion Park Phase 2 (P321): Transfer $171,616.00 from 2006 GO Parks Non-Departmental (P164) to South West Regional Park Pavilion (P320), $22,585.59 from 2006 GO Parks Non-Departmental (P164) To Champion Park Phase 2 (P321), $8,298.52 from Lake Creek Trail to Champion Park Phase 2 (P321), $2,179.89 from Berry Springs Dam to Champion Park Phase 2 (P321), $280 from South West Regional Park Office (P204) to Champion Park Phase 2 (P321).

Background

Fiscal Impact

From/To	Acct No.	Description	Amount

Attachments

No file(s) attached.

Form Review

Inbox	Reviewed By	Date
County Judge Exec Asst.	Wendy Coco	08/26/2015 11:15 AM
Form Started By: Jaime Aleman		Started On: 08/20/2015 09:17 AM
Final Approval Date: 08/26/2015		

Commissioners Court - Regular Session **22.**

Meeting Date: 09/01/2015

Adam Heath Services Contract Sign Shop Phase II Amended

Submitted By: Shirley Taylor, Facilities Maintenance

Department: Facilities Maintenance

Agenda Category: Regular Agenda Items

Information

Agenda Item

Discuss, consider, and take appropriate action regarding First Amended Services Agreement for Carpentry with Adam Heath Construction on the Sign Shop (Phase II) Project.

Background

The second quote for $7,885 was missed when this contract was originally approved. Therefore, an amendment is needed to cover the work done on the second attachment and to increase the not-to-exceed amount.

Fiscal Impact

From/To	Acct No.	Description	Amount

Attachments

Adam Heath Contract Sign Shop Phase II (Amended)

Exhibit A (Sign Shop Carpentry)

Exhibit A 2 (Sign Shop Carpentry)

Form Review

Inbox	Reviewed By	Date
County Judge Exec Asst.	Wendy Coco	08/27/2015 10:05 AM
Form Started By: Shirley Taylor		Started On: 08/27/2015 09:51 AM
Final Approval Date: 08/27/2015		

THE STATE OF TEXAS §

COUNTY OF WILLIAMSON §

FIRST AMENDED SERVICES CONTRACT FOR CARPENTRY (SIGN SHOP PHASE II)

THIS SERVICES CONTRACT (hereinafter "Contract") is made and entered into by and between **Williamson County, Texas** (hereinafter "The County"), a political subdivision of the State of Texas, acting herein by and through its governing body, and **Adam Heath Construction,** (hereinafter "Service Provider"). The County agrees to engage Service Provider as an independent contractor, to assist in providing certain operational services pursuant to the following terms, conditions, and restrictions:

I.

Services: Service Provider shall provide services *as an independent contractor* pursuant to terms and policies of the Williamson County Commissioners Court. Service Provider expressly acknowledges that he, she or it is not an employee of The County. The services include, but are not limited to the following items in order to complete the project:

A. As described in the two (2) attached Statement(s) of Work/Quotation(s), both dated May 17, 2015 and designated Exhibits "A" and "B" and are both incorporated herein as if copied in full.

Should The County choose to add services in addition to those described in Exhibits "A" and "B," such additional services shall be described in a separate written amendment to this Contract wherein the additional services shall be described and the parties shall set forth the amount of compensation to be paid by The County for the additional services. Service Provider shall not begin any additional services and The County shall not be obligated to pay for any additional services unless a written amendment to this Contract has been signed by both parties.

II.

Effective Date and Term: This contract shall be in full force and effect when signed by all parties and shall continue for a reasonable time period for the specific project

and shall terminate upon project completion or when terminated pursuant to paragraph X below.

III.

Consideration and Compensation: Service Provider will be compensated based on a fixed sum for the specific project herein. **The not-to-exceed amount under this agreement is $33,710.00, unless amended by a change order and approved by the Williamson County Commissioners Court.** 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 The 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 The 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 The 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.

IV.

Insurance: Service Provider shall provide and maintain, until the services covered in this Contract is completed and accepted by The County, the minimum insurance coverage in the minimum amounts as described below. Coverage shall be written on an occurrence basis by companies authorized and admitted to do business in the State of Texas and rated A- or better by A.M. Best Company or otherwise acceptable to The County and name The County as an additional insured.

	Type of Coverage	**Limits of Liability**
a.	Worker's Compensation	Statutory
b.	Employer's Liability	
	Bodily Injury by Accident	$500,000 Ea. Accident
	Bodily Injury by Disease	$500,000 Ea. Employee
	Bodily Injury by Disease	$500,000 Policy Limit

c. Comprehensive general liability including completed operations and contractual liability insurance for bodily injury, death, or property damages in the following amounts:

COVERAGE	PER PERSON	PER OCCURRENCE
Comprehensive General Liability (*including premises, completed operations and contractual*)	$1,000,000	$1,000,000
Aggregate policy limits:		$2,000,000

d. Comprehensive automobile and auto liability insurance (covering owned, hired, leased and non-owned vehicles):

COVERAGE	PER PERSON	PER OCCURRENCE
Bodily injury (including death)	$1,000,000	$1,000,000
Property damage	$1,000,000	$1,000,000
Aggregate policy limits		No aggregate limit

Service Provider, as an independent contractor, meets the qualifications of an "Independent Contractor" under Texas Worker's Compensation Act, Texas Labor Code, Section 406.141, and must provide its employees, agents and sub-subcontractors worker's compensation coverage. Contactor shall not be entitled to worker's compensation coverage or any other type of insurance coverage held by The County.

Upon execution of this Contract, Service Provider shall provide The County with insurance certificates evidencing compliance with the insurance requirements of this Contract.

V.

Entire Contract & Incorporated Documents: This Contract constitutes the entire Contract between the parties and may not be modified or amended other than by a written instrument executed by both parties. Documents expressly incorporated (as if copied in full) into this Contract include the following:

A. As described in the two (2) attached Statement(s) of Work/Quotation(s), both dated May 17, 2015 and designated Exhibits "A" and "B" and are both incorporated herein as if copied in full; and

B. Insurance certificates evidencing required coverages, including a payment bond.

The County reserves the right and discretion (pursuant to public policy and Texas

Constitutional principles) to determine applicable provisions where there is any conflict between this Contract and any of the above-referenced contract documents/exhibits or incorporated documents.

VI.

No Agency Relationship & Indemnification: It is understood and agreed that Service Provider shall not in any sense be considered a partner or joint venturer with The County, nor shall Service Provider hold himself out as an agent or official representative of The County unless expressly authorized to do so by a majority of the Williamson County Commissioners Court. Service Provider shall be considered an independent contractor for the purpose of this Contract and shall in no manner incur any expense or liability on behalf of The County other than what may be expressly allowed under this Contract. The County will not be liable for any loss, cost, expense or damage, whether indirect, incidental, punitive, exemplary, consequential of any kind whatsoever for any acts by Service Provider or failure to act relating to the services being provided.

VII.

INDEMNIFICATION - EMPLOYEE PERSONAL INJURY CLAIMS: TO THE FULLEST EXTENT PERMITTED BY LAW, THE SERVICE PROVIDER SHALL INDEMNIFY, DEFEND (WITH COUNSEL OF THE COUNTY'S CHOOSING), AND HOLD HARMLESS THE COUNTY, AND THE COUNTY'S EMPLOYEES, AGENTS, REPRESENTATIVES, PARTNERS, OFFICERS, AND DIRECTORS (COLLECTIVELY, THE "INDEMNITEES") AND SHALL ASSUME ENTIRE RESPONSIBILITY AND LIABILITY (OTHER THAN AS A RESULT OF INDEMNITEES' GROSS NEGLIGENCE) FOR ANY CLAIM OR ACTION BASED ON OR ARISING OUT OF THE PERSONAL INJURY, OR DEATH, OF ANY EMPLOYEE OF THE SERVICE PROVIDER, OR OF ANY SUBCONTRACTOR, OR OF ANY OTHER ENTITY FOR WHOSE ACTS THEY MAY BE LIABLE, WHICH OCCURRED OR WAS ALLEGED TO HAVE OCCURRED ON THE WORK SITE OR IN CONNECTION WITH THE PERFORMANCE OF THE WORK. SERVICE PROVIDER HEREBY INDEMNIFIES THE INDEMNITEES EVEN TO THE EXTENT THAT SUCH PERSONAL INJURY WAS CAUSED OR ALLEGED TO HAVE BEEN CAUSED BY THE SOLE, COMPARATIVE OR CONCURRENT NEGLIGENCE OF THE STRICT LIABILITY OF ANY INDEMNIFIED PARTY. THIS INDEMNIFICATION SHALL NOT BE LIMITED TO DAMAGES, COMPENSATION, OR BENEFITS PAYABLE UNDER INSURANCE POLICIES, WORKERS COMPENSATION ACTS, DISABILITY BENEFITS ACTS, OR OTHER EMPLOYEES BENEFIT ACTS.

INDEMNIFICATION - OTHER THAN EMPLOYEE PERSONAL INJURY CLAIMS: TO THE FULLEST EXTENT PERMITTED BY LAW, SERVICE PROVIDER SHALL INDEMNIFY, DEFEND (WITH COUNSEL OF THE COUNTY'S CHOOSING), AND HOLD HARMLESS THE COUNTY, AND THE COUNTY'S EMPLOYEES, AGENTS, REPRESENTATIVES, PARTNERS, OFFICERS, AND DIRECTORS (COLLECTIVELY, THE "INDEMNITEES") FROM AND AGAINST CLAIMS, DAMAGES, LOSSES AND EXPENSES, INCLUDING BUT NOT LIMITED TO ATTORNEYS' FEES, ARISING OUT OF OR ALLEGED TO BE RESULTING FROM THE PERFORMANCE OF THIS AGREEMENT OR THE WORK DESCRIBED HEREIN, TO THE EXTENT CAUSED BY THE NEGLIGENCE, ACTS, ERRORS, OR OMISSIONS OF SERVICE PROVIDER OR ITS SUBCONTRACTORS, ANYONE EMPLOYED BY THEM OR ANYONE FOR WHOSE ACTS THEY MAY BE LIABLE, REGARDLESS OF WHETHER OR NOT SUCH CLAIM,

DAMAGE, LOSS OR EXPENSE IS CAUSED IN WHOLE OR IN PART BY A PARTY INDEMNIFIED HEREUNDER.

VIII.

No Waiver of Sovereign Immunity or Powers: Nothing in this Contract will be deemed to constitute a waiver of sovereign immunity or powers of The County, the Williamson County Commissioners Court, or the Williamson County Judge.

IX.

Compliance With All Laws: Service Provider agrees and will comply with any and all local, state or federal requirements with respect to the services rendered.

X.

Termination: This Contract may be terminated at any time at the option of either party, without future or prospective liability for performance upon giving thirty (30) days written notice thereof.

XI.

Venue and Applicable Law: Venue of this Contract shall be Williamson County, Texas, and the laws of the State of Texas shall govern all terms and conditions.

XII.

Severability: In case any one or more of the provisions contained in this Contract shall for any reason be held to be invalid, illegal, or unenforceable in any respect, such invalidity, illegality, or unenforceability shall not affect any other provision in this Contract and this Contract shall be construed as if such invalid, illegal, or unenforceable provision had never been contained in it.

XIII.

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

XIV.

Confidentiality: Service Provider expressly agrees that he or she will not use any incidental confidential information that may be obtained while working in a governmental setting for his or her own benefit, and agrees that he or she will not enter any unauthorized areas or access confidential information and he or she will not disclose any information to unauthorized third parties, and will take care to guard the security of the information at all times.

XV.

Good Faith Clause: Service Provider agrees to act in good faith in the performance of this Contract.

XVI.

No Assignment: Service Provider may not assign this Contract.

XVII.

Confidentiality: Service Provider expressly agrees that he or she will not use any incidental confidential information that may be obtained while working in a governmental setting for his or her own benefit, and agrees that he or she will not enter any unauthorized areas or access confidential information and he or she will not disclose any information to unauthorized third parties, and will take care to guard the security of the information at all times.

XVIII.

County Judge or Presiding Officer Authorized to Sign Contract: The presiding officer of The County's governing body who is authorized to execute this instrument by order duly recorded may execute this Contract on behalf of The County.

WITNESS that this Contract shall be effective as of the date of the last party's execution below.

WILLIAMSON COUNTY:	**SERVICE PROVIDER:**
_____	_____
Authorized Signature	Authorized Signature
_____	_____
Printed Name	Printed Name
Date: _____ ___, 2015	Date: _____ ___, 2015

Exhibits “A” & “B”
Statement(s) of Work/Quotation(s)

EXHIBIT A

Adam Heath Construction

1122 W. White Oak Rd.
West, Tx. 76691

Estimate

Date	Estimate #
5/17/2015	1353

Name / Address
Sign Shop Phase #2 Williamson County

Project

Description	Qty	Rate	Total
Demo walls, cabinets, partitions and doors as per plans		2,600.00	2,600.00
Walls: build walls approx 330 LF, insulate and sheetrock		14,850.00	14,850.00
Tape, float, texture and paint walls and existing interior walls		4,500.00	4,500.00
Doors: supply and install 4 single and one double, owner to provide lock sets and closures if needed		3,875.00	3,875.00
	Total		$25,825.00

Signature _____

Phone #	Fax #	E-mail
254-829-0974	254-829-1338	adamheathadam@aol.com

Adam Heath Construction

1122 W. White Oak Rd.
West, Tx. 76691

Estimate

Date	Estimate #
5/17/2015	1352

Name / Address
Sign Shop Phase #2 Williamson County

Project

Description	Qty	Rate	Total
Install new acoustical ceiling with humiguard 2x4 fine fissured square edge 15/16 white grid, includes all materials and labor As per drawings		7,885.00	7,885.00
		Total	$7,885.00

Signature _____

Phone #	Fax #	E-mail
254-829-0974	254-829-1338	adamheathadam@aol.com

Commissioners Court - Regular Session **23.**

Meeting Date: 09/01/2015

Kimley Horn and Associates PSA

Submitted For: Terron Evertson **Submitted By:** Sarah Ramos, Unified Road System

Department: Unified Road System

Agenda Category: Regular Agenda Items

Information

Agenda Item

Discuss, consider and take appropriate action on new Professional Service Agreement with Kimley-Horn and Associates, Inc. to provide On Call Traffic Engineering Services for Williamson County Road & Bridge Division.

Background

Fiscal Impact

From/To	Acct No.	Description	Amount

Attachments

Kimley Horn On Call Traffic Engineering Services

Form Review

Inbox	Reviewed By	Date
County Judge Exec Asst.	Wendy Coco	08/26/2015 03:54 PM
Form Started By: Sarah Ramos		Started On: 08/24/2015 11:49 AM
Final Approval Date: 08/26/2015		

WILLIAMSON COUNTY
CONTRACT FOR ENGINEERING SERVICES

FIRM: **Kimley-Horn and Associates, Inc. ("Engineer")**
ADDRESS: **10814 Jollyville Rd., Avallon IV, Suite 300, Austin TX 78759**
PROJECT: **On Call Traffic Engineering Services for Road & Bridge Division ("Project")**

THE STATE OF TEXAS §
§
COUNTY OF WILLIAMSON §

THIS CONTRACT FOR ENGINEERING SERVICES ("Contract") is made and entered into, effective as the date of the last party's execution hereinbelow, by and between Williamson County, Texas, a political subdivision of the State of Texas, whose offices are located at 710 Main Street, Suite 101, Georgetown, Texas, 78626 (hereinafter referred to as "County"), and Engineer, and such Contract is for the purpose of contracting for professional engineering services.

RECITALS:

WHEREAS, V.T.C.A., Government Code §2254.002(2)(A)(vii) under Subchapter A entitled "Professional Services Procurement Act" provides for the procurement by counties of services of professional engineers; and

WHEREAS, County and Engineer desire to contract for such professional engineering services; and

WHEREAS, County and Engineer wish to document their agreement concerning the requirements and respective obligations of the parties;

NOW, THEREFORE, WITNESSETH:

That for and in consideration of the mutual promises contained herein and other good and valuable considerations, and the covenants and agreements hereinafter contained to be kept and performed by the respective parties hereto, it is agreed as follows:

ARTICLE 1
CONTRACT DOCUMENTS AND APPLICABLE PROJECT DOCUMENTS

A. Contract Documents. The Contract Documents consist of this Contract, any exhibits attached hereto (which exhibits are hereby incorporated into and made a part of this Contract), any fully executed Work Authorizations; any fully executed Supplemental Work Authorizations and all fully executed Contract Amendments (as defined herein in Article 14) which are subsequently issued. These form the entire contract, and all are as fully a part of this Contract as if attached to this Contract or repeated herein.

B. Project Documents. In addition to any other pertinent and necessary Project documents, the following documents shall be used in the development of the Project:

A. TxDOT 2011 Texas Manual of Uniform Traffic Control Devices for Streets and Highways, including latest revisions
B. Texas Department of Transportation's Standard Specifications for Construction of Highways, Streets, and Bridges, 2014 (English units)
C. National Environmental Policy Act (NEPA)
D. Texas Accessibility Standards (TAS) of the Architectural Barriers Act, Article 9102, Texas Civil Statutes, Effective April 4, 1994, including latest revisions
E. Americans with Disabilities Act (ADA) Regulations
F. U.S. Army Corps Regulations
G. International Building Code, current edition as updated
H. Williamson County Design Criteria & Project Development Manual, latest edition
I. Williamson County Multi-Corridor Transportation Plan Project Level Environmental Review and Compliance Protocol, latest edition
J. Williamson County Protocol for Sustainable Roadsides, latest edition
K. TxDOT Bridge Design Manual - LRFD, latest edition
L. TxDOT Geotechnical Manual, latest edition

ARTICLE 2
NON-COLLUSION; DEBARMENT; AND FINANCIAL INTEREST PROHIBITED

A. Non-collusion. Engineer warrants that he/she/it has not employed or retained any company or persons, other than a bona fide employee working solely for Engineer, to solicit or secure this Contract, and that he/she/it has not paid or agreed to pay any company or engineer any fee, commission, percentage, brokerage fee, gifts, or any other consideration, contingent upon or resulting from the award or making of this Contract. For breach or violation of this warranty, County reserves and shall have the right to annul this Contract without liability or, in its discretion and at its sole election, to deduct from the contract price or compensation, or to otherwise recover, the full amount of such fee, commission, percentage, brokerage fee, gift or contingent fee.

B. Debarment Certification. Engineer must sign the Debarment Certification enclosed herewith as **Exhibit A**.

C. Financial Interest Prohibited. Engineer covenants and represents that Engineer, his/her/its officers, employees, agents, consultants and subcontractors will have no financial interest, direct or indirect, in the purchase or sale of any product, materials or equipment that will be recommended or required for the construction of the Project.

ARTICLE 3
ENGINEERING SERVICES

Engineer shall perform Engineering Services as identified in **Exhibit B** entitled "Engineering Services."

County will prepare and issue Work Authorizations, in substantially the same form identified and attached hereto as **Exhibit C** and entitled "Work Authorization No. ____", to authorize the Engineer to perform one or more tasks of the Engineering Services. Each Work Authorization will include a description of the work to be performed, a description of the tasks and milestones, a work schedule for the tasks, definite review times by County and Engineer of all Engineering Services and a fee amount agreed upon by the County and Engineer. The amount payable for a Work Authorization shall be supported by the estimated cost of each work task as described in the Work Authorization. The Work Authorization will not waive the Engineer's responsibilities and obligations established in this Contract. The executed Work Authorizations shall become part of this Contract.

All work must be completed on or before the date specified in the Work Authorization. The Engineer shall promptly notify the County of any event which will affect completion of the Work Authorization, although such notification shall not relieve the Engineer from costs or liabilities resulting from delays in completion of the Work Authorization. Should the review times or Engineering Services take longer than shown on the Work Authorization, through no fault of Engineer, Engineer may submit a timely written request for additional time, which shall be subject to the approval of the County. Any changes in a Work Authorization shall be enacted by a written Supplemental Work Authorization before additional costs may be incurred. Any Supplemental Work Authorization must be executed by both parties within the period specified in the Work Authorization.

ARTICLE 4
CONTRACT TERM

A. Term. The Engineer is expected to complete the Engineering Services described herein in accordance with the above described Work Authorizations or any Supplemental Work Authorization related thereto. If Engineer does not perform the Engineering Services in accordance with each applicable Work Authorization or any Supplemental Work Authorization related thereto, then County shall have the right to terminate this Contract as set forth below in Article 20. So long as the County elects not to terminate this Contract, it shall continue from day to day until such time as the Engineering Services are completed in accordance with each

applicable Work Authorization or any Supplemental Work Authorization related thereto. Any Engineering Services performed or costs incurred after the date of termination shall not be eligible for reimbursement. Engineer shall notify County in writing as soon as possible if he/she/it determines, or reasonably anticipates, that the Engineering Services will not be completed in accordance with an applicable Work Authorization or any Supplemental Work Authorization related thereto.

B. Work Authorizations. Engineer acknowledges that each Work Authorization is of critical importance, and agrees to undertake all reasonably necessary efforts to expedite the performance of Engineering Services required herein so that construction of the Project will be commenced and completed as scheduled. In this regard, and subject to adjustments in a particular Work Authorization, as provided in Article 3 herein, Engineer shall proceed with sufficient qualified personnel and consultants necessary to fully and timely accomplish all Engineering Services required under this Contract in a professional manner.

C. Commencement of Engineering Services. After execution of this Contract, Engineer shall not proceed with Engineering Services until Engineer has been thoroughly briefed on the scope of the Project and has been notified in writing by the County to proceed, as provided in Article 8.

ARTICLE 5
COMPENSATION AND EXPENSES

County shall pay and Engineer agrees to accept up to the amount shown below as full compensation for the Engineering Services performed and to be performed under this Contract. The basis of compensation for the services of principals and employees engaged in the performance of the Engineering Services shall be based on the Rate Schedule set forth in the attached **Exhibit D**.

The maximum amount payable under this Contract, without modification, is **Two hundred fifty thousand and no/100 Dollars ($250,000.00)** (the "Compensation Cap"), provided that any amounts paid or payable shall be solely pursuant to a validly issued Work Authorization or any Supplemental Work Authorization related thereto. In no event may the aggregate amount of compensation authorized under Work Authorizations and Supplemental Work Authorizations exceed the Compensation Cap. The Compensation Cap shall be revised equitably only by written Contract Amendments executed by both parties in the event of a change the overall scope of the Engineering Services set forth in **Exhibit B**, as authorized by County.

The Compensation Cap is based upon all labor and non-labor costs estimated to be required in the performance of the Engineering Services provided for under this Contract. Should the actual costs of all labor and non-labor costs rendered under this Contract be less than the above stated Compensation Cap, then Engineer shall receive compensation for only actual fees and costs of the Engineering Services actually rendered and incurred, which may be less than the above stated Compensation Cap.

The Compensation Cap herein referenced may be adjusted for Additional Engineering Services requested and performed only if approved by a written Contract Amendment signed by both parties.

Engineer shall prepare and submit to County monthly progress reports in sufficient detail to support the progress of the Engineering Services and to support invoices requesting monthly payment. The format for such monthly progress reports and invoices must be in a format acceptable to County. Satisfactory progress of Engineering Services shall be an absolute condition of payment.

Engineer shall be reimbursed for actual non-labor and subcontract expenses incurred in the performance of the services under this Contract in accordance with the Williamson County Vendor Reimbursement Policy set forth under **Exhibit E**. Invoices requesting reimbursement for costs and expenditures related to the Project (reimbursables) must be accompanied by copies of the provider's invoice and comply with the Williamson County Vendor Reimbursement Policy. The copies of the provider's invoice must evidence the actual costs billed to Engineer without mark-up.

ARTICLE 6
METHOD OF PAYMENT

Payments to Engineer shall be made while Engineering Services are in progress. A monthly progress report, as referenced in Article 5 above (in a form acceptable to the County), shall be submitted to Williamson County Department of Infrastructure, to the attention of the Sr. Director of Infrastructure. Such progress report shall provide a summary of the work accomplished during the billing period for each Work Authorization task with an estimated percentage of completion for the task.

Simultaneous with submission of such progress report, Engineer shall prepare and submit one (1) original of a certified invoice to the Director of Road & Bridge in a form acceptable to the County Auditor. All invoices submitted to County must, at a minimum, be accompanied by an original complete packet of supporting documentation and time sheets detailing hours worked by staff persons with a description of the work performed by such persons. For Additional Engineering Services performed pursuant to this Contract, a separate invoice or itemization of the Additional Engineering Services must be presented with the same aforementioned requirements.

Payments shall be made by County based upon Engineering Services actually provided and performed.[a] Upon timely receipt and approval of each statement, County shall make a good faith effort to pay the amount which is due and payable within thirty (30) days of the County Auditor's receipt. County reserves the right to reasonably withhold payment pending verification of satisfactory Engineering Services performed. Engineer has the responsibility to submit proof to County, adequate and sufficient in its determination, that tasks of an applicable Work Authorization or any Supplemental Work Authorization related thereto were completed.

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[a] *See also,* Art. 32(P) "Termination of Work Authorization".

The certified statements shall show the total amount earned to the date of submission and shall show the amount due and payable as of the date of the current statement. Final payment does not relieve Engineer of the responsibility of correcting any errors and/or omissions resulting from his/her/its negligence.

Upon submittal of the initial invoice, Engineer shall provide the County Auditor with an Internal Revenue Form W-9, Request for Taxpayer Identification Number and Certification that is complete in compliance with the Internal Revenue Code, its rules and regulations.

ARTICLE 7
PROMPT PAYMENT POLICY

In accordance with Chapter 2251, V.T.C.A., Texas Government Code, payment to Engineer will be made within thirty (30) days of the day on which the performance of services was complete, or within thirty (30) days of the day on which the County Auditor receives a correct invoice for services, whichever is later.

Engineer may charge a late fee (fee shall not be greater than that which is permitted by Texas law) for payments not made in accordance with this prompt payment policy; however, this policy does not apply in the event:

A. There is a bona fide dispute between County and Engineer concerning the supplies, materials, or equipment delivered or the services performed that causes the payment to be late; or

B. The terms of a federal contract, grant, regulation, or statute prevent County from making a timely payment with federal funds; or

C. There is a bona fide dispute between Engineer and a subcontractor/subconsultant or between a subcontractor/subconsultant and its supplier concerning supplies, materials, or equipment delivered or the Engineering Services performed which causes the payment to be late; or

D. The invoice is not submitted to Williamson County[b] in strict accordance with instructions, if any, on the purchase order, or this Contract or other such contractual agreement.

The County Auditor shall document to Engineer the issues related to disputed invoices within ten (10) calendar days of receipt of such invoice. Any non-disputed invoices shall be considered correct and payable per the terms of Chapter 2251, V.T.C.A., Texas Government Code.

ARTICLE 8
COMMENCEMENT OF ENGINEERING SERVICES

The Engineer shall not proceed with any task of the Engineering Services until Engineer has been thoroughly briefed on the scope of the Project and instructed, in writing by the County, to proceed with the applicable Engineering Services. The County shall not be responsible for

[b] *See* Art. 6, *supra.*

work performed or costs incurred by Engineer related to any task for which a Work Authorization or a Supplemental Work Authorization related thereto has not been issued and signed by both parties. Engineer shall not be required to perform any work for which a Work Authorization or a Supplemental Work Authorization related thereto has not been issued and signed by both parties.

ARTICLE 9
PROJECT TEAM

County's Designated Representative for purposes of this Contract is as follows:

Williamson County Dept. of Infrastructure
Attn: Director of Road & Bridge
3151 SE Inner Loop, Suite B
Georgetown, Texas 78626

County shall have the right, from time to time, to change the County's Designated Representative by giving Engineer written notice thereof. With respect to any action, decision or determination which is to be taken or made by County under this Contract, the County's Designated Representative may take such action or make such decision or determination or shall notify Engineer in writing of an individual responsible for and capable of taking such action, decision or determination and shall forward any communications and documentation to such individual for response or action. Actions, decisions or determinations by the County's Designated Representative on behalf of County shall be done in his or her reasonable business judgment unless express standards or parameters therefor are included in this Contract, in which case, actions taken by the County's Designated Representative shall be in accordance with such express standards or parameters. Any consent, approval, decision or determination hereunder by the County's Designated Representative shall be binding on County; *provided, however,* the County's Designated Representative shall not have any right to modify, amend or terminate this Contract, an Executed Work Authorization, an executed Supplemental Work Authorization or executed Contract Amendment. County's Designated Representative shall not have any authority to execute a Contract Amendment, Work Authorization or any Supplemental Work Authorization unless otherwise granted such authority by the Williamson County Commissioners Court.

Engineer's Designated Representative for purposes of this Contract is as follows:

Andrew VanLeeuwen
Kimley-Horn and Associates, Inc.
10814 Jollyville Rd., Avallon IV, #300
Austin, TX 78759

Engineer shall have the right, from time to time, to change the Engineer's Designated Representative by giving County written notice thereof. With respect to any action, decision or determination which is to be taken or made by Engineer under this Contract, the Engineer's Designated Representative may take such action or make such decision or determination or shall

notify County in writing of an individual responsible for and capable of taking such action, decision or determination and shall forward any communications and documentation to such individual for response or action. Actions, decisions or determinations by the Engineer's Designated Representative on behalf of Engineer shall be done in his or her reasonable business judgment unless express standards or parameters therefor are included in this Contract, in which case, actions taken by the Engineer's Designated Representative shall be in accordance with such express standards or parameters. Any consent, approval, decision or determination hereunder by the Engineer's Designated Representative shall be binding on Engineer. Engineer's Designated Representative shall have the right to modify, amend and execute Work Authorizations, Supplemental Work Authorizations and Contract Amendments on behalf of Engineer.

ARTICLE 10
PROGRESS EVALUATION

Engineer shall, from time to time during the progress of the Engineering Services, confer with County at County's election. Engineer shall prepare and present such information as may be pertinent and necessary, or as may be reasonably requested by County, in order for County to evaluate features of the Engineering Services. At the request of County or Engineer, conferences shall be provided at Engineer's office, the offices of County, or at other locations designated by County. When requested by County, such conferences shall also include evaluation of the Engineering Services. County may, from time to time, require Engineer to appear and provide information to the Williamson County Commissioners Court.

Should County determine that the progress in Engineering Services does not satisfy an applicable Work Authorization or any Supplemental Work Authorization related thereto, then County shall review same with Engineer to determine corrective action required.

Engineer shall promptly advise County in writing of events which have or may have a significant impact upon the progress of the Engineering Services, including but not limited to the following:

A. Problems, delays, adverse conditions which may materially affect the ability to meet the objectives of an applicable Work Authorization or any Supplemental Work Authorization related thereto, or preclude the attainment of Project Engineering Services units by established time periods; and such disclosure shall be accompanied by statement of actions taken or contemplated, and County assistance needed to resolve the situation, if any; and

B. Favorable developments or events which enable meeting goals sooner than anticipated in relation to an applicable Work Authorization's or any Supplemental Work Authorization related thereto.

ARTICLE 11
SUSPENSION

Should County desire to suspend the Engineering Services, but not to terminate this Contract, then such suspension may be effected by County giving Engineer thirty (30) calendar days' verbal notification followed by written confirmation to that effect. Such thirty-day notice may be waived in writing by agreement and signature of both parties. The Engineering Services may be reinstated and resumed in full force and effect within sixty (60) days of receipt of written notice from County to resume the Engineering Services. Such sixty-day (60) notice may be waived in writing by agreement and signature of both parties. If this Contract is suspended for more than thirty (30) days, Engineer shall have the option of terminating this Contract and, in the event, Engineer shall be compensated for all Engineering Services performed and reimbursable expenses incurred, provided such Engineering Services and reimbursable expenses have been previously authorized and approved by County, to the effective date of suspension.

If County suspends the Engineering Services, the contract period as determined in Article 4, and the Work Authorization or any Supplemental Work Authorization related thereto, shall be extended for a time period equal to the suspension period.

County assumes no liability for Engineering Services performed or costs incurred prior to the date authorized by County for Engineer to begin Engineering Services, and/or during periods when Engineering Services is suspended, and/or subsequent to the completion date.

ARTICLE 12
ADDITIONAL ENGINEERING SERVICES

If Engineer forms a reasonable opinion that any work he/she/it has been directed to perform is beyond the overall scope of this Contract, as set forth in **Exhibit B,** and as such constitutes extra work ("Additional Engineering Services"), he/she/it shall promptly notify County in writing. In the event County finds that such work does constitute Additional Engineering Services, County shall so advise Engineer and a written Contract Amendment will be executed between the parties as provided in Article 14. Any increase to the Compensation Cap due to Additional Engineering Services must be set forth in such Contract Amendment. Engineer shall not perform any proposed Additional Engineering Services nor incur any additional costs prior to the execution, by both parties, of a written Contract Amendment. Following the execution of a Contract Amendment that provides for Additional Engineering Services, a written Work Authorization, which sets forth the Additional Engineering Services to be performed, must be executed by the parties. County shall not be responsible for actions by Engineer nor for any costs incurred by Engineer relating to Additional Engineering Services not directly associated with the performance of the Engineering Services authorized in this Contract, by a fully executed Work Authorization or a fully executed Contract Amendment thereto.

ARTICLE 13
CHANGES IN COMPLETED ENGINEERING SERVICES

If County deems it necessary to request changes to previously satisfactorily completed

Engineering Services or parts thereof which involve changes to the original Engineering Services or character of Engineering Services under this Contract, then Engineer shall make such revisions as requested and as directed by County. Such revisions shall be considered as Additional Engineering Services and paid for as specified under Article 12.

Engineer shall make revisions to Engineering Services authorized hereunder as are necessary to correct errors appearing therein, when required to do so by County. No additional compensation shall be due for such Engineering Services.

ARTICLE 14
CONTRACT AMENDMENTS

The terms set out in this Contract may be modified by a written fully executed Contract Amendment. Changes and modifications to a fully executed Work Authorization shall be made in the form of a Supplemental Work Authorization. To the extent that such changes or modifications to a Work Authorization do not also require modifications to the terms of this Contract (i.e. changes to the overall scope of Engineering Services set forth in **Exhibit B**, modification of the Compensation Cap, etc.) a Contract Amendment will not be required.

ARTICLE 15
USE OF DOCUMENTS

All documents, including but not limited to drawings, specifications and data or programs stored electronically, (hereinafter referred to as "Engineering Work Products") prepared by Engineer and its subcontractors/subconsultants are related exclusively to the services described in this Contract and are intended to be used with respect to this Project. However, it is expressly understood and agreed by and between the parties hereto that all of Engineer's designs under this Contract (including but not limited to tracings, drawings, estimates, specifications, investigations, studies and other documents, completed or partially completed), shall be the property of County to be thereafter used in any lawful manner as County elects. Any such subsequent use made of documents by County shall be at County's sole risk and without liability to Engineer.

By execution of this Contract and in confirmation of the fee for services to be paid under this Contract, Engineer hereby conveys, transfers and assigns to County all rights under the Federal Copyright Act of 1976 (or any successor copyright statute), as amended, all common law copyrights and all other intellectual property rights acknowledged by law in the Project Designs and work product developed under this Contract. Copies may be retained by Engineer. Engineer shall be liable to County for any loss or damage to any such documents while they are in the possession of or while being worked upon by Engineer or anyone connected with Engineer, including agents, employees, Engineers or subcontractors/subconsultants. All documents so lost or damaged shall be replaced or restored by Engineer without cost to County.

Upon execution of this Contract, Engineer grants to County permission to reproduce Engineer's work and documents for purposes of constructing, using and maintaining the Project, provided that County shall comply with its obligations, including prompt payment of all sums

when due, under this Contract. Engineer shall obtain similar permission from Engineer's subcontractors/subconsultants consistent with this Contract. If and upon the date Engineer is adjudged in default of this Contract, County is permitted to authorize other similarly credentialed design professionals to reproduce and, where permitted by law, to make changes, corrections or additions to the work and documents for the purposes of completing, using and maintaining the Project.

County shall not assign, delegate, sublicense, pledge or otherwise transfer any permission granted herein to another party without the prior written consent of Engineer. However, County shall be permitted to authorize the contractor, subcontractors and material or equipment suppliers to reproduce applicable portions of the Engineering Work Products appropriate to and for use in the execution of the Work. Submission or distribution of Engineering Work Products to meet official regulatory requirements or for similar purposes in connection with the Project is permitted. Any unauthorized use of the Engineering Work Products shall be at County's sole risk and without liability to Engineer and its Engineers.

Prior to Engineer providing to County any Engineering Work Products in electronic form or County providing to Engineer any electronic data for incorporation into the Engineering Work Products, County and Engineer shall by separate written contract set forth the specific conditions governing the format of such Engineering Work Products or electronic data, including any special limitations not otherwise provided in this Contract. Any electronic files are provided by Engineer for the convenience of County, and use of them is at County's sole risk. In the case of any defects in electronic files or any discrepancies between them and any hardcopy of the same documents prepared by Engineer, the hardcopy shall prevail. Only printed copies of documents conveyed by Engineer shall be relied upon.

Engineer shall have no liability for changes made to the drawings by other engineers subsequent to the completion of the Project. Any such change shall be sealed by the engineer making that change and shall be appropriately marked to reflect what was changed or modified.

ARTICLE 16
PERSONNEL, EQUIPMENT AND MATERIAL

Engineer shall furnish and maintain, at its own expense, quarters for the performance of all Engineering Services, and adequate and sufficient personnel and equipment to perform the Engineering Services as required. All employees of Engineer shall have such knowledge and experience as will enable them to perform the duties assigned to them. Any employee of Engineer who, in the reasonable opinion of County, is incompetent or whose conduct becomes detrimental to the Engineering Services shall immediately be removed from association with the Project when so instructed by County. Engineer certifies that it presently has adequate qualified personnel in its employment for performance of the Engineering Services required under this Contract, or will obtain such personnel from sources other than County. Engineer may not change the Project Manager without prior written consent of County.

ARTICLE 17
SUBCONTRACTING

Engineer shall not assign, subcontract or transfer any portion of the Engineering Services under this Contract without prior written approval from County. All subcontracts shall include the provisions required in this Contract. No subcontract shall relieve Engineer of any responsibilities under this Contract.

ARTICLE 18
REVIEW OF ENGINEERING SERVICES

Engineer's Engineering Services will be reviewed by County under its applicable technical requirements and procedures.

A. Completion. Reports, plans, specifications, and supporting documents shall be submitted by Engineer on or before the dates specified in the applicable Work Authorization or Supplemental Work Authorization related thereto. Upon receipt of same, the submission shall be checked for completion. "Completion" or "Complete" shall be defined as all of the required items, as set out in the applicable Work Authorization, have been included in compliance with the requirements of this Contract. The completeness of any Engineering Services submitted to County shall be determined by County within thirty (30) days of such submittal and County shall notify Engineer in writing within such thirty (30) day period if such Engineering Services have been found to be incomplete. If the submission is Complete, County shall notify Engineer and County's technical review process will begin.

If the submission is not Complete, County shall notify Engineer, who shall perform such professional services as are required to complete the Engineering Services and resubmit it to County. This process shall be repeated until a submission is Complete.

B. Acceptance. County shall review the completed Engineering Services for compliance with this Contract. If necessary, the completed Engineering Services shall be returned to Engineer, who shall perform any required Engineering Services and resubmit it to County. This process shall be repeated until the Engineering Services are Accepted. "Acceptance" or "Accepted" shall mean that in the County's reasonable opinion, substantial compliance with the requirements of this Contract has been achieved.

C. Final Approval. After Acceptance, Engineer shall perform any required modifications, changes, alterations, corrections, redesigns, and additional work necessary to receive Final Approval by the County. "Final Approval" in this sense shall mean formal recognition that the Engineering Services have been fully carried out.

D. Errors and Omissions. After Final Approval, Engineer shall, without additional compensation, perform any work required as a result of Engineer's development of the work which is found to be in error or omission due to Engineer's negligence. However, any work

required or occasioned for the convenience of County after Final Approval shall be paid for as Additional Engineering Services.

E. Disputes Over Classifications. In the event of any dispute over the classification of Engineer's Engineering Services as Complete, Accepted, or having attained Final Approved under this Contract, the decision of the County shall be final and binding on Engineer, subject to any civil remedy or determination otherwise available to the parties and deemed appropriate by the parties.

F. County's Reliance on Engineer. ENGINEER'S DUTIES AS SET FORTH HEREIN SHALL AT NO TIME BE IN ANY WAY DIMINISHED BY REASON OF ANY REVIEW, EVALUATION OR APPROVAL BY THE COUNTY NOR SHALL THE ENGINEER BE RELEASED FROM ANY LIABILITY BY REASON OF SUCH REVIEW, EVALUATION OR APPROVAL BY THE COUNTY, IT BEING UNDERSTOOD THAT THE COUNTY AT ALL TIMES IS ULTIMATELY RELYING UPON THE ENGINEER'S SKILL, ABILITY AND KNOWLEDGE IN PERFORMING THE ENGINEERING SERVICES REQUIRED HEREUNDER.

ARTICLE 19
VIOLATION OF CONTRACT TERMS/BREACH OF CONTRACT

Violation of contract terms or breach of contract by Engineer shall be grounds for termination of this Contract, and any increased costs arising from Engineer's default, breach of contract, or violation of contract terms shall be paid by Engineer.

ARTICLE 20
TERMINATION

This Contract may be terminated as set forth below.

A. By mutual agreement and consent, in writing, of both parties.

B. By County, by notice in writing to Engineer, as a consequence of failure by Engineer to perform the Engineering Services set forth herein in a satisfactory manner.

C. By either party, upon the failure of the other party to fulfill its obligations as set forth herein.

D. By County, for reasons of its own and not subject to the mutual consent of Engineer, upon not less than thirty (30) days' written notice to Engineer.

E. By satisfactory completion of all Engineering Services and obligations described herein.

Should County terminate this Contract as herein provided, no fees other than fees due and payable at the time of termination plus reimbursable expenses incurred shall thereafter be paid to Engineer. In determining the value of the Engineering Services performed by Engineer prior to termination, County shall be the sole judge. Compensation for Engineering Services at termination will be based on a percentage of the Engineering Services completed at that time.

Should County terminate this Contract under Subsection (D) immediately above, then the amount charged during the thirty-day notice period shall not exceed the amount charged during the preceding thirty (30) days.

If Engineer defaults in the performance of this Contract or if County terminates this Contract for fault on the part of Engineer, then County shall give consideration to the actual costs incurred by Engineer in performing the Engineering Services to the date of default, the amount of Engineering Services required which was satisfactorily completed to date of default, the value of the Engineering Services which are usable to County, the cost to County of employing another firm to complete the Engineering Services required and the time required to do so, and other factors which affect the value to County of the Engineering Services performed at the time of default.

The termination of this Contract and payment of an amount in settlement as prescribed above shall extinguish all rights, duties, and obligations of County under this Contract. If the termination of this Contract is due to the failure of Engineer to fulfill his/her/its contractual obligations, then County may take over the Project and prosecute the Engineering Services to completion. In such case, Engineer shall be liable to County for any additional and reasonable costs incurred by County.

Engineer shall be responsible for the settlement of all contractual and administrative issues arising out of any procurements made by Engineer in support of the Engineering Services under this Contract.

ARTICLE 21
COMPLIANCE WITH LAWS

A. Compliance. Engineer shall comply with all applicable federal, state and local laws, statutes, codes, ordinances, rules and regulations, and the orders and decrees of any court, or administrative bodies or tribunals in any manner affecting the performance of this Contract, including without limitation, minimum/maximum salary and wage statutes and regulations, and licensing laws and regulations. Engineer shall furnish County with satisfactory proof of his/her/its compliance.

Engineer shall further obtain all permits and licenses required in the performance of the Engineering Services contracted for herein.

B. Taxes. Engineer will pay all taxes, if any, required by law arising by virtue of the Engineering Services performed hereunder. County is qualified for exemption pursuant to the provisions of Section 151.309 of the Texas Limited Sales, Excise, and Use Tax Act.

ARTICLE 22
INDEMNIFICATION

ENGINEER AGREES, TO THE FULLEST EXTENT PERMITTED BY LAW, TO INDEMNIFY AND HOLD THE COUNTY HARMLESS FROM AND AGAINST ANY AND ALL LIABILITIES, LOSSES, PENALTIES,

JUDGMENTS, CLAIMS, LAWSUITS, DAMAGES, COSTS AND EXPENSES, INCLUDING, BUT NOT LIMITED TO, ATTORNEYS' FEES, ("LOSSES") TO THE EXTENT SUCH LOSSES ARE CAUSED BY OR RESULTS FROM AN NEGLIGENT ACT OR OMISSION, NEGLIGENCE, OR INTENTIONAL TORT COMMITTED BY ENGINEER, ENGINEER'S EMPLOYEES, AGENTS, OR ANY OTHER PERSON OR ENTITY UNDER CONTRACT WITH ENGINEER INCLUDING, WITHOUT LIMITATION, ENGINEER'S SUBCONSULTANTS, OR ANY OTHER ENTITY OVER WHICH ENGINEER EXERCISES CONTROL.

ENGINEER FURTHER AGREES, TO THE FULLEST EXTENT PERMITTED BY LAW, TO INDEMNIFY AND HOLD THE COUNTY HARMLESS FROM ANY AND ALL LIABILITIES, LOSSES, PENALTIES, JUDGMENTS, CLAIMS, LAWSUITS, DAMAGES, COSTS AND EXPENSES, INCLUDING, BUT NOT LIMITED TO, ATTORNEYS' FEES, ("LOSSES") TO THE EXTENT SUCH LOSSES ARE CAUSED BY OR RESULTS FROM ENGINEER'S FAILURE TO PAY ENGINEER'S EMPLOYEES, SUBCONTRACTORS, SUBCONSULTANTS, OR SUPPLIERS, IN CONNECTION WITH ANY OF THE WORK PERFORMED OR TO BE PERFORMED UNDER THIS CONTRACT BY ENGINEER.

ENGINEER FURTHER AGREES TO INDEMNIFY AND HOLD THE COUNTY HARMLESS FROM ANY AND ALL LIABILITIES, LOSSES, PENALTIES, CLAIMS, LAWSUITS, DAMAGES, COSTS AND EXPENSES, INCLUDING, BUT NOT LIMITED TO, ATTORNEYS' FEES, ("LOSSES") TO THE EXTENT SUCH LOSSES ARE CAUSED BY OR RESULTS FROM THE INFRINGEMENT OF ANY INTELLECTUAL PROPERTY ARISING OUT OF THE USE OF ANY PLANS, DESIGN, DRAWINGS, OR SPECIFICATIONS FURNISHED BY ENGINEER IN THE PERFORMANCE OF THIS CONTRACT.

THE LIMITS OF INSURANCE REQUIRED IN THIS CONTRACT AND/OR THE CONTRACT DOCUMENTS SHALL NOT LIMIT ENGINEER'S OBLIGATIONS UNDER THIS SECTION. THE TERMS AND CONDITIONS CONTAINED IN THIS SECTION SHALL SURVIVE THE TERMINATION OF THE CONTRACT AND/OR CONTRACT DOCUMENTS OR THE SUSPENSION OF THE WORK HEREUNDER. TO THE EXTENT THAT ANY LIABILITIES, PENALTIES, DEMANDS, CLAIMS, LAWSUITS, LOSSES, DAMAGES, COSTS AND EXPENSES ARE CAUSED IN PART BY THE ACTS OF THE COUNTY OR THIRD PARTIES FOR WHOM ENGINEER IS NOT LEGALLY LIABLE, ENGINEER'S OBLIGATIONS SHALL BE IN PROPORTION TO ENGINEER'S FAULT. THE OBLIGATIONS HEREIN SHALL ALSO EXTEND TO ANY ACTIONS BY THE COUNTY TO ENFORCE THIS INDEMNITY OBLIGATION.

IN THE EVENT THAT CONTRACTORS INITIATE LITIGATION AGAINST THE COUNTY IN WHICH THE CONTRACTOR ALLEGES DAMAGES AS A RESULT OF ANY NEGLIGENT ACTS, ERRORS OR OMISSIONS OF ENGINEER, ITS EMPLOYEES, AGENTS, SUBCONTRACTORS, SUBCONSULTANTS, OR SUPPLIERS, OR OTHER ENTITIES OVER WHICH ENGINEER EXERCISES CONTROL, INCLUDING, BUT NOT LIMITED TO, DEFECTS, ERRORS, OR OMISSIONS, THEN THE COUNTY SHALL HAVE THE RIGHT TO JOIN ENGINEER IN ANY SUCH PROCEEDINGS AT THE COUNTY'S COST. ENGINEER SHALL ALSO HOLD THE COUNTY HARMLESS AND INDEMNIFY THE COUNTY TO THE EXTENT THAT ENGINEER, ANY OF ITS EMPLOYEES, AGENTS, SUBCONTRACTORS, SUBCONSULTANTS, OR SUPPLIERS, OR OTHER ENTITIES OVER WHICH ENGINEER EXERCISES CONTROL, CAUSED SUCH DAMAGES TO CONTRACTOR, INCLUDING ANY AND ALL COSTS AND ATTORNEYS' FEES INCURRED BY THE COUNTY IN CONNECTION WITH THE DEFENSE OF ANY CLAIMS WHERE ENGINEER, ITS EMPLOYEES, AGENTS, SUBCONTRACTORS, SUBCONSULTANTS, OR SUPPLIERS, OR OTHER ENTITIES OVER WHICH ENGINEER EXERCISES CONTROL, ARE ADJUDICATED AT FAULT.

ARTICLE 23
ENGINEER'S RESPONSIBILITIES

Engineer shall be responsible for the accuracy of his/her/its Engineering Services and shall promptly make necessary revisions or corrections to its work product resulting from errors, omissions, or negligent acts, and same shall be done without compensation. County shall determine Engineer's responsibilities for all questions arising from design errors and/or omissions, subject to the dispute resolution provisions of Article 33. Engineer shall not be relieved of responsibility for subsequent correction of any such errors or omissions in its work product, or for clarification of any ambiguities until after the construction phase of the Project has been completed.

ARTICLE 24
ENGINEER'S SEAL

The responsible engineer shall sign, seal and date all appropriate engineering submissions to County in accordance with the Texas Engineering Practice Act and the rules of the State Board of Registration for Professional Engineers.

ARTICLE 25
INSURANCE

Engineer must comply with the following insurance requirements at all times during this Contract:

A. Coverage Limits. Engineer, at Engineer's sole cost, shall purchase and maintain during the entire term while this Contract is in effect the following insurance:

1. Worker's Compensation in accordance with statutory requirements.
2. Commercial General Liability Insurance with a combined minimum Bodily Injury and Property Damage limits of $1,000,000.00 per occurrence and $2,000,000.00 in the aggregate.
3. Automobile Liability Insurance for all owned, non-owned, and hired vehicles with combined minimum limits for Bodily Injury and Property Damage limits of $500,000.00 per occurrence and $1,000,000.00 in the aggregate.
4. Professional Liability Errors and Omissions Insurance in the amount of $2,000,000.00 per claim.

B. Additional Insureds; Waiver of Subrogation. County, its directors, officers and employees shall be added as additional insureds under policies listed under (2) and (3) above, and on those policies where County, its directors, officers and employees are additional insureds, such insurance shall be primary and any insurance maintained by County shall be excess and not contribute with it. Such policies shall also include waivers of subrogation in favor of County.

C. Premiums and Deductible. Engineer shall be responsible for payment of premiums for all of the insurance coverages required under this section. Engineer further agrees that for each claim, suit or action made against insurance provided hereunder, with respect to all matters for which the Engineer is responsible hereunder, Engineer shall be solely responsible for all deductibles and self-insured retentions. Any deductibles or self-insured retentions over $50,000.00 in the Engineer's insurance must be declared and approved in writing by County in advance.

D. Commencement of Work. Engineer shall not commence any field work under this Contract until he/she/it has obtained all required insurance and such insurance has been approved by County. As further set out below, Engineer shall not allow any subcontractor/subconsultant(s) to commence work to be performed in connection with this Contract until all required insurance has been obtained and approved and such approval shall not be unreasonably withheld. Approval of the insurance by County shall not relieve or decrease the liability of Engineer hereunder.

E. Insurance Company Rating. The required insurance must be written by a company approved to do business in the State or Texas with a financial standing of at least an A- rating, as reflected in Best's insurance ratings or by a similar rating system recognized within the insurance industry at the time the policy is issued.

F. Certification of Coverage. Engineer shall furnish County with a certification of coverage issued by the insurer. Engineer shall not cause any insurance to be canceled nor permit any insurance to lapse. **In addition to any other notification requires set forth hereunder, Engineer shall also notify County, within twenty-four (24) hours of receipt, of any notices of expiration, cancellation, non-renewal, or material change in coverage it receives from its insurer.**

G. No Arbitration. It is the intention of the County and agreed to and hereby acknowledged by the Engineer, that no provision of this Contract shall be construed to require the County to submit to mandatory arbitration in the settlement of any claim, cause of action or dispute, except as specifically required in direct connection with an insurance claim or threat of claim under an insurance policy required hereunder or as may be required by law or a court of law with jurisdiction over the provisions of this Contract.

H. Subcontractor/Subconsultant's Insurance. Without limiting any of the other obligations or liabilities of Engineer, Engineer shall require each subcontractor/subconsultant performing work under this Contract (to the extent a subcontractor/subconsultant is allowed by County) to maintain during the term of this Contract, at the subcontractor/subconsultant's own expense, the same stipulated minimum insurance required in this Article above, including the required provisions and additional policy conditions as shown below in this Article.

Engineer shall obtain and monitor the certificates of insurance from each subcontractor/subconsultant in order to assure compliance with the insurance requirements. Engineer must retain the certificates of insurance for the duration of this Contract, and shall have

the responsibility of enforcing these insurance requirements among its subcontractor/subconsultants. County shall be entitled, upon request and without expense, to receive copies of these certificates of insurance.

I. Insurance Policy Endorsements. Each insurance policy shall include the following conditions by endorsement to the policy:

1. County shall be notified thirty (30) days prior to the expiration, cancellation, non-renewal or any material change in coverage, and such notice thereof shall be given to County by certified mail to:

   Williamson County Auditor
   c/o: Pam Navarrette
   710 Main Street, Suite 301
   Georgetown, Texas 78626

   With copy to: Williamson County Dept. of Infrastructure
   Attn: Director of Road & Bridge
   3151 SE Inner Loop, Suite B
   Georgetown, Texas 78626

2. The policy clause "Other Insurance" shall not apply to any insurance coverage currently held by County, to any such future coverage, or to County's Self-Insured Retentions of whatever nature.

J. Cost of Insurance. The cost of all insurance required herein to be secured and maintained by Engineer shall be borne solely by Engineer, with certificates of insurance evidencing such minimum coverage in force to be filed with County. Such Certificates of Insurance are evidenced as **Exhibit F** herein entitled "Certificates of Insurance."

ARTICLE 26
COPYRIGHTS

County shall have the royalty-free, nonexclusive and irrevocable right to reproduce, publish or otherwise use, and to authorize others to use, any reports developed by Engineer for governmental purposes.

ARTICLE 27
SUCCESSORS AND ASSIGNS

This Contract shall be binding upon and inure to the benefit of the parties hereto, their successors, lawful assigns, and legal representatives. Engineer may not assign, sublet or transfer any interest in this Contract, in whole or in part, by operation of law or otherwise, without obtaining the prior written consent of County.

ARTICLE 28
SEVERABILITY

In the event any one or more of the provisions contained in this Contract shall for any reason be held to be invalid, illegal or unenforceable in any respect, then such invalidity, illegality or unenforceability shall not affect any other provision thereof and this Contract shall be construed as if such invalid, illegal or unenforceable provision had never been contained herein.

ARTICLE 29
PRIOR AGREEMENTS SUPERSEDED

This Contract constitutes the sole agreement of the parties hereto, and supersedes any prior understandings or written or oral contracts between the parties respecting the subject matter defined herein. This Contract may only be amended or supplemented by mutual agreement of the parties hereto in writing.

ARTICLE 30
ENGINEER'S ACCOUNTING RECORDS

Engineer agrees to maintain, for a period of three (3) years after final payment under this Contract, detailed records identifying each individual performing the Engineering Services, the date or dates the services were performed, the applicable hourly rates, the total amount billed for each individual and the total amount billed for all persons, records of reimbursable costs and expenses of other providers and provide such other details as may be requested by the County Auditor for verification purposes. Engineer agrees that County or its duly authorized representatives shall, until the expiration of three (3) years after final payment under this Contract, have access to and the right to examine and photocopy any and all books, documents, papers and records of Engineer which are directly pertinent to the services to be performed under this Contract for the purposes of making audits, examinations, excerpts, and transcriptions. Engineer further agrees that County shall have access during normal working hours to all necessary Engineer facilities and shall be provided adequate and appropriate work space in order to conduct audits in compliance with the provisions of this section. County shall give Engineer reasonable advance notice of intended audits.

ARTICLE 31
NOTICES

All notices to either party by the other required under this Contract shall be personally delivered or mailed to such party at the following respective addresses:

County: Williamson County Judge
710 Main Street, Suite 101
Georgetown, Texas 78626

With copy to: Williamson County Dept. of Infrastructure
Attn: Director of Road & Bridge
3151 SE Inner Loop, Suite B
Georgetown, Texas 78626

and to: Office of General Counsel
Williamson County
710 Main Street, Suite 102
Georgetown, Texas 78626

Engineer: Andrew VanLeeuwen
Kimley-Horn and Associates, Inc.
10814 Jollyville Rd., Avallon IV, #300
Austin, TX 78759

ARTICLE 32
GENERAL PROVISIONS

A. Time is of the Essence. Subject to Article 3 hereof, Engineer understands and agrees that time is of the essence and that any failure of Engineer to complete the Engineering Services for each phase of this Contract within the agreed work schedule set out in the applicable Work Authorization may constitute a material breach of this Contract. Engineer shall be fully responsible for his/her/its delays or for failures to use his/her/its reasonable efforts in accordance with the terms of this Contract and the Engineer's standard of performance as defined herein. Where damage is caused to County due to Engineer's negligent failure to perform County may accordingly withhold, to the extent of such damage, Engineer's payments hereunder without waiver of any of County's additional legal rights or remedies.

B. Force Majeure. Neither County nor Engineer shall be deemed in violation of this Contract if prevented from performing any of their obligations hereunder by reasons for which they are not responsible or circumstances beyond their control. However, notice of such impediment or delay in performance must be timely given, and all reasonable efforts undertaken to mitigate its effects.

C. Enforcement and Venue. This Contract shall be enforceable in Georgetown, Williamson County, Texas, and if legal action is necessary by either party with respect to the enforcement of any or all of the terms or conditions herein, exclusive venue for same shall lie in Williamson County, Texas. This Contract shall be governed by and construed in accordance with the laws and court decisions of the State of Texas excluding, however, its choice of law rules.

D. Standard of Performance. The standard of care for all professional engineering, consulting and related services performed or furnished by Engineer and its

employees under this Contract will be the care and skill ordinarily used by members of Engineer's profession practicing under the same or similar circumstances at the same time and in the same locality.

E. Opinion of Probable Cost. Any opinions of probable Project cost or probable construction cost provided by Engineer are made on the basis of information available to Engineer and on the basis of Engineer's experience and qualifications and represents its judgment as an experienced and qualified professional engineer. However, since Engineer has no control over the cost of labor, materials, equipment or services furnished by others, or over the contractor(s') methods of determining prices, or over competitive bidding or market conditions, Engineer does not guarantee that proposals, bids or actual Project or construction cost will not vary from opinions of probable cost Engineer prepares.

F. Opinions and Determinations. Where the terms of this Contract provide for action to be based upon opinion, judgment, approval, review, or determination of either party hereto, such terms are not intended to be and shall never be construed as permitting such opinion, judgment, approval, review, or determination to be arbitrary, capricious, or unreasonable.

G. Reports of Accidents. Within 24 hours after Engineer becomes aware of the occurrence of any accident or other event which results in, or might result in, injury to the person or property of any third person (other than an employee of the Engineer), whether or not it results from or involves any action or failure to act by the Engineer or any employee or agent of the Engineer and which arises in any manner from the performance of this Contract, the Engineer shall send a written report of such accident or other event to the County, setting forth a full and concise statement of the facts pertaining thereto. The Engineer shall also immediately send the County a copy of any summons, subpoena, notice, or other documents served upon the Engineer, its agents, employees, or representatives, or received by it or them, in connection with any matter before any court arising in any manner from the Engineer's performance of work under this Contract.

H. Gender, Number and Headings. Words of any gender used in this Contract shall be held and construed to include any other gender, and words in the singular number shall be held to include the plural, unless the context otherwise requires. The headings and section numbers are for convenience only and shall not be considered in interpreting or construing this Contract.

I. Construction. Each party hereto acknowledges that it and its counsel have reviewed this Contract and that the normal rules of construction are not applicable and there will be no presumption that any ambiguities will be resolved against the drafting party in the interpretation of this Contract.

J. Independent Contractor Relationship. Both parties hereto, in the performance of this Contract, shall act in an individual capacity and not as agents, employees, partners, joint ventures or associates of one another. The employees or agents of one party shall not be deemed or construed to be the employees or agents of the other party for any purposes whatsoever.

K. No Waiver of Immunities. Nothing in this Contract shall be deemed to waive, modify or amend any legal defense available at law or in equity to County, its past or present officers, employees, or agents or employees, nor to create any legal rights or claim on behalf of any third party. 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.

L. Texas Public Information Act. To the extent, if any, that any provision in this Contract 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 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 County as to whether or not the same are available to the public. It is further understood that County's officers and employees shall have the right to rely on the advice, decisions and opinions of the Attorney General, and that 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 County by a party hereto, in reliance of any advice, decision or opinion of the Attorney General of the State of Texas.

M. Governing Terms and Conditions. If there is an irreconcilable conflict between the terms and conditions set forth in this Contract or any Contract Amendment and the terms and conditions set forth in any Exhibit, Appendix, Work Authorization or Supplemental Work Authorization to this Contract, the terms and conditions set forth in this Contract or any Contract Amendment shall control over the terms and conditions set forth in any Exhibit, Appendix, Work Authorization or Supplemental Work Authorization to this Contract.

N. Meaning of Day. For purposes of this Contract, all references to a "day" or "days" shall mean a calendar day or calendar days.

O. Appropriation of Funds by County. County believes it has sufficient funds currently available and authorized for expenditure to finance the costs of this Contract. Engineer understands and agrees that County's payment of amounts under this Contract is contingent on the County receiving appropriations or other expenditure authority sufficient to allow the County, in the exercise of reasonable administrative discretion, to continue to make payments under this Contract. It is further understood and agreed by Engineer that County shall have the right to terminate this Contract at the end of any County fiscal year if the governing body of County does not appropriate sufficient funds as determined by County's budget for the fiscal year in question. County may effect such termination by giving written notice of termination to Engineer.

P. Termination of Work Authorization. Should it be determined that the progress in the production of Engineer's services and work does not satisfy the requirements of the approved Work Authorization as provided by Exhibit "C", attached hereto, the County shall review the approved Work Authorization with the Engineer to determine the corrective action needed, including potential termination of such Work Authorization by Williamson County.

Additionally, if an approved Work Authorization has not been completed by the end of the applicable County fiscal year under this contract and the Williamson County Commissioners Court does not provide for funding through its budgetary oversight for the subsequent County fiscal year, Williamson County reserves the right to terminate such Work Authorization at its discretion.

ARTICLE 33
DISPUTE RESOLUTION

Except as otherwise specifically set forth herein, County and Engineer shall work together in good faith to resolve any controversy, dispute or claim between them which arises out of or relates to this Contract, whether stated in tort, contract, statute, claim for benefits, bad faith, professional liability or otherwise ("Claim"). If the parties are unable to resolve the Claim within thirty (30) days following the date in which one party sent written notice of the Claim to the other party, and if a party wishes to pursue the Claim, such Claim shall be addressed through non-binding mediation. A single mediator engaged in the practice of law, who is knowledgeable about subject matter of this Contract, shall be selected by agreement of the parties and serve as the mediator. Any mediation under this Contract shall be conducted in Williamson County, Texas. The mediator's fees shall be borne equally between the parties. Such non-binding mediation is a condition precedent to seeking redress in a court of competent jurisdiction, but this provision shall not preclude either party from filing a lawsuit in a court of competent jurisdiction prior to completing a mediation if necessary to preserve the statute of limitations, in which case such lawsuit shall be stayed pending completion of the mediation process contemplated herein. This provision shall survive the termination of the Contract.

ARTICLE 34
EQUAL OPPORTUNITY IN EMPLOYMENT

During the performance of this Contract and to the extent the Project is a federally funded project, Engineer, for itself, its assignees and successors in interest agrees as follows:

A. Compliance with Regulations. The Engineer shall comply with the Regulations relative to nondiscrimination in Federally-assisted programs of the Department of Transportation (hereinafter, "DOT") Title 49, Code of Federal Regulations, Part 21, as they may be amended from time to time, (hereinafter referred to as the Regulations), which are herein incorporated by reference and made a part of this Contract.

B. Nondiscrimination. The Engineer, with regard to the work performed by it during the Contract, shall not discriminate on the grounds of race, color, or national origin in the selection and retention of subcontractors/subconsultants, including procurements of materials and leases of equipment. The Engineer shall not participate either directly or indirectly in the discrimination prohibited by section 21.5 of the Regulations, including employment practices when the contract covers a program set forth in Appendix B of the Regulations.

C. Solicitations for Subcontracts, Including Procurements of Materials and Equipment. In all solicitations either by competitive bidding or negotiation made by the

Engineer for work to be performed under a subcontract, including procurements of materials or leases of equipment, each potential subcontractor/subconsultant or supplier shall be notified by the Engineer of the Engineer's obligations under this Contract and the Regulations relative to nondiscrimination on the grounds of race, color, or national origin.

D. Information and Reports. The Engineer shall provide all information and reports required by the Regulations or directives issued pursuant thereto, and shall permit access to its books, records, accounts, other sources of information, and its facilities as may be determined by the County (referred to in this Article as the "Recipient") or the Texas Department of Transportation to be pertinent to ascertain compliance with such Regulations, orders and instructions. Where any information required of a contractor is in the exclusive possession of another who fails or refuses to furnish this information the Engineer shall so certify to the Recipient, or the Texas Department of Transportation as appropriate, and shall set forth what efforts it has made to obtain the information.

E. Sanctions for Noncompliance. In the event of the Engineer's noncompliance with the nondiscrimination provisions of this contract, the Recipient shall impose such contract sanctions as it or the Texas Department of Transportation may determine to be appropriate, including, but not limited to:

1. withholding of payments to the Engineer under the contract until the Engineer complies, and/or;
2. cancellation, termination or suspension of the Contract, in whole or in part.

F. Incorporation of Provisions. The Engineer shall include the provisions of Subsections (A) through (F) above in every subcontract, including procurements of materials and leases of equipment, unless exempt by the Regulations, or directives issued pursuant thereto. The Engineer shall take such action with respect to any subcontract or procurement as the Recipient or the Texas Department of Transportation may direct as a means of enforcing such provisions including sanctions for non-compliance: Provided, however, that, in the event a contractor becomes involved in, or is threatened with, litigation with a subcontractor/subconsultant or supplier as a result of such direction, the Engineer may request the Recipient to enter into such litigation to protect the interests of the Recipient, and, in addition, the Engineer may request the United States to enter into such litigation to protect the interests of the United States.

SIGNATORY WARRANTY

The undersigned signatory for Engineer hereby represents and warrants that the signatory is an officer of the organization for which he/she has executed this Contract and that he/she has full and complete authority to enter into this Contract on behalf of the firm. The above-stated representations and warranties are made for the purpose of inducing County to enter into this Contract.

IN WITNESS WHEREOF, County has caused this Contract to be signed in its name by its duly authorized County Judge, as has Engineer, signing by and through its duly authorized representative(s), thereby binding the parties hereto, their successors, assigns and representatives

for the faithful and full performance of the terms and provisions hereof, to be effective as of the date of the last party's execution below. NO OFFICIAL, EMPLOYEE, AGENT, OR REPRESENTATIVE OF THE COUNTY HAS ANY AUTHORITY, EITHER EXPRESS OR IMPLIED, TO AMEND, TERMINATE OR MODIFY THIS CONTRACT, EXCEPT PURSUANT TO SUCH EXPRESS AUTHORITY AS MAY BE GRANTED BY THE WILLIAMSON COUNTY COMMISSIONERS COURT.

COUNTY

WILLIAMSON COUNTY, TEXAS

By: _____
Dan A. Gattis, County Judge

Date: _____ ____, 20____

ENGINEER

KIMLEY-HORN AND ASSOCIATES, INC.

By Andrew W. VanLeeuwen

Printed Name: Andrew VanLeeuwen

Title: Sr. Vice President

Date: August 19, 20 15

SUBSCRIBED and sworn to before me the undersigned authority by ANDREW W. VanLeeuwen _____ the Sr. Vice President of **ENGINEER**, on behalf of said firm.

Takesia Tate

TAKESIA TATE
Notary Public, State of Texas
My Commission Expires
October 01, 2017

Notary Public in and for the
State of Texas

My commission expires: 10/01/17

LIST OF EXHIBITS ATTACHED

(1) **Exhibit A** Debarment Certification

(2) **Exhibit B** Engineering Services

(3) **Exhibit C** Work Authorization

(4) **Exhibit D** Rate Schedule

(5) **Exhibit E** Williamson County Vendor Reimbursement Policy

(6) **Exhibit F** Certificates of Insurance

EXHIBIT A
DEBARMENT CERTIFICATION

STATE OF TEXAS §
§
COUNTY OF WILLIAMSON §

I, the undersigned, being duly sworn or under penalty of perjury under the laws of the United States and the State of Texas, certifies that Engineer and its principals:

(a) Are not presently debarred, suspended, proposed for debarment, declared ineligible or voluntarily excluded from covered transactions by any federal department or agency:

(b) Have not within a three-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public* transaction or contract under a public transaction; violation of federal or state antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

(c) Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity* with commission of any of the offenses enumerated in paragraph (1)(b) of this certification;

(d) Have not within a three-year period preceding this application/proposal had one or more public transactions* terminated for cause or default; and

(e) Have not been disciplined or issued a formal reprimand by any State agency for professional accreditation within the past three years.

KIMLEY-HORN AND ASSOCIATES, INC.
Name of Firm

Signature of Certifying Official

Andrew VanLeeuwen
Printed Name of Certifying Official

Sr. Vice President
Title of Certifying Official

August 19, 2015
Date

(2) Where the PROVIDER is unable to certify to any of the statements in this certification, such PROVIDER shall attach an explanation to this certification.

* federal, state, or local

SUBSCRIBED and sworn to before me the undersigned authority by _____ _____ the _____ of _____,on behalf of said firm.

_____
Notary Public in and for the
State of Texas

My commission expires: _____

EXHIBIT B

ENGINEERING SERVICES

THE ATTACHED SCOPE OF SERVICES IS INTENDED TO BE CONSISTENT WITH THE WILLIAMSON COUNTY PROFESSIONAL SERVICES AGREEMENT. TO THE EXTENT THE SCOPE IS INCONSISTENT WITH THE PROFESSIONAL SERVICES AGREEMENT, THE PROFESSIONAL SERVICES AGREEMENT WILL SUPERSEDE THE SCOPE AND WILL BE CONTROLLING.

THE ENGINEER SHALL PROVIDE EXPERT TESTIMONY IN ANY ADMINISTRATIVE OR COURT PROCEEDINGS THROUGH AN APPROPRIATE ENGINEERING PROFESSIONAL TO BE DETERMINED BY COUNTY AS ADDITIONAL SERVICES AT THE RATE OF COMPENSATION SET FORTH IN EXHIBIT II.

EXCEPT AS PROVIDED FOR FEE SERVICES OR WORK-ORDER BASED SERVICES, THE ATTACHED SCOPE OF SERVICES SHALL INCLUDE A PRODUCTION SCHEDULE REFLECTING A TIMELINE FOR THE EXECUTION OF THE PROJECT.

The following scope of services is a general description of the types of projects that may be performed under this contract.

Traffic Signal Timing: Isolated Intersections, Corridor Timing Plans, and Grid Network Plans

Traffic Studies:

Signal and Stop Warrants
Speed Zones
Signing and Pavement Markings
School Zone
Bottleneck Studies
High Accident Locations
Special Event Studies
Travel Demand Modeling
Congestion / Access Management
Traffic Projections for Design Projects
Freeway Operations
Ramp Operations
Review of Other Studies (i.e. TIAs)
Innovative Intersection Studies
Shared Parking Studies
Roadway Impact Fees

Data Collection: Turning Movement Counts, Strip Maps, Tube Counts, Ball Bank Indicator

Plans Specifications & Estimates (PS&E), including:

- Traffic Signal Design
- Signal System Design (Wired or Wireless Interconnect)
- Minor Intersection Improvements
- Innovative Intersections
- Intelligent Transportation System (ITS) Projects
  - Dynamic Message Signs
  - CCTV Cameras
  - Detection Systems (microwave, loops, video)

        - Lane Control Signals
        - Wireless Communications (800 MHz, 900 MHz, 2.4 GHz, Ethernet, others)
        - Fiber Optic Communications (SONET, ATM, Ethernet)
        - Leased Communications (T1, ISDN, POTS)
        - Highway Advisory Radio
    - HUB Buildings
    - Control Centers
    - Networking (ISD, municipal)
- ❖ Traffic Management / Traffic Control Plans
- ❖ Illumination
- ❖ Large and Small Guide Signs

ITS Architectures

- ❖ Regional Architecture Updates
- ❖ Project Specific Architectures

Construction Support:

- ❖ Observation of Construction
- ❖ Review of Contractor Shop Drawing Submittals
- ❖ Review of Contractor RFIs - clarifications and interpretations
- ❖ Investigation of Change Order Requests and Designs
- ❖ Review of Testing Procedures

EXHIBIT C

WORK AUTHORIZATION

(To Be Completed and Executed After Contract Execution)

WORK AUTHORIZATION NO. _____
PROJECT: _____

This Work Authorization is made pursuant to the terms and conditions of the Williamson County Contract for Engineering Services, being dated _____ ____, 20____ and entered into by and between Williamson County, Texas, a political subdivision of the State of Texas, (the "County") and _____ (the "Engineer").

Part1. The Engineer will provide the following Engineering Services set forth in Attachment "B" of this Work Authorization.

Part 2. The maximum amount payable for services under this Work Authorization without modification is _____.

Part 3. Payment to the Engineer for the services established under this Work Authorization shall be made in accordance with the Contract.

Part 4. This Work Authorization shall become effective on the date of final acceptance and full execution of the parties hereto and shall terminate on _____ ____, 20_____. The Engineering Services set forth in Attachment "B" of this Work Authorization shall be fully completed on or before said date unless extended by a Supplemental Work Authorization.

Part 5. This Work Authorization does not waive the parties' responsibilities and obligations provided under the Contract.

Part 6. This Work Authorization is hereby accepted and acknowledged below.

EXECUTED this ____ day of _____, 20___.

ENGINEER:	COUNTY:
[Insert Company Name HERE]	Williamson County, Texas
By:_____	By:_____
Signature	Signature
_____	_____
Printed Name	Printed Name
_____	_____
Title	Title

LIST OF ATTACHMENTS

Attachment A - Services to be Provided by County

Attachment B - Services to be Provided by Engineer

Attachment C - Work Schedule

Attachment D - Fee Schedule

EXHIBIT D

RATE SCHEDULE

Classification	Hourly Billing Rate
Admin / Clerical	$75
Sr. CAD Technician	$95
Sr. Designer / Engineering Technician	$120
Analyst	$115
Engineer/Professional	$145
Sr. Engineer I/Professional I	$180
Sr. Engineer II/Senior Professional II	$215
Principal	$240

CPI Rate Adjustments: Rates will remain firm for the initial first year of the Contract and such rates shall be deemed the "Initial Base Rates". Engineer must request rate adjustments, in writing, at least thirty (30) days prior to each annual anniversary date of the Contract and any rate changes will take effect on the first day following the prior year. If Engineer fails to request a CPI rate adjustment, as set forth herein, the adjustment will be effective thirty (30) days after the County receives Engineer's written request. No retroactive rate adjustments will be allowed.

Price adjustments will be made in accordance with changes in the U.S. Department of Labor Consumer Price Index (CPI-U) for All Urban Consumers, All Items, South Region (Base 1982-84 = 100).

The rate adjustment will be determined by multiplying the Initial Base Rates by a fraction, the numerator of which is the index number for most recently released index before each annual anniversary date of the Contract and the denominator of which is the index number for the first month of the Contract (the index number for the month in which the Contract was originally executed). If the products are greater than the Initial Base Rates, County will pay the greater amounts as the rates during the successive year until the next rate adjustment. Rates for each successive year will never be less than the Initial Base Rates.

Williamson County
Vendor Reimbursement Policy

The purpose of this Williamson County Vendor Reimbursement Policy ("Policy") is to provide clear guidelines to vendors on Williamson County's expectations and requirements regarding allowable reimbursable expenditures and required backup. The Policy will also minimize conflicts related to invoice payments and define non-reimbursable items. This Policy is considered a guideline and is not a contract.

This Policy may be altered, deleted or amended, at any time and without prior notice to vendors, by action of the Williamson County Commissioners Court. Unenforceable provisions of this Policy, as imposed by applicable law, regulations, or judicial decisions, shall be deemed to be deleted. Any revisions to this Policy will be distributed to all current vendors doing business with the County.

1. **Invoices and Affidavits**
   - 1.1 Invoices must adequately describe the goods or services provided to County and include all required backup (i.e. reimbursable expenses, mileage log, timesheets, receipts detailing expenses incurred etc.) that is in a form acceptable to the Williamson County Auditor. Invoices that do not adequately describe the goods or services provided to County or contain backup that is satisfactory to the Williamson County Auditor will be returned to vendor for revisions and the provision above relating to invoice errors resolved in favor of the County shall control as to the required actions of vendor and when such invoice must be paid by the County.
   - 1.2 In the event an invoice includes charges based upon hourly billing rates for services or any other rates based upon the amount of time worked by an individual or individuals in performing services, whether the charges are being billed directly to the County or whether they are the basis of invoices from subcontractors for which the vendor seeks reimbursement from the County, the charges shall be accompanied by an affidavit signed by an officer or principal of the vendor certifying that the work was performed, it was authorized by the County and that all information contained in the invoice that is being submitted is true and correct.
   - 1.3 Upon County's request, vendor must submit all bills paid affidavits wherein vendor must swear and affirm that vendor has paid each of its subcontractors, laborers, suppliers and material in full for all labor and materials provided to vendor for or in connection with services and work performed for County and, further, vendor must swear and affirm that vendor is not aware of any unpaid bills, claims, demands, or causes of action by any of its subcontractors, laborers, suppliers, or material for or in connection with the furnishing of labor or materials, or both, for services and work performed for County.

2. **Travel Reimbursement**
   - 2.1 The County will only cover costs associated with travel on vendors outside a 50 mile radius from Williamson County, Texas.
   - 2.2 The County will only cover costs associated with travel as documented work for County. If a vendor is also doing business for another client, the travel costs must be split in proportion to the amount of work actually performed for County and the other client. The only allowable travel expense will be for the specific days worked for Williamson County.
   - 2.3 No advance payments will be made to vendor for travel expenditures. The travel expenditure may only be reimbursed after the expenditure/trip has already occurred and

vendor has provided the Williamson County Auditor with all necessary and required backup.

2.4 Vendors must submit all travel reimbursement requests on each employee in full. Specifically, a travel reimbursement request must include all related travel reimbursement expenses relating to a particular trip for which vendor seeks reimbursement. Partial travel reimbursement requests will not be accepted (i.e. vendor should not submit hotel and mileage one month then the next month submit rental car and airfare). If the travel reimbursement appears incomplete, the invoice will be sent back to the vendor to be submitted when all information is ready to submit in full.

2.5 Reimbursement for transportation costs will be at the most reasonable means of transportation (i.e.: airline costs will be reimbursed for coach rate, rental car costs will only be reimbursed if rental car travel was most reasonable means of travel as compared to travel by air).

2.6 The County will not be responsible for, nor will the County reimburse additional charges due to personal preference or personal convenience of individual traveling.

2.7 The County will not reimburse airfare costs if airfare costs were higher than costs of mileage reimbursement.

2.8 Additional expenses associated with travel that is extended to save costs (i.e. Saturday night stay) may be reimbursed if costs of airfare would be less than the cost of additional expenses (lodging, meals, car rental, mileage) if the trip had not been extended. Documentation satisfactory to the Williamson County Auditor will be required to justify expenditure.

2.9 County will only reimburse travel expense to necessary personnel of the vendor (i.e. no spouse, friends or family members).

2.10 Except as otherwise set forth herein, a vendor must provide a paid receipt for all expenses. If a receipt cannot be obtained, a written sworn statement of the expense from the vendor may be substituted for the receipt.

2.11 Sales tax for meals and hotel stays are the only sales taxes that will be reimbursed. Sales tax on goods purchased will not be reimbursed. A sales tax exemption form is available from the Williamson County Auditor's Office upon request.

2.12 The County will not pay for any late charges on reimbursable items. It is the responsibility of the vendor to pay the invoice first and seek reimbursement from the County.

3. Meals

3.1 Meal reimbursements are limited to a maximum of $40.00 per day on overnight travel. On day travel (travel that does not require an overnight stay), meal reimbursements are limited to a maximum of $20.00 per day. The travel must be outside the Williamson County, Texas line by a 50 mile radius.

3.2 Receipts are required on meal reimbursement amounts up to the maximum per day amount stated for overnight or day travel. If receipts are not presented, the vendor can request per diem (per diem limits refer to 3.2). However, a vendor cannot combine per diem and meal receipts. Only one method shall be allowed.

3.3 Meals are reimbursable only for vendors who do not have the necessary personnel located within a 50 mile radius of Williamson County, Texas that are capable of carrying the vendor's obligations to County. Meals will not be reimbursed to vendors who are located within a 50 mile radius of Williamson County, Texas.

3.4 County will not reimburse for alcoholic beverages.

3.5 Tips are reimbursable but must be reasonable to limitation of meal allowance.

3.6 No meals purchased for entertainment purposes will be allowed.

3.7 Meal reimbursement must be substantiated with a hotel receipt.

4. **Lodging**
   - 4.1 Hotel accommodations require an itemized hotel folio as a receipt. The lodging receipt should include name of the motel/hotel, number of occupant(s), goods or services for each individual charge (room rental, food, tax, etc.) and the name of the occupant(s). Credit card receipts or any other form of receipt are not acceptable.
   - 4.2 Vendors will be reimbursed for a single room rate charge plus any applicable tax. If a single room is not available, the vendor must provide documentation to prove that a single room was not available in order to justify the expense over and above the single room rate. A vendor may also be required to provide additional documentation if a particular room rate appears to be excessive.
   - 4.3 Personal telephone charges, whether local or long distance, will not be reimbursed.

5. **Airfare**
   - 5.1 The County will only reimburse up to a coach price fare for air travel.
   - 5.2 The County will exclude any additional charges due to personal preference or personal convenience of the individual traveling (i.e. early bird check in, seat preference charges, airline upgrades, etc. will not be an allowable reimbursement)
   - 5.3 Air travel expenses must be supported with receipt copy of an airline ticket or an itinerary with actual ticket price paid. If tickets are purchased through a website, vendor must submit a copy of the webpage showing the ticket price if no paper ticket was issued.
   - 5.4 Cancellation and/or change flight fees may be reimbursed by the County but vendor must provide the Williamson County Auditor with documentation in writing from a County department head providing authorization for the change.
   - 5.5 The County will not reimburse vendor for tickets purchased with frequent flyer miles.

6. **Car Rental**
   - 6.1 Vendors that must travel may rent a car at their destination when it is less expensive than other transportation such as taxis, airport shuttles or public transportation such as buses or subways.
   - 6.2 Cars rented must be economy or mid-size. Luxury vehicle rentals will not be reimbursed. Any rental costs over and above the cost of a mid-size rental will be adjusted.
   - 6.3 Vendors will be reimbursed for rental cars if the rental car cost would have been less than the mileage reimbursement cost (based on the distance from vendor's point of origin to Williamson County, Texas) had the vendor driven vendor's car.
   - 6.4 Vendors must return a car rental with appropriate fuel levels as required by rental agreement to avoid the car rental company from adding fuel charges.
   - 6.5 Rental agreement and credit card receipt must be provided to County as back up for the request for reimbursement.
   - 6.6 Insurance purchased when renting vehicle may also be reimbursed.
   - 6.7 Car Rental optional extras such as GPS, roadside assistance, and administrative fees on Tolls will not be reimbursed.

7. **Personal Car Usage**
   - 7.1 Personal vehicle usage will be reimbursed in an amount equal to the standard mileage rate allowed by the IRS.
   - 7.2 Per code of Federal Regulations, Title 26, Subtitle A, Chapter 1, Subchapter B, Part IX, Section 274(d), all expense reimbursement requests must include the following:
     - 7.2.1.1 Date

7.2.1.2 Destination
7.2.1.3 Purpose
7.2.1.4 Name of traveler(s)
7.2.1.5 Correspondence that verifies business purpose of the expense

7.3 The mileage for a personal vehicle must document the date, location of travel to/from, number of miles traveled and purpose of trip.

7.4 Mileage will be reimbursed on the basis of the most commonly used route.

7.5 Reimbursement for mileage shall not exceed the cost of a round trip coach airfare.

7.6 Reimbursement for mileage shall be prohibited between place of residence and usual place of work.

7.7 Mileage should be calculated from vendor's employee's regular place of work or their residence, whichever is the shorter distance when traveling to a meeting or traveling to Williamson County, Texas for vendors who are located outside of Williamson County, Texas by at least a 50 mile radius.

7.8 When more than one person travels in same vehicle, only one person may claim mileage reimbursement.

7.9 Tolls, if reasonable, are reimbursable. Receipts are required for reimbursement. If a receipt is not obtainable, then written documentation of expense must be submitted for reimbursement (administrative fees on Tolls will not be reimbursed).

7.10 Parking fees, if reasonable, are reimbursable for meetings and hotel stays. For vendors who contract with a third party for visitor parking at vendor's place of business, Williamson County will not reimburse a vendor based on a percentage of its contracted visitor parking fees. Rather, Williamson County will reimburse Vendor for visitor parking on an individual basis for each time a visitor uses Vendor's visitor parking. Receipts are required for reimbursement. If a receipt is not obtainable, then written documentation of expense must be submitted for reimbursement.

7.11 Operating and maintenance expenses, as well as other personal expenses, such as parking tickets, traffic violations, and car repairs and collision damage are not reimbursable.

8. Other Expenses

8.1 Taxi fare, bus tickets, conference registrations, parking, etc. must have a proper original receipt.

9. Repayment of Nonreimbursable Expense.

Vendors must, upon demand, immediately repay County for all inappropriately reimbursed expenses whenever an audit or subsequent review of any expense reimbursement documentation finds that such expense was reimbursed contrary to these guidelines and this Policy. Williamson County reserves the right to retain any amounts that are due or that become due to a vendor in order to collect any inappropriately reimbursed expenses that a vendor was paid.

10. Non-Reimbursable Expenses

In addition to the non-reimbursable items set forth above in this Policy, the following is a non-exhaustive list of expenses that will not be reimbursed by Williamson County:

10.1 Alcoholic beverages/tobacco products
10.2 Personal phone calls
10.3 Laundry service
10.4 Valet service
10.5 Movie rentals
10.6 Damage to personal clothing
10.7 Flowers/plants

10.8 Greeting cards
10.9 Fines and/or penalties
10.10 Entertainment, personal clothing, personal sundries and services
10.11 Transportation/mileage to places of entertainment or similar personal activities
10.12 Upgrades to air, hotel and/or car rental
10.13 Auto repairs
10.14 Baby sitter fees, kennel costs, pet or house-sitting fees
10.15 Saunas, massages or exercise facilities
10.16 Credit card delinquency fees
10.17 Doctor bills, prescription and other medical services
10.18 Hand tools
10.19 Safety Equipment (hard hats, safety vests, etc.)
10.20 Office supplies
10.21 Any other expenses which Williamson County deems, in its sole discretion, to be inappropriate or unnecessary expenditures.

EXHIBIT F

CERTIFICATES OF INSURANCE

ATTACHED BEHIND THIS PAGE

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 4/17/2015

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER
Greyling Insurance Brokerage
3780 Mansell Road
Suite 370
Alpharetta GA 30022

CONTACT NAME: Jerry Noyola
PHONE (A/C, No, Ext): (770) 552-4225 **FAX (A/C, No):** (866) 550-4082
E-MAIL ADDRESS: jerry.noyola@greyling.com

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A: National Union Fire Ins Co	19445 A
INSURER B: Commerce & Industry Insurance	19410 A
INSURER C: New Hampshire Insurance Company	23841 A
INSURER D: Lloyd's of London	085202 A
INSURER E :	
INSURER F :	

INSURED
Kimley-Horn and Associates, Inc.
P.O. Box 33068

Raleigh NC 27636

COVERAGES **CERTIFICATE NUMBER:** 15-16 (Kimley Amanda) **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	GENERAL LIABILITY X COMMERCIAL GENERAL LIABILITY CLAIMS-MADE X OCCUR X Contractual Liability GEN'L AGGREGATE LIMIT APPLIES PER: POLICY X PRO-JECT X LOC			9645227	4/1/2015	4/1/2016	EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG	$ 1,000,000 $ 500,000 $ 25,000 $ 1,000,000 $ 2,000,000 $ 2,000,000
A	AUTOMOBILE LIABILITY X ANY AUTO ALL OWNED AUTOS SCHEDULED AUTOS X HIRED AUTOS X NON-OWNED AUTOS			4982985	4/1/2015	4/1/2016	COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident)	$ 1,000,000 $ $ $
B	X UMBRELLA LIAB X OCCUR EXCESS LIAB CLAIMS-MADE DED X RETENTION $ 10,000			BE 020733086	4/1/2015	4/1/2016	EACH OCCURRENCE AGGREGATE	$ 5,000,000 $ 5,000,000
C A	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) Y/N: N If yes, describe under DESCRIPTION OF OPERATIONS below	N/A		39901450 (AOS) 39901451 (CA)	4/1/2015 4/1/2015	4/1/2016 4/1/2016	X WC STATU-TORY LIMITS OTH-ER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	$ 1,000,000 $ 1,000,000 $ 1,000,000
D	Professional Liability			P070831500	4/1/2015	4/1/2016	Per Claim Aggregate	$2,000,000 $2,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (Attach ACORD 101, Additional Remarks Schedule, if more space is required)
Re: On-Call Traffic Engineering. Williamson County is named as an Additional Insured on the above referenced liability policies with the exception of workers compensation & professional liability where required by written contract. Should any of the above described policies be cancelled by the issuing insurer before the expiration date thereof, 30 days' written notice (except 10 days for nonpayment of premium) will be provided to the Certificate Holder named below.

CERTIFICATE HOLDER

Williamson County
710 Main Street
Suite 301
Georgetown, TX 78626

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

David Collings/JERRY

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Commissioners Court - Regular Session **24.**

Meeting Date: 09/01/2015

CR 258 Contract

Submitted For: Charlie Crossfield **Submitted By:** Charlie Crossfield, Road Bond

Department: Road Bond

Agenda Category: Regular Agenda Items

Information

Agenda Item

Discuss and take appropriate action on a Real Estate Contract with Dennis and Shelley Eberwein for ROW needed on CR 258. (PARCEL 25)

Background

Fiscal Impact

From/To	Acct No.	Description	Amount

Attachments

Eberwein contract

Form Review

Inbox	Reviewed By	Date
County Judge Exec Asst.	Wendy Coco	08/27/2015 10:29 AM
Form Started By: Charlie Crossfield		Started On: 08/27/2015 10:17 AM
Final Approval Date: 08/27/2015		

REAL ESTATE CONTRACT

CR 258 Right of Way—Parcel 25

THIS REAL ESTATE CONTRACT ("Contract") is made by DENNIS EBERWEIN and SHELLEY EBERWEIN (referred to in this Contract as "Seller") and WILLIAMSON COUNTY, TEXAS (referred to in this Contract as "Purchaser"), upon the terms and conditions set forth in this Contract.

ARTICLE I
PURCHASE AND SALE

By this Contract, Seller sells and agrees to convey, and Purchaser purchases and agrees to pay for, the tract(s) of land described as follows:

> All of that certain tract of land comprising approximately 2.0 acres, more or less, in the B. Manlove Survey, Abstract No. 417, Williamson County and as further generally depicted on Exhibit "A" attached hereto and incorporated herein. Prior to the execution of a Deed document by Seller, Purchaser shall cause to be created a metes and bounds description of this parcel, which is to be attached to the executed Deed document for recording in the real property records of Williamson County, Texas (Parcel 25);

together with all and singular the rights and appurtenances pertaining to the property, including any right, title and interest of Seller in and to adjacent streets, alleys or rights-of-way (all of such real property, rights, and appurtenances being referred to in this Contract as the "Property"), and any improvements situated on and attached to the Property described in Exhibit "A" not otherwise agreed herein to be retained by Seller, for the consideration and upon and subject to the terms, provisions, and conditions set forth below.

ARTICLE II
PURCHASE PRICE

Purchase Price and Additional Consideration

2.01. The purchase price for the real Property described in Exhibit "A" shall be the sum of $20,000/acre multiplied by the total number of acres of property to be acquired. The total area of property to be acquired shall be determined by the final metes and bounds survey(s) to be completed as directed herein.

2.01.1. As Additional Consideration for any improvements upon the real property to be purchased herein, the replacement of fencing on the new right of way line and any damage or cost of cure for the remaining Property of Seller shall be the sum of FIFTEEN THOUSAND FIVE HUNDRED SIXTY and 00/100 Dollars ($15,560.00).

Payment of Purchase Price and Additional Compensation

2.02. The Purchase Price and Additional Compensation shall be payable in cash at the Closing.

ARTICLE III
PURCHASER'S OBLIGATIONS

Conditions to Purchaser's Obligations

3.01. The obligations of Purchaser hereunder to consummate the transactions contemplated hereby are subject to the satisfaction of each of the following conditions (any of which may be waived in whole or in part by Purchaser at or prior to the Closing).

Miscellaneous Conditions

3.02. Seller shall have performed, observed, and complied with all of the covenants, agreements, and conditions required by this Contract to be performed, observed, and complied with by Seller prior to or as of the closing.

ARTICLE IV
REPRESENTATIONS AND WARRANTIES OF SELLER

Seller hereby represents and warrants to Purchaser as follows, which representations and warranties shall be deemed made by Seller to Purchaser also as of the Closing Date, to the best of Seller's current actual knowledge:

(1) There are no parties in possession of any portion of the Property as lessees, tenants at sufferance, or trespassers, other than as previously disclosed to Purchaser;

(2) Seller has complied with all applicable laws, ordinances, regulations, statutes, rules and restrictions relating to the Property, or any part thereof;

The Property herein is being conveyed to Purchaser under threat of condemnation.

ARTICLE V
CLOSING

Closing Date

5.01. The Closing shall be held at the office of Texas American Title Company on or before September 30th, 2015, or at such time, date, and place as Seller and Purchaser may agree upon, or within 10 days after the completion of (1) any title curative matters if necessary for items as shown on the Title Commitment or in the contract or (2) the survey completion obligation described herein (which date is herein referred to as the "Closing Date").

Seller's Obligations at Closing

5.02. At the Closing Seller shall:

(1) Deliver to Purchaser a duly executed and acknowledged Deed conveying good and indefeasible title to Williamson County, Texas in fee simple to all of the Property described in Exhibit "A", free and clear of any and all liens and restrictions, except for the following:

(a) General real estate taxes for the year of closing and subsequent years not yet due and payable;

(b) Any exceptions approved by Purchaser pursuant to Article III hereof; and

(c) Any exceptions approved by Purchaser in writing.

The Deed shall be in the form as shown in Exhibit "B" attached hereto and incorporated herein.

(2) Deliver to Purchaser a Texas Owner's Title Policy at Purchaser's sole expense, issued by Title Company, in Grantee's favor in the full amount of the Purchase Price, insuring Purchaser's contracted interests in and to the Property subject only to those title exceptions listed herein, such other exceptions as may be approved in writing by Purchaser, and the standard printed exceptions contained in the usual form of Texas Owner's Title Policy, provided, however:

(a) The boundary and survey exceptions shall be deleted;

(b) The exception as to restrictive covenants shall be endorsed "None of Record", if applicable; and

(c) The exception as to the lien for taxes shall be limited to the year of Closing and shall be endorsed "Not Yet Due and Payable".

(d) Deliver to Purchaser possession of the Property if not previously done.

Purchaser's Obligations at Closing

5.03. At the Closing, Purchaser shall:

(a) Pay the cash portion of the Purchase Price and Additional Compensation.

Prorations

5.04. General real estate taxes for the then current year relating to the Property shall be prorated as of the Closing Date and shall be adjusted in cash at the closing. If the Closing shall occur before the tax rate is fixed for the then current year, the apportionment of taxes shall be upon the basis of the tax rate for the next preceding year applied to the latest assessed valuation. Agricultural roll-back taxes, if any, shall be paid by Purchaser.

Closing Costs

5.05. All costs and expenses of closing in consummating the sale and purchase of the Property shall be borne and paid as follows:

(1) Owner's Title Policy and survey to be paid by Purchaser.

(2) Deed, tax certificates, and title curative matters, if any, paid by Purchaser.

(3) All other closing costs shall be paid by Purchaser.

(4) Attorney's fees paid by each respectively.

ARTICLE VI
BREACH BY SELLER

In the event Seller shall fail to fully and timely perform any of its obligations hereunder or shall fail to consummate the sale of the Property for any reason, except Purchaser's default, Purchaser may: (1) enforce specific performance of this Contract; or (2) request that the Escrow Deposit, if any, shall be forthwith returned by the title company to Purchaser.

ARTICLE VII
BREACH BY PURCHASER

In the event Purchaser should fail to consummate the purchase of the Property, the conditions to Purchaser's obligations set forth in Article III having been satisfied and Purchaser being in default and Seller not being in default hereunder, Seller shall have the right to receive the Escrow Deposit, if any, from the title company, the sum being agreed on as liquidated damages for the failure of Purchaser to perform the duties, liabilities, and obligations imposed upon it by the terms and provisions of this Contract, and Seller agrees to accept and take this cash payment as its total damages and relief and as Seller's sole remedy hereunder in such event. If no Escrow Deposit has been made then Seller shall receive the amount of $500 as liquidated damages for any failure by Purchaser.

ARTICLE VIII
MISCELLANEOUS

Notice

8.01. Any notice required or permitted to be delivered hereunder shall be deemed received when sent by United States mail, postage prepaid, certified mail, return receipt requested, addressed to Seller or Purchaser, as the case may be, at the address set forth opposite the signature of the party.

Texas Law to Apply

8.02. This Contract shall be construed under and in accordance with the laws of the State of Texas, and all obligations of the parties created hereunder are performable in Williamson County, Texas.

Parties Bound

8.03. This Contract shall be binding upon and inure to the benefit of the parties and their respective heirs, executors, administrators, legal representatives, successors and assigns where permitted by this Contract.

Legal Construction

8.04. In case any one or more of the provisions contained in this Contract shall for any reason be held to be invalid, illegal, or unenforceable in any respect, this invalidity, illegality, or unenforceability shall not affect any other provision hereof, and this Contract shall be construed as if the invalid, illegal, or unenforceable provision had never been contained herein.

Prior Agreements Superseded

8.05. This Contract constitutes the sole and only agreement of the parties and supersedes any prior understandings or written or oral agreements between the parties respecting the within subject matter.

Time of Essence

8.06. Time is of the essence in this Contract.

Gender

8.07. Words of any gender used in this Contract shall be held and construed to include any other gender, and words in the singular number shall be held to include the plural, and vice versa, unless the context requires otherwise.

Memorandum of Contract

8.08. Upon request of either party, the parties shall promptly execute a memorandum of this Contract suitable for filing of record.

Compliance

8.09 In accordance with the requirements of Section 20 of the Texas Real Estate License Act, Purchaser is hereby advised that it should be furnished with or obtain a policy of title insurance or Purchaser should have the abstract covering the Property examined by an attorney of Purchaser's own selection.

Effective Date

8.10 This Contract shall be effective as of the date it is approved by Williamson County, Texas which date is indicated beneath the County Judge's signature below.

Counterparts

8.11 This Contract may be executed in any number of counterparts, which may together constitute the Contract. Signatures transmitted by facsimile or electronic mail may be considered effective as originals for purposes of this Contract.

[signature pages follow]

SELLER:

Dennis Eberwein

Address: 112 Snowy Egret Ln
Liberty Hill Leander
DE

Date: 8-26-15

Shelley Eberwein

Address: 112 Snowy Egret
Leander, TX 78641

Date: 8/26/15

PURCHASER:

WILLIAMSON COUNTY, TEXAS

By: _____
Dan A. Gattis
County Judge

Address: 710 Main Street, Suite 101
Georgetown, Texas 78626

Date: _____

EXHIBIT "A"

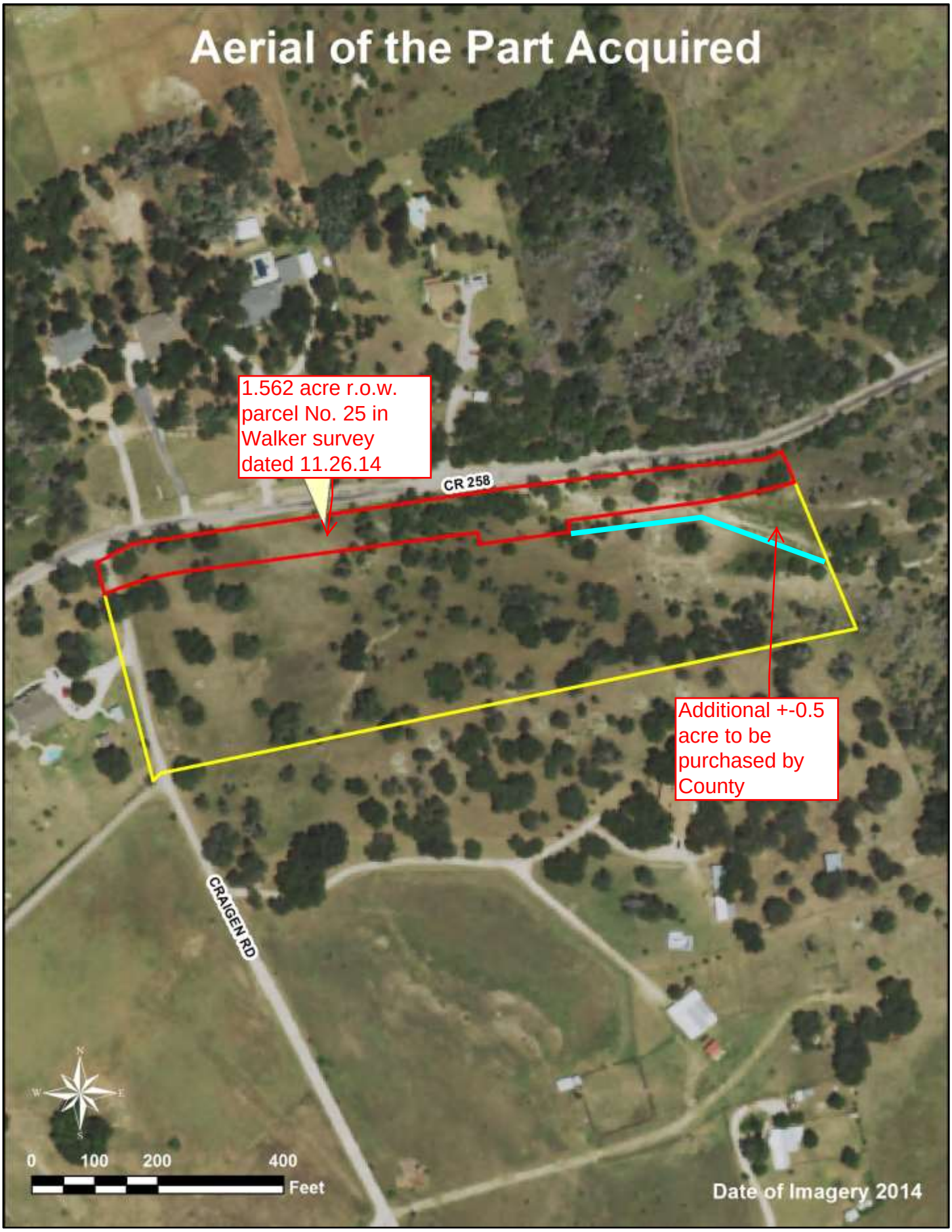

Aerial of the Part Acquired
1.562 acre r.o.w. parcel No. 25 in Walker survey dated 11.26.14
CR 258
Additional +-0.5 acre to be purchased by County
CRAIGEN RD
0
100
200
400
Feet
Date of Imagery 2014

EXHIBIT "B"

Parcel 25

DEED

County Road 258 Right of Way

THE STATE OF TEXAS §
§
COUNTY OF WILLIAMSON §

NOTICE OF CONFIDENTIALITY RIGHTS: IF YOU ARE A NATURAL PERSON, YOU MAY REMOVE OR STRIKE ANY OF THE FOLLOWING INFORMATION FROM THIS ANY INSTRUMENT THAT TRANSFERS AN INTEREST IN REAL PROPERTY BEFORE IT IS FILED FOR RECORD IN THE PUBLIC RECORDS: YOUR SOCIAL SECURITY NUMBER OR YOUR DRIVER'S LICENSE NUMBER.

NOW, THEREFORE, KNOW ALL MEN BY THESE PRESENTS:

That DENNIS EBERWEIN and SHELLEY EBERWEIN, hereinafter referred to as Grantor, whether one or more, for and in consideration of the sum of Ten Dollars ($10.00) and other good and valuable consideration to Grantor in hand paid by Williamson County, Texas, the receipt and sufficiency of which is hereby acknowledged, and for which no lien is retained, either expressed or implied, has this day Sold and by these presents do Grant, Bargain, Sell and Convey unto WILLIAMSON COUNTY, TEXAS, all of that certain tract or parcel of land lying and being situated in the County of Williamson, State of Texas, along with any improvements thereon, being more particularly described as follows:

> All of that certain _____ acre tract of land in the B. Manlove Survey, Abstract No. 417, Williamson County, Texas; said tract being more fully described by metes and bounds in Exhibit "A", attached hereto and incorporated herein (**Parcel 25**)

SAVE AND EXCEPT, HOWEVER, it is expressly understood and agreed that Grantor is retaining title to the following improvements located on the property described in said Exhibit "A" to wit: NONE

RESERVATIONS FROM AND EXCEPTIONS TO CONVEYANCE AND WARRANTY:

Visible and apparent easements not appearing of record;

Any discrepancies, conflicts, or shortages in area or boundary lines or any encroachments or any overlapping of improvements which a current survey would show;

Easements, restrictions, reservations, covenants, conditions, oil and gas leases, mineral severances, and encumbrances for taxes and assessments (other than liens and conveyances) presently of record in the Official Public Records of Williamson County, Texas, that affect the property, but only to the extent that said items are still valid and in force and effect at this time.

Grantor reserves all of the oil, gas and other minerals in and under the land herein conveyed but waives all rights of ingress and egress to the surface thereof for the purpose of exploring, developing, mining or drilling or pumping the same; provided, however, that operations for exploration or recovery of any such minerals shall be permissible so long as all surface operations in connection therewith are located at a point outside the acquired parcel and upon the condition that none of such operations shall be conducted so near the surface of said land as to interfere with the intended use thereof or in any way interfere with, jeopardize, or endanger the facilities of Williamson County, Texas or create a hazard to the public users thereof; it being intended, however, that nothing in this reservation shall affect the title and the rights of Grantee to take and use without additional compensation any, stone, earth, gravel, caliche, iron ore, gravel or any other road building material upon, in and under said land for the construction and maintenance of CR 258, but shall not be used or exported from the Property for any other purpose.

TO HAVE AND TO HOLD the property herein described and herein conveyed together with all and singular the rights and appurtenances thereto in any wise belonging unto Williamson County, Texas and its assigns forever; and Grantor does hereby bind itself, its heirs, executors, administrators, successors and assigns to Warrant and Forever Defend all and singular the said premises herein conveyed unto Williamson County, Texas and its assigns against every person whomsoever lawfully claiming or to claim the same or any part thereof.

This deed is being delivered in lieu of condemnation.

IN WITNESS WHEREOF, this instrument is executed on this the ___ day of _____, 2015.

GRANTOR:

_____
Dennis Eberwein

_____
Shelley Eberwein

ACKNOWLEDGMENT

STATE OF TEXAS §
§
COUNTY OF _____ §

This instrument was acknowledged before me on this the ____ day of _____, 2015 by Dennis Eberwein, in the capacity and for the purposes and consideration recited therein.

_____
Notary Public, State of Texas

STATE OF TEXAS §
§
COUNTY OF _____ §

This instrument was acknowledged before me on this the ____ day of _____, 2015 by Shelley Eberwein, in the capacity and for the purposes and consideration recited therein.

_____
Notary Public, State of Texas

PREPARED IN THE OFFICE OF:

Sheets & Crossfield, P.C.
309 East Main
Round Rock, Texas 78664

GRANTEE'S MAILING ADDRESS:

Williamson County, Texas
Attn: County Judge
710 Main Street, Suite 101
Georgetown, Texas 78626

AFTER RECORDING RETURN TO:

Commissioners Court - Regular Session **25.**

Meeting Date: 09/01/2015

CR 258 Contract

Submitted For: Charlie Crossfield **Submitted By:** Charlie Crossfield, Road Bond

Department: Road Bond

Agenda Category: Regular Agenda Items

Information

Agenda Item

Discuss and take appropriate action on a Real Estate Contract with Robert & Joanne Pontius for ROW needed on CR 258. (PARCEL 17)

Background

Fiscal Impact

From/To	Acct No.	Description	Amount

Attachments

Pontius Contract

Form Review

Inbox	Reviewed By	Date
County Judge Exec Asst.	Wendy Coco	08/27/2015 10:29 AM
Form Started By: Charlie Crossfield		Started On: 08/27/2015 10:19 AM
Final Approval Date: 08/27/2015		

REAL ESTATE CONTRACT
CR 258 Right of Way—Parcel 17

THIS REAL ESTATE CONTRACT ("Contract") is made by ROBERT E. PONTIUS and JOANNE M. PONTIUS (referred to in this Contract as "Seller") and WILLIAMSON COUNTY, TEXAS (referred to in this Contract as "Purchaser"), upon the terms and conditions set forth in this Contract.

ARTICLE I
PURCHASE AND SALE

By this Contract, Seller sells and agrees to convey, and Purchaser purchases and agrees to pay for, the tract(s) of land described as follows:

> All of that certain 0.554 acre (approximately 24,129 Sq. Ft.) tract of land in the B. Manlove Survey, Abstract No. 417, Williamson County; being more fully described by metes and bounds in Exhibit "A", attached hereto and incorporated herein (**Parcel 17**)

together with all and singular the rights and appurtenances pertaining to the property, including any right, title and interest of Seller in and to adjacent streets, alleys or rights-of-way (all of such real property, rights, and appurtenances being referred to in this Contract as the "Property"), and any improvements situated on and attached to the Property described in Exhibit "A" not otherwise agreed herein to be retained by Seller, for the consideration and upon and subject to the terms, provisions, and conditions set forth below.

ARTICLE II
PURCHASE PRICE

Purchase Price

2.01. The Purchase Price for the Property, any improvements thereon, and any damage or cost of cure for the remaining property of Seller shall be the sum of TWENTY THREE THOUSAND FIVE HUNDRED and 00/100 Dollars ($23,500.00).

Payment of Purchase Price

2.02. The Purchase Price shall be payable in cash at the Closing.

ARTICLE III
PURCHASER'S OBLIGATIONS

Conditions to Purchaser's Obligations

3.01. The obligations of Purchaser hereunder to consummate the transactions contemplated hereby are subject to the satisfaction of each of the following conditions (any of which may be waived in whole or in part by Purchaser at or prior to the Closing).

Miscellaneous Conditions

3.02. Seller shall have performed, observed, and complied with all of the covenants, agreements, and conditions required by this Contract to be performed, observed, and complied with by Seller prior to or as of the closing.

ARTICLE IV
REPRESENTATIONS AND WARRANTIES OF SELLER

Seller hereby represents and warrants to Purchaser as follows, which representations and warranties shall be deemed made by Seller to Purchaser also as of the Closing Date, to the best of Seller's current actual knowledge:

(1) There are no parties in possession of any portion of the Property as lessees, tenants at sufferance, or trespassers, other than as previously disclosed to Purchaser;

(2) Seller has complied with all applicable laws, ordinances, regulations, statutes, rules and restrictions relating to the Property, or any part thereof;

The Property herein is being conveyed to Purchaser under threat of condemnation.

ARTICLE V
CLOSING

Closing Date

5.01. The Closing shall be held at the office of Capital Title of Texas on or before September 30th, 2015, or at such time, date, and place as Seller and Purchaser may agree upon, or within 10 days after the completion of any title curative matters if necessary for items as shown on the Title Commitment or in the contract (which date is herein referred to as the "Closing Date").

Seller's Obligations at Closing

5.02. At the Closing Seller shall:

(1) Deliver to Purchaser a duly executed and acknowledged Deed conveying good and indefeasible title to Williamson County, Texas in fee simple to all of the Property described in Exhibit "A", free and clear of any and all liens and restrictions, except for the following:

(a) General real estate taxes for the year of closing and subsequent years not yet due and payable;

(b) Any exceptions approved by Purchaser pursuant to Article III hereof; and

(c) Any exceptions approved by Purchaser in writing.

The Deed shall be in the form as shown in Exhibit "B" attached hereto and incorporated herein.

(2) Deliver to Purchaser a Texas Owner's Title Policy at Purchaser's sole expense, issued by Title Company, in Grantee's favor in the full amount of the purchase price, insuring Purchaser's contracted interests in and to the Property subject only to those title exceptions listed herein, such other exceptions as may be approved in writing by Purchaser, and the standard printed exceptions contained in the usual form of Texas Owner's Title Policy, provided, however:

(a) The boundary and survey exceptions shall be deleted;

(b) The exception as to restrictive covenants shall be endorsed "None of Record", if applicable; and

(c) The exception as to the lien for taxes shall be limited to the year of Closing and shall be endorsed "Not Yet Due and Payable".

(d) Deliver to Purchaser possession of the Property if not previously done.

Purchaser's Obligations at Closing

5.03. At the Closing, Purchaser shall:

(a) Pay the cash portion of the Purchase Price.

Prorations

5.04. General real estate taxes for the then current year relating to the Property shall be prorated as of the Closing Date and shall be adjusted in cash at the closing. If the Closing shall occur before the tax rate is fixed for the then current year, the apportionment of taxes shall be upon the basis of the tax rate for the next preceding year applied to the latest assessed valuation. Agricultural roll-back taxes, if any, shall be paid by Purchaser.

Closing Costs

5.05. All costs and expenses of closing in consummating the sale and purchase of the Property shall be borne and paid as follows:

(1) Owner's Title Policy and survey to be paid by Purchaser.

(2) Deed, tax certificates, and title curative matters, if any, paid by Purchaser.

(3) All other closing costs shall be paid by Purchaser.

(4) Attorney's fees paid by each respectively.

ARTICLE VI
BREACH BY SELLER

In the event Seller shall fail to fully and timely perform any of its obligations hereunder or shall fail to consummate the sale of the Property for any reason, except Purchaser's default, Purchaser may: (1) enforce specific performance of this Contract; or (2) request that the Escrow Deposit, if any, shall be forthwith returned by the title company to Purchaser.

ARTICLE VII
BREACH BY PURCHASER

In the event Purchaser should fail to consummate the purchase of the Property, the conditions to Purchaser's obligations set forth in Article III having been satisfied and Purchaser being in default and Seller not being in default hereunder, Seller shall have the right to receive the Escrow Deposit, if any, from the title company, the sum being agreed on as liquidated damages for the failure of Purchaser to perform the duties, liabilities, and obligations imposed upon it by the terms and provisions of this Contract, and Seller agrees to accept and take this cash payment as its total damages and relief and as Seller's sole remedy hereunder in such event. If no Escrow Deposit has been made then Seller shall receive the amount of $500 as liquidated damages for any failure by Purchaser.

ARTICLE VIII
MISCELLANEOUS

Notice

8.01. Any notice required or permitted to be delivered hereunder shall be deemed received when sent by United States mail, postage prepaid, certified mail, return receipt requested, addressed to Seller or Purchaser, as the case may be, at the address set forth opposite the signature of the party.

Texas Law to Apply

8.02. This Contract shall be construed under and in accordance with the laws of the State of Texas, and all obligations of the parties created hereunder are performable in Williamson County, Texas.

Parties Bound

8.03. This Contract shall be binding upon and inure to the benefit of the parties and their respective heirs, executors, administrators, legal representatives, successors and assigns where permitted by this Contract.

Legal Construction

8.04. In case any one or more of the provisions contained in this Contract shall for any reason be held to be invalid, illegal, or unenforceable in any respect, this invalidity, illegality, or unenforceability shall not affect any other provision hereof, and this Contract shall be construed as if the invalid, illegal, or unenforceable provision had never been contained herein.

Prior Agreements Superseded

8.05. This Contract constitutes the sole and only agreement of the parties and supersedes any prior understandings or written or oral agreements between the parties respecting the within subject matter.

Time of Essence

8.06. Time is of the essence in this Contract.

Gender

8.07. Words of any gender used in this Contract shall be held and construed to include any other gender, and words in the singular number shall be held to include the plural, and vice versa, unless the context requires otherwise.

Memorandum of Contract

8.08. Upon request of either party, the parties shall promptly execute a memorandum of this Contract suitable for filing of record.

Compliance

8.09 In accordance with the requirements of Section 20 of the Texas Real Estate License Act, Purchaser is hereby advised that it should be furnished with or obtain a policy of title insurance or Purchaser should have the abstract covering the Property examined by an attorney of Purchaser's own selection.

Effective Date

8.10 This Contract shall be effective as of the date it is approved by Williamson County, Texas which date is indicated beneath the County Judge's signature below.

Counterparts

8.11 This Contract may be executed in any number of counterparts, which may together constitute the Contract. Signatures transmitted by facsimile or electronic mail may be considered effective as originals for purposes of this Contract.

[signature page follows]

SELLER:

Robert E. Pontius

Robert E. Pontius

Address: 12718 Cloud Mountain Crossing
Austin, TX 78726

Date: 8/25/15

Joanne M. Pontius

Joanne M. Pontius

Address: 12718 Cloud Mountain Crossing
Austin, TX 78726

Date: 8/25/15

PURCHASER:

WILLIAMSON COUNTY, TEXAS

By: _____
Dan A. Gattis
County Judge

Address: 710 Main Street, Suite 101
Georgetown, Texas 78626

Date: _____

EXHIBIT "A"

WALKER
TEXAS SURVEYORS, INC.
P. O. Box 324
Cedar Park, Texas 78630-0324
(512) 259-3361
T.B.P.L.S. Firm No. 10103800

0.554 ACRE RIGHT-OF-WAY PARCEL NO. 17
ROBERT E. PONTIUS AND JOANNE M. PONTIUS
B. MANLOVE SURVEY, ABSTRACT NO. 417
WILLIAMSON COUNTY, TEXAS

A DESCRIPTION OF 0.554 ACRES (APPROXIMATELY 24,129 SQ. FT.) IN THE B. MANLOVE SURVEY, ABSTRACT NO. 417, WILLIAMSON COUNTY, TEXAS, BEING A PORTION OF A 30.819 ACRE TRACT CONVEYED TO ROBERT E. PONTIUS AND JOANNE M. PONTIUS IN A WARRANTY DEED DATED APRIL 8, 1981 AND RECORDED IN VOLUME 840, PAGE 771 OF THE DEED RECORDS OF WILLIAMSON COUNTY, TEXAS; SAID 0.554 ACRES BEING MORE PARTICULARLY DESCRIBED BY METES AND BOUNDS AS FOLLOWS:

BEGINNING at a calculated point in the existing north right-of-way line of County Road 258 (right-of-way width varies), being the south deed line of a 469.31 acre tract described in Volume 631, Page 679 of the Deed Records of Williamson County, for the southwest corner of the said 30.819 acre tract, being also the southeast corner of a 6.34 acre tract conveyed to the San Gabriel Oaks Home Owners Association in a deed recorded in Volume 675, Page 674 of the Deed Records of Williamson County, Texas, being also the southeast corner of the 6.34 acre tract called Road Easement # 1, and referred to locally as San Gabriel Oaks Drive, recorded in Volume 675, Page 644 of the Deed Records of Williamson County, Texas, for the southwest corner of the herein described tract of land, from which a 1/2" iron rod found bears South 19°08'55" East, a distance of 0.23 feet, and also from which a concrete monument found at an angle point in the existing north right-of-way line of County Road 258, being the southwest corner of a 19.6519 acre tract conveyed to Mark LaRue and Ellen LaRue in a deed recorded in Document No. 2007093277 of the Official Public Records of Williamson County, Texas and being the southwest corner of the said 469.31 acre tract, bears South 57°02'57" West, a distance of 721.55 feet and South 60°03'57" West, a distance of 142.62 feet;

THENCE North 19°08'55" West, with the common line of the said 30.819 acre tract and the said 6.34 acre tract, being also the east line of San Gabriel Oaks Drive, a distance of 27.66 feet to a 1/2" iron rod with "Walker 5283" cap set in the proposed north right-of-way line of County Road 258, for the northwest corner of the herein described tract of land, from which a 1/2" iron rod found for angle point in the common line of the said 30.819 acre tract and the said 6.34 acre tract, being also the east line of San Gabriel Oaks Drive, bears North 19°08'55" West, a distance of 571.34 feet;

THENCE crossing the said 30.819 acre tract, with the proposed north right-of-way line of County Road 258, the following two (2) courses and distances:

1. North 56°48'11" East, distance of 723.90 feet to a 1/2" iron rod with "Walker 5283" cap set for point of curvature;

2. With said curve to the right, having a radius of 660.09 feet, a delta angle of 12°01'31", an arc length of 138.54 feet, and a chord bearing North 62°48'57" East, a distance of 138.29 feet to a 1/2" iron rod with "Walker 5283" cap set in the existing north right-of-way line of County Road 258, being the east line of the said 30.819 acre tract, for the northeast corner of the herein described tract of land, from which a 1/2" iron rod with "CCC 4835" cap found at an angle point in the existing north right-of-way line of County Road 258, being also in the east line of the said 30.819 acre tract and also being the southwest corner of Lot 3 of Kirk Acres, a subdivision of record in Document No. 2003078950 of the Official Public Records of Williamson County, Texas, recorded under Cabinet X, Slides 371-372 of the Plat Records of Williamson County, Texas, bears North 19°02'42" West, a distance of 4.43 feet;

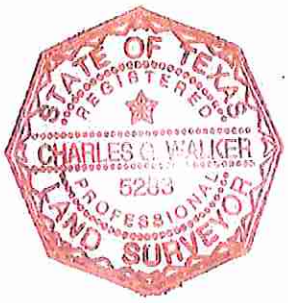
THENCE South 19°02'42" East, with the existing north right-of-way line of County Road 258, being the east line of the said 30.819 acre tract, distance of 16.56 feet to a 1/2" iron rod found for an angle point in the north right-of-way line of County Road 258, being also an angle point in the south deed line of said 469.31 acre tract, the southeast corner of the said 30.819 acre tract and the southeast corner of the herein described tract of land, from which a 1/2" iron rod with "CCC 4835" cap found bears North 63°17'44" East, a distance of 0.06 feet;

THENCE South 57°02'57" West, with the existing north right-of-way line of County Road 258, being the south line of the said 30.819 acre tract and the south deed line of said 469.31 acre tract, distance of 864.10 feet to the **POINT OF BEGINNING**, containing 0.554 acres of land, more or less.

Bearing Basis: The Texas Coordinate System of 1983 (NAD83), Central Zone, based on GPS solutions from the National Geodetic Survey (NGS) On-Line Positioning User Service (OPUS). Attachments: Survey Drawing No. 075029-PARCEL 17.

11.26.14

Charles G. Walker Date
Registered Professional Land Surveyor
State of Texas No. 5283
Walker Texas Surveyors, Inc.
T.B.P.L.S. FIRM NO. 10103800



SKETCH TO ACCOMPANY A DESCRIPTION OF 0.554 ACRES (APPROXIMATELY 24,129 SQ. FT.) IN THE B. MANLOVE SURVEY, ABSTRACT NO. 417, WILLIAMSON COUNTY, TEXAS, BEING A PORTION OF A 30.819 ACRE TRACT CONVEYED TO ROBERT E. PONTIUS AND JOANNE M. PONTIUS IN A WARRANTY DEED DATED APRIL 8, 1981 AND RECORDED IN VOLUME 840, PAGE 771 OF THE DEED RECORDS OF WILLIAMSON COUNTY, TEXAS.

LEGEND	
○	1/2" IRON ROD WITH "WALKER 5283" CAP SET
●	1/2" IRON ROD FOUND (UNLESS NOTED OTHERWISE)
●^{CCC}	1/2" IRON ROD WITH "CCC 4835" CAP FOUND
■	CONC. MONUMENT FOUND
△	CALCULATED POINT
D.R.W.C.T.	DEED RECORDS OF WILLIAMSON COUNTY, TEXAS
P.R.W.C.T.	PLAT RECORDS OF WILLIAMSON COUNTY, TEXAS
O.P.R.W.C.T.	OFFICIAL PUBLIC RECORDS OF WILLIAMSON COUNTY, TEXAS
( )	RECORD INFORMATION
[ ]	RECORD INFORMATION FROM 631/679 D.R.W.C.T.

CURVE TABLE					
CURVE	RADIUS	DELTA	ARC	BEARING	CHORD
C1	660.09'	12°01'31"	138.54'	N62°48'57"E	138.29'

LINE TABLE		
LINE	BEARING	DISTANCE
L1	N19°08'55"W	27.66'
L2	S19°02'42"E	16.56'
L3	N19°02'42"W	4.43'
L4	S60°03'57"W	142.62'
	[S59°59'W]	[142.61']
L5	S19°02'42"E	20.99'
L6	S19°08'55"E	0.23'

STATE OF TEXAS
REGISTERED
CHARLES G. WALKER
5283
PROFESSIONAL
LAND SURVEYOR

11.26.14

BEARING BASIS: THE TEXAS COORDINATE SYSTEM OF 1983 (NAD83), CENTRAL ZONE, BASED ON GPS SOLUTIONS FROM THE NATIONAL GEO DETIC SURVEY (NGS) ON-LINE POSITIONING USER SERVICE (OPUS).

COMBINED SCALE FACTOR = 0.999860020
(FOR SURFACE TO GRID CONVERSION)

INVERSE SCALE FACTOR = 1.00014
(FOR GRID TO SURFACE CONVERSION)

SCALED ABOUT 0,0

WALKER TEXAS SURVEYORS, INC.
P.O. BOX 324
CEDAR PARK, TEXAS 78630
(512) 259-3361
T.B.P.L.S. FIRM NO. 10103800

DATE OF SURVEY: 11/26/14
DRAWING NO.: 075029-PARCEL 17
PROJECT NO.: 075029
DRAWN BY: CWW

WILLIAMSON COUNTY
1848

WALKER
TEXAS SURVEYORS

THIS SURVEY WAS PERFORMED WITHOUT BENEFIT OF A TITLE COMMITMENT AND NO TITLE SEARCH WAS PERFORMED BY THE SURVEYOR. THERE MAY BE EASEMENTS OR OTHER INSTRUMENTS PERTAINING TO THIS PROPERTY THAT ARE NOT SHOWN HEREON.



SCALE: 1" = 100'

B. MANLOVE SURVEY ABS. 417

PT531
N: 10221928.28
E: 3077003.51
(SURFACE)

N: 10220497.41
E: 3076572.79
(GRID)

SAN GABRIEL OAKS
HOME OWNERS ASSOCIATION
6.34 ACRES
(675/674)
D.R.W.C.T.

N19°08'55"W 599.00'
(N18°53'10"W 598.96')
(N18°53'10"W 598.79')

ROBERT E. PONTIUS
AND JOANNE M. PONTIUS
30.819 ACRES
(840/771)
D.R.W.C.T.

MATCH PAGE 4 OF 5

MATCH PAGE 5 OF 5

SAN GABRIEL OAKS DRIVE
6.34 ACRE ROAD ESMT.#1
(675/644)
D.R.W.C.T.

N19°08'55"W 571.34'

MARK LARUE AND ELLEN LARUE
19.6519 ACRES
(2007093277)
O.P.R.W.C.T.

SOUTH DEED LINE OF
469.31 AC. DESCRIBED IN
(631/679)
D.R.W.C.T.

PROPOSED
R.O.W. LINE

PARCEL 17
0.554 ACRES
APPROX. 24,129 SQ. FT.

PT531 N56°48'11"E 723.90'

S57°02'57"W 721.55'

L4

L1

S57°02'57"W 864.10' (S57°18'17"W 863.93')

S57°02'57"W 1585.64'
[S56°58'W 1585.53']

P.O.B.

SEE DETAIL "A"

COUNTY ROAD 258
(R.O.W. WIDTH VARIES)

L1

L6

DETAIL "A"
(N.T.S.)

R.O.W. DEDICATED
(2001054055)
(U/372-373)

PROPOSED
R.O.W. LINE

LOT 1
THE CRAIGEN ADDITION
(2001054055) O.P.R.W.C.T.
(U/372-373) P.R.W.C.T.

LOT 2
THE CRAIGEN ADDITION
(2001054055) O.P.R.W.C.T.
(U/372-373) P.R.W.C.T.

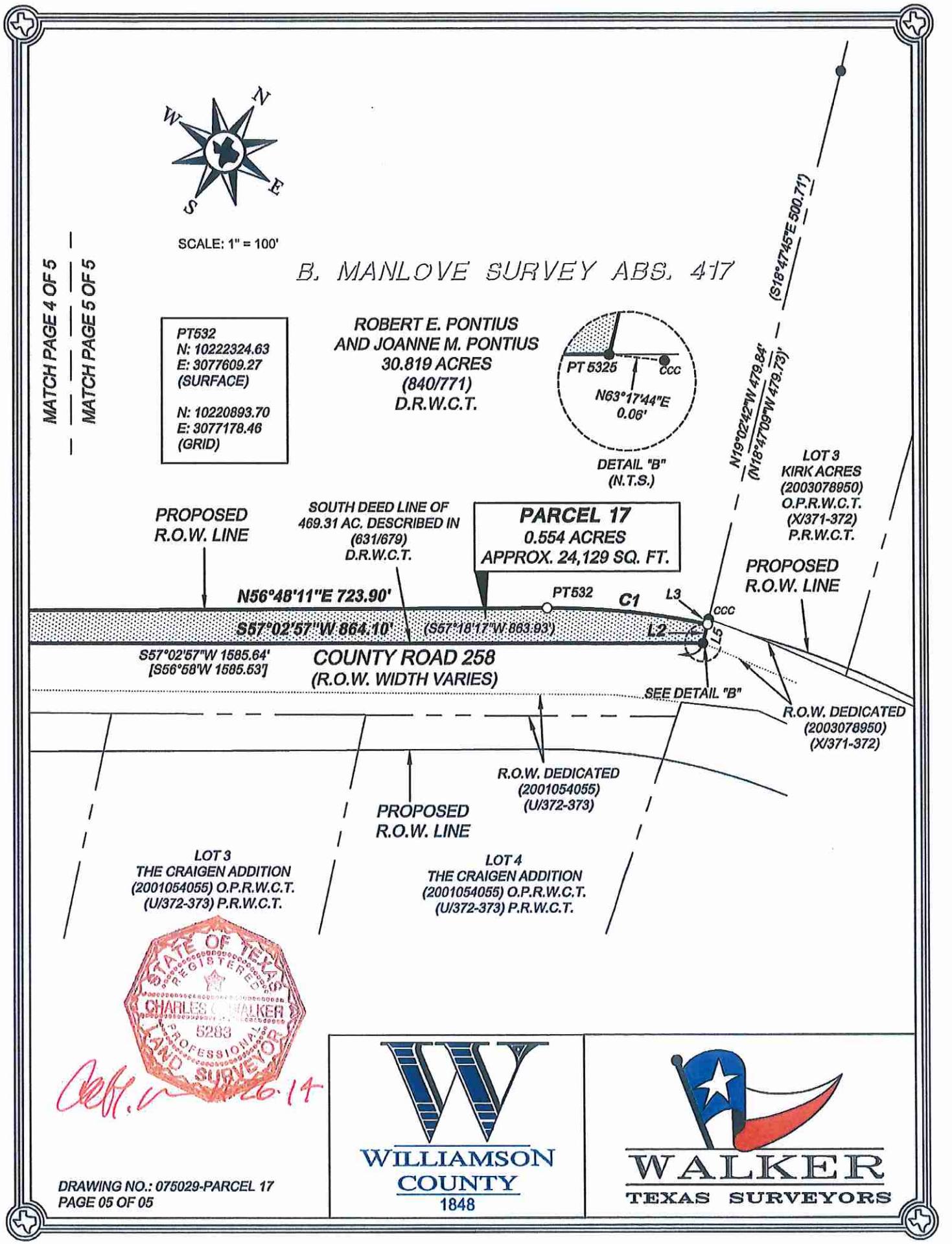
STATE OF TEXAS
REGISTERED
CHARLES G. WALKER
5283
PROFESSIONAL
LAND SURVEYOR

11-26-14

DRAWING NO.: 075029-PARCEL 17
PAGE 04 OF 05

WILLIAMSON COUNTY
1848

WALKER
TEXAS SURVEYORS



DRAWING NO.: 075029-PARCEL 17
PAGE 05 OF 05

WILLIAMSON COUNTY
1848

WALKER
TEXAS SURVEYORS

EXHIBIT "B"

Parcel 17

DEED
County Road 258 Right of Way

THE STATE OF TEXAS §
§
COUNTY OF WILLIAMSON §

NOTICE OF CONFIDENTIALITY RIGHTS: IF YOU ARE A NATURAL PERSON, YOU MAY REMOVE OR STRIKE ANY OF THE FOLLOWING INFORMATION FROM THIS ANY INSTRUMENT THAT TRANSFERS AN INTEREST IN REAL PROPERTY BEFORE IT IS FILED FOR RECORD IN THE PUBLIC RECORDS: YOUR SOCIAL SECURITY NUMBER OR YOUR DRIVER'S LICENSE NUMBER.

NOW, THEREFORE, KNOW ALL MEN BY THESE PRESENTS:

That ROBERT E. PONTIUS and JOANNE M. PONTIUS, hereinafter referred to as Grantor, whether one or more, for and in consideration of the sum of Ten Dollars ($10.00) and other good and valuable consideration to Grantor in hand paid by Williamson County, Texas, the receipt and sufficiency of which is hereby acknowledged, and for which no lien is retained, either expressed or implied, have this day Sold and by these presents do Grant, Bargain, Sell and Convey unto WILLIAMSON COUNTY, TEXAS, all that certain tract or parcel of land lying and being situated in the County of Williamson, State of Texas, along with any improvements thereon, being more particularly described as follows:

> All of that certain 0.554 acre (approximately 24,129 Sq. Ft.) tract of land in the B. Manlove Survey, Abstract No. 417, Williamson County; being more fully described by metes and bounds in Exhibit "A", attached hereto and incorporated herein (**Parcel 17**)

SAVE AND EXCEPT, HOWEVER, it is expressly understood and agreed that Grantor is retaining title to the following improvements located on the property described in said Exhibit "A" to wit: NONE

RESERVATIONS FROM AND EXCEPTIONS TO CONVEYANCE AND WARRANTY:

Visible and apparent easements not appearing of record;

Any discrepancies, conflicts, or shortages in area or boundary lines or any encroachments or any overlapping of improvements which a current survey would show;

Easements, restrictions, reservations, covenants, conditions, oil and gas leases, mineral severances, and encumbrances for taxes and assessments (other than liens and conveyances) presently of record in the Official Public Records of Williamson County, Texas, that affect the property, but only to the extent that said items are still valid and in force and effect at this time.

Grantor reserves all of the oil, gas and other minerals in and under the land herein conveyed but waives all rights of ingress and egress to the surface thereof for the purpose of exploring, developing, mining or drilling or pumping the same; provided, however, that operations for exploration or recovery of any such minerals shall be permissible so long as all surface operations in connection therewith are located at a point outside the acquired parcel and upon the condition that none of such operations shall be conducted so near the surface of said land as to interfere with the intended use thereof or in any way interfere with, jeopardize, or endanger the facilities of Williamson County, Texas or create a hazard to the public users thereof; it being intended, however, that nothing in this reservation shall affect the title and the rights of Grantee to take and use without additional compensation any, stone, earth, gravel, caliche, iron ore, gravel or any other road building material upon, in and under said land for the construction and maintenance of CR 258, but shall not be used or exported from the Property for any other purpose.

TO HAVE AND TO HOLD the property herein described and herein conveyed together with all and singular the rights and appurtenances thereto in any wise belonging unto Williamson County, Texas and its assigns forever; and Grantor does hereby bind itself, its heirs, executors, administrators, successors and assigns to Warrant and Forever Defend all and singular the said premises herein conveyed unto Williamson County, Texas and its assigns against every person whomsoever lawfully claiming or to claim the same or any part thereof.

This deed is being delivered in lieu of condemnation.

IN WITNESS WHEREOF, this instrument is executed on this the ____ day of _____, 2015.

GRANTOR:

_____
Robert E. Pontius

ACKNOWLEDGMENT

STATE OF TEXAS §
§
COUNTY OF WILLIAMSON §

This instrument was acknowledged before me on this the ____ day of _____, 2015 by Robert E. Pontius, in the capacity and for the purposes and consideration recited therein.

_____
Notary Public, State of Texas

GRANTOR:

_____
Joanne M. Pontius

ACKNOWLEDGMENT

STATE OF TEXAS §
§
COUNTY OF WILLIAMSON §

This instrument was acknowledged before me on this the ____ day of _____, 2015 by Joanne M. Pontius, in the capacity and for the purposes and consideration recited therein.

_____
Notary Public, State of Texas

PREPARED IN THE OFFICE OF:
Sheets & Crossfield, P.C.
309 East Main
Round Rock, Texas 78664

GRANTEE'S MAILING ADDRESS:
Williamson County, Texas
Attn: County Judge
710 Main Street, Suite 101
Georgetown, Texas 78626

AFTER RECORDING RETURN TO:

Commissioners Court - Regular Session **26.**

Meeting Date: 09/01/2015

CR 258 Contract

Submitted For: Charlie Crossfield **Submitted By:** Charlie Crossfield, Road Bond

Department: Road Bond

Agenda Category: Regular Agenda Items

Information

Agenda Item

Discuss and take appropriate action on a Real Estate Contract with Ted and Amanda Nichols for ROW needed on CR 258. (PARCEL 9)

Background

Fiscal Impact

From/To	Acct No.	Description	Amount

Attachments

Nichols Contract

Form Review

Inbox	Reviewed By	Date
County Judge Exec Asst.	Wendy Coco	08/27/2015 10:29 AM
Form Started By: Charlie Crossfield		Started On: 08/27/2015 10:21 AM
Final Approval Date: 08/27/2015		

REAL ESTATE CONTRACT
CR 258 Right of Way—Parcel 9

THIS REAL ESTATE CONTRACT ("Contract") is made by TED NICHOLS and AMANDA NICHOLS (referred to in this Contract as "Seller") and WILLIAMSON COUNTY, TEXAS (referred to in this Contract as "Purchaser"), upon the terms and conditions set forth in this Contract.

ARTICLE I
PURCHASE AND SALE

By this Contract, Seller sells and agrees to convey, and Purchaser purchases and agrees to pay for, the tract(s) of land described as follows:

> All of that certain 0.160 acre (approximately 6,982 Sq. Ft.) tract of land in the B. Manlove Survey, Abstract No. 417, Williamson County, Texas; being more fully described by metes and bounds in Exhibit "A", attached hereto and incorporated herein (**Parcel 9**)

together with all and singular the rights and appurtenances pertaining to the property, including any right, title and interest of Seller in and to adjacent streets, alleys or rights-of-way (all of such real property, rights, and appurtenances being referred to in this Contract as the "Property"), and any improvements situated on and attached to the Property described in Exhibit "A" not otherwise agreed herein to be retained by Seller or owned by the Carrington Ranch Property Owners Association, for the consideration and upon and subject to the terms, provisions, and conditions set forth below.

ARTICLE II
PURCHASE PRICE

Purchase Price

2.01. The Purchase Price for the Property, any improvements thereon (excluding the three rail vinyl fence owned by the Carrington Ranch Property Owners Association), and any damage or cost of cure for the remaining Property of Seller shall be the sum of TEN THOUSAND FIVE HUNDRED and 00/100 Dollars ($10,500.00).

Payment of Purchase Price

2.02. The Purchase Price shall be payable in cash at the Closing.

ARTICLE III
PURCHASER'S OBLIGATIONS

Conditions to Purchaser's Obligations

3.01. The obligations of Purchaser hereunder to consummate the transactions contemplated hereby are subject to the satisfaction of each of the following conditions (any of which may be waived in whole or in part by Purchaser at or prior to the Closing).

Miscellaneous Conditions

3.02. Seller shall have performed, observed, and complied with all of the covenants, agreements, and conditions required by this Contract to be performed, observed, and complied with by Seller prior to or as of the closing.

ARTICLE IV
REPRESENTATIONS AND WARRANTIES OF SELLER

Seller hereby represents and warrants to Purchaser as follows, which representations and warranties shall be deemed made by Seller to Purchaser also as of the Closing Date, to the best of Seller's current actual knowledge:

(1) There are no parties in possession of any portion of the Property as lessees, tenants at sufferance, or trespassers, other than as previously disclosed to Purchaser;

(2) Seller has complied with all applicable laws, ordinances, regulations, statutes, rules and restrictions relating to the Property, or any part thereof;

The Property herein is being conveyed to Purchaser under threat of condemnation.

ARTICLE V
CLOSING

Closing Date

5.01. The Closing shall be held at the office of Texas American Title Company on or before August 31, 2015, or at such time, date, and place as Seller and Purchaser may agree upon, or within 10 days after the completion of any title curative matters if necessary for items as shown on the Title Commitment or in the contract (which date is herein referred to as the "Closing Date").

Seller's Obligations at Closing

5.02. At the Closing Seller shall:

(1) Deliver to Purchaser a duly executed and acknowledged Deed conveying good and indefeasible title to Williamson County, Texas in fee simple to all of the Property described in Exhibit "A", free and clear of any and all liens and restrictions, except for the following:

(a) General real estate taxes for the year of closing and subsequent years not yet due and payable;

(b) Any exceptions approved by Purchaser pursuant to Article III hereof; and

(c) Any exceptions approved by Purchaser in writing.

The Deed shall be in the form as shown in Exhibit "B" attached hereto and incorporated herein.

(2) Deliver to Purchaser a Texas Owner's Title Policy at Purchaser's sole expense, issued by Title Company, in Grantee's favor in the full amount of the purchase price, insuring Purchaser's contracted interests in and to the Property subject only to those title exceptions listed herein, such other exceptions as may be approved in writing by Purchaser, and the standard printed exceptions contained in the usual form of Texas Owner's Title Policy, provided, however:

(a) The boundary and survey exceptions shall be deleted;

(b) The exception as to restrictive covenants shall be endorsed "None of Record", if applicable; and

(c) The exception as to the lien for taxes shall be limited to the year of Closing and shall be endorsed "Not Yet Due and Payable".

(d) Deliver to Purchaser possession of the Property if not previously done.

Purchaser's Obligations at Closing

5.03. At the Closing, Purchaser shall:

(a) Pay the cash portion of the Purchase Price.

Prorations

5.04. General real estate taxes for the then current year relating to the Property shall be prorated as of the Closing Date and shall be adjusted in cash at the closing. If the Closing shall occur before the tax rate is fixed for the then current year, the apportionment of taxes shall be upon the basis of the tax rate for the next preceding year applied to the latest assessed valuation. Agricultural roll-back taxes, if any, shall be paid by Purchaser.

Closing Costs

5.05. All costs and expenses of closing in consummating the sale and purchase of the Property shall be borne and paid as follows:

(1) Owner's Title Policy and survey to be paid by Purchaser.

(2) Deed, tax certificates, and title curative matters, if any, paid by Purchaser.

(3) All other closing costs shall be paid by Purchaser.

(4) Attorney's fees paid by each respectively.

ARTICLE VI
BREACH BY SELLER

In the event Seller shall fail to fully and timely perform any of its obligations hereunder or shall fail to consummate the sale of the Property for any reason, except Purchaser's default, Purchaser may: (1) enforce specific performance of this Contract; or (2) request that the Escrow Deposit, if any, shall be forthwith returned by the title company to Purchaser.

ARTICLE VII
BREACH BY PURCHASER

In the event Purchaser should fail to consummate the purchase of the Property, the conditions to Purchaser's obligations set forth in Article III having been satisfied and Purchaser being in default and Seller not being in default hereunder, Seller shall have the right to receive the Escrow Deposit, if any, from the title company, the sum being agreed on as liquidated damages for the failure of Purchaser to perform the duties, liabilities, and obligations imposed upon it by the terms and provisions of this Contract, and Seller agrees to accept and take this cash payment as its total damages and relief and as Seller's sole remedy hereunder in such event. If no Escrow Deposit has been made then Seller shall receive the amount of $500 as liquidated damages for any failure by Purchaser.

ARTICLE VIII
MISCELLANEOUS

Notice

8.01. Any notice required or permitted to be delivered hereunder shall be deemed received when sent by United States mail, postage prepaid, certified mail, return receipt requested, addressed to Seller or Purchaser, as the case may be, at the address set forth opposite the signature of the party.

Texas Law to Apply

8.02. This Contract shall be construed under and in accordance with the laws of the State of Texas, and all obligations of the parties created hereunder are performable in Williamson County, Texas.

Parties Bound

8.03. This Contract shall be binding upon and inure to the benefit of the parties and their respective heirs, executors, administrators, legal representatives, successors and assigns where permitted by this Contract.

Legal Construction

8.04. In case any one or more of the provisions contained in this Contract shall for any reason be held to be invalid, illegal, or unenforceable in any respect, this invalidity, illegality, or unenforceability shall not affect any other provision hereof, and this Contract shall be construed as if the invalid, illegal, or unenforceable provision had never been contained herein.

Prior Agreements Superseded

8.05. This Contract constitutes the sole and only agreement of the parties and supersedes any prior understandings or written or oral agreements between the parties respecting the within subject matter.

Time of Essence

8.06. Time is of the essence in this Contract.

Gender

8.07. Words of any gender used in this Contract shall be held and construed to include any other gender, and words in the singular number shall be held to include the plural, and vice versa, unless the context requires otherwise.

Memorandum of Contract

8.08. Upon request of either party, the parties shall promptly execute a memorandum of this Contract suitable for filing of record.

Compliance

8.09 In accordance with the requirements of Section 20 of the Texas Real Estate License Act, Purchaser is hereby advised that it should be furnished with or obtain a policy of title insurance or Purchaser should have the abstract covering the Property examined by an attorney of Purchaser's own selection.

Effective Date

8.10 This Contract shall be effective as of the date it is approved by Williamson County, Texas which date is indicated beneath the County Judge's signature below.

Counterparts

8.11 This Contract may be executed in any number of counterparts, which may together constitute the Contract. Signatures transmitted by facsimile or electronic mail may be considered effective as originals for purposes of this Contract.

[signature page follows]

SELLER:

Ted Nichols

Address: 101 Possum Trot
Liberty Hill, Tx
78642

Date: 8/15/15

Amanda Nichols

Address: 101 Possum Trot
Liberty Hill, Tx
78642

Date: 8/15/15

PURCHASER:

WILLIAMSON COUNTY, TEXAS

By: _____
Dan A. Gattis
County Judge

Address: 710 Main Street, Suite 101
Georgetown, Texas 78626

Date: _____

EXHIBIT "A"

WALKER
TEXAS SURVEYORS, INC.
P. O. Box 324
Cedar Park, Texas 78630-0324
(512) 259-3361
T.B.P.L.S. Firm No. 10103800

0.160 ACRE RIGHT-OF-WAY PARCEL NO. 9
TED NICHOLS AND AMANDA NICHOLS
LOT 38, CARRINGTON RANCH PHASE ONE
WILLIAMSON COUNTY, TEXAS

A DESCRIPTION OF 0.160 ACRES (APPROXIMATELY 6,982 SQ. FT.) IN THE B. MANLOVE SURVEY, ABSTRACT NO. 417, WILLIAMSON COUNTY, TEXAS, BEING A PORTION OF LOT 38 OF CARRINGTON RANCH PHASE ONE, A SUBDIVISION OF RECORD IN CABINET F, SLIDES 354-357 OF THE PLAT RECORDS OF WILLIAMSON COUNTY, TEXAS, CONVEYED TO TED NICHOLS AND AMANDA NICHOLS IN A GUARDIANSHP GENERAL WARRANTY DEED DATED JANUARY 15, 2010 AND RECORDED IN DOCUMENT NO. 2010011637 OF THE OFFICIAL PUBLIC RECORDS OF WILLIAMSON COUNTY, TEXAS; SAID 0.160 ACRES BEING MORE PARTICULARLY DESCRIBED BY METES AND BOUNDS AS FOLLOWS:

COMMENCING at a calculated point in the existing north right-of-way line of County Road 258 (right-of-way width varies) at the southwest corner of Lot 39 of The Carrington Ranch, Phase One, being the southeast corner of Lot 2, Feduccia Subdivision, a subdivision of record in Document No. 2008014770 of the Official Public Records of Williamson County, Texas, also recorded under Cabinet EE, Slides 179-180 of the Plat Records of Williamson County, Texas, from which a 1/2" iron rod found bears South 21°07'21" East, a distance of 20.02 feet, also from which a 1/2" iron rod with "Harris Grant" cap found in the existing north right-of-way line of County Road 258 at the southwest corner of Lot 3 of said Feduccia Subdivision, bears South 68°51'48" West, a distance of 59.56 feet, and also from which a 1/2" iron rod found at the northwest corner of Lot 40 of The Carrington Ranch, Phase One bears North 21°07'21" West, a distance of 573.19 feet;

THENCE North 69°15'51" East, with the existing north right-of-way line of County Road 258, being the south line of said Lot 39, a distance of 66.68 feet to a calculated point at the southeast corner of said Lot 39, for the southwest corner of said Lot 38, the **POINT OF BEGINNING** and the southwest corner of the herein described tract of land;

THENCE North 19°07'59" East, with the west line of said Lot 38, being the east line of said Lot 39, at a distance of 0.22 feet passing a 5/8" iron rod found, in all, a distance of 30.44 feet to a 1/2" iron rod with "Walker 5283" cap set in the proposed north right-of-way line of County Road 258 for the northwest corner of the herein described tract of land, from which a 1/2" iron rod found in the south right-of-way line of Possum Trot (50' right-of-way width) shown on The Carrington Ranch Phase One, at a common corner of said Lots 38 and 39, bears North 19°07'59" East, a distance of 398.99 feet;

THENCE North 69°23'54" East, crossing said Lot 38 with the proposed north right-of-way line of County Road 258, a distance of 297.32 feet to a 1/2" iron rod with "Walker 5283" cap set in the east line of said Lot 38, being the west line of Lot 37 of The Carrington Ranch Phase One, for the northeast corner of the herein described tract of land, from which a 1/2" iron rod found in the south right-of-way line of Possum Trot at a common corner of said Lots 38 and 37, bears North 01°49'58" West, a distance of 251.23 feet;

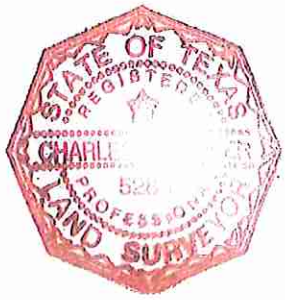
THENCE South 01°49'58" East, with the east line of said Lot 38, being the west line of said Lot 37, at a distance of 23.85 feet passing a 1/2" iron rod found, in all, a distance of 23.96 feet to a calculated point in the existing north right-of-way line of County Road 258, for the southeast corner of said Lot 38 and the southeast corner of the herein described tract of land, same being the southwest corner of said Lot 37, from which a 1/2" iron rod found in the existing north right-of-way line of County Road 258 at a common corner of Lots 35 and 36 of The Carrington Ranch Phase One, bears North 69°15'51" East, a distance of 453.96 feet;

THENCE South 69°15'51" West, with the south line of said Lot 38, a distance of 309.07 feet to the **POINT OF BEGINNING**, containing 0.160 acres of land, more or less.

Bearing Basis: The Texas Coordinate System of 1983 (NAD83), Central Zone, based on GPS solutions from the National Geodetic Survey (NGS) On-Line Positioning User Service (OPUS). Attachments: Survey Drawing No. 075029-PARCEL 9.

11.26.14

Charles G. Walker Date
Registered Professional Land Surveyor
State of Texas No. 5283
Walker Texas Surveyors, Inc.
T.B.P.L.S. FIRM NO. 10103800



SKETCH TO ACCOMPANY A DESCRIPTION OF 0.160 ACRES (APPROXIMATELY 6,982 SQ. FT.) IN THE B. MANLOVE SURVEY, ABSTRACT NO. 417, WILLIAMSON COUNTY, TEXAS, BEING A PORTION OF LOT 38, CARRINGTON RANCH PHASE ONE, A SUBDIVISION OF RECORD IN CABINET F, SLIDES 354-357 OF THE PLAT RECORDS OF WILLIAMSON COUNTY, TEXAS, CONVEYED TO TED NICHOLS AND AMANDA NICHOLS IN A GUARDIANSHP GENERAL WARRANTY DEED DATED JANUARY 15, 2010 AND RECORDED IN DOCUMENT NO. 2010011637 OF THE OFFICIAL PUBLIC RECORDS OF WILLIAMSON COUNTY, TEXAS .

LEGEND	
○	1/2" IRON ROD WITH "WALKER 5283" CAP SET
●	1/2" IRON ROD FOUND (UNLESS NOTED OTHERWISE)
$●_{HG}$	1/2" IRON ROD WITH "HARRIS GRANT" CAP FOUND
△	CALCULATED POINT
P.R.W.C.T.	PLAT RECORDS OF WILLIAMSON COUNTY, TEXAS
O.P.R.W.C.T.	OFFICIAL PUBLIC RECORDS OF WILLIAMSON COUNTY, TEXAS
O.R.W.C.T.	OFFICIAL RECORDS OF WILLIAMSON COUNTY, TEXAS
( )	RECORD INFORMATION

LINE TABLE		
LINE	BEARING	DISTANCE
L1	N19°07'59"E	30.44'
L2	S01°49'58"E	23.96'
L3	S68°51'48"W	59.56'
	(S70°12'58"W)	(60.00')
L4	N68°51'48"E	29.78'
	(N70°12'58"E)	(30.00')
L5	N68°51'48"E	29.78'
	(N70°12'58"E)	(30.00')
L6	N69°15'51"E	66.68'
	(N71°08'09"E)	(66.56')
L7	S21°07'21"E	20.02'
	(S19°50'44"E)	(20.00')

BEARING BASIS: THE TEXAS COORDINATE SYSTEM OF 1983 (NAD83), CENTRAL ZONE, BASED ON GPS SOLUTIONS FROM THE NATIONAL GEO DETIC SURVEY (NGS) ON-LINE POSITIONING USER SERVICE (OPUS).

COMBINED SCALE FACTOR = 0.999860020
(FOR SURFACE TO GRID CONVERSION)

INVERSE SCALE FACTOR = 1.00014
(FOR GRID TO SURFACE CONVERSION)

SCALED ABOUT 0,0

THIS SURVEY WAS PERFORMED WITHOUT BENEFIT OF A TITLE COMMITMENT AND NO TITLE SEARCH WAS PERFORMED BY THE SURVEYOR. THERE MAY BE EASEMENTS OR OTHER INSTRUMENTS PERTAINING TO THIS PROPERTY THAT ARE NOT SHOWN HEREON.

WALKER TEXAS SURVEYORS, INC.
P.O. BOX 324
CEDAR PARK, TEXAS 78630
(512) 259-3361
T.B.P.L.S. FIRM NO. 10103800

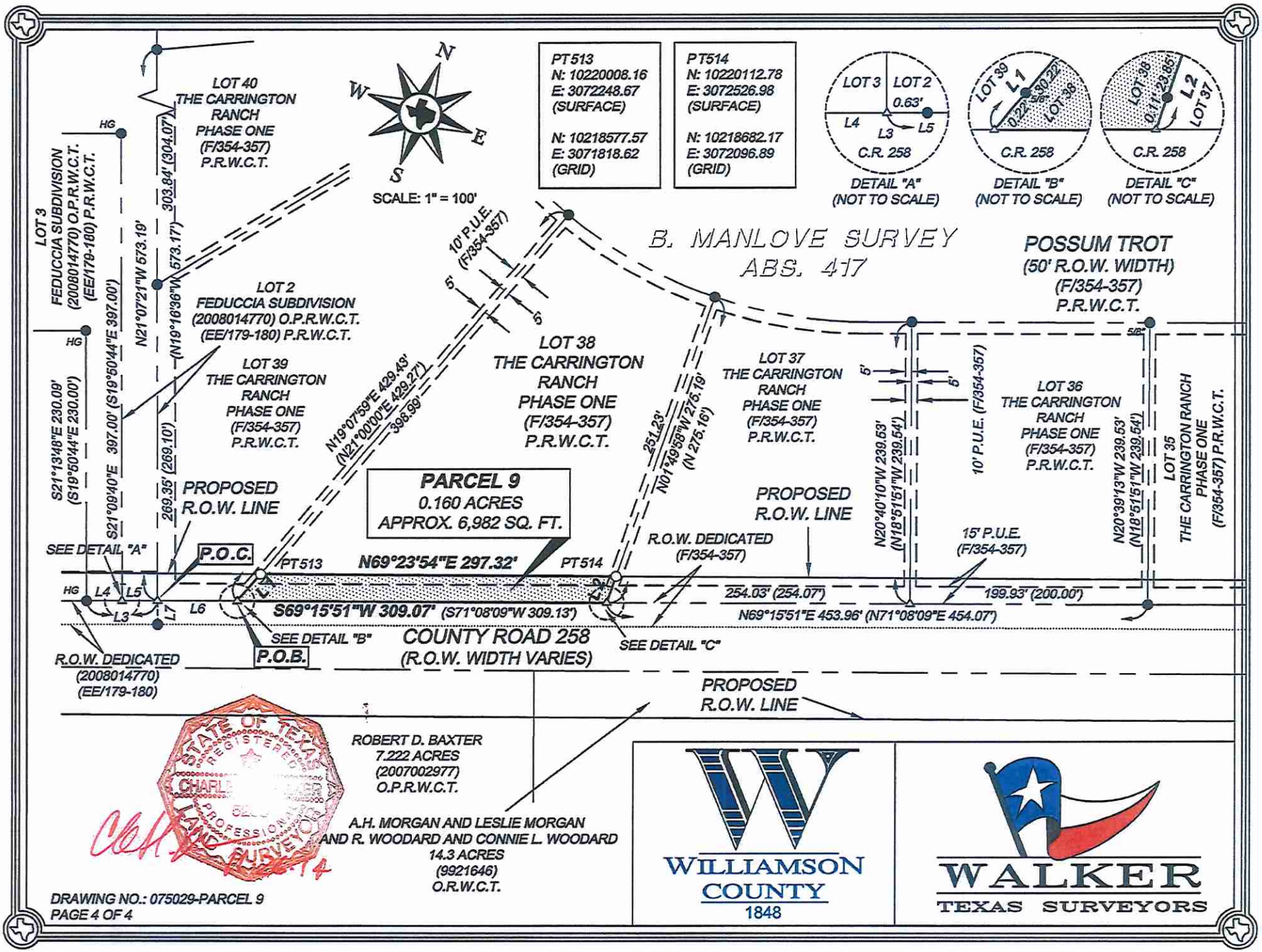
DATE OF SURVEY:11/26/14
DRAWING NO.: 075029-PARCEL 9
PROJECT NO.: 075029
DRAWN BY: CWW

STATE OF TEXAS
REGISTERED
CHARLES G. WALKER
5283
PROFESSIONAL
LAND SURVEYOR

6.14

WILLIAMSON COUNTY
1848

WALKER
TEXAS SURVEYORS



DRAWING NO.: 075029-PARCEL 9
PAGE 4 OF 4

Parcel 9

EXHIBIT "B"

DEED

County Road 258 Right of Way

THE STATE OF TEXAS §
§
COUNTY OF WILLIAMSON §

NOTICE OF CONFIDENTIALITY RIGHTS: IF YOU ARE A NATURAL PERSON, YOU MAY REMOVE OR STRIKE ANY OF THE FOLLOWING INFORMATION FROM THIS ANY INSTRUMENT THAT TRANSFERS AN INTEREST IN REAL PROPERTY BEFORE IT IS FILED FOR RECORD IN THE PUBLIC RECORDS: YOUR SOCIAL SECURITY NUMBER OR YOUR DRIVER'S LICENSE NUMBER.

NOW, THEREFORE, KNOW ALL MEN BY THESE PRESENTS:

That TED NICHOLS and AMANDA NICHOLS, hereinafter referred to as Grantor, whether one or more, for and in consideration of the sum of Ten Dollars ($10.00) and other good and valuable consideration to Grantor in hand paid by Williamson County, Texas, the receipt and sufficiency of which is hereby acknowledged, and for which no lien is retained, either expressed or implied, have this day Sold and by these presents do Grant, Bargain, Sell and Convey unto WILLIAMSON COUNTY, TEXAS, all that certain tract or parcel of land lying and being situated in the County of Williamson, State of Texas, along with any improvements thereon, being more particularly described as follows:

> All of that certain 0.160 acre (approximately 8,392 Sq. Ft.) tract of land in the B. Manlove Survey, Abstract No. 417, Williamson County, Texas; being more fully described by metes and bounds in Exhibit "A", attached hereto and incorporated herein (**Parcel 9**)

SAVE AND EXCEPT, HOWEVER, it is expressly understood and agreed that Grantor is retaining title to the following improvements located on the property described in said Exhibit "A" to wit: NONE

RESERVATIONS FROM AND EXCEPTIONS TO CONVEYANCE AND WARRANTY:

Visible and apparent easements not appearing of record;

Any discrepancies, conflicts, or shortages in area or boundary lines or any encroachments or any overlapping of improvements which a current survey would show;

Easements, restrictions, reservations, covenants, conditions, oil and gas leases, mineral severances, and encumbrances for taxes and assessments (other than liens and conveyances) presently of record in the Official Public Records of Williamson County, Texas, that affect the property, but only to the extent that said items are still valid and in force and effect at this time.

Grantor reserves all of the oil, gas and other minerals in and under the land herein conveyed but waives all rights of ingress and egress to the surface thereof for the purpose of exploring, developing, mining or drilling or pumping the same; provided, however, that operations for exploration or recovery of any such minerals shall be permissible so long as all surface operations in connection therewith are located at a point outside the acquired parcel and upon the condition that none of such operations shall be conducted so near the surface of said land as to interfere with the intended use thereof or in any way interfere with, jeopardize, or endanger the facilities of Williamson County, Texas or create a hazard to the public users thereof; it being intended, however, that nothing in this reservation shall affect the title and the rights of Grantee to take and use without additional compensation any, stone, earth, gravel, caliche, iron ore, gravel or any other road building material upon, in and under said land for the construction and maintenance of CR 258, but shall not be used or exported from the Property for any other purpose.

TO HAVE AND TO HOLD the property herein described and herein conveyed together with all and singular the rights and appurtenances thereto in any wise belonging unto Williamson County, Texas and its assigns forever; and Grantor does hereby bind itself, its heirs, executors, administrators, successors and assigns to Warrant and Forever Defend all and singular the said premises herein conveyed unto Williamson County, Texas and its assigns against every person whomsoever lawfully claiming or to claim the same or any part thereof.

This deed is being delivered in lieu of condemnation.

IN WITNESS WHEREOF, this instrument is executed on this the ____ day of _____, 2015.

[signature pages follow]

GRANTOR:

_____
Ted Nichols

ACKNOWLEDGMENT

STATE OF _____ §
§
COUNTY OF _____ §

This instrument was acknowledged before me on this the ____ day of _____, 2015 by Chris Harris, in the capacity and for the purposes and consideration recited therein.

_____
Notary Public, State of _____

GRANTOR:

_____
Amanda Nichols

ACKNOWLEDGMENT

STATE OF _____ §
§
COUNTY OF _____ §

This instrument was acknowledged before me on this the ____ day of _____, 2015 by Amanda Nichols, in the capacity and for the purposes and consideration recited therein.

_____
Notary Public, State of _____

PREPARED IN THE OFFICE OF:
Sheets & Crossfield, P.C.
309 East Main
Round Rock, Texas 78664

GRANTEE'S MAILING ADDRESS:
Williamson County, Texas
Attn: County Judge
710 Main Street, Suite 101
Georgetown, Texas 78626

AFTER RECORDING RETURN TO:

Commissioners Court - Regular Session **27.**

Meeting Date: 09/01/2015

WCID Amendment No.1

Submitted For: Charlie Crossfield **Submitted By:** Charlie Crossfield, Road Bond

Department: Road Bond

Agenda Category: Regular Agenda Items

Information

Agenda Item

Discuss and take appropriate action on the Amendment No. 1 with the Upper Brushy Creek Water Contract and Improvement District for Cost Sharing Related to Study and Improve the Great Oaks Drive Bridge.

Background

Fiscal Impact

From/To	Acct No.	Description	Amount

Attachments

WCID Amendment No. 1

Form Review

Inbox	Reviewed By	Date
County Judge Exec Asst.	Wendy Coco	08/27/2015 10:29 AM
Form Started By: Charlie Crossfield		Started On: 08/27/2015 10:22 AM
Final Approval Date: 08/27/2015		

AMENDMENT NO. 1

INTERLOCAL AGREEMENT BETWEEN WILLIAMSON COUNTY AND UPPER BRUSHY CREEK WATER CONTROL AND IMPROVEMENT DISTRICT FOR COST SHARING RELATED TO STUDY AND IMPROVE THE GREAT OAKS DRIVE BRIDGE

THE STATE OF TEXAS §

§ **KNOW ALL BY THESE PRESENTS:**

COUNTY OF WILLIAMSON §

This agreement made and entered on July 26, 2013 is hereby amended as follows:

1. Section 3, Effective Date; Term of Agreement, is revised from 540 days (January 17, 2015) to 1057 days (June 17, 2016).

2. All other terms and conditions of the Interlocal Agreement shall remain in effect.

IN WITNESS WHEREOF, the Parties hereto have caused this document to be signed, sealed, and attested in duplicate by their duly authorized officers, effective as of the date of the last Party's execution of this Agreement.

WILLIAMSON COUNTY

By: _____
Honorable Dan A. Gattis, County Judge

Date: _____

UPPER BRUSHY CREEK WATER CONTROL AND IMPROVEMENT DISTRICT

By: _____
Jeff Sawyer, Board President

Date: 8-21-15

Attachment 1

PE STRUCTURAL CONSULTANTS INCORPORATED
8436 SPICEWOOD SPRINGS ROAD • AUSTIN, TEXAS • 78759
512.250.5200 • FAX 512.250.5222 • WWW.PESTRUCTURAL.COM

MEMORANDUM

TO: Ruth Haberman, P.E. June 30, 2014
Upper Brushy Creek Water Control and Improvement District
1850 Round Rock Ave, Suite 100
Round Rock, TX 78681

FROM: Lisa Carter Powell, P.E.

PROJECT: **PESC Project No.** 13024

RE: **Great Oaks Drive at Brushy Creek – Phase I Project Design Status Summary**

Dear Ruth,

This memo summarizes the work to date by our design team on the Great Oaks Drive at Brushy Creek project. A topographic survey was performed from which base files were developed. We have coordinated Subsurface Utility Exploration and mapping and Environmental Constraints mapping and definition of the Ordinary High Water mark (both of these tasks were performed by On-Call consultants retained by Williamson County and are largely complete). Our team developed a number of potential configurations for the replacement of the existing Great Oaks Bridge over Brushy Creek and improvement of the intersection. Of these, two general approaches were deemed feasible and have been investigated in this preliminary study. One approach maintains the current at-grade intersection configuration of Brushy Creek Road and Great Oaks Drive, adjusts both roadways and the intersection to raise them above 100-year flood elevations, and replaces the existing bridge over Brushy Creek. This first approach improves the hydraulic conditions at the project site relative to the existing conditions. A second approach maintains Brushy Creek Road at its existing elevation and raises Great Oaks Drive to go over Brushy Creek Road and Brushy Creek with a bridge at an elevation above the 100-year flood elevations. This second option could provide significant hydraulic benefit (compared to the existing bridge), though Brushy Creek Road remains within floodwater elevations.

At this time more study is necessary to develop the approaches considering impacts of other projects planned within the watershed. The results of a traffic study in the area by Williamson County which is just beginning also need to be incorporated into these potential options. We expect it will take about one year for the technical work and subsequent public involvement effort to be completed before we can recommend alternatives.

Please call if you have any questions or comments.

Thank you,

Lisa Carter Powell, P.E.
President and Principal Engineer
P.E. Structural Consultants, Inc.

cc: file
Bob Daigh, P.E. / Williamson County

Commissioners Court - Regular Session **28.**

Meeting Date: 09/01/2015

FY 16 Public Hearing on County Budget

Submitted By: Ashlie Koenig, Budget Office

Department: Budget Office

Agenda Category: Regular Agenda Items

Information

Agenda Item

10:00 Hold Public Hearing on 2015-2016 County Budget.

Background

Fiscal Impact

From/To	Acct No.	Description	Amount

Attachments

No file(s) attached.

Form Review

Inbox	Reviewed By	Date
County Judge Exec Asst.	Rebecca Clemons	08/12/2015 02:55 PM
Form Started By: Ashlie Koenig		Started On: 08/07/2015 02:42 PM
Final Approval Date: 08/12/2015		

Commissioners Court - Regular Session **29.**

Meeting Date: 09/01/2015

FY 16 County Budget

Submitted By: Ashlie Koenig, Budget Office

Department: Budget Office

Agenda Category: Regular Agenda Items

Information

Agenda Item

Discuss, consider and take appropriate action regarding budget for 2015-2016.

Background

Fiscal Impact

From/To	Acct No.	Description	Amount

Attachments

No file(s) attached.

Form Review

Inbox	Reviewed By	Date
County Judge Exec Asst.	Rebecca Clemons	08/12/2015 02:55 PM
Form Started By: Ashlie Koenig		Started On: 08/07/2015 02:44 PM
Final Approval Date: 08/12/2015		

Commissioners Court - Regular Session **30.**

Meeting Date: 09/01/2015

FY 16 Generald Fund Budget Adoption

Submitted By: Ashlie Koenig, Budget Office

Department: Budget Office

Agenda Category: Regular Agenda Items

Information

Agenda Item

Discuss, consider and take appropriate action on the 2015-2016 General Fund County Budget.

Background

Fiscal Impact

From/To	Acct No.	Description	Amount

Attachments

No file(s) attached.

Form Review

Inbox	Reviewed By	Date
County Judge Exec Asst.	Rebecca Clemons	08/12/2015 02:55 PM
Form Started By: Ashlie Koenig		Started On: 08/07/2015 02:45 PM
Final Approval Date: 08/12/2015		

Commissioners Court - Regular Session **31.**

Meeting Date: 09/01/2015

FY 16 Road and Bridge Fund Budget Adoption

Submitted By: Ashlie Koenig, Budget Office

Department: Budget Office

Agenda Category: Regular Agenda Items

Information

Agenda Item

Discuss, consider and take appropriate action on the 2015-2016 Road and Bridge Fund County Budget.

Background

Fiscal Impact

From/To	Acct No.	Description	Amount

Attachments

No file(s) attached.

Form Review

Inbox	Reviewed By	Date
County Judge Exec Asst.	Rebecca Clemons	08/12/2015 02:55 PM
Form Started By: Ashlie Koenig		Started On: 08/07/2015 02:46 PM
Final Approval Date: 08/12/2015		

Commissioners Court - Regular Session **32.**

Meeting Date: 09/01/2015

FY 16 Debt Service Fund Budget Adoption

Submitted By: Ashlie Koenig, Budget Office

Department: Budget Office

Agenda Category: Regular Agenda Items

Information

Agenda Item

Discuss, consider and take appropriate action on the 2015-2016 Debt Service Fund County Budget.

Background

Fiscal Impact

From/To	Acct No.	Description	Amount

Attachments

No file(s) attached.

Form Review

Inbox	Reviewed By	Date
County Judge Exec Asst.	Rebecca Clemons	08/12/2015 02:55 PM
Form Started By: Ashlie Koenig		Started On: 08/07/2015 02:47 PM
Final Approval Date: 08/12/2015		

Commissioners Court - Regular Session **33.**

Meeting Date: 09/01/2015

10:00 AM Public hearing on the Williamson County proposed 2015 tax rate.

Submitted For: Deborah Hunt **Submitted By:** Larry Gaddes, County Tax Assessor Collector

Department: County Tax Assessor Collector

Agenda Category: Regular Agenda Items

Information

Agenda Item

10:00 AM Public hearing on proposed 2015 tax rate for Williamson County.

Background

This is the second of two public hearings on the proposed 2015 tax rate. The proposed rate was voted on 08/18 and is the combined rate of M&O, I&S and R/FM. the individual tax rates will be adopted September 8th

Proposed Rate: $0.486529
LY Rate : $0.486529
Effective Rate: $0.455623
Rollback Rate: $0.490162

Fiscal Impact

From/To	Acct No.	Description	Amount

Attachments

No file(s) attached.

Form Review

Inbox	Reviewed By	Date
County Judge Exec Asst.	Wendy Coco	08/20/2015 09:16 AM
Form Started By: Larry Gaddes		Started On: 08/17/2015 02:14 PM
Final Approval Date: 08/20/2015		

Commissioners Court - Regular Session **34.**

Meeting Date: 09/01/2015

EMS City of Gtown Agreements

Submitted For: Dan Gattis **Submitted By:** Hal Hawes, County Judge

Department: County Judge

Agenda Category: Regular Agenda Items

Information

Agenda Item

Discuss, consider and take appropriate action on an Interlocal Agreement Between Williamson County and the City of Georgetown, Texas Regarding Emergency Medical Services; a Mutual Assistance Agreement for Emergency Medical Services Between City of Georgetown, Texas and Williamson County, Texas; and an Interlocal Agreement for Ambulance Services for the Williamson County Jail.

Background

The Georgetown City Council approved each of the agreements, with out modification, at its Council Meeting on Tuesday, August 26, 2015.

Fiscal Impact

From/To	Acct No.	Description	Amount

Attachments

ILA RE EMS

Mutual Assistance Ag

Jail Transport Ag

Form Review

Inbox	Reviewed By	Date
County Judge Exec Asst.	Wendy Coco	08/27/2015 09:15 AM
Form Started By: Hal Hawes		Started On: 08/26/2015 05:01 PM
Final Approval Date: 08/27/2015		

INTERLOCAL AGREEMENT
BETWEEN WILLIAMSON COUNTY AND THE CITY OF GEORGETOWN, TEXAS
REGARDING EMERGENCY MEDICAL SERVICES

THIS INTERLOCAL AGREEMENT ("Agreement") is entered into between WILLIAMSON COUNTY, TEXAS (the "County") and the CITY OF GEORGETOWN, TEXAS (the "City"), political subdivisions of the State of Texas. In this Agreement, County and City are sometimes individually referred to as "Party" and collectively referred to as "the Parties."

WHEREAS, the City has received and maintains an Emergency Medical Services Provider License for the boundaries of the City's corporate limits and the City's extraterritorial jurisdiction; and

WHEREAS, County maintains an Emergency Medical Services Provider license for the boundaries of Williamson County, Texas, including the City's corporate limits and the City's extraterritorial jurisdiction; and

WHEREAS, the City and the County have determined that, as a result of the overlapping declared service areas and current response plans, it would be in the best interest of the citizens of the City's extraterritorial jurisdiction to designate the areas where the City and the County will provide emergency medical services; and

WHEREAS, the City and the County have further determined that it would be mutually beneficial and in the best interest of the citizens in the City's extraterritorial jurisdiction for emergency medical services to be provided with cooperation between the City and the County;

NOW, THEREFORE, in consideration of the foregoing premises, and for other good and valuable consideration, the receipt and sufficiency of which is acknowledged, the County and the City agree as follows:

1. AGREEMENT OF PARTIES

1.1 Beginning October 1, 2015, the City will provide emergency medical services within the legal boundaries of the Williamson County Emergency Services District #8 ("ESD #8").

1.2 Beginning October 1, 2015, the County will continue to provide emergency medical services within the City's extraterritorial jurisdiction outside of the legal boundaries of ESD #8.

1.3 The Parties also intend to enter into an agreement to render mutual emergency medical services aid and make available resources for such aid, providing that the party rendering aid may withhold resources to provide reasonable protection for the citizens within its jurisdiction or service area.

2. TERM AND TERMINATION

2.1 Term. The initial term of this Agreement shall commence on October 1, 2015 and continue thereafter until September 30, 2020. After that initial term, this Agreement will automatically renew for successive terms of five (5) years each unless otherwise terminated as set out herein.

2.2 Termination. Notwithstanding any other provision, either party may terminate this Agreement at any time with or without cause by giving the other party ninety (90) days written notice of termination, which notice shall specify the effective date of the termination.

3. MISCELLANEOUS PROVISIONS

3.1 Authority. Each Party represents and warrants that it has the full right, power and authority to execute this Agreement.

3.2 Severability. The provisions of this Agreement are severable and, if any provision of this Agreement is held to be invalid for any reason by a court or agency of competent jurisdiction, the remainder of this Agreement will not be affected and this Agreement will be construed as if the invalid portion had never been included.

3.3 Notices. Notices given under this Agreement will be effective if forwarded to a Party by hand-delivery, transmitted to a Party by confirmed fax or deposited with the U.S. Postal Service, certified mail, postage prepaid, to the address of the Party indicated below:

To County:

County Judge
710 Main Street, Suite 101
Georgetown, Texas 78626

To City:

City of Georgetown
Attn: City Manager
P.O. Box 409
Georgetown, Texas 78627-0409

Either Party may from time to time designate any other address for notice by written notice to the other Party.

3.4 No Waiver of Defenses/Immunity/Legal Standing. Nothing in this Agreement shall be deemed to waive, modify or amend any legal defense or immunity or standing available at law or in equity to either Party. Neither Party waives, modifies, or alters to any extent whatsoever the availability of the defense of governmental immunity.

3.5 Counterparts; Effect of Partial Execution. This Agreement may be executed in counterparts each of which, when executed and delivered, shall be deemed to be an original and all of which together shall constitute one and the same document.

3.6 Independent Relationship. Each Party, in the performance of this Agreement, shall act in an individual capacity and not as agents, employees, partners, joint ventures or associates of one another. The employees or agents of one Party shall not be deemed or construed to be the employees or agents of the other Party for any purpose.

3.7 Effective Date. This Agreement is executed to be effective on the date the last Party signs this Agreement.

3.8 Cooperation. The Parties agree to cooperate at all times in good faith to effectuate the purposes and intent of this Agreement.

3.9 Emergency Medical Services. For purposes of this Agreement, "emergency medical services" shall mean the services authorized by the Emergency Medical Services Provider License issued by the Texas Department of Health and Human Services.

3.10 Entire Agreement. This Agreement is the entire agreement of the Parties and supersedes all prior or contemporaneous understandings or representations, whether oral or written, regarding the subject matter of this Agreement. No promise, statement or representation that is not expressly stated in this Agreement has been made by any Party to induce execution of this Agreement. This Agreement is without regard to prior written contracts or agreements between the City and the County regarding any other subject or matter, and does not modify, amend, ratify, confirm, renew or otherwise affect any such other prior contract or agreement between the Parties.

3.11 Amendments. Any amendment of this Agreement shall be in writing and will be effective if signed by the authorized representative of each Party after approval by their respective governing bodies.

IN WITNESS WHEREOF, the Parties hereto have caused this Agreement to be signed and approved by the proper officers of each of the contracting Parties, and attested by the proper officer on the dates written below.

WILLIAMSON COUNTY, TEXAS

By: _____
Dan A. Gattis, County Judge

Date: _____ ___, 20____

CITY OF GEORGETOWN, TEXAS

By:_____
Dale Ross, Mayor

Date: _____ ___, 20____

ATTEST:

By: _____
Jessica Brettle, City Secretary

APPROVED AS TO FORM:

By: _____
Bridget Chapman,
City Attorney

STATE OF TEXAS §
§
COUNTY OF WILLIAMSON §

MUTUAL ASSISTANCE AGREEMENT FOR EMERGENCY MEDICAL SERVICES BETWEEN CITY OF GEORGETOWN, TEXAS AND WILLIAMSON COUNTY, TEXAS

This **Mutual Assistance Agreement for Emergency Medical Services** ("Agreement") is made and entered into between the **CITY OF GEORGETOWN, TEXAS**, acting by and through its duly authorized City Council, hereinafter referred to as "City", and **WILLIAMSON COUNTY, TEXAS**, acting herein by and through the Williamson County Commissioners Court, hereinafter referred to as "County". In this Agreement, County and City are sometimes individually referred to as "Party" and collectively referred to as "the Parties."

RECITALS

WHEREAS, from time to time, situations arise demanding combined efforts of two or more emergency medical services to provide service in the areas served by City and areas served by County: and,

WHEREAS, this Agreement is made pursuant to and under the provisions of Chapter 791 of the Texas Government Code, V.T.C.A., the Interlocal Cooperation Act and Section 774.001 of the Texas Health and Safety Code; and

WHEREAS, the governing body of City and County desire to improve the provisions of emergency medical services by entering into this Agreement pursuant to the Interlocal Cooperation Act and Section 774.001 of the Texas Health and Safety Code; and

WHEREAS, City and County, pursuant to the provisions of the Interlocal Cooperation Act, have determined that it would be in the best interest of City and County and the citizens thereof, to enter into this Agreement in order to provide Emergency Medical Services by authorizing cooperation among the emergency medical services of City and County; and,

WHEREAS, City and County, therefore, desire to enter into this Agreement for the provisions of mutual assistance emergency medical services;

NOW, THEREFORE, it is mutually agreed by and between City, acting herein by and through its duly authorized City Council and County, acting herein by and through its duly authorized Commissioners Court, as follows:

ARTICLE I
Obligations of the Parties, Requests for Assistance and Existence of Emergency

A. Obligations of County. On request of the City, County shall provide emergency medical services for City if:

1. an emergency exists within the City's corporate limits or within the legal boundaries of Williamson County Emergency Services District #8;
2. the City is temporarily unable to provide its own emergency medical services in response to the existing emergency;
3. the City's request is for services that the County provides or contracts to provide for persons within its jurisdiction; and
4. the County has available resources and is able to provide reasonable protection to persons that it serves outside of the City's corporate limits and outside of the legal boundaries of Williamson County Emergency Services District #8 while providing emergency medical services in response to the City's request.

B. Obligations of City. On request of the County, City shall provide emergency medical services for County if:

1. an emergency exists outside of the City's corporate limits or outside of the legal boundaries of Williamson County Emergency Services District #8;
2. the County is temporarily unable to provide its own emergency medical services in response to the existing emergency;
3. the County's request is for services that the City provides or contracts to provide for persons within its jurisdiction; and
4. the City has available resources and is able to provide reasonable protection to persons it serves within the City's corporate limits and within the legal boundaries of Williamson County Emergency Services District #8 while providing emergency medical services in response to the County's request.

C. Requests for Mutual Assistance. Assistance pursuant to this Agreement shall be made by and to the respective Party's Emergency Communications Center.

D. Notification of Resources Availability. In the event that a Party's resource needs may be imminent, such Party must notify the other Party's Emergency Communications Center.

E. Existence of Emergency. The Parties acknowledge and agree that "emergency medical services" means services used to respond to an individual's perceived need for immediate medical care and to prevent death or aggravation of physiological or psychological illness or injury. Therefore, the Parties further agree and acknowledge that neither Party is required to provide "stand-by" type assistance under this Agreement. The responding Party will only be requested in the event that an emergency currently exists within a Party's service area and such Party is, at the time of such request, unable to provide its own emergency medical services in response to the existing emergency.

ARTICLE II
Remuneration and Reimbursement

A. Reimbursement for Services. City and County shall not be responsible for reimbursement for mutual assistance emergency medical services rendered hereunder. All remuneration for such services shall be the responsibility of patient(s) treated, or a third party, and shall be based upon usual costs assigned for this service.

B. Reimbursement for Costs. Each Party to this Agreement shall be responsible for its own costs and expenses.

ARTICLE III
Standards of Service, Independent Status and Response Times

A. Standard of Services. It is agreed that Parties to this Agreement shall make requisite assurances that all service personnel have the certification, qualifications, skill and expertise to perform the services to be rendered under this Agreement. Service personnel shall operate under their own existing operations protocols, and, in the absence of a physician, shall work under their own medical direction. If there is a discrepancy between protocols, the Party that is rendering service shall operate under its own protocol.

B. Independent Status and Relationship. It is understood that each Party, while rendering assistance under this Agreement, shall retain the same powers, duties, rights, privileges and immunities as if it were performing its duties in the City of Georgetown, Texas or in Williamson County, Texas in which it normally employed or rendered services. Furthermore, each party to this Agreement, in the performance of this Agreement, shall act in an individual capacity and not as agents, employees, partners, joint ventures or associates of one another. The employees or agents of one party shall not be deemed or construed to be the employees or agents of the other party for any purposes whatsoever.

ARTICLE IV
Liability of the Parties

It is understood that liability to all Parties is limited by existing laws covering medical personnel in the performance of their duties in emergency situations. Furthermore, the Parties may avail themselves of all defenses and immunities that are available at law; including, but not limited to the Texas Tort Claims Act. It is expressly understood and agreed that each Party hereto shall have no liability for the wages, disability payments, worker's compensation, pension payments, damage to equipment and clothing, medical expenses, expenses of travel, food lodging or other compensation, or expenses of personnel of another Party’s emergency medical services, regardless of whether such personnel performed services outside the jurisdiction of his or her employer.

ARTICLE IV
Term and Termination

A. The initial term of this Agreement shall commence on October 1, 2015 and continue thereafter until September 30, 2020. After that initial term, this Agreement will automatically renew for successive terms of five (5) years each unless otherwise terminated as set out herein.

B. It is expressly understood and agreed by the Parties that this Agreement may be terminated at any time without cause by either Party upon ninety (90) days written notice to the other Party.

ARTICLE VI
Miscellaneous Provisions

A. Laws, Statutes and Ordinances. The Parties shall observe and comply with all federal, state, county, and city laws, rules, ordinances, and regulations in any manner affecting the conduct of services herein provided and performance of all obligations undertaken by this Agreement.

B. Authority. This Agreement is entered, in part, pursuant to the authority of the Act. The provisions of the Act are incorporated in this Agreement and this Agreement shall be interpreted in accordance with the Act. This Agreement is also being entered into pursuant to the authority set out under Section 774.001 of the Texas Health and Safety Code. Each Party represents and warrants that it has the full right, power and authority to execute this Agreement.

C. Severability. The provisions of this Agreement are severable and, if any provision of this Agreement is held to be invalid for any reason by a court or agency of competent jurisdiction, the remainder of this Agreement will not be affected and this Agreement will be construed as if the invalid portion had never been included.

D. Notices. Notices given under this Agreement will be effective if forwarded to a Party by hand-delivery, transmitted to a Party by confirmed fax or deposited with the U.S. Postal Service, certified mail, postage prepaid, to the address of the Party indicated below:

To County:

County Judge
710 Main Street, Suite 101
Georgetown, Texas 78626

To City:

City of Georgetown
Attn: City Manager
P.O. Box 409
Georgetown, Texas 78627-0409

Either Party may from time to time designate any other address for notice by written notice to the other Party.

E. No Waiver of Defenses/Immunity/Legal Standing. Nothing in this Agreement shall be deemed to waive, modify or amend any legal defense or immunity or standing available at law or in equity to either Party. Neither Party waives, modifies, or alters to any extent whatsoever the availability of the defense of governmental immunity.

F. Counterparts; Effect of Partial Execution. This Agreement may be executed in counterparts each of which, when executed and delivered, shall be deemed to be an original and all of which together shall constitute one and the same document.

G. Effective Date. This Agreement is executed to be effective on the date the last Party signs this Agreement.

H. Cooperation. The Parties agree to cooperate at all times in good faith to effectuate the purposes and intent of this Agreement.

I. Entire Agreement. This Agreement is the entire agreement of the Parties and supersedes all prior or contemporaneous understandings or representations, whether oral or written, regarding the subject matter of this Agreement. No promise, statement or representation that is not expressly stated in this Agreement has been made by any Party to induce execution of this Agreement. This Agreement is without regard to prior written contracts or agreements between the City and the County regarding any other subject or matter, and does not modify, amend, ratify, confirm, renew or otherwise affect any such other prior contract or agreement between the Parties.

J. Amendments. Any amendment of this Agreement shall be in writing and will be effective if signed by the authorized representative of each Party after approval by their respective governing bodies.

IN WITNESS WHEREOF, the Parties hereto have caused this Agreement to be signed and approved by the proper officers of each of the contracting Parties, and attested by the proper officer on the dates written below.

WILLIAMSON COUNTY, TEXAS

By: _____
Dan A. Gattis, County Judge

Date: _____ ___, 20____

CITY OF GEORGETOWN, TEXAS

By:_____
Dale Ross, Mayor

Date: _____ ___, 20____

ATTEST:

By: _____
Jessica Brettle, City Secretary

APPROVED AS TO FORM:

By: _____
Bridget Chapman,
City Attorney

INTERLOCAL AGREEMENT
FOR AMBULANCE SERVICES FOR THE WILLIAMSON COUNTY JAIL

THIS INTERLOCAL AGREEMENT ("Agreement") is entered into between WILLIAMSON COUNTY, TEXAS (the "County") and the CITY OF GEORGETOWN, TEXAS (the "City"), political subdivisions of the State of Texas. In this Agreement, County and City are sometimes individually referred to as "Party" and collectively referred to as "the Parties."

RECITALS

WHEREAS, the Interlocal Cooperation Act, Texas Government Code Chapter 791 (the "Act") provides that local governments may contract with each other for the performance of governmental functions or services, including providing ambulance services, for the mutual benefit and in the mutual interest of the Parties; and,

WHEREAS, the City has received an Emergency Medical Services Provider license and will begin providing emergency medical services in the City limits beginning October 1, 2015; and,

WHEREAS, City will be providing ground basic and advanced life support ambulance services, and will be licensed by applicable State authorities to provide those services; and,

WHEREAS, the County owns and operates the Williamson County Jail ("Jail"), which is located inside the corporate limits of the City; and,

WHEREAS, the Parties wish to set forth their agreements as to the City's provision of ground basic and advanced life support ambulance services to the Jail and the payment for such services; and,

NOW, THEREFORE, in consideration of the foregoing premises, and for other good and valuable consideration, the receipt and sufficiency of which is acknowledged, the County and the City agree as follows:

1. **Incorporation of Recitals.** The recitals set forth above are hereby incorporated by reference into this Agreement and made a part hereof as if set forth in their entirety.

2. **Ambulance Services Provider to Jail.** Pursuant to the City's Code of Ordinances, Chapters 2.28 and 2.29, the City is providing ground basic and advanced life support ambulance service (hereinafter, collectively, "Ambulance Services") for County's inmate patients at the Jail who require such Ambulance Services, 24 hours-per-day, 7 days-per-week, pursuant to the terms of this Agreement. "Ambulance Services" consist of a response by City to the Jail, treatment and other pre-transport activities, including the rendering of emergency medical service at the Jail, appropriate care and treatment during transport, and one-way transportation to the patient's designated destination.

3. **Qualifications and Obligations.**

a. Licensure and Certification. The Parties covenant and agree that at all times they shall remain licensed, certified or enrolled in good standing with applicable state and federal licensing authorities, with all state and federal health care programs, and all required state or national accrediting organizations.

b. Response. City shall respond to requests for emergency services and non-emergency services in accordance with any applicable City standard operating procedures, City ordinances, laws or regulations.

c.. Information Concerning Status of Patient. County shall provide City with all necessary information about the patient to enable City to properly provide the necessary Ambulance Services and bill the appropriate payor. Such information shall include the patient's insurance status.

5. **Billing and Compensation.**

a. Billing to County. Except as otherwise provided herein, City will bill County directly for Ambulance Services rendered to inmate patients at the Jail. County agrees to pay City according to the Medicare allowable rate for ambulance transports in accordance with the most current definitions and rates for each level of service, as set forth by the Centers for Medicare and Medicaid Services (CMS).

c. Billing to Patient. In the event the inmate patient has available insurance (excluding Medicare and Medicaid), County shall provide City with insurance documentation so that City may bill the patient directly for the Ambulance Services rendered. In such case, City shall comply with its billing practices and procedures for Ambulance Services..In the event City is unsuccessful at receiving payment from the patient within ninety (90) days, after complying with the City's billing practices and procedures for Ambulance Services, City may bill County directly for such Ambulance Services rendered and County shall pay for such services in the same manner as set forth in Paragraph 5.(a.) above.

b. Payment Conditions for Services Covered by County

(i) Payment in Full. City shall not bill any patient, financially responsible Party, insurer, or third party payor for any transports that are paid for by County. When charges are properly billed for transports, City shall accept the fee schedule amounts outlined in this Agreement as payment in full.

(ii) Prompt Payment. County agrees to remit payment to City for all transports for which it is responsible to pay under this Agreement pursuant to 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 City, County shall notify City 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 City, City shall be entitled to receive interest on the unpaid balance of the invoice submitted by City beginning on the date that the payment for the invoice became overdue. If the error is resolved in favor of the County, City 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.

6. **Term.** The initial term of this Agreement shall commence on October 1, 2015 and continue thereafter until September 30, 2020. After that initial term, this Agreement will automatically renew for successive terms of five (5) years each unless otherwise terminated as set out herein.

7. **Termination.** Notwithstanding any other provision, either party may terminate this Agreement at any time with or without cause by giving the other party ninety (90) days written notice of termination, which notice shall specify the effective date of the termination.

8. **Notices.** Notices required or permitted to be given under this Agreement shall be made to the Parties at the following addresses and shall be presumed to have been received by the other Party (i) five business days after mailing by the Party when notices are sent by First Class mail, postage prepaid; (ii) upon transmission (if sent via facsimile with a confirmed transmission report); or (iii) upon receipt (if sent by hand delivery or courier service) as follows:

To County:

County Judge
710 Main Street, Suite 101
Georgetown, Texas 78626

To City:

City of Georgetown
Attn: City Manager
P.O. Box 409
Georgetown, Texas 78627-0409

Either Party may from time to time designate any other address for notice by written notice to the other Party.

9. **Events of Default.** Each of the following shall be an "Event of Default" under this Agreement entitling the non-defaulting Party to declare this Agreement void and of no further force and effect without additional prior notice:

a. If County fails to pay City for the Ambulance Services when required hereunder or otherwise meet its obligations hereunder.

b. If City fails to meet its obligations hereunder.

c. If either Party fails to maintain its required licenses, permits or certifications.

d. If any of the representations of either Party as set forth in this Agreement are false or misleading in any material respect.

10. **Mutual Hold Harmless.** City and County each shall hold harmless the other Party and the other Party's directors, officers, agents, members and employees against any and all claims, causes of action, injuries and damages including, but not limited to, personal injury and property damage, to the extent caused by any of its own acts or omissions or from the acts or omissions of its own agents, contractors or employees and arising out of or due to the performance, failure to perform or breach of this Agreement.

11. **Entire Agreement.** This Agreement, including any hereto, constitutes the sole and only agreement of the Parties regarding its subject matter and supersedes any prior understandings or written or oral agreements between the Parties respecting this subject matter. Neither Party has received or relied upon any written or oral representations to induce it to enter into this Agreement except that each Party has relied only on any written representations contained herein.

12. **Amendments.** No agreement or understandings varying or extending this Agreement shall be binding upon the Parties unless it is memorialized in a written amendment signed by an authorized officer or representative of both Parties.

13. **Assignment.** This Agreement may be assigned by a Party upon the written approval of the other Party. This Agreement shall be binding upon all successors and assigns.

14. **Construction and Compliance.**

a. Severability. In the event that any one or more of the provisions contained in this Agreement shall for any reason be held by any court or by the Office of Inspector General (OIG) of the United States Department of Health and Human Services to be invalid, illegal, or unenforceable in any respect, such invalidity, illegality, or unenforceability shall not affect any other provisions and the Agreement shall be construed as if such invalid, illegal, or unenforceable provision had never been contained in it.

b. Compliance. The Parties intend to comply fully with all applicable state and federal laws and regulations, including but not limited to the Balanced Budget Act of 1997, the Social Security Act, the federal Anti-Kickback Statute, the federal False Claims Act, and all applicable state and federal fraud and abuse laws and rules. Insofar as any terms or conditions of this Agreement are determined by any court or by the OIG to be contrary to any such statutes or regulations, the Parties will promptly and in good faith confer and resolve any issues so as to make the performance of this Agreement consistent with all applicable statutes and regulations.

c. Notification of Actual or Potential Violation of Law. If either Party becomes aware of any actual or potential violations by the other Party, whether intentional or inadvertent, of any applicable state or federal statutes or regulations, it shall promptly notify the other Party.

d. Protection of Patient Information. The Parties, each of which are "covered entities," shall carry out their obligations under this Agreement in compliance with the privacy and security regulations of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), to protect the privacy and security of any personally identifiable, protected health information ("PHI") that is collected, processed or learned as a result of the services provided pursuant to this Agreement. Both Parties acknowledge that their relationship to patients receiving services hereunder is a "direct treatment relationship" as that term is defined in the Privacy Regulations and that this contractual relationship does not constitute a "business associate" agreement pursuant to the Privacy Rule. The Parties also understand that it is permissible under HIPAA to freely exchange PHI for purposes of treatment, payment, or health care operations, including information to determine medical necessity. Both Parties agree to a free exchange of PHI for purposes of treatment, payment, or health care operations, and County will provide all documents requested by City so that it may properly bill for covered transports.

15. **Complaints.** County agrees that all complaints or unusual incidents involving personnel, equipment or service of City will be promptly reported to management of City and will be described in an incident report detailing the circumstances surrounding the complaint or incident, including the persons or entities involved, date and time of events at issue, and description of events at issue within five (5) business days of the occurrence.

16. **Force Majeure.** The Parties shall be excused for the period of any delay in or impossibility of the performance of any obligations hereunder, when prevented from doing so by any cause or causes beyond a Party's control, which shall include without limitation: all labor disputes, civil commotion, war, nuclear disturbances, hostilities, sabotage, terroristic acts, governmental regulations or controls, fire, accident or other casualty, interruption in the supply of any utilities or fuel, inability to obtain any material or services, or through acts of God.

17. **Independent Contractor Relationship.** The relationship of the Parties is that of independent contractors. Neither Party shall be deemed to be the agent nor partner nor fiduciary of the other, and neither is authorized to take any action binding upon the other. The employees or agents of one Party shall not be deemed or construed to be the employees or agents of the other Party for any purposes whatsoever.

18. **Governing Law.** This Agreement is made and shall be construed in accordance with, and governed by, the laws of the State of Texas, without consideration of conflict of laws principles.

19. **Access to Books and Records.** City shall, for a period of four (4) years after this Agreement terminates, make available, upon the written request of the Secretary of Health and Human Services or the Comptroller General, or their representatives, this Agreement, and such books, documents and records as may be necessary to verify the nature and extent of the costs of the Ambulance Services for County inmate patients provided by the City.

20. **County's Right to Audit.** City agrees that County or its duly authorized representatives shall, until the expiration of three (3) years after final payment under this Agreement, have access to and the right to examine and photocopy any and all books, documents, papers and records of City which are directly pertinent to Ambulance Services for County inmate patients at the Jail provided by the City and billed to the County pursuant to this Agreement for the purposes of making audits, examinations, excerpts, and transcriptions. City agrees that County shall have access during normal working hours to all necessary City facilities and shall be provided adequate and appropriate work space in order to conduct audits in compliance with the provisions of this section. County shall give City reasonable advance notice of intended audits.

21. **Authority.** This Agreement is entered, in part, pursuant to the authority of the Act. The provisions of the Act are incorporated in this Agreement and this Agreement shall be interpreted in accordance with the Act. Each Party represents and warrants that it has the full right, power and authority to execute this Agreement.

22. **Waiver and Consent.** The failure of either Party at any time to require performance by the other Party of any provision hereof shall not affect in any way the rights to require such performance of any other provision hereof, nor shall the waiver by either Party of a breach of any provision hereof be taken or held to be a waiver of the provision itself. If the consent of either Party is necessary pursuant to the terms of this Agreement, such consent shall not be unreasonably withheld.

23. **No Waiver of Defenses/Immunity/Legal Standing.** Nothing in this Agreement shall be deemed to waive, modify or amend any legal defense or immunity or standing available at law or in equity to either Party. Neither Party waives, modifies, or alters to any extent whatsoever the availability of the defense of governmental immunity.

24. **Regulatory Changes.** The Parties recognize that this Agreement is at all times subject to applicable state, local, and federal laws and shall be construed accordingly. The Parties further recognize that this Agreement may become subject to or be affected by amendments in such laws and regulations or to new legislation or regulations. Any provisions of law that invalidate, or are otherwise inconsistent with, the material terms and conditions of this Agreement, or that would cause one or both of the Parties hereto to be in violation of law, shall be deemed to have superseded the terms of this Agreement and, in such event, the Parties agree to utilize their best efforts to modify the terms and conditions of this Agreement to be consistent with the requirements of such law(s) in order to effectuate the purposes and intent of this Agreement. In the event that any such laws or regulations affecting this Agreement are enacted, amended or promulgated, either Party may propose to the other a written amendment to this Agreement to be consistent with the provisions of such laws or regulations. In the event that the Parties do not agree on such written amendments within thirty (30) days of receipt of the proposed written amendments, then either Party may terminate this Agreement without further notice, unless this Agreement would expire earlier by its terms.

25. **Non-Discrimination.** All services provided under this Agreement shall be provided without regard to the race, color, creed, sex, age, disability status, payor source or national origin of

the resident requiring such services. City agrees to comply with all applicable laws prohibiting discrimination in the provision of services hereunder.

26. **Authorization of Agreement.** Each Party represents and warrants, each to the other with respect to itself, that the execution and delivery of this Agreement has been duly authorized and the individual executing this Agreement on behalf of each Party respectively has full power and authority to do so.

IN WITNESS WHEREOF, the Parties hereto have caused this Agreement to be signed and approved by the proper officers of each of the contracting Parties, and attested by the proper officer on the dates written below.

WILLIAMSON COUNTY, TEXAS

By: _____
Dan A. Gattis, County Judge

Date: _____ ___, 20____

CITY OF GEORGETOWN, TEXAS

By:_____
Dale Ross, Mayor

Date: _____ ___, 20____

ATTEST:

By: _____
Jessica Brettle, City Secretary

APPROVED AS TO FORM:

By: _____
Bridget Chapman,
City Attorney

Commissioners Court - Regular Session **35.**

Meeting Date: 09/01/2015

WCEMS Education Affiliation Agreement renewal updates

Submitted For: Kenny Schnell **Submitted By:** Kenny Schnell, EMS

Department: EMS

Agenda Category: Regular Agenda Items

Information

Agenda Item

Discuss, consider and take appropriate action on approving the renewal of education affiliation agreements between Williamson County EMS and Leander Fire Department, Austin Community College, Laramie County Community College, Emergency Management Training and Services, Life Start Training and Consulting.

Background

This is a request for the renewal of existing education affiliation agreements with the increase in compensation being paid to the county to allow their students the opportunity and means to receive supervised experience in a professional setting under direct supervision of a WCEMS qualified instructor during an EMS ride out. The increase is comparable with other EMS services in the area.

Fiscal Impact

From/To	Acct No.	Description	Amount

Attachments

BLS.Affiliation.Agreement.LeanderFire

BLS.Affiliation.Agreement.ACC

ALS.Affiliation.Agreement.ACC

Education.Affiliation.Agreement.Laramie.County.Community.College

BLS.Affiliation.Agreement.EMTS

ALS.Affiliation.Agreement.EMTS

BLS.Affiliation.Agreement.Life Start

Form Review

Inbox	Reviewed By	Date
County Judge Exec Asst.	Wendy Coco	08/27/2015 09:15 AM
Form Started By: Kenny Schnell		Started On: 08/27/2015 08:08 AM
Final Approval Date: 08/27/2015		

BLS EDUCATION AFFILIATION AGREEMENT
FOR
EMERGENCY MEDICAL PRECEPTOR PROGRAM BETWEEN

WILLIAMSON COUNTY EMERGENCY MEDICAL SERVICES
AND
LEANDER FIRE DEPARTMENT

This Agreement is between Williamson County Emergency Medical Services (hereinafter referred to as "COUNTY") and Leander Fire Department (hereinafter referred to as "LEANDER FIRE").

RECITALS:

LEANDER FIRE provides courses of study in emergency medical services to students enrolled in its Emergency Medical Technician program of study.

LEANDER FIRE desires program components that will provide to the students clinical experience as part of their educational instruction.

COUNTY, through its Emergency Medical Services Department, has facilities that can provide a clinical setting for educational instruction and is willing to make available the use of its facilities to LEANDER FIRE for its Emergency Medical Technician program of study.

COUNTY and LEANDER FIRE desire to enter into this Educational Affiliation Agreement in accordance with the terms stated below:

TERMS:

RESPONSIBILITIES OF LEANDER FIRE

1. LEANDER FIRE shall be responsible for the selection of students and their supervised instruction and grading. Students shall have satisfactorily completed curriculum prerequisites for participation in the internships or rotations.

2. LEANDER FIRE instructors shall possess current and appropriate professional credentials or certifications and LEANDER FIRE shall be responsible for the coordination and implementation of the program of study.

3. Services rendered by LEANDER FIRE instructors and students shall be without charge to COUNTY. LEANDER FIRE instructors and students shall not be responsible for the quality of patient or client care.

4. Neither LEANDER FIRE instructors nor students shall be deemed to be COUNTY employees, nor shall they be entitled to any COUNTY benefits, compensation or workers compensation benefits.

5. LEANDER FIRE shall annually provide COUNTY with anticipated enrollments for courses intending to provide clinical internships or experience through this Agreement. The number of students and the schedule of use of COUNTY's facilities shall be subject to annual, mutual approval.

6. LEANDER FIRE shall provide COUNTY with a list of students authorized to participate in the clinical instruction facilitated under this Agreement. LEANDER FIRE shall promptly inform COUNTY in writing of any student withdrawing from the course or otherwise unqualified to continue the internship or clinical experience made available under this Agreement.

7. LEANDER FIRE shall require all instructors and students to abide by all applicable policies, regulations and laws governing the facility or its work environment. LEANDER FIRE shall withdraw authorization for participation under this Agreement for any instructor or student found to have committed a violation of applicable policies, regulations or laws, or determined by COUNTY to be unqualified to continue in the program.

8. During the term of this Agreement, LEANDER FIRE shall maintain a professional liability insurance policy with a limit of liability of not less than $1,000,000 per occurrence and $3,000,000 annual aggregate that covers the activities of LEANDER FIRE'S students, employees and faculty under this Agreement. LEANDER FIRE shall ensure that each current student, employee and faculty member is individually insured under such policy in the above-stated amounts, and shall provide COUNTY with a proof of such insurance coverage each year, and at other times upon request. LEANDER FIRE agrees to require each student to be covered by or to carry accident insurance for injury while enrolled in the program, and to ensure that each employee or faculty member is covered by worker's compensation insurance while participating in the program. No student or faculty member shall be permitted to participate in the program until such insurance coverage has been verified to the satisfaction of COUNTY.

9. LEANDER FIRE agrees to secure a release of liability form from each student and faculty member who will participate in the program in a form acceptable to COUNTY.

RESPONSIBILITIES OF COUNTY

10. COUNTY shall, on a space available basis, the use of designated facilities to provide a clinical education to participating students. COUNTY agrees to provide evaluations for student course-work done on forms provided by LEANDER FIRE.

11. COUNTY shall provide an orientation session to inform students and LEANDER FIRE staff about the rules, regulations, policies and procedures of the facilities.

12. COUNTY agrees to provide, on a space-available basis, the use of conference rooms, classrooms, lounges and lockers to the instructors and the students.

13. COUNTY shall notify LEANDER FIRE of any change of any accreditation or status concerning a facility and affecting internship or course requirements for clinical experience at a LEANDER FIRE credited facility. Representatives of LEANDER FIRE crediting agency for LEANDER FIRE shall be permitted to conduct inspections for purposes relating to LEANDER FIRE'S accreditation.

14. COUNTY shall cooperate with LEANDER FIRE in matters relating to academic performance and student conduct relating to course work performed under this Agreement.

15. Unless prohibited or restricted by law, COUNTY shall timely notify an instructor or student of any instance in which a facility employee has been exposed to blood-borne or airborne pathogens and the student or instructor may have been exposed in the same instance. Notification shall be provided in a time frame sufficient to allow the student or faculty member to seek appropriate treatment for potential exposure.

16. COUNTY shall obtain and maintain all licenses required for its participating facilities and shall assure that COUNTY personnel are appropriately licensed.

17. In the event emergency care is required for an LEANDER FIRE student or faculty member, it shall be provided in the same manner that emergency care is provided to COUNTY employees and the general public. Emergency care provided by COUNTY shall be at the expense of the student or faculty member.

MUTUAL RESPONSIBILITIES

18. The Parties agree to designate a liaison for each program to do the following:

A Meet annually, or more often as needed, to schedule use of the facilities;

B. Meet on a per semester basis to set the number of students allowed to participate;

C. Design and approve curriculum assignments as they *affect* the operation of the facility and as affected by LEANDER FIRE crediting standards;

D. Meet to review protocols, policies and rules and regulations concerning the operation of the facility and its use under this Agreement;

E. Meet annually to evaluate changes or amendments to this Agreement or the performance of the Agreement.

19. In the event any claim or demand is made on one of the Parties for actions relating or authorized by this Agreement, the other party shall be notified of such claim or demand in writing within five business (Monday-Friday) days. COUNTY shall not be liable for any claims, damages or attorney's fees arising from the negligent acts or omissions of LEANDER FIRE, its employees, agents or students under this Agreement. LEANDER FIRE shall not be liable for any claims, damages or attorney's fees arising from the negligent acts or omissions of COUNTY or its employees under this Agreement.

20. Notices shall be in writing and shall be effective when received. Notices shall be delivered in person or by certified mail, return receipt requested, to the following addresses:

Kenny Schnell
WCEMS Director
PO Box 873
Georgetown, TX 7827
512-943-1264

And

Bill Gardner
Leander Fire Chief
101 E. Sonny Drive
Leander, TX 78641

ADDITIONAL TERMS

21. Compensation benefits for this Agreement shall include $40.00 total per EMT student to be paid by LEANDER FIRE to the COUNTY. Compensation shall be paid to COUNTY within thirty (30) days from the date of the COUNTY'S invoice for payment.

22. LEANDER FIRE acknowledges that COUNTY is a hybrid entity under the privacy regulations of the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA Privacy Rule"). COUNTY has designated its Emergency Medical Services Department as a health care component, as defined in HIPAA, and the Department is therefore required to comply with the HIPAA Privacy Rule. This compliance includes obtaining written contractual assurances from LEANDER FIRE that LEANDER FIRE, its employees and agents will protect all individually identifiable health information they may access or use under this Agreement in accordance with the terms of the HIPAA Business Associate Agreement, which is hereby attached to and made a part of this Agreement, for all purposes, as Exhibit "C".

23. The parties agree that COUNTY shall at all times maintain the right to terminate a student's participation in the program if COUNTY, in its sole discretion, determines that the student's continued participation would be disruptive to the program or the operations of the facility, or would pose a danger.

24. LEANDER FIRE instructors and students shall maintain confidential all records and information concerning patients treated or attended to in COUNTY's facilities. Each LEANDER FIRE instructor and student involved in medical or EMS programs shall be required to sign a confidentiality agreement regarding records and information about patients treated or attended by COUNTY employees.

25. Failure of either party to exercise any right or privilege granted by this Agreement shall not operate to waive such right or privilege in the event of subsequent defaults or assertions of right. Neither party waives nor shall be deemed to have waived any immunity or defense that would otherwise be available to it against claims arising under the performance of this Agreement.

26. The provisions of this Agreement shall be severable in the event any provision is declared invalid, illegal or unenforceable.

27. Either party may terminate this Agreement without cause upon 90 days written notice to the other party. In addition, COUNTY shall have the right to terminate the Agreement immediately in the event the facility becomes inoperable for any reason or COUNTY no longer controls a program.

28. Either Party may terminate this Agreement if the other breaches the Agreement and fails to cure such breach within 15 days of receiving notice of breach. If more than 15 days are required to cure the breach, the Parties may agree to an extension of the cure period in writing.

29. This agreement is effective when all parties have executed it. The term of the Agreement is from January 1, 2015 through December 31, 2016 unless this Agreement is otherwise terminated pursuant to the termination provision contained in Article 27 of this Agreement. All services shall be completed during this term. This Agreement may be reviewed annually by agreement of both parties via written instrument and subject to required approvals. There is no right or expectation of renewal and any renewal will be determined at the discretion of both Parties.

30. Nothing in this Agreement shall be construed to confer third party rights or to constitute a waiver of any governmental immunity of the parties.

31. This Agreement constitutes the entire agreement between the Parties and any prior or contemporaneous agreements, written or oral, are hereby superseded and of no further effect.

32. The laws of the State of Texas shall govern the validity, interpretation and enforcement of this Agreement, and venue for any dispute or cause of action shall be in Williamson County, Texas.

33. The Parties will comply with applicable federal, state and local laws, ordinances and regulations in the performance of this Agreement.

34. The performance of this Agreement shall be undertaken in a manner that does not discriminate against any person on a basis prohibited by law, including but not limited to race, color, national origin, religion, sex, age, veteran status or disability.

35. Notwithstanding any other provision of this Agreement, a COUNTY department may suspend participation in this Agreement due to space needs, staff training needs, budgetary issues or other urgent considerations. In the event of suspension, COUNTY shall give LEANDER FIRE written notification stating the date of suspension and the date on which participation is anticipated to resume.

Williamson County:

Kenny Schnell
WCEMS Director

Date

Leander Fire Department:

6-29-15

Bill Gardner
Leander Fire Chief
101 Sonny Drive
Leander, Texas 78641

Date

ATTACHMENT A

RELEASE OF LIABILITY

In consideration of the educational benefits extended to me by Williamson County Emergency Medical Services Department in making available its facilities for clinical course instruction as part of LEANDER FIRE course regarding emergency medical service training, I hereby release and hold harmless Williamson County, its employees and agents from any claim, cause of action or injury that may result during my participation in a Williamson County program due to the negligence of Williamson County, its employees or agents.

Student's signature: _____

Printed Name

Date:

BLS EDUCATION AFFILIATION AGREEMENT
FOR
EMERGENCY MEDICAL PRECEPTOR PROGRAM BETWEEN

WILLIAMSON COUNTY EMERGENCY MEDICAL SERVICES
AND
AUSTIN COMMUNITY COLLEGE

This Agreement is between Williamson County Emergency Medical Services (hereinafter referred to as "COUNTY") and Austin Community College EMS Professions Department (hereinafter referred to as "ACC").

RECITALS:

ACC provides courses of study in emergency medical services to students enrolled in its Emergency Medical Technician program of study.

ACC desires program components that will provide to the students clinical experience as part of their educational instruction.

COUNTY, through its Emergency Medical Services Department, has facilities that can provide a clinical setting for educational instruction and is willing to make available the use of its facilities to ACC for its Emergency Medical Technician program of study.

COUNTY and ACC desire to enter into this Educational Affiliation Agreement in accordance with the terms stated below:

TERMS:

RESPONSIBILITIES OF ACC

1. ACC shall be responsible for the selection of students and their supervised instruction and grading. Students shall have satisfactorily completed curriculum prerequisites for participation in the internships or rotations.

2. ACC instructors shall possess current and appropriate professional credentials or certifications and ACC shall be responsible for the coordination and implementation of the program of study.

3. Services rendered by ACC instructors and students shall be without charge to COUNTY. ACC instructors and students shall not be responsible for the quality of patient or client care.

4. Neither ACC instructors nor students shall be deemed to be COUNTY employees, nor shall they be entitled to any COUNTY benefits, compensation or workers compensation benefits.

5. ACC shall annually provide COUNTY with anticipated enrollments for courses intending to provide clinical internships or experience through this Agreement. The number of students and the schedule of use of COUNTY's facilities shall be subject to annual, mutual approval.

6. ACC shall provide COUNTY with a list of students authorized to participate in the clinical instruction facilitated under this Agreement. ACC shall promptly inform COUNTY in writing of any student withdrawing from the course or otherwise unqualified to continue the internship or clinical experience made available under this Agreement.

7. ACC shall require all instructors and students to abide by all applicable policies, regulations and laws governing the facility or its work environment. ACC shall withdraw authorization for participation under this Agreement for any instructor or student found to have committed a violation of applicable policies, regulations or laws, or determined by COUNTY to be unqualified to continue in the program.

8. During the term of this Agreement, ACC shall maintain a professional liability insurance policy with a limit of liability of not less than $1,000,000 per occurrence and $3,000,000 annual aggregate that covers the activities of ACC'S students, employees and faculty under this Agreement. ACC shall ensure that each current student, employee and faculty member is individually insured under such policy in the above-stated amounts, and shall provide COUNTY with a proof of such insurance coverage each year, and at other times upon request. ACC agrees to require each student to be covered by or to carry accident insurance for injury while enrolled in the program, and to ensure that each employee or faculty member is covered by worker's compensation insurance while participating in the program. No student or faculty member shall be permitted to participate in the program until such insurance coverage has been verified to the satisfaction of COUNTY.

9. ACC agrees to secure a release of liability form from each student and faculty member who will participate in the program in a form acceptable to COUNTY.

RESPONSIBILITIES OF COUNTY

10. COUNTY shall, on a space available basis, the use of designated facilities to provide a clinical education to participating students. COUNTY agrees to provide evaluations for student course-work done on forms provided by ACC.

11. COUNTY shall provide an orientation session to inform students and ACC staff about the rules, regulations, policies and procedures of the facilities.

12. COUNTY agrees to provide, on a space-available basis, the use of conference rooms, classrooms, lounges and lockers to the instructors and the students.

13. COUNTY shall notify ACC of any change of any accreditation or status concerning a facility and affecting internship or course requirements for clinical experience at an ACC credited facility. Representatives of ACC crediting agency for ACC shall be permitted to conduct inspections for purposes relating to ACC's accreditation.

14. COUNTY shall cooperate with ACC in matters relating to academic performance and student conduct relating to course work performed under this Agreement.

15. Unless prohibited or restricted by law, COUNTY shall timely notify an instructor or student of any instance in which a facility employee has been exposed to blood-borne or airborne pathogens and the student or instructor may have been exposed in the same instance. Notification shall be provided in a time frame sufficient to allow the student or faculty member to seek appropriate treatment for potential exposure.

16. COUNTY shall obtain and maintain all licenses required for its participating facilities and shall assure that COUNTY personnel are appropriately licensed.

17. In the event emergency care is required for an ACC student or faculty member, it shall be provided in the same manner that emergency care is provided to COUNTY employees and the general public. Emergency care provided by COUNTY shall be at the expense of the student or faculty member.

MUTUAL RESPONSIBILITIES

18. The Parties agree to designate a liaison for each program to do the following:

A Meet annually, or more often as needed, to schedule use of the facilities;

B. Meet on a per semester basis to set the number of students allowed to participate;

C. Design and approve curriculum assignments as they *affect* the operation of the facility and as affected by ACC crediting standards;

D. Meet to review protocols, policies and rules and regulations concerning the operation of the facility and its use under this Agreement;

E. Meet annually to evaluate changes or amendments to this Agreement or the performance of the Agreement.

19. In the event any claim or demand is made on one of the Parties for actions relating or authorized by this Agreement, the other party shall be notified of such claim or demand in writing within five business (Monday-Friday) days. COUNTY shall not be liable for any claims, damages or attorney's fees arising from the negligent acts or omissions of ACC, its employees, agents or students under this Agreement. ACC shall not be liable for any claims, damages or attorney's fees arising from the negligent acts or omissions of COUNTY or its employees under this Agreement.

20. Notices shall be in writing and shall be effective when received. Notices shall be delivered in person or by certified mail, return receipt requested, to the following addresses:

Kenny Schnell
WCEMS Director
PO Box 873
Georgetown, TX 7827
512-943-1264

And

Don Gwynn
Department Chair
Austin Community
College
Emergency
Medical Services
Professions
3401 Webberville
Road
Austin, TX 78702

ADDITIONAL TERMS

21. Compensation benefits for this Agreement shall include $40.00 total per EMT student to be paid by ACC to the COUNTY. Compensation shall be paid to COUNTY within thirty (30) days from the date of the COUNTY'S invoice for payment.

22. ACC acknowledges that COUNTY is a hybrid entity under the privacy regulations of the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA Privacy Rule"). COUNTY has designated its Emergency Medical Services Department as a health care component, as defined in HIPAA, and the Department is therefore required to comply with the HIPAA Privacy Rule. This compliance includes obtaining written contractual assurances from ACC that ACC, its employees and agents will protect all individually identifiable health information they may access or use under this Agreement in accordance with the terms of the HIPAA Business Associate Agreement, which is hereby attached to and made a part of this Agreement, for all purposes, as Exhibit "C".

23. The parties agree that COUNTY shall at all times maintain the right to terminate a student's participation in the program if COUNTY, in its sole discretion, determines that the student's continued participation would be disruptive to the program or the operations of the facility, or would pose a danger.

24. ACC instructors and students shall maintain confidential all records and information concerning patients treated or attended to in COUNTY's facilities. Each ACC instructor and student involved in medical or EMS programs shall be required to sign a confidentiality agreement regarding records and information about patients treated or attended by COUNTY employees.

25. Failure of either party to exercise any right or privilege granted by this Agreement shall not operate to waive such right or privilege in the event of subsequent defaults or assertions of right. Neither party waives nor shall be deemed to have waived any immunity or defense that would otherwise be available to it against claims arising under the performance of this Agreement.

26. The provisions of this Agreement shall be severable in the event any provision is declared invalid, illegal or unenforceable.

27. Either party may terminate this Agreement without cause upon 90 days written notice to the other party. In addition, COUNTY shall have the right to terminate the Agreement immediately in the event the facility becomes inoperable for any reason or COUNTY no longer controls a program.

28. Either Party may terminate this Agreement if the other breaches the Agreement and fails to cure such breach within 15 days of receiving notice of breach. If more than 15 days are required to cure the breach, the Parties may agree to an extension of the cure period in writing.

29. This agreement is effective when all parties have executed it. The term of the Agreement is from August 1, 2015 through December 31, 2017 unless this Agreement is otherwise terminated pursuant to the termination provision contained in Article 27 of this Agreement. All services shall be completed during this term. This Agreement may be reviewed annually by agreement of both parties via written instrument and subject to required approvals. There is no right or expectation of renewal and any renewal will be determined at the discretion of both Parties.

30. Nothing in this Agreement shall be construed to confer third party rights or to constitute a waiver of any governmental immunity of the parties.

31. This Agreement constitutes the entire agreement between the Parties and any prior or contemporaneous agreements, written or oral, are hereby superseded and of no further effect.

32. The laws of the State of Texas shall govern the validity, interpretation and enforcement of this Agreement, and venue for any dispute or cause of action shall be in Williamson County, Texas.

33. The Parties will comply with applicable federal, state and local laws, ordinances and regulations in the performance of this Agreement.

34. The performance of this Agreement shall be undertaken in a manner that does not discriminate against any person on a basis prohibited by law, including but not limited to race, color, national origin, religion, sex, age, veteran status or disability.

35. Notwithstanding any other provision of this Agreement, a COUNTY department may suspend participation in this Agreement due to space needs, staff training needs, budgetary issues or other urgent considerations. In the event of suspension, COUNTY shall give ACC written notification stating the date of suspension and the date on which participation is anticipated to resume.

Williamson County:

Kenny Schnell
WCEMS Director

Date

Austin Community College:

7/10/15

Date

Don Gwynn
Department Chair
Emergency Medical Services Professions
Austin Community College
3401 Webberville Road
Austin, TX 78702

ATTACHMENT A

RELEASE OF LIABILITY

In consideration of the educational benefits extended to me by Williamson County Emergency Medical Services Department in making available its facilities for clinical course instruction as part of ACC course regarding emergency medical service training, I hereby release and hold harmless Williamson County, its employees and agents from any claim, cause of action or injury that may result during my participation in a Williamson County program due to the negligence of Williamson County, its employees or agents.

Student's signature: _____

Printed Name

Date:

ALS EDUCATION AFFILIATION AGREEMENT
FOR
EMERGENCY MEDICAL PRECEPTOR PROGRAM BETWEEN

WILLIAMSON COUNTY EMERGENCY MEDICAL SERVICES
AND
AUSTIN COMMUNITY COLLEGE

This Agreement is between Williamson County Emergency Medical Services (hereinafter referred to as "COUNTY") and Austin Community College EMS Professions Department (hereinafter referred to as "ACC").

RECITALS:

ACC provides courses of study in emergency medical services to students enrolled in its Paramedic program of study.

ACC desires program components that will provide to the students clinical experience as part of their educational instruction.

COUNTY, through its Emergency Medical Services Department, has facilities that can provide a clinical setting for educational instruction and is willing to make available the use of its facilities to ACC for its Emergency Medical Technician program of study.

COUNTY and ACC desire to enter into this Educational Affiliation Agreement in accordance with the terms stated below:

TERMS:

RESPONSIBILITIES OF ACC

1. ACC shall be responsible for the selection of students and their supervised instruction and grading. Students shall have satisfactorily completed curriculum prerequisites for participation in the internships or rotations.

2. ACC instructors shall possess current and appropriate professional credentials or certifications and ACC shall be responsible for the coordination and implementation of the program of study.

3. Services rendered by ACC instructors and students shall be without charge to COUNTY. ACC instructors and students shall not be responsible for the quality of patient or client care.

4. Neither ACC instructors nor students shall be deemed to be COUNTY employees, nor shall they be entitled to any COUNTY benefits, compensation or workers compensation benefits.

5. ACC shall annually provide COUNTY with anticipated enrollments for courses intending to provide clinical internships or experience through this Agreement. The number of students and the schedule of use of COUNTY's facilities shall be subject to annual, mutual approval.

6. ACC shall provide COUNTY with a list of students authorized to participate in the clinical instruction facilitated under this Agreement. ACC shall promptly inform COUNTY in writing of any student withdrawing from the course or otherwise unqualified to continue the internship or clinical experience made available under this Agreement.

7. ACC shall require all instructors and students to abide by all applicable policies, regulations and laws governing the facility or its work environment. ACC shall withdraw authorization for participation under this Agreement for any instructor or student found to have committed a violation of applicable policies, regulations or laws, or determined by COUNTY to be unqualified to continue in the program.

8. During the term of this Agreement, A C C shall maintain a professional liability insurance policy with a limit of liability of not less than $1,000,000 per occurrence and $3,000,000 annual aggregate that covers the activities of ACC'S students, employees and faculty under this Agreement. A C C shall ensure that each current student, employee and faculty member is individually insured under such policy in the above-stated amounts, and shall provide COUNTY with a proof of such insurance coverage each year, and at other times upon request. A C C agrees to require each student to be covered by or to carry accident insurance for injury while enrolled in the program, and to ensure that each employee or faculty member is covered by worker's compensation insurance while participating in the program. No student or faculty member shall be permitted to participate in the program until such insurance coverage has been verified to the satisfaction of COUNTY.

9. ACC agrees to secure a release of liability form from each student and faculty member who will participate in the program in a form acceptable to COUNTY.

RESPONSIBILITIES OF COUNTY

10. COUNTY shall, on a space available basis, the use of designated facilities to provide a clinical education to participating students. COUNTY agrees to provide evaluations for student course-work done on forms provided by ACC.

11. COUNTY shall provide an orientation session to inform students and ACC staff about the rules, regulations, policies and procedures of the facilities.

12. COUNTY agrees to provide, on a space-available basis, the use of conference rooms, classrooms, lounges and lockers to the instructors and the students.

13. COUNTY shall notify ACC of any change of any accreditation or status concerning a facility and affecting internship or course requirements for clinical experience at an ACC credited facility. Representatives of ACC crediting agency for ACC shall be permitted to conduct inspections for purposes relating to ACC'S accreditation.

14. COUNTY shall cooperate with ACC in matters relating to academic performance and student conduct relating to course work performed under this Agreement.

15. Unless prohibited or restricted by law, COUNTY shall timely notify an instructor or student of any instance in which a facility employee has been exposed to blood-borne or airborne pathogens and the student or instructor may have been exposed in the same instance. Notification shall be provided in a time frame sufficient to allow the student or faculty member to seek appropriate treatment for potential exposure.

16. COUNTY shall obtain and maintain all licenses required for its participating facilities and shall assure that COUNTY personnel are appropriately licensed.

17. In the event emergency care is required for an ACC student or faculty member, it shall be provided in the same manner that emergency care is provided to COUNTY employees and the general public. Emergency care provided by COUNTY shall be at the expense of the student or faculty member.

MUTUAL RESPONSIBILITIES

18. The Parties agree to designate a liaison for each program to do the following:

A Meet annually, or more often as needed, to schedule use of the facilities;

B. Meet on a per semester basis to set the number of students allowed to participate;

C. Design and approve curriculum assignments as they *affect* the operation of the facility and as affected by ACC crediting standards;

D. Meet to review protocols, policies and rules and regulations concerning the operation of the facility and its use under this Agreement;

E. Meet annually to evaluate changes or amendments to this Agreement or the performance of the Agreement.

19. In the event any claim or demand is made on one of the Parties for actions relating or authorized by this Agreement, the other party shall be notified of such claim or demand in writing within five business (Monday-Friday) days. COUNTY shall not be liable for any claims, damages or attorney's fees arising from the negligent acts or omissions of ACC, its employees, agents or students under this Agreement. ACC shall not be liable for any claims, damages or attorney's fees arising from the negligent acts or omissions of COUNTY or its employees under this Agreement.

20. Notices shall be in writing and shall be effective when received. Notices shall be delivered in person or by certified mail, return receipt requested, to the following addresses:

Kenny Schnell
WCEMS Director
PO Box 873
Georgetown, TX 7827
512-943-1264

And

Don Gwynn
Department Chair
Austin Community
College
Emergency
Medical Services
Professions
3401 Webberville
Road
Austin, TX 78702

ADDITIONAL TERMS

21. Compensation benefits for this Agreement shall include $1.75/hour per ALS student to be paid by ACC to the COUNTY. Compensation shall be paid to COUNTY within thirty (30) days from the date of the COUNTY'S invoice for payment.

22. ACC acknowledges that COUNTY is a hybrid entity under the privacy regulations of the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA Privacy Rule"). COUNTY has designated its Emergency Medical Services Department as a health care component, as defined in HIPAA, and the Department is therefore required to comply with the HIPAA Privacy Rule. This compliance includes obtaining written contractual assurances from ACC that ACC, its employees and agents will protect all individually identifiable health information they may access or use under this Agreement in accordance with the terms of the HIPAA Business Associate Agreement, which is hereby attached to and made a part of this Agreement, for all purposes, as Exhibit "C".

23. The parties agree that COUNTY shall at all times maintain the right to terminate a student's participation in the program if COUNTY, in its sole discretion, determines that the student's continued participation would be disruptive to the program or the operations of the facility, or would pose a danger.

24. ACC instructors and students shall maintain confidential all records and information concerning patients treated or attended to in COUNTY's facilities. Each ACC instructor and student involved in medical or EMS programs shall be required to sign a confidentiality agreement regarding records and information about patients treated or attended by COUNTY employees.

25. Failure of either party to exercise any right or privilege granted by this Agreement shall not operate to waive such right or privilege in the event of subsequent defaults or assertions of right. Neither party waives nor shall be deemed to have waived any immunity or defense that would otherwise be available to it against claims arising under the performance of this Agreement.

26. The provisions of this Agreement shall be severable in the event any provision is declared invalid, illegal or unenforceable.

27. Either party may terminate this Agreement without cause upon 90 days written notice to the other party. In addition, COUNTY shall have the right to terminate the Agreement immediately in the event the facility becomes inoperable for any reason or COUNTY no longer controls a program.

28. Either Party may terminate this Agreement if the other breaches the Agreement and fails to cure such breach within 15 days of receiving notice of breach. If more than 15 days are required to cure the breach, the Parties may agree to an extension of the cure period in writing.

29. This agreement is effective when all parties have executed it. The term of the Agreement is from August 1, 2015 through December 31, 2017 unless this Agreement is otherwise terminated pursuant to the termination provision contained in Article 27 of this Agreement. All services shall be completed during this term. This Agreement may be reviewed annually by agreement of both parties via written instrument and subject to required approvals. There is no right or expectation of renewal and any renewal will be determined at the discretion of both Parties.

30. Nothing in this Agreement shall be construed to confer third party rights or to constitute a waiver of any governmental immunity of the parties.

31. This Agreement constitutes the entire agreement between the Parties and any prior or contemporaneous agreements, written or oral, are hereby superseded and of no further effect.

32. The laws of the State of Texas shall govern the validity, interpretation and enforcement of this Agreement, and venue for any dispute or cause of action shall be in Williamson County, Texas.

33. The Parties will comply with applicable federal, state and local laws, ordinances and regulations in the performance of this Agreement.

34. The performance of this Agreement shall be undertaken in a manner that does not discriminate against any person on a basis prohibited by law, including but not limited to race, color, national origin, religion, sex, age, veteran status or disability.

35. Notwithstanding any other provision of this Agreement, a COUNTY department may suspend participation in this Agreement due to space needs, staff training needs, budgetary issues or other urgent considerations. In the event of suspension, COUNTY shall give ACC written notification stating the date of suspension and the date on which participation is anticipated to resume.

Williamson County:

Kenny Schnell
WCEMS Director

Date

Austin Community College:

7/10/15

Don Gwynn
Department Chair
Emergency Medical Services Professions
Austin Community College
3401 Webberville Road
Austin, TX 78702

Date

ATTACHMENT A

RELEASE OF LIABILITY

In consideration of the educational benefits extended to me by Williamson County Emergency Medical Services Department in making available its facilities for clinical course instruction as part of ACC course regarding emergency medical service training, I hereby release and hold harmless Williamson County, its employees and agents from any claim, cause of action or injury that may result during my participation in a Williamson County program due to the negligence of Williamson County, its employees or agents.

Student's signature: _____

Printed Name

Date:

EDUCATION AFFILIATION AGREEMENT

Agreement No. **EA-16011**

THIS AGREEMENT, made and entered into as of the date set forth on the signature page below, by and between Laramie County Community College (*hereinafter referred to as LCCC*), whose address is 1400 East College Drive, Cheyenne WY, 82007, and Williamson County EMS, acting by and through Williamson County, a political subdivision of the State of Texas (*hereinafter referred to as Provider*) whose address is PO Box 873, Georgetown, TX 78627.

W I T N E S S E T H:

WHEREAS, LCCC desires to obtain and Provider represents and warrants that it has the skill and expertise to provide certain services, the scope of which is more fully described herein;

WHEREAS, LCCC has an established emergency medical technician program and offers to its enrolled students a degree in the field of emergency medical services;

WHEREAS, Provider operates healthcare facilities in proximity to LCCC that are suitable for educational need and are a mutual benefit to both Parties and the community;

WHEREAS, LCCC desires to provide to its students a hands-on education and clinical learning experience through the application of knowledge and skills in actual patient-centered situations and facilities; and,

WHEREAS, Provider has agreed and is willing to provide such facilities, and is uniquely qualified to provide such services;

NOW, THEREFORE, The Parties mutually agree to cooperate in the arrangement for the students to acquire clinical experience in the observation and/or performance of patient upon terms and conditions set forth herein:

I. DEFINITIONS

A. "Clinical Experience" means a program of study as part of LCCC's course or degree requirements, conducted in cooperation with the Provider, whereby students receive supervised experience and instruction in a professional setting under the direct supervision of a qualified clinical instructor. Clinical Experience shall be the same as clinical training.

B. "Site Supervisor" means that person qualified, employed or retained by the Provider as responsible for the development and administration of the Clinical Experience affiliation with LCCC, jointly approved by both parties.

C. "Student" means a person enrolled through LCCC and who is to perform the Clinical Experience and registered in the appropriate certification or degreed program.

D. "LCCC Supervisor" means the person employed by LCCC to serve at a qualified clinical facility and is responsible for the development and administration of this Clinical affiliation with the Provider. Said supervisor shall be jointly approved by both parties.

E. "Program" means the course of academic requirements necessary to obtain the appropriate certification or degree.

F. "Program Participant" means a student, staff, faculty or support personnel related to Program.

II. AGREEMENT DOCUMENTS

The Agreement documents consist of the Agreement between LCCC and Provider (*hereinafter the Agreement*), all attachments, exhibits or other documents hereby incorporated by reference and made a part of this Agreement. Unless specifically identified in the Agreement, the Agreement documents do not include any other documents not described herein, any conversations, other memoranda, or other matter between the parties relating to the subject of this Agreement, oral or written. The Parties agree to comply with the Agreement Documents.

III. TERMS OF AGREEMENT

This agreement is effective when all parties have executed it per Agreement Article XIV. The term of this Agreement is from the date of the last signature and shall automatically renew for successive one (1) year terms unless this Agreement is otherwise terminated pursuant to the termination provision contained in Article XI of this Agreement. All services shall be completed during this term. This Agreement may be reviewed annually by agreement of both parties via written instrument and subject to required approvals. There is no right or expectation of renewal and any renewal will be determined at the discretion of both Parties.

IV. REPRESENTATIONS AND RESPONSIBILITIES OF LCCC

LCCC shall be responsible for the implementation and operation of the clinical component of its program at the designated facility, which Program shall be pre-approved by Provider. Specific responsibilities shall include, but not be limited to:

A. Provide, implement and maintain the respective program related to the student experience including: (i) establish & evaluate classroom theory and practical instruction; (ii) coordinate placement, assignment and rotation of students; (iii) administer training, education and other information for the students; (iv) provide students with a grade and appropriate credit hours for completing clinical training; (v) maintain ultimate control over academic aspects of clinical experience; and,

B. Performance of such other duties as may from time to time be agreed to via written instrument between LCCC and Provider; and,

C. Require each student to sign a "Confidentiality Statement" (*Exhibit "A"*) and a "Statement of Responsibility" (*Exhibit "B"*).

D. Maintain sole responsibility for developing and maintaining the educational curriculum, establishing objectives and standards of clinical training experiences, offering programs eligible for accreditation, and all other matters pertaining to acquiring the educational goals and needs of LCCC.

E. Provide (*upon request*) documentation of measles and rubella titer showing immunity or record of MMR vaccine less than ten (10) years old, Hepatitis B vaccine series, a signed declaration statement, or Anti-HBs or HbsAB and PPD (mantoux) less than twelve (12) months old, or an annual Tuberculosis questionnaire.

F. Inform Program Participants of their responsibility to provide any transportation, meals and lodging related to the Clinical Experience.

G. Advise faculty and students assigned to Provider's facilities of their responsibility for complying with the policies, rules and regulations of Provider.

H. Provide general comprehensive liability insurance in the amount of $1,000,000 covering bodily injury and property damage liability with a professional liability endorsement which includes "malpractice" coverage for faculty and students of LCCC while students are involved with Provider. The required insurance shall not be canceled, limited in scope or coverage, or non-renewed until after thirty (30) days prior written notice, or ten (10) days for non-payment of premium, has been given to the Provider.

LCCC acknowledges that LCCC's insurance shall be deemed primary with respect to any insurance or self insurance, if any, carried by Provider for liability arising out of operations under this Agreement. The Provider, it officials, directors, employees, representatives, and volunteers shall be added as additional insured as respects operations and activities of, or on behalf of the named insured performed under this Agreement. In addition, LCCC will provide, if required by applicable State law, Workman's Compensation as required by the respective State law for faculty and students participating in the program.

I. Shall agree to conduct a background investigation for its faculty and students participating in the respective Program in a similar manner and in accordance with the policies required of Provider employees. The background check shall include a criminal background check that complies with the federal and state laws and regulations and Provider policy to ensure individuals are suitable for a patient care environment.

J. Shall agree to require Program Participants to undergo "for cause" drug screening in a similar manner and under policies similar to those affecting employees of the Provider.

V. REPRESENTATIONS AND RESPONSIBILITIES OF PROVIDER

A. Shall provide professional instruction for appropriate training and clinical experiences at approved and designated facilities.

B. Shall provide and/or pay for necessary physical facilities, clinical equipment, materials, supplies, or other expenses reasonably necessary to provide this clinical service in accordance with affiliation objectives(*unless otherwise specified*).

C. Shall provide each student with access to a planned program of hands-on experience, consistent with the educational and accreditation objectives per the respective program established by LCCC.

D. Shall provide a designated staff member by respective department to serve as a liaison with respective LCCC program to observe and assist with various aspects of patient care.

E. To the extent Provider deems necessary, Provider shall provide general comprehensive liability insurance in the amount of $1,000,000 covering bodily injury and property damage liability including a professional liability endorsement which includes "malpractice" and other relevant coverage for its officers, agents, volunteers, employees and representatives.

F. Will provide all assigned students with an orientation to Provider's facilities, rules and regulations, confidentiality laws, and procedures with regard to patient and medical records.

G. Provider may immediately remove from the designated facility premises any student(s) who pose an immediate threat or danger to personnel or to the quality of medical services or for unprofessional behavior. Such removal shall be documented via written instrument and be forwarded to LCCC for review.

H. Shall maintain ultimate responsibility for patient care and treatment, and for the safety, health and welfare of Provider's patients.

VI. MUTUAL REPRESENTATION AND RESPONSIBILITIES

The Parties shall cooperate to fulfill the following mutual representations and responsibilities:

A. Students shall be treated as trainees who have no expectation of receiving compensation or future employment from Provider or its designated facility.

B. Any courtesy appointments to faculty or staff by either Provider or LCCC or a designated facility shall be without entitlement of the individual to compensation or benefits for the appointed party.

C. Reserves the right to withdraw from the Clinical Program any student whose health (*given reasonable accommodation*) or performance is a detriment to patient well-being or to the achievement of the stated objectives of the respective Program and complies with applicable due process per respective Program discipline.

D. Affirms that they have an Exposure Plan Protocol which meets OSHA requirements for an infection control program.

E. Will establish the education objectives for the affiliation, devise methods for their implementation, and evaluate their effectiveness.

F. Will not unlawfully discriminate against any employee, applicant, or student enrolled in their respective program because of race, color, creed, religion, age, handicap, sex, ancestry, veteran's status or national origin.

VII. COMPENSATION

Compensation benefits for this Agreement shall include $1.75 per hour per student to be paid by LCCC to Provider. Compensation shall be paid to Provider within thirty (30) days from the date of Provider's invoice for payment.

VIII. REPRESENTATIVES

All notices, communications, correspondence and transmittals regarding this Agreement shall be done so via written instrument to the below designated Agreement representatives.

LCCC's representative for commercial and contractual matters is Jamie Spezzano, (307) 778-1280, 1400 East College Drive, Cheyenne WY 82007 or jspezzano@lccc.wy.edu

LCCC's program representative is Patrick Currie, (307) 778-1149, 1400 East College Drive, Cheyenne WY 82007.

Provider's representative for this Agreement is Kenny Schnell (512) 943-1264, whose address is PO Box 873, Georgetown TX 78627.

IX. OTHER PROVISIONS

This Agreement shall include additional provisions as applicable to the specific scope of services and/or work.

A. **Amendments**: Any changes, modifications, revisions, or amendments to this Agreement which are mutually agreed upon by the Parties to this Agreement shall be incorporated by written instrument, executed and signed by all Parties to this Agreement.

B. **Americans with Disabilities Act**: The Provider shall not discriminate against a qualified individual with a disability and shall comply with the Americans with Disabilities Act, P.L. 101-336, 42 U.S.C. 12101 *et seq.*, and any properly promulgated rules. There shall be no discrimination on the basis of race, national origin, religion, creed, sex, age, veteran status or handicap in either the selection of students for participation in the Program, or as to any respect of the clinical training, provided however, that with respect to the handicap, the handicap must not be such as would, even with reasonable accommodation, in and of itself preclude the student's effective participation in the Program. LCCC assures that, at all times during the performance of any resulting contract, no qualified individual with a disability shall, by reason of that disability, be excluded from participation in, or be denied benefits of, services, programs, or activities performed by LCCC for the benefit of the Provider.

C. **Applicable Law/Venue**: The construction, interpretation and enforcement of this Agreement shall be governed by the laws of the state of Texas. The Courts of the state of

Texas shall have jurisdiction over this Agreement and the parties, and the Venue shall lie exclusively in either Williamson County, Texas or in the Austin Division of the Western Federal District of Texas.

D. **Compliance of Law**: The Provider and LCCC shall keep informed of and comply with all applicable federal, state and local laws and regulations in the performance of this Agreement.

E. **Confidentiality**: Each party and its employees and agents shall keep confidential all knowledge, information and documents entrusted to its care by the other party. Neither party nor any of its employees or agents shall disclose any knowledge, information or documents entrusted to it or them by the other party to any person, firm or corporation other than the person, firm or corporation designated by the other party. Knowledge, information and documents entrusted by each party to the other party may include, but are not limited to, the names of vendors and the terms and conditions (*including financial information*) with vendors, the names of patients and the terms and conditions (*including financial information*) of agreements with, or for the benefit of, patients, medical records and information, trade secrets, proprietary information, non public information, clinical, marketing, personnel and administrative policies, procedures, manuals and reports, written agreements, contracts, including this Agreement, and other assets of either party.

To the extent, if any, that any provision in this Agreement 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 Provider, 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 Provider as to whether or not the same are available to the public. It is further understood that Provider's officers and employees shall have the right to rely on the advice, decisions and opinions of the Attorney General, and that Provider, 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 Provider by a party hereto, in reliance of any advice, decision or opinion of the Attorney General of the State of Texas.

F. **Force Majeure**: Neither party shall be liable for failure to perform under this Agreement if such failure to perform arises out of causes beyond the control and without the fault or negligence of the nonperforming Party. Such causes may include, but are not limited to, acts of God or the public enemy, fires, floods, epidemics, quarantine restrictions, freight embargoes, and unusually severe weather. This provision shall become effective only if the Party failing to perform immediately notifies the other Party of the extent and nature of the problem, limits delay in performance to that required by the event, and takes all reasonable steps to minimize delays. This provision shall not be effective unless the failure to perform is beyond the control and without the fault or negligence of the nonperforming Party.

G. **Indemnification:**

1. LCCC WILL DEFEND, INDEMNIFY AND HOLD HARMLESS PROVIDER, ITS OFFICERS, AGENTS, VOLUNTEERS, EMPLOYEES AND REPRESENTATIVES, FROM AND AGAINST ANY AND ALL CLAIMS FOR LOSS AND DAMAGE TO PROPERTY OR INJURY OR DEATH TO PERSONS, INCLUDING COSTS, EXPENSES AND REASONABLE ATTORNEY'S FEES, ARISING FROM THE ACTS OR OMISSIONS OF LCCC, ITS FACULTY OR STUDENTS. LCCC SHALL BE LIABLE UNDER THE PROVISIONS OF THIS PARAGRAPH FOR SUCH OBLIGATION, COSTS OR EXPENSES ONLY TO THE EXTENT THAT SUCH ACT OR OMISSION IS CAUSED BY THE FACULTY OR STUDENTS OF LCCC.

2. TO THE EXTENT ALLOWED BY TEXAS LAW, PROVIDER WILL DEFEND, INDEMNIFY AND HOLD HARMLESS LCCC, ITS OFFICERS, AGENTS, VOLUNTEERS, EMPLOYEES AND REPRESENTATIVES, FROM AND AGAINST ANY AND ALL CLAIMS FOR LOSS AND DAMAGE TO PROPERTY OR INJURY OR DEATH TO PERSONS, INCLUDING COSTS, EXPENSES AND REASONABLE ATTORNEY'S FEES, ARISING FROM THE ACTS OR OMISSIONS OF PROVIDER. TO THE EXTENT AUTHORIZED BY TEXAS LAW, PROVIDER SHALL BE LIABLE UNDER THE PROVISIONS OF THIS PARAGRAPH FOR SUCH OBLIGATION, COSTS OR EXPENSES ONLY TO THE EXTENT THAT SUCH ACT OR OMISSION IS CAUSED BY PROVIDER.

H. **Non-Exclusive Agreement**: This Agreement is not exclusive. Accordingly, either party shall have the right to enter into one or more agreements relating to the same or similar matters as are covered by this certain Agreement, and execution by either party of such agreements shall not constitute a breach of this Agreement.

I. **Proof of Insurance**: Neither the Provider nor LCCC shall commence the services under this Agreement until LCCC has provided a "Certificate of Liability Insurance Certificate" document. Proof of required insurance must be submitted via written certificate and submitted to Agreement representatives.

J. **Severability:** If any provision of this Agreement is held to be invalid or unenforceable for any reason, this Agreement shall remain in full force and effect in accordance with its' terms disregarding such unenforceable or invalid provision.

K. **Sovereign Immunity**: Neither party waives sovereign immunity by entering into this Agreement and specifically retains all immunity and all defenses available to it as a sovereign pursuant to applicable Wyoming Statutes and all other Wyoming law and Texas law.

X. ASSIGNMENT; SUCCESSORS AND ASSIGNS

Neither this Agreement nor any of the rights and obligations of either party shall be assigned or transferred in whole or in part without the prior written consent of the other party. This Agreement shall be binding upon and inure to the benefit of parties hereto and their respective successors and assigns.

XI. TERMINATION

A. **Term.** This Agreement shall commence upon the day and date last signed and executed by the duly authorized representatives of the parties to this Agreement and shall remain in full force and effect until terminated. This Agreement may be terminated upon six (6) month's written notice of either party, but not unreasonably terminated during an academic terms so that students presently enrolled will be allowed to complete the educational requirements of the respective program.

B. **For Convenience.** If for any other reason either party desires to terminate this Agreement for convenience and upon the condition that such Party is not in breach of any of the terms and conditions of this Agreement at such time, it may terminate this Agreement for convenience upon one-hundred eighty (180) calendar day advance written notice to the other Party. Upon receipt of such notice, Provider will immediately discontinue specific services and subsequent financial obligations.

C. **Termination Compensation.** In the event of a termination for convenience, it is understood and agreed that only the amounts due for services provided and expenses incurred to and including the date of termination, will be due and payable. No penalty will be assessed for either Party's termination of this Agreement for convenience.

D. **Termination Notices.** It is agreed that any and all termination notices by both Parties shall be transmitted via signed written instrument, and shall be deemed given upon the mailing thereof, postage prepaid, by certified or registered mail, return receipt requested, addressed to the other party at the address set forth in Agreement Article VIII, or at such other address as either Party shall designate to the other Party in writing hereafter.

XII. ENTIRE AGREEMENT

This Agreement sets forth the entire agreement between the parties with respect to the subject matter hereof and shall govern the respective duties and obligations of the parties. This Agreement and all incorporated documents by reference contain the entire understanding of the Parties with respect to the subject matter hereof and supersedes all prior agreements, oral or written, and all other communications between the Parties relating to such subject matter.

XIII. RELATIONSHIP OF THE PARTIES

Each Party to this Agreement, in the performance of this Agreement, shall act in an individual capacity and not as agents, employees, partners, joint ventures, students or associates of one another. The employees, students or agents of one party shall not be deemed or construed to be the employees, students or agents of the other party for any purposes whatsoever.

XIV. AGREEMENT ATTACHMENTS AND EXHIBITS

The following Attachments and Exhibits are incorporated herein by reference and attached hereto and shall become a part of this Agreement for all purposes:

Exhibit "A"	Student Confidentiality Statement and Student Statement of Responsibility

XIV. SIGNATURES

IN WITNESS WHEREOF, the parties hereto have executed this Agreement in triplicate as of the date written below.

Williamson County EMS
Provider Name

By: _____
Signature

Name: _____
Printed Name

Title: _____

Date: _____

Laramie County Community College
LCCC

By: _____
Signature

Name: Dr. Joe Schaffer
Printed Name

Title: College President

Date: 7/27/15

BLS EDUCATION AFFILIATION AGREEMENT
FOR
EMERGENCY MEDICAL PRECEPTOR PROGRAM BETWEEN

WILLIAMSON COUNTY EMERGENCY MEDICAL SERVICES
AND
EMERGENCY MANAGEMENT TRAINING AND SERVICES

This Agreement is between Williamson County Emergency Medical Services (hereinafter referred to as "COUNTY") and Emergency Management Training and Services (hereinafter referred to as "EMTS").

RECITALS:

EMTS provides courses of study in emergency medical services to students enrolled in its Emergency Medical Technician-Basic program of study.

EMTS desires program components that will provide to the students clinical experience as part of their educational instruction.

COUNTY, through its Emergency Medical Services Department, has facilities that can provide a clinical setting for educational instruction and is willing to make available the use of its facilities to EMTS for its Emergency Medical Technician program of study.

COUNTY and EMTS desire to enter into this Educational Affiliation Agreement in accordance with the terms stated below:

TERMS:

RESPONSIBILITIES OF EMTS

1. EMTS shall be responsible for the selection of students and their supervised instruction and grading. Students shall have satisfactorily completed curriculum prerequisites for participation in the internships or rotations.

2. EMTS instructors shall possess current and appropriate professional credentials or certifications and EMTS shall be responsible for the coordination and implementation of the program of study.

3. Services rendered by EMTS instructors and students shall be without charge to COUNTY. EMTS instructors and students shall not be responsible for the quality of patient or client care.

4. Neither EMTS instructors nor students shall be deemed to be COUNTY employees, nor shall they be entitled to any COUNTY benefits, compensation or workers compensation benefits.

5. EMTS shall annually provide COUNTY with anticipated enrollments for courses intending to provide clinical internships or experience through this Agreement. The number of students and the schedule of use of COUNTY's facilities shall be subject to annual, mutual approval.

6. EMTS shall provide COUNTY with a list of students authorized to participate in the clinical instruction facilitated under this Agreement. EMTS shall promptly inform COUNTY in writing of any student withdrawing from the course or otherwise unqualified to continue the internship or clinical experience made available under this Agreement.

7. EMTS shall require all instructors and students to abide by all applicable policies, regulations and laws governing the facility or its work environment. EMTS shall withdraw authorization for participation under this Agreement for any instructor or student found to have committed a violation of applicable policies, regulations or laws, or determined by COUNTY to be unqualified to continue in the program.

8. During the term of this Agreement, EMTS shall maintain a professional liability insurance policy with a limit of liability of not less than $1,000,000 per occurrence and $3,000,000 annual aggregate that covers the activities of EMTS'S students, employees and faculty under this Agreement. EMTS shall ensure that each current student, employee and faculty member is individually insured under such policy in the above-stated amounts, and shall provide COUNTY with a proof of such insurance coverage each year, and at other times upon request. EMTS agrees to require each student to be covered by or to carry accident insurance for injury while enrolled in the program, and to ensure that each employee or faculty member is covered by worker's compensation insurance while participating in the program. No student or faculty member shall be permitted to participate in the program until such insurance coverage has been verified to the satisfaction of COUNTY.

9. EMTS agrees to secure a release of liability form from each student and faculty member who will participate in the program in a form acceptable to COUNTY.

RESPONSIBILITIES OF COUNTY

10. COUNTY shall, on a space available basis, the use of designated facilities to provide a clinical education to participating students. COUNTY agrees to provide evaluations for student course-work done on forms provided by EMTS.

11. COUNTY shall provide an orientation session to inform students and EMTS staff about the rules, regulations, policies and procedures of the facilities.

12. COUNTY agrees to provide, on a space-available basis, the use of conference rooms, classrooms, lounges and lockers to the instructors and the students.

13. COUNTY shall notify EMTS of any change of any accreditation or status concerning a facility and affecting internship or course requirements for clinical experience at an EMTS credited facility. Representatives of EMTS crediting agency for EMTS shall be permitted to conduct inspections for purposes relating to EMTS'S accreditation.

14. COUNTY shall cooperate with EMTS in matters relating to academic performance and student conduct relating to course work performed under this Agreement.

15. Unless prohibited or restricted by law, COUNTY shall timely notify an instructor or student of any instance in which a facility employee has been exposed to blood-borne or airborne pathogens and the student or instructor may have been exposed in the same instance. Notification shall be provided in a time frame sufficient to allow the student or faculty member to seek appropriate treatment for potential exposure.

16. COUNTY shall obtain and maintain all licenses required for its participating facilities and shall assure that COUNTY personnel are appropriately licensed.

17. In the event emergency care is required for an EMTS student or faculty member, it shall be provided in the same manner that emergency care is provided to COUNTY employees and the general public. Emergency care provided by COUNTY shall be at the expense of the student or faculty member.

MUTUAL RESPONSIBILITIES

18. The Parties agree to designate a liaison for each program to do the following:

A Meet annually, or more often as needed, to schedule use of the facilities;

B. Meet on a per semester basis to set the number of students allowed to participate;

C. Design and approve curriculum assignments as they *affect* the operation of the facility and as affected by EMTS crediting standards;

D. Meet to review protocols, policies and rules and regulations concerning the operation of the facility and its use under this Agreement;

E. Meet annually to evaluate changes or amendments to this Agreement or the performance of the Agreement.

19. In the event any claim or demand is made on one of the Parties for actions relating or authorized by this Agreement, the other party shall be notified of such claim or demand in writing within five business (Monday-Friday) days. COUNTY shall not be liable for any claims, damages or attorney's fees arising from the negligent acts or omissions of EMTS, its employees, agents or students under this Agreement. EMTS shall not be liable for any claims, damages or attorney's fees arising from the negligent acts or omissions of COUNTY or its employees under this Agreement.

20. Notices shall be in writing and shall be effective when received. Notices shall be delivered in person or by certified mail, return receipt requested, to the following addresses:

Kenny Schnell
WCEMS Director
PO Box 873
Georgetown, TX 7827
512-943-1264

And

Matt Nealand
Emergency
Management
Training and
Services
16238 RR 620 N
Suite F-185
Austin, TX 78717

ADDITIONAL TERMS

21. Compensation benefits for this Agreement shall include $40.00 total per EMT student to be paid by EMTS to the COUNTY. Compensation shall be paid to COUNTY within thirty (30) days from the date of the COUNTY'S invoice for payment.

22. EMTS acknowledges that COUNTY is a hybrid entity under the privacy regulations of the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA Privacy Rule"). COUNTY has designated its Emergency Medical Services Department as a health care component, as defined in HIPAA, and the Department is therefore required to comply with the HIPAA Privacy Rule. This compliance includes obtaining written contractual assurances from EMTS that EMTS, its employees and agents will protect all individually identifiable health information they may access or use under this Agreement in accordance with the terms of the HIPAA Business Associate Agreement, which is hereby attached to and made a part of this Agreement, for all purposes, as Exhibit "C".

23. The parties agree that COUNTY shall at all times maintain the right to terminate a student's participation in the program if COUNTY, in its sole discretion, determines that the student's continued participation would be disruptive to the program or the operations of the facility, or would pose a danger.

24. EMTS instructors and students shall maintain confidential all records and information concerning patients treated or attended to in COUNTY's facilities. Each EMTS instructor and student involved in medical or EMS programs shall be required to sign a confidentiality agreement regarding records and information about patients treated or attended by COUNTY employees.

25. Failure of either party to exercise any right or privilege granted by this Agreement shall not operate to waive such right or privilege in the event of subsequent defaults or assertions of right. Neither party waives nor shall be deemed to have waived any immunity or defense that would otherwise be available to it against claims arising under the performance of this Agreement.

26. The provisions of this Agreement shall be severable in the event any provision is declared invalid, illegal or unenforceable.

27. Either party may terminate this Agreement without cause upon 90 days written notice to the other party. In addition, COUNTY shall have the right to terminate the Agreement immediately in the event the facility becomes inoperable for any reason or COUNTY no longer controls a program.

28. Either Party may terminate this Agreement if the other breaches the Agreement and fails to cure such breach within 15 days of receiving notice of breach. If more than 15 days are required to cure the breach, the Parties may agree to an extension of the cure period in writing.

29. This agreement is effective when all parties have executed it. The term of the Agreement is from January 1, 2015 through December 31, 2016 unless this Agreement is otherwise terminated pursuant to the termination provision contained in Article 27 of this Agreement. All services shall be completed during this term. This Agreement may be reviewed annually by agreement of both parties via written instrument and subject to required approvals. There is no right or expectation of renewal and any renewal will be determined at the discretion of both Parties.

30. Nothing in this Agreement shall be construed to confer third party rights or to constitute a waiver of any governmental immunity of the parties.

31. This Agreement constitutes the entire agreement between the Parties and any prior or contemporaneous agreements, written or oral, are hereby superseded and of no further effect.

32. The laws of the State of Texas shall govern the validity, interpretation and enforcement of this Agreement, and venue for any dispute or cause of action shall be in Williamson County, Texas.

33. The Parties will comply with applicable federal, state and local laws, ordinances and regulations in the performance of this Agreement.

34. The performance of this Agreement shall be undertaken in a manner that does not discriminate against any person on a basis prohibited by law, including but not limited to race, color, national origin, religion, sex, age, veteran status or disability.

35. Notwithstanding any other prov1s1on of this Agreement, a COUNTY department may suspend participation in this Agreement due to space needs, staff training needs, budgetary issues or other urgent considerations. In the event of suspension, COUNTY shall give EMTS written notification stating the date of suspension and the date on which participation is anticipated to resume.

Williamson County:

Kenny Schnell
WCEMS Director

Date

Emergency Management Training and Services:

Matt Nealand

6/24/15
Date

Matt Nealand
Program Director
Emergency Management Training and Services
16238 RR 620 N
Suite #F-185
Austin, Texas 78717

ATTACHMENT A

RELEASE OF LIABILITY

In consideration of the educational benefits extended to me by Williamson County Emergency Medical Services Department in making available its facilities for clinical course instruction as part of EMTS course regarding emergency medical service training, I hereby release and hold harmless Williamson County, its employees and agents from any claim, cause of action or injury that may result during my participation in a Williamson County program due to the negligence of Williamson County, its employees or agents.

Student's signature: _____

Printed Name

Date:

ALS EDUCATION AFFILIATION AGREEMENT
FOR
EMERGENCY MEDICAL PRECEPTOR PROGRAM BETWEEN

WILLIAMSON COUNTY EMERGENCY MEDICAL SERVICES
AND
EMERGENCY MANAGEMENT TRAINING AND SERVICES

This Agreement is between Williamson County Emergency Medical Services (hereinafter referred to as "COUNTY") and EMTS Academy and St. David's Round Rock Medical Center Paramedic Program Consortium (hereinafter referred to as "EMTS").

RECITALS:

EMTS provides courses of study in emergency medical services to students enrolled in its Paramedic program of study.

EMTS desires program components that will provide to the students clinical experience as part of their educational instruction.

COUNTY, through its Emergency Medical Services Department, has facilities that can provide a clinical setting for educational instruction and is willing to make available the use of its facilities to EMTS for its Emergency Medical Technician program of study.

COUNTY and EMTS desire to enter into this Educational Affiliation Agreement in accordance with the terms stated below:

TERMS:

RESPONSIBILITIES OF EMTS

1. EMTS shall be responsible for the selection of students and their supervised instruction and grading. Students shall have satisfactorily completed curriculum prerequisites for participation in the internships or rotations.

2. EMTS instructors shall possess current and appropriate professional credentials or certifications and EMTS shall be responsible for the coordination and implementation of the program of study.

3. Services rendered by EMTS instructors and students shall be without charge to COUNTY. EMTS instructors and students shall not be responsible for the quality of patient or client care.

4. Neither EMTS instructors nor students shall be deemed to be COUNTY employees, nor shall they be entitled to any COUNTY benefits, compensation or workers compensation benefits.

5. EMTS shall annually provide COUNTY with anticipated enrollments for courses intending to provide clinical internships or experience through this Agreement. The number of students and the schedule of use of COUNTY's facilities shall be subject to annual, mutual approval.

6. EMTS shall provide COUNTY with a list of students authorized to participate in the clinical instruction facilitated under this Agreement. EMTS shall promptly inform COUNTY in writing of any student withdrawing from the course or otherwise unqualified to continue the internship or clinical experience made available under this Agreement.

7. EMTS shall require all instructors and students to abide by all applicable policies, regulations and laws governing the facility or its work environment. EMTS shall withdraw authorization for participation under this Agreement for any instructor or student found to have committed a violation of applicable policies, regulations or laws, or determined by COUNTY to be unqualified to continue in the program.

8. During the term of this Agreement, EMTS shall maintain a professional liability insurance policy with a limit of liability of not less than $1,000,000 per occurrence and $3,000,000 annual aggregate that covers the activities of EMTS'S students, employees and faculty under this Agreement. EMTS shall ensure that each current student, employee and faculty member is individually insured under such policy in the above-stated amounts, and shall provide COUNTY with a proof of such insurance coverage each year, and at other times upon request. EMTS agrees to require each student to be covered by or to carry accident insurance for injury while enrolled in the program, and to ensure that each employee or faculty member is covered by worker's compensation insurance while participating in the program. No student or faculty member shall be permitted to participate in the program until such insurance coverage has been verified to the satisfaction of COUNTY.

9. EMTS agrees to secure a release of liability form from each student and faculty member who will participate in the program in a form acceptable to COUNTY.

RESPONSIBILITIES OF COUNTY

10. COUNTY shall, on a space available basis, the use of designated facilities to provide a clinical education to participating students. COUNTY agrees to provide evaluations for student course-work done on forms provided by EMTS.

11. COUNTY shall provide an orientation session to inform students and EMTS staff about the rules, regulations, policies and procedures of the facilities.

12. COUNTY agrees to provide, on a space-available basis, the use of conference rooms, classrooms, lounges and lockers to the instructors and the students.

13. COUNTY shall notify EMTS of any change of any accreditation or status concerning a facility and affecting internship or course requirements for clinical experience at an EMTS credited facility. Representatives of EMTS crediting agency for EMTS shall be permitted to conduct inspections for purposes relating to EMTS's accreditation.

14. COUNTY shall cooperate with EMTS in matters relating to academic performance and student conduct relating to course work performed under this Agreement.

15. Unless prohibited or restricted by law, COUNTY shall timely notify an instructor or student of any instance in which a facility employee has been exposed to blood-borne or airborne pathogens and the student or instructor may have been exposed in the same instance. Notification shall be provided in a time frame sufficient to allow the student or faculty member to seek appropriate treatment for potential exposure.

16. COUNTY shall obtain and maintain all licenses required for its participating facilities and shall assure that COUNTY personnel are appropriately licensed.

17. In the event emergency care is required for an EMTS student or faculty member, it shall be provided in the same manner that emergency care is provided to COUNTY employees and the general public. Emergency care provided by COUNTY shall be at the expense of the student or faculty member.

MUTUAL RESPONSIBILITIES

18. The Parties agree to designate a liaison for each program to do the following:

A Meet annually, or more often as needed, to schedule use of the facilities;

B. Meet on a per semester basis to set the number of students allowed to participate;

C. Design and approve curriculum assignments as they *affect* the operation of the facility and as affected by EMTS crediting standards;

D. Meet to review protocols, policies and rules and regulations concerning the operation of the facility and its use under this Agreement;

E. Meet annually to evaluate changes or amendments to this Agreement or the performance of the Agreement.

19. In the event any claim or demand is made on one of the Parties for actions relating or authorized by this Agreement, the other party shall be notified of such claim or demand in writing within five business (Monday-Friday) days. COUNTY shall not be liable for any claims, damages or attorney's fees arising from the negligent acts or omissions of EMTS, its employees, agents or students under this Agreement. EMTS shall not be liable for any claims, damages or attorney's fees arising from the negligent acts or omissions of COUNTY or its employees under this Agreement.

20. Notices shall be in writing and shall be effective when received. Notices shall be delivered in person or by certified mail, return receipt requested, to the following addresses:

Kenny Schnell
WCEMS Director
PO Box 873
Georgetown, TX 7827
512-943-1264

And

Matt Nealand
Emergency
Management
Training and
Services
16238 RR 620 N
Suite F-185
Austin, TX 78717

ADDITIONAL TERMS

21. Compensation benefits for this Agreement shall include $1.75/hour per ALS student to be paid by EMTS to the COUNTY. Compensation shall be paid to COUNTY within thirty (30) days from the date of the COUNTY'S invoice for payment.

22. EMTS acknowledges that COUNTY is a hybrid entity under the privacy regulations of the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA Privacy Rule"). COUNTY has designated its Emergency Medical Services Department as a health care component, as defined in HIPAA, and the Department is therefore required to comply with the HIPAA Privacy Rule. This compliance includes obtaining written contractual assurances from EMTS that EMTS, its employees and agents will protect all individually identifiable health information they may access or use under this Agreement in accordance with the terms of the HIPAA Business Associate Agreement, which is hereby attached to and made a part of this Agreement, for all purposes, as Exhibit "C".

23. The parties agree that COUNTY shall at all times maintain the right to terminate a student's participation in the program if COUNTY, in its sole discretion, determines that the student's continued participation would be disruptive to the program or the operations of the facility, or would pose a danger.

24. EMTS instructors and students shall maintain confidential all records and information concerning patients treated or attended to in COUNTY's facilities. Each EMTS instructor and student involved in medical or EMS programs shall be required to sign a confidentiality agreement regarding records and information about patients treated or attended by COUNTY employees.

25. Failure of either party to exercise any right or privilege granted by this Agreement shall not operate to waive such right or privilege in the event of subsequent defaults or assertions of right. Neither party waives nor shall be deemed to have waived any immunity or defense that would otherwise be available to it against claims arising under the performance of this Agreement.

26. The provisions of this Agreement shall be severable in the event any provision is declared invalid, illegal or unenforceable.

27. Either party may terminate this Agreement without cause upon 90 days written notice to the other party. In addition, COUNTY shall have the right to terminate the Agreement immediately in the event the facility becomes inoperable for any reason or COUNTY no longer controls a program.

28. Either Party may terminate this Agreement if the other breaches the Agreement and fails to cure such breach within 15 days of receiving notice of breach. If more than 15 days are required to cure the breach, the Parties may agree to an extension of the cure period in writing.

29. This agreement is effective when all parties have executed it. The term of the Agreement is from January 1, 2015 through December 31, 2016 unless this Agreement is otherwise terminated pursuant to the termination provision contained in Article 27 of this Agreement. All services shall be completed during this term. This Agreement may be reviewed annually by agreement of both parties via written instrument and subject to required approvals. There is no right or expectation of renewal and any renewal will be determined at the discretion of both Parties.

30. Nothing in this Agreement shall be construed to confer third party rights or to constitute a waiver of any governmental immunity of the parties.

31. This Agreement constitutes the entire agreement between the Parties and any prior or contemporaneous agreements, written or oral, are hereby superseded and of no further effect.

32. The laws of the State of Texas shall govern the validity, interpretation and enforcement of this Agreement, and venue for any dispute or cause of action shall be in Williamson County, Texas.

33. The Parties will comply with applicable federal, state and local laws, ordinances and regulations in the performance of this Agreement.

34. The performance of this Agreement shall be undertaken in a manner that does not discriminate against any person on a basis prohibited by law, including but not limited to race, color, national origin, religion, sex, age, veteran status or disability.

35. Notwithstanding any other provision of this Agreement, a COUNTY department may suspend participation in this Agreement due to space needs, staff training needs, budgetary issues or other urgent considerations. In the event of suspension, COUNTY shall give EMTS written notification stating the date of suspension and the date on which participation is anticipated to resume.

Williamson County:

_____ _____

Kenny Schnell
WCEMS Director

Date

Emergency Management Training and Services:

Matt Nealand 6/26/15

Matt Nealand
Program Director
Emergency Management Training and Services
16238 RR 620 N
Suite #F-185
Austin, Texas 78717

ATTACHMENT A

RELEASE OF LIABILITY

In consideration of the educational benefits extended to me by Williamson County Emergency Medical Services Department in making available its facilities for clinical course instruction as part of EMTS course regarding emergency medical service training, I hereby release and hold harmless Williamson County, its employees and agents from any claim, cause of action or injury that may result during my participation in a Williamson County program due to the negligence of Williamson County, its employees or agents.

Student's signature: _____

Printed Name

Date:

BLS EDUCATION AFFILIATION AGREEMENT
FOR
EMERGENCY MEDICAL PRECEPTOR PROGRAM BETWEEN

WILLIAMSON COUNTY EMERGENCY MEDICAL SERVICES
AND
LIFE START TRAINING AND CONSULTING

This Agreement is between Williamson County Emergency Medical Services (hereinafter referred to as "COUNTY") and Life Start Training and Consulting (hereinafter referred to as "LIFE START").

RECITALS:

LIFE START provides courses of study in emergency medical services to students enrolled in its Emergency Medical Technician program of study.

LIFE START desires program components that will provide to the students clinical experience as part of their educational instruction.

COUNTY, through its Emergency Medical Services Department, has facilities that can provide a clinical setting for educational instruction and is willing to make available the use of its facilities to LIFE START for its Emergency Medical Technician program of study.

COUNTY and LIFE START desire to enter into this Educational Affiliation Agreement in accordance with the terms stated below:

TERMS:

RESPONSIBILITIES OF LIFE START

1. LIFE START shall be responsible for the selection of students and their supervised instruction and grading. Students shall have satisfactorily completed curriculum prerequisites for participation in the internships or rotations.

2. LIFE START instructors shall possess current and appropriate professional credentials or certifications and LIFE START be responsible for the coordination and implementation of the program of study.

3. Services rendered by LIFE START instructors and students shall be without charge to COUNTY. LIFE START instructors and students shall not be responsible for the quality of patient or client care.

4. Neither LIFE START instructors nor students shall be deemed to be COUNTY employees, nor shall they be entitled to any COUNTY benefits, compensation or workers compensation benefits.

5. LIFE START shall annually provide COUNTY with anticipated enrollments for courses intending to provide clinical internships or experience through this Agreement. The number of students and the schedule of use of COUNTY's facilities shall be subject to annual, mutual approval.

6. LIFE START shall provide COUNTY with a list of students authorized to participate in the clinical instruction facilitated under this Agreement. LIFE START shall promptly inform COUNTY in writing of any student withdrawing from the course or otherwise unqualified to continue the internship or clinical experience made available under this Agreement.

7. LIFE START shall require all instructors and students to abide by all applicable policies, regulations and laws governing the facility or its work environment. LIFE START shall withdraw authorization for participation under this Agreement for any instructor or student found to have committed a violation of applicable policies, regulations or laws, or determined by COUNTY to be unqualified to continue in the program.

8. During the term of this Agreement, LIFE START shall maintain a professional liability insurance policy with a limit of liability of not less than $1,000,000 per occurrence and $3,000,000 annual aggregate that covers the activities of LIFE START's students, employees and faculty under this Agreement. LIFE START shall ensure that each current student, employee and faculty member is individually insured under such policy in the above-stated amounts, and shall provide COUNTY with a proof of such insurance coverage each year, and at other times upon request. LIFE START agrees to require each student to be covered by or to carry accident insurance for injury while enrolled in the program, and to ensure that each employee or faculty member is covered by worker's compensation insurance while participating in the program. No student or faculty member shall be permitted to participate in the program until such insurance coverage has been verified to the satisfaction of COUNTY.

9. LIFE START agrees to secure a release of liability form from each student and faculty member who will participate in the program in a form acceptable to COUNTY.

RESPONSIBILITIES OF COUNTY

10. COUNTY shall, on a space available basis, the use of designated facilities to provide a clinical education to participating students. COUNTY agrees to provide evaluations for student course-work done on forms provided by LIFE START.

11. COUNTY shall provide an orientation session to inform students and LIFE START staff about the rules, regulations, policies and procedures of the facilities.

12. COUNTY agrees to provide, on a space-available basis, the use of conference rooms, classrooms, lounges and lockers to the instructors and the students.

13. COUNTY shall notify LIFE START of any change of any accreditation or status concerning a facility and affecting internship or course requirements for clinical experience at a LIFE START credited facility. Representatives of LIFE START crediting agency for LIFE START shall be permitted to conduct inspections for purposes relating to LIFE START's accreditation.

14. COUNTY shall cooperate with LIFE START in matters relating to academic performance and student conduct relating to course work performed under this Agreement.

15. Unless prohibited or restricted by law, COUNTY shall timely notify an instructor or student of any instance in which a facility employee has been exposed to blood-borne or airborne pathogens and the student or instructor may have been exposed in the same instance. Notification shall be provided in a time frame sufficient to allow the student or faculty member to seek appropriate treatment for potential exposure.

16. COUNTY shall obtain and maintain all licenses required for its participating facilities and shall assure that COUNTY personnel are appropriately licensed.

17. In the event emergency care is required for a LIFE START student or faculty member, it shall be provided in the same manner that emergency care is provided to COUNTY employees and the general public. Emergency care provided by COUNTY shall be at the expense of the student or faculty member.

MUTUAL RESPONSIBILITIES

18. The Parties agree to designate a liaison for each program to do the following:

A Meet annually, or more often as needed, to schedule use of the facilities;

B. Meet on a per semester basis to set the number of students allowed to participate;

C. Design and approve curriculum assignments as they *affect* the operation of the facility and as affected by LIFE START crediting standards;

D. Meet to review protocols, policies and rules and regulations concerning the operation of the facility and its use under this Agreement;

E. Meet annually to evaluate changes or amendments to this Agreement or the performance of the Agreement.

19. In the event any claim or demand is made on one of the Parties for actions relating or authorized by this Agreement, the other party shall be notified of such claim or demand in writing within five business (Monday-Friday) days. COUNTY shall not be liable for any claims, damages or attorney's fees arising from the negligent acts or omissions of LIFE START, its employees, agents or students under this Agreement. LIFE START shall not be liable for any claims, damages or attorney's fees arising from the negligent acts or omissions of COUNTY or its employees under this Agreement.

20. Notices shall be in writing and shall be effective when received. Notices shall be delivered in person or by certified mail, return receipt requested, to the following addresses:

Kenny Schnell
WCEMS Director
PO Box 873
Georgetown, TX 7827
512-943-1264

And

Steven
Villavicencio
Program
Coordinator
13740
Research
Blvd.
Suites L5 & L6
Austin, TX
78750

ADDITIONAL TERMS

21. Compensation benefits for this Agreement shall include $40.00 each per BLS student to be paid by LIFE START to the COUNTY. Compensation shall be paid to COUNTY within thirty (30) days from the date of the COUNTY'S invoice for payment.

22. LIFE START acknowledges that COUNTY is a hybrid entity under the privacy regulations of the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA Privacy Rule"). COUNTY has designated its Emergency Medical Services Department as a health care component, as defined in HIPAA, and the Department is therefore required to comply with the HIPAA Privacy Rule. This compliance includes obtaining written contractual assurances from LIFE START that LIFE START, its employees and agents will protect all individually identifiable health information they may access or use under this Agreement in accordance with the terms of the HIPAA Business Associate Agreement, which is hereby attached to and made a part of this Agreement, for all purposes, as Exhibit "C".

23. The parties agree that COUNTY shall at all times maintain the right to terminate a student's participation in the program if COUNTY, in its sole discretion, determines that the student's continued participation would be disruptive to the program or the operations of the facility, or would pose a danger.

24. LIFE START instructors and students shall maintain confidential all records and information concerning patients treated or attended to in COUNTY's facilities. Each LIFE START instructor and student involved in medical or EMS programs shall be required to sign a confidentiality agreement regarding records and information about patients treated or attended by COUNTY employees.

25. Failure of either party to exercise any right or privilege granted by this Agreement shall not operate to waive such right or privilege in the event of subsequent defaults or assertions of right. Neither party waives nor shall be deemed to have waived any immunity or defense that would otherwise be available to it against claims arising under the performance of this Agreement.

26. The provisions of this Agreement shall be severable in the event any provision is declared invalid, illegal or unenforceable.

27. Either party may terminate this Agreement without cause upon 90 days written notice to the other party. In addition, COUNTY shall have the right to terminate the Agreement immediately in the event the facility becomes inoperable for any reason or COUNTY no longer controls a program.

28. Either Party may terminate this Agreement if the other breaches the Agreement and fails to cure such breach within 15 days of receiving notice of breach. If more than 15 days are required to cure the breach, the Parties may agree to an extension of the cure period in writing.

29. This agreement is effective when all parties have executed it. The term of the Agreement is from January 1, 2015 through December 31, 2016 unless this Agreement is otherwise terminated pursuant to the termination provision contained in Article 27 of this Agreement. All services shall be completed during this term. This Agreement may be reviewed annually by agreement of both parties via written instrument and subject to required approvals. There is no right or expectation of renewal and any renewal will be determined at the discretion of both Parties.

30. Nothing in this Agreement shall be construed to confer third party rights or to constitute a waiver of any governmental immunity of the parties.

31. This Agreement constitutes the entire agreement between the Parties and any prior or contemporaneous agreements, written or oral, are hereby superseded and of no further effect.

32. The laws of the State of Texas shall govern the validity, interpretation and enforcement of this Agreement, and venue for any dispute or cause of action shall be in Williamson County, Texas.

33. The Parties will comply with applicable federal, state and local laws, ordinances and regulations in the performance of this Agreement.

34. The performance of this Agreement shall be undertaken in a manner that does not discriminate against any person on a basis prohibited by law, including but not limited to race, color, national origin, religion, sex, age, veteran status or disability.

35. Notwithstanding any other provision of this Agreement, a COUNTY department may suspend participation in this Agreement due to space needs, staff training needs, budgetary issues or other urgent considerations. In the event of suspension, COUNTY shall give LIFE START written notification stating the date of suspension and the date on which participation is anticipated to resume.

Williamson County:

Kenny Schnell
WCEMS Director

Date

Life Start Training and Consulting:

Steven Villavicencio
Program Coordinator
Life Start Training and Consulting
13740 Research Blvd.
Suites L5 & L6
Austin, Texas 78750

7/7/15

ATTACHMENT A

RELEASE OF LIABILITY

In consideration of the educational benefits extended to me by Williamson County Emergency Medical Services Department in making available its facilities for clinical course instruction as part of LIFE START course regarding emergency medical service training, I hereby release and hold harmless Williamson County, its employees and agents from any claim, cause of action or injury that may result during my participation in a Williamson County program due to the negligence of Williamson County, its employees or agents.

Student's signature: _____

Printed Name

Date:

Commissioners Court - Regular Session **36.**

Meeting Date: 09/01/2015

Line Item Transfer

Submitted By: Ashlie Koenig, Budget Office

Department: Budget Office

Agenda Category: Regular Agenda Items

Information

Agenda Item

Discuss, consider and take appropriate action on the contract with the Williamson Museum for FY 16.

Background

This is simply a renewal with no increase for FY 16.

Fiscal Impact

From/To	Acct No.	Description	Amount

Attachments

Museum FY 16

Form Review

Inbox	Reviewed By	Date
County Judge Exec Asst.	Wendy Coco	08/27/2015 11:57 AM
Form Started By: Ashlie Koenig		Started On: 08/27/2015 11:32 AM
Final Approval Date: 08/27/2015		

STATE OF TEXAS §
COUNTY OF WILLIAMSON §

CONTRACT
IN THE PUBLIC INTEREST
BETWEEN
WILLIAMSON COUNTY, TEXAS
AND
THE WILLIAMSON MUSEUM
(FY2016)

THIS CONTRACT is entered into by and between WILLIAMSON COUNTY, a political subdivision of the State of Texas, hereinafter referred to as ("WILLIAMSON COUNTY"), and THE WILLIAMSON MUSEUM, hereinafter referred to as ("MUSEUM").

W I T N E S S E T H

WHEREAS, WILLIAMSON COUNTY has an interest in supporting historic preservation efforts and promoting community based expressions of arts and cultural, including but not limited to promoting efforts that serve a public benefit and further economic development;

WHEREAS, MUSEUM has an interest in supporting the provision of community and county-wide historical preservation efforts;

WHEREAS, WILLIAMSON COUNTY believes that it is in the public interest to enter into this CONTRACT with MUSEUM;

NOW, THEREFORE, THE PARTIES agree as follows:

1. **Public Purpose and Public Benefit**. MUSEUM will operate as an independent contractor in Williamson County, Texas. MUSEUM shall use the funding paid hereunder to perform the services and achieve the broad goals outlined in this CONTRACT.

2. **Payment/Inspections & Audits**. MUSEUM shall cooperate with inspections and audits that WILLIAMSON COUNTY or the auditor on behalf of WILLIAMSON COUNTY may make to ensure service standards and fiscal responsibility.

In return, WILLIAMSON COUNTY agrees to pay from funding provided by WILLIAMSON COUNTY to MUSEUM the full yearly amount of **$225,834.00 payable after October 1, 2015 and *prior* to the end of FY2016 or September 30, 2016 in the form of equal monthly installments and generally paid each month on WILLIAMSON COUNTY's first check run for accounts payable.**

3. Reimbursement of Funds. Despite the agreed upon method of payment set forth above, MUSEUM agrees to return to WILLIAMSON COUNTY all funds distributed to MUSEUM if (a.) MUSEUM's use of the funds for intended purposes is insufficient; (b.) this CONTRACT is terminated for any reason; (c.) MUSEUM fails in any other respect under this CONTRACT; (d.) MUSEUM changes its operations in such a way that, in WILLIAMSON COUNTY's opinion, the museum no longer serves a public purpose; or (e) MUSEUM conveys, leases or otherwise transfers its interest in the its operations to another entity without the prior written consent of WILLIAMSON COUNTY, which such consent shall not be unreasonably withheld provided the successor entity continues to use the museum a public purpose consistent with the spirit of this CONTRACT. The reimbursement of funds may be prorated based on those portions that were reasonably used for intended purposes.

4. Records. MUSEUM shall keep sufficient records of all of its expenditures in connection with services rendered pursuant to this CONTRACT. MUSEUM agrees that WILLIAMSON COUNTY'S auditors shall have the right to audit such MUSEUM records on an annual basis along with their regular review of records in a manner and form to be agreed upon by WILLIAMSON COUNTY and MUSEUM. MUSEUM further agrees that WILLIAMSON COUNTY or its duly authorized representatives shall, until the expiration of three (3) years after final payment under this Agreement, have access to and the right to examine and photocopy any and all books, documents, papers and records of MUSEUM which are directly pertinent to the services to be performed under this Agreement for the purposes of making audits, examinations, excerpts, and transcriptions. MUSEUM expressly agrees that WILLIAMSON COUNTY shall have access during normal working hours to all necessary MUSEUM facilities and shall be provided adequate and appropriate work space in order to conduct audits in compliance with the provisions of this section. Additionally, WILLIAMSON COUNTY shall give MUSEUM reasonable advance notice of intended audits.

5. Indemnity. MUSEUM shall in no manner incur any expenses or liability on behalf of WILLIAMSON COUNTY.

MUSEUM FURTHER AGREES TO HOLD WILLIAMSON COUNTY HARMLESS FOR ANY AND ALL CLAIMS BY THIRD PARTIES FOR ANY INJURIES, DAMAGES, OR LIABILITY OF ANY KIND ARISING UNDER OR OCCASIONED BY MUSEUM.

6. Compliance With All Laws. MUSEUM and WILLIAMSON COUNTY each agree, in connection with the services or any related items to the subject matter of this CONTRACT, to comply with any and all local, state or federal requirements.

7. Notice. Any notice required to be given under the terms of this CONTRACT shall be effective if and when given in writing and mailed by certified mail to the addresses listed below or subsequently provided in writing:

WILLIAMSON COUNTY:
WILLIAMSON COUNTY JUDGE
710 MAIN STREET, SUITE 101
GEORGETOWN, TEXAS 78626

MUSEUM:
THE WILLIAMSON MUSEUM
716 S. AUSTIN AVENUE
GEORGETOWN, TEXAS 78626

GENERAL COUNSEL:
GENERAL COUNSEL
OFFICE OF WILLIAMSON COUNTY JUDGE
710 MAIN STREET, SUITE 200
GEORGETOWN, TEXAS 78626

8. No Assignment. This CONTRACT may not be assigned.

9. Termination. Notwithstanding the agreed upon term, this CONTRACT may be terminated upon the occurrence of any of the following:

a. the termination of the corporate or business existence of MUSEUM;
b. the insolvency of MUSEUM, the filing of a petition in bankruptcy either by or against MUSEUM, or an assignment by MUSEUM for the benefit of creditors;
c. the breach by MUSEUM of any of the terms of this CONTRACT and the continuation of such breach for a period of ten (10) days after written notice is given by WILLIAMSON COUNTY to MUSEUM of such breach.
d. upon WILLIAMSON COUNTY's sole discretion with or without cause by providing thirty (30) days written notice.

10. Term. The stated term of this CONTRACT shall be until **September 30, 2016**, but with on-going contractual obligations by MUSEUM extending beyond the termination date (and the payment of funds by WILLIAMSON COUNTY).

11. Venue & Applicable Law. Venue of this CONTRACT shall be WILLIAMSON COUNTY, Texas, and the laws of the State of Texas shall govern all terms and conditions.

12. Severability. In case any one or more of the provisions contained in this CONTRACT shall for any reason be held to be invalid, illegal, or unenforceable in any respect, such invalidity, illegality, or unenforceability shall not affect any other provision

in this CONTRACT and this CONTRACT shall be construed as if such invalid, illegal, or unenforceable provision had never been contained in it

13. Mediation. The parties agree to use mediation for dispute resolution prior to and formal legal action being taken on this CONTRACT.

14. Proof of Non-Profit Status. MUSEUM has provided proof of status as a 501(c) non-profit corporate entity, which is attached and marked as "Exhibit A" and is incorporated herein as if copied in full. **Exhibit "A".**

EXECUTED to be effective as of the date of the last party's execution below.

FOR WILLIAMSON COUNTY:

_____
Presiding Officer
Williamson County Commissioners Court
Williamson County, Texas

Date: _____ _____, 20____

FOR MUSEUM:

Mickie Ross
Authorized Agent
The Williamson Museum

Date: August 26, 2015

STATE OF TEXAS *
COUNTY OF WILLIAMSON *

This instrument was acknowledged before me on the _____day of _____, 2015, by _____, of the Williamson Museum, on behalf of the organization.

_____
Notary Public, State of Texas

Commissioners Court - Regular Session **37.**

Meeting Date: 09/01/2015

Cash Ending Reduction Programs 2013-2015

Submitted For: Julie Kiley **Submitted By:** Julie Kiley, County Auditor

Department: County Auditor

Agenda Category: Regular Agenda Items

Information

Agenda Item

Discuss, consider and take any necessary action in regards to Status of Projects and Allocation of Funds in the 2013 Cash Ending Reduction Program, 2014 Cash Ending Reduction Program, and 2015 Cash Ending Reduction Program.

Background

A report will be provided in Commissioners Court reflecting current projects and their status as well as suggested uses for fund balances in each program.

Fiscal Impact

From/To	Acct No.	Description	Amount

Attachments

No file(s) attached.

Form Review

Inbox	Reviewed By	Date
County Judge Exec Asst.	Wendy Coco	08/27/2015 10:05 AM
Form Started By: Julie Kiley		Started On: 08/27/2015 09:58 AM
Final Approval Date: 08/27/2015		

Commissioners Court - Regular Session **38.**

Meeting Date: 09/01/2015

2016 Cash Ending Reduction Program

Submitted By: Julie Kiley, County Auditor

Department: County Auditor

Agenda Category: Regular Agenda Items

Information

Agenda Item

Discuss, consider and take any possible action regarding Fiscal Year 2016 Cash Ending Reduction Program.

Background

The recommended amount for Fiscal Year 2016 will be provided during the meeting. This item will begin the discussion of the amount and possible projects or expenditures.

Fiscal Impact

From/To	Acct No.	Description	Amount

Attachments

No file(s) attached.

Form Review

Inbox	Reviewed By	Date
County Judge Exec Asst.	Wendy Coco	08/27/2015 10:05 AM
Form Started By: Julie Kiley		Started On: 08/27/2015 10:01 AM
Final Approval Date: 08/27/2015		

Commissioners Court - Regular Session **39.**

Meeting Date: 09/01/2015

ESD 11 Board of Directors Appointment

Submitted For: Cynthia Long **Submitted By:** Kathy Pierce, Commissioner Pct. #2

Department: Commissioner Pct. #2

Agenda Category: Regular Agenda Items

Information

Agenda Item

Discuss, consider and take appropriate action on appointment of Kelley Masters to the place four position on the ESD #11 Board of Directors, for the remainder of the January 1, 2015 to December 31, 2016 term.

Background

Fiscal Impact

From/To	Acct No.	Description	Amount

Attachments

Kelley Masters

Form Review

Inbox	Reviewed By	Date
County Judge Exec Asst.	Rebecca Clemons	08/12/2015 02:57 PM
Form Started By: Kathy Pierce		Started On: 08/10/2015 12:22 PM
Final Approval Date: 08/12/2015		

Dear Ms. Long,

My name is Kelley Masters, I own the home and reside at 1526 Shenandoah Drive in Cedar Park. I understand that the ESD is in need of board members. I am submitting the following information for your consideration.

Education
Newport High School, Bellevue, Washington
Graduated 1989

Washington State University
1989 – 1990

Austin Community College
2002

Work Experience
CMS Professional Recoveries – Administrative Assistant and Data Entry
1992 – 1994

IBM Austin – Administrative Assistant
1993 – 1994

State of Texas Department of Family and Protective Services – Administrative Assistant
1994 – 1998

President and Owner, Masters Software, Inc. – developing custom software solutions and creator of CakeBoss Software for Bakers at www.cakeboss.com
2002 – Present

Community Activities
Responsible for introduction of the first "cottage food" bill in Texas in 2009 by Representative Dan Gattis. Actively involved in passing local foods legislation in 2011 and 2013 in the form of SB 81 (2011) and HB 970 (2013). I maintain www.texascottagefoodlaw.com and remain active in supporting the rights of local foods producers.

If you have any questions or wish to contact me, I can be reached at the number below.

Thank you,
Kelley Masters

Commissioners Court - Regular Session **40.**

Meeting Date: 09/01/2015

ESD 11 Board Appointment

Submitted For: Cynthia Long **Submitted By:** Kathy Pierce, Commissioner Pct. #2

Department: Commissioner Pct. #2

Agenda Category: Regular Agenda Items

Information

Agenda Item

Discuss, consider and take appropriate action on appointment of Kelley Masters to Place 4 of the ESD #11 Board of Directors for the term of January 1, 2015 through December 31, 2016.

Background

Fiscal Impact

From/To	Acct No.	Description	Amount

Attachments

Kelley Masters Bio

Form Review

Inbox	Reviewed By	Date
County Judge Exec Asst.	Wendy Coco	08/21/2015 09:20 AM
Form Started By: Kathy Pierce		Started On: 08/20/2015 02:31 PM
Final Approval Date: 08/21/2015		

Education
Newport High School, Bellevue, Washington
Graduated 1989

Washington State University
1989 – 1990

Austin Community College
2002

Work Experience
CMS Professional Recoveries – Administrative Assistant and Data Entry
1992 – 1994

IBM Austin – Administrative Assistant
1993 – 1994

State of Texas Department of Family and Protective Services – Administrative Assistant
1994 – 1998

President and Owner, Masters Software, Inc. – developing custom software solutions and creator of CakeBoss Software for Bakers at www.cakeboss.com
2002 – Present

Community Activities
Responsible for introduction of the first "cottage food" bill in Texas in 2009 by Representative Dan Gattis. Actively involved in passing local foods legislation in 2011 and 2013 in the form of SB 81 (2011) and HB 970 (2013). I maintain www.texascottagefoodlaw.com and remain active in supporting the rights of local foods producers.

If you have any questions or wish to contact me, I can be reached at the number below.

Thank you,
Kelley Masters

Commissioners Court - Regular Session **41.**

Meeting Date: 09/01/2015

Texas Department of Agriculture Resolution

Submitted For: Cynthia Long **Submitted By:** Kathy Pierce, Commissioner Pct. #2

Department: Commissioner Pct. #2

Agenda Category: Regular Agenda Items

Information

Agenda Item

Discuss, consider and take appropriate action on resolution authorizing Williamson-Burnet County Opportunities to apply for grant funds from the Texas Department of Agriculture for Home-Delivered Meal Grant Program.

Background

Fiscal Impact

From/To	Acct No.	Description	Amount

Attachments

Resolution Authorizing Grant

Form Review

Inbox	Reviewed By	Date
County Judge Exec Asst.	Wendy Coco	08/21/2015 09:20 AM
Form Started By: Kathy Pierce		Started On: 08/20/2015 04:44 PM
Final Approval Date: 08/21/2015		

State of Texas
County of Williamson
Know all men by these presents:

That on the 1st day of September, 2015 the Commissioners Court of Williamson County, Texas met in duly called session at the Williamson County Courthouse, 710 Main Street, Georgetown, Texas, with the following members present:

Dan A. Gattis, County Judge
Lisa L. Birkman, Commissioner Precinct One
Cynthia P. Long, Commissioner Precinct Two
Valerie Covey, Commissioner Precinct Three
Ron Morrison, Commissioner Precinct Four

And at said meeting, among other business, the Court considered the following:

RESOLUTION AUTHORIZING COUNTY GRANT

A RESOLUTION OF THE COUNTY OF WILLIAMSON, TEXAS CERTIFYING THAT THE COUNTY HAS MADE A GRANT TO WILLIAMSON-BURNET COUNTY OPPORTUNITIES, AN ORGANIZATION THAT PROVIDES HOME-DELIVERED MEALS TO HOMEBOUND PERSONS IN THE COUNTY WHO ARE ELDERLY AND/OR HAVE A DISABILITY AND CERTIFYING THAT THE COUNTY HAS APPROVED THE ORGANIZATIONS ACCOUNTING SYSTEM OR FISCAL AGENT.

WHEREAS, Williamson-Burnet County Opportunities desires to apply for grant funds from the Texas Department of Agriculture to supplement and extend existing services homebound persons in the County who are elderly and/or have a disability, pursuant to the Home-Delivered Meal Grant Program (Program); and

WHEREAS, the Program rules require the County in which an Organization is providing home-delivered meal services to make a grant to the Organization, in order for the Organization to be eligible to receive Program grant funds; and

WHEREAS, the Program rules require the County to approve the Organization's accounting system or fiscal agent, in order for the Organization to be eligible to receive Program grant funds.

BE IT RESOLVED BY THE COUNTY:
SECTION 1: The County hereby certifies that it has made a grant to the Organization in the amount of $30,000.00 to be used between the 1st day of October, 2015 and the 31st day of September, 2016.

SECTION 2: The County hereby certifies that the Organization provides home-delivered meals to homebound persons in the County who are elderly and/or have a disability.

SECTION 3: The County hereby certifies that it has approved the Organization's accounting system or fiscal agent which meets financial management system requirements as set forth in Uniform Grant Management Standards.

RESOLVED THIS 1st DAY OF SEPTEMBER, 2015.

_____
Dan A. Gattis, County Judge

Commissioners Court - Regular Session **42.**

Meeting Date: 09/01/2015

Texas Workforce Commission

Submitted For: Cynthia Long **Submitted By:** Kathy Pierce, Commissioner Pct. #2

Department: Commissioner Pct. #2

Agenda Category: Regular Agenda Items

Information

Agenda Item

Discuss, consider, and take appropriate action regarding renewal of agreement with Texas Workforce Commission for Williamson County Constable, Precinct Two access to agency data for FY2016 to support county operations.

Background

This renewal agreement has been reviewed by Stan Springerley and has been approved to be placed on the consent agenda.

Fiscal Impact

From/To	Acct No.	Description	Amount

Attachments

Texas Workforce Commission Renewal

Form Review

Inbox	Reviewed By	Date
County Judge Exec Asst.	Wendy Coco	08/26/2015 03:54 PM
Form Started By: Kathy Pierce		Started On: 08/26/2015 03:24 PM
Final Approval Date: 08/26/2015		

Texas Workforce Commission

A Member of Texas Workforce Solutions

Andres Alcantar, Chairman
Commissioner Representing
the Public

Ronald G. Congleton
Commissioner Representing
Labor

Hope Andrade
Commissioner Representing
Employers

Larry E. Temple
Executive Director

August 24, 2015

Randolph Doyer, Chief Deputy
Williamson County Constable Precinct 2
350 Discovery Blvd., Suite 205
Cedar Park, TX 78613

Re: TWC Contract/s or Amendment/s

Dear Mr. Doyer:

Enclosed are original signature copies of the Contract/s or Amendment/s listed below:

TWC Contract - Amendment Number	Contract Manager/Phone Number
2916PEN010	Michelle Smith 512-936-3296

Please sign all the copies of the Contract/s or Amendment/s where indicated and complete the Contract/Amendment Language Change Certification Form for each transaction.

Retain one (1) set for your records and provide one (1) set to your Fiscal Agent (if applicable) and return one (1) set to:

Texas Workforce Commission
Contract Services Department
101 East 15th Street, Room 350-T
Austin, Texas 78778-0001
Attn: Sylvia Daves

If you have any questions or need additional assistance regarding the contents of these documents prior to signature, please contact the contract manager at the number indicated above.

Sincerely,

Marisela Ramirez
Director, Contract Services Department

MR: sd
Enclosures

TEXAS WORKFORCE COMMISSION

TWC Contract Number	2916PEN010

TITLE	INFORMATION RELEASE CONTRACT

Recipient

Name	**Williamson County Constable Precinct 2**
Street Address	**350 Discovery Blvd., Suite 205**
City/State/Zip	**Cedar Park, TX 78613**
Telephone Number	**512-260-4270**

Contract Period

This Contract shall begin on **September 1, 2015** and shall terminate on **August 31, 2016** unless amended by mutual written agreement of the parties.

Funding Information

The total amount of this Contract will not exceed the sum of	**$1,500.00**

Remarks

This Contract is contingent on Recipient's acceptance of and compliance with the terms and conditions of this Contract and any referenced attachments.

Summary

Online access only

Number of online users and rate: 1-10 for $1,500/year - *Maximum 10 users at 1,500.00 per year for one (1) year.*

Signature Authority

Each person signing this Contract hereby warrants that he or she has been fully authorized by the respective organization to:

- Execute this Contract on behalf of the organization, and
- Validly and legally bind the organization to all the terms, performances, and provisions of this Contract.

Agency Approval	Recipient Approval
Agency: **Texas Workforce Commission**	Recipient: **Williamson County Constable Precinct 2**
Lisa Richardson 8/21/15	
Lisa Richardson Date Director of Information Technology	Dan Gattis Date County Judge

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TEXAS WORKFORCE COMMISSION

INFORMATION RELEASE CONTRACT

GENERAL TERMS AND CONDITIONS

SECTION 1 – Purpose and Legal Authority

1.1 This Contract sets forth the obligations of the Texas Workforce Commission ("Agency") and the Recipient identified on the cover page (each a "Party" and together "the Parties") with respect to Agency's release of confidential data to Recipient. The obligations of the Parties are set forth in detail in **Attachment A.**

1.2 Subject to certain limitations, the Interlocal Cooperation Act, Texas Government Code, Chapter 791, authorizes Recipient to enter into contracts for services with governmental entities, including state agencies.

SECTION 2 – Term, Termination, and Amendment

2.1 This Contract is effective from the Begin Date to the End Date specified on the cover page.

2.2 Either Party may suspend or terminate this Contract at any time, on written notice to the other Party specifying a termination date at least thirty (30) calendar days after the date of the notice. Suspension or termination shall not relieve Recipient of the obligation to pay for all services provided before suspension or termination at the rates specified herein, nor shall it entitle Recipient to any refund of the annual subscription fee for online access to Agency records.

2.3 No modification will be valid unless in writing and signed by both Parties, except for rate revisions made under Section 3.2 of these General Terms and Conditions.

SECTION 3 – Consideration

3.1 Recipient shall pay Agency for the services described, and at the rates set forth, in Attachment A.

3.2 Notwithstanding Section 3.1 of these General Terms and Conditions, Agency may unilaterally revise rates upon written notice to Recipient of at least thirty (30) calendar days.

SECTION 4 – Protecting the Confidentiality of TWC Information

4.1 "TWC Information" means records maintained by Agency, and records obtained by Recipient from Agency under this Contract, including (1) records and data compilations provided electronically, on

paper, or via online access or e-mail, (2) records and data compilations that Recipient has converted into another format or medium (such as handwritten or electronic notes), and (3) records and data compilations incorporated in any manner into Recipient's records, files or data compilations.

4.2 Recipient shall protect the confidentiality of TWC Information and comply with all statutory, regulatory and contract requirements. Confidentiality is required by Texas Labor Code §§ 301.081 and 301.085, the Social Security Act of 1934, and 20 Code of Federal Regulations (C.F.R.) Part 603.

SECTION 5 – Records and Audit

Recipient shall keep and maintain complete and accurate records sufficient to allow Agency, the Texas State Auditor's Office, the United States government, and their authorized representatives to determine Recipient's compliance with this Contract.

SECTION 6 – Breach of Agreement, Default, and Remedies

6.1 If Recipient or any official, employee, or agent of Recipient fails to comply with any provision of this Contract, including timely payment of Agency's invoices, Agency may suspend services to Recipient (including any data requests being processed) until Agency is satisfied that corrective action has been taken to assure there will be no future breach.

6.2 In the absence of prompt and satisfactory corrective action to cure default and assure future compliance with Contract requirements, Agency shall terminate this Contract immediately and Recipient shall surrender to Agency all TWC Information that has not previously been returned to Agency, and any other records relevant to this Contract.

6.3 Termination of this Contract under Section 6.2 of these General Terms and Conditions will not limit Agency from pursuing penalties under state and federal law for the unauthorized disclosure of TWC Information.

6.4 Agency shall undertake any other action under this Contract or under any law of this State or of the United States, to enforce this Contract and to secure satisfactory corrective action and return of TWC Information.

6.5 Agency shall take other remedial actions permitted under state or federal law to enforce this Contract and 20 C.F.R. Part 603 including seeking damages, penalties, and restitution for all costs incurred by Agency in enforcing this Contract and responding to Recipient's breach.

SECTION 7 – Miscellaneous

7.1 Texas Labor Code § 301.085 provides that unemployment compensation records are not "public information" for purposes of the Public Information Act, Texas Government Code, Chapter 552.

Recipient shall not release any TWC Information in response to a request made under the Public Information Act or any other law, regulation, or ordinance addressing public access to government records.

7.2 Recipient shall notify Agency within twenty-four (24) hours of the receipt of any subpoena, other judicial request, or request for appearance for testimony upon any matter concerning TWC Information. Federal regulations at 20 C.F.R. § 603.7 dictate the handling of subpoenas for TWC Information.

7.3 This Contract is made in and performed in the State of Texas, and shall be construed, interpreted, and applied in accordance with the laws of the State of Texas, excluding its choice of law rules. Venue of any court action brought directly or indirectly by reason of this Contract shall be in a court of competent jurisdiction in Travis County, Texas. **NOTHING IN THIS SECTION SHALL BE CONSTRUED AS A WAIVER OF SOVEREIGN IMMUNITY BY AGENCY.**

7.4 Agency's failure to enforce any provision of this Contract does not constitute a waiver of that provision or any other.

7.5 Recipient agrees to indemnify and hold harmless Agency, the State of Texas, and their employees and officials for any loss, damages, judgments, and costs arising or resulting from any acts or omissions or alleged acts or omissions of Recipient or its employees, agents, contractors, and subcontractors, including the inappropriate release or use of TWC Information.

7.6 Recipient shall be responsible and liable for any damages resulting from a breach by Recipient including damages and losses of third parties. Recipient shall reimburse Agency for any costs incurred by Agency in reimbursing third parties damaged by Recipient's breach and costs incurred in attempts by Agency to limit third party losses resulting from Recipient's breach.

7.7 Recipient agrees to accept liability for any damage to Agency's hardware, software, or TWC Information when such damage is caused by the actions of employees, contractors, subcontractors or agents of Recipient, whether or not the individual was an authorized User under this Contract.

7.8 If any provision of this Contract is held to be unenforceable by a court, this Contract will be construed as if such provision did not exist and the unenforceability of such provision will not render any other provisions of this Contract unenforceable.

7.9 This Contract is the entire agreement between the Parties.

7.10 The subject headings used in this Contract are for convenience only and are not intended to expand or limit meanings.

7.11 Attachments listed in the Table of Contents are incorporated in their entirety as terms and conditions of this Contract.

7.12 The following provisions survive the expiration or earlier termination of this Contract: Sections 4.2, 5, 6.2, 6.3, 7.1, 7.2, 7.5, 7.6, and 7.7 of these General Terms and Conditions; Sections 3.2.3, 3.2.4, and 3.2.5 of Attachment A; and Attachment B.

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Attachment A

INFORMATION RELEASE CONTRACT BETWEEN TEXAS WORKFORCE COMMISSION AND WILLIAMSON COUNTY CONSTABLE PRECINCT 2

STATEMENT OF WORK – PROJECT OBLIGATIONS

SECTION 1 – Project Abstract

1.1 Contract Purpose. The purpose of this Contract is to provide Recipient with access to confidential Agency data, to ensure that Recipient will maintain the confidentiality of the data, and to require Recipient to reimburse Agency for costs of providing access at the rates set out in this Contract.

1.2 Authorized Use of TWC Information. Subject to the security and confidentiality provisions of this Contract, Recipient is authorized to use TWC Information solely for the following purpose: **to assist in criminal investigations; and to assist in locating defendants, witnesses, fugitives, and persons with outstanding warrants in criminal cases** (the "Limited Purpose"). Any other use of TWC Information by Recipient is a breach of this Contract.

1.3 References. Section references are to sections of this Attachment A unless otherwise specified.

SECTION 2 – Obligations of Agency

2.1 Online Access.

2.1.1 Description. Agency agrees to provide online "read-only" access to the following Agency mainframe computer screens:

- BN75: wage records file; and
- CMES, CTCS, and BPCS: unemployment compensation claim benefit data.

2.1.2 Number of Users. Subject to Section 3.1, Agency will grant access to the screens listed in Section 2.1.1 to a **maximum of ten (10) "Users,"** all of whom must be direct Recipient employees.

2.1.3 Availability. Online access will routinely be available Monday through Friday, 8:00 a.m. to 5:00 p.m. Central Time, excluding State holidays, although Agency does not guarantee access during these periods. Agency may terminate or limit access without notice based on business necessity or in the event of an emergency.

SECTION 3 – Obligations of Recipient

3.1 Online Access.

3.1.1 Annual Fee and Payment. Recipient shall pay Agency a **one thousand five hundred dollar ($1,500.00) annual subscription fee** for the online access described in Section 2.1. The annual subscription fee covers the twelve (12) month period that begins on the Begin Date. Payment of the annual subscription fee is due within thirty (30) days of Recipient's execution of this Contract. The annual subscription fee is nonrefundable and will not be prorated in case of early termination of this Contract or suspension of services. Recipient shall send payment to Texas Workforce Commission, Revenue and Trust Management, P.O. Box 322, Austin, TX 78767-0322.

3.1.2 User Documents. All prospective online Users must execute a *Texas Workforce Commission User Agreement* ("User Agreement"), Attachment C, and complete online TWC Information Technology Security Awareness Training ("Security Training").

3.1.3 User Document Submission and Maintenance. Before Agency RACF Administration will issue a User ID and password to a prospective User, Agency RACF Administration must receive from Recipient Contact Person (designated in Section 4.1) copies of a completed User Agreement and certificate of completion of Security Training ("Training Certificate"), with a completed *Cover Sheet for Transmitting User Agreement and Training Certificate* ("Cover Sheet"), Attachment D. Agency may deny access to any prospective User on security grounds. Recipient must maintain on file all original Training Certificates and User Agreements.

3.1.4 Notice of User Employment Change. Recipient shall notify Agency within three (3) calendar days of a User's termination, resignation, or reassignment into a position not requiring access to TWC Information, so that the User's password can be immediately revoked. Failure to provide such notice is a breach of this Contract and may result in immediate suspension of all online access, termination of this Contract, and other penalties provided by law and this Contract.

3.1.5 User Document Renewal. **On October 1, 2015,** the online access of each User established under a prior contract will be terminated unless Agency RACF Administration has received for the User, from Recipient Contact Person, copies of a new User Agreement and new Training Certificate executed or dated, respectively, no more than thirty (30) calendar days before submission, with a completed Cover Sheet.

3.1.6 Changes Prohibited. Users shall not change or update any TWC Information contained in Agency's computer stored files. Users shall not use any automated system or software to make multiple queries of Agency's computer stored files.

3.1.7 Instructions. Recipient shall be solely responsible for disseminating to Users any instructions provided by Agency regarding navigation of online access to TWC Information.

3.2 Additional Requirements.

3.2.1 Security Safeguards. Recipient shall establish, maintain, and comply with security safeguards and procedures to protect the confidentiality of all TWC Information. Recipient shall comply with the requirements in *Safeguards for TWC Information*, Attachment B, and in *Protection of Confidentiality - 20 C.F.R. § 603.9*, Attachment G. Failure to comply with any requirement of Attachment B or Attachment G is a breach of this Contract.

3.2.2 Suspension. Agency may suspend all services without notice if Agency suspects a violation of the security provisions in Attachment B. Services will remain suspended until Agency has fully investigated any suspected security violations and is satisfied that resumption of services will not result in security breaches. In the event of an extended suspension of services, Agency will notify Recipient as soon as possible.

3.2.3 Enduring Obligation. Termination or expiration of this Contract will not end Recipient's responsibility to protect the confidentiality of TWC Information remaining in Recipient's possession, under Recipient's control, or held by a third party subject to contract or agreement with Recipient.

3.2.4 Audit. Recipient's security safeguards and procedures, as well as Recipient's access to and use of TWC Information, are subject to monitoring, evaluation and audit by Agency.

3.2.5 Inspections. Recipient shall cooperate fully with any on-site inspections and monitoring activities of Agency. So that Agency may audit Recipient's compliance with the requirements of state and federal law and this Contract, Recipient shall permit Agency access to all sites containing TWC Information (including sites where data is maintained electronically), and to all workplaces used by personnel who have access to TWC Information.

3.2.6 Self-Assessment Report. Recipient shall submit to Agency a fully-executed *Quarterly Self-Assessment Report*, Attachment H, on the next-occurring quarterly filing date after the Begin Date, and on each quarterly filing date for as long as this Contract is in effect. The quarterly filing dates are January 1, April 1, July 1, and October 1. Each report must have been signed within thirty (30) days preceding submission.

3.2.7 Identity Theft Protection. In case of unauthorized disclosure of TWC Information by Recipient, Recipient shall purchase identity theft protection service for all individuals whose information was disclosed without authorization. The protection service shall cover each individual for a two-year period and must include, at a minimum, automatic fraud alerts to the individual.

3.2.8 Significant Change. Recipient agrees to notify Agency in writing within ten (10) calendar days of any significant change affecting Recipient and Recipient's identity, including but not limited to changes in its ownership or control, name, governing board membership, authority of governing board, officeholders, or vendor identification number.

3.2.9 Computer Resources. Recipient shall provide and maintain its own computer hardware and software to accomplish the necessary computer communications linkages with Agency.

3.2.10 Data Source. Agency does not warrant or guarantee the accuracy of TWC Information. TWC Information includes data provided to Agency by third parties, including employers and employees.

SECTION 4 – Contact Persons

4.1 Designation. The Parties designate the following primary liaisons for implementation of this Contract:

Agency Contact Person

Michelle D. Smith
External Data Exchange Contracts (EDEC)
Risk & Security Management Department
Texas Workforce Commission
1117 Trinity Street, Room 324T
Austin, TX 78778-0001

Phone: 512-936-3296
Fax: 512-463-2990
Email: RSMContracts@twc.state.tx.us

Recipient Contact Person

Randolph Doyer
Chief Deputy
Williamson County Constable Precinct 2
350 Discovery Blvd., Suite 205
Cedar Park, TX 78613

Phone: 512-260-4270
Email: rdoyer@wilco.org

Send invoices to:

Same as above

4.2 Notice. Any notice required under this Contract must be given to the other Party's Contact Person.

4.3 Notice to Alternate. If Recipient designates an alternate Contact Person, written notification by Agency to one (1) of the Recipient Contact Persons will satisfy any notification requirement of this Contract.

4.4 Change. Recipient may request a change in Recipient Contact Person by submitting to Agency Contact Person a written request on organizational letterhead signed by the person who signed this Contract on behalf of Recipient, or by a successor with authority to bind Recipient contractually. The request must include the TWC Contract Number, the name of the person being replaced, and the name of the new Recipient Contact Person, with job title, work address, phone number, and email address. No change in Recipient Contact Person is effective until acknowledged in writing by Agency.

4.5 Communications. Recipient shall include the TWC Contract Number in all communications with Agency.

SECTION 5 – Effect on Other Contracts

The Parties agree that this Contract supersedes and replaces all other contracts between them for information release or data sharing, including 2913PEN069.

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Attachment B

SAFEGUARDS FOR TWC INFORMATION

1. "Recipient" in this Contract shall maintain sufficient safeguards over all TWC Information to prevent unauthorized access to or disclosure of TWC Information:

   "TWC Information" means records maintained by Agency (TWC), and records obtained by Recipient from Agency under this Contract, including (1) records and data compilations provided electronically, on paper, or via online access or e-mail, (2) records and data compilations that Recipient has converted into another format or medium (such as handwritten or electronic notes), and (3) records and data compilations incorporated in any manner into Recipient's records, files or data compilations.

2. Monitoring. Recipient shall monitor its Users' access to and use of TWC Information, and shall ensure that TWC Information is used only for the following "Limited Purpose": **to assist in criminal investigations; and to assist in locating defendants, witnesses, fugitives, and persons with outstanding warrants in criminal cases**. Recipient shall also ensure that TWC Information is used only for purposes authorized by law and in compliance with all other provisions of this Contract.

3. Storage. Recipient shall store TWC Information in a place physically secure from access by unauthorized persons.

4. Protection. Recipient shall store and process TWC Information, including that maintained in electronic format, such as magnetic tapes or discs, in such a way that unauthorized persons cannot obtain TWC Information by any means.

5. Access. Recipient shall undertake precautions to ensure that only authorized personnel are given access to TWC Information stored in computer systems.

6. Instruction. Recipient shall instruct all personnel having access to TWC Information about all confidentiality requirements including the requirements of 20 C.F.R. Part 603 as well as the sanctions specified in this Contract and under state and federal law for unauthorized disclosure of TWC Information. Recipient acknowledges that all personnel who will have access to TWC Information have been instructed as required.

7. Disposal. Recipient shall dispose of TWC Information and any copies thereof after the Limited Purpose is achieved, except for TWC Information possessed by any court. Disposal means return of TWC Information to Agency or destruction of TWC Information, as directed by Agency. Disposal includes deletion of personal identifiers in lieu of destruction. In any case, Recipient shall dispose of all TWC Information within thirty (30) calendar days after the termination, cancellation, or expiration of this Contract, or as required by federal, state, or local government approved records retention requirements.

8. System. Recipient shall establish and maintain a system sufficient to allow an audit of compliance with the requirements of this Attachment B and the other provisions of this Contract.

9. No Disclosure or Release. Recipient shall not disclose or release any TWC Information other than as permitted in this Contract, without prior written consent of Agency.

10. Unauthorized Disclosure. It is a breach of this Contract to disclose TWC Information orally, electronically, in written or printed form, or in any other manner without the prior written consent of Agency:
    10.1 to any contract employee of Recipient or any individual not employed by Recipient;

    10.2 to another government entity, including a law enforcement entity;

10.3 to Recipient employees who do not have a need to use TWC Information for the Limited Purpose.

11. Authorized Disclosure. TWC Information may only be disclosed:
    11.1 to employees under the direct hiring-and-firing control of Recipient who have a need to use the TWC Information for the Limited Purpose; and

    11.2 in a criminal judicial proceeding if the TWC Information is introduced in court as a sealed record with access limited to the prosecutor, defendant, judge, and jury.

12. Security Violation. Recipient shall monitor access of Users and shall notify Agency within twenty-four (24) hours if a security violation of this Contract is detected, or if Recipient suspects that the security or integrity of TWC Information has or may have been compromised in any way.

13. Format. TWC Information is subject to the requirements of this Contract even if the TWC Information is converted by Recipient into another format or medium, or incorporated in any manner into Recipient's records, files, or data compilations.

14. Access Limited. Recipient shall limit access to TWC Information to its employees who need access to achieve the Limited Purpose.

15. Mobile Device and Removal. Recipient shall not place TWC Information on mobile, remote, or portable storage devices, or remove storage media from Recipient's facility, without the prior written authorization of Agency.

16. Public Information Act. Under Texas Labor Code § 301.085, TWC Information is not "public information" for purposes of the Public Information Act, Texas Government Code, Chapter 552. Recipient shall not release any TWC Information in response to a request made under the Public Information Act or under any other law, regulation, or ordinance addressing public access to government records.

17. Subpoena. Recipient shall notify Agency within twenty-four (24) hours of the receipt of any subpoena, other judicial request, or request for appearance for testimony upon any matter concerning TWC Information. Federal regulations dictate the handling of subpoenas for TWC Information. Recipient shall comply with the requirements of 20 C.F.R. § 603.7 in responding to any subpoena, other judicial request, or request for appearance for testimony upon any matter concerning TWC Information.

18. Federal Regulation. Recipient shall comply with all requirements of *Protection of Confidentiality - 20 C.F.R. § 603.9* (Attachment G of this Contract) relating to safeguarding TWC Information and insuring its confidentiality.

19. Unauthorized Lookup. A User shall not access TWC Information listed under the User's SSN or the SSN of a co-worker, family member, or friend.

20. Screening – Online Users. Recipient shall screen potential Users and seek online access only for employees that Recipient has determined pose no threat to the security of TWC Information.

21. Screening – All Handlers. Recipient shall permit access to TWC Information only to employees that Recipient has determined pose no threat to the security of TWC Information.

22. Internet. Recipient shall not transmit any TWC Information over the Internet unless it is encrypted using at least 128-bit encryption.

23. Screen Dump. Recipient's security guidelines shall ensure that any screen dump or other extraction of TWC Information will be protected from unauthorized use or disclosure.

24. No Transfer. Recipient shall not transfer the authority or ability to access or maintain TWC Information under this Contract to any other person or entity.

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Attachment C

TEXAS WORKFORCE COMMISSION USER AGREEMENT

I, _____
(User's Printed Name) (User's Social Security Number)

_____
(User's work phone number) (Print User's work street address)

_____
(Print User's employer) (Print User's work email)

acknowledge that I will be assigned a personal User ID and password to gain access to the Texas Workforce Commission (TWC) computer system. Under no circumstances will I allow my User ID or password to be used by any other individual, nor will I use one belonging to anyone else. As an online User with access to confidential TWC data ("TWC Information"), I understand that I will be held personally accountable for my actions and for any activity performed under my User ID. I understand that the use of TWC Information is limited to the following Limited Purpose only: **to assist in criminal investigations; and to assist in locating defendants, witnesses, fugitives, and persons with outstanding warrants in criminal cases.** I understand that TWC maintains a record of the individuals and employers whose TWC Information I gain access to, and that I am not allowed access to TWC Information about any individual or employer except as necessary for the Limited Purpose. I understand that I am not allowed access to TWC Information about myself.

I will not enter any unauthorized data or make any changes to data. I will not disclose any TWC Information orally, electronically, in written or printed form, or in any other manner without prior written authorization from TWC. I will not disclose any TWC Information to other governmental entities, including law enforcement entities.

I understand that under Texas Labor Code § 301.085, all TWC Information I obtain under this User Agreement is confidential and that it is a criminal offense to solicit, disclose, receive or use, or to authorize, permit, participate in, or acquiesce in another person's use of TWC Information that reveals: (1) identifying information regarding any individual or past or present employer; or (2) information that foreseeably could be combined with other publicly available information to reveal identifying information regarding any individual or past or present employer. This offense is punishable by as much as a year in jail, a fine up to $4,000, or both.

I understand that under Texas Penal Code § 33.02(a), it is a criminal offense knowingly to access a computer, computer network, or computer system without the effective consent of the owner. Depending on the circumstances, the offense is punishable by 180 days in jail up to 99 years or life in prison, a fine of $2,000-$10,000, or both.

I have read and had explained to me the confidentiality and security requirements of 20 C.F.R. § 603.9 and of my employer's contract with TWC. I understand and agree to abide by these requirements. I understand that if I violate any of these requirements or any provision of this User Agreement, I will jeopardize my employer's contract with TWC.

_____
Signature of User Date signed

Supervisor Approval: I have instructed the User listed above about all confidentiality requirements applicable to TWC Information obtained under the contract with TWC, including the requirements of 20 C.F.R. § 603.9 and the sanctions specified in the Contract and in state law for unauthorized disclosure of TWC Information.

_____
Signature of Supervisor Printed Name Date signed

Approval of Contract Signatory or Contact Person named in Contract:

_____
Signature of Contract Signatory or Recipient Contact Person Printed Name Date signed

All fields on this agreement are required. Employer must retain signed original and give a copy to User. Employer must send copy of User Agreement to TWC RACF Administration as specified on the required Cover Sheet, Attachment D to this Contract.

Attachment D

COVER SHEET FOR TRANSMITTING USER AGREEMENT AND TRAINING CERTIFICATE

To: **RACF Administration**

___ via email to: **racf.administration@twc.state.tx.us**
(Document must be scanned and **encrypted** before sending)

___ via fax to: **512-463-6394**
Number of pages including cover sheet: _____

___ via mail to: **RACF Administration**
Texas Workforce Commission
101 East 15th Street, Room 0330
Austin, TX 78778-0001

From: **Williamson County Constable Precinct 2 (Recipient)**

_____ (Recipient Contact Person)

_____ (Recipient Contact Person email)

Re: **User Agreement(s) and Training Certificate(s) attached**

Instructions:

- User Agreement and Training Certificate must be submitted together for each individual.
- Only one cover sheet is required if submitting documents for more than one User at the same time.
- An incomplete User Agreement will be rejected.
- **For questions regarding the User Agreement, please email racf.administration@twc.state.tx.us**

Attachment G

PROTECTION OF CONFIDENTIALITY - 20 C.F.R. § 603.9

CHAPTER V--EMPLOYMENT AND TRAINING ADMINISTRATION, DEPARTMENT OF LABOR
PART 603--FEDERAL-STATE UNEMPLOYMENT COMPENSATION (UC) PROGRAM; CONFIDENTIALITY AND DISCLOSURE OF STATE UC INFORMATION
SUBPART B--CONFIDENTIALITY AND DISCLOSURE REQUIREMENTS

20 C.F.R. § 603.9 What safeguards and security requirements apply to disclosed information?

(a) In general. For disclosures of confidential UC information under § 603.5(d)(2) (to a third party (other than an agent) or disclosures made on an ongoing basis); § 603.5(e) (to a public official), except as provided in paragraph (d) of this section; § 603.5(f) (to an agent or contractor of a public official); § 603.6(b)(1) through (4), (6), and (7)(i) (as required by Federal UC law); and § 603.22 (to a requesting agency for purposes of an IEVS), a State or State UC agency must require the recipient to safeguard the information disclosed against unauthorized access or redisclosure, as provided in paragraphs (b) and (c) of this section, and must subject the recipient to penalties provided by the State law for unauthorized disclosure of confidential UC information.

(b) Safeguards to be required of recipients.

(1) The State or State UC agency must:

(i) Require the recipient to use the disclosed information only for purposes authorized by law and consistent with an agreement that meets the requirements of § 603.10;

(ii) Require the recipient to store the disclosed information in a place physically secure from access by unauthorized persons;

(iii) Require the recipient to store and process disclosed information maintained in electronic format, such as magnetic tapes or discs, in such a way that unauthorized persons cannot obtain the information by any means;

(iv) Require the recipient to undertake precautions to ensure that only authorized personnel are given access to disclosed information stored in computer systems;

(v) Require each recipient agency or entity to:

(A) Instruct all personnel having access to the disclosed information about confidentiality requirements, the requirements of this subpart B, and the sanctions specified in the State law for unauthorized disclosure of information, and

(B) Sign an acknowledgment that all personnel having access to the disclosed information have been instructed in accordance with paragraph (b)(1)(v)(A) of this section and will adhere to the State's or State UC agency's confidentiality requirements and procedures which are consistent with this subpart B and the agreement required by § 603.10, and agreeing to report any infraction of these rules to the State UC agency fully and promptly.

(vi) Require the recipient to dispose of information disclosed or obtained, and any copies thereof made by the recipient agency, entity, or contractor, after the purpose for which the information is disclosed is served, except for disclosed information possessed by any court. Disposal means return of the information to the disclosing State or State UC agency or destruction of the information, as directed by the State or State UC agency. Disposal includes deletion of personal identifiers by the State or State UC agency in lieu of destruction. In any case, the information disclosed must not be retained with personal identifiers for longer than such period of time as the State or State UC agency deems appropriate on a case-by-case basis; and

(vii) Maintain a system sufficient to allow an audit of compliance with the requirements of this part.

(2) In the case of disclosures made under § 603.5(d)(2) (to a third party (other than an agent) or disclosures made on an ongoing basis), the State or State UC agency must also –

(i) Periodically audit a sample of transactions accessing information disclosed under that section to assure that the entity receiving disclosed information has on file a written release authorizing each access. The audit must ensure that the information is not being used for any unauthorized purpose;

(ii) Ensure that all employees of entities receiving access to information disclosed under § 603.5(d)(2) are subject to the same confidentiality requirements, and State criminal penalties for violation of those requirements, as are employees of the State UC agency.

(c) Redisclosure of confidential UC information.

(1) A State or State UC agency may authorize any recipient of confidential UC information under paragraph (a) of this section to redisclose information only as follows:

(i) To the individual or employer who is the subject of the information;

(ii) To an attorney or other duly authorized agent representing the individual or employer;

(iii) In any civil or criminal proceedings for or on behalf of a recipient agency or entity;

(iv) In response to a subpoena only as provided in § 603.7;

(v) To an agent or contractor of a public official only if the person redisclosing is a public official, if the redisclosure is authorized by the State law, and if the public official retains responsibility for the uses of the confidential UC information by the agent or contractor;

(vi) From one public official to another if the redisclosure is authorized by the State law;

(vii) When so authorized by Section 303(e)(5), SSA, (redisclosure of wage information by a State or local child support enforcement agency to an agent under contract with such agency for purposes of carrying out child support enforcement) and by State law; or

(viii) When specifically authorized by a written release that meets the requirements of § 603.5(d) (to a third party with informed consent).

(2) Information redisclosed under paragraphs (c)(1)(v) and (vi) of this section must be subject to the safeguards in paragraph (b) of this section.

(d) The requirements of this section do not apply to disclosures of UC information to a Federal agency which the Department has determined, by notice published in the Federal Register, to have in place safeguards adequate to satisfy the confidentiality requirement of Section 303(a)(1), SSA.

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Attachment H

QUARTERLY SELF-ASSESSMENT REPORT

Failure to submit this report when due may result in termination of all access to TWC Information.

The entity receiving TWC Information under TWC Contract ("Recipient") confirms it is in compliance with the following requirements of the Contract and of Protection of Confidentiality - 20 C.F.R. § 603.9 (Attachment G of the Contract):

1. Recipient uses the disclosed TWC Information only for purposes authorized by law and consistent with the Limited Purpose set forth in Section 1.2 of Attachment A of the Contract. Yes: _____ No: _____

2. Recipient stores the disclosed TWC Information in a place physically secure from access by unauthorized persons. Yes: _____ No: _____

3. Recipient stores and processes disclosed TWC Information maintained in electronic format, such as magnetic tapes or discs, in such a way that unauthorized persons cannot obtain the TWC Information by any means. Yes: _____ No: _____

4. Recipient undertakes precautions to ensure that only authorized personnel are given access to disclosed TWC Information stored in computer systems. Yes: _____ No: _____

5. Recipient has instructed all personnel having access to the disclosed TWC Information about confidentiality requirements, the requirements of 20 C.F.R. § 603.9, and the sanctions specified in State law for unauthorized disclosure. (Each violation is a Class A Misdemeanor, punishable by a fine of $4,000, a year in jail, or both). By your signature below you acknowledge that all personnel having access to the disclosed TWC Information have been instructed in accordance with paragraph (b)(1)(v)(A) of 20 C.F.R. § 603.9. Yes: _____ No: _____

6. Recipient adheres to confidentiality requirements and procedures that are consistent with 20 C.F.R. § 603.9 and the requirements of the TWC Contract, and reports any infraction of these requirements and procedures to TWC fully and promptly. Yes: _____ No: _____

7. Recipient disposes of disclosed TWC Information, and any copies thereof made by Recipient, after the purpose for which the TWC Information was disclosed is served, or as required by court order. Disposal means return of the TWC Information to TWC or destruction of the TWC Information, as directed by TWC. Disposal includes deletion of personal identifiers in lieu of destruction. Yes: _____ No: _____

8. Recipient ensures that the disclosed TWC Information is not retained with personal identifiers for longer than such period of time as TWC deems appropriate. Yes: _____ No: _____

9. Recipient maintains a system sufficient to allow an audit of compliance with the requirements of 20 C.F.R. § 603.9 and the TWC Contract. Yes: _____ No: _____

10. Attach a description of the system referred to in item 9.

By signature hereon, the Contract signatory or the entity's internal auditor certifies that: All statements and information submitted in response to this Quarterly Self-Assessment Report are current, accurate, and complete.

_____ _____
Signature Date

_____
Printed Name and Title

Williamson County Constable Precinct 2 - 2916PEN010

Return this Report to: External Data Sharing Contracts Manager | Risk and Security Management
Texas Workforce Commission | 1117 Trinity Street, Room 324T | Austin, Texas 78778-0001
Email: Self-AssessmentReports@twc.state.tx.us Fax: 512- 936-0219

TWC Contract - Amendment Number: 2916PEN010

CONTRACT/AMENDMENT LANGUAGE CHANGE CERTIFICATION FORM

Please check the appropriate box and sign below:

☐ **No Changes.** I hereby certify that no changes have been made to documents contained in this Contract/Amendment package.

☐ **Changes to Demographic Information.** I hereby certify that changes in demographic information items only (such as contact or signatory) have been made to documents contained in this Contract/Amendment package. Pen and ink corrections have been entered, initialed and the revised areas have been flagged.

☐ **Changes to Contract/Amendment Terms and Conditions.** I hereby certify that changes to the contract/amendment terms and conditions have been proposed. The proposed changes have been entered on all copies of the documents in pen and ink, initialed, and the revised areas have been flagged. I understand that I am to sign and then send all copies of the contract/amendment back to TWC for evaluation of the proposed changes. If the proposed changes are approved by the TWC signatory, they will be initialed and my copy (and the fiscal agent's copy, if applicable) will be returned to me. I understand that if there are any questions or issues regarding the proposed pen and ink changes that I will be contacted by a TWC representative to discuss them.

Williamson County Constable Precinct 2

_____

Dan Gattis Date
County Judge

Commissioners Court - Regular Session **43.**

Meeting Date: 09/01/2015

Reject proposals and readvertise Speific and Aggregate Stop Loss

Submitted By: Kerstin Hancock, Purchasing

Department: Purchasing

Agenda Category: Regular Agenda Items

Information

Agenda Item

Discuss, consider, and take appropriate action on rejecting proposals received for RFP#1506-010, Specific and Aggregate Stop Loss Insurance, and authorizing Purchasing Agent to re-advertise and receive proposals for same under new RFP#1508-009.

Background

It is the recommendation that it is in the best interest of the County to reject the only proposal received and re-solicit this RFP as additional information was added to the package to allow for greater competition.

Fiscal Impact

From/To	Acct No.	Description	Amount

Attachments

RFP Packet

Form Review

Inbox	Reviewed By	Date
County Judge Exec Asst.	Wendy Coco	08/27/2015 10:05 AM
Form Started By: Kerstin Hancock		Started On: 08/06/2015 07:27 AM
Final Approval Date: 08/27/2015		

PUBLIC ANNOUNCEMENT AND GENERAL INFORMATION

WILLIAMSON COUNTY PURCHASING DEPARTMENT

SOLICITATION

Specific & Aggregate Stop Loss Insurance

PROPOSALS MUST BE RECEIVED ON OR BEFORE:
Sep 22, 2015 3:00:00 PM CDT
PROPOSALS WILL BE PUBLICLY OPENED:
Sep 22, 2015 3:00:00 PM CDT

Notice is hereby given that sealed Proposals for the above-mentioned goods and/or services will be accepted by the Williamson County Purchasing Department. Williamson County uses BidSync to distribute and receive proposals. Specifications for this RFP may be obtained by registering at www.bidsync.com.

Williamson County prefers and requests electronic submittal of this proposal.

All electronic proposals must be submitted via: www.bidsync.com

All interested Respondents are invited to submit a Proposal in accordance with the Instructions and General Requirements, Proposal Format, Proposal Specifications, and Definitions, Terms and Conditions stated in this RFP.

Respondents are strongly encouraged to carefully read this entire RFP.

Electronic proposals are requested, however paper proposals will currently still be received, until further notice and may be mailed or delivered to the address listed below.

Please note that a complete package must be submitted choosing one of the above two methods. Split packages submitted will be considered "unresponsive" and will not be accepted or evaluated.

- ✓ If mailed or delivered in person, Proposals and Proposal addenda are to be delivered in sealed envelope on or before the submittal deadline, as noted in the 'Public Announcement and General Information' listed above for this RFP, to:

Williamson County Purchasing Department
Attn: **PROPOSAL NAME AND NUMBER**
901 South Austin Avenue
Georgetown, Texas 78626

- ✓ Respondents should list the Proposal Number, Proposal Name, Name and Address of Respondent, and the Date of the Proposal opening on the outside of the box or envelope and note "Sealed Proposal Enclosed."
- ✓ Respondent should submit one (1) original; **AND** one (1) CD **OR** (1) USB copy of the Proposal.
- ✓ **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.
- ✓ Facsimile transmittals will NOT be accepted.

✓ Proposals will be publicly opened in a manner to avoid public disclosure of contents; however, names of Respondents will be read aloud.

✓ All submitted questions with their answers will be posted and updated on www.bidsync.com.

✓ It is the Respondent's responsibility to review all documents in BidSync including any addenda that may have been added after the document packet was originally released and posted.

✓ Any addenda and/or other information relevant to the RFP will be posted on www.bidsync.com.

✓ The Williamson County Purchasing Department takes no responsibility to ensure any interested Respondent has obtained any outstanding addenda or additional information.

✓ Williamson County will NOT be responsible for unmarked or improperly marked envelopes.

Bid 1508-009
Specific & Aggregate Stop Loss Insurance

Bid Number	**1508-009**
Bid Title	**Specific & Aggregate Stop Loss Insurance**
Bid Start Date	**In Held**
Bid End Date	**Sep 22, 2015 3:00:00 PM CDT**
Question & Answer End Date	**Sep 16, 2015 5:00:00 PM CDT**
Bid Contact	**Kerstin N Hancock** **512-943-1546** **khancock@wilco.org**
Contract Duration	**14 months**
Contract Renewal	**2 annual renewals**
Prices Good for	**90 days**
Bid Comments	**Williamson County is seeking proposal for Specific Aggregate Stop Loss Insurance. Respondent must specify any deviation from the RFP in their proposal on the "Statement of Compliance" form. It will be assumed that the Respondent's Proposal is in compliance with the RFP specifications if deviations are not noted on the "Statement of Compliance" form. Also, important to note that the current Stop Loss Policy is for a 12-month period, however, the County is moving the Plan Year to a Calendar Year. in order to do this we are requesting a 14-month period to assist in this transition. The County has the past enrollment year moved from a Third Party Claims Administrator to Aetna Insurance Carrier, for third party administration for both network as well as plan discounts and claims management.** **Secure copy of the census and the LCR (Large Claim Review) or any additional information can be obtained by emailing khancock@wilco.org.**

Item Response Form

Item	**1508-009--01-01 - Please attach all required proposal documents to this line item**
Quantity	**1 each**

Prices are not requested for this item.

Delivery Location **Williamson County, Texas**

No Location Specified

Qty 1

Description

Please attach all required documents such as Fee proposal, Statement of Compliance, notarized RFP Affidavit etc... to this line item.

PROPOSAL SPECIFICATIONS

1.1 Background Information

Williamson County has a self-insured Medical benefit program administered by Aetna Inc. utilizing both Aetna's Choice POS 2 network and The Seton Health Alliance ACO. The County offers Four (4) Medical plans. These plans differ by network, deductible and co-insurance amounts.

The County's current ISL is $250,000 and the Aggregate is a 120% corridor.

This RFP is for:

Specific & Aggregate Stop Loss Insurance

The County does not have the staff to increase their job functions being performed currently. Therefore, any carrier/administrator must be willing to meet all the stated current services as a minimum and clearly outlined in his or her Proposal any deviations from those stated within the RFP.

You must specify any and all deviations in your Proposal 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".** This RFP has outlined the services the County expects as a minimum requirement.

Any prospective Respondent will be responsible for having qualified personnel and computerized systems capable of handling a case of this size and the flexible plan of benefits. The Respondent must provide references and proof of the provider's ability to serve satisfactory to the County. This Contract will not be based upon cost alone but will place equal importance on ability to pay claims timely and accurately, and on the ability of the provider to serve satisfactorily to the County.

It is not the intent of the County that commissions are built into the Proposals. Commissions, fees or other reimbursement arrangements are prohibited. Each Respondent must sign the **Non- Collusion Affidavit enclosed or their Proposal will not be considered.**

If you have any technical questions about the specifications, please put all questions in writing to the attention of the Purchasing contact at khancock@wilco.org and copy purchase@wilco.org.

***FOR AN ELECTRONIC COPY OF THE CENSUS OR INFORMATION ON CLAIMS THAT ARE 50% OF THE INDIVIDUAL SPECIFIC, PLEASE SUBMIT YOUR REQUEST IN WRITING* TO khancock@wilco.org and copy purchase@wilco.org**

1.2 General Carrier Requirements

1.2.1 Specific Stop-Loss

Williamson County is looking to go to a 14 month contract from 11/1/15 through 12/31/16. The requested specific is for $250,000 Deductible and should be a 24/14 paid contract. The optional requests are for a $225,000 and $275,000 deductible and it should be a 24/14 contract. The specific and aggregate should include all **prescription drug** claims and exclude all claims from the stand alone dental and vision plans. Proposals must clearly

state any limitations in regards to an unlimited lifetime maximum benefit.

Note: Respondents are encouraged to give options for more than a single year contract. Any Lasers, Aggregating Specific or different contract periods, must be finalized after the receipt of updated materials. Non-acceptance of this requirement must be outlined on the Statement of Compliance Form in the Proposal.

1.2.2 Aggregate Excess Protection

The aggregate attachment point must be proposed on 120% of projected paid claims. Corridors of lesser amounts such as 115% will receive preferential review. A monthly cap should be given as an option. Each Proposal must state exactly the monthly and total attachment point dollar amount the time period covered, and if there are any restrictions.

1.2.3. Transitional Process

The selected carrier shall be responsible for all claims incurred on/or after **November 1, 2014 and paid from November 1 2015 through December 31, 2016.** The County desires that covered employees and their dependents should not be adversely affected by a change in insurance carriers. A "no-loss/no-gain" approach will apply to all participants covered under the new plan. It is imperative that any exclusions, limitations, or any other deviation be clearly outlined and discussed. A Respondent is expected to explain, in detail, their approach and responsibilities for total disabilities, active at work clauses, or any other limitations.

Proposals received with full protection – no limitations – will receive preference.

1.2.4 Commission

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

1.2.5 Compliance with the Proposal

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

1.2.6 Effective Date

The effective date of the new contract(s) will be **November 1, 2015 for 14 months.** Following the initial contract term from November 1, 2015 to December 31, 2016, the County will have the option to renew the contract for two (2) one-year annual renewals.

1.2.7 Proposed Rates

A minimum rate guarantee of 14 (fourteen) months is required. Please confirm this guarantee in your Proposal and denote any additional guarantees your company may wish to extend to the County. It is the County's intent to establish a one year contract with the new carrier(s) provided renewal rates are acceptable and can be given within your Proposal. **Multiple year, rate guaranteed, contracts will receive preference. Multiple year contracts must include a not to exceed cap for rate increase in the**

additional years.

1.2.8 Renewal Rates

The selected carrier is asked to deliver a rate adjustment no later than 90 (ninety) days prior to the anniversary date each year.

1.2.9 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 (thirty days of notice of termination.

1.2.10 Master Policy

The master policy shall be provided to the County no later than 30 (thirty) days from effective date. Please confirm your ability to provide this service and meet the deadline in your Proposal.

1.2.11 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.

1.2.12 Carrier Selection

The selection of the carrier is tentatively scheduled to occur on 09-08-2015

1.2.13 Data Caveat

Williamson County and Aetna have supplied the data contained herein. It has been gathered and coordinated by the consultant and reviewed as to accuracy on a "best effort" manner. This Request for Proposal is qualified to the extent the data provided is accurate.

1.2.14 Financial Statements

Two (2) most recent annual financial statements are required prior to contract award.

1.3 Stop Loss Questionnaire

CARRIER INFORMATION

1. When did the insurer start writing Medical Stop Loss Insurance?

2. Please note any years in which the insurer ceased writing or renewing medical stop loss business.

3. Please provide the names, titles and phone numbers for key contact persons for claims, billing and eligibility.

FINANCIAL INFORMATION

1. Please provide information relative to your reinsurance arrangements for your medical stop loss coverage.

2. What percentage of the risk do you retain? Describe in detail.

UNDERWRITING INFORMATION

1. At renewal, what information do you require? Specifically address all disclosure requirements.

2. How far in advance of the anniversary date (November 1) can the group expect to receive renewal rates?

RATING PROCEDURES

1. Discuss your renewal philosophy. Be specific as it relates to known ongoing large claims, high deductibles, lasering, rating up, exclusion, etc.

2. Has a renewal ever been denied solely due to claim experience?

3. Does your contract allow you to limit or exclude coverage for an individual who becomes disabled or begins receiving treatment after you are awarded the contract but prior to the contract effective date?

CLAIMS INFORMATION

1. What information do you require to process a specific stop loss claim?

2. What information do you require to process an aggregate stop loss claim?

3. What kind of timeframe can we expect for you to pay both claim types?

4. What proof of payment is required for specific and aggregate claims?

5. What is your definition of a paid claim?

6. If you purchase reinsurance protection, does the reinsurer need to review all claims before they are paid, or are your decisions binding on the reinsurance?

7. If a claim is delayed beyond the end of the contract period, do you grant a waiver of the time limits for payments if the circumstances are reported to you prior to the end of the period? If not, how are such situations handled?

8. Do you require that large claim management services be used? Under what circumstances? Do you pay for such services?

9. Do you accept the reasonable and customary determinations made by the TPA, or do you have a database you use?

CONTRACT INFORMATION

1. Please provide a sample policy for our review.

2. Please list any exclusion(s) that are mandatory, regardless of the client's proposed plan document language or benefit design.

3. Do you have an "actively at work" provision? What are the procedures for waiving it?

4. What is the maximum time allowed for submission after the termination date of valid claims that were paid within the contract period?

5. Please provide the definition of experimental procedures and note how this provision is interpreted for a claim approved for payment under the medical plan.

6. Does the insurer assist in claim determination before reimbursement is requested?

7. Are there any circumstances where the insurer can deny reimbursement of a claim which has been approved by the UR program and/or the Large Case Manager and paid under the Plan?

8. Please specify all terms and conditions under which the insurer may terminate or modify its policy.

9. If the policy is issued through an MGU, delineate what happens when the reinsurer changes on a date other than the client's Plan anniversary.

1.4 Plan Designs Claims Experience

FOR AN ELECTRONIC COPY OF THE CENSUS AND LARGE CLAIMANT INFORMATION, PLEASE EMAIL khancock@wilco.org and copy purchase@wilco.org

1.5 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 A e t n a ' s website at www.aetna.com to access l inks 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 a 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 Aetna. 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 Aetna. 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.

Additional Stipulations

1. Introduction

The Proposal evaluation and selection process is detailed in this section, as are other factors, and the format in which the Price Proposal of each Proposal should be submitted.

2. Price Proposal

The Respondent must utilize the price sheet form provided in the Appendix A which will be attached to this RFP. The Price Proposal should be included in each copy of the Proposal if submitted in paper form. 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.

3. Proposal Evaluation and Selection

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.

3.2 Evaluation Committee and Selection Process

All Proposals will 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 Evaluation Committee, 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 Evaluation Committee will present its recommendation 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:

Respondents' Proposals must meet all mandatory requirements in order to be scored according to the criteria following the mandatory requirements. Scoring may also be based on total information gathered by Williamson County at its discretion, including but not limited to respondent's ability to perform "without delay or interference"; respondent's "character, responsibility, integrity, and experience or demonstrated capability; quality of prior work; compliance with laws; and noncompliance with requirements as to submission of relevant information.".

3.2.1 Mandatory criteria (has to be met in order to be scored)

3.3.1 Must have been rated by A.M. Best for at least the past three years as an A- rated company

3.3.2 Insurance company is published in the current listing of insurance companies

Authorized to transact business in Texas; and

3.3.3 Will consider waiving the Employee Actively at Work/Dependent Non-Confined Underwriting provision

3.3.4 Additional criteria to be considered:
Financial Stability of Insurance Company

3.4 Graded Evaluation Factors
The following graded evaluation factors will be used to determine how well a Respondent(s) meet(s) the desired performance.

FACTORS	POINTS
Price	35
Individual Lasers	25
Proposal Responsiveness	15
Policy Exclusions	20
Public Entity Experience	5
Maximum Total points	**100**

3.5 Additional Evaluation information
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.

4. Contract Administration
Shelley Loughrey, Benefits Administrator (or successor), Williamson County,301 SE Inner Loop, Ste 108, Georgetown, TX 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 Williamson County Commissioners Court and the Successful Respondent.

5. Initial Contract Term
The Successful Respondent shall provide the goods and/or services described herein for an initial term of fourteen (14) months beginning on the date of Commissioners Court award beginning November 1, 2015 and ending December 31, 2016

6. 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 thirty-eight (38) 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.

7. Workers' Compensation Coverage Requirements

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

8. Confidentiality

Respondent expressly agrees that it will not use any direct or incidental confidential information that may be obtained while working in a governmental setting for its own benefit, and agrees that it will not access unauthorized areas or confidential information and it will not disclose any information to unauthorized third parties, and will take care to guard the security of the information at all times.

9. Tentative Schedule

Event	Date
RFP distributed to selected vendors	09/01/15
Deadline for RFP questions	09/16/15
RFP final responses due	09/22/15
Notification of finalists	09/29/15
Best and Final Offer & Sample Contract	10/02/15
Benefit Committee Meeting – Final Selection of Vendor	10/21/15
Contract awarded	10/27/15
Contract effective date	11/01/15

Proposer References

List at least **(3) companies or governmental agencies,** where the same or similar goods and/or services as contained in this RFP package, were recently provided by Respondent in the last 4 years.

Reference 1

Client Name: Location:
City or County

Contact Name: Title:

Phone: Email: Contract Dates:
Contract Value: $

Scope of Work:

Reference 2

Client Name: Location:
City or County

Contact Name: Title:

Phone: Email: Contract Dates:
Contract Value: $

Scope of Work:

Reference 3

Client Name: Location:
City or County

Contact Name: Title:

Phone: Email: Contract Dates:
Contract Value: $

Scope of Work:

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 is 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.

CONFLICT OF INTEREST QUESTIONNAIRE **FORM CIQ**

For Respondent or other person doing business with local government entity

1. 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.

Cooperative Purchasing Program

Check one of the following options below. A non-affirmative Proposal will in no way have a negative impact on the evaluation of the Proposal.

☐ I will offer the quoted prices to all authorized entities during the term of the contract.

☐ I will not offer the quoted prices to all authorized entities.

1. RESPONSE FORMAT AND SUBMISSION

1.1 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. If mailed or delivered in person, please limit additional, non-requested information.

Please provide your Proposal response using:

3 8 ½" x 11" pages, inclusive of any cover letter or supporting materials
4 The least amount of plastic/laminate or other non-recyclable binding materials
5 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.

1.2 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:

(1) Transmittal Letter
(2) Table of Contents
(3) Executive Summary
(4) Proposal Response to Criteria (see Specifications & Cost Proposal, Experience and Qualifications, References, Implementation Strategy)
(5) Price Sheet
(6) References: Identification of three (3) references *within the last 4 years* for which the Respondent is providing or has provided the goods and services (public sector) of the type requested, including the name, position, and telephone number of a contact person at each entity
(7) Conflict of Interest Questionnaire
(8) Proposal Affidavit and Addenda Acknowledgement
(9) Signature Page
(10) Attach your entities Sample Contract

1.3 Transmittal Letter

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

A. Name and address of individual or business entity submitting the Proposal;
B. Respondent's type of business entity (i.e., Corporation, General Partnership, Limited Partnership, LLC, etc.);
C. Place of incorporation or organization, if applicable;
D. Name and location of major offices and other facilities that relate to the Respondent's performance under the terms of this RFP;
E. Name, address, business and fax number of the Respondent's principal contact person regarding all contractual matters relating to this RFP;
F. The Respondent's Federal Employer Identification Number;
G. A commitment by the Respondent to provide the services required by Williamson County;
H. 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.);

l. 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 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.

1.4 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 should not include any information concerning the cost of the Proposal.

The Respondent should 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 should 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 should describe in detail the current and historical experience the Respondent and its subcontractors have that would be relevant to completing the project. References must 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.

1.5 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/e n-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 in accordance with this RFP.

1.6 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.

1.7 Delivery of Proposals

Williamson County uses BidSync to distribute and receive bids and proposals Bids can be submitted electronically through BidSync or by hard copy. Refer to www.bidsync.com for further information.

If mailed or delivered in person, Proposals and Proposal addenda are to be delivered in sealed envelope on or before the submittal deadline, as noted in the 'Public Announcement and General Information' listed above for this RFP, to:
Williamson County Purchasing Department
Attn: **PROPOSAL NAME AND NUMBER**
901 South Austin Avenue
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, two (2) paper copies** and **one (1) CD or (1) USB** 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, Proposal Name, Name and Address of Respondent, and the Date of the Proposal opening on the outside of the box or envelope and note "Sealed Bid Enclosed."

2.0 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.

2.1 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.

2.2 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.

2.3 Proposal Preparation Cost

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

2.4 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.

2.5 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.

2.6 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.

2.7 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.

2.8 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.

2.9 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.

2.10 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.

2.11 Responsibility

It is expected that a Respondent will be able to affirmatively demonstrate Respondent's responsibility. 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.

2.12 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.

2.13 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.

2.14 References

Williamson County requires Respondent to supply a list of at least three (3) references **within the last 4 years** where like services and/or goods have been supplied by Respondent if Respondent has not done business with the County within the past five (5) years.

3.0 DEFINITIONS, TERMS AND CONDITIONS

3.1 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.

3.2 Terms and Conditions

3.2.1 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.

3.2.2 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.

3.2.3 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.

3.2.4 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.

3.2.5 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.

3.2.6 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.

3.2.7 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.

3.2.8 Termination

3.2.8.1 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.

3.2.8.2 Termination for Convenience: Williamson County may terminate the Contract and/or any ensuing Agreement for convenience and without cause or further liability, upon no less than thirty (30) calendar days written notice to Successful Respondent. Williamson County reserves the right to extend this period if it is in the best interest of the County. 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.

3.2.9 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.

3.2.10 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.

3.2.11 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.

3.2.12 Inspections and Testing

Williamson County reserves the right to inspect and test equipment, supplies, material(s) and goods for quality and compliance with this RFP, and ability to meet the needs of the user. Demonstration units must be available for review. Should the goods or services fail to meet requirements and/or be unavailable for evaluation, Williamson County can deem the Respondent to be in breach and terminate the Contract and/or any ensuing Agreement(s).

3.2.13 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.

3.2.14 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.

3.2.15 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.

3.2.16 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.

3.2.17 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.

3.2.18 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.

3.2.19 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.

3.2.20 Equal Opportunity

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

3.2.21 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
Max Bricka, 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.

3.2.22 Sales and Use Tax Exemption

Williamson County is a 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.

3.2.23 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.

3.2.24 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.

3.2.25 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.

3.2.26 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.

3.2.27 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 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 of Williamson County does not appropriate sufficient funds as determined by Williamson County's budget for the fiscal year in question. Williamson County may affect such termination by giving written notice of termination to the Successful Respondent at the end of its then-current fiscal year.

3.2.28 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.

3.2.29 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.

3.2.30 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.

3.2.31 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.

3.2.32 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.

3.2.33 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.

3.2.34 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.

3.2.35 Contractual Formation and Ensuing Agreement

The RFP and 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. 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.

THE RESPONDENT'S PROPOSAL SHOULD INCLUDE A SAMPLE CONTRACT, ANY OR ALL ADDITIONAL AGREEMENTS OR TERMS AND CONDITIONS AT THE TIME THE RESPONDENT'S PROPOSAL IS SUBMMITTED USING SEPARATE ATTACHED DOCUMENTS FOR THE COUNTY'S REVIEW AND CONSIDERATION.

3.2.36 Legal Liability Information

The Successful Bidder shall disclose all legal liability information by listing any pending litigation or anticipated litigation that your firm is involved in, including but not limited to, potential or actual legal matters with private parties and any local, State, Federal or international governmental entities. Williamson County reserves the right to consider legal liability information in the recommendation of any proposed contract to the Williamson County Commissioners Court.

3.2.37 Confidentiality

Respondent expressly agrees that it will not use any direct or incidental confidential information that may be obtained while working in a governmental setting for its own benefit, and agrees that it will not access unauthorized areas or confidential information and it will not disclose any information to unauthorized third parties, and will take care to guard the security of the information at all times.

FEE PROPOSALS

Each stop-loss Respondent must complete this form using the census head count provided.

A. Individual Specific $ 225,000 Pooling Point **(includes RX)**
Contract Type: 26/14 Rate Guarantee: _____.
# of Years

Employee Composite _____ X _____ = _____.
#EEs Rate Monthly Prem.

Or

Employee Only _____ X _____ = _____.
#EEs Rate Monthly Prem.

Dependents Only _____ X _____ = _____.
#DEPs Rate Monthly Prem.

(Note: If rates are EE and Family, you will have to make subtraction.)

B. Aggregate stop-loss Option(s) with $ 225,000 Specific
Contract Type 26/14 Paid

(1) Corridor 120% **(includes RX)** Rate Guarantee: _____
Contract Type 26/14 # of Years

_____ X _____ = _____
Premium #EEs Monthly Att.

_____ X _____ = _____
Att. Factor #EEs Monthly Att.

_____ X _____ = _____
Att. Factor #DEPs Monthly Att.

NOTES: The County is requesting a 120% Aggregating Corridor.

(CONTINUED)
FEE PROPOSALS

A. Individual Specific $ 250,000 Pooling Point **(includes RX)**
Contract Type: 26/14 Rate Guarantee: _____.
# of Years

Employee Composite _____X_____=_____.
#EEs Rate Monthly Prem.

Or

Employee Only _____X_____=_____.
#EEs Rate Monthly Prem.

Dependents Only _____X_____=_____.
#DEPs Rate Monthly Prem.

(Note: If rates are EE and Family, you will have to make subtraction.)

B. Aggregate stop-loss Option(s) with $ 250,000 Specific
Contract Type 26/14 Paid

(1) Corridor 120% **(includes RX)** Rate Guarantee: _____
Contract Type 26/14 # of Years

_____ X _____= _____
Premium #EEs Monthly Att.

_____ X _____= _____
Att. Factor #EEs Monthly Att.

_____ X _____= _____
Att. Factor #DEPs Monthly Att.

NOTES: The County is requesting a 120% Aggregating Corridor.

(CONTINUED)
FEE PROPOSALS

A. Individual Specific $ 275,000 Pooling Point **(includes RX)**
Contract Type: 26/14 Rate Guarantee: _____.
# of Years

Employee Composite _____X_____=_____.
#EEs Rate Monthly Prem.

Or

Employee Only _____X_____=_____.
#EEs Rate Monthly Prem.

Dependents Only _____X_____=_____.
#DEPs Rate Monthly Prem.

(Note: If rates are EE and Family, you will have to make subtraction.)

B. Aggregate stop-loss Option(s) with $ 275,000 Specific
Contract Type 26/14 Paid

(1) Corridor 120% **(includes RX)** Rate Guarantee: _____
Contract Type 26/14 # of Years

_____ X _____= _____
Premium #EEs Monthly Att.

_____ X _____= _____
Att. Factor #EEs Monthly Att.

_____ X _____= _____
Att. Factor #DEPs Monthly Att.

NOTES: The County is requesting a 120% Aggregating Corridor.

(CONTINUED)
FEE PROPOSALS

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

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: _____

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.

PROPOSAL AFFIDAVIT

This form must be completed, signed, notarized and returned with Proposal package

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_____

BEFORE ME, the undersigned authority, a Notary Public in and for the State of_____, on this

day personally appeared_____(*Name of Signer*), who after being by me duly sworn, did depose and say:

"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 Proposal on, or to influence any person or persons to submit a Proposal or not to submit a Proposal thereon."

Name and Address of Respondent:

_____

Fax: _____ Telephone#:_____

By: _____ Printed Name: _____

Title: _____

SUBSCRIBED AND SWORN to before me by the above-named_____

_____on this the_____day of__, 20_

_____.

_____

Notary Public in and for

The State of _____

STATEMENT OF COMPLIANCE

This form must be completed and submitted as a part of your Proposal (if additional space is needed please attach additional sheet)

RE: **WILLIAMSON COUNTY**

We hereby acknowledge receipt of Request for Proposal for Health Related Services for Williamson County Benefit Enrollment 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

IMPORTANT NOTICE

To obtain information or make a complaint:

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights, or complaints at:

1-800-252-3439

You may write the Texas Department of Insurance at:

Texas Department of Insurance
P.O. Box 149104
Austin, TX 78714-9104
FAX No. (512) 475-1771
Web: http://www.tdi.state.tx.us

PREMIUM OR CLAIM DISPUTES:

Should you have a dispute concerning your premium or about a claim you should contact Aetna first. If the dispute is not resolved you may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR POLICY:

This notice is for information only and does not become a part or condition of the attached document.

AVISO IMPORTANTE

Para obtener información o para someter una queja:

Puede comunicarse con el Departamento de Seguros de Texas para obtener información acerca de compañías, coberturas, derechos, o quejas llamando al:

1-800-252-3439

Puede escribir al Departamento de Seguros de Texas:

Texas Department of Insurance
P.O. Box 149104
Austin, TX 78714-9104
FAX No. (512) 475-1771
Web: http://www.tdi.state.tx.us

DISPUTAS SOBRE PRIMAS O RECLAMOS:

Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con el (agente) (la compania) (agente o la compania) primero. Si no se resuelve la disputa, puede entonces comunicarse con el departamento (TDI).

UNA ESTE AVISO A SU POLIZA:

Este aviso es solo para proposito de informacion y no se convierte en parte o condicion del documento adjunto.

Stop Loss Insurance Policy

Aetna Life Insurance Company
Hartford, Connecticut 06156

(A Stock Company herein called Aetna)

This Policy will be construed in accordance with the law of the jurisdiction in which it is delivered.

In consideration of premium payments by the Insured in the amounts and at the times provided, Aetna agrees with the Insured to provide insurance in accordance with the Policy terms.

For the purpose of effective dates and termination dates under this Policy, all days begin and end at 12:00 midnight.

This Policy is non-participating.

In Witness Whereof, Aetna Life Insurance Company has signed this Policy at **Hartford, Connecticut**.

Mark T. Bertolini
Chairman, Chief Executive Officer and President

Registrar

This is not a policy of workers' compensation insurance. The Policyholder does not become a subscriber to the workers' compensation system by purchasing this policy, and if the Policyholder is a non-subscriber, the Policyholder loses those benefits which would otherwise accrue under the workers' compensation laws. The Policyholder must comply with the workers' compensation law as it pertains to non-subscribers and the required notifications that must be filed and posted.

The Employer understands the liability assumed under the portion of the employee benefit plan which he is self-insuring and further understands that he is exempted from Chapter 101 of the Texas Insurance Code only if a qualified employee benefits plan has been filed and meets the requirements of ERISA.

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, Connecticut 06156

Section 1. Declarations

STOP LOSS INSURANCE POLICY FOR:

INSURED:
Williamson County a political subdivision of the
State of Texas a body politic duly organized and existing
under the laws of the State of Texas
710 Main Street,
Suite 101
Georgetown, Texas 78626

POLICY NUMBER:
SL–866349

POLICY EFFECTIVE DATE:
November 1, 2014

DATE OF ISSUE:
July 21, 2014

POLICY DELIVERED IN:
Texas

Section 2. Schedule of Insurance

Individual Stop Loss Specifications:

FIRST POLICY YEAR:	November 1, 2014 through October 31, 2015
PREMIUM RATE:	$55.10 per employee per month Composite rate for both Individual and Aggregate Stop Loss
INDIVIDUAL STOP LOSS AMOUNT:	$250,000 Certain Participants have Individual Stop Loss Amounts that are in excess of $250,000. These Participants and their Individual Stop Loss Amounts are listed on Attachment A.
INDIVIDUAL LIFETIME STOP LOSS PAYMENT AMOUNT:	Unlimited
CONTRACT BASIS:	Eligible Claim Expenses incurred between May 1, 2014 through October 31, 2015 and paid between November 1, 2014 through October 31, 2015**.** Run-in Period: 6 months Run-in Limit: $750,000 This amount represents a limit on the total amount of claims per Participant we will consider for the 6 month run-in period. All run-in claims reported to Aetna must be paid pursuant to the plan of benefits in effect during the run-in period and in accordance with Aetna's then current standard claim practices. The Policy will not cover run-in claims for a Participant who is not enrolled in the Aetna administered Plan on the Policy Effective Date unless Aetna is the only claims administrator and/or Stop Loss insurer as of the Policy Effective Date. Run-in claims must be reported to Aetna no later than 6 months after the end of the First Policy Year.
COVERED BENEFITS:	Medical Benefits Prescription Drug Benefits

The information provided in this Schedule of Insurance for each Policy Year after the first shall be indicated in a written notice sent to the Insured and shall be effective on the date stated in such notice.

Section 2. Schedule of Insurance (Continued)

Aggregate Stop Loss Specifications:

FIRST POLICY YEAR:	November 1, 2014 through October 31, 2015
PREMIUM RATE:	$55.10 per employee per month Composite rate for both Individual and Aggregate Stop Loss
AGGREGATE STOP LOSS PERCENTAGE:	120%
AGGREGATE STOP LOSS FACTOR:	$1,244.10
MAXIMUM ANNUAL AGGREGATE STOP LOSS PAYMENT AMOUNT:	$1,000,000
CONTRACT BASIS:	Eligible Claim Expenses incurred between May 1, 2014 through October 31, 2015 and Paid between November 1, 2014 through October 31, 2015**.** Run-in Period: 6 months Run-in Limit: $3,000,000 This amount represents a limit on the total amount of claims we will consider for the 6 month run-in period. All run-in claims reported to Aetna must be paid pursuant to the plan of benefits in effect during the run-in period and in accordance with Aetna's then current standard claim practices. The Policy will not cover run-in claims for a Participant who is not enrolled in the Aetna administered Plan on the Policy Effective Date unless Aetna is the only claims administrator and/or Stop Loss insurer as of the Policy Effective Date. Run-in claims must be reported to Aetna no later than 6 months after the end of the First Policy Year.
COVERED BENEFITS:	Medical Benefits Prescription Drug Benefits

The information provided in this Schedule of Insurance for each Policy Year after the first shall be indicated in a written notice sent to the Insured and shall be effective on the date stated in such notice.

Section 3. Insuring Agreement

Aetna will reimburse the Insured for Eligible Claim Expenses during a Policy Year, which are in excess of any of the following:

(a) the Aggregate Stop Loss Amount;

(b) the Individual Stop Loss Amount for any one Participant.

Such payments are hereafter called Stop Loss payments.

In no event will Stop Loss payments in any Policy Year for Eligible Claim Expenses in excess of the Aggregate Stop Loss Amount exceed the Maximum Annual Aggregate Stop Loss Payment Amount shown in the Schedule of Insurance.

In no event will Stop Loss payments for all Eligible Claim Expenses with respect to a Participant during his or her lifetime exceed the Individual Lifetime Stop Loss Payment Amount shown in the Schedule of Insurance.

Section 4. Definitions

As used in this Policy:

1. “Aggregate Stop Loss Amount” is the total dollar amount of Eligible Claim Expenses which must be paid by the Insured for all Participants during the Policy Year before Aggregate Stop Loss benefits are payable. It is determined at the end of the Policy Year and is the greater of: (1) the sum of each month’s number of eligible employees reported to Aetna multiplied by the Stop Loss Factor or (2) the Minimum Aggregate Stop Loss Amount. The Aggregate Stop Loss Amount does not include claim payments made during a Policy Year on behalf of a Participant in excess of the Individual Stop Loss Amount set forth in the **Schedule of Insurance** or any amounts reimbursable to the Insured as Individual Stop Loss payments.

2. “Aggregate Stop Loss Factor” is expected claims times the Aggregate Stop Loss Percentage, divided by the expected number of employees at the beginning of the Policy Year, divided by the number of months in the Policy Year.

3. “Aggregate Stop Loss Percentage” means the percentage amount (e.g., 20%) above expected paid claims (e.g., 120%).

4. "Contract" means Master Services Agreement No. MSA-866349, an Agreement between the Insured and Aetna.

5. “Contract Basis” establishes the time period during which Eligible Claim Expenses must be incurred by a Participant through the Plan and the time period during which those expenses must be paid by Aetna or a prior claim administrator in order for those Eligible Claim Expenses to be included in the calculation of benefits under this Policy.

6. “Covered Benefits” are the benefits provided for Participants by the Plan as indicated on the Schedule of Insurance.

7. “Eligible Claim Expenses” are expenses for Covered Benefits that are paid by the Insured pursuant to the Plan and are not excluded under the terms of this Policy. Payment for Eligible Claim Expenses is considered to be paid as of the date the payment instrument is issued by Aetna. Eligible Claim Expenses will include payments made in New York on behalf of the Insured to fund indigent care and graduate medical education when paid directly into the New York state pool.

8. "Employee" means a U.S. based employee of the Insured who is regularly working at least 20 hours per week and for whom the Insured is deducting any required U.S. FICA taxes.

9. “Experimental and Investigational” means a drug, device, procedure, or treatment that Aetna determines is not accepted as standard medical treatment of a condition or illness. Examples of Aetna’s experimental and investigational determinations are found at Aetna.com under Clinical Policy Bulletins.

10. “Individual Lifetime Stop Loss Payment Amount” means the maximum amount of Eligible Claim Expenses funded by Individual Stop Loss under this Policy on any one Participant during his/her lifetime. In the event the Eligible Claim Expenses funded by Individual Stop Loss reach the Individual Lifetime Stop Loss Payment Amount, all subsequent Eligible Claim Expenses for that individual will be funded by the Insured.

11. “Individual Stop Loss Amount” is the dollar amount of Eligible Claim Expenses per Participant that must be paid by the Insured prior to any Individual Stop Loss Benefit becoming payable under this policy.

12. "Insured" is the plan sponsor identified in the Declarations section of the Policy.

13. “Maximum Annual Aggregate Stop Loss Payment Amount” is the limit on the aggregate benefit amount, which will be paid by Aetna for the Policy Year.

14. “Medically Necessary” means a service or supply that is furnished by a provider that Aetna determines is appropriate for the diagnosis, the care or the treatment of a disease or the injury. Examples of Aetna’s medically necessary determinations are found at Aetna.com under Clinical Policy Bulletins.

15. “Minimum Aggregate Stop Loss Amount” is the minimum amount of claim liability that must be paid by the Insured before Aggregate Stop Loss benefits may be payable. For any Policy Year, the Aggregate Stop Loss Amount is subject to the Minimum Aggregate Stop Loss Amount. In no event will the Minimum Aggregate Stop Loss Amount be less than 100% of the sum of the products of: (i) the number of employees on the first day of the first Policy Month, times (ii) the Stop Loss Factor times (iii) the number of months in the Policy Year determined by mutual agreement between the Insured and Aetna at the beginning of the Policy Year.

16. "Participant" means an Employee or an under age 65 retired employee of the Insured, or a dependent of an Employee or under age 65 retired employee, on whose behalf Eligible Claim Expenses are payable under the Plan. "Participant" also means an employee or dependent who is entitled to extended benefits under the Plan or who elects COBRA coverage, following termination of eligibility. Employees who qualify for extended benefits under the Plan will include employees who are laid off, on leave of absence, Temporary Disability or Long Term Disability.

17. "Plan" means the self-funded medical benefit plan established by the Insured and described in the Appendix which is attached to the Contract.

18. “Policy” means all of the following:
    (a) The Insured’s Application for Stop Loss Insurance.
    (b) This policy and any riders to it.

19. A "policy month" shall coincide with a calendar month; except that the first policy month shall commence on the Effective Date of this Policy and the last policy month shall end on termination of this Policy.

20. A "policy year" shall coincide with a Plan year under the Plan; except that the first policy year shall commence on the Effective Date of this Policy and the last policy year shall end on termination of this Policy.

Section 5. Exclusions

The following are not included as Eligible Claim Expenses:

1. Expenses paid on the direction of the Insured that Aetna determines are not payable under the Contract in accordance with Aetna's then current standard claim practices established for insured group accident and health insurance plan administered by Aetna. This includes expenses for services or supplies which are not Medically Necessary or expenses for drugs, treatment, services or supplies which are considered Experimental or Investigational.

2. If the Insured has valid and collectible insurance, reinsurance or indemnity or any reimbursement agreements covering a loss also covered by this Policy, the insurance afforded by this Policy shall be in excess of and shall not contribute with such other insurance, reinsurance or indemnity.

3. Expenses incurred by an individual who is not a Participant under the Plan when the expense is incurred.

4. Expenses paid with respect to an employee and his/her dependents who did not enroll in accordance with the terms of the Plan, until such time as they are enrolled in accordance with the terms of the Plan.

5. Expenses that are incurred prior to the Effective Date of this Policy unless otherwise specified in the Schedule of Insurance.

6. Expenses paid with respect to a Participant following termination of coverage under the Contract with respect to a class of employees and their dependents that includes the Participant.

7. Benefits paid for expenses incurred for treatment of an illness or injury for which a Participant is entitled to Benefits under any Workers' Compensation law, occupational disease law or under any other legislation of similar purpose.

8. Expenses paid for Covered Benefits not listed on the Schedule of Insurance.

9. Expenses for taxes, fees and surcharges that may be imposed on the Plan by any government body. This exclusion does not apply to New York Health Care Reform Act surcharges unless they are excess or punitive payments made on behalf of an Insured to fund indigent care and graduate medical education solely as a result of that Insured’s decision not to pay directly into the New York state pool.

10. Benefits paid with respect to Retired employees age 65 and older and their dependents.

11. Incentive payments, care coordination payments, risk share payments and other non-fee for service payments paid or received in connection with an agreement with an accountable care or similar provider organization.

12. Expenses for any other benefits which the Insured and Aetna mutually agree will not be subject to the Stop Loss insurance.

Section 6. Conditions

Premiums

The first Policy Year's monthly premium rate is shown in Section 2. Schedule of Insurance.

Premium Calculation: An estimated premium will be calculated which will be payable on a monthly basis or any other basis mutually agreed upon by the Insured and Aetna. The estimated premium will be based on the Premium Rate shown in the Schedule of Insurance and the estimated number of employees.

Premium Payments: Aetna will issue a Stop Loss premium invoice for the payment of estimated premium. Within 120 days following the end of each Policy Year, Aetna will prepare and submit to the Insured a financial accounting as to the total actual premium for that Policy Year. The total actual premium will be the sum of the products, for each month of that Policy Year, of:

(a) the Premium Rate, times

(b) the number of employees.

Grace Period: The Insured will pay all estimated premium payments as directed on the invoice, but no later than 31 days after the due date shown on the invoice (the grace period).

Right to Recalculate: Aetna reserves the right to make adjustments in the premium rate or the estimated premium on the first day of any Policy Month, as of the date any of the following events occur:

(a) any change of 15% +/- in the number of employees;
(b) any change in the coverage or types or amounts of benefits offered under the Plan which will change expected cost of coverage;
(c) any change in this Policy;
(d) any addition or deletion of a unit, division, subsidiary, affiliated or associated company from this Policy; and
(e) any other change in factors bearing on the risk assumed (including but not limited to: age, sex, geographic changes, occupations etc.) which Aetna determines change the nature of the risk by more than 15%.
(f) participation in the Seton Health Alliance Accountable Care Organization (SHA ACO) terminates or employee enrollment in the SHA ACO falls below 65%

Failure to adjust the Premium Rate or the estimated Premium during a Policy Year will not preclude making an adjustment during any subsequent Policy Year.

If the total actual Premium (determined at the financial accounting) is less than the amount of estimated premiums paid, the difference will be paid to the Insured at the time the accounting is submitted. If the total actual Premium exceeds the amount paid, the difference will be paid to Aetna within 31 days of the date the accounting is furnished to the Insured.

Aggregate Stop Loss Factor

Aetna reserves the right to make adjustments in the Stop Loss Factor as of the date of any change in the Plan or as of the date of any other change in factors bearing on the risk assumed, including but not limited to:

(a) a 15%+/- change in the census estimate used to calculate the Stop Loss Factor;
(b) any change in the coverage or types or amounts of benefits offered under the Plan which will change expected cost for coverage.
(c) any change in this Policy;
(d) any addition or deletion of a unit, division, subsidiary, affiliated or associated company from this Policy; and
(e) any other change in factors bearing on the risk assumed (i.e., age, sex, geographic changes, occupations etc.) which are expected to change the nature of the risk by more than 15%.

Failure to adjust the factor during a Policy Year will not preclude making an adjustment during any subsequent Policy Year.

Modification of Policy

Changes in this Policy may be made by written mutual agreement between Aetna and the Insured.

Optional Policy Renewal

The Policy will renew on the Policy anniversary date, upon the Insured's acceptance of the renewal terms, unless it has otherwise terminated or is subject to termination in accordance with the Termination provisions. Changes to Section 2, Schedule of Insurance, for each Policy Year after the first shall be indicated in a written notice sent to the Insured and shall be effective on the date stated in such notice.

Stop Loss Payments

Aetna will make payment, not later than 120 days after the end of each Policy Year to or on behalf of the Insured of the Stop Loss payment due under the terms of this Policy. The amount of any premiums due but unpaid may be deducted from the Stop Loss payment otherwise payable to the Insured. This right will not prevent the termination, of this Policy, for non-payment of premium under the Termination provisions of this Policy.

Subrogation/Right of Recovery

The Plan is required to include a comprehensive provision for subrogation/reimbursement in its Summary Plan Description and the Plan must pursue enforcement of this provision. Should the Plan fail to pursue any claims or action against a responsible party, then Plan Sponsor agrees that Aetna shall be subrogated to or assigned Plan Sponsor's reimbursement rights and shall assume the Plan's rights to pursue any claims against any and all parties and the Plan will be responsible for any reasonable expenses incurred in the pursuit of such claims, including the fees and costs charged by any contracted subrogation vendor or attorney and any additional legal costs. Aetna has the right to pursue any and all claims covered under this Policy and paid by the Plan and to pursue recovery, in the name of the Plan, of the entire claim, including both the portion of the Plan benefits for which the Plan has been paid under this Policy and the portion of the claim consisting of benefits paid by the Plan but not payable under this Policy.

The Plan must notify Aetna within 30 days of receiving any information that may give rise to the Aetna's subrogation rights. Further, the Plan shall cooperate fully with Aetna and do all things necessary and required for Aetna to pursue any action to recover against a responsible party. The Plan may not take any action, or neglect to take any action, that will prejudice or impair the rights of Aetna to pursue recovery from any other responsible party. The Plan may not, without consent of Aetna, settle or give release for any claim to any other party if doing so would impair or prevent Aetna from exercising its rights of recovery.

Aetna is entitled to recover first, in full, any amount paid by Aetna under this Policy as well as any expenses of collection incurred by Aetna, before the Plan shares in any amount so recovered. Aetna will reduce its recovery amount by a pro rata share to reflect the Net Recovery obtained by the Plan. Net Recovery is the gross amount recovered by the Plan, less such factors as costs incurred by the Plan in obtaining the recovery, comparative fault issues involving the Plan member or factors involving the Plan member's inability to fully recover for their injuries. In the event Aetna recovers an amount greater than its reimbursement, the excess, reduced by the costs to obtain the recovery, will be returned to the Plan. If the Plan recovers any such payment from a responsible party, the recovered amount cannot be used to satisfy any retention requirement, Individual or Aggregate Stop Loss Specifications noted in Section 2. Schedule of Insurance, until Aetna's recovery rights are satisfied.

If the Plan receives a recovery prior to Aetna reimbursing any covered expenses under the Policy, the Plan must deduct the amount of such recovery from any reimbursement request. If the Plan receives a recovery after Aetna has made payment to the Plan for some or all of a particular claim, then the Plan must reimburse Aetna to the full extent of the payment by the Aetna, less a pro rata reduction to reflect the Net Recovery obtained by the Plan. Net Recovery is the gross amount recovered by the Plan, less such factors as costs incurred by the Plan in obtaining the recovery, comparative fault issues involving the Plan member or factors involving the Plan member's inability to fully recover for their injuries. The obligation of the Plan to reimburse Aetna remains, regardless of whether this Policy is still in force on the date of recovery, and such reimbursement to Aetna must occur within 30 days of any recovery by the Plan or Plan Sponsor. The Plan shall account to Aetna for all amounts recovered. These rights and obligations imposed on the Plan and Aetna under this section shall survive termination of the Policy.

Stop Loss Overpayments

If Aetna determines that the Insured has been overpaid due to a claim credit which may be the result of a Coordination of Benefit change, a Subrogation Recovery, Audit and /or billing/payment error, the Insured will promptly refund such overpayment to Aetna. If this Policy terminates, any reimbursements made for claims paid by the Insured after the date of termination will immediately be refunded to Aetna. If the Insured fails to refund any overpayments to Aetna in a timely manner, Aetna reserves the right to obtain such overpayments from future payments due under this Policy.

Termination of Policy

Aetna may terminate this policy on any policy anniversary date by providing at least 30 days prior written notice to the Insured. The Insured may terminate this policy on any premium due date by providing at least 30 days prior written notice to Aetna. The policy may also be terminated on any date mutually agreed to by Aetna and the Insured.

If the Insured does not comply with any terms and conditions of the policy, including but not limited to providing required reports or other information reasonably requested by Aetna, Aetna reserves the right to terminate the Policy effective on the date of any such failure.

This Policy shall also terminate automatically upon the occurrence of any of the following:

a. If the Insured fails to pay any premium in full within the Grace Period, this Policy will terminate as of the due date shown on the invoice.
b. If the Contract terminates, this Policy will terminate on the same date and at the same time that the Contract terminates.
c. If the Insured fails to meet the underwriting requirements established by Aetna, including but not limited to the minimum number of 51 Employees, the policy will terminate as of the first day of the first month following the date the underwriting requirement was not met.
d. If the Insured fails to pay claims under the Plan or make available funds to pay claims as required by the Plan, the policy will terminate on the first day that the Insured failed to fund benefits.

Reports

The Insured shall furnish Aetna with all information Aetna determines to be necessary to carry out the provisions of the Policy.

Inspection and Audit

Aetna shall be permitted to inspect the Insured's records pertaining to the Contract at any reasonable time during the effectiveness of this Policy and within three years after termination of this Policy, to the extent that they relate to the premium basis or Eligible Claim Expenses under this Policy.

Fraud

This entire Policy will be void if, whether before or after a claim or loss, the Insured has concealed or misrepresented any material fact or circumstance concerning this Policy or the subject of this Policy, including any claim under this Policy, or in any case of fraud by the Insured relating to this Policy.

Incontestability

The validity of this Policy shall not be contested, except for non-payment of premium, after it has been in force for two years from the Policy Effective Date.

Liability and Indemnification

Aetna has neither the right nor the obligation under this Policy to directly pay any Participant or provider of covered services for any benefit the Insured has agreed to provide through the terms of the Plan(s). Aetna’s sole liability under this Policy is to the Insured, subject to the terms, conditions, and limitations of this Policy.

Assignment

Assignment of interest under this Policy shall not bind Aetna without its written consent.

Notice of Actions

The Insured agrees to give Aetna prompt notice of any event or development which might result in an action at law or equity related to this Policy and to forward promptly to Aetna copies of any pleadings and reports of investigation that Aetna requests. A copy of any document filed by or against the Insured in any court in connection with such litigation under the Plan must immediately be furnished to Aetna.

The Insured shall pay all attorneys’ fees, expenses of experts and investigations, and any damages (including exemplary or punitive damages) payable by Aetna in connection with any litigation in which Aetna shall, without Aetna’s fault, become involved through or on account of this Policy or the Plan.

If any time limitation in this Policy is less than that permitted by the law of the state in which the Application was taken, the limitation is hereby extended to agree with the minimum period permitted by the law.

ATTACHMENT A

Williamson County a political subdivision of the State of Texas a body politic duly organized and existing under the laws of the State of Texas

Individual Stop Loss Amounts:

Name of Participant	Relationship to Employee	Employee's Social Security Number	Individual Stop Loss Amount
Val McMinn	Self	xxx-xx-4383	$500,000
Noah Henderson	Dependent Child	xxx-xx-2566	$850,000
Rudy Gonzalez	Dependent Child	xxx-xx-8964	$1,000,000

BENEFIT PLAN

Prepared Exclusively for
Williamson County

Aetna Whole Health℠ Seton Health Alliance – Open Access Aetna Select

What Your Plan Covers and How Benefits are Paid

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Preface

The medical benefits plan described in this *Booklet* is a benefit plan of the Employer. These benefits are not insured with **Aetna** or any of its affiliates, but will be paid from the Employer's funds. **Aetna** and its HMO affiliates will provide certain administrative services under the **Aetna** medical benefits plan.

Aetna agrees with the Employer to provide administrative services in accordance with the conditions, rights, and privileges as set forth in this *Booklet*. The Employer selects the products and benefit levels under the **Aetna** medical benefits plan.

The *Booklet* describes your rights and obligations, what the **Aetna** medical benefits plan covers, and how benefits are paid for that coverage. It is your responsibility to understand the terms and conditions in this *Booklet*. Your *Booklet* includes the *Schedule of Benefits* and any amendments.

This *Booklet* replaces and supercedes all **Aetna** *Booklets* describing coverage for the medical benefits plan described in this *Booklet* that you may previously have received.

Employer:	Williamson County
Contract Number:	866349
Effective Date:	November 1, 2014
Issue Date:	April 17, 2015
Booklet Number:	1

Coverage for You and Your Dependents

Health Expense Coverage

Benefits are payable for covered health care expenses that are incurred by you or your covered dependents while coverage is in effect. An expense is "incurred" on the day you receive a health care service or supply.

Coverage under this plan is non-occupational. Only **non-occupational injuries** and **non-occupational illnesses** are covered.

Refer to the *What the Plan Covers* section of the *Booklet* for more information about your coverage.

Treatment Outcomes of Covered Services

Aetna is not a provider of health care services and therefore is not responsible for and does not guarantee any results or outcomes of the covered health care services and supplies you receive. Except for Aetna RX Home Delivery LLC, providers of health care services, including hospitals, institutions, facilities or agencies, are independent contractors and are neither agents nor employees of **Aetna** or its affiliates.

When Your Coverage Begins

Who Is Eligible

How and When to Enroll

When Your Coverage Begins

Throughout this section you will find information on who can be covered under the plan, how to enroll and what to do when there is a change in your life that affects coverage. In this section, "you" means the employee.

Who Is Eligible

Employees

To be covered by this plan, the following requirements must be met:

- You will need to be in an "eligible class," as defined below; and
- You will need to meet the "eligibility date criteria" described below.

Determining if You Are in an Eligible Class

You are in an eligible class if:

- You are a retired employee of an employer participating in this plan, and you:
  - Retired before the effective date of this plan and were covered under the prior plan for health care coverage on the day before you retired; or
  - Were covered under this plan or another plan sponsored by your employer on the day before you retired; and
  - Retire under your employer's IRS-qualified retirement plan.

Determining if You Are in an Eligible Class

You are in an eligible class if:

- You are a regular full-time employee, as defined by your employer, who is scheduled to work at least 30 hours per week on a regular basis.

Probationary Period

Once you enter an eligible class, you will need to complete the probationary period before your coverage under this plan begins.

Determining When You Become Eligible

You become eligible for the plan on your eligibility date, which is determined as follows.

On the Effective Date of the Plan

If you are in an eligible class on the effective date of this plan, and you had previously satisfied the plan's probationary period, your coverage eligibility date is the effective date of this plan. If you are in an eligible class on the effective date of this plan, but you have not yet satisfied the plan's probationary period, your coverage eligibility date is the first day of the month coinciding with or next following the date you complete 60 days from the date of hire of continuous service with your employer. This is defined as the probationary period. If you had already satisfied the probationary period before you entered the eligible class, your coverage eligibility date is the date you enter the eligible class.

After the Effective Date of the Plan
If you are hired or enter an eligible class after the effective date of this plan, your coverage eligibility date is the first day of the month coinciding with or next following the date you complete 60 days from the date of hire of continuous service with your employer. This is defined as the probationary period. If you have already satisfied the probationary period before you entered the eligible class, your coverage eligibility date is the date you enter the eligible class.

Obtaining Coverage for Dependents

Your dependents can be covered under this Plan. You may enroll the following dependents:

- Your spouse.
- Your dependent children.

Aetna will rely upon your employer to determine whether or not a person meets the definition of a dependent for coverage under this Plan. This determination will be conclusive and binding upon all persons for the purposes of this Plan.

Coverage for Dependent Children

To be eligible for coverage, a dependent child must be under 26 years of age.

An eligible dependent child includes:

- Your biological children;
- Your stepchildren;
- Your legally adopted children;
- Your foster children, including any children placed with you for adoption;
- Any children for whom you are responsible under court order;
- Your grandchildren in your court-ordered custody; and
- Any other child with whom you have a parent-child relationship.

Coverage for a handicapped child may be continued past the age limits shown above. See *Handicapped Dependent Children* for more information.

Important Reminder
Keep in mind that you cannot receive coverage under this Plan as:

- Both an employee and a dependent; or
- A dependent of more than one employee.

How and When to Enroll

Initial Enrollment in the Plan

You will be provided with plan benefit and enrollment information when you first become eligible to enroll. You will need to enroll in a manner determined by **Aetna** and your employer. To complete the enrollment process, you will need to provide all requested information for yourself and your eligible dependents. You will also need to agree to make required contributions for any contributory coverage. Your employer will determine the amount of your plan contributions, which you will need to agree to before you can enroll. Your employer will advise you of the required amount of your contributions and will deduct your contributions from your pay. Remember plan contributions are subject to change.

You will need to enroll within 31 days of your eligibility date. Otherwise, you may be considered a Late Enrollee. If you miss the enrollment period, you will not be able to participate in the plan until the next annual enrollment period, unless you qualify under a Special Enrollment Period, as described below.

If you do not enroll for coverage when you first become eligible, but wish to do so later, your employer will provide you with information on when and how you can enroll.

Newborns are automatically covered for 31 days after birth. To continue coverage after 31 days, you will need to complete a change form and return it to your employer within the 31-day enrollment period.

Late Enrollment

If you do not enroll during the Initial Enrollment Period, or a subsequent annual enrollment period, you and your eligible dependents may be considered **Late Enrollees** and coverage may be deferred until the next annual enrollment period. If, at the time of your initial enrollment, you elect coverage for yourself only and later request coverage for your eligible dependents, they may be considered **Late Enrollees**.

You must return your completed enrollment form before the end of the next annual enrollment period as described below.

However, you and your eligible dependents may not be considered **Late Enrollees** if you qualify for one of the circumstances described in the "Special Enrollment Periods" section below.

Annual Enrollment

During the annual enrollment period, you will have the opportunity to review your coverage needs for the upcoming year. During this period, you have the option to change your coverage. The choices you make during this annual enrollment period will become effective the following year.

If you do not enroll yourself or a dependent for coverage when you first become eligible, but wish to do so later, you will need to do so during the next annual enrollment period, unless you qualify under one of the Special Enrollment Periods, as described below.

Special Enrollment Periods

You will not be considered a **Late Enrollee** if you qualify under a Special Enrollment Period as defined below. If one of these situations applies, you may enroll before the next annual enrollment period.

Loss of Other Health Care Coverage

You or your dependents may qualify for a Special Enrollment Period if:

- You did not enroll yourself or your dependent when you first became eligible or during any subsequent annual enrollments because, at that time:
  - You or your dependents were covered under other **creditable coverage**; and
  - You refused coverage and stated, in writing, at the time you refused coverage that the reason was that you or your dependents had other **creditable coverage**; and
- You or your dependents are no longer eligible for other **creditable coverage** because of one of the following:
  - The end of your employment;
  - A reduction in your hours of employment (for example, moving from a full-time to part-time position);
  - The ending of the other plan's coverage;
  - Death;
  - Divorce or legal separation;
  - Employer contributions toward that coverage have ended;
  - COBRA coverage ends;
  - The employer's decision to stop offering the group health plan to the eligible class to which you belong;

  - Cessation of a dependent's status as an eligible dependent as such is defined under this Plan;
  - With respect to coverage under Medicaid or an S-CHIP Plan, you or your dependents no longer qualify for such coverage; or
  - You or your dependents have reached the lifetime maximum of another Plan for all benefits under that Plan.
- You or your dependents become eligible for premium assistance, with respect to coverage under the group health plan, under Medicaid or an S-CHIP Plan.

You will need to enroll yourself or a dependent for coverage within:

- 31 days of when other **creditable coverage** ends;
- within 60 days of when coverage under Medicaid or an S-CHIP Plan ends; or
- within 60 days of the date you or your dependents become eligible for Medicaid or S-CHIP premium assistance.

Evidence of termination of **creditable coverage** must be provided to your employer or the party it designates. If you do not enroll during this time, you will need to wait until the next annual enrollment period.

New Dependents

You and your dependents may qualify for a Special Enrollment Period if:

- You did not enroll when you were first eligible for coverage; and
- You later acquire a dependent, as defined under the plan, through marriage, birth, adoption, or placement for adoption; and
- You elect coverage for yourself and your dependent within 31 days of acquiring the dependent.

Your spouse or child who meets the definition of a dependent under the plan may qualify for a Special Enrollment Period if:

- You did not enroll them when they were first eligible; and
- You later elect coverage for them within 31 days of a court order requiring you to provide coverage.

You will need to report any new dependents by completing a change form, which is available from your employer. The form must be completed and returned to your employer within 31 days of the change. If you do not return the form within 31 days of the change, you will need to make the changes during the next annual enrollment period.

If You Adopt a Child

Your plan will cover a child who is placed for adoption. This means you have taken on the legal obligation for total or partial support of a child whom you plan to adopt.

Your plan will provide coverage for a child who is placed with you for adoption if:

- The child meets the plan's definition of an eligible dependent on the date he or she is placed for adoption; and
- You request coverage for the child in writing within 31 days of the placement;
- Proof of placement will need to be presented to your employer prior to the dependent enrollment;
- Any coverage limitations for a preexisting condition will not apply to a child placed with you for adoption provided that the placement occurs on or after the effective date of your coverage.

When You Receive a Qualified Child Support Order

A Qualified Medical Child Support Order (QMCSO) is a court order requiring a parent to provide health care coverage to one or more children. Your plan will provide coverage for a child who is covered under a QMCSO, if:

- The child meets the plan's definition of an eligible dependent; and
- You request coverage for the child in writing within 31 days of the court order.

Coverage for the dependent will become effective on the date of the court order. Any coverage limitations for a preexisting condition will not apply, as long as you submit a written request for coverage within the 31-day period.

If you do not request coverage for the child within the 31-day period, you will need to wait until the next annual enrollment period.

Under a QMCSO, if you are the non-custodial parent, the custodial parent may file claims for benefits. Benefits for such claims will be paid to the custodial parent.

When Your Coverage Begins

Your Effective Date of Coverage

If you have met all the eligibility requirements, your coverage takes effect on the later of:

- The date you are eligible for coverage; and
- The date you return your completed enrollment information; and
- Your application is received and approved in writing by **Aetna**; and
- The date your required contribution is received by **Aetna**.

If you do not return your completed enrollment information within 31 days of your eligibility date, the rules under the *Special or Late Enrollment Periods* section will apply.

Important Notice:
You must pay the required contribution in full or coverage will not be effective.

Your Dependent's Effective Date of Coverage

Your dependent's coverage takes effect on the same day that your coverage becomes effective, if you have enrolled them in the plan.

Note: New dependents need to be reported to your employer within 31 days because they may affect your contributions. If you do not report a new dependent within 31 days of his or her eligibility date, the rules under the *Special or Late Enrollment Periods* section will apply.

Retired Employees

In lieu of corresponding rules which apply to employees:

- If any health expense benefits are payable based on a "period of disability", the rule which applies to determine when a dependent's period of disability ends will also apply to you.
- The rule which applies to a dependent to determine if total disability exists when health expense insurance ends will also apply to you.

How Your Medical Plan Works

Common Terms

Accessing Designated Network Providers

It is important that you have the information and useful resources to help you get the most out of your **Aetna** medical plan. This Booklet explains:

- Definitions you need to know;
- How to access care, including procedures you need to follow;
- What expenses for services and supplies are covered and what limits may apply;
- What expenses for services and supplies are not covered by the plan;
- How you share the cost of your covered services and supplies; and
- Other important information such as eligibility, complaints and appeals, termination, continuation of coverage, and general administration of the plan.

Important Notes

- Unless otherwise indicated, "you" refers to you and your covered dependents.
- Your health plan pays benefits only for services and supplies described in this Booklet as **covered expenses** that are **medically necessary**.
- This Booklet applies to coverage only and does not restrict your ability to receive health care services that are not or might not be covered benefits under this health plan.
- Store this Booklet in a safe place for future reference.

Common Terms

Many terms throughout this Booklet are defined in the *Glossary* section at the back of this document. Defined terms appear in bolded print. Understanding these terms will also help you understand how your plan works and provide you with useful information regarding your coverage.

About Your Aetna Whole Health℠ – Aetna Select Medical Plan

This Aetna Whole Health℠ Aetna Select plan provides coverage of medical expenses for the treatment of **illness** or **injury** and other preventive care and routine medical expenses.

With your Aetna Select plan, you can directly access any **network physician**, **hospital** or other health care provider for covered services and supplies under the plan.

The plan will pay for **covered expenses** up to the maximum benefits shown in this Booklet.

Coverage is subject to all the terms, policies, and procedures outlined in this Booklet. Not all medical expenses are covered under the plan. Exclusions and limitations apply to certain medical services, supplies and expenses. Refer to the *What the Plan Covers* and *Exclusions*, *Limitations* sections and the *Schedule of Benefits* sections to determine if medical services are covered, excluded or limited.

This Aetna Whole Health℠ Aetna Select plan provides access to covered benefits through a network of health care providers and facilities. These **designated network providers** have contracted with **Aetna** or an affiliate to provide health care services and supplies to **Aetna** plan members at a reduced fee called the **negotiated charge**.

Except for emergency and urgent care services, benefits will only be paid when you utilize **designated network providers**.

Designated and Non-Designated Network Providers

This Aetna Whole Health℠ Aetna Select plan provides preferred benefit coverage and access to certain covered services and supplies through a designated network of health care providers and facilities that are unique to your plan. This plan is designed to lower your out-of-pocket costs when you use **designated network providers** for **covered expenses**. Your cost sharing will be lower when you use these **designated network providers**. These **designated network providers** are identified in the printed **directory** and the on-line version of the **directory** via DocFind at www.aetna.com. Please be sure to look at the appropriate **directory** that applies to your plan, since different **Aetna** plans use different networks of providers. This plan includes different benefit levels based upon the type of **network provider** that you use (designated or non-designated) or if you choose to see an **out-of-network** provider. For this plan only, **non-designated network providers** are *not* listed in the **Aetna** directory.

Important Note
If you live in an area with a designated network, in order to be covered at the network level of benefits and for maximum savings, you must select a **designated network provider**. If you select a **non-designated network provider** for your care, such expenses will not be covered under this Plan. Carefully read the details on cost-sharing provided later in this *Schedule of Benefits*.

Availability of Providers

Aetna cannot guarantee the availability or continued participation of a particular provider. Either **Aetna** or any **designated network provider** may terminate the provider contract or limit the number of patients accepted in a practice. If the **physician** initially selected cannot accept additional patients, you will be notified and given an opportunity to make another selection. If the agreement between **Aetna** and your selected **PCP** is terminated, **Aetna** will notify you of the termination and request you to select another **PCP**

Ongoing Reviews:

Aetna conducts ongoing reviews of those services and supplies which are recommended or provided by health professionals to determine whether such services and supplies are covered benefits under this Booklet. If **Aetna** determines that the recommended services or supplies are not covered benefits, you will be notified. You may appeal such determinations by contacting **Aetna** to seek a review of the determination. Please refer to the *Claims, Appeals and External Review* section of this Booklet.

To better understand the choices that you have with your Aetna Whole Health℠ Aetna Select plan, please carefully review the following information.

How Your Your Aetna Whole Health℠ – Aetna Select Medical Plan Works

The Primary Care Physician:

To access network benefits at the time of enrollment, you are encouraged to select a **Primary Care Physician (PCP)** from **Aetna**'s designated network of providers. Each covered family member may select his or her own **PCP**. If your covered dependent is a minor, or otherwise incapable of selecting a **PCP**, you should select a **PCP** on their behalf.

You may search online for the most current list of **designated network providers** in your area by using DocFind, **Aetna**'s online provider directory at www.aetna.com. You can choose a **PCP** based on geographic location, group practice, medical specialty, language spoken, or **hospital** affiliation. DocFind is updated several times a week. You may also request a printed copy of the provider directory through your employer or by contacting Member Services through e-mail or by calling the toll free number on your ID card.

A **PCP** may be a general practitioner, family **physician**, internist, or pediatrician. Your **PCP** provides routine preventive care and will treat you for **illness** or **injury**.

A **PCP** coordinates your medical care, as appropriate either by providing treatment or by issuing **referrals** to direct you to other **designated network providers** for other covered services and supplies. The **PCP** can also order lab tests and x-rays, prescribe medicines or therapies, and arrange **hospitalization**. When your **PCP** refers you to other **designated network providers**, your **PCP** will give you a written **referral**, or send an electronic **referral** to a **designated network provider**. See the section on *The Referral Process* for more information.

Except in a medical emergency or for certain direct access services described in this Booklet, only those services which are provided by or **referred** by a your **PCP** will be covered at the network level of benefits.

Changing Your PCP

You may change your **PCP** at any time on **Aetna**'s website, www.aetna.com, or by calling the Member Services toll-free number on your identification card. The change will become effective upon **Aetna**'s receipt and approval of the request.

Important Note
ID Card: You will receive an ID card. It identifies you as a member when you receive services from health care **providers**. If you have not received your ID card or if your card is lost or stolen, notify **Aetna** immediately and a new card will be issued.

Accessing Designated Network Providers and Benefits

- You may select a **PCP** or other direct access **designated network provider** from the **Aetna directory** or by logging on to **Aetna**'s website at www.aetna.com. You can search **Aetna**'s online **directory**, DocFind, for names and locations of **physicians, hospitals** and **other health care** providers and facilities. You can change your **PCP** at any time.
- If a service or supply you need is covered under this Plan but not available from a **designated network provider** in your area, please contact Member Services by email or at the toll-free number on your ID card for assistance.
- Except for your **prescription drug** expenses, you will not have to submit medical claims for treatment received from **designated network providers**. Your **designated network provider** will take care of claim submission. **Aetna** will directly pay the **designated network provider** or facility less any cost sharing required by you. You will be responsible for **deductibles**, **payment percentage** and **copayments**, if any.
- You will receive notification of what the plan has paid toward your **covered expenses**. It will indicate any amounts you owe towards any **deductible**, **copayments**, or **payment percentage** amounts or other non-**covered expenses** you have incurred. You may elect to receive this notification by e-mail, or through the mail. Call or e-mail Member Services if you have questions regarding your statement.

Cost Sharing for the Network Benefit Level

You share in the cost of your benefits. Cost Sharing amounts and provisions are described in the *Schedule of Benefits*.

Designated network providers have agreed to accept the **negotiated charge. Aetna** will reimburse you for a **covered expense,** incurred from a **designated network provider,** up to the **negotiated charge** and the maximum benefits under this Plan, less any cost sharing required by you such as **copayments** and **payment percentage**. Your **payment percentage** is based on the **negotiated charge**. You will *not* have to pay any balance bills above the **negotiated charge** for that covered service or supply.

- For certain types of services and supplies, you will be responsible for any **copayments** shown in your *Schedule of Benefits*. The **copayments** will vary depending upon the type of service and whether you obtain covered health care services from a provider who is a **specialist** or non-specialist**.** You will be subject to the **PCP copayments** shown on the *Schedule of Benefits* when you obtain covered health care services from any **PCP** who is a **designated network provider.**
- After you satisfy any applicable **deductible**, you will be responsible for any applicable **payment percentage** for **covered expenses** that you incur. You will be responsible for your **payment percentage** up to the **maximum out-of-pocket limit** applicable to your plan.

- Once you satisfy any applicable **maximum out-of-pocket limit**, the plan will pay 100% of the **covered expenses** that apply toward the limits for the rest of the Plan Year. Certain designated out-of-pocket expenses may not apply to the **maximum out-of-pocket limits**. Refer to your *Schedule of Benefits* for information on what **covered expenses** do not apply to the **maximum out-of-pocket limits** and for the specific **maximum out-of-pocket limit** amounts that apply to your plan.
- The plan will pay for **covered expenses**, up to the benefit maximums shown in the *What the Plan Covers* section or the *Schedule of Benefits*. You are responsible for any expenses incurred over the maximum limits outlined in the *What the Plan Covers* section or the *Schedule of Benefits*.
- You may be billed for any **deductible**, **copayment**, or **payment percentage** amounts, or any non-covered expenses that you incur.

Emergency and Urgent Care

You have coverage 24 hours a day, 7 days a week, anywhere inside or outside the plan's service area, for:

- An **emergency medical condition**; or
- An **urgent condition**.

In Case of a Medical Emergency

When **emergency care** is necessary, please follow the guidelines below:

- Seek the nearest emergency room, or dial 911 or your local emergency response service for medical and ambulatory assistance. If possible, call your **primary care physician** provided a delay would not be detrimental to your health.
- After assessing and stabilizing your condition, the emergency room should contact your **PCP** to obtain your medical history to assist the emergency **physician** in your treatment.
- If you are admitted to an inpatient facility, notify your **PCP** as soon as reasonably possible.

- If you seek care in an emergency room for a non-emergency condition, the plan will not cover the expenses you incur. Please refer to the *Schedule of Benefits* for specific details about the plan. No other plan benefits will pay for non-emergency care in the emergency room unless otherwise specified under the plan.

Coverage for Emergency Medical Conditions

Refer to **Coverage for Emergency Medical Conditions** in the *What the Plan Covers* section.

Important Reminder
If you visit a **hospital** emergency room for a non-emergency condition, the plan will not cover your expenses, as shown in the *Schedule of Benefits*. No other plan benefits will pay for non-emergency care in the emergency room unless otherwise specified under the Plan.

In Case of an Urgent Condition

Call your **PCP** if you think you need urgent care. **Network providers** are required to provide urgent care coverage 24 hours a day, including weekends and holidays. You may contact any **physician** or **urgent care provider**, in- or out-of-network, for an **urgent care condition** if you cannot reach your **physician**.

If it is not feasible to contact your **PCP**, please do so as soon as possible after urgent care is provided. If you need help finding a **network urgent care provider** you may call Member Services at the toll-free number on your I.D. card, or you may access **Aetna**'s online provider directory at www.aetna.com.

Coverage for an Urgent Condition

Refer to **Coverage for Urgent Medical Conditions** in the *What the Plan Covers* section.

Non-Urgent Care

If you seek care from an **urgent care provider** for a non-**urgent condition**, (one that does not meet the criteria above), the plan will not cover the expenses you incur unless otherwise specified under the Plan. Please refer to the *Schedule of Benefits* for specific plan details.

Important Reminder

If you visit an **urgent care provider** for a non-**urgent condition**, the plan will not cover your expenses, as shown in the *Schedule of Benefits*. No other plan benefits will pay for non-urgent care received at a hospital or an urgent care provider unless otherwise specified.

Follow-Up Care After Treatment of an Emergency or Urgent Medical Condition

Follow-up care is not considered an emergency or **urgent condition** and is not covered as part of any emergency or urgent care visit. Once you have been treated and discharged, you should contact your **physician** for any necessary follow-up care.

For coverage purposes, follow-up care is treated as any other expense for **illness** or **injury**. If you access a **hospital** emergency room for follow-up care, your expenses will not be covered and you will be responsible for the entire cost of your treatment. Refer to your *Schedule of Benefits* for cost sharing information applicable to your plan.

To keep your out-of-pocket costs lower, your follow-up care should be accessed through your **PCP**.

Important Notice

Follow up care, which includes (but is not limited to) suture removal, cast removal and radiological tests such as x-rays, should ***not*** be provided by an emergency room facility.

Requirements For Coverage

To be covered by the plan, services and supplies and **prescription drugs** must meet all of the following requirements:

1. The service or supply or **prescription drug** must be covered by the plan. For a service or supply or **prescription drug** to be covered, it must:

   - Be included as a covered expense in this Booklet;
   - Not be an excluded expense under this Booklet. Refer to the *Exclusions* sections of this Booklet for a list of services and supplies that are excluded;
   - Not exceed the maximums and limitations outlined in this Booklet. Refer to the *What the Plan Covers* section and the *Schedule of Benefits* for information about certain expense limits; and
   - Be obtained in accordance with all the terms, policies and procedures outlined in this Booklet.

2. The service or supply or **prescription drug** must be provided while coverage is in effect. See the *Who Can Be Covered, How and When to Enroll, When Your Coverage Begins, When Coverage Ends* and *Continuation of Coverage* sections for details on when coverage begins and ends.

3. The service or supply or **prescription drug** must be **medically necessary**. To meet this requirement, the medical services, supply or **prescription drug** must be provided by a **physician**, or other health care provider, exercising prudent clinical judgment, to a patient for the purpose of preventing, evaluating, diagnosing or treating an **illness**, **injury**, disease or its symptoms. The provision of the service or supply must be:

   (a) In accordance with generally accepted standards of medical practice;
   (b) Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's **illness**, **injury** or disease; and
   (c) Not primarily for the convenience of the patient, **physician** or other health care provider;
   (d) And not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's **illness**, **injury**, or disease.

For these purposes "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, or otherwise consistent with **physician** specialty society recommendations and the views of **physicians** practicing in relevant clinical areas and any other relevant factors.

Important Note
Not every service, supply or **prescription drug** that fits the definition for **medical necessity** is covered by the plan. Exclusions and limitations apply to certain medical services, supplies and expenses. For example some benefits are limited to a certain number of days, visits or a dollar maximum. Refer to the *What the Plan Covers* section and the *Schedule of Benefits* for the plan limits and maximums.

What The Plan Covers

Wellness

Physician Services

Hospital Expenses

Other Medical Expenses

Aetna Select Medical Plan

Many preventive and routine medical expenses as well as expenses incurred for a serious **illness** or **injury** are covered. This section describes which expenses are **covered expenses**. Only expenses incurred for the services and supplies shown in this section are **covered expenses**. Limitations and exclusions apply.

Routine Physical Exams

Covered expenses include charges made by your **primary care physician** (**PCP**) for routine physical exams. This includes routine vision and hearing screenings given as part of the routine physical exam. A routine exam is a medical exam given by a **physician** for a reason other than to diagnose or treat a suspected or identified **illness** or **injury**, and also includes:

- Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force.
- Services as recommended in the American Academy of Pediatrics/Bright Futures Guidelines for Children and Adolescents.
- Screenings and counseling services as provided for in the comprehensive guidelines recommended by the Health Resources and Services Administration. These services may include but are not limited to:
  - Screening and counseling services, such as:
    - Interpersonal and domestic violence;
    - Sexually transmitted diseases; and
    - Human Immune Deficiency Virus (HIV) infections.
  - Screening for gestational diabetes for women.
  - High risk Human Papillomavirus (HPV) DNA testing for women age 30 and older.
- X-rays, lab and other tests given in connection with the exam.
- For covered newborns, an initial **hospital** check up.

Limitations:
Unless specified above, not covered under this Preventive Care benefit are charges for:

- Services which are covered to any extent under any other part of this Plan;
- Services which are for diagnosis or treatment of a suspected or identified **illness** or **injury**;
- Exams given during your **stay** for medical care;
- Services not given by a **physician** or under his or her direction;
- Psychiatric, psychological, personality or emotional testing or exams;
- Services and supplies furnished by an **out-of-network provider**.

Preventive Care Immunizations

Covered expenses include charges made by your **physician** or a facility for:

- immunizations for infectious diseases; and
- the materials for administration of immunizations;

that have been recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

Limitations

Not covered under this Preventive Care benefit are charges incurred for immunizations that are not considered Preventive Care such as those required due to your employment or travel.

Well Woman Preventive Visits

Covered expenses include charges made by your **physician obstetrician, or gynecologist for:**

- a routine well woman preventive exam office visit, including Pap smears. A routine well woman preventive exam is a medical exam given by a **physician** for a reason other than to diagnose or treat a suspected or identified **illness** or **injury;** and
- routine preventive care breast cancer genetic counseling and breast cancer (BRCA) gene blood testing. Covered expenses include charges made by a physician and lab for the BRCA gene blood test and charges made by a genetic counselor to interpret the test results and evaluate treatment.

These benefits will be subject to any age; family history; and frequency guidelines that are:

- Evidence-based items or services that have in effect a rating of A or B in the recommendations of the United States Preventive Services Task Force; and
- Evidence-informed items or services provided in the comprehensive guidelines supported by the Health Resources and Services Administration.

Limitations:

Unless specified above, not covered under this *Preventive Care* benefit are charges for:

- Services which are covered to any extent under any other part of this Plan;
- Services which are for diagnosis or treatment of a suspected or identified **illness** or **injury**;
- Exams given during your **stay** for medical care;
- Services not given by a **physician** or under his or her direction;
- Psychiatric, psychological, personality or emotional testing or exams; and
- Services and supplies furnished by an **out-of-network provider**.

Routine Cancer Screenings

Covered expenses include, but are not limited to, charges incurred for routine cancer screening as follows:

- Mammograms;
- Fecal occult blood tests;

- Digital rectal exams;
- Prostate specific antigen (PSA) tests;
- Sigmoidoscopies;
- Double contrast barium enemas (DCBE)
- Colonoscopies (removal of polyps performed during a screening procedure is a covered expense); and
- Lung cancer screening.

These benefits will be subject to any age; family history; and frequency guidelines that are:
- Evidence-based items or services that have in effect a rating of A or B in the recommendations of the United States Preventive Services Task Force; and
- Evidence-informed items or services provided in the comprehensive guidelines supported by the Health Resources and Services Administration.

Limitations:
Unless specified above, not covered under this benefit are:

- Charges incurred for services which are covered to any extent under any other part of this Plan.
- Services and supplies furnished by an **out-of-network provider.**

Important Notes:
Refer to the *Schedule of Benefits* for details about cost sharing and benefit maximums that apply to Preventive Care. For details on the frequency and age limits that apply to Routine Physical Exams and Routine Cancer Screenings, contact your **physician** or Member Services by logging onto the **Aetna** website www.aetna.com, or calling the number on the back of your ID card.

Screening and Counseling Services

Covered expenses include charges made by your **primary care physician** in an individual or group setting for the following:

Obesity and/or Healthy Diet
Screening and counseling services to aid in weight reduction due to obesity. Coverage includes:
- preventive counseling visits and/or risk factor reduction intervention;
- nutrition counseling; and
- healthy diet counseling visits provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease.

Misuse of Alcohol and/or Drugs
Screening and counseling services to aid in the prevention or reduction of the use of an alcohol agent or controlled substance. Coverage includes preventive counseling visits, risk factor reduction intervention and a structured assessment.

Use of Tobacco Products
Screening and counseling services to aid in the cessation of the use of tobacco products. Tobacco product means a substance containing tobacco or nicotine including: cigarettes, cigars; smoking tobacco; snuff; smokeless tobacco and candy-like products that contain tobacco. Coverage includes:
- preventive counseling visits;
- treatment visits; and
- class visits;

to aid in the cessation of the use of tobacco products.

Sexually Transmitted Infections
Covered expenses include the counseling services to help you prevent or reduce sexually transmitted infections.

Genetic Risks for Breast and Ovarian Cancer
Covered expenses include the counseling and evaluation services to help you assess your breast and ovarian cancer susceptibility.

Benefits for the screening and counseling services above are subject to any visit maximums shown in your *Schedule of Benefits*.

Limitations:
Unless specified above, not covered under this Preventive Care benefit are charges incurred for:

- Services which are covered to any extent under any other part of this plan;
- Services and supplies furnished by an **out-of-network provider**.

Prenatal Care

Prenatal care will be covered as Preventive Care for services received by a pregnant female in a **physician's**, obstetrician's, or gynecologist's office but only to the extent described below.

Coverage for prenatal care under this Preventive Care benefit is limited to pregnancy-related **physician** office visits including the initial and subsequent history and physical exams of the pregnant woman (maternal weight, blood pressure, fetal heart rate check, and fundal height).

Limitations:
Unless specified above, not covered under this Preventive Care benefit are charges incurred for:

- Services which are covered to any extent under any other part of this Plan;
- Pregnancy expenses (other than prenatal care as described above); and
- Services and supplies furnished by **out-of-network provider**.

Important Notes:
Refer to the *Pregnancy Expenses* and *Exclusions* sections of this Booklet for more information on coverage for pregnancy expenses under this Plan, including other prenatal care, delivery and postnatal care office visits.

Comprehensive Lactation Support and Counseling Services

Covered expenses include comprehensive lactation support (assistance and training in breast feeding) and counseling services provided to females during pregnancy, or at any time following delivery, for breast-feeding by a certified lactation support provider. **Covered expenses** also include the rental or purchase of breast feeding equipment as described below.

Lactation support and lactation counseling services are **covered expenses** when provided in either a group or individual setting. Benefits for lactation counseling services are subject to the visit maximum shown in your *Schedule of Benefits***.**

Breast Feeding Durable Medical Equipment
Coverage includes the rental or purchase of breast feeding **durable medical equipment** for the purpose of lactation support (pumping and storage of breast milk) as follows.

Breast Pump
Covered expenses include the following:
- The rental of a hospital-grade electric pump for a newborn child when the newborn child is confined in a **hospital**.
- The purchase of:
  - An electric breast pump (non-hospital grade). A purchase will be covered once every three years; or
  - A manual breast pump. A purchase will be covered once per pregnancy.
- If an electric breast pump was purchased within the previous three year period, the purchase of another breast pump will not be covered until a three year period has elapsed from the last purchase.

Breast Pump Supplies
Coverage is limited to only one purchase per pregnancy in any year where a covered female would not qualify for the purchase of a new pump.

Coverage for the purchase of breast pump equipment is limited to one item of equipment, for the same or similar purpose, and the accessories and supplies needed to operate the item. You are responsible for the entire cost of any additional pieces of the same or similar equipment you purchase or rent for personal convenience or mobility.

Aetna reserves the right to limit the payment of charges up to the most cost efficient and least restrictive level of service or item which can be safely and effectively provided. The decision to rent or purchase is at the discretion of **Aetna**.

Limitations:
Unless specified above, not covered under this *Preventive Care* benefit are charges incurred for:
- Services which are covered to any extent under any other part of this Plan; and
- Services and supplies furnished by an **out-of-network provider**.

Family Planning Services - Female Contraceptives

For females with reproductive capacity, **covered expenses** include those charges incurred for services and supplies that are provided to prevent pregnancy. All contraceptive methods, services and supplies covered under this Preventive Care benefit must be approved by the U.S. Food and Drug Administration (FDA).

Coverage includes counseling services on contraceptive methods provided by a **physician**, obstetrician or gynecologist. Such counseling services are **covered expenses** when provided in either a group or individual setting. They are subject to the contraceptive counseling services visit maximum shown in your *Schedule of Benefits***.**

The following contraceptive methods are **covered expenses** under this Preventive Care benefit:

Voluntary Sterilization
Covered expenses include charges billed separately by the provider for female voluntary sterilization procedures and related services and supplies including, but not limited to, tubal ligation and sterilization implants.

Covered expenses under this *Preventive Care* benefit would not include charges for a voluntary sterilization procedure to the extent that the procedure was not billed separately by the provider or because it was not the primary purpose of a confinement.

Contraceptives
Contraceptives can be paid either under your medical plan or **pharmacy** plan depending on the type of expense and how and where the expense is incurred. Benefits are paid under your medical plan for female contraceptive **prescription drugs** and devices (including any related services and supplies) when they are provided, administered, or removed, by a **physician** during an office visit.

Important Note:
For a list of the types of female contraceptives covered under this Plan, refer to the section *What the Pharmacy Plan Covers* and the *Contraceptives* benefit later in this Booklet.

Limitations:
Unless specified above, not covered under this Preventive Care benefit are charges for:

- Services which are covered to any extent under any other part of this Plan;
- Services and supplies incurred for an abortion;
- Services provided as a result of complications resulting from a voluntary sterilization procedure and related follow-up care;
- Services which are for the treatment of an identified **illness** or **injury**;
- Services that are not given by a **physician** or under his or her direction;
- Psychiatric, psychological, personality or emotional testing or exams;
- Any contraceptive methods that are only "reviewed" by the FDA and not "approved" by the FDA;
- Male contraceptive methods, sterilization procedures or devices;
- The reversal of voluntary sterilization procedures, including any related follow-up care.

Family Planning Services - Other

Covered expenses include charges for certain family planning services, even though not provided to treat an illness or injury.

- Voluntary sterilization for males

Limitations:
Not covered are:

- Voluntary termination of pregnancy;
- Reversal of voluntary sterilization procedures, including related follow-up care;
- Charges for services which are covered to any extent under any other part of this Plan or any other group plans sponsored by your employer; and
- Charges incurred for family planning services while confined as an inpatient in a hospital or other facility for medical care; and
- Services and supplies furnished by an out-of-network provider.

Important Notes:
1. Refer to the Schedule of Benefits for details about cost sharing and benefit maximums that apply to Family Planning Services - Other.
2. For more information, see the sections on Family Planning Services - Female Contraceptives, Pregnancy Expenses and Treatment of Infertility in this Booklet.

Vision Care Services

Covered expenses include charges made by a legally qualified ophthalmologist or optometrist for the following services:

- ***Routine*** eye exam: The plan covers expenses for a complete routine eye exam that includes refraction and glaucoma testing. A routine eye exam does not include a contact lens exam. The plan covers charges for one routine eye exam in any Calendar Year consecutive month period.

Limitations
Unless specified above, the benefit plan does not cover charges for a service or supply furnished by other than a **network provider**.

Coverage is subject to any applicable Plan Year **deductibles**, **copays** and **payment** percentages shown in your *Schedule of Benefits*.

Hearing Exam
Covered expenses include charges for an audiometric hearing exam if the exam is performed by:

- A **physician** certified as an otolaryngologist or otologist; or
- An audiologist who:
  - Is legally qualified in audiology; or
  - Holds a certificate of Clinical Competence in Audiology from the American Speech and Hearing Association (in the absence of any applicable licensing requirements); and
  - Performs the exam at the written direction of a legally qualified otolaryngologist or otologist.

The plan will not cover expenses for charges for more than one hearing exam for any 36-month period.

All **covered expenses** for the hearing exam are subject to any applicable **deductible**, **copay** and **payment percentage** shown in your *Schedule of Benefits*.

Physician Services

Physician Visits
Covered medical expenses include charges made by a **physician** during a visit to treat an **illness** or **injury**. The visit may be at the **physician**'s office, in your home, in a **hospital** or other facility during your **stay** or in an outpatient facility. **Covered expenses** also include:

- Immunizations for infectious disease, but not if solely for your employment;
- Allergy testing, treatment and injections; and
- Charges made by the **physician** for supplies, radiological services, x-rays, and tests provided by the **physician**.

Surgery
Covered expenses include charges made by a **physician** for:

- Performing your surgical procedure;
- Pre-operative and post-operative visits; and
- Consultation with another **physician** to obtain a second opinion prior to the surgery.

Anesthetics
Covered expenses include charges for the administration of anesthetics and oxygen by a **physician**, other than the operating **physician**, or Certified Registered Nurse Anesthetist (C.R.N.A.) in connection with a covered procedure.

Alternatives to Physician Office Visits
Walk-In Clinic Visits
Covered expenses include charges made by network **walk-in clinics** for:
- Unscheduled, non-emergency illnesses and injuries;
- The administration of certain immunizations administered within the scope of the clinic's license; and
- Individual screening and counseling services to aid you:
  - to stop the use of tobacco products;

- in weight reduction due to obesity.

Unless specified above, not covered under this benefit are charges incurred for services and supplies furnished:
- In a group setting for screening and counseling services; and
- By an out-of-network provider

Important Note:
- Not all services are available at all Walk-In Clinics. The types of services offered will vary by the provider and location of the clinic.
- For a complete description of the screening and counseling services provided on the use of tobacco products and to aid in weight reduction due to obesity, refer to the *Preventive Care Benefits* section in this Booklet and the *Screening and Counseling Services* benefit for a description of these services. These services may also be obtained from your physician

E-Visits
Covered expenses include charges made by your **primary care physician (PCP)** for a routine, non-emergency, medical consultation. You must make your **E-visit** through an **Aetna** authorized internet service vendor. You may have to register with that internet service vendor. Information about providers who are signed up with an authorized vendor may be found in the provider Directory or online in DocFind on www.Aetna.com or by calling the number on your identification card.

Hospital Expenses

Covered medical expenses include services and supplies provided by a **hospital** during your **stay**.

Room and Board
Covered expenses include charges for **room and board** provided at a **hospital** during your **stay**. Private room charges that exceed the **hospital**'s **semi-private room rate** are not covered unless a private room is required because of a contagious **illness** or immune system problem.

Room and board charges also include:

- Services of the **hospital's** nursing staff;
- Admission and other fees;
- General and special diets; and
- Sundries and supplies.

Other Hospital Services and Supplies
Covered expenses include charges made by a **hospital** for services and supplies furnished to you in connection with your **stay**.

Covered expenses include hospital charges for other services and supplies provided, such as:

- **Ambulance** services.
- **Physicians** and surgeons.
- Operating and recovery rooms.
- Intensive or special care facilities.
- Administration of blood and blood products, but not the cost of the blood or blood products.
- Radiation therapy.
- Speech therapy, physical therapy and occupational therapy.
- Oxygen and oxygen therapy.
- Radiological services, laboratory testing and diagnostic services.
- Medications.

- Intravenous (IV) preparations.
- Discharge planning.

Outpatient Hospital Expenses

Covered expenses include **hospital** charges made for covered services and supplies provided by the outpatient department of a **hospital**.

Important Reminders
The plan will only pay for nursing services provided by the **hospital** as part of its charge. The plan does *not* cover private duty nursing services as part of an inpatient **hospital** stay.

If a **hospital** or other health care facility does not itemize specific **room and board** charges and other charges, **Aetna** will assume that 40 percent of the total is for **room and board** charge, and 60 percent is for other charges.

In addition to charges made by the **hospital**, certain **physicians** and other providers may bill you separately during your stay.

Refer to the *Schedule of Benefits* for any applicable **deductible**, **copay** and **payment percentage** and maximum benefit limits.

Coverage for Emergency Medical Conditions

Covered expenses include charges made by a **hospital** or a **physician** for services provided in an emergency room to evaluate and treat an **emergency medical condition**.

The **emergency care** benefit covers:

- Use of emergency room facilities;
- Emergency room **physicians** services;
- **Hospital** nursing staff services; and
- Radiologists and pathologists services.

Please contact your **PCP** after receiving treatment for an **emergency medical condition**.

Important Reminder
With the exception of Urgent Care described below, if you visit a **hospital** emergency room for a non-emergency condition, the plan will not cover your expenses, as shown in the *Schedule of Benefits*. No other plan benefits will pay for non-emergency care in the emergency room.

Coverage for Urgent Conditions

Covered expenses include charges made by a **hospital** or **urgent care provider** to evaluate and treat an **urgent condition**.

Your coverage includes:

- Use of emergency room facilities when network urgent care facilities are not in the service area and you cannot reasonably wait to visit your **physician**;
- Use of urgent care facilities;
- **Physicians** services;
- Nursing staff services; and
- Radiologists and pathologists services.

Please contact your **PCP** after receiving treatment of an **urgent condition**.

If you visit an **urgent care provider** for a non-**urgent condition**, the plan will not cover your expenses, as shown in the *Schedule of Benefits*.

Alternatives to Hospital Stays

Outpatient Surgery and Physician Surgical Services

Covered expenses include charges for services and supplies furnished in connection with outpatient surgery made by:

- A **physician** or **dentist** for professional services;
- A **surgery center**; or
- The outpatient department of a **hospital**.

The surgery must meet the following requirements:

- The surgery can be performed adequately and safely only in a **surgery center** or **hospital** and
- The surgery is not normally performed in a **physician**'s or **dentist**'s office.

Important Note
Benefits for surgery services performed in a **physician**'s or **dentist**'s office are described under Physician Services benefits in the previous section.

The following outpatient surgery expenses are covered:

- Services and supplies provided by the **hospital**, **surgery center** on the day of the procedure;
- The operating **physician**'s services for performing the procedure, related pre- and post-operative care, and administration of anesthesia; and
- Services of another **physician** for related post-operative care and administration of anesthesia. This does not include a local anesthetic.

Limitations

Not covered under this plan are charges made for:

- The services of a **physician** or other health care provider who renders technical assistance to the operating **physician**.
- A **stay** in a **hospital**.
- Facility charges for office based surgery.

Birthing Center

Covered expenses include charges made by a **birthing center** for services and supplies related to your care in a **birthing center** for:

- Prenatal care;
- Delivery; and
- Postpartum care within 48 hours after a vaginal delivery and 96 hours after a Cesarean delivery.

Limitations

Unless specified above, not covered under this benefit are charges:

- In connection with a pregnancy for which pregnancy related expenses are not included as a covered expense.

See *Pregnancy Related Expenses* for information about other **covered expenses** related to maternity care.

Home Health Care

Covered expenses include charges for home health care services when ordered by a **physician** as part of a home health plan and provided you are:

- Transitioning from a **hospital** or other inpatient facility, and the services are in lieu of a continued inpatient **stay**; or
- **Homebound**

Covered expenses include only the following:

- **Skilled nursing services** that require medical training of, and are provided by, a licensed nursing professional within the scope of his or her license. These services need to be provided during intermittent visits of 4 hours or less, with a daily maximum of 3 visits. Intermittent visits are considered periodic and recurring visits that skilled nurses make to ensure your proper care, which means they are not on site for more than four hours at a time. If you are discharged from a **hospital** or **skilled nursing facility** after an inpatient **stay**, the intermittent requirement may be waived to allow coverage for up to 12 hours (3 visits) of continuous **skilled nursing services**. However, these services must be provided for within 10 days of discharge.
- Home health aide services, when provided in conjunction with skilled nursing care, that directly support the care. These services need to be provided during intermittent visits of 4 hours or less, with a daily maximum of 3 visits.
- Medical social services, when provided in conjunction with skilled nursing care, by a qualified social worker.
- Skilled behavioral health care services provided in the home by a **behavioral health provider** when ordered by a **physician** and directly related to an active treatment plan of care established by the **physician**. All of the following must be met:
  - The skilled behavioral health care is appropriate for the active treatment of a condition, **illness** or disease to avoid placing you at risk for serious complications.
  - The services are in lieu of a continued confinement in a **hospital** or **residential treatment facility**, or receiving outpatient services outside of the home.
  - You are **homebound** because of **illness** or **injury**.
  - The services provided are not primarily for comfort, convenience or custodial in nature.
  - The services are intermittent or hourly in nature.
  - The services are not for Applied Behavior Analysis.

Benefits for home health care visits are payable up to the Home Health Care Maximum. Each visit by a nurse, **behavioral health provider** or therapist is 1 visit.

In figuring the Plan Year Maximum Visits, each visit of a:

- Nurse or Therapist, up to 4 hours is 1 visit and
- **behavioral health provider**, of up to 1 hour, is 1 visit.

This maximum will not apply to care given by an **R.N.** or **L.P.N.** when:

- Care is provided within 10 days of discharge from a **hospital** or **skilled nursing facility** as a full-time inpatient; and
- Care is needed to transition from the **hospital** or **skilled nursing facility** to home care.

When the above criteria are met, **covered expenses** include up to 12 hours of continuous care by an **R.N.** or **L.P.N.** per day.

Coverage for Home Health Care services is not determined by the availability of caregivers to perform them. The absence of a person to perform a non-skilled or **custodial care** service does not cause the service to become covered. If the covered person is a minor or an adult who is dependent upon others for non-skilled care (e.g. bathing, eating, toileting), coverage for home health services will only be provided during times when there is a family member or caregiver present in the home to meet the person's non-skilled needs.

Note: Home short-term physical, speech, or occupational therapy is covered when the above home health care criteria are met. Services are subject to the conditions and limitations listed in the Short Term Rehabilitation Therapies section of the *Schedule of Benefits*.

Limitations

Unless specified above, *not* covered under this benefit are charges for:

- Services or supplies that are not a part of the **Home Health Care Plan**.
- Services of a person who usually lives with you, or who is a member of your or your spouse's family.
- Services of a certified or licensed social worker.
- Services for physical, occupational and speech therapy. Refer to Short Term Rehabilitation Therapies section for coverage information.
- Services for Infusion Therapy.
- Transportation.
- Services or supplies provided to a minor or dependent adult when a family member or caregiver is not present.
- Services that are **custodial care**.

Important Reminders

The plan does *not* cover **custodial care**, even if care is provided by a nursing professional, and family member or other caretakers cannot provide the necessary care.

Refer to the *Schedule of Benefits* for details about any applicable home health care visit maximums.

Private Duty Nursing

Covered expenses include private duty nursing provided by a **R.N.** or **L.P.N.** if the person's condition requires **skilled nursing** care and visiting nursing care is not adequate. However, **covered expenses** will not include private duty nursing for any shifts during a Plan Year in excess of the Private Duty Nursing Care Maximum Shifts. Each period of private duty nursing of up to 8 hours will be deemed to be one private duty nursing shift.

The plan also covers skilled observation for up to one four-hour period per day, for up to 10 consecutive days following:

- A change in your medication;
- Treatment of an urgent or **emergency medical condition** by a **physician**;
- The onset of symptoms indicating a need for emergency treatment;
- Surgery;
- An inpatient **stay**.

Limitations

Unless specified above, *not* covered under this benefit are charges for:

- Nursing care that does not require the education, training and technical skills of a **R.N.** or **L.P.N.**
- Nursing care assistance for daily life activities, such as:
  - Transportation;
  - Meal preparation;
  - Vital sign charting;
  - Companionship activities;
  - Bathing;
  - Feeding;
  - Personal grooming;
  - Dressing;

  - Toileting; and
  - Getting in/out of bed or a chair.
- Nursing care provided for skilled observation.
- Nursing care provided while you are an inpatient in a **hospital** or health care facility.
- A service provided solely to administer oral medicine, except where law requires a **R.N.** or **L.P.N.** to administer medicines.

Skilled Nursing Facility

Covered expenses include charges made by a **skilled nursing facility** during your **stay** for the following services and supplies, up to the maximums shown in the *Schedule of Benefits*, including:

- **Room and board**, up to the **semi-private room rate**. The plan will cover up to the private room rate if it is needed due to an infectious illness or a weak or compromised immune system;
- Use of special treatment rooms;
- Radiological services and lab work;
- Physical, occupational, or speech therapy;
- Oxygen and other gas therapy;
- Other medical services and general nursing services usually given by a **skilled nursing facility** (this does not include charges made for private or special nursing, or **physician's** services); and
- Medical supplies.

Important Reminder
Refer to the *Schedule of Benefits* for details about any applicable **skilled nursing facility** maximums.

Limitations

Unless specified above, *not* covered under this benefit are charges for:

- Charges made for the treatment of:
  - Drug addiction;
  - Alcoholism;
  - Senility;
  - Mental retardation; or
  - Any other mental illness; and
- Daily **room and board** charges over the **semi private rate**.

Hospice Care

Covered expenses include charges made by the following furnished to you for **hospice care** when given as part of a **hospice care program**.

Facility Expenses

The charges made by a **hospital**, **hospice** or **skilled nursing facility** for:

- **Room and Board** and other services and supplies furnished during a **stay** for pain control and other acute and chronic symptom management; and
- Services and supplies furnished to you on an outpatient basis.

Outpatient Hospice Expenses

Covered expenses include charges made on an outpatient basis by a **Hospice Care Agency** for:

- Part-time or intermittent nursing care by a **R.N.** or **L.P.N.** for up to eight hours a day;
- Part-time or intermittent home health aide services to care for you up to eight hours a day.

- Medical social services under the direction of a **physician**. These include but are not limited to:
  - Assessment of your social, emotional and medical needs, and your home and family situation;
  - Identification of available community resources; and
  - Assistance provided to you to obtain resources to meet your assessed needs.
- Physical and occupational therapy; and
- Consultation or case management services by a **physician**;
- Medical supplies;
- Prescription drugs;
- Dietary counseling; and
- Psychological counseling.

Charges made by the providers below if they are not an employee of a **Hospice Care Agency**; and such Agency retains responsibility for your care:

- A **physician** for a consultation or case management;
- A physical or occupational therapist;
- A **home health care agency** for:
  - Physical and occupational therapy;
  - Part time or intermittent home health aide services for your care up to eight hours a day;
  - Medical supplies;
  - **Prescription drugs**;
  - Psychological counseling; and
  - Dietary counseling.

Limitations

Unless specified above, *not* covered under this benefit are charges for:

- Daily **room and board** charges over the **semi-private room rate**.
- Funeral arrangements.
- Pastoral counseling.
- Financial or legal counseling. This includes estate planning and the drafting of a will.
- Homemaker or caretaker services. These are services which are not solely related to your care. These include, but are not limited to: sitter or companion services for either you or other family members; transportation; maintenance of the house.

Important Reminders
Refer to the *Schedule of Benefits* for details about any applicable **hospice care** maximums.

Other Covered Health Care Expenses

Acupuncture

The plan covers charges made for acupuncture services provided by a **physician**, if the service is performed:

- As a form of anesthesia in connection with a covered surgical procedure.

Important Reminder
Refer to the *Schedule of Benefits* for details about any applicable acupuncture benefit maximum.

Ambulance Service

Covered expenses include charges made by a professional **ambulance**, as follows:

Ground Ambulance

Covered expenses include charges for transportation:

- To the first **hospital** where treatment is given in a medical emergency.
- From one **hospital** to another **hospital** in a medical emergency when the first **hospital** does not have the required services or facilities to treat your condition.
- From **hospital** to home or to another facility when other means of transportation would be considered unsafe due to your medical condition.
- From home to **hospital** for covered inpatient or outpatient treatment when other means of transportation would be considered unsafe due to your medical condition. Transport is limited to 100 miles.
- When during a covered inpatient **stay** at a **hospital**, **skilled nursing facility** or acute rehabilitation **hospital**, an **ambulance** is required to safely and adequately transport you to or from inpatient or outpatient **medically necessary** treatment.

Air or Water Ambulance

Covered expenses include charges for transportation to a **hospital** by air or water **ambulance** when:

- Ground **ambulance** transportation is not available; and
- Your condition is unstable, and requires medical supervision and rapid transport; and
- In a medical emergency, transportation from one **hospital** to another **hospital**; when the first **hospital** does not have the required services or facilities to treat your condition and you need to be transported to another **hospital**; and the two conditions above are met.

Limitations

Not covered under this benefit are charges incurred to transport you:

- If an **ambulance** service is not required by your physical condition; or
- If the type of **ambulance** service provided is not required for your physical condition; or
- By any form of transportation other than a professional **ambulance** service; or
- By fixed wing air ambulance from an **out-of-network provider**.

Diagnostic and Preoperative Testing

Diagnostic Complex Imaging Expenses

The plan covers charges made on an outpatient basis by a **physician**, **hospital** or a licensed imaging or radiological facility for complex imaging services to diagnose an **illness** or **injury**, including:

- C.A.T. scans;
- Magnetic Resonance Imaging (MRI);
- Nuclear medicine imaging including positron emission tomography (PET) Scans; and
- Any other outpatient diagnostic imaging service where the **recognized charge** exceeds $500.

Complex Imaging Expenses for preoperative testing will be payable under this benefit.

Limitations

The plan does not cover diagnostic complex imaging expenses under this part of the plan if such imaging expenses are covered under any other part of the plan.

Outpatient Diagnostic Lab Work and Radiological Services

Covered expenses include charges for radiological services (other than diagnostic complex imaging), lab services, and pathology and other tests provided to diagnose an **illness** or **injury**. You must have definite symptoms that start, maintain or change a plan of treatment prescribed by a **physician**. The charges must be made by a **physician**, **hospital** or licensed radiological facility or lab.

Important Reminder
Refer to the *Schedule of Benefits* for details about any **deductible**, **payment percentage** and maximum that may apply to outpatient diagnostic testing, and lab and radiological services.

Outpatient Preoperative Testing

Prior to a scheduled covered surgery, **covered expenses** include charges made for tests performed by a **hospital**, **surgery center**, **physician** or licensed diagnostic laboratory provided the charges for the surgery are **covered expenses** and the tests are:

- Related to your surgery, and the surgery takes place in a **hospital** or **surgery center**;
- Completed within 14 days before your surgery;
- Performed on an outpatient basis;
- Covered if you were an inpatient in a **hospital**;
- Not repeated in or by the **hospital** or **surgery center** where the surgery will be performed.
- Test results should appear in your medical record kept by the **hospital** or **surgery center** where the surgery is performed.

Limitations

The plan does not cover diagnostic complex imaging expenses under this part of the plan if such imaging expenses are covered under any other part of the plan.

- If your tests indicate that surgery should not be performed because of your physical condition, the plan will pay for the tests, however surgery will ***not*** be covered.

Important Reminder
Complex Imaging testing for preoperative testing is covered under the complex imaging section. Separate cost sharing may apply. Refer to your *Schedule of Benefits* for information on cost sharing amounts for complex imaging.

Durable Medical and Surgical Equipment (DME)

Covered expenses include charges by a **DME** supplier for the rental of equipment or, in lieu of rental:

The initial purchase of **DME** if:

- Long term care is planned; and
- The equipment cannot be rented or is likely to cost less to purchase than to rent.

Repair of purchased equipment. Maintenance and repairs needed due to misuse or abuse are not covered.

Replacement of purchased equipment if:

- The replacement is needed because of a change in your physical condition; and
- It is likely to cost less to replace the item than to repair the existing item or rent a similar item.

The plan limits coverage to one item of equipment, for the same or similar purpose and the accessories needed to operate the item. You are responsible for the entire cost of any additional pieces of the same or similar equipment you purchase or rent for personal convenience or mobility.

Covered **Durable Medical Equipment** includes those items covered by Medicare unless excluded in the Exclusions section of this Booklet. **Aetna** reserves the right to limit the payment of charges up to the most cost efficient and least restrictive level of service or item which can be safely and effectively provided. The decision to rent or purchase is at the discretion of **Aetna**.

Important Reminder
Refer to the *Schedule of Benefits* for details about **durable medical and surgical equipment deductible**, **payment percentage** and benefit maximums. Also refer to *Exclusions* for information about Home and Mobility exclusions.

Clinical Trials

*Clinical Trial Therapies (**Experimental or Investigational**)*

Covered expenses include charges made for **experimental or investigational** drugs, devices, treatments or procedures "under an approved clinical trial" only when you have cancer or a terminal illness, and ***all*** of the following conditions are met:

- Standard therapies have not been effective or are inappropriate;
- **Aetna** determines, based on published, peer-reviewed scientific evidence that you may benefit from the treatment; and
- You are enrolled in an approved clinical trial that meets these criteria.

An "approved clinical trial" is a clinical trial that meets these criteria:
- The FDA has approved the drug, device, treatment, or procedure to be investigated or has granted it investigational new drug (IND) or group c/treatment IND status. This requirement does not apply to procedures and treatments that do not require FDA approval.
- The clinical trial has been approved by an Institutional Review Board that will oversee the investigation.
- The clinical trial is sponsored by the National Cancer Institute (NCI) or similar federal organization.
- The trial conforms to standards of the NCI or other, applicable federal organization.
- The clinical trial takes place at an NCI-designated cancer center or takes place at more than one institution.
- You are treated in accordance with the protocols of that study.

Routine Patient Costs

Covered expenses include charges made by a provider for "routine patient costs" furnished in connection with your participation in an "approved clinical trial" for cancer or other life-threatening disease or condition, as those terms are defined in the federal Public Health Service Act, Section 2709.

Limitations:
Not covered under this Plan are:
- Services and supplies related to data collection and record-keeping that is solely needed due to the clinical trial (i.e. protocol-induced costs);
- Services and supplies provided by the trial sponsor without charge to you; and
- The experimental intervention itself (except medically necessary Category B investigational devices and promising experimental or investigational interventions for terminal illnesses in certain clinical trials in accordance with Aetna's claim policies).

Important Note:
1. Refer to the *Schedule of Benefits* for details about cost sharing and any benefit maximums that apply to the Clinical Trial benefit.
2. These Clinical Trial benefits are subject to all of the terms, conditions, provisions, limitations, and exclusions of this Plan including, but not limited to, any precertification and referral requirements.

Pregnancy Related Expenses

Covered expenses include charges made by a **physician** for pregnancy and childbirth services and supplies at the same level as any **illness** or **injury**. This includes prenatal visits, delivery and postnatal visits.

For inpatient care of the mother and newborn child, **covered expenses** include charges made by a **Hospital** for a minimum of:

- 48 hours after a vaginal delivery; and
- 96 hours after a cesarean section.
- A shorter stay, if the attending **physician**, with the consent of the mother, discharges the mother or newborn earlier.

Covered expenses also include charges made by a **birthing center** as described under Alternatives to **Hospital** Care.

Note: **Covered expenses** also include services and supplies provided for circumcision of the newborn during the stay.

Important Note:

Refer to the *Preventive Care* section of this *Booklet* for additional information on coverage for female contraceptive coverage under this Plan.

Prosthetic Devices

Covered expenses include charges made for internal and external prosthetic devices and special appliances, if the device or appliance improves or restores body part function that has been lost or damaged by **illness**, **injury** or congenital defect. **Covered expenses** also include instruction and incidental supplies needed to use a covered prosthetic device.

The plan covers the first prosthesis you need that temporarily or permanently replaces all or part of a body part lost or impaired as a result of disease or injury or congenital defects as described in the list of covered devices below for an:

- Internal body part or organ; or
- External body part.

Covered expenses also include replacement of a prosthetic device if:

- The replacement is needed because of a change in your physical condition; or normal growth or wear and tear; or
- It is likely to cost less to buy a new one than to repair the existing one; or
- The existing one cannot be made serviceable.

The list of covered devices includes but is not limited to:

- An artificial arm, leg, hip, knee or eye;
- Eye lens;
- An external breast prosthesis and the first bra made solely for use with it after a mastectomy;
- A breast implant after a mastectomy;
- Ostomy supplies, urinary catheters and external urinary collection devices;
- Speech generating device;
- A cardiac pacemaker and pacemaker defibrillators; and
- A durable brace that is custom made for and fitted for you.

The plan will not cover expenses and charges for, or expenses related to:

- Orthopedic shoes, therapeutic shoes, foot orthotics, or other devices to support the feet; unless the orthopedic shoe is an integral part of a covered leg brace; or
- Trusses, corsets, and other support items; or
- Any item listed in the *Exclusions* section.

Hearing Aids

Covered hearing care expenses include charges for electronic hearing aids (monaural and binaural), installed in accordance with a **prescription** written during a covered hearing exam.

Benefits are payable up to the hearing supply maximum listed in the Schedule of Benefits.

All **covered expenses** are subject to the hearing expense exclusions in this *Booklet*- and are subject to **deductible(s)**, **copayments** or **payment percentage** listed in the *Schedule of Benefits*, if any.

Benefits After Termination of Coverage

Expenses incurred for hearing aids within 30 days of termination of the person's coverage under this benefit section will be deemed to be covered hearing care expenses if during the 30 days before the date coverage ends:

- The **prescription** for the hearing aid was written; and
- The hearing aid was ordered.

Short-Term Rehabilitation Therapy Services

Covered expenses include charges for short-term therapy services when prescribed by a **physician** as described below up to the benefit maximums listed on your *Schedule of Benefits*. The services have to be performed by:

- A licensed or certified physical, occupational or speech therapist;
- A **hospital**, **skilled nursing facility**, or **hospice facility**;
- A **home health care agency**; or
- A **physician**.

Charges for the following short term rehabilitation expenses are covered:

Cardiac and Pulmonary Rehabilitation Benefits.

- Cardiac rehabilitation benefits are available as part of an inpatient **hospital stay**. A limited course of outpatient cardiac rehabilitation is covered when following angioplasty, cardiovascular surgery, congestive heart failure or myocardial infarction. The plan will cover charges in accordance with a treatment plan as determined by your risk level when recommended by a physician. This course of treatment is limited to a maximum of 36 sessions in a 12 week period.
- Pulmonary rehabilitation benefits are available as part of an inpatient **hospital stay**. A limited course of outpatient pulmonary rehabilitation is covered for the treatment of reversible pulmonary disease states. This course of treatment is limited to a maximum of 36 hours or a six week period.

Outpatient Cognitive Therapy, Physical Therapy, Occupational Therapy and Speech Therapy Rehabilitation Benefits.

Coverage is subject to the limits, if any, shown on the *Schedule of Benefits*. Inpatient rehabilitation benefits for the services listed will be paid as part of your Inpatient Hospital and Skilled Nursing Facility benefits provision in this **Booklet**.

- Physical therapy is covered for non-chronic conditions and acute **illnesses** and **injuries**, provided the therapy expects to significantly improve, develop or restore physical functions lost or impaired as a result of an acute **illness**, **injury** or surgical procedure. Physical therapy does not include educational training or services designed to develop physical function.
- Occupational therapy (except for vocational rehabilitation or employment counseling) is covered for non-chronic conditions and acute **illnesses** and **injuries**, provided the therapy expects to significantly improve, develop or restore physical functions lost or impaired as a result of an acute **illness**, **injury** or surgical procedure, or to relearn skills to significantly improve independence in the activities of daily living. Occupational therapy does not include educational training or services designed to develop physical function.
- Speech therapy is covered for non-chronic conditions and acute illnesses and injuries provided the therapy is expected to restore the speech function or correct a speech impairment resulting from **illness** or **injury**; or for delays in speech function development as a result of a gross anatomical defect present at birth. Speech function is the ability to express thoughts, speak words and form sentences. Speech impairment is difficulty with expressing one's thoughts with spoken words.
- Cognitive therapy associated with physical rehabilitation is covered when the cognitive deficits have been acquired as a result of neurologic impairment due to trauma, stroke, or encephalopathy, and when the therapy is part of a treatment plan intended to restore previous cognitive function.

A "visit" consists of no more than one hour of therapy. Refer to the *Schedule of Benefits* for the visit maximum that applies to the plan. **Covered expenses** include charges for two therapy visits of no more than one hour in a 24-hour period.

The therapy should follow a specific treatment plan that:

- Details the treatment, and specifies frequency and duration; and
- Provides for ongoing reviews and is renewed only if continued therapy is appropriate.
- Allows therapy services, provided in your home, if you are **homebound**.

Important Reminder
Refer to the *Schedule of Benefits* for details about the short-term rehabilitation therapy maximum benefit.

Unless specifically covered above, *not* covered under this benefit are charges for:

- Therapies for the treatment of delays in development, unless resulting from acute illness or injury, or congenital defects amenable to surgical repair (such as cleft lip/palate), are not covered. Examples of non-covered diagnoses include Pervasive Developmental Disorders (including Autism), Down's syndrome, and Cerebral Palsy, as they are considered both developmental and/or chronic in nature.
- Any services which are **covered expenses** in whole or in part under any other group plan sponsored by an employer;
- Any services unless provided in accordance with a specific treatment plan;
- Services for the treatment of delays in speech development, unless resulting from **illness, injury**, or congenital defect;
- Services provided during a **stay** in a **hospital**, **skilled nursing facility**, or **hospice facility except as stated above**;
- Services not performed by a **physician** or under the direct supervision of a **physician**;
- Treatment covered as part of the Spinal Manipulation Treatment. This applies whether or not benefits have been paid under that section;
- Services provided by a **physician** or physical, occupational or speech therapist who resides in your home; or who is a member of your family, or a member of your spouse's family;
- Special education to instruct a person whose speech has been lost or impaired, to function without that ability. This includes lessons in sign language.

Reconstructive or Cosmetic Surgery and Supplies

Covered expenses include charges made by a **physician**, **hospital**, or **surgery center** for reconstructive services and supplies, including:

- Surgery needed to improve a significant functional impairment of a body part.
- Surgery to correct the result of an accidental injury, including subsequent related or staged surgery, provided that the surgery occurs no more than 24 months after the original injury. For a covered child, the time period for coverage may be extended through age 18.
- Surgery to correct the result of an injury that occurred during a covered surgical procedure provided that the reconstructive surgery occurs no more than 24 months after the original injury.

Note: Injuries that occur as a result of a medical (*i.e.*, non surgical) treatment are not considered accidental injuries, even if unplanned or unexpected.

- Surgery to correct a gross anatomical defect present at birth or appearing after birth (but not the result of an illness or injury) when
  - the defect results in severe facial disfigurement, or
  - the defect results in significant functional impairment and the surgery is needed to improve function

Reconstructive Breast Surgery

Covered expenses include reconstruction of the breast on which a mastectomy was performed, including an implant and areolar reconstruction. Also included is surgery on a healthy breast to make it symmetrical with the reconstructed breast and physical therapy to treat complications of mastectomy, including lymphedema.

Important Notice
A benefit maximum may apply to reconstructive or **cosmetic** surgery services. Please refer to the *Schedule of Benefits.*

Specialized Care

Chemotherapy

Covered expenses include charges for chemotherapy treatment. Coverage levels depend on where treatment is received. In most cases, chemotherapy is covered as outpatient care. Inpatient **hospitalization** for chemotherapy is limited to the initial dose while **hospitalized** for the diagnosis of cancer and when a **hospital stay** is otherwise **medically necessary** based on your health status.

Radiation Therapy Benefits

Covered expenses include charges for the treatment of **illness** by x-ray, gamma ray, accelerated particles, mesons, neutrons, radium or radioactive isotopes.

Outpatient Infusion Therapy Benefits

Covered expenses include infusion therapy received from an outpatient setting including but not limited to:

- A free-standing outpatient facility;
- The outpatient department of a **hospital**; or
- A **physician** in his/her office or in your home.

The list of preferred infusion locations can be found by contacting Member Services by logging onto your Aetna Navigator® secure member website at www.aetna.com or calling the number on the back of your ID card.

Certain infused medications may be covered under the prescription drug plan. You can access the list of specialty care prescription drugs by contacting Member Services or by logging onto your Aetna Navigator® secure member website at www.aetna.com or calling the number on the back of your ID card to determine if coverage is under the prescription drug plan or this booklet.

Infusion therapy is the intravenous or continuous administration of medications or solutions that are a part of your course of treatment. Charges for the following outpatient Infusion Therapy services and supplies are **covered expenses**:

- The pharmaceutical when administered in connection with infusion therapy and any medical supplies, equipment and nursing services required to support the infusion therapy;
- Professional services;
- Total parenteral nutrition (TPN);
- Chemotherapy;
- Drug therapy (includes antibiotic and antivirals);
- Pain management (narcotics); and
- Hydration therapy (includes fluids, electrolytes and other additives).

Not included under this infusion therapy benefit are charges incurred for:

- Enteral nutrition;
- Blood transfusions and blood products;
- Dialysis; and
- Insulin.

Coverage is subject to the maximums, if any, shown in the *Schedule of Benefits*.

Coverage for inpatient infusion therapy is provided under the *Inpatient Hospital* and *Skilled Nursing Facility Benefits* sections of this *Booklet*.

Benefits payable for infusion therapy will not count toward any applicable **Home Health Care** maximums.

Important Reminder
Refer to the *Schedule of Benefits* for details about any applicable **deductible**, **coinsurance** and maximum benefit limits.

Specialty Care Prescription Drugs

Covered expenses include **specialty care prescription drugs** when they are:

- Purchased by your **provider,** and
- Injected or infused by your **provider** in an outpatient setting such as:
  - A free-standing outpatient facility
  - The outpatient department of a **hospital**
  - A **physician** in his/her office
  - A home care **provider** in your home
- And, listed on our **specialty care prescription drug** list as covered under this booklet.

Certain infused medications may be covered under the **prescription drug** plan. You can access the list of **specialty care prescription drugs** by contacting Member Services or by logging onto your Aetna Navigator® secure member website at www.aetna.com or calling the number on the back of your ID card to determine if coverage is under the **prescription drug** plan of this booklet.

Diabetic Equipment, Supplies and Education

Covered expenses include charges for the following services, supplies, equipment and training for the treatment of insulin and non-insulin dependent diabetes and for elevated blood glucose levels during pregnancy:

- External insulin pumps;
- Blood glucose monitors without special features unless required due to blindness;
- Alcohol swabs;
- Glucagon emergency kits;
- Self-management training provided by a licensed health care provider certified in diabetes self-management training; and
- Foot care to minimize the risk of infection.

Treatment of Infertility

Basic Infertility Expenses

Covered expenses include charges made by a **network physician** to diagnose and to surgically treat the underlying medical cause of **infertility**.

Spinal Manipulation Treatment

Covered expenses include charges made by a **physician** on an outpatient basis for manipulative (adjustive) treatment or other physical treatment for conditions caused by (or related to) biomechanical or nerve conduction disorders of the spine.

Your benefits are subject to the maximum shown in the *Schedule of Benefits*. However, this maximum does not apply to expenses incurred:

- During your **hospital stay**; or
- For surgery. This includes pre- and post-surgical care provided or ordered by the operating **physician**.

Transplant Services

Covered expenses include charges incurred during a transplant occurrence. The following will be considered to be one transplant occurrence once it has been determined that you or one of your dependents may require an organ transplant. Organ means solid organ; stem cell; bone marrow; and tissue.

- Heart;
- Lung;
- Heart/Lung;
- Simultaneous Pancreas Kidney (SPK);
- Pancreas;
- Kidney;
- Liver;
- Intestine;
- Bone Marrow/Stem Cell;
- Multiple organs replaced during one transplant surgery;
- Tandem transplants (Stem Cell);
- Sequential transplants;
- Re-transplant of same organ type within 180 days of the first transplant;
- Any other single organ transplant, unless otherwise excluded under the plan.

The following will be considered to be *more than one* Transplant Occurrence:

- Autologous blood/bone marrow transplant followed by allogenic blood/bone marrow transplant (when not part of a tandem transplant);
- Allogenic blood/bone marrow transplant followed by an autologous blood/bone marrow transplant (when not part of a tandem transplant);
- Re-transplant after 180 days of the first transplant;
- Pancreas transplant following a kidney transplant;
- A transplant necessitated by an additional organ failure during the original transplant surgery/process;
- More than one transplant when not performed as part of a planned tandem or sequential transplant, (e.g., a liver transplant with subsequent heart transplant).

The **network** level of benefits is paid only for a treatment received at a facility designated by the plan as an **Institute of Excellence™ (IOE)** for the type of transplant being performed. Each **IOE** facility has been selected to perform only certain types of transplants.

Services obtained from a facility that is not designated as an **IOE** for the transplant being performed will be covered as **out-of-network** services and supplies, even if the facility is a **network** facility or **IOE** for other types of services.

The plan covers:

- Charges made by a **physician** or transplant team.
- Charges made by a **hospital**, outpatient facility or **physician** for the medical and surgical expenses of a live donor, but only to the extent not covered by another plan or program.
- Related supplies and services provided by the facility during the transplant process. These services and supplies may include: physical, speech and occupational therapy; bio-medicals and immunosuppressants; home health care expenses and home infusion services.
- Charges for activating the donor search process with national registries.

- Compatibility testing of prospective organ donors who are immediate family members. For the purpose of this coverage, an "immediate" family member is defined as a first-degree biological relative. These are your biological parents, siblings or children.
- Inpatient and outpatient expenses directly related to a transplant.

Covered transplant expenses are typically incurred during the four phases of transplant care described below. Expenses incurred for one transplant during these four phases of care will be considered one transplant occurrence.

A transplant occurrence is considered to begin at the point of evaluation for a transplant and end either 180 days from the date of the transplant; ***or*** upon the date you are discharged from the **hospital** or outpatient facility for the admission or visit(s) related to the transplant, whichever is later.

The four phases of one transplant occurrence and a summary of covered transplant expenses during each phase are:

1. Pre-transplant evaluation/screening: Includes all transplant-related professional and technical components required for assessment, evaluation and acceptance into a transplant facility's transplant program;
2. Pre-transplant/candidacy screening: Includes HLA typing/compatibility testing of prospective organ donors who are immediate family members;
3. Transplant event: Includes inpatient and outpatient services for all covered transplant-related health services and supplies provided to you and a donor during the one or more surgical procedures or medical therapies for a transplant; **prescription drugs** provided during your inpatient **stay** or outpatient visit(s), including bio-medical and immunosuppressant drugs; physical, speech or occupational therapy provided during your inpatient **stay** or outpatient visit(s); cadaveric and live donor organ procurement; and
4. Follow-up care: Includes all covered transplant expenses; home health care services; home infusion services; and transplant-related outpatient services rendered within 180 days from the date of the transplant event.

If you are a participant in the **IOE** program, the program will coordinate all solid organ and bone marrow transplants and other specialized care you need. Any **covered expenses** you incur from an **IOE** facility will be considered network care expenses.

Important Reminders
Refer to the *Schedule of Benefits* for details about transplant expense maximums, if applicable.

Limitations
Unless specified above, *not* covered under this benefit are charges incurred for:

- Outpatient drugs including bio-medicals and immunosuppressants not expressly related to an outpatient transplant occurrence;
- Services that are covered under any other part of this plan;
- Services and supplies furnished to a donor when the recipient is not covered under this plan;
- Home infusion therapy after the transplant occurrence;
- Harvesting or storage of organs, without the expectation of immediate transplantation for an existing illness;
- Harvesting and/or storage of bone marrow, tissue or stem cells, without the expectation of transplantation within 12 months for an existing illness;
- Cornea (Corneal Graft with Amniotic Membrane) or Cartilage (autologous chondrocyte or autologous osteochondral mosaicplasty) transplants, unless otherwise authorized by **Aetna**.

Network of Transplant Specialist Facilities
Through the **IOE** network, you will have access to a provider network that specializes in transplants. Benefits may vary if an **IOE** facility or non-**IOE** or **out-of-network provider** is used. In addition, some expenses are payable only within the **IOE** network. The **IOE** facility must be specifically approved and designated by **Aetna** to perform the procedure you require. Each facility in the **IOE** network has been selected to perform only certain types of transplants, based on quality of care and successful clinical outcomes.

Alcoholism, Substance Abuse and Mental Disorders Treatment

Covered expenses include charges made for the treatment of alcoholism, **substance abuse** and **mental disorders** by **behavioral health providers**.

Important Notice
Not all types of services are covered. For example, educational services and certain types of therapies are not covered. See the *Health Plan Exclusions and Limits* section for more information.

Treatment of Mental Disorders

Covered expenses include charges made for the treatment of other **mental disorders** by **behavioral health providers**.

Benefits are payable for charges incurred in a **hospital, psychiatric hospital, residential treatment facility** or **behavioral health provider's** office for the treatment of **mental disorders** as follows:

Inpatient Treatment

Covered expenses include charges for **room and board** at the **semi-private room rate,** and other services and supplies provided during your **stay** in a **hospital, psychiatric hospital** or **residential treatment facility**. Inpatient benefits are payable only if your condition requires services that are only available in an inpatient setting.

Partial Confinement Treatment

Covered expenses include charges made for **partial confinement treatment** provided in a facility or program for the intermediate short-term or medically-directed intensive treatment of a **mental disorder**. Such benefits are payable if your condition requires services that are only available in a **partial confinement treatment** setting.

Outpatient Treatment

Covered expenses include charges for treatment received while not confined as a full-time inpatient in a **hospital**, **psychiatric hospital** or **residential treatment facility**.

The plan covers partial **hospitalization** services (more than 4 hours, but less than 24 hours per day) provided in a facility or program for the intermediate short-term or medically-directed intensive treatment. The partial **hospitalization** will only be covered if you would need inpatient care if you were not admitted to this type of facility.

Alcoholism and Substance Abuse

Covered expenses include charges made for the treatment of alcoholism and **substance abuse** by **behavioral health providers.**

The *Schedule of Benefits* shows the benefits payable and applicable benefit maximums for the treatment of alcoholism and **substance abuse**.

Inpatient Treatment for Alcoholism and Substance Abuse

The plan covers **room and board** at the **semi-private room rate** and other services and supplies provided during your **stay** in a **psychiatric hospital** or **residential treatment facility**, appropriately licensed by the State Department of Health or its equivalent.

Coverage includes:

- Treatment in a **hospital** for the medical complications of alcoholism or **substance abuse**.
- "Medical complications" include **detoxification**, electrolyte imbalances, malnutrition, cirrhosis of the liver, delirium tremens and hepatitis.
- Treatment in a **hospital**, when the **hospital** does not have a separate treatment facility section.

Outpatient Treatment for Alcoholism and Substance Abuse

The plan covers outpatient treatment of alcoholism or **substance abuse**.

The plan covers partial **hospitalization** services (more than 4 hours, but less than 24 hours per day) provided in a facility or program for the intermediate short-term or medically-directed intensive treatment of alcoholism or **substance abuse**. The partial **hospitalization** will only be covered if you would need inpatient treatment if you were not admitted to this type of facility.

Partial Confinement Treatment for Alcoholism and Substance Abuse

Covered expenses include charges made for **partial confinement treatment** provided in a facility or program for the intermediate short-term or medically-directed intensive treatment of alcoholism or **substance abuse**.

The **partial confinement treatment** will only be covered if you would need a **hospital stay** if you were not admitted to this type of facility.

Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)

Covered expenses include charges made by a **physician**, a **dentist** and **hospital** for:

- Non-surgical treatment of infections or diseases of the mouth, jaw joints or supporting tissues.

Services and supplies for treatment of, or related conditions of, the teeth, mouth, jaws, jaw joints or supporting tissues, (this includes bones, muscles, and nerves), for surgery needed to:

- Treat a fracture, dislocation, or wound.
- Cut out cysts, tumors, or other diseased tissues.
- Cut into gums and tissues of the mouth. This is only covered when ***not*** done in connection with the removal, replacement or repair of teeth.
- Alter the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement.

Hospital services and supplies received for a **stay** required because of your condition.

Dental work, surgery and **orthodontic treatment** needed to remove, repair, restore or reposition:

(a) Natural teeth damaged, lost, or removed; or
(b) Other body tissues of the mouth fractured or cut

due to **injury**.

Any such teeth must have been free from decay or in good repair, and are firmly attached to the jaw bone at the time of the **injury**.

The treatment must be completed in the Plan Year of the accident or in the next Plan Year.

If crowns, dentures, bridges, or in-mouth appliances are installed due to **injury**, **covered expenses** only include charges for:

- The first denture or fixed bridgework to replace lost teeth;
- The first crown needed to repair each damaged tooth; and
- An in-mouth appliance used in the first course of **orthodontic treatment** after the **injury**.

Medical Plan Exclusions

Not every medical service or supply is covered by the plan, even if prescribed, recommended, or approved by your **physician** or **dentist**. The plan covers only those services and supplies that are **medically necessary** and included in the *What the Plan Covers* section. Charges made for the following are not covered except to the extent listed under the *What The Plan Covers* section or by amendment attached to this Booklet.

Important Note:
You have medical and prescription drug coverage. The exclusions listed below apply to all coverage under your plan. Additional exclusions apply to specific prescription drug coverage. Those additional exclusions are listed separately under the *What The Plan Covers* section for each of these benefits.

Acupuncture, acupressure and acupuncture therapy, except as provided in the *What the Plan Covers* section.

Allergy: Specific non-standard allergy services and supplies, including but not limited to, skin titration (Rinkel method), cytotoxicity testing (Bryan's Test) treatment of non-specific candida sensitivity, and urine autoinjections.

Any charges in excess of the benefit, dollar, day, visit or supply limits stated in this Booklet.

Any non-emergency charges incurred outside of the United States if you traveled to such location to obtain medical services, **prescription drugs**, or supplies, even if otherwise covered under this Booklet. This also includes **prescription drugs** or supplies if:

- such **prescription drugs** or supplies are unavailable or illegal in the United States; or
- the purchase of such **prescription drugs** or supplies outside the United States is considered illegal.

Applied Behavioral Analysis, the LEAP, TEACCH, Denver and Rutgers programs.

Behavioral Health Services:

- Alcoholism or **substance abuse** rehabilitation treatment on an inpatient or outpatient basis, except to the extent coverage for **detoxification** or treatment of alcoholism or **substance abuse** is specifically provided in the *What the Medical Plan Covers* Section.
- Treatment of a covered health care provider who specializes in the mental health care field and who receives treatment as a part of their training in that field.
- Treatment of impulse control disorders such as pathological gambling, kleptomania, pedophilia, caffeine or nicotine use.
- Treatment of antisocial personality disorder.
- Treatment in wilderness programs or other similar programs.
- Treatment of mental retardation, defects, and deficiencies. This exclusion does not apply to mental health services or to medical treatment of mentally retarded in accordance with the benefits provided in the *What the Plan Covers* section of this Booklet.

Blood, blood plasma, synthetic blood, blood products or substitutes, including but not limited to, the provision of blood, other than blood derived clotting factors. Any related services including processing, storage or replacement costs, and the services of blood donors, apheresis or plasmapheresis are not covered. For autologous blood donations, only administration and processing costs are covered.

Charges for a service or supply furnished by a **network provider** in excess of the **negotiated charge**.

Charges submitted for services that are not rendered, or rendered to a person not eligible for coverage under the plan.

Charges submitted for services by an unlicensed **hospital**, **physician** or other provider or not within the scope of the provider's license.

Contraception, except as specifically described in the *What the Plan Covers* Section:

- Over the counter contraceptive supplies including but not limited to condoms, contraceptive foams, jellies and ointments.

Cosmetic services and plastic surgery: any treatment, surgery (cosmetic or plastic), service or supply to alter, improve or enhance the shape or appearance of the body whether or not for psychological or emotional reasons including:

- Face lifts, body lifts, tummy tucks, liposuctions, removal of excess skin, removal or reduction of non-malignant moles, blemishes, varicose veins, cosmetic eyelid surgery and other surgical procedures;
- Procedures to remove healthy cartilage or bone from the nose (even if the surgery may enhance breathing) or other part of the body;
- Chemical peels, dermabrasion, laser or light treatments, bleaching, creams, ointments or other treatments or supplies to alter the appearance or texture of the skin;
- Insertion or removal of any implant that alters the appearance of the body (such as breast or chin implants); except removal of an implant will be covered when **medically necessary**;
- Removal of tattoos (except for tattoos applied to assist in covered medical treatments, such as markers for radiation therapy); and
- Repair of piercings and other voluntary body modifications, including removal of injected or implanted substances or devices;
- Surgery to correct Gynecomastia;
- Breast augmentation;
- Otoplasty.

Counseling: Services and treatment for marriage, religious, family, career, social adjustment, pastoral, or financial counselor except as specifically provided in the *What the Plan Covers* section.

Court ordered services, including those required as a condition of parole or release.

Custodial Care

Dental Services: any treatment, services or supplies related to the care, filling, removal or replacement of teeth and the treatment of injuries and diseases of the teeth, gums, and other structures supporting the teeth. This includes but is not limited to:

- services of **dentist**s, oral surgeons, dental hygienists, and orthodontists including apicoectomy (dental root resection), root canal treatment, soft tissue impactions, removal of bony impacted teeth, treatment of periodontal disease, alveolectomy, augmentation and vestibuloplasty and fluoride and other substances to protect, clean or alter the appearance of teeth;
- dental implants, false teeth, prosthetic restoration of dental implants, plates, dentures, braces, mouth guards, and other devices to protect, replace or reposition teeth; and
- non-surgical treatments to alter bite or the alignment or operation of the jaw, including treatment of malocclusion or devices to alter bite or alignment.

Disposable outpatient supplies: Any outpatient disposable supply or device, including sheaths, bags, elastic garments, support hose, bandages, bedpans, syringes, blood or urine testing supplies, and other home test kits; and splints, neck braces, compresses, and other devices not intended for reuse by another patient.

Drugs, medications and supplies:

- Over-the-counter drugs, biological or chemical preparations and supplies that may be obtained without a **prescription** including vitamins;
- Any services related to the dispensing, injection or application of a drug;
- Any prescription drug purchased illegally outside the United States, even if otherwise covered under this plan within the United States;
- Immunizations related to work;
- Needles, syringes and other injectable aids, except as covered for diabetic supplies;
- Drugs related to the treatment of non-**covered expenses**;
- Performance enhancing steroids;
- Injectable drugs if an alternative oral drug is available;
- Outpatient **prescription drug**s;
- Self-injectable **prescription drug**s and medications;
- Any **prescription drug**s, injectables, or medications or supplies provided by the customer or through a third party vendor contract with the customer; and
- Any expenses for prescription drugs, and supplies covered under an Aetna Pharmacy plan will not be covered under this medical expense plan. Prescription drug exclusions that apply to the Aetna Pharmacy plan will apply to the medical expense coverage; and
- Charges for any prescription drug for the treatment of erectile dysfunction, impotence, or sexual dysfunction or inadequacy.

Durable medical and surgical equipment including purchase, rental, replacement or repair from an **out-of-network provider**, except as specifically provided in the *What the Plan Covers* section.

Educational services:

- Any services or supplies related to education, training or retraining services or testing, including: special education, remedial education, job training and job hardening programs;
- Evaluation or treatment of learning disabilities, minimal brain dysfunction, developmental, learning and communication disorders, behavioral disorders, (including pervasive developmental disorders) training or cognitive rehabilitation, regardless of the underlying cause; and
- Services, treatment, and educational testing and training related to behavioral (conduct) problems, learning disabilities and delays in developing skills.

Examinations:

- Any health examinations required:
  - by a third party, including examinations and treatments required to obtain or maintain employment, or which an employer is required to provide under a labor agreement;
  - by any law of a government;
  - for securing insurance, school admissions or professional or other licenses;
  - to travel;
  - to attend a school, camp, or sporting event or participate in a sport or other recreational activity; and

  Any special medical reports not directly related to treatment except when provided as part of a covered service.

Experimental or investigational drugs, devices, treatments or procedures, except as described in the *What the Plan Covers* section.

Facility charges for care services or supplies provided in:

- rest homes;
- assisted living facilities;
- similar institutions serving as an individual's primary residence or providing primarily custodial or rest care;
- health resorts;
- spas, sanitariums; or
- infirmaries at schools, colleges, or camps.

Food items: Any food item, including infant formulas, nutritional supplements, vitamins, including prescription vitamins, medical foods and other nutritional items, even if it is the sole source of nutrition. This exclusion does not apply to specialized medical foods delivered enterally (only when delivered via a tube directly into the stomach or intestines) or parenterally.

Foot care: Any services, supplies, or devices to improve comfort or appearance of toes, feet or ankles, including but not limited to:

- treatment of calluses, bunions, toenails, hammer-toes, subluxations, fallen arches, weak feet, chronic foot pain or conditions caused by routine activities such as walking, running, working or wearing shoes; and
- Shoes (including orthopedic shoes), foot orthotics, arch supports, shoe inserts, ankle braces, guards, protectors, creams, ointments and other equipment, devices and supplies, even if required following a covered treatment of an **illness** or **injury**.

Growth/Height: Any treatment, device, drug, service or supply (including surgical procedures, devices to stimulate growth and growth hormones), solely to increase or decrease height or alter the rate of growth.

Hearing:

- Any hearing service or supply that does not meet professionally accepted standards;
- Hearing exams given during a **stay** in a **hospital** or other facility;
- Replacement parts or repairs for a hearing aid;
- Any service or supply furnished by **out-of-network** providers; and
- Any tests, appliances, and devices for the improvement of hearing (including hearing aids and amplifiers), or to enhance other forms of communication to compensate for hearing loss or devices that simulate speech, except as otherwise provided under the *What the Plan Covers* section.

Home and mobility: Any addition or alteration to a home, workplace or other environment, or vehicle and any related equipment or device, such as:

- Purchase or rental of exercise equipment, air purifiers, central or unit air conditioners, water purifiers, waterbeds. and swimming pools;
- Exercise and training devices, whirlpools, portable whirlpool pumps, sauna baths, or massage devices;
- Equipment or supplies to aid sleeping or sitting, including non-hospital electric and air beds, water beds, pillows, sheets, blankets, warming or cooling devices, bed tables and reclining chairs;
- Equipment installed in your home, workplace or other environment, including stair-glides, elevators, wheelchair ramps, or equipment to alter air quality, humidity or temperature;
- Other additions or alterations to your home, workplace or other environment, including room additions, changes in cabinets, countertops, doorways, lighting, wiring, furniture, communication aids, wireless alert systems, or home monitoring;
- Services and supplies furnished mainly to provide a surrounding free from exposure that can worsen your **illness** or **injury**;

- Removal from your home, worksite or other environment of carpeting, hypo-allergenic pillows, mattresses, paint, mold, asbestos, fiberglass, dust, pet dander, pests or other potential sources of allergies or **illness**; and
- Transportation devices, including stair-climbing wheelchairs, personal transporters, bicycles, automobiles, vans or trucks, or alterations to any vehicle or transportation device.

Home births: Any services and supplies related to births occurring in the home or in a place not licensed to perform deliveries.

Infertility: except as specifically described in the *What the Plan Covers* Section, any services, treatments, procedures or supplies that are designed to enhance fertility or the likelihood of conception, including but not limited to:

- Drugs related to the treatment of non-covered benefits;
- Injectable infertility medications, including but not limited to menotropins, hCG, GnRH agonists, and IVIG;
- Artificial Insemination;
- Any advanced reproductive technology ("ART") procedures or services related to such procedures, including but not limited to in vitro fertilization ("IVF"), gamete intra-fallopian transfer ("GIFT"), zygote intra-fallopian transfer ("ZIFT"), and intra-cytoplasmic sperm injection ("ICSI"); Artificial Insemination for covered females attempting to become pregnant who are not infertile as defined by the plan;
- Infertility services for couples in which 1 of the partners has had a previous sterilization procedure, with or without surgical reversal;
- Procedures, services and supplies to reverse voluntary sterilization;
- Infertility services for females with FSH levels 19 or greater mIU/ml on day 3 of the menstrual cycle;
- The purchase of donor sperm and any charges for the storage of sperm; the purchase of donor eggs and any charges associated with care of the donor required for donor egg retrievals or transfers or gestational carriers or surrogacy; donor egg retrieval or fees associated with donor egg programs, including but not limited to fees for laboratory tests;
- Charges associated with cryopreservation or storage of cryopreserved eggs and embryos (e.g., office, **hospital**, ultrasounds, laboratory tests, etc.); any charges associated with a frozen embryo or egg transfer, including but not limited to thawing charges;
- Home ovulation prediction kits or home pregnancy tests;
- Any charges associated with care required to obtain ART Services (e.g., office, **hospital**, ultrasounds, laboratory tests); and any charges associated with obtaining sperm for any ART procedures; and
- Ovulation induction and intrauterine insemination services if you are not infertile.

Maintenance Care.

Medicare: Payment for that portion of the charge for which Medicare or another party is the primary payer.

Miscellaneous charges for services or supplies including:

- Annual or other charges to be in a **physician's** practice;
- Charges to have preferred access to a **physician's** services such as boutique or concierge **physician** practices;
- Cancelled or missed appointment charges or charges to complete claim forms;
- Charges the recipient has no legal obligation to pay; or the charges would not be made if the recipient did not have coverage (to the extent exclusion is permitted by law) including:
  - Care in charitable institutions;
  - Care for conditions related to current or previous military service;
  - Care while in the custody of a governmental authority;
  - Any care a public **hospital** or other facility is required to provide; or
  - Any care in a **hospital** or other facility owned or operated by any federal, state or other governmental entity, except to the extent coverage is required by applicable laws.

Nursing and home health aide services provided outside of the home (such as in conjunction with school, vacation, work or recreational activities).

Non-**medically necessary** services, including but not limited to, those treatments, services, **prescription drugs** and supplies which are not **medically necessary**, as determined by **Aetna**, for the diagnosis and treatment of **illness**, **injury**, restoration of physiological functions, or covered preventive services. This applies even if they are prescribed, recommended or approved by your **physician** or **dentist**.

Personal comfort and convenience items: Any service or supply primarily for your convenience and personal comfort or that of a third party, including: Telephone, television, internet, barber or beauty service or other guest services; housekeeping, cooking, cleaning, shopping, monitoring, security or other home services; and travel, transportation, or living expenses, rest cures, recreational or diversional therapy.

Private duty nursing during your **stay** in a **hospital**, and outpatient private duty nursing services, except as specifically described in the *Private Duty Nursing* provision in the *What the Plan Covers* Section.

Sex change: Any treatment, drug, service or supply related to changing sex or sexual characteristics, including:

- Surgical procedures to alter the appearance or function of the body;
- Hormones and hormone therapy;
- Prosthetic devices; and
- Medical or psychological counseling.

Services provided by a spouse, domestic partner, parent, child, step-child, brother, sister, in-law or any household member.

Services of a resident **physician** or intern rendered in that capacity.

Services provided where there is no evidence of pathology, dysfunction, or disease; except as specifically provided in connection with covered routine care and cancer screenings.

Sexual dysfunction/enhancement: Any treatment, drug, service or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including:

- Surgery, drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity, or alter the shape or appearance of a sex organ; and
- Sex therapy, sex counseling, marriage counseling or other counseling or advisory services.

Services, including those related to pregnancy, rendered before the effective date or after the termination of coverage, unless coverage is continued under the *Continuation of Coverage* section of this Booklet.

Services that are not covered under this Booklet.

Services and supplies provided in connection with treatment or care that is not covered under the plan.

Services and supplies provided by an **out-of-network provider**.

Speech therapy for treatment of delays in speech development, except as specifically provided in the *What the Medical Plan Covers Section*. For example, the plan does not cover therapy when it is used to improve speech skills that have not fully developed.

Spinal disorder, including care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion or dislocation in the human body or other physical treatment of any condition caused by or related to biomechanical or nerve conduction disorders of the spine including manipulation of the spine treatment, except as specifically provided in the *What the Plan Covers* section.

Strength and performance: Services, devices and supplies to enhance strength, physical condition, endurance or physical performance, including:

- Exercise equipment, memberships in health or fitness clubs, training, advice, or coaching;
- Drugs or preparations to enhance strength, performance, or endurance; and
- Treatments, services and supplies to treat **illnesses**, **injuries** or disabilities related to the use of performance-enhancing drugs or preparations.

Therapies for the treatment of delays in development, unless resulting from acute illness or injury, or congenital defects amenable to surgical repair (such as cleft lip/palate), are not covered. Examples of non-covered diagnoses include Pervasive Developmental Disorders (including Autism), Down Syndrome, and Cerebral Palsy, as they are considered both developmental and/or chronic in nature.

Therapies and tests: Any of the following treatments or procedures:

- Aromatherapy;
- Bio-feedback and bioenergetic therapy;
- Carbon dioxide therapy;
- Chelation therapy (except for heavy metal poisoning);
- Computer-aided tomography (CAT) scanning of the entire body;
- Educational therapy;
- Gastric irrigation;
- Hair analysis;
- Hyperbaric therapy, except for the treatment of decompression or to promote healing of wounds;
- Hypnosis, and hypnotherapy, except when performed by a **physician** as a form of anesthesia in connection with covered surgery;
- Lovaas therapy;
- Massage therapy;
- Megavitamin therapy;
- Primal therapy;
- Psychodrama;
- Purging;
- Recreational therapy;
- Rolfing;
- Sensory or auditory integration therapy;
- Sleep therapy;
- Thermograms and thermography.

Tobacco Use: Any treatment, drug, service or supply to stop or reduce smoking or the use of other tobacco products or to treat or reduce nicotine addiction, dependence or cravings, including counseling, hypnosis and other therapies, medications, nicotine patches and gum except as specifically provided in the *What the Plan Covers* section.

Transplant-The transplant coverage does not include charges for:

- Outpatient drugs including bio-medicals and immunosuppressants not expressly related to an outpatient transplant occurrence;
- Services and supplies furnished to a donor when recipient is not a covered person;
- Home infusion therapy after the transplant occurrence;
- Harvesting and/or storage of organs, without the expectation of immediate transplantation for an existing **illness**;
- Harvesting and/or storage of bone marrow, tissue or stem cells without the expectation of transplantation within 12 months for an existing **illness**;
- Cornea (corneal graft with amniotic membrane) or cartilage (autologous chondrocyte or autologous osteochondral mosaicplasty) transplants, unless otherwise **precertified** by **Aetna**.

Transportation costs, including **ambulance** services for routine transportation to receive outpatient or inpatient services except as described in the *What the Plan Covers* section.

Unauthorized services, including any service obtained by or on behalf of a covered person without Precertification by Aetna when required. This exclusion does not apply in a Medical Emergency or in an Urgent Care situation.

Vision-related services and supplies, except as described in the *What the Plan Covers* section. The plan does not cover:

- Special supplies such as non-**prescription** sunglasses and subnormal vision aids;
- Vision service or supply which does not meet professionally accepted standards;
- Eye exams during your **stay** in a **hospital** or other facility for health care;
- Eye exams for contact lenses or their fitting;
- Eyeglasses or duplicate or spare eyeglasses or lenses or frames;
- Replacement of lenses or frames that are lost or stolen or broken;
- Acuity tests;
- Eye surgery for the correction of vision, including radial keratotomy, LASIK and similar procedures;
- Services to treat errors of refraction.

Voluntary termination of pregnancy, including related services.

Weight: Any treatment, drug service or supply intended to decrease or increase body weight, control weight or treat obesity, including **morbid obesity**, regardless of the existence of comorbid conditions; except as specifically provided in the *What the Plan Covers* section, including but not limited to:

- Liposuction, banding, gastric stapling, gastric by-pass and other forms of bariatric surgery; surgical procedures medical treatments, weight control/loss programs and other services and supplies that are primarily intended to treat, or are related to the treatment of obesity, including **morbid obesity**;
- Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food supplements, appetite suppressants and other medications;
- Counseling, coaching, training, hypnosis or other forms of therapy; and
- Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancement.

Wilderness treatment programs (whether or not the program is part of a licensed **residential treatment facility**, or otherwise licensed institution), educational services, schooling or any such related or similar program, including therapeutic programs within a school setting.

Work related: Any **illness** or **injury** related to employment or self-employment including any **illness** or **injury** that arises out of (or in the course of) any work for pay or profit, unless no other source of coverage or reimbursement is available to you for the services or supplies. Sources of coverage or reimbursement may include your employer, workers' compensation, or an occupational illness or similar program under local, state or federal law. A source of coverage or reimbursement will be considered available to you even if you waived your right to payment from that source. If you are also covered under a workers' compensation law or similar law, and submit proof that you are not covered for a particular illness or **injury** under such law, that illness or **injury** will be considered "non-occupational" regardless of cause.

Your Pharmacy Benefit

How the Pharmacy Plan Works

It is important that you have the information and useful resources to help you get the most out of your **prescription drug** plan. This Booklet explains:

- Definitions you need to know;
- How to access **network pharmacies** and procedures you need to follow;
- What **prescription drug** expenses are covered and what limits may apply;
- What **prescription drug** expenses are not covered by the plan;
- How you share the cost of your covered **prescription drug** expenses; and
- Other important information such as eligibility, complaints and appeals, termination, and general administration of the plan.

A few important notes to consider before moving forward:

- Unless otherwise indicated, "you" refers to you and your covered dependents.
- Your **prescription drug** plan pays benefits only for **prescription drug** expenses described in this Booklet as **covered expenses** that are **medically necessary**.
- This Booklet applies to coverage only and does not restrict your ability to receive **prescription drugs** that are not or might not be covered benefits under this **prescription drug** plan.
- Store this Booklet in a safe place for future reference.

Notice
The plan does not cover all **prescription drugs**, medications and supplies. Refer to the Limitations section of this coverage and *Exclusions* section of your Booklet.

- **Covered expenses** are subject to cost sharing requirements as described in the Cost Sharing sections of this coverage and in your Schedule of Benefits.
- **Injectable prescription drug** refills will only be covered when obtained through **Aetna's specialty pharmacy network**.

Getting Started: Common Terms

You will find the terms below used throughout this Booklet. They are described within the sections that follow, and you can also refer to the *Glossary* at the back of this document for helpful definitions. Words in bold print throughout the document are defined in the *Glossary*.

Brand-Named Prescription Drug is a **prescription drug** with a proprietary name assigned to it by the manufacturer and so indicated by Medispan or any other similar publication designated by **Aetna**.

Generic Prescription Drug is a **prescription drug**, whether identified by its chemical, proprietary, or non-proprietary name, that is accepted by the U.S. Food and Drug Administration as therapeutically equivalent and interchangeable with drugs having an identical amount of the same active ingredient and so indicated by Medispan or any other publication designated by **Aetna**.

Network pharmacy is a description of a retail, **mail order or specialty pharmacy** that has entered into a contractual agreement with **Aetna**, an affiliate, or a third party vendor, for the provision of **covered services** to you and your covered dependents. The appropriate **pharmacy** type may also be substituted for the word **pharmacy**. (E.g. **network** retail **pharmacy, network mail order pharmacy or specialty pharmacy network**).

Non-Preferred Drug (Non-Formulary) is a **brand-named prescription drug** or **generic prescription drug** that does not appear on the **preferred drug guide**.

Out-of-network pharmacy is a description of a **pharmacy** that has not contracted with **Aetna**, an affiliate, or a third party vendor and does not participate in the pharmacy network.

Preferred Drug (Formulary) is a **brand-named prescription drug** or **generic prescription drug** that appears on the **preferred drug guide**.

Preferred Drug Guide is a listing of **prescription drugs** established by **Aetna** or an affiliate, which includes both **brand-named prescription drugs** and **generic prescription drugs**. This list is subject to periodic review and modification by **Aetna**. A copy of the **preferred drug guide** will be available upon your request or may be accessed on the **Aetna** website at www.aetna.com/formulary.

Prescription Drug is a drug, biological, or compounded **prescription** which, by State or Federal Law, may be dispensed only by **prescription** and which is required by Federal Law to be labeled "Caution: Federal Law prohibits dispensing without prescription." This includes an injectable drug prescribed to be self-administered or administered by any other person except one who is acting within his or her capacity as a paid healthcare professional. Covered injectable drugs include insulin.

Provider is any recognized health care professional, pharmacy or facility providing services with the scope of their license.

Self-injectable Drug(s). Prescription drugs that are intended to be self-administered by injection to a specific part of the body to treat certain chronic medical conditions.

Accessing Pharmacies and Benefits

This plan provides access to **covered benefits** through a network of pharmacies, vendors or suppliers. **Aetna** has contracted for these **network pharmacies** to provide **prescription drugs** and other supplies to you.

Obtaining your benefits through **network pharmacies** has many advantages. Your out-of-pocket costs may vary between **network** and **out-of-network benefits**. Benefits and cost sharing may also vary by the type of **network pharmacy** where you obtain your **prescription drug** and whether or not you purchase a brand-name or generic drug. **Network pharmacies** include retail, mail order and specialty pharmacies.

Accessing Network Pharmacies and Benefits

You may select a **network pharmacy** from Aetna's on-line provider directory which can be found at www.aetna.com. You can search **Aetna**'s online directory, DocFind, for names and locations of **network pharmacies**. If you cannot locate a **network pharmacy** in your area, call Member Services at the number on your ID card.

You must present your ID card to the **network pharmacy** every time you get a **prescription** filled to be eligible for **network pharmacy benefits**. The **network pharmacy** will calculate your claim online. You will pay any **deductible**, **copaymen**t or **coinsurance** directly to the **network pharmacy**. You do not have to complete or submit claim forms. The **network pharmacy** will take care of claim submission.

Emergency Prescriptions

When you need a **prescription** filled in an emergency or urgent care situation, or when you are traveling, you can obtain **network pharmacy** benefits by filling your **prescription** at any **network pharmacy**. The **network pharmacy** will fill your **prescription** and only charge you your plan's cost sharing amount.

If you access an **out-of-network pharmacy** you will pay the full cost of the **prescription** and will need to file a claim for reimbursement. You will be reimbursed for your **covered expenses** up to the cost of the **prescription** less your plan's cost sharing for **network pharmacy** benefits.

Availability of Providers

Aetna cannot guarantee the availability or continued network participation of a particular **pharmacy**. Either **Aetna** or any **network pharmacy** may terminate the provider contract.

Cost Sharing for Network Benefits

You share in the cost of your benefits. Cost Sharing amounts and provisions are described in the Schedule of Benefits.

- You will need to satisfy any applicable **deductibles** before the plan will begin to pay benefits.
- You will be responsible for the **copayment** for each **prescription** or refill as specified in the *Schedule of Benefits*. The **copayment** is payable directly to the **network pharmacy** at the time the **prescription** is dispensed.
- After you satisfy any applicable **deductible** and pay the applicable **copayment**, you will be responsible for any applicable payment percentage for **covered expenses** that you incur Your **payment percentage** is determined by applying the applicable **payment** percentage to the **negotiated charge** if the **prescription** is filled at a **network pharmacy**. When you obtain your **prescription drugs** through a **network pharmacy**, you will not be subject to balance billing.

When You Use an Out-of-Network Pharmacy

You can directly access an out-of-network **pharmacy** to obtain covered outpatient **prescription drugs**. You will pay the **pharmacy** for your **prescription drugs** at the time of purchase and submit a claim form to receive reimbursement from the plan. You are responsible for completing and submitting claim forms for reimbursement of **covered expenses** you paid directly to an out-of-network **pharmacy**. The Plan will reimburse you for a **covered expense** up to the **recognized charge**, less any cost sharing required by you.

Cost Sharing for Out-of-Network Benefits

You share in the cost of your benefits. Cost Sharing amounts and provisions are described in the Schedule of Benefits.

- You will need to satisfy any applicable plan year **deductibles** before the plan will begin to pay benefits.
- After you satisfy any applicable year **deductible(s)**, you will be responsible for any applicable payment percentage for **covered expenses** that you incur. Your payment percentage share is based on the **recognized charge**. If the **out-of-network pharmacy** charges more than the **recognized charge**, you will be responsible for any expenses above the **recognized charge**.

Pharmacy Benefit

What the Plan Covers

The plan covers charges for **medically necessary** outpatient **prescription drugs** for the treatment of an **illness** or injury, subject to the *Prescription Drug Limitations* section below and the *Exclusions* section of the *Booklet*. **Prescriptions** must be written by a **prescriber** licensed to prescribe federal legend **prescription drugs**.

Your prescription drug benefit coverage is based on **Aetna's preferred drug guide**. Your out-of-pocket expenses may be higher if your **physician** prescribes a covered **prescription drug** not appearing on the **preferred drug guide**.

Preferred generic prescription drugs may be substituted by your pharmacist for **brand-name prescription drugs**. You may minimize your out-of-pocket expenses by selecting a **generic prescription drug** when available.

Coverage of **prescription drugs** may, in **Aetna**'s sole discretion, be subject to **precertification** or other **Aetna** requirements or limitations. **Prescription drugs** covered by this plan are subject to drug and narcotic utilization review by **Aetna**, your **provider** and/or your **network pharmacy**. This may include limiting access of **prescription drugs prescribed** by a specific **provider**. Such limitation may be enforced in the event that **Aetna** identifies an unusual pattern of claims for **covered expenses**.

Coverage for **prescription drugs** and supplies is limited to the supply limits as described below.

Retail Pharmacy Benefits

Outpatient **prescription drugs** are covered when dispensed by a **network retail pharmacy**. Each **prescription** is limited to a maximum 30 day supply when filled at a **network retail pharmacy**. **Prescriptions** for more than a 30 day supply are not eligible for coverage when dispensed by a **network retail pharmacy**.

Mail Order Pharmacy Benefits

Outpatient **prescription drugs** are covered when dispensed by a **network mail order pharmacy**. Each **prescription** is limited to a maximum 90 day supply. **Prescriptions** for less than a 30 day supply or more than a 90 day supply are not eligible for coverage when dispensed by a **network mail order pharmacy**.

Network Benefits for Specialty Care Drugs

Specialty care drugs are covered at the network level of benefits only when dispensed through a **network retail pharmacy** or **Aetna's specialty pharmacy network pharmacy**. **Specialty care drugs** often include typically high-cost drugs that require special handling, special storage or monitoring and include but are not limited to oral, topical, inhaled and injected routes of administration. Refer to **Aetna's** website, www.aetna.com to review the list of **specialty care drugs** required to be dispensed through a **network pharmacy** or **specialty pharmacy network pharmacy**. The list may be updated from time to time.

The initial prescription for **specialty care drugs** must be filled at a **network retail pharmacy** or at **Aetna's specialty pharmacy network**.

You are required to obtain **specialty care drugs** at **Aetna's specialty pharmacy network** for all prescription drug refills after the initial fill.

Other Covered Expenses

The following **prescription drugs**, medications and supplies are also **covered expenses** under this Coverage.

Off-Label Use

FDA approved **prescription drugs** may be covered when the off-label use of the drug has not been approved by the FDA for that indication. The drug must be recognized for treatment of the indication in one of the standard compendia (the United States Pharmacopoeia Drug Information, the American Medical Association Drug Evaluations, or the American Hospital Formulary Service Drug Information). Or, the safety and effectiveness of use for this indication has been adequately demonstrated by at least one study published in a nationally recognized peer review journal. Coverage of off label use of these drugs may, in **Aetna's** sole discretion, be subject to **precertification**, or other **Aetna** requirements or limitations.

Diabetic Supplies

Covered expenses include but are not limited to the following diabetic supplies upon **prescription** by a **physician**:

- Diabetic needles and syringes.
- Test strips for glucose monitoring and/or visual reading.
- Diabetic test agents.
- Lancets/lancing devices.
- Alcohol swabs.

Contraceptives

Covered expenses include charges made by a network **pharmacy** for the following contraceptive methods when prescribed by a **prescriber** and the **prescription** is submitted to the pharmacist for processing:

- Female oral and injectable contraceptives that are **generic prescription drugs** and **brand-name prescription drugs.**
- Female contraceptive devices.
- FDA-approved female generic emergency contraceptives; and.
- FDA-approved female generic over-the-counter (OTC) contraceptives.

Important Note:

This Plan does not cover all contraceptives. For a current listing, contact Member Services by logging onto the Aetna website at www.aetna.com or calling the toll-free number on the back of the ID card.

Contraceptives can be paid either under your medical plan or pharmacy plan depending on the type of expense and how and where the expense is incurred. Benefits are paid under your medical plan for female contraceptive prescription drugs and devices (including any related services and supplies) when they are provided, administered, or removed, by a physician during an office visit.

Refer to the *Copay and Deductible Waiver* section of your *Schedule of Benefits* for cost-sharing information.

Important Notes:

1. The Copay and Deductible Waiver does not apply to contraceptive methods that are:
   - **brand-name prescription drugs**;
   - FDA-approved female brand-name emergency contraceptives**.**
   - FDA–approved female brand-name over-the-counter (OTC) contraceptives.

   However, the Copay and Deductible Waiver does apply when:

   - such contraceptive methods are not available within the same **therapeutic drug class**; or
   - a generic equivalent, or generic alternative, within the same **therapeutic drug class** is not available; and
   - you are granted a medical exception. Refer to *Medical Exceptions* in the *Precertification* section for information on how you or your **prescriber** can obtain a medical exception.

2. A *generic equivalent* contains the identical amounts of the same active ingredients as the **brand-name prescription drug** or device. A *generic alternative* is used for the same purpose, but can have different ingredients or different amounts of ingredients.

Oral and Self-Injectable Infertility Drugs

The following **prescription drugs** used for the purpose of treating infertility including, but not limited to:

- Urofollitropin, menotropin, human chorionic gonadotropin and progesterone.

Lifestyle/Performance Drugs

The following lifestyle/performance drugs:

- Sildenafil Citrate, phentolamine, apomorphine and alprostadil in oral, injectable and topical (including but not limited to gels, creams, ointments and patches) forms or any other form used internally or externally. Expenses include any prescription drug in oral or topical form that is similar or identical class, has a similar or identical mode of action or exhibits similar or identical outcomes.
- Coverage is limited to 6 pills or other form, determined cumulatively among all forms, for unit amounts as determined by **Aetna** to be similar in cost to oral forms, per 30 day supply. Mail order and 60 to 90 day supplies are not covered.

Preventive Care Drugs and Supplements

Covered expenses include preventive care drugs and supplements (including over-the-counter drugs and supplements) obtained at a **network pharmacy**. They are covered when they are:

- prescribed by a **physician**;
- obtained at a **pharmacy**; and
- submitted to a pharmacist for processing.

The preventive care drugs and supplements covered under this Plan include, but may not be limited to:

- Aspirin: Benefits are available to adults.
- Oral Fluoride Supplements: Benefits are available to children whose primary water source is deficient in fluoride.
- Folic Acid Supplements: Benefits are available to adult females planning to become pregnant or capable of pregnancy.
- Iron Supplements: Benefits are available to children without symptoms of iron deficiency. Coverage is limited to children who are at increased risk for iron deficiency anemia.
- Vitamin D Supplements: Benefits are available to adults to promote calcium absorption and bone growth in their bodies.
- Risk-Reducing Breast Cancer **Prescription Drugs**: Covered medical expenses include charges incurred for generic **prescription drugs** prescribed by a **physician** for a woman who is at increased risk for breast cancer and is at low risk for adverse medication side effects.

Coverage of preventive care drugs and supplements will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force.

Important Note:
For details on the guidelines and the current list of covered preventive care drugs and supplements, contact your **physician** or Member Services by logging onto the Aetna website www.aetna.com and Aetna Navigator, or calling the number on the back of your ID card.

Tobacco Cessation Prescription and Over-the-Counter Drugs

Covered expenses include FDA-approved **prescription drugs** and over-the-counter (OTC) drugs to help stop the use of tobacco products, when prescribed by a prescriber and the **prescription** is submitted to the pharmacist for processing.

Refer to the *Schedule of Benefits* for the cost-sharing and supply limits that apply to these benefits.

Precertification

Precertification is required for certain outpatient **prescription drugs**. **Prescribers** must contact **Aetna** to request and obtain coverage for such **prescription drugs**. The list of drugs requiring **precertification** is subject to periodic review and change by **Aetna**. For the most up to date information, call the toll-free number on your member ID card or log on to your Aetna Navigator secure member website at www.aetna.com.

Benefits will be reduced or denied if **Aetna** does not **precertify** your **prescription drug**. So ask your **prescriber** or pharmacist if your **prescription drug** needs to be **precertified.**

How to Obtain Precertification

If an outpatient **prescription drug** requires **precertification** and you use a **network pharmacy** the **prescriber** is required to obtain **precertification** for you.

When you use an **out-of-network pharmacy**, you can begin the **precertification** process by having the **prescriber** call **Aetna** at the number on your ID card.

Aetna will let your **prescriber** know if the **prescription drug** is **precertified**.

If **precertification** is denied **Aetna** will notify you how the decision can be appealed.

Medical Exceptions:

Your **prescriber** may seek a medical exception to obtain coverage for drugs for which coverage is denied through **Precertification**. You or your **prescriber** must submit such exception requests to Aetna. Coverage granted as a result of a medical exception shall be based on an individual, case by case **medical necessity** determination and coverage will not apply or extend to other covered persons.

Pharmacy Benefit Limitations

A **network pharmacy** may refuse to fill a prescription order or refill when in the professional judgment of the pharmacist the prescription should not be filled.

The plan will not cover expenses for any **prescription drug** for which the actual charge to you is less than the required **copayment** or **deductible**, or for any **prescription drug** for which no charge is made to you.

You will be charged the **out-of-network prescription drug cost sharing** for **prescription drugs** recently approved by the FDA, but which have not yet been reviewed by the Aetna Health Pharmacy Management Department and Therapeutics Committee.

Aetna retains the right to review all requests for reimbursement and in its sole discretion make reimbursement determinations subject to the Complaint and Appeals section(s) of the Booklet.

Aetna reserves the right to include only one manufacturer's product on the **preferred drug list** when the same or similar drug (that, a drug with the same active ingredient), supply or equipment is made by two or more different manufacturers.

Aetna reserves the right to include only one dosage or form of a drug on the **preferred drug list** when the same drug (that is, a drug with the same active ingredient) is available in different dosages or forms from the same or different manufacturers. The product in the dosage or form that is listed on our **preferred drug list** will be covered at the applicable **copayment** or **coinsurance**.

The number of **copayments/deductibles** you are responsible for per vial of Depo-Provera, an injectable contraceptive, or similar type contraceptive dispensed for more than a 30 day supply, will be based on the 90 day supply level. Coverage is limited to a maximum of 5 vials per plan year.

The plan will not pay charges for any **prescription drug** dispensed by a **mail order pharmacy** for the treatment of erectile dysfunction, impotence or sexual dysfunction or inadequacy.

Some **prescription drugs** are subject to quantity limits. These quantity limits help your **prescriber** and pharmacist check that your **prescription drug** is used correctly and safely. **Aetna** relies on medical guidelines, FDA-approved recommendations from drug makers and other criteria developed by **Aetna** to set these quantity limits. The quantity limit may restrict either the amount dispensed per **prescription** order or refill.

Depending on the form and packing of the product, some **prescription drugs** are limited to a single commercially prepackaged item excluding insulin, diabetic supplies, test strips dispensed per **prescription** order or refill.

Depending on the form and packing of the product, some **prescription drugs** are limited to 100 units excluding insulin dispensed per **prescription** order or refill.

Any **prescription drug** that has duration of action extending beyond one (1) month shall require the number of **copayments** per prescribing unit that is equal to the anticipated duration of the medication. For example, a single injection of a drug that is effective for three (3) months would require three (3) **copayments**.

Specialty care prescription drugs may have limited access or distribution and are subject to supply limits.

Plan approved blood glucose meters, asthma holding chambers and peak flow meters are **eligible health services**, but are limited to one (1) **prescription** order per **contract year**.

Pharmacy Benefit Exclusions

Not every health care service or supply is covered by the plan. Even if prescribed, recommended, or approved by your **physician** or **dentist** it may not be covered. The plan covers only those services and supplies that are **medically necessary** and included in the *What the Plan Covers* section. Charges made for the following are not covered except to the extent listed under the *What the Plan Covers* section or by amendment attached to this *Booklet*. In addition, some services are specifically limited or excluded. This section describes expenses that are not covered or subject to special limitations.

These **prescription drug** exclusions are in addition to the exclusions listed under your medical coverage.

The plan does not cover the following expenses:

Abortion drugs.

Administration or injection of any drug.

Any charges in excess of the benefit, dollar, day, or supply limits stated in this *Booklet*.

Allergy sera and extracts.

Any non-emergency charges incurred outside of the United States if you traveled to such location to obtain **prescription drugs**, or supplies, even if otherwise covered under this *Booklet*. This also includes **prescription drugs** or supplies if:

- Such drugs or supplies are unavailable or illegal in the United States, or
- The purchase of such **prescription drugs** or supplies outside the United States is considered illegal.

Any drugs or medications, services and supplies that are not **medically necessary**, as determined by **Aetna**, for the diagnosis, care or treatment of the **illness** or **injury** involved. This applies even if they are prescribed, recommended or approved by your **physician** or **dentist**.

Biological sera, blood, blood plasma, blood products or substitutes or any other blood products.

Contraception:

- Over the counter contraceptive supplies including but not limited to:
  - condoms;
  - contraceptive foams;
  - jellies; and
  - ointments;
- Services associated with the prescribing, monitoring and/or administration of contraceptives.

Cosmetic drugs, medications or preparations used for **cosmetic** purposes or to promote hair growth or removal, including but not limited to:

- health and beauty aids;
- chemical peels;
- dermabrasion;
- treatments;
- bleaching;
- creams;
- ointments or other treatments or supplies, to remove tattoos, scars or to alter the appearance or texture of the skin.

Compounded **prescriptions**.

Devices and appliances that do not have the National Drug Code (NDC).

Dietary supplements including medical foods.

Drugs given or entirely consumed at the time and place it is prescribed or dispensed.

Drugs for which the cost is recoverable under any federal, state, or government agency or any medication for which there is no charge made to the recipient.

Drugs which do not, by federal or state law, require a **prescription** order (i.e. over-the-counter (OTC) drugs), even if a **prescription** is written (except as specifically covered in the *What the Pharmacy Plan Covers* section.

Drugs provided by, or while the person is an inpatient in, any healthcare facility; or for any drugs provided on an outpatient basis in any such institution to the extent benefits are payable for it.

Drugs that include vitamins and minerals, both over-the counter (OTC) and legend, except legend pre-natal vitamins for pregnant or nursing females, liquid or chewable legend pediatric vitamins for children under age 13, and potassium supplements to prevent/treat low potassium and legend vitamins that are medically necessary for the treatment of renal disease, hyperparathyroidism or other covered conditions with prior approval from us unless recommended by the United States Preventive Services Task Force (USPSTF).

Drugs used for methadone maintenance medications used for drug detoxification.

Drugs used for the purpose of weight gain or reduction, including but not limited to:

- stimulants;
- preparations;
- foods or diet supplements;
- dietary regimens and supplements;
- food or food supplements;
- appetite suppressants; and

- other medications.

Drugs used for the treatment of obesity.

All drugs or growth hormones used to stimulate growth and treat idiopathic short stature unless there is evidence that the member meets one or more clinical criteria detailed in our precertification and clinical policies.

Drugs or medications that include the same active ingredient or a modified version of an active ingredient.

Drug or medication that is therapeutically equivalent or therapeutically alternative to a covered **prescription drug**.

Drug or medication that is therapeutically equivalent or therapeutically alternative to an over-the-counter (OTC) product.

Duplicative drug therapy (e.g. two antihistamine drugs.

Durable medical equipment, monitors and other equipment.

Experimental or investigational drugs or devices, except as described in the *What the Plan Covers* section.

This exclusion will ***not*** apply with respect to drugs that:

- Have been granted treatment investigational new drug (IND); or Group c/treatment IND status; or
- Are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute; and
- **Aetna** determines, based on available scientific evidence, are effective or show promise of being effective for the **illness**.

Food items: Any food item, including:
- infant formulas;
- nutritional supplements;
- vitamins;
- medical foods and other nutritional items, even if it is the sole source of nutrition.

Genetics: Any treatment, device, drug, or supply to alter the body's genes, genetic make-up, or the expression of the body's genes except for the correction of congenital birth defects.

Immunization or immunological agents.

Implantable drugs and associated devices.

Injectables:

- Any charges for the administration or injection of **prescription drugs** or injectable insulin and other injectable drugs covered by the Plan;
- Needles and syringes, except for diabetic needles and syringes;
- Injectable drugs if an alternative oral drug is available;
- For any refill of a designated self-injectable drug not dispensed by or obtained through the **specialty pharmacy network**. An updated copy of the list of self-injectable drugs designated by this plan to be refilled by or obtained through the **specialty pharmacy network** is available upon request. You may also get a copy of the list on **Aetna's** website at www.aetna.com.
- For any drug, which due to its characteristics as determined by us must typically be administered or supervised by a qualified **provider** or licensed certified **health professional** in an outpatient setting. This exception does not apply to Depo Provera and other injectable drugs used for contraception.

Insulin pumps or tubing or other ancillary equipment and supplies for insulin pumps.

Prescription drugs for which there is an over-the-counter (OTC) product which has the same active ingredient and strength even if a **prescription** is written.

Prescription drugs, medications, injectables or supplies provided through a third party vendor contract with the contractholder.

Prescription drugs dispensed by a **mail order pharmacy** that include **prescription drugs** that cannot be shipped by mail due to state or federal laws or regulations, or when the plan considers shipment through the mail to be unsafe. Examples of these types of drugs include, but are not limited to, narcotics, amphetamines, DEA controlled substances and anticoagulants.

Prescription drugs that include an active metabolite, stereoisomer, prodrug (precursor) or altered formulation of another drug and is not clinically superior to that drug as determined by the plan.

Prescription drugs that are ordered by a **dentist** or prescribed by an oral surgeon in relation to the removal of teeth, or **prescription drugs** for the treatment of a dental condition.

Prescription drugs that are **non-preferred drugs**, unless **non-preferred drugs** are specifically covered as described in your schedule of benefits. However, a **non-preferred drug** will be covered if in the judgment of the **prescriber** there is no equivalent **prescription drug** on the **preferred drug guide** or the product on the **preferred drug guide** is ineffective in treating your disease or condition or has caused or is likely to cause an adverse reaction or harm you.

Prescription drugs that are being used or abused in a manner that is determined to be furthering an addiction to a habit-forming substance, the use of or intended use of which would be illegal, unethical, imprudent, abusive, not **medically necessary**, or otherwise improper; and drugs obtained for use by anyone other than the member identified on the ID card.

Prescription orders filled prior to the effective date or after the termination date of coverage under this Booklet.

Progesterone for the treatment of premenstrual syndrome (PMS) and compounded natural hormone therapy replacement.

Prophylactic drugs for travel.

Refills over the amount specified by the **prescription** order. Before recognizing charges, **Aetna** may require a new **prescription** or proof as to need, if a **prescription** or refill appears excessive under accepted medical practice standards.

Refills dispensed more than one year from the date the latest **prescription** order was written, or as otherwise allowed by applicable law of the jurisdiction in which the drug is dispensed.

Replacement of lost or stolen **prescription**s.

Drugs, services and supplies given in connection with treatment of an **occupational injury or occupational illness**.

Strength and performance: Drugs or preparations, devices or supplies to enhance strength, physical condition, endurance or physical performance, including performance enhancing steroids.

Sex change: Any treatment, drug or supply related to changing sex or sexual characteristics, including hormones and hormone therapy.

Supplies, devices or equipment of any type, except as specifically provided in the *What the Plan Covers* section.

Test agents except diabetic test agents.

When Coverage Ends

Coverage under your plan can end for a variety of reasons. In this section, you will find details on how and why coverage ends, and how you may still be able to continue coverage.

When Coverage Ends for Employees

Your **Aetna** health benefits coverage will end if:

- The **Aetna** health benefits plan is discontinued;
- You voluntarily stop your coverage;
- You are no longer eligible for coverage;
- You do not make any required contributions;
- You become covered under another plan offered by your employer;
- You have exhausted your overall maximum lifetime benefit under your health plan, if your plan contains such a maximum benefit; or
- Your employer notifies **Aetna** that your employment is ended.

It is your employer's responsibility to let **Aetna** know when your employment ends.

Your Proof of Prior Medical Coverage

Under the Health Insurance Portability and Accountability Act of 1996, your employer is required to give you a certificate of **creditable coverage** when your employment ends. This certificate proves that you were covered under this plan when you were employed. Ask your employer about the certificate of **creditable coverage**.

When Coverage Ends for Dependents

Coverage for your dependents will end if:

- You are no longer eligible for dependents' coverage;
- You do not make your contribution for the cost of dependents' coverage;
- Your own coverage ends for any of the reasons listed under *When Coverage Ends* for Employees. (This does not apply if you use up your overall lifetime maximum, if included);
- Your dependent is no longer eligible for coverage. Coverage ends at the end of the pay period when your dependent does not meet the plan's definition of a dependent; or
- As permitted under applicable federal and state law, your dependent becomes eligible for like benefits under this or any other group plan offered by your employer.

Coverage for dependents may continue for a period after your death. Coverage for handicapped dependents may continue after they reach any limiting age. See *Continuation of Coverage* for more information.

Continuation of Coverage

Continuing Health Care Benefits

Continuing Coverage for Dependent Students on Medical Leave of Absence

If your dependent child who is eligible for coverage and enrolled in this plan by reason of his or her status as a full-time student at a postsecondary educational institution ceases to be eligible due to:

- a medically necessary leave of absence from school; or
- a change in his or her status as a full-time student,

resulting from a serious **illness** or **injury**, such child's coverage under this plan may continue.

Coverage under this continuation provision will end when the first of the following occurs:

- The end of the 12 month period following the first day of your dependent child's leave of absence from school, or a change in his or her status as a full-time student;
- Your dependent child's coverage would otherwise end under the terms of this plan;
- Dependent coverage is discontinued under this plan; or
- You fail to make any required contribution toward the cost of this coverage.

To be eligible for this continuation, the dependent child must have been enrolled in this plan and attending school on a full-time basis immediately before the first day of the leave of absence.

To continue your dependent child's coverage under this provision you should notify your employer as soon as possible after your child's leave of absence begins or the change in his or her status as a full-time student. **Aetna** may require a written certification from the treating **physician** which states that the child is suffering from a serious **illness** or **injury** and that the resulting leave of absence (or change in full-time student status) is **medically necessary**.

Important Note
If at the end of this 12 month continuation period, your dependent child's leave of absence from school (or change in full-time student status) continues, such child may qualify for a further continuation of coverage under the Handicapped Dependent Children provision of this plan. Please see the section, *Handicapped Dependent Children*, for more information.

Handicapped Dependent Children

Health Expense Coverage for your fully handicapped dependent child may be continued past the maximum age for a dependent child. However, such coverage may not be continued if the child has been issued an individual medical conversion policy.

Your child is fully handicapped if:

- he or she is not able to earn his or her own living because of mental retardation or a physical handicap which started prior to the date he or she reaches the maximum age for dependent children under your plan; and
- he or she depends chiefly on you for support and maintenance.

Proof that your child is fully handicapped must be submitted to **Aetna** no later than 31 days after the date your child reaches the maximum age under your plan.

Coverage will cease on the first to occur of:

- Cessation of the handicap.
- Failure to give proof that the handicap continues.
- Failure to have any required exam.
- Termination of Dependent Coverage as to your child for any reason other than reaching the maximum age under your plan.

Aetna will have the right to require proof of the continuation of the handicap. **Aetna** also has the right to examine your child as often as needed while the handicap continues at its own expense. An exam will not be required more often than once each year after 2 years from the date your child reached the maximum age under your plan.

Coordination of Benefits - What Happens When There is More Than One Health Plan

Other Plans Not Including Medicare

Other Plans Not Including Medicare

Some persons have health coverage in addition to coverage under this Plan. Under these circumstances, it is not intended that a plan provide duplicate benefits. For this reason, many plans, including this Plan, have a "coordination of benefits" provision.

Under the coordination of benefits provision of this Plan, the amount normally reimbursed under this Plan is reduced to take into account payments made by "other plans".

When this and another health expenses coverage plan applies, the order in which the various plans will pay benefits must be figured. This will be done as follows using the first rule that applies:

1. A plan with no rules for coordination with other benefits will be deemed to pay its benefits before a plan which contains such rules.
2. A plan which covers a person other than as a dependent will be deemed to pay its benefits before a plan which covers the person as a dependent; except that if the person is also a Medicare beneficiary and as a result of the Social Security Act of 1965, as amended, Medicare is:
   - secondary to the plan covering the person as a dependent; and
   - primary to the plan covering the person as other than a dependent;

   The benefits of a plan which covers the person as a dependent will be determined before the benefits of a plan which:
   - covers the person as other than a dependent; and
   - is secondary to Medicare.
3. Except in the case of a dependent child whose parents are divorced or separated; the plan which covers the person as a dependent of a person whose birthday comes first in a calendar year will be primary to the plan which covers the person as a dependent of a person whose birthday comes later in that calendar year. If both parents have the same birthday, the benefits of a plan which covered one parent longer are determined before those of a plan which covered the other parent for a shorter period of time.

   If the other plan does not have the rule described in this provision (3) but instead has a rule based on the gender of the parent and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.
4. In the case of a dependent child whose parents are divorced or separated:

   a. If there is a court decree which states that the parents shall share joint custody of a dependent child, without stating that one of the parents is responsible for the health care expenses of the child, the order of benefit determination rules specified in (3) above will apply.
   b. If there is a court decree which makes one parent financially responsible for the medical, dental or other health care expenses of such child, the benefits of a plan which covers the child as a dependent of such parent will be determined before the benefits of any other plan which covers the child as a dependent child.

c. If there is not such a court decree:

- If the parent with custody of the child has not remarried, the benefits of a plan which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody.
- If the parent with custody of the child has remarried, the benefits of a plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a plan which covers that child as a dependent of the stepparent. The benefits of a plan which covers that child as a dependent of the stepparent will be determined before the benefits of a plan which covers that child as a dependent of the parent without custody.

5. If 1, 2, 3 and 4 above do not establish an order of payment, the plan under which the person has been covered for the longest will be deemed to pay its benefits first; except that:

The benefits of a plan which covers the person on whose expenses claim is based as a:
- laid-off or retired employee; or
- the dependent of such person.

Shall be determined after the benefits of any other plan which covers such person as:
- an employee who is not laid-off or retired; or
- dependent of such person.

If the other plan does not have a provision:
- regarding laid-off or retired employees; and
- as a result, each plan determines its benefits after the other;

then the above paragraph will not apply.

The benefits of a plan which covers the person on whose expenses claim is based under a right of continuation pursuant to federal or state law shall be determined after the benefits of any other plan which covers the person other than under such right of continuation.

If the other plan does not have a provision:
- regarding right of continuation pursuant to federal or state law; and
- as a result, each plan determines its benefits after the other;

then the above paragraph will not apply.

The general rule is that the benefits otherwise payable under this Plan for all expenses processed during a single "processed claim transaction" will be reduced by the total benefits payable under all "other plans" for the same expenses. An exception to this rule is that when the coordination of benefits rules of this Plan and any "other plan" both agree that this Plan is primary, the benefits of the other plan will be ignored in applying this rule. As used in this paragraph, a "processed claim transaction" is a group of actual or prospective charges submitted to Aetna for consideration, that have been grouped together for administrative purposes as a "claim transaction" in accordance with Aetna's then current rules. If the contract includes both medical and dental coverage, those coverages will be considered separate plans. The Medical/Pharmacy coverage will be coordinated with other Medical/Pharmacy plans. In turn, the dental coverage will be coordinated with other dental plans.

In order to administer this provision, Aetna can release or obtain data. Aetna can also make or recover payments.

Other Plan
This means any other plan of health expense coverage under:

- Group insurance.
- Any other type of coverage for persons in a group. This includes plans that are insured and those that are not.
- No-fault auto insurance required by law and provided on other than a group basis. Only the level of benefits required by the law will be counted.

When You Have Medicare Coverage

Effect of Medicare

Effect of Medicare

Health Expense Coverage under this Plan will be changed for any person while eligible for Medicare.

A person is "eligible for Medicare" if he or she:

- Is covered under it;
- Is not covered under it because of:
  - Having refused it;
  - Having dropped it;
  - Having failed to make proper request for it.

These are the changes:

- The total amount of "regular benefits" under all Health Expense Benefits will be figured. (This will be the amount that would be payable if there were no Medicare benefits.) If this is more than the amount Medicare provides for the expenses involved, this Plan will pay the difference. Otherwise, this Plan will pay no benefits. This will be done for each claim.
- Charges used to satisfy a person's Part B deductible under Medicare will be applied under this Plan in the order received by **Aetna**. Two or more charges received at the same time will be applied starting with the largest first.
- Medicare benefits will be taken into account for any person while he or she is eligible for Medicare. This will be done whether or not he or she is entitled to Medicare benefits.
- Any rule for coordinating "other plan" benefits with those under this Plan will be applied after this Plan's benefits have been figured under the above rules. Any benefits under Medicare will not be deemed to be an "Allowable Expense."

Coverage will not be changed at any time when your Employer's compliance with federal law requires this Plan's benefits for a person to be figured before benefits are figured under Medicare.

General Provisions

Type of Coverage

Coverage under the plan is **non-occupational**. Only **non-occupational** accidental **injuries** and **non-occupational illnesses** are covered. The plan covers charges made for services and supplies only while the person is covered under the plan.

Physical Examinations

Aetna will have the right and opportunity to examine and evaluate any person who is the basis of any claim at all reasonable times while a claim is pending or under review. This will be done at no cost to you.

Legal Action

No legal action can be brought to recover payment under any benefit after 3 years from the deadline for filing claims.

Additional Provisions

The following additional provisions apply to your coverage:

- This Booklet applies to coverage only, and does not restrict your ability to receive health care services that are not, or might not be, covered.
- You cannot receive multiple coverage under the plan because you are connected with more than one employer.
- In the event of a misstatement of any fact affecting your coverage under the plan, the true facts will be used to determine the coverage in force.
- This document describes the main features of the plan. If you have any questions about the terms of the plan or about the proper payment of benefits, contact your employer or **Aetna**.
- The plan may be changed or discontinued with respect to your coverage.

Assignments

Coverage and your rights under this plan may not be assigned. A direction to pay a provider is not an assignment of any right under this plan or of any legal or equitable right to institute any court proceeding.

Misstatements

Aetna's failure to implement or insist upon compliance with any provision of this plan at any given time or times, shall not constitute a waiver of **Aetna's** right to implement or insist upon compliance with that provision at any other time or times.

Fraudulent misstatements in connection with any claim or application for coverage may result in termination of all coverage under this plan.

Rescission of Coverage

Aetna may rescind your coverage if you, or the person seeking coverage on your behalf:

- Performs an act, practice or omission that constitutes fraud; or

- Makes an intentional misrepresentation of material fact.

You will be given 30 days advance written notice of any rescission of coverage.

As to medical and prescription drug coverage only, you have the right to an internal Appeal with **Aetna** and/or the right to a third party review conducted by an independent External Review Organization if your coverage under this Booklet is rescinded retroactive to its Effective Date.

Subrogation and Right of Recovery Provision

The provisions of this section apply to all current or former plan participants and also to the parents, guardian, or other representative of a dependent child who incurs claims and is or has been covered by the plan. The plan's right to recover (whether by subrogation or reimbursement) shall apply to the personal representative of your estate, your decedents, minors, and incompetent or disabled persons. "You" or "your" includes anyone on whose behalf the plan pays benefits. No adult covered person hereunder may assign any rights that it may have to recover medical expenses from any tortfeasor or other person or entity to any minor child or children of said adult covered person without the prior express written consent of the plan.

The plan's right of subrogation or reimbursement, as set forth below, extend to all insurance coverage available to you due to an **injury**, **illness** or condition for which the plan has paid medical claims (including, but not limited to, liability coverage, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers' compensation coverage, no-fault automobile coverage or any first party insurance coverage).

Your health plan is always secondary to automobile no-fault coverage, personal injury protection coverage, or medical payments coverage.

Subrogation
The right of subrogation means the plan is entitled to pursue any claims that you may have in order to recover the benefits paid by the plan. Immediately upon paying or providing any benefit under the plan, the plan shall be subrogated to (stand in the place of) all rights of recovery with respect to any claim or potential claim against any party, due to an **injury**, **illness** or condition to the full extent of benefits provided or to be provided by the plan. The plan may assert a claim or file suit in your name and take appropriate action to assert its subrogation claim, with or without your consent. The plan is not required to pay you part of any recovery it may obtain, even if it files suit in your name.

Reimbursement
If you receive any payment as a result of an **injury**, **illness** or condition, you agree to reimburse the plan first from such payment for all amounts the plan has paid and will pay as a result of that **injury**, **illness** or condition, up to and including the full amount of your recovery.

Constructive Trust
By accepting benefits (whether the payment of such benefits is made to you or made on your behalf to any provider) you agree that if you receive any payment as a result of an **injury**, **illness** or condition, you will serve as a constructive trustee over those funds. Failure to hold such funds in trust will be deemed a breach of your fiduciary duty to the plan.

Lien Rights
Further, the plan will automatically have a lien to the extent of benefits paid by the plan for the treatment of the **illness**, **injury** or condition upon any recovery whether by settlement, judgment, or otherwise, related to treatment for any **illness**, **injury** or condition for which the plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the plan including, but not limited to, you, your representative or agent, and/or any other source possessing funds representing the amount of benefits paid by the plan.

Assignment
In order to secure the plan's recovery rights, you agree to assign to the plan any benefits or claims or rights of recovery you have under any automobile policy or other coverage, to the full extent of the plan's subrogation and reimbursement claims. This assignment allows the plan to pursue any claim you may have, whether or not you choose to pursue the claim.

First-Priority Claim
By accepting benefits from the plan, you acknowledge that the plan's recovery rights are a first priority claim and are to be repaid to the plan before you receive any recovery for your damages. The plan shall be entitled to full reimbursement on a first-dollar basis from any payments, even if such payment to the plan will result in a recovery which is insufficient to make you whole or to compensate you in part or in whole for the damages sustained. The plan is not required to participate in or pay your court costs or attorney fees to any attorney you hire to pursue your damage claim.

Applicability to All Settlements and Judgments
The terms of this entire subrogation and right of recovery provision shall apply and the plan is entitled to full recovery regardless of whether any liability for payment is admitted and regardless of whether the settlement or judgment identifies the medical benefits the plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses. The plan is entitled to recover from *any and all* settlements or judgments, even those designated as pain and suffering, non-economic damages, and/or general damages only. The plan's claim will not be reduced due to your own negligence.

Cooperation
You agree to cooperate fully with the plan's efforts to recover benefits paid. It is your duty to notify the plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of your intention to pursue or investigate a claim to recover damages or obtain compensation due to your **injury**, **illness** or condition. You and your agents shall provide all information requested by the plan, the Claims Administrator or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the plan may reasonably request and all documents related to or filed in person injury litigation. Failure to provide this information, failure to assist the plan in pursuit of its subrogation rights, or failure to reimburse the plan from any settlement or recovery you receive may result in the termination of your health benefits or the institution of court proceedings against you.

You shall do nothing to prejudice the plan's subrogation or recovery interest or to prejudice the plan's ability to enforce the terms of this plan provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the plan. If you fail to cooperate with the plan in its efforts to recover such amounts or do anything to hinder or prevent such a recovery, you will cease to be entitled to any further plan benefits. The plan will also have the right to withhold or offset future benefit payments up to the amount of any settlement, judgment, or recovery you obtain, regardless of whether the settlement, judgment or recovery is designated to cover future medical benefits or expenses.

You acknowledge that the plan has the right to conduct an investigation regarding the **injury**, **illness** or condition to identify potential sources of recovery. The plan reserves the right to notify all parties and his/ her agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

You acknowledge that the plan has notified you that it has the right pursuant to the Health Insurance Portability & Accountability Act ("HIPAA"), 42 U.S.C. Section 1301 *et seq,* to share your personal health information in exercising its subrogation and reimbursement rights.

Interpretation
In the event that any claim is made that any part of this subrogation and right of recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the Claims Administrator for the plan shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

Jurisdiction
By accepting benefits from the plan, you agree that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the plan may elect. By accepting such benefits, you hereby submit to each such jurisdiction, waiving whatever rights may correspond by reason of your present or future domicile. By accepting such benefits, you also agree to pay all attorneys' fees the plan incurs in successful attempts to recover amounts the plan is entitled to under this section.

Workers' Compensation

If benefits are paid under the **Aetna** medical benefits plan and **Aetna** determines you received Workers' Compensation benefits for the same incident, **Aetna** has the right to recover as described under the *Subrogation and Right of Reimbursement* provision. **Aetna**, on behalf of the Plan, **w**ill exercise its right to recover against you.

The Recovery Rights will be applied even though:

- The Workers' Compensation benefits are in dispute or are made by means of settlement or compromise;
- No final determination is made that bodily **injury** or **illness** was sustained in the course of or resulted from your employment;
- The amount of Workers' Compensation due to medical or health care is not agreed upon or defined by you or the Workers' Compensation carrier; or
- The medical or health care benefits are specifically excluded from the Workers' Compensation settlement or compromise.

You hereby agree that, in consideration for the coverage provided by this **Aetna** medical benefits plan, you will notify **Aetna** of any Workers' Compensation claim you make, and that you agree to reimburse **Aetna**, on behalf of the Plan, as described above.

If benefits are paid under this **Aetna** medical benefits plan, and you or your covered dependent recover from a responsible party by settlement, judgment or otherwise, **Aetna**, on behalf of the Plan, has a right to recover from you or your covered dependent an amount equal to the amount the Plan paid.

Recovery of Overpayments

Health Coverage

If a benefit payment is made by the Plan, to or on your behalf, which exceeds the benefit amount that you are entitled to receive, the Plan has the right:

- To require the return of the overpayment; or
- To reduce by the amount of the overpayment, any future benefit payment made to or on behalf of that person or another person in his or her family.

Such right does not affect any other right of recovery the Plan may have with respect to such overpayment.

Reporting of Claims

A claim must be submitted to **Aetna** in writing. It must give proof of the nature and extent of the loss. Your employer has claim forms.

All claims should be reported promptly. The deadline for filing a claim is 90 days after the date of the loss.

If, through no fault of your own, you are not able to meet the deadline for filing claim, your claim will still be accepted if you file as soon as possible. Unless you are legally incapacitated, late claims for health benefits will not be covered if they are filed more than 2 years after the deadline.

Payment of Benefits

Benefits will be paid as soon as the necessary proof to support the claim is received. Written proof must be provided for all benefits.

All covered health benefits are payable to you. However, **Aetna** has the right to pay any health benefits to the service provider. This will be done unless you have told **Aetna** otherwise by the time you file the claim.

The Plan may pay up to $1,000 of any other benefit to any of your relatives whom it believes fairly entitled to it. This can be done if the benefit is payable to you and you are a minor or not able to give a valid release.

When a **PCP** provides care for you or a covered dependent, or care is provided by a **network provider** (**network services or supplies**), the **network provider** will take care of filing claims.

Records of Expenses

Keep complete records of the expenses of each person. They will be required when a claim is made.

Very important are:

- Names of **physicians**, **dentists** and others who furnish services.
- Dates expenses are incurred.
- Copies of all bills and receipts.

Contacting Aetna

If you have questions, comments or concerns about your benefits or coverage, or if you are required to submit information to **Aetna**, you may contact **Aetna**'s Home Office at:

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156

You may also use **Aetna**'s toll free Member Services phone number on your ID card or visit **Aetna**'s web site at www.aetna.com.

Effect of Benefits Under Other Plans

Effect of A Health Maintenance Organization Plan (HMO Plan) On Coverage

If you are in an eligible class and have chosen coverage under an HMO Plan offered by your employer, you will be excluded from medical expense coverage (except Vision Care, if any,) on the date of your coverage under such HMO Plan.

If you are in an eligible class and are covered under an HMO Plan, you can choose to change to coverage for yourself and your covered dependents under this plan. If you:

- Live in an HMO Plan enrollment area and choose to change coverage during an open enrollment period, coverage will take effect on the group contract anniversary date after the open enrollment period. There will be no rules for waiting periods or preexisting conditions.
- Live in an HMO Plan enrollment area and choose to change coverage when there is not an open enrollment period, coverage will take effect only if and when **Aetna** gives its written consent.
- Move from an HMO Plan enrollment area or if the HMO discontinues and you choose to change coverage within 31 days of the move or the discontinuance, coverage will take effect on the date you elect such coverage. There will be no restrictions for waiting periods or preexisting conditions. If you choose to change coverage after 31 days, coverage will take effect only if and when **Aetna** gives its written consent.

No benefits will be paid for any charges for services rendered or supplies furnished under an HMO Plan.

Discount Programs

Discount Arrangements

From time to time, we may offer, provide, or arrange for discount arrangements or special rates from certain service providers such as pharmacies, optometrists, **dentists**, alternative medicine, wellness and healthy living providers to you under this plan. Some of these arrangements may be made available through third parties who may make payments to **Aetna** in exchange for making these services available.

The third party service providers are independent contractors and are solely responsible to you for the provision of any such goods and/or services. We reserve the right to modify or discontinue such arrangements at any time. These discount arrangements are not insurance. There are no benefits payable to you nor do we compensate providers for services they may render through discount arrangements.

Incentives

In order to encourage you to access certain medical services when deemed appropriate by you in consultation with your **physician** or other service providers, we may, from time to time, offer to waive or reduce a member's **copayment**, **payment percentage**, and/or a **deductible** otherwise required under the plan or offer coupons or other financial incentives. We have the right to determine the amount and duration of any waiver, reduction, coupon, or financial incentive and to limit the covered persons to whom these arrangements are available.

Claims, Appeals and External Review

Filing Health Claims under the Plan

Under the Plan, you may file claims for Plan benefits and appeal adverse claim determinations. Any reference to "you" in this Claims, Appeals and External Review section includes you and your Authorized Representative. An "Authorized Representative" is a person you authorize, in writing, to act on your behalf. The Plan will also recognize a court order giving a person authority to submit claims on your behalf. In the case of an urgent care claim, a health care professional with knowledge of your condition may always act as your Authorized Representative.

If your claim is denied in whole or in part, you will receive a written notice of the denial from Aetna Life Insurance Company (Aetna). The notice will explain the reason for the denial and the appeal procedures available under the Plan.

Urgent Care Claims
An "Urgent Care Claim" is any claim for medical care or treatment for which the application of the time periods for making non-urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function, or, in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

If the Plan requires advance approval of a service, supply or procedure before a benefit will be payable, and if Aetna or your physician determines that it is an Urgent Care Claim, you will be notified of the decision, whether adverse or not, as soon as possible but not later than 72 hours after the claim is received.

If there is not sufficient information to decide the claim, you will be notified of the information necessary to complete the claim as soon as possible, but not later than 24 hours after receipt of the claim. You will be given a reasonable additional amount of time, but not less than 48 hours, to provide the information, and you will be notified of the decision not later than 48 hours after the end of that additional time period (or after receipt of the information, if earlier).

Other Claims (Pre-Service and Post-Service)
If the Plan requires you to obtain advance approval of a non-urgent service, supply or procedure before a benefit will be payable, a request for advance approval is considered a pre-service claim. You will be notified of the decision not later than 15 days after receipt of the pre-service claim.

For other claims (post-service claims), you will be notified of the decision not later than 30 days after receipt of the claim.

For either a pre-service or a post-service claim, these time periods may be extended up to an additional 15 days due to circumstances outside Aetna's control. In that case, you will be notified of the extension before the end of the initial 15 or 30-day period. For example, they may be extended because you have not submitted sufficient information, in which case you will be notified of the specific information necessary and given an additional period of at least 45 days after receiving the notice to furnish that information. You will be notified of Aetna's claim decision no later than 15 days after the end of that additional period (or after receipt of the information, if earlier).

For pre-service claims which name a specific claimant, medical condition, and service or supply for which approval is requested, and which are submitted to an Aetna representative responsible for handling benefit matters, but which otherwise fail to follow the Plan's procedures for filing pre-service claims, you will be notified of the failure within 5 days (within 24 hours in the case of an urgent care claim) and of the proper procedures to be followed. The notice may be oral unless you request written notification.

Ongoing Course of Treatment
If you have received pre-authorization for an ongoing course of treatment, you will be notified in advance if the previously authorized course of treatment is intended to be terminated or reduced so that you will have an opportunity to appeal any decision to Aetna and receive a decision on that appeal before the termination or reduction takes effect. If the course of treatment involves urgent care, and you request an extension of the course of treatment at least 24 hours before its expiration, you will be notified of the decision within 24 hours after receipt of the request.

Health Claims – Standard Appeals
As an individual enrolled in the Plan, you have the right to file an appeal from an Adverse Benefit Determination relating to service(s) you have received or could have received from your health care provider under the Plan.

An "Adverse Benefit Determination" is defined as a denial, reduction, termination of, or failure to, provide or make payment (in whole or in part) for a service, supply or benefit. Such Adverse Benefit Determination may be based on:

- Your eligibility for coverage, including a retrospective termination of coverage (whether or not there is an adverse effect on any particular benefit);
- Coverage determinations, including plan limitations or exclusions;
- The results of any Utilization Review activities;
- A decision that the service or supply is **experimental or investigational**; or
- A decision that the service or supply is not **medically necessary**.

A "Final Internal Adverse Benefit Determination" is defined as an Adverse Benefit Determination that has been upheld by the appropriate named fiduciary (Aetna) at the completion of the internal appeals process, or an Adverse Benefit Determination for which the internal appeals process has been exhausted.

Exhaustion of Internal Appeals Process
Generally, you are required to complete all appeal processes of the Plan before being able to obtain External Review or bring an action in litigation. However, if Aetna, or the Plan or its designee, does not strictly adhere to all claim determination and appeal requirements under applicable federal law, you are considered to have exhausted the Plan's appeal requirements ("Deemed Exhaustion") and may proceed with External Review or may pursue any available remedies under §502(a) of ERISA or under state law, as applicable.

There is an exception to the Deemed Exhaustion rule. Your claim or internal appeal may not go straight to External Review if:

A rule violation was minor and is not likely to influence a decision or harm you; and
It was for a good cause or was beyond Aetna's or the Plan's or its designee's control; and
It was part of an ongoing good faith exchange between you and Aetna or the Plan.

This exception is not available if the rule violation is part of a pattern or practice of violations by Aetna or the Plan.

You may request a written explanation of the violation from the Plan or Aetna, and the Plan or Aetna must provide such explanation within 10 days, including a specific description of its bases, if any, for asserting that the violation should not cause the internal claims and appeals process to be deemed exhausted. If an External Reviewer or a court rejects your request for immediate review on the basis that the plan met the standards for the exception, you have the right to resubmit and pursue the internal appeal of the claim. In such a case, within a reasonable time after the External Reviewer or court rejects the claim for immediate review (not to exceed 10 days), you will receive notice of the opportunity to resubmit and pursue the internal appeal of the claim. Time periods for re-filing the claim shall begin to run upon your receipt of such notice.

Full and Fair Review of Claim Determinations and Appeals
Aetna will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by Aetna (or at the direction of Aetna), or any new or additional rationale as soon as possible and sufficiently in advance of the date on which the notice of Final Internal Adverse Benefit Determination is provided, to give you a reasonable opportunity to respond prior to that date.

You may file an appeal in writing to Aetna at the address provided in this booklet, or, if your appeal is of an urgent nature, you may call Aetna's Member Services Unit at the toll-free phone number on your ID card. Your request should include the group name (that is, your employer), your name, member ID, or other identifying information shown on the front of the Explanation of Benefits form, and any other comments, documents, records and other information you would like to have considered, whether or not submitted in connection with the initial claim.

An Aetna representative may call you or your health care provider to obtain medical records and/or other pertinent information in order to respond to your appeal.

You will have 180 days following receipt of an Adverse Benefit Determination to appeal the determination to Aetna. You will be notified of the decision not later than 15 days (for pre-service claims) or 30 days (for post-service claims) after the appeal is received. You may submit written comments, documents, records and other information relating to

your claim, whether or not the comments, documents, records or other information were submitted in connection with the initial claim. A copy of the specific rule, guideline or protocol relied upon in the Adverse Benefit Determination will be provided free of charge upon request by you or your Authorized Representative. You may also request that Aetna provide you, free of charge, copies of all documents, records and other information relevant to the claim.

If your claim involves urgent care, an expedited appeal may be initiated by a telephone call to the phone number included in your denial, or to Aetna's Member Services. Aetna's Member Services telephone number is on your Identification Card. You or your Authorized Representative may appeal urgent care claim denials either orally or in writing. All necessary information, including the appeal decision, will be communicated between you or your Authorized Representative and Aetna by telephone, facsimile, or other similar method. You will be notified of the decision not later than 36 hours after the appeal is received.

If you are dissatisfied with the appeal decision on an urgent care claim, you may file a second level appeal with Aetna. You will be notified of the decision not later than 36 hours after the appeal is received.

If you are dissatisfied with a pre-service or post-service appeal decision, you may file a second level appeal with Aetna within 60 days of receipt of the level one appeal decision. Aetna will notify you of the decision not later than 15 days (for pre-service claims) or 30 days (for post-service claims) after the appeal is received.

If you do not agree with the Final Internal Adverse Benefit Determination on review, you have the right to bring a civil action under Section 502(a) of ERISA, if applicable.

Health Claims – Voluntary Appeals

External Review

"External Review" is a review of an eligible Adverse Benefit Determination or a Final Internal Adverse Benefit Determination by an Independent Review Organization/External Review Organization (ERO) or by the State Insurance Commissioner, if applicable.

A "Final External Review Decision" is a determination by an ERO at the conclusion of an External Review.

You must complete all of the levels of standard appeal described above before you can request External Review, other than in a case of Deemed Exhaustion. Subject to verification procedures that the Plan may establish, your Authorized Representative may act on your behalf in filing and pursuing this voluntary appeal.

You may file a voluntary appeal for External Review of any Adverse Benefit Determination or any Final Internal Adverse Benefit Determination that qualifies as set forth below.

The notice of Adverse Benefit Determination or Final Internal Adverse Benefit Determination that you receive from Aetna will describe the process to follow if you wish to pursue an External Review, and will include a copy of the *Request for External Review Form*.

You must submit the *Request for External Review Form* to Aetna within 123 calendar days of the date you received the Adverse Benefit Determination or Final Internal Adverse Benefit Determination notice. If the last filing date would fall on a Saturday, Sunday or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday or Federal holiday. You also must include a copy of the notice and all other pertinent information that supports your request.

If you file a voluntary appeal, any applicable statute of limitations will be tolled while the appeal is pending. The filing of a claim will have no effect on your rights to any other benefits under the Plan. However, the appeal is voluntary and you are not required to undertake it before pursuing legal action.

If you choose not to file for voluntary review, the Plan will not assert that you have failed to exhaust your administrative remedies because of that choice.

Request for External Review
The External Review process under this Plan gives you the opportunity to receive review of an Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination) conducted pursuant to applicable law. Your request will be eligible for External Review if the claim decision involves medical judgment and the following are satisfied:

- Aetna, or the Plan or its designee, does not strictly adhere to all claim determination and appeal requirements under federal law (except for minor violations); or
- the standard levels of appeal have been exhausted; or
- the appeal relates to a rescission, defined as a cancellation or discontinuance of coverage which has retroactive effect.

An Adverse Benefit Determination based upon your eligibility is not eligible for External Review.

If upon the final standard level of appeal, the coverage denial is upheld and it is determined that you are eligible for External Review, you will be informed in writing of the steps necessary to request an External Review.

An independent review organization refers the case for review by a neutral, independent clinical reviewer with appropriate expertise in the area in question. The decision of the independent external expert reviewer is binding on you, Aetna and the Plan unless otherwise allowed by law.

Preliminary Review
Within 5 business days following the date of receipt of the request, Aetna must provide a preliminary review determining: you were covered under the Plan at the time the service was requested or provided, the determination does not relate to eligibility, you have exhausted the internal appeals process (unless Deemed Exhaustion applies), and you have provided all paperwork necessary to complete the External Review and you are eligible for external review.

Within one business day after completion of the preliminary review, Aetna must issue to you a notification in writing. If the request is complete but not eligible for External Review, such notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, such notification will describe the information or materials needed to make the request complete and Aetna must allow you to perfect the request for External Review within the 123 calendar days filing period or within the 48 hour period following the receipt of the notification, whichever is later.

Referral to ERO
Aetna will assign an ERO accredited as required under federal law, to conduct the External Review. The assigned ERO will timely notify you in writing of the request's eligibility and acceptance for External Review, and will provide an opportunity for you to submit in writing within 10 business days following the date of receipt, additional information that the ERO must consider when conducting the External Review. Within one (1) business day after making the decision, the ERO must notify you, Aetna and the Plan.

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

(i) Your medical records;
(ii) The attending health care professional's recommendation;
(iii) Reports from appropriate health care professionals and other documents submitted by the Plan or issuer, you, or your treating provider;
(iv) The terms of your Plan to ensure that the ERO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law;
(v) Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards,

and associations;
(vi) Any applicable clinical review criteria developed and used by Aetna, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and
(vii) The opinion of the ERO's clinical reviewer or reviewers after considering the information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

The assigned ERO must provide written notice of the Final External Review Decision within 45 days after the ERO receives the request for the External Review. The ERO must deliver the notice of Final External Review Decision to you, Aetna and the Plan.

After a Final External Review Decision, the ERO must maintain records of all claims and notices associated with the External Review process for six years. An ERO must make such records available for examination by the claimant, Plan, or State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws.

Upon receipt of a notice of a Final External Review Decision reversing the Adverse Benefit Determination or Final Internal Adverse Benefit Determination, the Plan immediately must provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

Expedited External Review
The Plan must allow you to request an expedited External Review at the time you receive:

(a) An Adverse Benefit Determination if the Adverse Benefit Determination involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or
(b) A Final Internal Adverse Benefit Determination, if you have a medical condition where the timeframe for completion of a standard External Review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the Final Internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but have not been discharged from a facility.

Immediately upon receipt of the request for expedited External Review, Aetna will determine whether the request meets the reviewability requirements set forth above for standard External Review. Aetna must immediately send you a notice of its eligibility determination.

Referral of Expedited Review to ERO
Upon a determination that a request is eligible for External Review following preliminary review, Aetna will assign an ERO. The ERO shall render a decision as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the ERO receives the request for an expedited External Review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned ERO must provide written confirmation of the decision to you, Aetna and the Plan.

Glossary

In this section, you will find definitions for the words and phrases that appear in **bold type** throughout the text of this Booklet.

A

Aetna
Aetna Life Insurance Company, an affiliate, or a third party vendor under contract with **Aetna**.

Ambulance
A vehicle that is staffed with medical personnel and equipped to transport an ill or injured person.

Average Wholesale Price (AWP)
The current **average wholesale price** of a **prescription drug** listed in the Facts and Comparisons weekly price updates (or any other similar publication designated by **Aetna**) on the day that a **pharmacy** claim is submitted for adjudication.

B

Behavioral Health Provider/Practitioner
A licensed organization or professional providing diagnostic, therapeutic or psychological services for behavioral health conditions.

Birthing Center
A freestanding facility that meets ***all*** of the following requirements:

- Meets licensing standards.
- Is set up, equipped and run to provide prenatal care, delivery and immediate postpartum care.
- Charges for its services.
- Is directed by at least one **physician** who is a **specialist** in obstetrics and gynecology.
- Has a **physician** or certified nurse midwife present at all births and during the immediate postpartum period.
- Extends staff privileges to **physicians** who practice obstetrics and gynecology in an area **hospital**.
- Has at least 2 beds or 2 birthing rooms for use by patients while in labor and during delivery.
- Provides, during labor, delivery and the immediate postpartum period, full-time **skilled nursing services** directed by an **R.N.** or certified nurse midwife.
- Provides, or arranges with a facility in the area for, diagnostic X-ray and lab services for the mother and child.
- Has the capacity to administer a local anesthetic and to perform minor surgery. This includes episiotomy and repair of perineal tear.
- Is equipped and has trained staff to handle **emergency medical conditions** and provide immediate support measures to sustain life if:
  - Complications arise during labor; or
  - A child is born with an abnormality which impairs function or threatens life.
- Accepts only patients with low-risk pregnancies.
- Has a written agreement with a **hospital** in the area for emergency transfer of a patient or a child. Written procedures for such a transfer must be displayed and the staff must be aware of them.
- Provides an ongoing quality assurance program. This includes reviews by **physicians** who do not own or direct the facility.
- Keeps a medical record on each patient and child.

Body Mass Index
This is a practical marker that is used to assess the degree of obesity and is calculated by dividing the weight in kilograms by the height in meters squared.

Brand-Name Prescription Drug
A **prescription drug** with a proprietary name assigned to it by the manufacturer or distributor and so indicated by Medi-Span or any other similar publication designated by **Aetna** or an affiliate.

C

Copay or Copayment
The specific dollar amount or percentage required to be paid by you or on your behalf. The plan includes various **copayments**, and these **copayment** amounts or percentages are specified in the *Schedule of Benefits*.

Cosmetic
Services or supplies that alter, improve or enhance appearance.

Covered Expenses
Medical, dental, vision or hearing services and supplies shown as covered under this Booklet.

Creditable Coverage
A person's prior medical coverage as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Such coverage includes:

- Health coverage issued on a group or individual basis;
- Medicare;
- Medicaid;
- Health care for members of the uniformed services;
- A program of the Indian Health Service;
- A state health benefits risk pool;
- The Federal Employees' Health Benefit Plan (FEHBP);
- A public health plan (any plan established by a State, the government of the United States, or any subdivision of a State or of the government of the United States, or a foreign country);
- Any health benefit plan under Section 5(e) of the Peace Corps Act; and
- The State Children's Health Insurance Program (S-Chip).

Custodial Care
Services and supplies that are primarily intended to help you meet personal needs. **Custodial care** can be prescribed by a **physician** or given by trained medical personnel. It may involve artificial methods such as feeding tubes, ventilators or catheters. Examples of **custodial care** include:

- Routine patient care such as changing dressings, periodic turning and positioning in bed, administering medications;
- Care of a stable tracheostomy (including intermittent suctioning);
- Care of a stable colostomy/ileostomy;
- Care of stable gastrostomy/jejunostomy/nasogastric tube (intermittent or continuous) feedings;
- Care of a stable indwelling bladder catheter (including emptying/changing containers and clamping tubing);
- Watching or protecting you;
- Respite care, adult (or child) day care, or convalescent care;
- Institutional care, including **room and board** for rest cures, adult day care and convalescent care;

- Help with the daily living activities, such as walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating or preparing foods;
- Any services that a person without medical or paramedical training could be trained to perform; and
- Any service that can be performed by a person without any medical or paramedical training.

D

Day Care Treatment

A **partial confinement treatment** program to provide treatment for you during the day. The **hospital**, **psychiatric hospital** or **residential treatment facility** does not make a room charge for **day care treatment.** Such treatment must be available for at least 4 hours, but not more than 12 hours in any 24-hour period.

Deductible

The part of your **covered expenses** you pay before the plan starts to pay benefits. Additional information regarding **deductibles** and **deductible** amounts can be found in the *Schedule of Benefits*.

Dentist

A legally qualified **dentist**, or a **physician** licensed to do the dental work he or she performs.

Designated Network Providers

Network providers that are shown in the **directory** and in DocFind® as Aetna Whole Health℠ Seton Health Alliance providers for the class of employees of which you are a member.

Detoxification

The process by which an alcohol-intoxicated or drug-intoxicated; or an alcohol-dependent or drug-dependent person is medically managed through the period of time necessary to eliminate, by metabolic or other means, the:

- Intoxicating alcohol or drug;
- Alcohol or drug-dependent factors; or
- Alcohol in combination with drugs;

as determined by a **physician**. The process must keep the physiological risk to the patient at a minimum, and take place in a facility that meets any applicable licensing standards established by the jurisdiction in which it is located.

Directory

A listing of all **designated network providers** serving the class of employees to which you belong. The contractholder will give you a copy of this **directory**. **Designated network provider** information is available through **Aetna**'s online provider **directory**, DocFind®.

Durable Medical and Surgical Equipment (DME)

Equipment, and the accessories needed to operate it, that is:

- Made to withstand prolonged use;
- Made for and mainly used in the treatment of an **illness** or **injury**;
- Suited for use in the home;
- Not normally of use to people who do not have an **illness** or **injury**;
- Not for use in altering air quality or temperature; and

- Not for exercise or training.

Durable medical and surgical equipment does not include equipment such as whirlpools, portable whirlpool pumps, sauna baths, massage devices, over bed tables, elevators, communication aids, vision aids and telephone alert systems.

E

E-visit

An **E-visit** is an online internet consultation between a network **physician** and an established patient about a non-emergency healthcare matter. This visit must be conducted through an **Aetna** authorized internet E-visit service vendor.

Effective Treatment of a Mental Disorder

This is a program that:

- Is prescribed; and supervised; by a **physician**; and
- Is for a **mental disorder** that can be favorably changed.

Emergency Care

This means the treatment given in a **hospital**'s emergency room to evaluate and treat an **emergency medical condition**.

Emergency Medical Condition

A recent and severe medical condition, including (but not limited to) severe pain, which would lead a prudent layperson possessing an average knowledge of medicine and health, to believe that his or her condition, **illness**, or **injury** is of such a nature that failure to get immediate medical care could result in:

- Placing your health in serious jeopardy; or
- Serious impairment to bodily function; or
- Serious dysfunction of a body part or organ; or
- In the case of a pregnant woman, serious jeopardy to the health of the fetus.

Experimental or Investigational

Except as provided for under the Clinical Trials benefit provision, a drug, a device, a procedure, or treatment will be determined to be **experimental or investigational** if:

- There is not enough outcomes data available from controlled clinical trials published in the peer-reviewed literature to substantiate its safety and effectiveness for the **illness** or **injury** involved; or
- Approval required by the U. S. Food and Drug Administration (FDA) has not been granted for marketing; or
- A recognized national medical or dental society or regulatory agency has determined, in writing, that it is **experimental or investigational**, or for research purposes; or
- It is a type of drug, device, procedure or treatment that is the subject of a Phase I or Phase II clinical trial or the experimental or research arm of a Phase III clinical trial, using the definition of "phases" indicated in regulations and other official actions and publications of the FDA and Department of Health and Human Services; or
- The written protocol or protocols used by the treating facility, or the protocol or protocols of any other facility studying substantially the same:
  - drug;
  - device;
  - procedure; or
  - treatment.

It also includes the written informed consent used by:

- the treating facility; or
- by another facility studying the same:
  - drug;
  - device;
  - procedure; or
  - treatment.

  that states that it is **experimental or investigational**, or for research purposes.

G

Generic Prescription Drug

A **prescription drug**, that is identified by its:

- chemical;
- proprietary; or
- non-proprietary name; and
- is accepted by the U.S. Food and Drug Administration as therapeutically the same; and
- can be replaced with drugs with the same amount of active ingredient; and
- so stated by Medispan or any other publication named by **Aetna** or consort.

H

Homebound

This means that you are confined to your place of residence:

- Due to an **illness** or **injury** which makes leaving the home medically contraindicated; or
- Because the act of transport would be a serious risk to your life or health.

Situations where you would not be considered **homebound** include (but are not limited to) the following:

- You do not often travel from home because of feebleness or insecurity brought on by advanced age (or otherwise); or
- You are wheelchair bound but could safely be transported via wheelchair accessible transportation.

Home Health Care Agency

An agency that meets all of the following requirements.

- Mainly provides skilled nursing and other therapeutic services.
- Is associated with a professional group (of at least one **physician** and one **R.N.**) which makes policy.
- Has full-time supervision by a **physician** or an **R.N.**
- Keeps complete medical records on each person.
- Has an administrator.
- Meets licensing standards.

Home Health Care Plan

This is a plan that provides for continued care and treatment of an **illness** or **injury**. The care and treatment must be:

- Prescribed in writing by the attending **physician**; and
- An alternative to a **hospital** or **skilled nursing facility stay**.

Hospice Care

This is care given to a **terminally ill** person by or under arrangements with a **hospice care agency**. The care must be part of a **hospice care program**.

Hospice Care Agency

An agency or organization that meets all of the following requirements:

- Has **hospice care** available 24 hours a day.
- Meets any licensing or certification standards established by the jurisdiction where it is located.
- Provides:
  - **Skilled nursing services**;
  - Medical social services; and
  - Psychological and dietary counseling.
- Provides, or arranges for, other services which include:
  - **Physician** services;
  - Physical and occupational therapy;
  - Part-time home health aide services which mainly consist of caring for **terminally ill** people; and
  - Inpatient care in a facility when needed for pain control and acute and chronic symptom management.
- Has at least the following personnel:
  - One **physician**;
  - One **R.N.**; and
  - One licensed or certified social worker employed by the agency.
- Establishes policies about how **hospice care** is provided.
- Assesses the patient's medical and social needs.
- Develops a **hospice care program** to meet those needs.
- Provides an ongoing quality assurance program. This includes reviews by **physicians**, other than those who own or direct the agency.
- Permits all area medical personnel to utilize its services for their patients.
- Keeps a medical record on each patient.
- Uses volunteers trained in providing services for non-medical needs.
- Has a full-time administrator.

Hospice Care Program

This is a written plan of **hospice care**, which:

- Is established by and reviewed from time to time by a **physician** attending the person, and appropriate personnel of a **hospice care agency**;
- Is designed to provide palliative and supportive care to **terminally ill** persons, and supportive care to their families; and
- Includes an assessment of the person's medical and social needs; and a description of the care to be given to meet those needs.

Hospice Facility
A facility, or distinct part of one, that meets all of the following requirements:

- Mainly provides inpatient **hospice care** to **terminally ill** persons.
- Charges patients for its services.
- Meets any licensing or certification standards established by the jurisdiction where it is located.
- Keeps a medical record on each patient.
- Provides an ongoing quality assurance program including reviews by **physicians** other than those who own or direct the facility.
- Is run by a staff of **physicians**. At least one staff **physician** must be on call at all times.
- Provides 24-hour-a-day nursing services under the direction of an **R.N.**
- Has a full-time administrator.

Hospital
An institution that:

- Is primarily engaged in providing, on its premises, inpatient medical, surgical and diagnostic services;
- Is supervised by a staff of **physicians**;
- Provides twenty-four (24) hour-a-day **R.N.** service,
- Charges patients for its services;
- Is operating in accordance with the laws of the jurisdiction in which it is located; and
- Does not meet all of the requirements above, but does meet the requirements of the jurisdiction in which it operates for licensing as a **hospital** and is accredited as a **hospital** by the Joint Commission on the Accreditation of Healthcare Organizations.

In no event does **hospital** include a convalescent nursing home or any institution or part of one which is used principally as a convalescent facility, rest facility, nursing facility, facility for the aged, extended care facility, intermediate care facility, **skilled nursing facility**, hospice, rehabilitative **hospital** or facility primarily for rehabilitative or custodial services.

Hospitalization
A continuous confinement as an inpatient in a **hospital** for which a **room and board** charge is made.

I

Illness
A pathological condition of the body that presents a group of clinical signs and symptoms and laboratory findings peculiar to the findings set the condition apart as an abnormal entity differing from other normal or pathological body states.

Infertile or Infertility
The condition of a presumably healthy covered person who is unable to conceive or produce conception after:

- *For a* woman *who is under 35 years of age*: 1 year or more of timed, unprotected coitus, or 12 cycles of artificial insemination; or
- *For a* woman *who is 35 years of age or older*: 6 months or more of timed, unprotected coitus, or 6 cycles of artificial insemination.

Injury
An accidental bodily **injury** that is the sole and direct result of:

- An unexpected or reasonably unforeseen occurrence or event; or
- The reasonable unforeseeable consequences of a voluntary act by the person.
- An act or event must be definite as to time and place.

Institute of Excellence (IOE)
A **hospital** or other facility that has contracted with **Aetna** to give services or supplies to an **IOE** patient in connection with specific transplants, procedures at a **negotiated charge**. A facility is an **IOE** facility only for those types of transplants, procedures for which it has signed a contract.

J

Jaw Joint Disorder
This is:

- A Temporomandibular Joint (TMJ) dysfunction or any alike disorder of the jaw joint; or
- A Myofacial Pain Dysfunction (MPD); or
- Any alike disorder in the relationship of the jaw joint and the related muscles and nerves.

L

Late Enrollee
This is an employee in an Eligible Class who requests enrollment under this Plan after the Initial Enrollment Period. In addition, this is an eligible dependent for whom the employee did not elect coverage within the Initial Enrollment Period, but for whom coverage is elected at a later time.

However, an eligible employee or dependent may not be considered a **Late Enrollee** under certain circumstances. See the *Special Enrollment Periods* section of the Booklet.

L.P.N.
A licensed practical or vocational nurse.

M

Mail Order Pharmacy
An establishment where **prescription drugs** are legally given out by mail or other carrier.

Maintenance Care
Care made up of services and supplies that:

- Are given mainly to maintain, rather than to improve, a level of physical, or mental function; and
- Give a surrounding free from exposures that can worsen the person's physical or mental condition.

Maximum Out-of-Pocket Limit
Your plan has a **maximum out-of-pocket limit**. Your **deductibles**, **payment percentage, copays** and other eligible out-of-pocket expense apply to the **maximum out-of-pocket limit**. Once you satisfy the maximum amount the plan will pay 100% of **covered expenses** that apply toward the limit for the rest of the calendar year.

Medically Necessary or Medical Necessity

These are health care or dental services, and supplies or **prescription drug**s that a **physician**, other health care provider or **dental provider**, exercising prudent clinical judgment, would give to a patient for the purpose of:

- preventing;
- evaluating;
- diagnosing; or
- treating:
  - an **illness**;
  - an **injury**;
  - a disease; or
  - its symptoms.

The provision of the service, supply or **prescription drug** must be:

a) In accordance with generally accepted standards of medical or dental practice;
b) Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's **illness**, **injury** or disease; and
c) Not mostly for the convenience of the patient, **physician**, other health care or **dental provider**; and
d) And do not cost more than an alternative service or sequence of services at least as likely to produce the same therapeutic or diagnostic results as to the diagnosis or treatment of that patient's **illness**, **injury**, or disease.

For these purposes "generally accepted standards of medical or dental practice" means standards that are based on credible scientific evidence published in peer-reviewed literature. They must be generally recognized by the relevant medical or dental community. Otherwise, the standards are consistent with **physician** or dental specialty society recommendations. They must be consistent with the views of **physicians** or **dentists** practicing in relevant clinical areas and any other relevant factors.

Mental Disorder

An **illness** commonly understood to be a **mental disorder**, whether or not it has a physiological basis, and for which treatment is generally provided by or under the direction of a **behavioral health provider** such as a **psychiatric physician**, a psychologist or a psychiatric social worker. A **mental disorder** includes; but is not limited to:

- Alcoholism and substance abuse.
- Bipolar disorder.
- Major depressive disorder.
- Obsessive compulsive disorder.
- Panic disorder.
- Pervasive developmental disorder (including Autism).
- Psychotic depression.
- Schizophrenia.

For the purposes of benefits under this plan, **mental disorder** will include alcoholism and substance abuse only if any separate benefit for a particular type of treatment does not apply to alcoholism and substance abuse.

Morbid Obesity

This means a **Body Mass Index** that is: greater than 40 kilograms per meter squared; or equal to or greater than 35 kilograms per meter squared with a comorbid medical condition, including: hypertension; a cardiopulmonary condition; sleep apnea; or diabetes.

N

Negotiated Charge

As to health expense coverage, other than Prescription Drug Expense Coverage:

The **negotiated charge** is the maximum charge a **network provider** has agreed to make as to any service or supply for the purpose of the benefits under this plan.

As to Prescription Drug Expense Coverage:
The **negotiated charge** is the amount **Aetna** has established for each **prescription drug** obtained from a **network pharmacy** under this plan. This **negotiated charge** may reflect amounts **Aetna** has agreed to pay directly to the **network pharmacy** or to a third party vendor for the **prescription drug**, and may include an additional service or risk charge set by **Aetna**.

The **negotiated charge** does not include or reflect any amount **Aetna**, an affiliate, or a third party vendor, may receive under a rebate arrangement between **Aetna,** an affiliate or a third party vendor and a drug manufacturer for any **prescription drug**, including **prescription drugs** on the **preferred drug guide**.

Based on its overall drug purchasing, **Aetna** may receive rebates from the manufacturers of **prescription drugs** and may receive or pay additional amounts from or to third parties under price guarantees. These amounts will not change the **negotiated charge** under this plan.

Network Advanced Reproductive Technology (ART) Specialist

A specialist **physician** who has entered into a contractual agreement with **Aetna** for the provision of covered **Advanced Reproductive Technology** (**ART**) services.

Network Provider

A health care provider or **pharmacy** who has contracted to furnish services or supplies for this plan; but only if the provider is, with **Aetna's** consent, included in the **directory** as a **network provider** for:

- The service or supply involved; and
- The class of employees to which you belong.

Network Service(s) or Supply(ies)

Health care service or supply that is:

- Furnished by a **designated network provider** or
- Furnished or arranged by your **primary care physician (PCP)**.

Night Care Treatment

A **partial confinement treatment** program provided when you need to be confined during the night. A room charge is made by the **hospital, psychiatric hospital** or **residential treatment facility**. Such treatment must be available at least:

- 8 hours in a row a night; and
- 5 nights a week.

Non-Designated Network Providers
These are **network providers** that are *not* shown in the **directory** and in DocFind® as Aetna Whole Health℠ Seton Health Alliance providers for the class of employees of which you are a member.

Non-Occupational Illness
A **non-occupational illness** is an **illness** that does not:

- Arise out of (or in the course of) any work for pay or profit; or
- Result in any way from an **illness** that does.

An **illness** will be deemed to be non-occupational regardless of cause if proof is furnished that the person:

- Is covered under any type of workers' compensation law; and
- Is not covered for that **illness** under such law.

Non-Occupational Injury
A **non-occupational injury** is an accidental bodily **injury** that does not:

- Arise out of (or in the course of) any work for pay or profit; or
- Result in any way from an **injury** which does.

Non-Preferred Drug (Non-Formulary)
A **prescription drug** that is not listed in the **preferred drug guide**. This includes **prescription drugs** on the **preferred drug guide exclusions list** that are approved by medical exception.

Non-Specialist
A **physician** who is not a **specialist**.

Non-Urgent Admission
An inpatient admission that is not an **emergency admission** or an **urgent admission**.

O

Occupational Injury or Occupational Illness
An **injury** or **illness** that:

- Arises out of (or in the course of) any activity in connection with employment or self-employment whether or not on a full time basis; or
- Results in any way from an **injury** or **illness** that does.

Occurrence
This means a period of disease or **injury**. An **occurrence** ends when 60 consecutive days have passed during which the covered person:

- Receives no medical treatment; services; or supplies; for a disease or **injury**; and
- Neither takes any medication, nor has any medication prescribed, for a disease or **injury**.

Orthodontic Treatment

This is any:

- Medical service or supply; or
- Dental service or supply;

furnished to prevent or to diagnose or to correct a misalignment:

- Of the teeth; or
- Of the bite; or
- Of the jaws or jaw joint relationship;

whether or not for the purpose of relieving pain.

The following are not considered **orthodontic treatment**:

- The installation of a space maintainer; or
- A surgical procedure to correct malocclusion.

Out-of-Network Provider

A health care provider or **pharmacy** who has not contracted with **Aetna**, an affiliate, or a third party vendor, to furnish services or supplies for this plan.

Out-of-Network Service(s) or Supply(ies)

Health care service or supply that is:

- Furnished by a **non-designated network provider**; or
- Furnished by an **out-of-network provider**; or
- Not furnished or arranged by your **primary care physician (PCP)**.

P

Partial Confinement Treatment

A plan of medical, psychiatric, nursing, counseling, or therapeutic services to treat alcoholism, substance abuse, or **mental disorders**. The plan must meet these tests:

- It is carried out in a **hospital**; **psychiatric hospital** or **residential treatment facility**; on less than a full-time inpatient basis.
- It is in accord with accepted medical practice for the condition of the person.
- It does not require full-time confinement.
- It is supervised by a **psychiatric physician** who weekly reviews and evaluates its effect.
- **Day care treatment** and **night care treatment** are considered **partial confinement treatment**.

Payment Percentage

Payment percentage is both the percentage of **covered expenses** that the plan pays, and the percentage of **covered expenses** that you pay. The percentage that the plan pays is referred to as the "plan **payment percentage**," and varies by the type of expense. Please refer to the *Schedule of Benefits* for specific information on **payment percentage** amounts.

Pharmacy
An establishment where **prescription drugs** are legally dispensed. **Pharmacy** includes a retail **pharmacy**, **mail order pharmacy** and **specialty pharmacy network pharmacy**.

Physician
A duly licensed member of a medical profession who:

- Has an M.D. or D.O. degree;
- Is properly licensed or certified to provide medical care under the laws of the jurisdiction where the individual practices; and
- Provides medical services which are within the scope of his or her license or certificate.

This also includes a health professional who:

- Is properly licensed or certified to provide medical care under the laws of the jurisdiction where he or she practices;
- Provides medical services which are within the scope of his or her license or certificate;
- Under applicable insurance law is considered a "physician" for purposes of this coverage;
- Has the medical training and clinical expertise suitable to treat your condition;
- Specializes in psychiatry, if your **illness** or **injury** is caused, to any extent, by alcohol abuse, substance abuse or a mental disorder; and
- A physician is not you or related to you.

Precertification or Precertify
A process where **Aetna** is contacted before certain services are provided, such as **hospitalization** or outpatient surgery, or **prescription drugs** are prescribed to determine whether the services being recommended or the drugs prescribed are considered **covered expenses** under the plan. It is not a guarantee that benefits will be payable.

Preferred Drug Guide
A listing of **prescription drugs** established by **Aetna** or an affiliate, which includes both **brand name prescription drugs** and **generic prescription drugs**. This list is subject to periodic review and modification by **Aetna** or an affiliate. A copy of the **preferred drug guide** will be available upon your request or may be accessed on the **Aetna** website at www.**Aetna**.com/formulary.

Preferred Drug Guide Exclusions List
A list of **prescription drugs** in the **preferred drug guide** that are identified as excluded under the plan. This list is subject to periodic review and modification by **Aetna**.

Preferred Network Pharmacy
A **network retail pharmacy** that has contracted with **Aetna**, an affiliate, or a third party vendor, to provide outpatient **prescription drugs** that we have identified as a **preferred network pharmacy**.

Prescriber
Any **physician** or **dentist**, acting within the scope of his or her license, who has the legal authority to write an order for a **prescription drug**.

Prescription
An order for the dispensing of a **prescription drug** by a **prescriber**. If it is an oral order, it must be promptly put in writing by the pharmacy.

Prescription Drug

A drug, biological, or compounded **prescription** which, by State and Federal Law, may be dispensed only by **prescription** and which is required to be labeled "Caution: Federal Law prohibits dispensing without prescription." This includes:

- An injectable drug prescribed to be self-administered or administered by any other person except one who is acting within his or her capacity as a paid healthcare professional. Covered injectable drugs include injectable insulin.

Primary Care Physician (PCP)

This is the **network provider** who:

- Is selected by a person from the list of **primary care physicians** in the **directory**;
- Supervises, coordinates and provides initial care and basic medical services to a person as a general or family care practitioner, or in some cases, as an internist or a pediatrician; and
- Is shown on **Aetna**'s records as the person's **PCP**.

Psychiatric Hospital

This is an institution that meets all of the following requirements.

- Mainly provides a program for the diagnosis, evaluation, and treatment of alcoholism, substance abuse or **mental disorders**.
- Is not mainly a school or a custodial, recreational or training institution.
- Provides infirmary-level medical services. Also, it provides, or arranges with a **hospital** in the area for, any other medical service that may be required.
- Is supervised full-time by a **psychiatric physician** who is responsible for patient care and is there regularly.
- Is staffed by **psychiatric physicians** involved in care and treatment.
- Has a **psychiatric physician** present during the whole treatment day.
- Provides, at all times, **psychiatric** social work and nursing services.
- Provides, at all times, **skilled nursing services** by licensed nurses who are supervised by a full-time **R.N.**
- Prepares and maintains a written plan of treatment for each patient based on medical, psychological and social needs. The plan must be supervised by a **psychiatric physician**.
- Makes charges.
- Meets licensing standards.

Psychiatric Physician

This is a **physician** who:

- Specializes in psychiatry; or
- Has the training or experience to do the required evaluation and treatment of alcoholism, substance abuse or **mental disorders**.

R

Recognized Charge

The **covered expense** is only that part of a charge which is the **recognized charge**.

As to medical, vision and hearing expenses, the **recognized charge** for each service or supply is the lesser of:

- What the provider bills or submits for that service or supply; and
- For professional services and other services or supplies not mentioned below:
  - the 80th percentile of the Prevailing Charge Rate;

  for the Geographic Area where the service is furnished.

As to **prescription drug** expenses, the **recognized charge** for each service or supply is the lesser of:

- What the provider bills or submits for that service or supply; and
- 110% of the **Average Wholesale Price (AWP)** or other similar resource. **Average Wholesale Price (AWP)** is the current average wholesale price of a **prescription drug** listed in the Medi-Span weekly price updates (or any other similar publication chosen by **Aetna**).

If **Aetna** has an agreement with a provider (directly, or indirectly through a third party) which sets the rate that **Aetna** will pay for a service or supply, then the **recognized charge** is the rate established in such agreement.

Aetna may also reduce the **recognized charge** by applying **Aetna** Reimbursement Policies. **Aetna** Reimbursement Policies address the appropriate billing of services, taking into account factors that are relevant to the cost of the service such as:

- the duration and complexity of a service;
- whether multiple procedures are billed at the same time, but no additional overhead is required;
- whether an assistant surgeon is involved and necessary for the service;
- if follow up care is included;
- whether there are any other characteristics that may modify or make a particular service unique; and
- when a charge includes more than one claim line, whether any services described by a claim line are part of or incidental to the primary service provided.

Aetna Reimbursement Policies are based on **Aetna's** review of: the policies developed for Medicare; the generally accepted standards of medical and dental practice, which are based on credible scientific evidence published in peer-reviewed literature generally recognized by the relevant medical or dental community or which is otherwise consistent with **physician** or dental specialty society recommendations; and the views of **physicians** and dentists practicing in the relevant clinical areas. **Aetna** uses a commercial software package to administer some of these policies.

As used above, Geographic Area and Prevailing Charge Rates are defined as follows:

- Geographic Area: This means an expense area grouping defined by the first three digits of the U.S. Postal Service zip codes. If the volume of charges in a single three digit zip code is sufficient to produce a statistically valid sample, an expense area is made up of a single three digit zip code. If the volume of charges is not sufficient to produce a statistically valid sample, two or more three digit zip codes are grouped to produce a statistically valid sample. When it is necessary to group three digit zip codes, the grouping never crosses state lines.
- Prevailing Charge Rates: These are rates reported by FAIR Health, a nonprofit company, in their database. FAIR Health reviews and, if necessary, changes these rates periodically. **Aetna** updates its systems with these changes within 180 days after receiving them from FAIR Health.

Important Note
Aetna periodically updates its systems with changes made to the Prevailing Charge Rates.

What this means to you is that the **recognized charge** is based on the version of the rates that is in use by **Aetna** on the date that the service or supply was provided.

Additional Information
Aetna's website aetna.com may contain additional information which may help you determine the cost of a service or supply. Log on to **Aetna** Navigator to access the "Estimate the Cost of Care" feature. Within this feature, view our "Cost of Care" and "Member Payment Estimator" tools, or contact our Customer Service Department for assistance.

Rehabilitation Facility
A facility, or a distinct part of a facility which provides **rehabilitative services**, meets any licensing or certification standards established by the jurisdiction where it is located, and makes charges for its services.

Rehabilitative Services
The combined and coordinated use of medical, social, educational and vocational measures for training or retraining if you are disabled by **illness** or **injury**.

Residential Treatment Facility (Mental Disorders)
This is an institution that meets all of the following requirements:

- Is accredited by one of the following agencies, commissions or committees for the services being provided: The Joint Commission (TJC), Committee on Accreditation of Rehabilitation Facilities (CARF), American Osteopathic Association's Healthcare Facilities Accreditation Program (HFAP) or the Council on Accreditation (COA); or is credentialed by **Aetna**;
- Meets all applicable licensing standards established by the jurisdiction in which it is located;
- Performs a comprehensive patient assessment preferably before admission, but at least upon admission;
- Creates individualized active treatment plans directed toward the alleviation of the impairment that caused the admission;
- Has the ability to involve family/support systems in the therapeutic process;
- Has the level of skilled intervention and provision of care must be consistent with the patient's **illness** and risk;
- Provides access to psychiatric care by a **psychiatrist** as necessary for the provision of such care;
- Provides treatment services that are managed by a **behavioral health provider** who functions under the direction/supervision of a medical director; and
- Is not a wilderness treatment program (whether or not the program is part of a licensed **residential treatment facility**, or otherwise licensed institution), educational services, schooling or any such related or similar program, including therapeutic programs within a school setting.

In addition to the above requirements, for Mental Health Residential Treatment Programs:

- A **behavioral health provider** must be actively on duty 24 hours per day for 7 days a week;
- The patient is treated by a **psychiatrist** at least once per week; and
- The medical director must be a **psychiatrist**.

Residential Treatment Facility (Substance Abuse)
This is an institution that meets all of the following requirements:

- Is accredited by one of the following agencies, commissions or committees for the services being provided: The Joint Commission (TJC), Committee on Accreditation of Rehabilitation Facilities (CARF), American Osteopathic Association's Healthcare Facilities Accreditation Program (HFAP), or the Council on Accreditation (COA); or is credentialed by **Aetna**;
- Meets all applicable licensing standards established by the jurisdiction in which it is located;
- Performs a comprehensive patient assessment preferably before admission, but at least upon admission;
- Creates individualized active treatment plans directed toward the alleviation of the impairment that caused the admission;
- Has the ability to involve family and/or support systems in the therapeutic process;
- Has the level of skilled intervention and provision of care that is consistent with the patient's **illness** and risk;

- Provides access to psychiatric care by a **psychiatrist** as necessary for the provision of such care;
- Provides treatment services that are managed by a **behavioral health provider** who functions under the direction/supervision of a medical director; and
- Is not a wilderness treatment program (whether or not the program is part of a licensed **residential treatment facility**, or otherwise licensed institution), educational services, schooling or any such related or similar program, including therapeutic programs within a school setting.

In addition to the above requirements, for Chemical Dependence Residential Treatment Programs:

- Is a **behavioral health provider** or an appropriately state certified professional (for example, CADC, CAC);
- Is actively on duty during the day and evening therapeutic programming; and
- The medical director must be a **physician** who is an addiction **specialist**.

In addition to the above requirements, for Chemical Dependence Detoxification Programs within a residential setting:

- An **R.N**. is onsite 24 hours per day for 7 days a week; and
- The care must be provided under the direct supervision of a **physician**.

R.N.
A registered nurse.

Room and Board
Charges made by an institution for **room and board** and other **medically necessary** services and supplies. The charges must be regularly made at a daily or weekly rate.

S

Self-injectable Drug(s)
Prescription drugs that are intended to be self-administered by injection to a specific part of the body to treat medical conditions.

Semi-Private Room Rate
The **room and board** charge that an institution applies to the most beds in its semi-private rooms with 2 or more beds. If there are no such rooms, **Aetna** will figure the rate based on the rate most commonly charged by similar institutions in the same geographic area.

Service Area
This is the geographic area, as determined by **Aetna**, in which **network providers** for this plan are located.

Skilled Nursing Facility
An institution that meets all of the following requirements:

- It is licensed to provide, and does provide, the following on an inpatient basis for persons convalescing from **illness** or **injury**:
  - Professional nursing care by an **R.N.**, or by a **L.P.N.** directed by a full-time **R.N.**; and
  - Physical restoration services to help patients to meet a goal of self-care in daily living activities.
- Provides 24 hour a day nursing care by licensed nurses directed by a full-time **R.N.**
- Is supervised full-time by a **physician** or an **R.N.**
- Keeps a complete medical record on each patient.
- Has a utilization review plan.

- Is not mainly a place for rest, for the aged, for drug addicts, for alcoholics, for mental retardates, for custodial or educational care, or for care of **mental disorder**s.
- Charges patients for its services.
- An institution or a distinct part of an institution that meets all of the following requirements:
  - It is licensed or approved under state or local law.
  - Is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons.
- Qualifies as a **skilled nursing facility** under Medicare or as an institution accredited by**:**
  - The Joint Commission on Accreditation of Health Care Organizations;
  - The Bureau of **Hospitals** of the American Osteopathic Association; or
  - The Commission on the Accreditation of Rehabilitative Facilities

Skilled nursing facilities also include rehabilitation **hospitals** (all levels of care, e.g. acute) and portions of a **hospital** designated for skilled or **rehabilitation services**.

Skilled nursing facility does not include:

- Institutions which provide only:
  - Minimal care;
  - Custodial care services;
  - Ambulatory; or
  - Part-time care services.
- Institutions which primarily provide for the care and treatment of alcoholism, **substance abuse** or **mental disorders**.

Skilled Nursing Services
Services that meet all of the following requirements:

- The services require medical or paramedical training.
- The services are rendered by an **R.N.** or **L.P.N.** within the scope of his or her license.
- The services are not custodial.

Specialist
A **physician** who practices in any generally accepted medical or surgical sub-specialty.

Specialty Care
Health care services or supplies that require the services of a **specialist**.

Specialty Care Drugs
Injectable, infusion and oral **prescription drugs** that are prescribed to address complex, chronic diseases with associated co-morbidities such as cancer, rheumatoid arthritis, hemophilia, multiple sclerosis.
You can access the list of these **specialty care prescription drugs** by calling the toll-free number on your Member ID card or by logging on to your Aetna Navigator® secure member website at www.aetna.com

Specialty Pharmacy Network
A network of pharmacies designated to fill **specialty care drugs**.

Stay
A full-time inpatient confinement for which a **room and board** charge is made.

Step Therapy

A form of **precertification** under which certain **prescription drugs** will be excluded from coverage, unless a first-line therapy drug(s) is used first by you. The list of step-therapy drugs is subject to change by **Aetna** or an affiliate. An updated copy of the list of drugs subject to **step therapy** shall be available upon request by you or may be accessed on the **Aetna** website at www.**Aetna**.com/formulary.

Substance Abuse

This is a physical or psychological dependency, or both, on a controlled substance or alcohol agent (These are defined on Axis I in the Diagnostic and Statistical Manual of **Mental Disorders** (DSM) published by the American Psychiatric Association which is current as of the date services are rendered to you or your covered dependents.) This term does not include conditions not attributable to a **mental disorder** that are a focus of attention or treatment (the V codes on Axis I of DSM); an addiction to nicotine products, food or caffeine intoxication.

Surgery Center

A freestanding ambulatory surgical facility that meets all of the following requirements:

- Meets licensing standards.
- Is set up, equipped and run to provide general surgery.
- Charges for its services.
- Is directed by a staff of **physicians**. At least one of them must be on the premises when surgery is performed and during the recovery period.
- Has at least one certified anesthesiologist at the site when surgery requiring general or spinal anesthesia is performed and during the recovery period.
- Extends surgical staff privileges to:
  - **Physicians** who practice surgery in an area **hospital**; and
  - **Dentists** who perform oral surgery.
- Has at least 2 operating rooms and one recovery room.
- Provides, or arranges with a medical facility in the area for, diagnostic x-ray and lab services needed in connection with surgery.
- Does not have a place for patients to **stay** overnight.
- Provides, in the operating and recovery rooms, full-time **skilled nursing services** directed by an **R.N.**
- Is equipped and has trained staff to handle **emergency medical conditions**.

Must have all of the following:

- A **physician** trained in cardiopulmonary resuscitation; and
- A defibrillator; and
- A tracheotomy set; and
- A blood volume expander.
- Has a written agreement with a **hospital** in the area for immediate emergency transfer of patients.
- Written procedures for such a transfer must be displayed and the staff must be aware of them.
- Provides an ongoing quality assurance program. The program must include reviews by **physicians** who do not own or direct the facility.
- Keeps a medical record on each patient.

T

Terminally Ill (Hospice Care)

Terminally ill means a medical prognosis of 12 months or less to live.

Therapeutic Drug Class
A group of drugs or medications that have a similar or identical mode of action or exhibit similar or identical outcomes for the treatment of a disease or **injury**.

U

Urgent Admission
A **hospital** admission by a **physician** due to:

- The onset of or change in an **illness**; or
- The diagnosis of an **illness**; or
- An **injury**.
- The condition, while not needing an **emergency admission**, is severe enough to require confinement as an inpatient in a **hospital** within 2 weeks from the date the need for the confinement becomes apparent.

Urgent Care Facility
A facility licensed as a freestanding medical facility by applicable state and federal laws to treat an **urgent condition.**

Urgent Care Provider
This is:

- A freestanding medical facility that meets all of the following requirements.
  - Provides unscheduled medical services to treat an **urgent condition** if the person's **physician** is not reasonably available.
  - Routinely provides ongoing unscheduled medical services for more than 8 consecutive hours.
  - Charges for its services and supplies.
  - Is licensed and certified as required by any state or federal law or regulation.
  - Keeps a medical record on each patient.
  - Provides an ongoing quality assurance program. This includes reviews by **physicians** other than those who own or direct the facility.
  - Is run by a staff of **physicians**. At least one **physician** must be on call at all times.
  - Has a full-time administrator who is a licensed **physician**.
- A **physician**'s office, but only one that:
  - Has contracted with **Aetna** to provide urgent care; and
  - Is, with **Aetna**'s consent, included in the **directory** as a network **urgent care provider**.

It is not the emergency room or outpatient department of a **hospital**.

Urgent Condition
This means a sudden **illness**; **injury**; or condition; that:

- Is severe enough to require prompt medical attention to avoid serious deterioration of your health;
- Includes a condition which would subject you to severe pain that could not be adequately managed without urgent care or treatment;
- Does not require the level of care provided in the emergency room of a hospital; and
- Requires immediate outpatient medical care that cannot be postponed until your physician becomes reasonably available.

W

Walk-in Clinic

Walk-in Clinics are free-standing health care facilities. They are an alternative to a **physician's** office visit for treatment of:

- Unscheduled, non-emergency **illnesses** and **injuries**;
- The administration of certain immunizations; and
- Individual screening and counseling services.

It is not an alternative for emergency room services or the ongoing care provided by a **physician**.

Neither:

- An emergency room; nor
- The outpatient department of a **hospital**;

shall be considered a **Walk-in Clinic**.

IMPORTANT HEALTH CARE REFORM NOTICES

CHOICE OF PROVIDER

If your Aetna plan generally requires or allows the designation of a primary care provider, you have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. If the plan or health insurance coverage designates a primary care provider automatically, then until you make this designation, Aetna designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your Employer or, if you are a current member, your Aetna contact number on the back of your ID card.

If your Aetna plan allows for the designation of a primary care provider for a child, you may designate a pediatrician as the primary care provider.

If your Aetna plan provides coverage for obstetric or gynecological care and requires the designation of a primary care provider then you do not need prior authorization from Aetna or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact your Employer or, if you are a current member, your Aetna contact number on the back of your ID card.

Statement of Rights under the Newborns' and Mothers' Health Protection Act

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

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

In addition, a plan or issuer may not, under federal law, require that you, your physician, or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, you may be required to obtain precertification for any days of confinement that exceed 48 hours (or 96 hours). For information on precertification, contact your plan administrator.

Notice Regarding Women's Health and Cancer Rights Act

Under this health plan, as required by the Women's Health and Cancer Rights Act of 1998, coverage will be provided to a person who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with the mastectomy for:

(1) all stages of reconstruction of the breast on which a mastectomy has been performed;
(2) surgery and reconstruction of the other breast to produce a symmetrical appearance;
(3) prostheses; and
(4) treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the attending physician and the patient, and will be provided in accordance with the plan design, limitations, copays, deductibles, and referral requirements, if any, as outlined in your plan documents.

If you have any questions about our coverage of mastectomies and reconstructive surgery, please contact the Member Services number on your ID card.

For more information, you can visit this U.S. Department of Health and Human Services website, http://www.cms.gov/home/regsguidance.asp, and this U.S. Department of Labor website, http://www.dol.gov/ebsa/consumer_info_health.html.

Continuation of Coverage During an Approved Leave of Absence Granted to Comply With Federal Law

This continuation of coverage section applies only for the period of any approved family or medical leave (approved FMLA leave) required by Family and Medical Leave Act of 1993 (FMLA). If your Employer grants you an approved FMLA leave for a period in excess of the period required by FMLA, any continuation of coverage during that excess period will be determined by your Employer.

If your Employer grants you an approved FMLA leave in accordance with FMLA, you may, during the continuance of such approved FMLA leave, continue Health Expense Benefits for you and your eligible dependents.

At the time you request the leave, you must agree to make any contributions required by your Employer to continue coverage.

If any coverage your Employer allows you to continue has reduction rules applicable by reason of age or retirement, the coverage will be subject to such rules while you are on FMLA leave.

Coverage will not be continued beyond the first to occur of:

- The date you are required to make any contribution and you fail to do so.
- The date your Employer determines your approved FMLA leave is terminated.
- The date the coverage involved discontinues as to your eligible class. However, coverage for health expenses may be available to you under another plan sponsored by your Employer.

Any coverage being continued for a dependent will not be continued beyond the date it would otherwise terminate.

If Health Expense Benefits terminate because your approved FMLA leave is deemed terminated by your Employer, you may, on the date of such termination, be eligible for Continuation Under Federal Law on the same terms as though your employment terminated, other than for gross misconduct, on such date. If this Plan provides any other continuation of coverage (for example, upon termination of employment, death, divorce or ceasing to be a defined dependent), you (or your eligible dependents) may be eligible for such continuation on the date your Employer determines your approved FMLA leave is terminated or the date of the event for which the continuation is available.

If you acquire a new dependent while your coverage is continued during an approved FMLA leave, the dependent will be eligible for the continued coverage on the same terms as would be applicable if you were actively at work, not on an approved FMLA leave.

If you return to work for your Employer following the date your Employer determines the approved FMLA leave is terminated, your coverage under this Plan will be in force as though you had continued in active employment rather than going on an approved FMLA leave provided you make request for such coverage within 31 days of the date your Employer determines the approved FMLA leave to be terminated. If you do not make such request within 31 days, coverage will again be effective under this Plan only if and when this Plan gives its written consent.

If any coverage being continued terminates because your Employer determines the approved FMLA leave is terminated, any Conversion Privilege will be available on the same terms as though your employment had terminated on the date your Employer determines the approved FMLA leave is terminated.

BENEFIT PLAN

Prepared Exclusively for
Williamson County

Choice POS II

What Your Plan Covers and How Benefits are Paid

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Preface

The medical benefits plan described in this *Booklet* is a benefit plan of the Employer. These benefits are not insured with **Aetna** or any of its affiliates, but will be paid from the Employer's funds. **Aetna** and its HMO affiliates will provide certain administrative services under the **Aetna** medical benefits plan.

Aetna agrees with the Employer to provide administrative services in accordance with the conditions, rights, and privileges as set forth in this *Booklet*. The Employer selects the products and benefit levels under the **Aetna** medical benefits plan.

The *Booklet* describes your rights and obligations, what the **Aetna** medical benefits plan covers, and how benefits are paid for that coverage. It is your responsibility to understand the terms and conditions in this *Booklet*. Your *Booklet* includes the *Schedule of Benefits* and any amendments.

This *Booklet* replaces and supercedes all **Aetna** *Booklets* describing coverage for the medical benefits plan described in this *Booklet* that you may previously have received.

Employer:	Williamson County
Contract Number:	866349
Effective Date:	November 1, 2014
Issue Date:	April 17, 2015
Booklet Number:	2

Coverage for You and Your Dependents

Health Expense Coverage

Benefits are payable for covered health care expenses that are incurred by you or your covered dependents while coverage is in effect. An expense is "incurred" on the day you receive a health care service or supply.

Coverage under this plan is non-occupational. Only **non-occupational injuries** and **non-occupational illnesses** are covered.

Refer to the *What the Plan Covers* section of the *Booklet* for more information about your coverage.

Treatment Outcomes of Covered Services

Aetna is not a provider of health care services and therefore is not responsible for and does not guarantee any results or outcomes of the covered health care services and supplies you receive. Except for Aetna RX Home Delivery LLC, providers of health care services, including hospitals, institutions, facilities or agencies, are independent contractors and are neither agents nor employees of **Aetna** or its affiliates.

When Your Coverage Begins

Who Is Eligible

How and When to Enroll

When Your Coverage Begins

Throughout this section you will find information on who can be covered under the plan, how to enroll and what to do when there is a change in your life that affects coverage. In this section, "you" means the employee.

Who Is Eligible

Employees

To be covered by this plan, the following requirements must be met:

- You will need to be in an "eligible class," as defined below; and
- You will need to meet the "eligibility date criteria" described below.

Determining if You Are in an Eligible Class

You are in an eligible class if:

- You are a retired employee of an employer participating in this plan, and you:
  - Retired before the effective date of this plan and were covered under the prior plan for health care coverage on the day before you retired; or
  - Were covered under this plan or another plan sponsored by your employer on the day before you retired; and
  - Retire under your employer's IRS-qualified retirement plan.

Determining if You Are in an Eligible Class

You are in an eligible class if:

- You are a regular full-time employee, as defined by your employer, who is scheduled to work at least 30 hours per week on a regular basis.

Probationary Period

Once you enter an eligible class, you will need to complete the probationary period before your coverage under this plan begins.

Determining When You Become Eligible

You become eligible for the plan on your eligibility date, which is determined as follows.

On the Effective Date of the Plan

If you are in an eligible class on the effective date of this plan, your coverage eligibility date is the effective date of the plan.

After the Effective Date of the Plan

If you are hired or enter an eligible class after the effective date of this plan, your coverage eligibility date is the first day of the month coinciding with or next following the date you complete 60 days from the date of hire of continuous service with your employer. This is defined as the probationary period. If you had already satisfied the probationary period before you entered the eligible class, your coverage eligibility date is the date you enter the eligible class.

Obtaining Coverage for Dependents

Your dependents can be covered under this Plan. You may enroll the following dependents:

- Your spouse.
- Your dependent children.

Aetna will rely upon your employer to determine whether or not a person meets the definition of a dependent for coverage under this Plan. This determination will be conclusive and binding upon all persons for the purposes of this Plan.

Coverage for Dependent Children

To be eligible for coverage, a dependent child must be under 26 years of age.

An eligible dependent child includes:

- Your biological children;
- Your stepchildren;
- Your legally adopted children;
- Your foster children, including any children placed with you for adoption;
- Any children for whom you are responsible under court order;
- Your grandchildren in your court-ordered custody; and
- Any other child with whom you have a parent-child relationship.

Coverage for a handicapped child may be continued past the age limits shown above. See *Handicapped Dependent Children* for more information.

Important Reminder

Keep in mind that you cannot receive coverage under this Plan as:

- Both an employee and a dependent; or
- A dependent of more than one employee.

How and When to Enroll

Initial Enrollment in the Plan

You will be provided with plan benefit and enrollment information when you first become eligible to enroll. You will need to enroll in a manner determined by **Aetna** and your employer. To complete the enrollment process, you will need to provide all requested information for yourself and your eligible dependents. You will also need to agree to make required contributions for any contributory coverage. Your employer will determine the amount of your plan contributions, which you will need to agree to before you can enroll. Your employer will advise you of the required amount of your contributions and will deduct your contributions from your pay. Remember plan contributions are subject to change.

You will need to enroll within 31 days of your eligibility date. Otherwise, you may be considered a Late Enrollee. If you miss the enrollment period, you will not be able to participate in the plan until the next annual enrollment period, unless you qualify under a Special Enrollment Period, as described below.

If you do not enroll for coverage when you first become eligible, but wish to do so later, your employer will provide you with information on when and how you can enroll.

Newborns are automatically covered for 31 days after birth. To continue coverage after 31 days, you will need to complete a change form and return it to your employer within the 31-day enrollment period.

Late Enrollment

If you do not enroll during the Initial Enrollment Period, or a subsequent annual enrollment period, you and your eligible dependents may be considered **Late Enrollees** and coverage may be deferred until the next annual enrollment period. If, at the time of your initial enrollment, you elect coverage for yourself only and later request coverage for your eligible dependents, they may be considered **Late Enrollees**.

You must return your completed enrollment form before the end of the next annual enrollment period as described below.

However, you and your eligible dependents may not be considered **Late Enrollees** if you qualify for one of the circumstances described in the "Special Enrollment Periods" section below.

Annual Enrollment

During the annual enrollment period, you will have the opportunity to review your coverage needs for the upcoming year. During this period, you have the option to change your coverage. The choices you make during this annual enrollment period will become effective the following year.

If you do not enroll yourself or a dependent for coverage when you first become eligible, but wish to do so later, you will need to do so during the next annual enrollment period, unless you qualify under one of the Special Enrollment Periods, as described below.

Special Enrollment Periods

You will not be considered a **Late Enrollee** if you qualify under a Special Enrollment Period as defined below. If one of these situations applies, you may enroll before the next annual enrollment period.

Loss of Other Health Care Coverage

You or your dependents may qualify for a Special Enrollment Period if:

- You did not enroll yourself or your dependent when you first became eligible or during any subsequent annual enrollments because, at that time:
  - You or your dependents were covered under other **creditable coverage**; and
  - You refused coverage and stated, in writing, at the time you refused coverage that the reason was that you or your dependents had other **creditable coverage**; and
- You or your dependents are no longer eligible for other **creditable coverage** because of one of the following:
  - The end of your employment;
  - A reduction in your hours of employment (for example, moving from a full-time to part-time position);
  - The ending of the other plan's coverage;
  - Death;
  - Divorce or legal separation;
  - Employer contributions toward that coverage have ended;
  - COBRA coverage ends;
  - The employer's decision to stop offering the group health plan to the eligible class to which you belong;
  - Cessation of a dependent's status as an eligible dependent as such is defined under this Plan;
  - With respect to coverage under Medicaid or an S-CHIP Plan, you or your dependents no longer qualify for such coverage; or
  - You or your dependents have reached the lifetime maximum of another Plan for all benefits under that Plan.
- You or your dependents become eligible for premium assistance, with respect to coverage under the group health plan, under Medicaid or an S-CHIP Plan.

You will need to enroll yourself or a dependent for coverage within:

- 31 days of when other **creditable coverage** ends;
- within 60 days of when coverage under Medicaid or an S-CHIP Plan ends; or
- within 60 days of the date you or your dependents become eligible for Medicaid or S-CHIP premium assistance.

Evidence of termination of **creditable coverage** must be provided to your employer or the party it designates. If you do not enroll during this time, you will need to wait until the next annual enrollment period.

New Dependents

You and your dependents may qualify for a Special Enrollment Period if:

- You did not enroll when you were first eligible for coverage; and
- You later acquire a dependent, as defined under the plan, through marriage, birth, adoption, or placement for adoption; and
- You elect coverage for yourself and your dependent within 31 days of acquiring the dependent.

Your spouse or child who meets the definition of a dependent under the plan may qualify for a Special Enrollment Period if:

- You did not enroll them when they were first eligible; and
- You later elect coverage for them within 31 days of a court order requiring you to provide coverage.

You will need to report any new dependents by completing a change form, which is available from your employer. The form must be completed and returned to your employer within 31 days of the change. If you do not return the form within 31 days of the change, you will need to make the changes during the next annual enrollment period.

If You Adopt a Child

Your plan will cover a child who is placed for adoption. This means you have taken on the legal obligation for total or partial support of a child whom you plan to adopt.

Your plan will provide coverage for a child who is placed with you for adoption if:

- The child meets the plan's definition of an eligible dependent on the date he or she is placed for adoption; and
- You request coverage for the child in writing within 31 days of the placement;
- Proof of placement will need to be presented to your employer prior to the dependent enrollment;
- Any coverage limitations for a preexisting condition will not apply to a child placed with you for adoption provided that the placement occurs on or after the effective date of your coverage.

When You Receive a Qualified Child Support Order

A Qualified Medical Child Support Order (QMCSO) is a court order requiring a parent to provide health care coverage to one or more children. Your plan will provide coverage for a child who is covered under a QMCSO, if:

- The child meets the plan's definition of an eligible dependent; and
- You request coverage for the child in writing within 31 days of the court order.

Coverage for the dependent will become effective on the date of the court order. Any coverage limitations for a preexisting condition will not apply, as long as you submit a written request for coverage within the 31-day period.

If you do not request coverage for the child within the 31-day period, you will need to wait until the next annual enrollment period.

Under a QMCSO, if you are the non-custodial parent, the custodial parent may file claims for benefits. Benefits for such claims will be paid to the custodial parent.

When Your Coverage Begins

Your Effective Date of Coverage

If you have met all the eligibility requirements, your coverage takes effect on the later of:

- The date you are eligible for coverage; and
- The date you return your completed enrollment information; and
- Your application is received and approved in writing by **Aetna**; and
- The date your required contribution is received by **Aetna**.

If you do not return your completed enrollment information within 31 days of your eligibility date, the rules under the *Special or Late Enrollment Periods* section will apply.

Important Notice:
You must pay the required contribution in full or coverage will not be effective.

Your Dependent's Effective Date of Coverage

Your dependent's coverage takes effect on the same day that your coverage becomes effective, if you have enrolled them in the plan.

Note: New dependents need to be reported to your employer within 31 days because they may affect your contributions. If you do not report a new dependent within 31 days of his or her eligibility date, the rules under the *Special or Late Enrollment Periods* section will apply.

Retired Employees

In lieu of corresponding rules which apply to employees:

- If any health expense benefits are payable based on a "period of disability", the rule which applies to determine when a dependent's period of disability ends will also apply to you.
- The rule which applies to a dependent to determine if total disability exists when health expense insurance ends will also apply to you.

How Your Medical Plan Works

Common Terms

Accessing Providers

Precertification

It is important that you have the information and useful resources to help you get the most out of your **Aetna** medical plan. This Booklet explains:

- Definitions you need to know;
- How to access care, including procedures you need to follow;
- What expenses for services and supplies are covered and what limits may apply;
- What expenses for services and supplies are not covered by the plan;
- How you share the cost of your covered services and supplies; and
- Other important information such as eligibility, complaints and appeals, termination, continuation of coverage, and general administration of the plan.

Important Notes

- Unless otherwise indicated, "you" refers to you and your covered dependents.
- Your health plan pays benefits only for services and supplies described in this Booklet as **covered expenses** that are **medically necessary**.
- This Booklet applies to coverage only and does not restrict your ability to receive health care services that are not or might not be covered benefits under this health plan.
- Store this Booklet in a safe place for future reference.

Common Terms

Many terms throughout this Booklet are defined in the *Glossary* section at the back of this document. Defined terms appear in bolded print. Understanding these terms will also help you understand how your plan works and provide you with useful information regarding your coverage.

About Your Aetna Choice POS II Medical Plan

This Aetna Choice POS II medical plan provides coverage for a wide range of medical expenses for the treatment of **illness** or **injury**. It does not provide benefits for all medical care. The plan also provides coverage for certain preventive and wellness benefits. With your Aetna Choice POS II plan, you can directly access any **network** or **out-of-network physician**, **hospital** or other health care provider for covered services and supplies under the plan. The plan pays benefits differently when services and supplies are obtained through **network providers** or **out-of-network providers** under this plan.

Important Note
Network providers have contracted with **Aetna**, an affiliate or third party vendor to provide health care services and supplies to **Aetna** plan members. **Network providers** are generally identified in the printed **directory** and the on-line version of the **directory** via DocFind at www.aetna.com unless otherwise noted in this section. **Out-of-network providers** are not listed in the **Aetna directory**.

The plan will pay for **covered expenses** up to the maximum benefits shown in this Booklet.

Coverage is subject to all the terms, policies and procedures outlined in this Booklet. Not all medical expenses are covered under the plan. Exclusions and limitations apply to certain medical services, supplies and expenses. Refer to the *What the Plan Covers*, *Exclusions*, *Limitations* sections and *Schedule of Benefits* to determine if medical services are covered, excluded or limited.

This Aetna Choice POS II plan provides access to covered benefits through a broad network of health care providers and facilities. This Aetna Choice POS II plan is designed to lower your out-of-pocket costs when you use **network providers** for **covered expenses**. Your **deductibles**, **copayments**, and **payment percentage** will generally be lower when you use **network providers** and facilities.

You also have the choice to access licensed **providers**, **hospitals** and facilities outside the network for covered services and supplies. Your out-of-pocket costs will generally be higher when you use **out-of-network** providers because the **deductibles**, **copayments**, and **payment percentage** that you are required to pay are usually higher when you utilize **out-of-network providers**. **Out-of-network providers** have not agreed to accept the **negotiated charge** and may balance bill you for charges over the amount **Aetna** pays under the plan.

Some services and supplies may only be covered through **network providers**. Refer to the *Covered Benefit* sections and your *Schedule of Benefits* to determine if any services are limited to network coverage only.

Your out-of-pocket costs may vary between network and out-of-network benefits. Read your *Schedule of Benefits* carefully to understand the cost sharing charges applicable to you.

Availability of Providers

Aetna cannot guarantee the availability or continued participation of a particular provider. Either **Aetna** or any **network provider** may terminate the **provider** contract or limit the number of patients accepted in a practice. If the **physician** initially selected cannot accept additional patients, you will be notified and given an opportunity to make another selection.

Ongoing Reviews

Aetna conducts ongoing reviews of those services and supplies which are recommended or provided by health professionals to determine whether such services and supplies are **covered expenses** under this Booklet. If **Aetna** determines that the recommended services or supplies are not **covered expenses**, you will be notified. You may appeal such determinations by contacting **Aetna** to seek a review of the determination. Please refer to the *Reporting of Claims* and the *Claims and Appeals* sections of this Booklet.

To better understand the choices that you have with your Aetna Choice POS II plan, please carefully review the following information.

How Your Aetna Choice POS II Medical Plan Works

The Primary Care Physician:

To access network benefits, you are encouraged to select a **Primary Care Physician (PCP**) from **Aetna**'s network of providers at the time of enrollment. Each covered family member may select his or her own **PCP**. If your covered dependent is a minor, or otherwise incapable of selecting a **PCP**, you should select a **PCP** on their behalf.

You may search online for the most current list of participating providers in your area by using DocFind, **Aetna**'s online provider directory at www.aetna.com. You can choose a **PCP** based on geographic location, group practice, medical specialty, language spoken, or **hospital** affiliation. DocFind is updated several times a week. You may also request a printed copy of the provider directory through your employer or by contacting Member Services through e-mail or by calling the toll free number on your ID card.

A **PCP** may be a general practitioner, family **physician**, internist, or pediatrician. Your **PCP** provides routine preventive care and will treat you for **illness** or **injury**.

A **PCP** coordinates your medical care, as appropriate either by providing treatment or may direct you to other **network providers** for other covered services and supplies. The **PCP** can also order lab tests and x-rays, prescribe medicines or therapies, and arrange **hospitalization**.

Changing Your PCP

You may change your **PCP** at any time on **Aetna**'s website, www.aetna.com, or by calling the Member Services toll-free number on your identification card. The change will become effective upon **Aetna**'s receipt and approval of the request.

Specialists and Other Network Providers

You may directly access **specialists** and other health care professionals in the network for covered services and supplies under this Booklet. Refer to the **Aetna provider directory** to locate network **specialists**, **providers** and **hospitals** in your area. Refer to the *Schedule of Benefits* section for benefit limitations and out-of-pocket costs applicable to your plan.

Important Note
ID Card: You will receive an ID card. It identifies you as a member when you receive services from health care **providers**. If you have not received your ID card or if your card is lost or stolen, notify **Aetna** immediately and a new card will be issued.

Accessing Network Providers and Benefits

- You may select a **PCP** or other direct access **network provider** from the **network provider directory** or by logging on to **Aetna**'s website at www.aetna.com. You can search **Aetna**'s online **directory**, DocFind, for names and locations of **physicians, hospitals** and **other health care** providers and facilities. You can change your **PCP** at anytime.
- If a service or supply you need is covered under this Plan but not available from a **network provider** in your area, your **PCP** may refer you to an **out-of-network provider**. As long as your **PCP** has provided you with a **referral** that has been approved by **Aetna**, you will receive the network benefit level as shown in your *Schedule of Benefits*.
- If a service or supply you need is covered under this Plan but not available from a **network provider in your area,** please contact Member Services by email or at the toll-free number on your ID card for assistance.
- Certain health care services such as **hospitalization, outpatient surgery** and certain other outpatient services, require **precertification** with **Aetna** to verify coverage for these services. You do not need to **precertify** services provided by a **network provider**. **Network providers** will be responsible for obtaining necessary **precertification** for you. Since **precertification** is the provider's responsibility, there are no additional out-of-pocket costs to you as a result of a **network provider's** failure to **precertify** services. Refer to the *Understanding Precertification* section for more information on the **precertification** process and what to do if your request for **precertification** is denied.
- Except for your **prescription drug** expenses, you will not have to submit medical claims for treatment received from network health care professionals and facilities. Your **network provider** will take care of claim submission. **Aetna** will directly pay the **network provider** or facility less any cost sharing required by you. You will be responsible for **deductibles**, **payment percentage** and **copayments**, if any.
- You may be required to pay some **network providers** at the time of service. When you pay a **network provider** directly, you will be responsible for completing a claim form to receive reimbursement of **covered expenses** from **Aetna**. You must submit a completed claim form and proof of payment to **Aetna**. Refer to the *General Provisions* section of this Booklet for a complete description of how to file a claim under this Plan.
- You will receive notification of what the plan has paid toward your **covered expenses**. It will indicate any amounts you owe towards your **deductible**, **copayments**, or **payment percentage** or other non-covered expenses you have incurred. You may elect to receive this notification by e-mail, or through the mail. Call or e-mail Member Services if you have questions regarding your statement.

Cost Sharing For Network Benefits

You share in the cost of your benefits. Cost Sharing amounts and provisions are described in the *Schedule of Benefits*.

- **Network providers** have agreed to accept the **negotiated charge**. **Aetna** will reimburse you for a **covered expense,** incurred from a **network provider,** up to the **negotiated charge** and the maximum benefits under this Plan, less any cost sharing required by you such as **deductibles**, **copayments** and **payment percentage**. Your **payment percentage** is based on the **negotiated charge**. You will not have to pay any balance bills above the **negotiated charge** for that covered service or supply.
- You must satisfy any applicable **deductibles** before the plan will begin to pay benefits.
- **Deductibles** and **payment percentage** are usually lower when you use **network providers** than when you use **out-of-network providers.**

- For certain types of services and supplies, you will be responsible for any **copayments** shown in your *Schedule of Benefits*. The **copayments** will vary depending upon the type of service and whether you obtain covered health care services from a provider who is a **specialist** or non-**specialist.** You will be subject to the **PCP copayments** shown on the *Schedule of Benefits* when you obtain covered health care services from any **PCP** who is a **network provider.** If the provider is a **network specialist**, then the **specialist copayment** will apply.
- After you satisfy any applicable **deductible**, you will be responsible for any applicable **payment percentage** for **covered expenses** that you incur. You will be responsible for your **payment percentage** up to the **maximum out-of-pocket limit** applicable to your plan.
- Once you satisfy any applicable **maximum out-of-pocket limit**, the plan will pay 100% of the **covered expenses** that apply toward the limits for the rest of the Plan Year. Certain designated out-of-pocket expenses may not apply to the **maximum out-of-pocket limits**. Refer to your *Schedule of Benefits* for information on what **covered expenses** do not apply to the **maximum out-of-pocket limits** and for the specific **maximum out-of-pocket limit** amounts that apply to your plan.
- The plan will pay for **covered expenses**, up to the benefit maximums shown in the *What the Plan Covers* section or the *Schedule of Benefits*. You are responsible for any expenses incurred over the maximum limits outlined in the *What the Plan Covers* section or the *Schedule of Benefits*.
- You may be billed for any **deductible**, **copayment**, or **payment percentage** amounts, or any non-covered expenses that you incur.

Accessing Out-of-Network Providers and Benefits

- Certain health care services such as hospitalization, outpatient surgery and certain other outpatient services, require **precertification** with **Aetna** to verify coverage for these services. When you receive services from an **out-of-network provider**, you are responsible for obtaining the necessary **precertification** from **Aetna**. Your provider may **precertify** the services for you. However, you should verify with **Aetna** prior to the service, that the provider has obtained **precertification** from **Aetna**. If the service is not **precertified**, the benefit payable may be significantly reduced or may not be covered. This means you will be responsible for the unpaid balance of any bills. You must call the **precertification** toll-free number on your ID card to **precertify** services. Refer to the *Understanding Precertification* section for more information on the **precertification** process and what to do if your request for **precertification** is denied.
- When you use **out-of-network providers**, you may have to pay for services at the time they are rendered. You may be required to pay the full charges and submit a claim form to **Aetna** for reimbursement. You are responsible for completing and submitting claim forms for reimbursement of **covered expenses** that you paid directly to an **out-of-network provider**.

- When you pay an **out-of-network provider** directly, you will be responsible for completing a claim form to receive reimbursement of **covered expenses** from **Aetna**. You must submit a completed claim form and proof of payment to **Aetna**. Refer to the *General Provisions* section of this Booklet for a complete description of how to file a claim under this plan.
- You will receive notification of what the plan has paid toward your **covered expenses**. It will indicate any amounts you owe towards any **deductible**, or **payment percentage** amounts or other non-covered expenses you have incurred. You may elect to receive this notification by e-mail, or through the mail. Call or e-mail Member Services if you have questions regarding your statement.

Important Note
Failure to **precertify** services and supplies will result in a reduction of benefits or no coverage for the services or supplies under this Booklet. Please refer to the *Understanding Precertification* section for information on how to request **precertification**.

Cost Sharing for Out-of-Network Benefits

You share in the cost of your benefits. Cost Sharing amounts and provisions are described in the *Schedule of Benefits*.

- **Out-of-network providers** have not agreed to accept the **negotiated charge. Aetna** will reimburse you for a **covered expense,** incurred from an **out-of network provider**, up to the **recognized charge** and the maximum benefits under this Plan, less any cost-sharing required by you such as **deductibles** and **payment percentage.** The **recognized charge** is the maximum amount **Aetna** will pay for a **covered expense** from an **out-of-network provider**. Your **payment percentage** is based on the **recognized charge**. If your **out-of-network provider** charges more than the **recognized charge**, you will be responsible for any expenses incurred above the **recognized charge**. Except for emergency services, **Aetna** will only pay up to the **recognized charge**.
- You must satisfy any applicable **deductibles** before the plan begins to pay benefits.
- **Deductibles** and **payment percentage** are usually higher when you use **out-of network providers** than when you use **network providers.**

- After you satisfy any applicable **deductible**, you will be responsible for any applicable **payment percentage** for **covered expenses** that you incur. You will be responsible for your **payment percentage** up to the **maximum out-of-pocket limits** that apply to your plan.
- Once you satisfy any applicable **maximum out-of-pocket limit**, the plan will pay 100% of the **covered expenses** that apply toward the limits for the rest of the Plan Year. Certain designated out-of-pocket expenses may not apply to the **maximum out-of-pocket limit**. Refer to your *Schedule of Benefits* for information on what **covered expenses** do not apply to the **maximum out-of-pocket limits** and for the specific **maximum out-of-pocket limit** amounts that apply to your plan.
- The plan will pay for **covered expenses**, up to the benefit maximums shown in the *What the Plan Covers* section or the *Schedule of Benefits*. You are responsible for any expenses incurred over the maximum limits outlined in the *What the Plan Covers* section or the *Schedule of Benefits*.

Understanding Precertification

Precertification

Certain services, such as inpatient **stays**, certain tests, procedures and **outpatient surgery** require **precertification** by **Aetna**. **Precertification** is a process that helps you and your **physician** determine whether the services being recommended are **covered expenses** under the plan. It also allows **Aetna** to help your provider coordinate your transition from an inpatient setting to an outpatient setting (called discharge planning), and to register you for specialized programs or case management when appropriate.

You do not need to **precertify** services provided by a **network provider**. **Network providers** will be responsible for obtaining necessary **precertification** for you. Since **precertification** is the provider's responsibility, there is no additional out-of-pocket cost to you as a result of a **network provider's** failure to **precertify** services.

When you go to an **out-of-network provider**, it is your responsibility to obtain **precertification** from **Aetna** for any services or supplies on the **precertification** list below. If you do not **precertify**, your benefits may be reduced, or the plan may not pay any benefits. The list of services requiring **precertification** follows on the next page.

Important Note
Please read the following sections in their entirety for important information on the **precertification** process, and any impact it may have on your coverage.

The Precertification Process

Prior to being **hospitalized** or receiving certain other medical services or supplies there are certain **precertification** procedures that must be followed.

You or a member of your family, a **hospital** staff member, or the attending **physician**, must notify **Aetna** to **precertify** the admission or medical services and expenses prior to receiving any of the services or supplies that require **precertification** pursuant to this Booklet in accordance with the following timelines:

Precertification should be secured within the timeframes specified below. To obtain **precertification**, call **Aetna** at the telephone number listed on your ID card. This call must be made:

For non-emergency admissions:	You, your **physician** or the facility will need to call and request **precertification** at least 14 days before the date you are scheduled to be admitted.
For an **emergency** outpatient **medical condition**:	You or your **physician** should call prior to the outpatient care, treatment or procedure if possible; or as soon as reasonably possible.
For an **emergency admission**:	You, your **physician** or the facility must call within 48 hours or as soon as reasonably possible after you have been admitted.
For an **urgent admission**:	You, your **physician** or the facility will need to call before you are scheduled to be admitted. An urgent admission is a **hospital** admission by a **physician** due to the onset of or change in an **illness**; the diagnosis of an **illness**; or an **injury**.
For outpatient non-emergency medical services requiring **precertification**:	You or your **physician** must call at least 14 days before the outpatient care is provided, or the treatment or procedure is scheduled.

Aetna will provide a written notification to you and your **physician** of the **precertification** decision. If your **precertified** expenses are approved the approval is good for 60 days as long as you remain enrolled in the plan.

When you have an inpatient admission to a facility, **Aetna** will notify you, your **physician** and the facility about your **precertified** length of **stay**. If your **physician** recommends that your **stay** be extended, additional days will need to be certified. You, your **physician**, or the facility will need to call **Aetna** at the number on your ID card as soon as reasonably possible, but no later than the final authorized day. **Aetna** will review and process the request for an extended **stay**. You and your **physician** will receive a notification of an approval or denial.

If **precertification** determines that the **stay** or services and supplies are not **covered expenses**, the notification will explain why and how **Aetna**'s decision can be appealed. You or your provider may request a review of the **precertification** decision pursuant to the Claims and Appeals section included with this Booklet.

Services and Supplies Which Require Precertification

Precertification is required for the following types of medical expenses:

Inpatient and Outpatient Care

- **Stays** in a **hospital**;
- **Stays** in a **skilled nursing facility**;
- **Stays** in a **rehabilitation facility**;
- **Stays** in a **hospice** facility;
- Outpatient **hospice care**;
- **Stays** in a **Residential Treatment Facility** for treatment of mental disorders and substance abuse;
- **Partial Hospitalization Programs** for mental disorders and substance abuse;
- **Home health care**;
- Private duty nursing care;
- Intensive Outpatient Programs for mental disorders and substance abuse;
- Amytal interview;
- Applied Behavioral Analysis;
- Biofeedback;
- Electroconvulsive therapy;
- Neuropsychological testing;
- Outpatient detoxification;
- Psychiatric home care services;
- Psychological testing.

How Failure to Precertify Affects Your Benefits

A **precertification** benefit reduction will be applied to the benefits paid if you fail to obtain a required **precertification** prior to incurring medical expenses. This means **Aetna** will reduce the amount paid towards your coverage, or your expenses may not be covered. You will be responsible for the unpaid balance of the bills.

You are responsible for obtaining the necessary **precertification** from **Aetna** prior to receiving services from an **out-of-network provider**. Your provider may **precertify** your treatment for you; however you should verify with **Aetna** prior to the procedure, that the provider has obtained **precertification** from **Aetna**. If your treatment is not **precertified** by you or your provider, the benefit payable may be significantly reduced or your expenses may not be covered.

How Your Benefits are Affected

The chart below illustrates the effect on your benefits if necessary **precertification** is not obtained.

If **precertification** is:	then the expenses are:
▪ requested and approved by **Aetna**.	▪ covered.
▪ requested and denied.	▪ not covered, may be appealed.
▪ not requested, but would have been covered if requested.	▪ covered after a **precertification** benefit reduction is applied.*
▪ not requested, would not have been covered if requested.	▪ not covered, may be appealed.

It is important to remember that any additional out-of-pocket expenses incurred because your **precertification** requirement was not met will not count toward your **deductible** or **payment limit** or **maximum out-of-pocket limit**.

*Refer to the *Schedule of Benefits* section for the amount of **precertification** benefit reduction that applies to your plan.

Emergency and Urgent Care

You have coverage 24 hours a day, 7 days a week, anywhere inside or outside the plan's service area, for:

- An **emergency medical condition**; or
- An **urgent condition**.

In Case of a Medical Emergency

When **emergency care** is necessary, please follow the guidelines below:

- Seek the nearest emergency room, or dial 911 or your local emergency response service for medical and ambulatory assistance. If possible, call your **physician** provided a delay would not be detrimental to your health.
- After assessing and stabilizing your condition, the emergency room should contact your **physician** to obtain your medical history to assist the emergency **physician** in your treatment.
- If you are admitted to an inpatient facility, notify your **physician** as soon as reasonably possible.

- If you seek care in an emergency room for a non-emergency condition, the plan will not cover the expenses you incur. Please refer to the *Schedule of Benefits* for specific details about the plan. No other plan benefits will pay for non-emergency care in the emergency room unless otherwise specified under the plan.

Coverage for Emergency Medical Conditions

Refer to **Coverage for Emergency Medical Conditions** in the *What the Plan Covers* section.

Important Reminder
If you visit a **hospital** emergency room for a non-emergency condition, the plan will not cover your expenses, as shown in the *Schedule of Benefits*. No other plan benefits will pay for non-emergency care in the emergency room unless otherwise specified under the Plan.

In Case of an Urgent Condition

Call your **PCP** if you think you need urgent care. **Network providers** are required to provide urgent care coverage 24 hours a day, including weekends and holidays. You may contact any **physician** or **urgent care provider**, in- or out-of-network, for an **urgent care condition** if you cannot reach your **physician**.

If it is not feasible to contact your **physician**, please do so as soon as possible after urgent care is provided. If you need help finding an **urgent care provider** you may call Member Services at the toll-free number on your I.D. card, or you may access **Aetna**'s online provider directory at www.aetna.com.

Coverage for an Urgent Condition

Refer to **Coverage for Urgent Medical Conditions** in the *What the Plan Covers* section.

Non-Urgent Care

If you seek care from an **urgent care provider** for a non-**urgent condition**, (one that does not meet the criteria above), the plan will not cover the expenses you incur unless otherwise specified under the Plan. Please refer to the *Schedule of Benefits* for specific plan details.

Important Reminder
If you visit an **urgent care provider** for a non-**urgent condition**, the plan will not cover your expenses, as shown in the *Schedule of Benefits*. No other plan benefits will pay for non-urgent care received at a hospital or an urgent care provider unless otherwise specified.

Follow-Up Care After Treatment of an Emergency or Urgent Medical Condition

Follow-up care is not considered an emergency or **urgent condition** and is not covered as part of any emergency or urgent care visit. Once you have been treated and discharged, you should contact your **physician** for any necessary follow-up care.

For coverage purposes, follow-up care is treated as any other expense for **illness** or **injury**. If you access a **hospital** emergency room for follow-up care, your expenses will not be covered and you will be responsible for the entire cost of your treatment. Refer to your *Schedule of Benefits* for cost sharing information applicable to your plan.

To keep your out-of-pocket costs lower, your follow-up care should be provided by a **physician**.

You may use an **out-of-network provider** for your follow-up care. You will be subject to the **deductible and payment percentage** that apply to out-of-network expenses, which may result in higher out-of-pocket costs to you.

Important Notice
Follow up care, which includes (but is not limited to) suture removal, cast removal and radiological tests such as x-rays, should ***not*** be provided by an emergency room facility.

Requirements For Coverage

To be covered by the plan, services and supplies and **prescription drugs** must meet all of the following requirements:

1. The service or supply or **prescription drug** must be covered by the plan. For a service or supply or **prescription drug** to be covered, it must:

   - Be included as a covered expense in this Booklet;
   - Not be an excluded expense under this Booklet. Refer to the *Exclusions* sections of this Booklet for a list of services and supplies that are excluded;
   - Not exceed the maximums and limitations outlined in this Booklet. Refer to the *What the Plan Covers* section and the *Schedule of Benefits* for information about certain expense limits; and
   - Be obtained in accordance with all the terms, policies and procedures outlined in this Booklet.

2. The service or supply or **prescription drug** must be provided while coverage is in effect. See the *Who Can Be Covered, How and When to Enroll, When Your Coverage Begins, When Coverage Ends* and *Continuation of Coverage* sections for details on when coverage begins and ends.

3. The service or supply or **prescription drug** must be **medically necessary**. To meet this requirement, the medical services, supply or **prescription drug** must be provided by a **physician**, or other health care provider, exercising prudent clinical judgment, to a patient for the purpose of preventing, evaluating, diagnosing or treating an **illness**, **injury**, disease or its symptoms. The provision of the service or supply must be:

   (a) In accordance with generally accepted standards of medical practice;
   (b) Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's **illness**, **injury** or disease; and
   (c) Not primarily for the convenience of the patient, **physician** or other health care provider;
   (d) And not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's **illness**, **injury**, or disease.

For these purposes "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, or otherwise consistent with **physician** specialty society recommendations and the views of **physicians** practicing in relevant clinical areas and any other relevant factors.

Important Note
Not every service, supply or **prescription drug** that fits the definition for **medical necessity** is covered by the plan. Exclusions and limitations apply to certain medical services, supplies and expenses. For example some benefits are limited to a certain number of days, visits or a dollar maximum. Refer to the *What the Plan Covers* section and the *Schedule of Benefits* for the plan limits and maximums.

What The Plan Covers

Wellness

Physician Services

Hospital Expenses

Other Medical Expenses

Aetna Choice POS II Medical Plan

Many preventive and routine medical expenses as well as expenses incurred for a serious **illness** or **injury** are covered. This section describes which expenses are **covered expenses**. Only expenses incurred for the services and supplies shown in this section are **covered expenses**. Limitations and exclusions apply.

Preventive Care

This section on Preventive Care describes the **covered expenses** for services and supplies provided when you are well.

Important Notes:

1. The recommendations and guidelines of the:
   - Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
   - United States Preventive Services Task Force;
   - Health Resources and Services Administration; and
   - American Academy of Pediatric/Bright Futures Guidelines for Children and Adolescents.

   as referenced throughout this *Preventive Care* section may be updated periodically. This Plan is subject to updated recommendations or guidelines that are issued by these organizations beginning on the first day of the plan year, one year after the recommendation or guideline is issued.

2. If any diagnostic x-rays, lab, or other tests or procedures are ordered, or given, in connection with any of the *Preventive Care* benefits described below, those tests or procedures will not be covered as *Preventive Care* benefits. Those tests and procedures that are **covered expenses** will be subject to the cost-sharing that applies to those specific services under this Plan.

3. Refer to the Schedule of Benefits for information about cost-sharing and maximums that apply to *Preventive Care* benefits.

Routine Physical Exams

Covered expenses include charges made by your **physician** for routine physical exams. This includes routine vision and hearing screenings given as part of the routine physical exam. A routine exam is a medical exam given by a **physician** for a reason other than to diagnose or treat a suspected or identified **illness** or **injury**, and also includes:

- Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force.
- Services as recommended in the American Academy of Pediatrics/Bright Futures Guidelines for Children and Adolescents.
- Screenings and counseling services as provided for in the comprehensive guidelines recommended by the Health Resources and Services Administration. These services may include but are not limited to:
  - Screening and counseling services, such as:

        - Interpersonal and domestic violence;
        - Sexually transmitted diseases; and
        - Human Immune Deficiency Virus (HIV) infections.
    - Screening for gestational diabetes for women.
    - High risk Human Papillomavirus (HPV) DNA testing for women age 30 and older.
- X-rays, lab and other tests given in connection with the exam.
- For covered newborns, an initial **hospital** check up.

Limitations:
Unless specified above, not covered under this Preventive Care benefit are charges for:
- Services which are covered to any extent under any other part of this Plan;
- Services which are for diagnosis or treatment of a suspected or identified **illness** or **injury**;
- Exams given during your **stay** for medical care;
- Services not given by a **physician** or under his or her direction;
- Psychiatric, psychological, personality or emotional testing or exams;

Preventive Care Immunizations
Covered expenses include charges made by your **physician** or a facility for:

- immunizations for infectious diseases; and
- the materials for administration of immunizations;

that have been recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

Limitations
Not covered under this Preventive Care benefit are charges incurred for immunizations that are not considered Preventive Care such as those required due to your employment or travel.

Well Woman Preventive Visits
Covered expenses include charges made by your **physician obstetrician, or gynecologist for:**
- a routine well woman preventive exam office visit, including Pap smears. A routine well woman preventive exam is a medical exam given by a **physician** for a reason other than to diagnose or treat a suspected or identified **illness** or **injury;** and
- routine preventive care breast cancer genetic counseling and breast cancer (BRCA) gene blood testing. Covered expenses include charges made by a physician and lab for the BRCA gene blood test and charges made by a genetic counselor to interpret the test results and evaluate treatment.

These benefits will be subject to any age; family history; and frequency guidelines that are:
- Evidence-based items or services that have in effect a rating of A or B in the recommendations of the United States Preventive Services Task Force; and
- Evidence-informed items or services provided in the comprehensive guidelines supported by the Health Resources and Services Administration.

Limitations:
Unless specified above, not covered under this Preventive Care benefit are charges for:
- Services which are covered to any extent under any other part of this Plan;
- Services which are for diagnosis or treatment of a suspected or identified **illness** or **injury**;
- Exams given during your **stay** for medical care;
- Services not given by a **physician** or under his or her direction;
- Psychiatric, psychological, personality or emotional testing or exams.

Routine Cancer Screenings

Covered expenses include, but are not limited to, charges incurred for routine cancer screening as follows:

- Mammograms;
- Fecal occult blood tests;
- Digital rectal exams;
- Prostate specific antigen (PSA) tests;
- Sigmoidoscopies;
- Double contrast barium enemas (DCBE)
- Colonoscopies (removal of polyps performed during a screening procedure is a covered expense); and
- Lung cancer screening.

These benefits will be subject to any age; family history; and frequency guidelines that are:

- Evidence-based items or services that have in effect a rating of A or B in the recommendations of the United States Preventive Services Task Force; and
- Evidence-informed items or services provided in the comprehensive guidelines supported by the Health Resources and Services Administration.

Limitations:
Unless specified above, not covered under this Preventive Care benefit are charges incurred for:

- Services which are covered to any extent under any other part of this Plan.

Important Notes:
Refer to the *Schedule of Benefits* for details about cost sharing and benefit maximums that apply to Preventive Care. For details on the frequency and age limits that apply to Routine Physical Exams and Routine Cancer Screenings, contact your **physician** or Member Services by logging onto the **Aetna** website www.aetna.com, or calling the number on the back of your ID card.

Screening and Counseling Services

Covered expenses include charges made by your **primary care physician** in an individual or group setting for the following:

Obesity and/or Healthy Diet
Screening and counseling services to aid in weight reduction due to obesity. Coverage includes:

- preventive counseling visits and/or risk factor reduction intervention;
- nutrition counseling; and
- healthy diet counseling visits provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease.

Misuse of Alcohol and/or Drugs
Screening and counseling services to aid in the prevention or reduction of the use of an alcohol agent or controlled substance. Coverage includes preventive counseling visits, risk factor reduction intervention and a structured assessment.

Use of Tobacco Products
Screening and counseling services to aid in the cessation of the use of tobacco products. Tobacco product means a substance containing tobacco or nicotine including: cigarettes, cigars; smoking tobacco; snuff; smokeless tobacco and candy-like products that contain tobacco. Coverage includes:

- preventive counseling visits;
- treatment visits; and
- class visits;

to aid in the cessation of the use of tobacco products.

Sexually Transmitted Infections
Covered expenses include the counseling services to help you prevent or reduce sexually transmitted infections.

Genetic Risks for Breast and Ovarian Cancer
Covered expenses include the counseling and evaluation services to help you assess your breast and ovarian cancer susceptibility.

Benefits for the screening and counseling services above are subject to any visit maximums shown in your Schedule of Benefits.

Limitations:
Unless specified above, not covered under this Preventive Care benefit are charges incurred for:

- Services which are covered to any extent under any other part of this Plan.

Prenatal Care

Prenatal care will be covered as Preventive Care for services received by a pregnant female in a physician's, obstetrician's, or gynecologist's office but only to the extent described below.

Coverage for prenatal care under this Preventive Care benefit is limited to pregnancy-related physician office visits including the initial and subsequent history and physical exams of the pregnant woman (maternal weight, blood pressure, fetal heart rate check, and fundal height).

Limitations:
Unless specified above, not covered under this Preventive Care benefit are charges incurred for:

- Services which are covered to any extent under any other part of this Plan;
- Pregnancy expenses (other than prenatal care as described above).

Important Notes:
Refer to the *Pregnancy Expenses* and *Exclusions* sections of this Booklet for more information on coverage for pregnancy expenses under this Plan, including other prenatal care, delivery and postnatal care office visits.

Comprehensive Lactation Support and Counseling Services

Covered expenses include comprehensive lactation support (assistance and training in breast feeding) and counseling services provided to females during pregnancy, or at any time following delivery, for breast-feeding by a certified lactation support provider. **Covered expenses** also include the rental or purchase of breast feeding equipment as described below.

Lactation support and lactation counseling services are **covered expenses** when provided in either a group or individual setting. Benefits for lactation counseling services are subject to the visit maximum shown in your *Schedule of Benefits*.

Breast Feeding Durable Medical Equipment
Coverage includes the rental or purchase of breast feeding **durable medical equipment** for the purpose of lactation support (pumping and storage of breast milk) as follows.

Breast Pump
Covered expenses include the following:
- The rental of a hospital-grade electric pump for a newborn child when the newborn child is confined in a **hospital**.
- The purchase of:
  - An electric breast pump (non-hospital grade). A purchase will be covered once every three years; or
  - A manual breast pump. A purchase will be covered once per pregnancy.
- If an electric breast pump was purchased within the previous three year period, the purchase of another breast pump will not be covered until a three year period has elapsed from the last purchase.

Breast Pump Supplies
Coverage is limited to only one purchase per pregnancy in any year where a covered female would not qualify for the purchase of a new pump.

Coverage for the purchase of breast pump equipment is limited to one item of equipment, for the same or similar purpose, and the accessories and supplies needed to operate the item. You are responsible for the entire cost of any additional pieces of the same or similar equipment you purchase or rent for personal convenience or mobility.

Aetna reserves the right to limit the payment of charges up to the most cost efficient and least restrictive level of service or item which can be safely and effectively provided. The decision to rent or purchase is at the discretion of **Aetna**.

Limitations:
Unless specified above, not covered under this *Preventive Care* benefit are charges incurred for services which are covered to any extent under any other part of this Plan.

Family Planning Services - Female Contraceptives
For females with reproductive capacity, **covered expenses** include those charges incurred for services and supplies that are provided to prevent pregnancy. All contraceptive methods, services and supplies covered under this Preventive Care benefit must be approved by the U.S. Food and Drug Administration (FDA).

Coverage includes counseling services on contraceptive methods provided by a **physician**, obstetrician or gynecologist. Such counseling services are **covered expenses** when provided in either a group or individual setting. They are subject to the contraceptive counseling services visit maximum shown in your *Schedule of Benefits***.**

The following contraceptive methods are **covered expenses** under this Preventive Care benefit:

Voluntary Sterilization
Covered expenses include charges billed separately by the provider for female voluntary sterilization procedures and related services and supplies including, but not limited to, tubal ligation and sterilization implants.

Covered expenses under this *Preventive Care* benefit would not include charges for a voluntary sterilization procedure to the extent that the procedure was not billed separately by the provider or because it was not the primary purpose of a confinement.

Contraceptives
Contraceptives can be paid either under your medical plan or **pharmacy** plan depending on the type of expense and how and where the expense is incurred. Benefits are paid under your medical plan for female contraceptive

prescription drugs and devices (including any related services and supplies) when they are provided, administered, or removed, by a **physician** during an office visit.

Important Note:
For a list of the types of female contraceptives covered under this Plan, refer to the section *What the Pharmacy Plan Covers* and the *Contraceptives* benefit later in this Booklet.

Limitations:
Unless specified above, not covered under this Preventive Care benefit are charges for:

- Services which are covered to any extent under any other part of this Plan;
- Services and supplies incurred for an abortion;
- Services provided as a result of complications resulting from a voluntary sterilization procedure and related follow-up care;
- Services which are for the treatment of an identified **illness** or **injury**;
- Services that are not given by a **physician** or under his or her direction;
- Psychiatric, psychological, personality or emotional testing or exams;
- Any contraceptive methods that are only "reviewed" by the FDA and not "approved" by the FDA;
- Male contraceptive methods, sterilization procedures or devices;
- The reversal of voluntary sterilization procedures, including any related follow-up care;
- Services and supplies furnished by an **out-of-network provider**.

Family Planning Services - Other

Covered expenses include charges for certain family planning services, even though not provided to treat an illness or injury.

- Voluntary sterilization for males

Limitations:
Not covered are:

- Voluntary termination of pregnancy;
- Reversal of voluntary sterilization procedures, including related follow-up care;
- Charges for services which are covered to any extent under any other part of this Plan or any other group plans sponsored by your employer; and
- Charges incurred for family planning services while confined as an inpatient in a hospital or other facility for medical care.

Important Notes:
Refer to the Schedule of Benefits for details about cost sharing and benefit maximums that apply to Family Planning Services - Other. For more information, see the sections on Family Planning Services - Female Contraceptives, Pregnancy Expenses and Treatment of Infertility in this Booklet.

Vision Care Services

Covered expenses include charges made by a legally qualified ophthalmologist or optometrist for the following services:

- ***Routine*** eye exam: The plan covers expenses for a complete routine eye exam that includes refraction and glaucoma testing. A routine eye exam does not include a contact lens exam. The plan covers charges for one routine eye exam in any Plan Year consecutive month period.

Limitations

Coverage is subject to any applicable Plan Year **deductibles**, **copays** and **payment** percentages shown in your *Schedule of Benefits*.

Hearing Exam

Covered expenses include charges for an audiometric hearing exam if the exam is performed by:

- A **physician** certified as an otolaryngologist or otologist; or
- An audiologist who:
  - Is legally qualified in audiology; or
  - Holds a certificate of Clinical Competence in Audiology from the American Speech and Hearing Association (in the absence of any applicable licensing requirements); and
  - Performs the exam at the written direction of a legally qualified otolaryngologist or otologist.

The plan will not cover expenses for charges for more than one hearing exam for any 36-month period.

All **covered expenses** for the hearing exam are subject to any applicable **deductible**, **copay** and **payment percentage** shown in your *Schedule of Benefits*.

Physician Services

Physician Visits

Covered medical expenses include charges made by a **physician** during a visit to treat an **illness** or **injury**. The visit may be at the **physician**'s office, in your home, in a **hospital** or other facility during your **stay** or in an outpatient facility. **Covered expenses** also include:

- Immunizations for infectious disease, but not if solely for your employment;
- Allergy testing, treatment and injections; and
- Charges made by the **physician** for supplies, radiological services, x-rays, and tests provided by the **physician**.

Surgery

Covered expenses include charges made by a **physician** for:

- Performing your surgical procedure;
- Pre-operative and post-operative visits; and
- Consultation with another **physician** to obtain a second opinion prior to the surgery.

Anesthetics

Covered expenses include charges for the administration of anesthetics and oxygen by a **physician**, other than the operating **physician**, or Certified Registered Nurse Anesthetist (C.R.N.A.) in connection with a covered procedure.

Important Reminder
Certain procedures need to be **precertified** by **Aetna**. Refer to *How the Plan Works* for more information about **precertification**.

Alternatives to Physician Office Visits

Walk-In Clinic Visits

Covered expenses include charges made by **walk-in clinics** for:

- Unscheduled, non-emergency illnesses and injuries;
- The administration of certain immunizations administered within the scope of the clinic's license; and
- Individual screening and counseling services to aid you:
  - to stop the use of tobacco products;
  - in weight reduction due to obesity.

Unless specified above, not covered under this benefit are charges incurred for services and supplies furnished:

- In a group setting for screening and counseling services.

Important Note:
- Not all services are available at all Walk-In Clinics. The types of services offered will vary by the provider and location of the clinic.
- For a complete description of the screening and counseling services provided on the use of tobacco products and to aid in weight reduction due to obesity, refer to the *Preventive Care Benefits* section in this Booklet and the *Screening and Counseling Services* benefit for a description of these services. These services may also be obtained from your physician

E-Visits
Covered expenses include charges made by your network **primary care physician (PCP)** for a routine, non-emergency, medical consultation. You must make your **E-visit** through an **Aetna** authorized internet service vendor. You may have to register with that internet service vendor. Information about providers who are signed up with an authorized vendor may be found in the provider Directory or online in DocFind on www.Aetna.com or by calling the number on your identification card.

Hospital Expenses

Covered medical expenses include services and supplies provided by a **hospital** during your **stay**.

Room and Board
Covered expenses include charges for **room and board** provided at a **hospital** during your **stay**. Private room charges that exceed the **hospital**'s **semi-private room rate** are not covered unless a private room is required because of a contagious **illness** or immune system problem.

Room and board charges also include:

- Services of the **hospital's** nursing staff;
- Admission and other fees;
- General and special diets; and
- Sundries and supplies.

Other Hospital Services and Supplies
Covered expenses include charges made by a **hospital** for services and supplies furnished to you in connection with your **stay**.

Covered expenses include hospital charges for other services and supplies provided, such as:

- **Ambulance** services.
- **Physicians** and surgeons.
- Operating and recovery rooms.
- Intensive or special care facilities.
- Administration of blood and blood products, but not the cost of the blood or blood products.
- Radiation therapy.
- Speech therapy, physical therapy and occupational therapy.
- Oxygen and oxygen therapy.
- Radiological services, laboratory testing and diagnostic services.
- Medications.
- Intravenous (IV) preparations.
- Discharge planning.

Outpatient Hospital Expenses

Covered expenses include **hospital** charges made for covered services and supplies provided by the outpatient department of a **hospital**.

Important Reminders
The plan will only pay for nursing services provided by the **hospital** as part of its charge. The plan does *not* cover private duty nursing services as part of an inpatient **hospital** stay.

If a **hospital** or other health care facility does not itemize specific **room and board** charges and other charges, **Aetna** will assume that 40 percent of the total is for **room and board** charge, and 60 percent is for other charges.

Hospital admissions need to be **precertified** by **Aetna**. Refer to *How the Plan Works* for details about **precertification**.

In addition to charges made by the **hospital**, certain **physicians** and other providers may bill you separately during your stay.

Refer to the *Schedule of Benefits* for any applicable **deductible**, **copay** and **payment percentage** and maximum benefit limits.

Coverage for Emergency Medical Conditions

Covered expenses include charges made by a **hospital** or a **physician** for services provided in an emergency room to evaluate and treat an **emergency medical condition**.

The **emergency care** benefit covers:

- Use of emergency room facilities;
- Emergency room **physicians** services;
- **Hospital** nursing staff services; and
- Radiologists and pathologists services.

Please contact your **physician** after receiving treatment for an **emergency medical condition**.

Important Reminder
With the exception of Urgent Care described below, if you visit a **hospital** emergency room for a non-emergency condition, the plan will not cover your expenses, as shown in the *Schedule of Benefits*. No other plan benefits will pay for non-emergency care in the emergency room.

Coverage for Urgent Conditions

Covered expenses include charges made by a **hospital** or **urgent care provider** to evaluate and treat an **urgent condition**.

Your coverage includes:

- Use of emergency room facilities when network urgent care facilities are not in the service area and you cannot reasonably wait to visit your **physician**;
- Use of urgent care facilities;
- **Physicians** services;
- Nursing staff services; and
- Radiologists and pathologists services.

Please contact your **PCP** after receiving treatment of an **urgent condition**.

If you visit an **urgent care provider** for a non-**urgent condition**, the plan will not cover your expenses, as shown in the *Schedule of Benefits*.

Alternatives to Hospital Stays

Outpatient Surgery and Physician Surgical Services

Covered expenses include charges for services and supplies furnished in connection with outpatient surgery made by:

- A **physician** or **dentist** for professional services;
- A **surgery center**; or
- The outpatient department of a **hospital**.

The surgery must meet the following requirements:

- The surgery can be performed adequately and safely only in a **surgery center** or **hospital** and
- The surgery is not normally performed in a **physician**'s or **dentist**'s office.

Important Note
Benefits for surgery services performed in a **physician**'s or **dentist**'s office are described under Physician Services benefits in the previous section.

The following outpatient surgery expenses are covered:

- Services and supplies provided by the **hospital**, **surgery center** on the day of the procedure;
- The operating **physician**'s services for performing the procedure, related pre- and post-operative care, and administration of anesthesia; and
- Services of another **physician** for related post-operative care and administration of anesthesia. This does not include a local anesthetic.

Limitations

Not covered under this plan are charges made for:

- The services of a **physician** or other health care provider who renders technical assistance to the operating **physician**.
- A **stay** in a **hospital**.
- Facility charges for office based surgery.

Birthing Center

Covered expenses include charges made by a **birthing center** for services and supplies related to your care in a **birthing center** for:

- Prenatal care;
- Delivery; and
- Postpartum care within 48 hours after a vaginal delivery and 96 hours after a Cesarean delivery.

Limitations

Unless specified above, not covered under this benefit are charges:

- In connection with a pregnancy for which pregnancy related expenses are not included as a covered expense.

See *Pregnancy Related Expenses* for information about other **covered expenses** related to maternity care.

Home Health Care

Covered expenses include charges for home health care services when ordered by a **physician** as part of a home health plan and provided you are:

- Transitioning from a **hospital** or other inpatient facility, and the services are in lieu of a continued inpatient **stay**; or
- **Homebound**

Covered expenses include only the following:

- **Skilled nursing services** that require medical training of, and are provided by, a licensed nursing professional within the scope of his or her license. These services need to be provided during intermittent visits of 4 hours or less, with a daily maximum of 3 visits. Intermittent visits are considered periodic and recurring visits that skilled nurses make to ensure your proper care, which means they are not on site for more than four hours at a time. If you are discharged from a **hospital** or **skilled nursing facility** after an inpatient **stay**, the intermittent requirement may be waived to allow coverage for up to 12 hours (3 visits) of continuous **skilled nursing services**. However, these services must be provided for within 10 days of discharge.
- Home health aide services, when provided in conjunction with skilled nursing care, that directly support the care. These services need to be provided during intermittent visits of 4 hours or less, with a daily maximum of 3 visits.
- Medical social services, when provided in conjunction with skilled nursing care, by a qualified social worker.
- Skilled behavioral health care services provided in the home by a **behavioral health provider** when ordered by a **physician** and directly related to an active treatment plan of care established by the **physician**. All of the following must be met:
  - The skilled behavioral health care is appropriate for the active treatment of a condition, **illness** or disease to avoid placing you at risk for serious complications.
  - The services are in lieu of a continued confinement in a **hospital** or **residential treatment facility**, or receiving outpatient services outside of the home.
  - You are **homebound** because of **illness** or **injury**.
  - The services provided are not primarily for comfort, convenience or custodial in nature.
  - The services are intermittent or hourly in nature.
  - The services are not for Applied Behavior Analysis.

Benefits for home health care visits are payable up to the Home Health Care Maximum. Each visit by a nurse, **behavioral health provider** or therapist is 1 visit.

In figuring the Plan Year Maximum Visits, each visit of a:

- Nurse or Therapist, up to 4 hours is 1 visit and
- **behavioral health provider**, of up to 1 hour, is 1 visit.

This maximum will not apply to care given by an **R.N.** or **L.P.N.** when:

- Care is provided within 10 days of discharge from a **hospital** or **skilled nursing facility** as a full-time inpatient; and
- Care is needed to transition from the **hospital** or **skilled nursing facility** to home care.

When the above criteria are met, **covered expenses** include up to 12 hours of continuous care by an **R.N.** or **L.P.N.** per day.

Coverage for Home Health Care services is not determined by the availability of caregivers to perform them. The absence of a person to perform a non-skilled or **custodial care** service does not cause the service to become covered. If the covered person is a minor or an adult who is dependent upon others for non-skilled care (e.g. bathing, eating, toileting), coverage for home health services will only be provided during times when there is a family member or caregiver present in the home to meet the person's non-skilled needs.

Note: Home short-term physical, speech, or occupational therapy is covered when the above home health care criteria are met. Services are subject to the conditions and limitations listed in the Short Term Rehabilitation Therapies section of the *Schedule of Benefits*.

Limitations

Unless specified above, *not* covered under this benefit are charges for:

- Services or supplies that are not a part of the **Home Health Care Plan**.
- Services of a person who usually lives with you, or who is a member of your or your spouse's family.
- Services of a certified or licensed social worker.
- Services for physical, occupational and speech therapy. Refer to Short Term Rehabilitation Therapies section for coverage information.
- Services for Infusion Therapy.
- Transportation.
- Services or supplies provided to a minor or dependent adult when a family member or caregiver is not present.
- Services that are **custodial care**.

Important Reminders

The plan does *not* cover **custodial care**, even if care is provided by a nursing professional, and family member or other caretakers cannot provide the necessary care.

Home health care needs to be **precertified** by **Aetna**. Refer to the *How the Plan Works* section for details about **precertification**.

Refer to the *Schedule of Benefits* for details about any applicable home health care visit maximums.

Private Duty Nursing

Covered expenses include private duty nursing provided by a **R.N.** or **L.P.N.** if the person's condition requires **skilled nursing** care and visiting nursing care is not adequate. However, **covered expenses** will not include private duty nursing for any shifts during a Plan Year in excess of the Private Duty Nursing Care Maximum Shifts. Each period of private duty nursing of up to 8 hours will be deemed to be one private duty nursing shift.

The plan also covers skilled observation for up to one four-hour period per day, for up to 10 consecutive days following:

- A change in your medication;
- Treatment of an urgent or **emergency medical condition** by a **physician**;
- The onset of symptoms indicating a need for emergency treatment;
- Surgery;
- An inpatient **stay**.

Limitations

Unless specified above, *not* covered under this benefit are charges for:

- Nursing care that does not require the education, training and technical skills of a **R.N.** or **L.P.N.**
- Nursing care assistance for daily life activities, such as:
  - Transportation;
  - Meal preparation;
  - Vital sign charting;
  - Companionship activities;
  - Bathing;
  - Feeding;

  - Personal grooming;
  - Dressing;
  - Toileting; and
  - Getting in/out of bed or a chair.
- Nursing care provided for skilled observation.
- Nursing care provided while you are an inpatient in a **hospital** or health care facility.
- A service provided solely to administer oral medicine, except where law requires a **R.N.** or **L.P.N.** to administer medicines.

Skilled Nursing Facility

Covered expenses include charges made by a **skilled nursing facility** during your **stay** for the following services and supplies, up to the maximums shown in the *Schedule of Benefits*, including:

- **Room** and **board**, up to the **semi-private room rate**. The plan will cover up to the private room rate if it is needed due to an infectious illness or a weak or compromised immune system;
- Use of special treatment rooms;
- Radiological services and lab work;
- Physical, occupational, or speech therapy;
- Oxygen and other gas therapy;
- Other medical services and general nursing services usually given by a **skilled nursing facility** (this does not include charges made for private or special nursing, or **physician's** services); and
- Medical supplies.

Important Reminder
Refer to the *Schedule of Benefits* for details about any applicable **skilled nursing facility** maximums.

Admissions to a **skilled nursing facility** must be **precertified** by **Aetna**. Refer to *Using Your Medical Plan* for details about **precertification**.

Limitations

Unless specified above, *not* covered under this benefit are charges for:

- Charges made for the treatment of:
  - Drug addiction;
  - Alcoholism;
  - Senility;
  - Mental retardation; or
  - Any other mental illness; and
- Daily **room and board** charges over the **semi private rate**.

Hospice Care

Covered expenses include charges made by the following furnished to you for **hospice care** when given as part of a **hospice care program**.

Facility Expenses

The charges made by a **hospital**, **hospice** or **skilled nursing facility** for:

- **Room and Board** and other services and supplies furnished during a **stay** for pain control and other acute and chronic symptom management; and
- Services and supplies furnished to you on an outpatient basis.

Outpatient Hospice Expenses

Covered expenses include charges made on an outpatient basis by a **Hospice Care Agency** for:

- Part-time or intermittent nursing care by a **R.N.** or **L.P.N.** for up to eight hours a day;
- Part-time or intermittent home health aide services to care for you up to eight hours a day.
- Medical social services under the direction of a **physician**. These include but are not limited to:
  - Assessment of your social, emotional and medical needs, and your home and family situation;
  - Identification of available community resources; and
  - Assistance provided to you to obtain resources to meet your assessed needs.
- Physical and occupational therapy; and
- Consultation or case management services by a **physician**;
- Medical supplies;
- Prescription drugs;
- Dietary counseling; and
- Psychological counseling.

Charges made by the providers below if they are not an employee of a **Hospice Care Agency**; and such Agency retains responsibility for your care:

- A **physician** for a consultation or case management;
- A physical or occupational therapist;
- A **home health care agency** for:
  - Physical and occupational therapy;
  - Part time or intermittent home health aide services for your care up to eight hours a day;
  - Medical supplies;
  - **Prescription drugs**;
  - Psychological counseling; and
  - Dietary counseling.

Limitations

Unless specified above, *not* covered under this benefit are charges for:

- Daily **room and board** charges over the **semi-private room rate**.
- Funeral arrangements.
- Pastoral counseling.
- Financial or legal counseling. This includes estate planning and the drafting of a will.
- Homemaker or caretaker services. These are services which are not solely related to your care. These include, but are not limited to: sitter or companion services for either you or other family members; transportation; maintenance of the house.

Important Reminders

Refer to the *Schedule of Benefits* for details about any applicable **hospice care** maximums.

Inpatient **hospice care** and home health care must be **precertified** by **Aetna**. Refer to *How the Plan Works* for details about **precertification**.

Other Covered Health Care Expenses

Acupuncture

The plan covers charges made for acupuncture services provided by a **physician**, if the service is performed:

- As a form of anesthesia in connection with a covered surgical procedure.

Important Reminder
Refer to the *Schedule of Benefits* for details about any applicable acupuncture benefit maximum.

Ambulance Service

Covered expenses include charges made by a professional **ambulance**, as follows:

Ground Ambulance

Covered expenses include charges for transportation:

- To the first **hospital** where treatment is given in a medical emergency.
- From one **hospital** to another **hospital** in a medical emergency when the first **hospital** does not have the required services or facilities to treat your condition.
- From **hospital** to home or to another facility when other means of transportation would be considered unsafe due to your medical condition.
- From home to **hospital** for covered inpatient or outpatient treatment when other means of transportation would be considered unsafe due to your medical condition. Transport is limited to 100 miles.
- When during a covered inpatient **stay** at a **hospital**, **skilled nursing facility** or acute rehabilitation **hospital**, an **ambulance** is required to safely and adequately transport you to or from inpatient or outpatient **medically necessary** treatment.

Air or Water Ambulance

Covered expenses include charges for transportation to a **hospital** by air or water **ambulance** when:

- Ground **ambulance** transportation is not available; and
- Your condition is unstable, and requires medical supervision and rapid transport; and
- In a medical emergency, transportation from one **hospital** to another **hospital**; when the first **hospital** does not have the required services or facilities to treat your condition and you need to be transported to another **hospital**; and the two conditions above are met.

Limitations

Not covered under this benefit are charges incurred to transport you:

- If an **ambulance** service is not required by your physical condition; or
- If the type of **ambulance** service provided is not required for your physical condition; or
- By any form of transportation other than a professional **ambulance** service; or
- By fixed wing air ambulance from an **out-of-network provider**.

Diagnostic and Preoperative Testing

Diagnostic Complex Imaging Expenses

The plan covers charges made on an outpatient basis by a **physician**, **hospital** or a licensed imaging or radiological facility for complex imaging services to diagnose an **illness** or **injury**, including:

- C.A.T. scans;
- Magnetic Resonance Imaging (MRI);

- Nuclear medicine imaging including positron emission tomography (PET) Scans; and
- Any other outpatient diagnostic imaging service where the **recognized charge** exceeds $500.

Complex Imaging Expenses for preoperative testing will be payable under this benefit.

Limitations

The plan does not cover diagnostic complex imaging expenses under this part of the plan if such imaging expenses are covered under any other part of the plan.

Outpatient Diagnostic Lab Work and Radiological Services

Covered expenses include charges for radiological services (other than diagnostic complex imaging), lab services, and pathology and other tests provided to diagnose an **illness** or **injury**. You must have definite symptoms that start, maintain or change a plan of treatment prescribed by a **physician**. The charges must be made by a **physician**, **hospital** or licensed radiological facility or lab.

Important Reminder
Refer to the *Schedule of Benefits* for details about any **deductible**, **payment percentage** and maximum that may apply to outpatient diagnostic testing, and lab and radiological services.

Outpatient Preoperative Testing

Prior to a scheduled covered surgery, **covered expenses** include charges made for tests performed by a **hospital**, **surgery center**, **physician** or licensed diagnostic laboratory provided the charges for the surgery are **covered expenses** and the tests are:

- Related to your surgery, and the surgery takes place in a **hospital** or **surgery center**;
- Completed within 14 days before your surgery;
- Performed on an outpatient basis;
- Covered if you were an inpatient in a **hospital**;
- Not repeated in or by the **hospital** or **surgery center** where the surgery will be performed.
- Test results should appear in your medical record kept by the **hospital** or **surgery center** where the surgery is performed.

Limitations

The plan does not cover diagnostic complex imaging expenses under this part of the plan if such imaging expenses are covered under any other part of the plan.

- If your tests indicate that surgery should not be performed because of your physical condition, the plan will pay for the tests, however surgery will ***not*** be covered.

Important Reminder
Complex Imaging testing for preoperative testing is covered under the complex imaging section. Separate cost sharing may apply. Refer to your *Schedule of Benefits* for information on cost sharing amounts for complex imaging.

Durable Medical and Surgical Equipment (DME)

Covered expenses include charges by a **DME** supplier for the rental of equipment or, in lieu of rental:

The initial purchase of **DME** if:

- Long term care is planned; and
- The equipment cannot be rented or is likely to cost less to purchase than to rent.

Repair of purchased equipment. Maintenance and repairs needed due to misuse or abuse are not covered.

Replacement of purchased equipment if:

- The replacement is needed because of a change in your physical condition; and
- It is likely to cost less to replace the item than to repair the existing item or rent a similar item.

The plan limits coverage to one item of equipment, for the same or similar purpose and the accessories needed to operate the item. You are responsible for the entire cost of any additional pieces of the same or similar equipment you purchase or rent for personal convenience or mobility.

Covered **Durable Medical Equipment** includes those items covered by Medicare unless excluded in the Exclusions section of this Booklet. **Aetna** reserves the right to limit the payment of charges up to the most cost efficient and least restrictive level of service or item which can be safely and effectively provided. The decision to rent or purchase is at the discretion of **Aetna**.

Important Reminder
Refer to the *Schedule of Benefits* for details about **durable medical and surgical equipment deductible**, **payment percentage** and benefit maximums. Also refer to *Exclusions* for information about Home and Mobility exclusions.

Clinical Trials

*Clinical Trial Therapies (**Experimental or Investigational**)*

Covered expenses include charges made for **experimental or investigational** drugs, devices, treatments or procedures "under an approved clinical trial" only when you have cancer or a terminal illness, and ***all*** of the following conditions are met:

- Standard therapies have not been effective or are inappropriate;
- **Aetna** determines, based on published, peer-reviewed scientific evidence that you may benefit from the treatment; and
- You are enrolled in an approved clinical trial that meets these criteria.

An "approved clinical trial" is a clinical trial that meets these criteria:
- The FDA has approved the drug, device, treatment, or procedure to be investigated or has granted it investigational new drug (IND) or group c/treatment IND status. This requirement does not apply to procedures and treatments that do not require FDA approval.
- The clinical trial has been approved by an Institutional Review Board that will oversee the investigation.
- The clinical trial is sponsored by the National Cancer Institute (NCI) or similar federal organization.
- The trial conforms to standards of the NCI or other, applicable federal organization.
- The clinical trial takes place at an NCI-designated cancer center or takes place at more than one institution.
- You are treated in accordance with the protocols of that study.

Routine Patient Costs

Covered expenses include charges made by a provider for "routine patient costs" furnished in connection with your participation in an "approved clinical trial" for cancer or other life-threatening disease or condition, as those terms are defined in the federal Public Health Service Act, Section 2709.

Limitations:
Not covered under this Plan are:
- Services and supplies related to data collection and record-keeping that is solely needed due to the clinical trial (i.e. protocol-induced costs);
- Services and supplies provided by the trial sponsor without charge to you; and

- The experimental intervention itself (except medically necessary Category B investigational devices and promising experimental or investigational interventions for terminal illnesses in certain clinical trials in accordance with Aetna's claim policies).

Important Note:
1. Refer to the *Schedule of Benefits* for details about cost sharing and any benefit maximums that apply to the Clinical Trial benefit.
2. These Clinical Trial benefits are subject to all of the terms, conditions, provisions, limitations, and exclusions of this Plan including, but not limited to, any precertification and referral requirements.

Pregnancy Related Expenses

Covered expenses include charges made by a **physician** for pregnancy and childbirth services and supplies at the same level as any **illness** or **injury**. This includes prenatal visits, delivery and postnatal visits.

For inpatient care of the mother and newborn child, **covered expenses** include charges made by a **Hospital** for a minimum of:

- 48 hours after a vaginal delivery; and
- 96 hours after a cesarean section.
- A shorter stay, if the attending **physician**, with the consent of the mother, discharges the mother or newborn earlier.

Covered expenses also include charges made by a **birthing center** as described under Alternatives to **Hospital** Care.

Note: **Covered expenses** also include services and supplies provided for circumcision of the newborn during the stay.

Important Note:

Refer to the *Preventive Care* section of this *Booklet* for additional information on coverage for female contraceptive coverage under this Plan.

Prosthetic Devices

Covered expenses include charges made for internal and external prosthetic devices and special appliances, if the device or appliance improves or restores body part function that has been lost or damaged by **illness**, **injury** or congenital defect. **Covered expenses** also include instruction and incidental supplies needed to use a covered prosthetic device.

The plan covers the first prosthesis you need that temporarily or permanently replaces all or part of a body part lost or impaired as a result of disease or injury or congenital defects as described in the list of covered devices below for an:

- Internal body part or organ; or
- External body part.

Covered expenses also include replacement of a prosthetic device if:

- The replacement is needed because of a change in your physical condition; or normal growth or wear and tear; or
- It is likely to cost less to buy a new one than to repair the existing one; or
- The existing one cannot be made serviceable.

The list of covered devices includes but is not limited to:

- An artificial arm, leg, hip, knee or eye;
- Eye lens;
- An external breast prosthesis and the first bra made solely for use with it after a mastectomy;
- A breast implant after a mastectomy;
- Ostomy supplies, urinary catheters and external urinary collection devices;
- Speech generating device;
- A cardiac pacemaker and pacemaker defibrillators; and
- A durable brace that is custom made for and fitted for you.

The plan will not cover expenses and charges for, or expenses related to:

- Orthopedic shoes, therapeutic shoes, foot orthotics, or other devices to support the feet; unless the orthopedic shoe is an integral part of a covered leg brace; or
- Trusses, corsets, and other support items; or
- Any item listed in the *Exclusions* section.

Hearing Aids

Covered hearing care expenses include charges for electronic hearing aids (monaural and binaural), installed in accordance with a **prescription** written during a covered hearing exam.

Benefits are payable up to the hearing supply maximum listed in the Schedule of Benefits.

All **covered expenses** are subject to the hearing expense exclusions in this *Booklet-* and are subject to **deductible(s)**, **copayments** or **payment percentage** listed in the *Schedule of Benefits*, if any.

Benefits After Termination of Coverage

Expenses incurred for hearing aids within 30 days of termination of the person's coverage under this benefit section will be deemed to be covered hearing care expenses if during the 30 days before the date coverage ends:

- The **prescription** for the hearing aid was written; and
- The hearing aid was ordered.

Short-Term Rehabilitation Therapy Services

Covered expenses include charges for short-term therapy services when prescribed by a **physician** as described below up to the benefit maximums listed on your *Schedule of Benefits*. The services have to be performed by:

- A licensed or certified physical, occupational or speech therapist;
- A **hospital**, **skilled nursing facility**, or **hospice facility**;
- A **home health care agency**; or
- A **physician**.

Charges for the following short term rehabilitation expenses are covered:

Cardiac and Pulmonary Rehabilitation Benefits.

- Cardiac rehabilitation benefits are available as part of an inpatient **hospital stay**. A limited course of outpatient cardiac rehabilitation is covered when following angioplasty, cardiovascular surgery, congestive heart failure or myocardial infarction. The plan will cover charges in accordance with a treatment plan as determined by your risk level when recommended by a physician. This course of treatment is limited to a maximum of 36 sessions in a 12 week period.
- Pulmonary rehabilitation benefits are available as part of an inpatient **hospital stay**. A limited course of outpatient pulmonary rehabilitation is covered for the treatment of reversible pulmonary disease states. This course of treatment is limited to a maximum of 36 hours or a six week period.

Outpatient Cognitive Therapy, Physical Therapy, Occupational Therapy and Speech Therapy Rehabilitation Benefits.

Coverage is subject to the limits, if any, shown on the *Schedule of Benefits*. Inpatient rehabilitation benefits for the services listed will be paid as part of your Inpatient Hospital and Skilled Nursing Facility benefits provision in this **Booklet**.

- Physical therapy is covered for non-chronic conditions and acute **illnesses** and **injuries**, provided the therapy expects to significantly improve, develop or restore physical functions lost or impaired as a result of an acute **illness**, **injury** or surgical procedure. Physical therapy does not include educational training or services designed to develop physical function.
- Occupational therapy (except for vocational rehabilitation or employment counseling) is covered for non-chronic conditions and acute **illnesses** and **injuries**, provided the therapy expects to significantly improve, develop or restore physical functions lost or impaired as a result of an acute **illness**, **injury** or surgical procedure, or to relearn skills to significantly improve independence in the activities of daily living. Occupational therapy does not include educational training or services designed to develop physical function.
- Speech therapy is covered for non-chronic conditions and acute illnesses and injuries provided the therapy is expected to restore the speech function or correct a speech impairment resulting from **illness** or **injury**; or for delays in speech function development as a result of a gross anatomical defect present at birth. Speech function is the ability to express thoughts, speak words and form sentences. Speech impairment is difficulty with expressing one's thoughts with spoken words.
- Cognitive therapy associated with physical rehabilitation is covered when the cognitive deficits have been acquired as a result of neurologic impairment due to trauma, stroke, or encephalopathy, and when the therapy is part of a treatment plan intended to restore previous cognitive function.

A "visit" consists of no more than one hour of therapy. Refer to the *Schedule of Benefits* for the visit maximum that applies to the plan. **Covered expenses** include charges for two therapy visits of no more than one hour in a 24-hour period.

The therapy should follow a specific treatment plan that:

- Details the treatment, and specifies frequency and duration; and
- Provides for ongoing reviews and is renewed only if continued therapy is appropriate.
- Allows therapy services, provided in your home, if you are **homebound**.

Important Reminder
Refer to the *Schedule of Benefits* for details about the short-term rehabilitation therapy maximum benefit.

Unless specifically covered above, *not* covered under this benefit are charges for:

- Therapies for the treatment of delays in development, unless resulting from acute illness or injury, or congenital defects amenable to surgical repair (such as cleft lip/palate), are not covered. Examples of non-covered diagnoses include Pervasive Developmental Disorders (including Autism), Down's syndrome, and Cerebral Palsy, as they are considered both developmental and/or chronic in nature.
- Any services which are **covered expenses** in whole or in part under any other group plan sponsored by an employer;
- Any services unless provided in accordance with a specific treatment plan;
- Services for the treatment of delays in speech development, unless resulting from **illness, injury**, or congenital defect;
- Services provided during a **stay** in a **hospital**, **skilled nursing facility**, or **hospice facility except as stated above**;
- Services not performed by a **physician** or under the direct supervision of a **physician**;
- Treatment covered as part of the Spinal Manipulation Treatment. This applies whether or not benefits have been paid under that section;
- Services provided by a **physician** or physical, occupational or speech therapist who resides in your home; or who is a member of your family, or a member of your spouse's family;
- Special education to instruct a person whose speech has been lost or impaired, to function without that ability. This includes lessons in sign language.

Reconstructive or Cosmetic Surgery and Supplies

Covered expenses include charges made by a **physician**, **hospital**, or **surgery center** for reconstructive services and supplies, including:

- Surgery needed to improve a significant functional impairment of a body part.
- Surgery to correct the result of an accidental injury, including subsequent related or staged surgery, provided that the surgery occurs no more than 24 months after the original injury. For a covered child, the time period for coverage may be extended through age 18.
- Surgery to correct the result of an injury that occurred during a covered surgical procedure provided that the reconstructive surgery occurs no more than 24 months after the original injury.

Note: Injuries that occur as a result of a medical (*i.e.*, non surgical) treatment are not considered accidental injuries, even if unplanned or unexpected.

- Surgery to correct a gross anatomical defect present at birth or appearing after birth (but not the result of an illness or injury) when
  - the defect results in severe facial disfigurement, or
  - the defect results in significant functional impairment and the surgery is needed to improve function

Reconstructive Breast Surgery

Covered expenses include reconstruction of the breast on which a mastectomy was performed, including an implant and areolar reconstruction. Also included is surgery on a healthy breast to make it symmetrical with the reconstructed breast and physical therapy to treat complications of mastectomy, including lymphedema.

Important Notice
A benefit maximum may apply to reconstructive or **cosmetic** surgery services. Please refer to the *Schedule of Benefits.*

Specialized Care

Chemotherapy

Covered expenses include charges for chemotherapy treatment. Coverage levels depend on where treatment is received. In most cases, chemotherapy is covered as outpatient care. Inpatient **hospitalization** for chemotherapy is limited to the initial dose while **hospitalized** for the diagnosis of cancer and when a **hospital stay** is otherwise **medically necessary** based on your health status.

Radiation Therapy Benefits

Covered expenses include charges for the treatment of **illness** by x-ray, gamma ray, accelerated particles, mesons, neutrons, radium or radioactive isotopes.

Outpatient Infusion Therapy Benefits

Covered expenses include infusion therapy received from an outpatient setting including but not limited to:

- A free-standing outpatient facility;
- The outpatient department of a **hospital**; or
- A **physician** in his/her office or in your home.

The list of preferred infusion locations can be found by contacting Member Services by logging onto your Aetna Navigator® secure member website at www.aetna.com or calling the number on the back of your ID card.

Certain infused medications may be covered under the prescription drug plan. You can access the list of specialty care prescription drugs by contacting Member Services or by logging onto your Aetna Navigator® secure member website at www.aetna.com or calling the number on the back of your ID card to determine if coverage is under the prescription drug plan or this booklet.

Infusion therapy is the intravenous or continuous administration of medications or solutions that are a part of your course of treatment. Charges for the following outpatient Infusion Therapy services and supplies are **covered expenses**:

- The pharmaceutical when administered in connection with infusion therapy and any medical supplies, equipment and nursing services required to support the infusion therapy;
- Professional services;
- Total parenteral nutrition (TPN);
- Chemotherapy;
- Drug therapy (includes antibiotic and antivirals);
- Pain management (narcotics); and
- Hydration therapy (includes fluids, electrolytes and other additives).

Not included under this infusion therapy benefit are charges incurred for:

- Enteral nutrition;
- Blood transfusions and blood products;
- Dialysis; and
- Insulin.

Coverage is subject to the maximums, if any, shown in the *Schedule of Benefits*.

Coverage for inpatient infusion therapy is provided under the *Inpatient Hospital* and *Skilled Nursing Facility Benefits* sections of this *Booklet*.

Benefits payable for infusion therapy will not count toward any applicable **Home Health Care** maximums.

Important Reminder
Refer to the *Schedule of Benefits* for details about any applicable **deductible**, **coinsurance** and maximum benefit limits.

Specialty Care Prescription Drugs

Covered expenses include **specialty care prescription drugs** when they are:

- Purchased by your **provider,** and
- Injected or infused by your **provider** in an outpatient setting such as:
  - A free-standing outpatient facility
  - The outpatient department of a **hospital**
  - A **physician** in his/her office
  - A home care **provider** in your home
- And, listed on our **specialty care prescription drug** list as covered under this booklet.

Certain infused medications may be covered under the **prescription drug** plan. You can access the list of **specialty care prescription drugs** by contacting Member Services or by logging onto your Aetna Navigator® secure member website at www.aetna.com or calling the number on the back of your ID card to determine if coverage is under the **prescription drug** plan of this booklet.

Diabetic Equipment, Supplies and Education

Covered expenses include charges for the following services, supplies, equipment and training for the treatment of insulin and non-insulin dependent diabetes and for elevated blood glucose levels during pregnancy:

- External insulin pumps;
- Blood glucose monitors without special features unless required due to blindness;
- Alcohol swabs;
- Glucagon emergency kits;
- Self-management training provided by a licensed health care provider certified in diabetes self-management training; and
- Foot care to minimize the risk of infection.

Treatment of Infertility

Basic Infertility Expenses

Covered expenses include charges made by a **physician** to diagnose and to surgically treat the underlying medical cause of **infertility**.

Spinal Manipulation Treatment

Covered expenses include charges made by a **physician** on an outpatient basis for manipulative (adjustive) treatment or other physical treatment for conditions caused by (or related to) biomechanical or nerve conduction disorders of the spine.

Your benefits are subject to the maximum shown in the *Schedule of Benefits*. However, this maximum does not apply to expenses incurred:

- During your **hospital stay**; or
- For surgery. This includes pre- and post-surgical care provided or ordered by the operating **physician**.

Transplant Services

Covered expenses include charges incurred during a transplant occurrence. The following will be considered to be one transplant occurrence once it has been determined that you or one of your dependents may require an organ transplant. Organ means solid organ; stem cell; bone marrow; and tissue.

- Heart;
- Lung;
- Heart/Lung;
- Simultaneous Pancreas Kidney (SPK);
- Pancreas;
- Kidney;
- Liver;
- Intestine;
- Bone Marrow/Stem Cell;
- Multiple organs replaced during one transplant surgery;
- Tandem transplants (Stem Cell);
- Sequential transplants;
- Re-transplant of same organ type within 180 days of the first transplant;
- Any other single organ transplant, unless otherwise excluded under the plan.

The following will be considered to be *more than one* Transplant Occurrence:

- Autologous blood/bone marrow transplant followed by allogenic blood/bone marrow transplant (when not part of a tandem transplant);
- Allogenic blood/bone marrow transplant followed by an autologous blood/bone marrow transplant (when not part of a tandem transplant);
- Re-transplant after 180 days of the first transplant;
- Pancreas transplant following a kidney transplant;
- A transplant necessitated by an additional organ failure during the original transplant surgery/process;
- More than one transplant when not performed as part of a planned tandem or sequential transplant, (e.g., a liver transplant with subsequent heart transplant).

The **network** level of benefits is paid only for a treatment received at a facility designated by the plan as an **Institute of Excellence™ (IOE)** for the type of transplant being performed. Each **IOE** facility has been selected to perform only certain types of transplants.

Services obtained from a facility that is not designated as an **IOE** for the transplant being performed will be covered as **out-of-network** services and supplies, even if the facility is a **network** facility or **IOE** for other types of services.

The plan covers:

- Charges made by a **physician** or transplant team.
- Charges made by a **hospital**, outpatient facility or **physician** for the medical and surgical expenses of a live donor, but only to the extent not covered by another plan or program.
- Related supplies and services provided by the facility during the transplant process. These services and supplies may include: physical, speech and occupational therapy; bio-medicals and immunosuppressants; home health care expenses and home infusion services.
- Charges for activating the donor search process with national registries.

- Compatibility testing of prospective organ donors who are immediate family members. For the purpose of this coverage, an "immediate" family member is defined as a first-degree biological relative. These are your biological parents, siblings or children.
- Inpatient and outpatient expenses directly related to a transplant.

Covered transplant expenses are typically incurred during the four phases of transplant care described below. Expenses incurred for one transplant during these four phases of care will be considered one transplant occurrence.

A transplant occurrence is considered to begin at the point of evaluation for a transplant and end either 180 days from the date of the transplant; ***or*** upon the date you are discharged from the **hospital** or outpatient facility for the admission or visit(s) related to the transplant, whichever is later.

The four phases of one transplant occurrence and a summary of covered transplant expenses during each phase are:

1. Pre-transplant evaluation/screening: Includes all transplant-related professional and technical components required for assessment, evaluation and acceptance into a transplant facility's transplant program;
2. Pre-transplant/candidacy screening: Includes HLA typing/compatibility testing of prospective organ donors who are immediate family members;
3. Transplant event: Includes inpatient and outpatient services for all covered transplant-related health services and supplies provided to you and a donor during the one or more surgical procedures or medical therapies for a transplant; **prescription drugs** provided during your inpatient **stay** or outpatient visit(s), including bio-medical and immunosuppressant drugs; physical, speech or occupational therapy provided during your inpatient **stay** or outpatient visit(s); cadaveric and live donor organ procurement; and
4. Follow-up care: Includes all covered transplant expenses; home health care services; home infusion services; and transplant-related outpatient services rendered within 180 days from the date of the transplant event.

If you are a participant in the **IOE** program, the program will coordinate all solid organ and bone marrow transplants and other specialized care you need. Any **covered expenses** you incur from an **IOE** facility will be considered network care expenses.

Important Reminders
To ensure coverage, all transplant procedures need to be **precertified** by **Aetna**. Refer to the *How the Plan Works* section for details about **precertification**.

Refer to the *Schedule of Benefits* for details about transplant expense maximums, if applicable.

Limitations

Unless specified above, *not* covered under this benefit are charges incurred for:

- Outpatient drugs including bio-medicals and immunosuppressants not expressly related to an outpatient transplant occurrence;
- Services that are covered under any other part of this plan;
- Services and supplies furnished to a donor when the recipient is not covered under this plan;
- Home infusion therapy after the transplant occurrence;
- Harvesting or storage of organs, without the expectation of immediate transplantation for an existing illness;
- Harvesting and/or storage of bone marrow, tissue or stem cells, without the expectation of transplantation within 12 months for an existing illness;
- Cornea (Corneal Graft with Amniotic Membrane) or Cartilage (autologous chondrocyte or autologous osteochondral mosaicplasty) transplants, unless otherwise authorized by **Aetna**.

Network of Transplant Specialist Facilities

Through the **IOE** network, you will have access to a provider network that specializes in transplants. Benefits may vary if an **IOE** facility or non-**IOE** or **out-of-network provider** is used. In addition, some expenses are payable only within the **IOE** network. The **IOE** facility must be specifically approved and designated by **Aetna** to perform the procedure you require. Each facility in the **IOE** network has been selected to perform only certain types of transplants, based on quality of care and successful clinical outcomes.

Alcoholism, Substance Abuse and Mental Disorders Treatment

Covered expenses include charges made for the treatment of alcoholism, **substance abuse** and **mental disorders** by **behavioral health providers**.

Important Notice
Not all types of services are covered. For example, educational services and certain types of therapies are not covered. See the *Health Plan Exclusions and Limits* section for more information.

Treatment of Mental Disorders

Covered expenses include charges made for the treatment of other **mental disorders** by **behavioral health providers**.

Benefits are payable for charges incurred in a **hospital, psychiatric hospital, residential treatment facility** or **behavioral health provider's** office for the treatment of **mental disorders** as follows:

Inpatient Treatment

Covered expenses include charges for **room and board** at the **semi-private room rate,** and other services and supplies provided during your **stay** in a **hospital, psychiatric hospital** or **residential treatment facility**. Inpatient benefits are payable only if your condition requires services that are only available in an inpatient setting.

Partial Confinement Treatment

Covered expenses include charges made for **partial confinement treatment** provided in a facility or program for the intermediate short-term or medically-directed intensive treatment of a **mental disorder**. Such benefits are payable if your condition requires services that are only available in a **partial confinement treatment** setting.

Outpatient Treatment

Covered expenses include charges for treatment received while not confined as a full-time inpatient in a **hospital**, **psychiatric hospital** or **residential treatment facility**.

The plan covers partial **hospitalization** services (more than 4 hours, but less than 24 hours per day) provided in a facility or program for the intermediate short-term or medically-directed intensive treatment. The partial **hospitalization** will only be covered if you would need inpatient care if you were not admitted to this type of facility.

Important Reminder:
Inpatient care must be **precertified** by **Aetna**. Refer to the *How the Plan Works* section for more information about **precertification**.

Alcoholism and Substance Abuse

Covered expenses include charges made for the treatment of alcoholism and **substance abuse** by **behavioral health providers**.

The *Schedule of Benefits* shows the benefits payable and applicable benefit maximums for the treatment of alcoholism and **substance abuse**.

Inpatient Treatment for Alcoholism and Substance Abuse

The plan covers **room and board** at the **semi-private room rate** and other services and supplies provided during your **stay** in a **psychiatric hospital** or **residential treatment facility**, appropriately licensed by the State Department of Health or its equivalent.

Coverage includes:

- Treatment in a **hospital** for the medical complications of alcoholism or **substance abuse**.
- "Medical complications" include **detoxification**, electrolyte imbalances, malnutrition, cirrhosis of the liver, delirium tremens and hepatitis.
- Treatment in a **hospital**, when the **hospital** does not have a separate treatment facility section.

Outpatient Treatment for Alcoholism and Substance Abuse

The plan covers outpatient treatment of alcoholism or **substance abuse**.

The plan covers partial **hospitalization** services (more than 4 hours, but less than 24 hours per day) provided in a facility or program for the intermediate short-term or medically-directed intensive treatment of alcoholism or **substance abuse**. The partial **hospitalization** will only be covered if you would need inpatient treatment if you were not admitted to this type of facility.

Partial Confinement Treatment for Alcoholism and Substance Abuse

Covered expenses include charges made for **partial confinement treatment** provided in a facility or program for the intermediate short-term or medically-directed intensive treatment of alcoholism or **substance abuse**.

The **partial confinement treatment** will only be covered if you would need a **hospital stay** if you were not admitted to this type of facility.

Important Reminder:
Inpatient care must be **precertified** by **Aetna**. Refer to *How the Plan Works* for more information about **precertification**.

Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)

Covered expenses include charges made by a **physician**, a **dentist** and **hospital** for:

- Non-surgical treatment of infections or diseases of the mouth, jaw joints or supporting tissues.

Services and supplies for treatment of, or related conditions of, the teeth, mouth, jaws, jaw joints or supporting tissues, (this includes bones, muscles, and nerves), for surgery needed to:

- Treat a fracture, dislocation, or wound.
- Cut out cysts, tumors, or other diseased tissues.
- Cut into gums and tissues of the mouth. This is only covered when ***not*** done in connection with the removal, replacement or repair of teeth.
- Alter the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement.

Hospital services and supplies received for a **stay** required because of your condition.

Dental work, surgery and **orthodontic treatment** needed to remove, repair, restore or reposition:

(a) Natural teeth damaged, lost, or removed; or
(b) Other body tissues of the mouth fractured or cut

due to **injury**.

Any such teeth must have been free from decay or in good repair, and are firmly attached to the jaw bone at the time of the **injury**.

The treatment must be completed in the Plan Year of the accident or in the next Plan Year.

If crowns, dentures, bridges, or in-mouth appliances are installed due to **injury**, **covered expenses** only include charges for:

- The first denture or fixed bridgework to replace lost teeth;
- The first crown needed to repair each damaged tooth; and
- An in-mouth appliance used in the first course of **orthodontic treatment** after the **injury**.

Medical Plan Exclusions

Not every medical service or supply is covered by the plan, even if prescribed, recommended, or approved by your **physician** or **dentist**. The plan covers only those services and supplies that are **medically necessary** and included in the *What the Plan Covers* section. Charges made for the following are not covered except to the extent listed under the *What The Plan Covers* section or by amendment attached to this Booklet.

Important Note:
You have medical and prescription drug and vision coverage. The exclusions listed below apply to all coverage under your plan. Additional exclusions apply to specific prescription drug and vision coverage. Those additional exclusions are listed separately under the *What The Plan Covers* section for each of these benefits.

Acupuncture, acupressure and acupuncture therapy, except as provided in the *What the Plan Covers* section.

Allergy: Specific non-standard allergy services and supplies, including but not limited to, skin titration (Rinkel method), cytotoxicity testing (Bryan's Test) treatment of non-specific candida sensitivity, and urine autoinjections.

Any charges in excess of the benefit, dollar, day, visit or supply limits stated in this Booklet.

Any non-emergency charges incurred outside of the United States if you traveled to such location to obtain medical services, **prescription drugs**, or supplies, even if otherwise covered under this Booklet. This also includes **prescription drugs** or supplies if:

- such **prescription drugs** or supplies are unavailable or illegal in the United States; or
- the purchase of such **prescription drugs** or supplies outside the United States is considered illegal.

Applied Behavioral Analysis, the LEAP, TEACCH, Denver and Rutgers programs.

Behavioral Health Services:

- Alcoholism or **substance abuse** rehabilitation treatment on an inpatient or outpatient basis, except to the extent coverage for **detoxification** or treatment of alcoholism or **substance abuse** is specifically provided in the *What the Medical Plan Covers* Section.
- Treatment of a covered health care provider who specializes in the mental health care field and who receives treatment as a part of their training in that field.

- Treatment of impulse control disorders such as pathological gambling, kleptomania, pedophilia, caffeine or nicotine use.
- Treatment of antisocial personality disorder.
- Treatment in wilderness programs or other similar programs.
- Treatment of mental retardation, defects, and deficiencies. This exclusion does not apply to mental health services or to medical treatment of mentally retarded in accordance with the benefits provided in the *What the Plan Covers* section of this Booklet.

Blood, blood plasma, synthetic blood, blood products or substitutes, including but not limited to, the provision of blood, other than blood derived clotting factors. Any related services including processing, storage or replacement costs, and the services of blood donors, apheresis or plasmapheresis are not covered. For autologous blood donations, only administration and processing costs are covered.

Charges for a service or supply furnished by a **network provider** in excess of the **negotiated charge**.

Charges for a service or supply furnished by an **out-of-network provider** in excess of the **recognized charge**.

Charges submitted for services that are not rendered, or rendered to a person not eligible for coverage under the plan.

Charges submitted for services by an unlicensed **hospital**, **physician** or other provider or not within the scope of the provider's license.

Contraception, except as specifically described in the *What the Plan Covers* Section:

- Over the counter contraceptive supplies including but not limited to condoms, contraceptive foams, jellies and ointments.

Cosmetic services and plastic surgery: any treatment, surgery (cosmetic or plastic), service or supply to alter, improve or enhance the shape or appearance of the body whether or not for psychological or emotional reasons including:

- Face lifts, body lifts, tummy tucks, liposuctions, removal of excess skin, removal or reduction of non-malignant moles, blemishes, varicose veins, cosmetic eyelid surgery and other surgical procedures;
- Procedures to remove healthy cartilage or bone from the nose (even if the surgery may enhance breathing) or other part of the body;
- Chemical peels, dermabrasion, laser or light treatments, bleaching, creams, ointments or other treatments or supplies to alter the appearance or texture of the skin;
- Insertion or removal of any implant that alters the appearance of the body (such as breast or chin implants); except removal of an implant will be covered when **medically necessary**;
- Removal of tattoos (except for tattoos applied to assist in covered medical treatments, such as markers for radiation therapy); and
- Repair of piercings and other voluntary body modifications, including removal of injected or implanted substances or devices;
- Surgery to correct Gynecomastia;
- Breast augmentation;
- Otoplasty.

Counseling: Services and treatment for marriage, religious, family, career, social adjustment, pastoral, or financial counselor except as specifically provided in the ***What the Plan Covers*** section.

Court ordered services, including those required as a condition of parole or release.

Custodial Care

Dental Services: any treatment, services or supplies related to the care, filling, removal or replacement of teeth and the treatment of injuries and diseases of the teeth, gums, and other structures supporting the teeth. This includes but is not limited to:

- services of **dentist**s, oral surgeons, dental hygienists, and orthodontists including apicoectomy (dental root resection), root canal treatment, soft tissue impactions, removal of bony impacted teeth, treatment of periodontal disease, alveolectomy, augmentation and vestibuloplasty and fluoride and other substances to protect, clean or alter the appearance of teeth;
- dental implants, false teeth, prosthetic restoration of dental implants, plates, dentures, braces, mouth guards, and other devices to protect, replace or reposition teeth; and
- non-surgical treatments to alter bite or the alignment or operation of the jaw, including treatment of malocclusion or devices to alter bite or alignment.

Disposable outpatient supplies: Any outpatient disposable supply or device, including sheaths, bags, elastic garments, support hose, bandages, bedpans, syringes, blood or urine testing supplies, and other home test kits; and splints, neck braces, compresses, and other devices not intended for reuse by another patient.

Drugs, medications and supplies:

- Over-the-counter drugs, biological or chemical preparations and supplies that may be obtained without a **prescription** including vitamins;
- Any services related to the dispensing, injection or application of a drug;
- Any prescription drug purchased illegally outside the United States, even if otherwise covered under this plan within the United States;
- Immunizations related to work;
- Needles, syringes and other injectable aids, except as covered for diabetic supplies;
- Drugs related to the treatment of non-**covered expenses**;
- Performance enhancing steroids;
- Injectable drugs if an alternative oral drug is available;
- Outpatient **prescription drug**s;
- Self-injectable **prescription drug**s and medications;
- Any **prescription drug**s, injectables, or medications or supplies provided by the customer or through a third party vendor contract with the customer; and
- Any expenses for prescription drugs, and supplies covered under an Aetna Pharmacy plan will not be covered under this medical expense plan. Prescription drug exclusions that apply to the Aetna Pharmacy plan will apply to the medical expense coverage; and
- Charges for any prescription drug for the treatment of erectile dysfunction, impotence, or sexual dysfunction or inadequacy.

Educational services:

- Any services or supplies related to education, training or retraining services or testing, including: special education, remedial education, job training and job hardening programs;
- Evaluation or treatment of learning disabilities, minimal brain dysfunction, developmental, learning and communication disorders, behavioral disorders, (including pervasive developmental disorders) training or cognitive rehabilitation, regardless of the underlying cause; and
- Services, treatment, and educational testing and training related to behavioral (conduct) problems, learning disabilities and delays in developing skills.

Examinations:

- Any health examinations required:
  - by a third party, including examinations and treatments required to obtain or maintain employment, or which an employer is required to provide under a labor agreement;
  - by any law of a government;
  - for securing insurance, school admissions or professional or other licenses;
  - to travel;
  - to attend a school, camp, or sporting event or participate in a sport or other recreational activity; and

  Any special medical reports not directly related to treatment except when provided as part of a covered service.

Experimental or investigational drugs, devices, treatments or procedures, except as described in the *What the Plan Covers* section.

Facility charges for care services or supplies provided in:

- rest homes;
- assisted living facilities;
- similar institutions serving as an individual's primary residence or providing primarily custodial or rest care;
- health resorts;
- spas, sanitariums; or
- infirmaries at schools, colleges, or camps.

Food items: Any food item, including infant formulas, nutritional supplements, vitamins, including prescription vitamins, medical foods and other nutritional items, even if it is the sole source of nutrition. This exclusion does not apply to specialized medical foods delivered enterally (only when delivered via a tube directly into the stomach or intestines) or parenterally.

Foot care: Any services, supplies, or devices to improve comfort or appearance of toes, feet or ankles, including but not limited to:

- Treatment of calluses, bunions, toenails, hammer-toes, subluxations, fallen arches, weak feet, chronic foot pain or conditions caused by routine activities such as walking, running, working or wearing shoes; and
- Shoes (including orthopedic shoes), foot orthotics, arch supports, shoe inserts, ankle braces, guards, protectors, creams, ointments and other equipment, devices and supplies, even if required following a covered treatment of an **illness** or **injury**.

Growth/Height: Any treatment, device, drug, service or supply (including surgical procedures, devices to stimulate growth and growth hormones), solely to increase or decrease height or alter the rate of growth.

Hearing:

- Any hearing service or supply that does not meet professionally accepted standards;
- Hearing exams given during a **stay** in a **hospital** or other facility;
- Replacement parts or repairs for a hearing aid; and
- Any tests, appliances, and devices for the improvement of hearing (including hearing aids and amplifiers), or to enhance other forms of communication to compensate for hearing loss or devices that simulate speech, except as otherwise provided under the *What the Plan Covers* section.

Home and mobility: Any addition or alteration to a home, workplace or other environment, or vehicle and any related equipment or device, such as:

- Purchase or rental of exercise equipment, air purifiers, central or unit air conditioners, water purifiers, waterbeds. and swimming pools;
- Exercise and training devices, whirlpools, portable whirlpool pumps, sauna baths, or massage devices;
- Equipment or supplies to aid sleeping or sitting, including non-hospital electric and air beds, water beds, pillows, sheets, blankets, warming or cooling devices, bed tables and reclining chairs;
- Equipment installed in your home, workplace or other environment, including stair-glides, elevators, wheelchair ramps, or equipment to alter air quality, humidity or temperature;
- Other additions or alterations to your home, workplace or other environment, including room additions, changes in cabinets, countertops, doorways, lighting, wiring, furniture, communication aids, wireless alert systems, or home monitoring;
- Services and supplies furnished mainly to provide a surrounding free from exposure that can worsen your **illness** or **injury**;
- Removal from your home, worksite or other environment of carpeting, hypo-allergenic pillows, mattresses, paint, mold, asbestos, fiberglass, dust, pet dander, pests or other potential sources of allergies or **illness**; and
- Transportation devices, including stair-climbing wheelchairs, personal transporters, bicycles, automobiles, vans or trucks, or alterations to any vehicle or transportation device.

Home births: Any services and supplies related to births occurring in the home or in a place not licensed to perform deliveries.

Infertility: except as specifically described in the *What the Plan Covers* Section, any services, treatments, procedures or supplies that are designed to enhance fertility or the likelihood of conception, including but not limited to:

- Drugs related to the treatment of non-covered benefits;
- Injectable infertility medications, including but not limited to menotropins, hCG, GnRH agonists, and IVIG;
- Artificial Insemination;
- Any advanced reproductive technology ("ART") procedures or services related to such procedures, including but not limited to in vitro fertilization ("IVF"), gamete intra-fallopian transfer ("GIFT"), zygote intra-fallopian transfer ("ZIFT"), and intra-cytoplasmic sperm injection ("ICSI"); Artificial Insemination for covered females attempting to become pregnant who are not infertile as defined by the plan;
- Infertility services for couples in which 1 of the partners has had a previous sterilization procedure, with or without surgical reversal;
- Procedures, services and supplies to reverse voluntary sterilization;
- Infertility services for females with FSH levels 19 or greater mIU/ml on day 3 of the menstrual cycle;
- The purchase of donor sperm and any charges for the storage of sperm; the purchase of donor eggs and any charges associated with care of the donor required for donor egg retrievals or transfers or gestational carriers or surrogacy; donor egg retrieval or fees associated with donor egg programs, including but not limited to fees for laboratory tests;
- Charges associated with cryopreservation or storage of cryopreserved eggs and embryos (e.g., office, **hospital**, ultrasounds, laboratory tests, etc.); any charges associated with a frozen embryo or egg transfer, including but not limited to thawing charges;
- Home ovulation prediction kits or home pregnancy tests;
- Any charges associated with care required to obtain ART Services (e.g., office, **hospital**, ultrasounds, laboratory tests); and any charges associated with obtaining sperm for any ART procedures; and
- Ovulation induction and intrauterine insemination services if you are not infertile.

Maintenance Care.

Medicare: Payment for that portion of the charge for which Medicare or another party is the primary payer.

Miscellaneous charges for services or supplies including:

- Annual or other charges to be in a **physician's** practice;
- Charges to have preferred access to a **physician's** services such as boutique or concierge **physician** practices;
- Cancelled or missed appointment charges or charges to complete claim forms;
- Charges the recipient has no legal obligation to pay; or the charges would not be made if the recipient did not have coverage (to the extent exclusion is permitted by law) including:
  - Care in charitable institutions;
  - Care for conditions related to current or previous military service;
  - Care while in the custody of a governmental authority;
  - Any care a public **hospital** or other facility is required to provide; or
  - Any care in a **hospital** or other facility owned or operated by any federal, state or other governmental entity, except to the extent coverage is required by applicable laws.

Nursing and home health aide services provided outside of the home (such as in conjunction with school, vacation, work or recreational activities).

Non-**medically necessary** services, including but not limited to, those treatments, services, **prescription drugs** and supplies which are not **medically necessary**, as determined by **Aetna**, for the diagnosis and treatment of **illness**, **injury**, restoration of physiological functions, or covered preventive services. This applies even if they are prescribed, recommended or approved by your **physician** or **dentist**.

Personal comfort and convenience items: Any service or supply primarily for your convenience and personal comfort or that of a third party, including: Telephone, television, internet, barber or beauty service or other guest services; housekeeping, cooking, cleaning, shopping, monitoring, security or other home services; and travel, transportation, or living expenses, rest cures, recreational or diversional therapy.

Private duty nursing during your **stay** in a **hospital**, and outpatient private duty nursing services, except as specifically described in the *Private Duty Nursing* provision in the *What the Plan Covers* Section.

Sex change: Any treatment, drug, service or supply related to changing sex or sexual characteristics, including:

- Surgical procedures to alter the appearance or function of the body;
- Hormones and hormone therapy;
- Prosthetic devices; and
- Medical or psychological counseling.

Services provided by a spouse, domestic partner, parent, child, step-child, brother, sister, in-law or any household member.

Services of a resident **physician** or intern rendered in that capacity.

Services provided where there is no evidence of pathology, dysfunction, or disease; except as specifically provided in connection with covered routine care and cancer screenings.

Sexual dysfunction/enhancement: Any treatment, drug, service or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including:

- Surgery, drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity, or alter the shape or appearance of a sex organ; and
- Sex therapy, sex counseling, marriage counseling or other counseling or advisory services.

Services, including those related to pregnancy, rendered before the effective date or after the termination of coverage, unless coverage is continued under the *Continuation of Coverage* section of this Booklet.

Services that are not covered under this Booklet.

Services and supplies provided in connection with treatment or care that is not covered under the plan.

Speech therapy for treatment of delays in speech development, except as specifically provided in the *What the Medical Plan Covers Section*. For example, the plan does not cover therapy when it is used to improve speech skills that have not fully developed.

Spinal disorder, including care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion or dislocation in the human body or other physical treatment of any condition caused by or related to biomechanical or nerve conduction disorders of the spine including manipulation of the spine treatment, except as specifically provided in the *What the Plan Covers* section.

Strength and performance: Services, devices and supplies to enhance strength, physical condition, endurance or physical performance, including:

- Exercise equipment, memberships in health or fitness clubs, training, advice, or coaching;
- Drugs or preparations to enhance strength, performance, or endurance; and
- Treatments, services and supplies to treat **illnesses**, **injuries** or disabilities related to the use of performance-enhancing drugs or preparations.

Therapies for the treatment of delays in development, unless resulting from acute illness or injury, or congenital defects amenable to surgical repair (such as cleft lip/palate), are not covered. Examples of non-covered diagnoses include Pervasive Developmental Disorders (including Autism), Down Syndrome, and Cerebral Palsy, as they are considered both developmental and/or chronic in nature.

Therapies and tests: Any of the following treatments or procedures:

- Aromatherapy;
- Bio-feedback and bioenergetic therapy;
- Carbon dioxide therapy;
- Chelation therapy (except for heavy metal poisoning);
- Computer-aided tomography (CAT) scanning of the entire body;
- Educational therapy;
- Gastric irrigation;
- Hair analysis;
- Hyperbaric therapy, except for the treatment of decompression or to promote healing of wounds;
- Hypnosis, and hypnotherapy, except when performed by a **physician** as a form of anesthesia in connection with covered surgery;
- Lovaas therapy;
- Massage therapy;
- Megavitamin therapy;
- Primal therapy;
- Psychodrama;

- Purging;
- Recreational therapy;
- Rolfing;
- Sensory or auditory integration therapy;
- Sleep therapy;
- Thermograms and thermography.

Tobacco Use: Any treatment, drug, service or supply to stop or reduce smoking or the use of other tobacco products or to treat or reduce nicotine addiction, dependence or cravings, including counseling, hypnosis and other therapies, medications, nicotine patches and gum except as specifically provided in the ***What the Plan Covers*** section.

Transplant-The transplant coverage does not include charges for:

- Outpatient drugs including bio-medicals and immunosuppressants not expressly related to an outpatient transplant occurrence;
- Services and supplies furnished to a donor when recipient is not a covered person;
- Home infusion therapy after the transplant occurrence;
- Harvesting and/or storage of organs, without the expectation of immediate transplantation for an existing **illness**;
- Harvesting and/or storage of bone marrow, tissue or stem cells without the expectation of transplantation within 12 months for an existing **illness**;
- Cornea (corneal graft with amniotic membrane) or cartilage (autologous chondrocyte or autologous osteochondral mosaicplasty) transplants, unless otherwise **precertified** by **Aetna**.

Transportation costs, including **ambulance** services for routine transportation to receive outpatient or inpatient services except as described in the *What the Plan Covers* section.

Unauthorized services, including any service obtained by or on behalf of a covered person without Precertification by Aetna when required. This exclusion does not apply in a Medical Emergency or in an Urgent Care situation.

Vision-related services and supplies, except as described in the *What the Plan Covers* section. The plan does not cover:

- Special supplies such as non-**prescription** sunglasses and subnormal vision aids;
- Vision service or supply which does not meet professionally accepted standards;
- Eye exams during your **stay** in a **hospital** or other facility for health care;
- Eye exams for contact lenses or their fitting;
- Eyeglasses or duplicate or spare eyeglasses or lenses or frames;
- Replacement of lenses or frames that are lost or stolen or broken;
- Acuity tests;
- Eye surgery for the correction of vision, including radial keratotomy, LASIK and similar procedures;
- Services to treat errors of refraction.

Voluntary termination of pregnancy, including related services.

Weight: Any treatment, drug service or supply intended to decrease or increase body weight, control weight or treat obesity, including **morbid obesity**, regardless of the existence of comorbid conditions; except as specifically provided in the *What the Plan Covers* section, including but not limited to:

- Liposuction, banding, gastric stapling, gastric by-pass and other forms of bariatric surgery; surgical procedures medical treatments, weight control/loss programs and other services and supplies that are primarily intended to treat, or are related to the treatment of obesity, including **morbid obesity**;
- Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food supplements, appetite suppressants and other medications;

- Counseling, coaching, training, hypnosis or other forms of therapy; and
- Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancement.

Wilderness treatment programs (whether or not the program is part of a licensed **residential treatment facility**, or otherwise licensed institution), educational services, schooling or any such related or similar program, including therapeutic programs within a school setting.

Work related: Any **illness** or **injury** related to employment or self-employment including any **illness** or **injury** that arises out of (or in the course of) any work for pay or profit, unless no other source of coverage or reimbursement is available to you for the services or supplies. Sources of coverage or reimbursement may include your employer, workers' compensation, or an occupational illness or similar program under local, state or federal law. A source of coverage or reimbursement will be considered available to you even if you waived your right to payment from that source. If you are also covered under a workers' compensation law or similar law, and submit proof that you are not covered for a particular illness or **injury** under such law, that illness or **injury** will be considered "non-occupational" regardless of cause.

Your Pharmacy Benefit

How the Pharmacy Plan Works

It is important that you have the information and useful resources to help you get the most out of your **prescription drug** plan. This Booklet explains:

- Definitions you need to know;
- How to access **network pharmacies** and procedures you need to follow;
- What **prescription drug** expenses are covered and what limits may apply;
- What **prescription drug** expenses are not covered by the plan;
- How you share the cost of your covered **prescription drug** expenses; and
- Other important information such as eligibility, complaints and appeals, termination, and general administration of the plan.

A few important notes to consider before moving forward:

- Unless otherwise indicated, "you" refers to you and your covered dependents.
- Your **prescription drug** plan pays benefits only for **prescription drug** expenses described in this Booklet as **covered expenses** that are **medically necessary**.
- This Booklet applies to coverage only and does not restrict your ability to receive **prescription drugs** that are not or might not be covered benefits under this **prescription drug** plan.
- Store this Booklet in a safe place for future reference.

Notice
The plan does not cover all **prescription drugs**, medications and supplies. Refer to the Limitations section of this coverage and *Exclusions* section of your Booklet.

- **Covered expenses** are subject to cost sharing requirements as described in the Cost Sharing sections of this coverage and in your Schedule of Benefits.
- **Injectable prescription drug** refills will only be covered when obtained through **Aetna's specialty pharmacy network**.

Getting Started: Common Terms

You will find the terms below used throughout this Booklet. They are described within the sections that follow, and you can also refer to the *Glossary* at the back of this document for helpful definitions. Words in bold print throughout the document are defined in the *Glossary*.

Brand-Named Prescription Drug is a **prescription drug** with a proprietary name assigned to it by the manufacturer and so indicated by Medispan or any other similar publication designated by **Aetna**.

Generic Prescription Drug is a **prescription drug**, whether identified by its chemical, proprietary, or non-proprietary name, that is accepted by the U.S. Food and Drug Administration as therapeutically equivalent and interchangeable with drugs having an identical amount of the same active ingredient and so indicated by Medispan or any other publication designated by **Aetna**.

Network pharmacy is a description of a retail, **mail order or specialty pharmacy** that has entered into a contractual agreement with **Aetna**, an affiliate, or a third party vendor, for the provision of **covered services** to you and your covered dependents. The appropriate **pharmacy** type may also be substituted for the word **pharmacy**. (E.g. **network** retail **pharmacy, network mail order pharmacy or specialty pharmacy network**).

Non-Preferred Drug (Non-Formulary) is a **brand-named prescription drug** or **generic prescription drug** that does not appear on the **preferred drug guide**.

Out-of-network pharmacy is a description of a **pharmacy** that has not contracted with **Aetna**, an affiliate, or a third party vendor and does not participate in the pharmacy network.

Preferred Drug (Formulary) is a **brand-named prescription drug** or **generic prescription drug** that appears on the **preferred drug guide**.

Preferred Drug Guide is a listing of **prescription drugs** established by **Aetna** or an affiliate, which includes both **brand-named prescription drugs** and **generic prescription drugs**. This list is subject to periodic review and modification by **Aetna**. A copy of the **preferred drug guide** will be available upon your request or may be accessed on the **Aetna** website at www.aetna.com/formulary.

Prescription Drug is a drug, biological, or compounded **prescription** which, by State or Federal Law, may be dispensed only by **prescription** and which is required by Federal Law to be labeled "Caution: Federal Law prohibits dispensing without prescription." This includes an injectable drug prescribed to be self-administered or administered by any other person except one who is acting within his or her capacity as a paid healthcare professional. Covered injectable drugs include insulin.

Provider is any recognized health care professional, pharmacy or facility providing services with the scope of their license.

Self-injectable Drug(s). Prescription drugs that are intended to be self-administered by injection to a specific part of the body to treat certain chronic medical conditions.

Accessing Pharmacies and Benefits

This plan provides access to **covered benefits** through a network of pharmacies, vendors or suppliers. **Aetna** has contracted for these **network pharmacies** to provide **prescription drugs** and other supplies to you.

Obtaining your benefits through **network pharmacies** has many advantages. Your out-of-pocket costs may vary between **network** and **out-of-network benefits**. Benefits and cost sharing may also vary by the type of **network pharmacy** where you obtain your **prescription drug** and whether or not you purchase a brand-name or generic drug. **Network pharmacies** include retail, mail order and specialty pharmacies.

Accessing Network Pharmacies and Benefits

You may select a **network pharmacy** from Aetna's on-line provider directory which can be found at www.aetna.com. You can search **Aetna**'s online directory, DocFind, for names and locations of **network pharmacies**. If you cannot locate a **network pharmacy** in your area, call Member Services at the number on your ID card.

You must present your ID card to the **network pharmacy** every time you get a **prescription** filled to be eligible for **network pharmacy benefits**. The **network pharmacy** will calculate your claim online. You will pay any **deductible**, **copaymen**t or **coinsurance** directly to the **network pharmacy**. You do not have to complete or submit claim forms. The **network pharmacy** will take care of claim submission.

Emergency Prescriptions

When you need a **prescription** filled in an emergency or urgent care situation, or when you are traveling, you can obtain **network pharmacy** benefits by filling your **prescription** at any **network pharmacy**. The **network pharmacy** will fill your **prescription** and only charge you your plan's cost sharing amount.

If you access an **out-of-network pharmacy** you will pay the full cost of the **prescription** and will need to file a claim for reimbursement. You will be reimbursed for your **covered expenses** up to the cost of the **prescription** less your plan's cost sharing for **network pharmacy** benefits.

Availability of Providers

Aetna cannot guarantee the availability or continued network participation of a particular **pharmacy**. Either **Aetna** or any **network pharmacy** may terminate the provider contract.

Cost Sharing for Network Benefits

You share in the cost of your benefits. Cost Sharing amounts and provisions are described in the Schedule of Benefits.

- You will need to satisfy any applicable **deductibles** before the plan will begin to pay benefits.
- You will be responsible for the **copayment** for each **prescription** or refill as specified in the *Schedule of Benefits*. The **copayment** is payable directly to the **network pharmacy** at the time the **prescription** is dispensed.
- After you satisfy any applicable **deductible** and pay the applicable **copayment**, you will be responsible for any applicable payment percentage for **covered expenses** that you incur Your **payment percentage** is determined by applying the applicable **payment** percentage to the **negotiated charge** if the **prescription** is filled at a **network pharmacy**. When you obtain your **prescription drugs** through a **network pharmacy**, you will not be subject to balance billing.

When You Use an Out-of-Network Pharmacy

You can directly access an out-of-network **pharmacy** to obtain covered outpatient **prescription drugs**. You will pay the **pharmacy** for your **prescription drugs** at the time of purchase and submit a claim form to receive reimbursement from the plan. You are responsible for completing and submitting claim forms for reimbursement of **covered expenses** you paid directly to an out-of-network **pharmacy**. The Plan will reimburse you for a **covered expense** up to the **recognized charge**, less any cost sharing required by you.

Cost Sharing for Out-of-Network Benefits

You share in the cost of your benefits. Cost Sharing amounts and provisions are described in the Schedule of Benefits.

- You will need to satisfy any applicable plan year **deductibles** before the plan will begin to pay benefits.
- After you satisfy any applicable year **deductible(s)**, you will be responsible for any applicable payment percentage for **covered expenses** that you incur. Your payment percentage share is based on the **recognized charge**. If the **out-of-network pharmacy** charges more than the **recognized charge**, you will be responsible for any expenses above the **recognized charge**.

Pharmacy Benefit

What the Plan Covers

The plan covers charges for **medically necessary** outpatient **prescription drugs** for the treatment of an **illness** or injury, subject to the *Prescription Drug Limitations* section below and the *Exclusions* section of the *Booklet*. **Prescriptions** must be written by a **prescriber** licensed to prescribe federal legend **prescription drugs**.

Your prescription drug benefit coverage is based on **Aetna's preferred drug guide**. Your out-of-pocket expenses may be higher if your **physician** prescribes a covered **prescription drug** not appearing on the **preferred drug guide**.

Preferred generic prescription drugs may be substituted by your pharmacist for **brand-name prescription drugs**. You may minimize your out-of-pocket expenses by selecting a **generic prescription drug** when available.

Coverage of **prescription drugs** may, in **Aetna**'s sole discretion, be subject to **precertification** or other **Aetna** requirements or limitations. **Prescription drugs** covered by this plan are subject to drug and narcotic utilization review by **Aetna**, your **provider** and/or your **network pharmacy**. This may include limiting access of **prescription drugs prescribed** by a specific **provider**. Such limitation may be enforced in the event that **Aetna** identifies an unusual pattern of claims for **covered expenses**.

Coverage for **prescription drugs** and supplies is limited to the supply limits as described below.

Retail Pharmacy Benefits

Outpatient **prescription drugs** are covered when dispensed by a **network retail pharmacy**. Each **prescription** is limited to a maximum 30 day supply when filled at a **network retail pharmacy**. **Prescriptions** for more than a 30 day supply are not eligible for coverage when dispensed by a **network retail pharmacy**.

Mail Order Pharmacy Benefits

Outpatient **prescription drugs** are covered when dispensed by a **network mail order pharmacy**. Each **prescription** is limited to a maximum 90 day supply. **Prescriptions** for less than a 30 day supply or more than a 90 day supply are not eligible for coverage when dispensed by a **network mail order pharmacy**.

Network Benefits for Specialty Care Drugs

Specialty care drugs are covered at the network level of benefits only when dispensed through a **network retail pharmacy** or **Aetna's specialty pharmacy network pharmacy**. **Specialty care drugs** often include typically high-cost drugs that require special handling, special storage or monitoring and include but are not limited to oral, topical, inhaled and injected routes of administration. Refer to **Aetna's** website, www.aetna.com to review the list of **specialty care drugs** required to be dispensed through a **network pharmacy** or **specialty pharmacy network pharmacy**. The list may be updated from time to time.

The initial prescription for **specialty care drugs** must be filled at a **network retail pharmacy** or at **Aetna's specialty pharmacy network**.

You are required to obtain **specialty care drugs** at **Aetna's specialty pharmacy network** for all prescription drug refills after the initial fill.

Other Covered Expenses

The following **prescription drugs**, medications and supplies are also **covered expenses** under this Coverage.

Off-Label Use

FDA approved **prescription drugs** may be covered when the off-label use of the drug has not been approved by the FDA for that indication. The drug must be recognized for treatment of the indication in one of the standard compendia (the United States Pharmacopoeia Drug Information, the American Medical Association Drug Evaluations, or the American Hospital Formulary Service Drug Information). Or, the safety and effectiveness of use for this indication has been adequately demonstrated by at least one study published in a nationally recognized peer review journal. Coverage of off label use of these drugs may, in **Aetna's** sole discretion, be subject to **precertification**, or other **Aetna** requirements or limitations.

Diabetic Supplies

Covered expenses include but are not limited to the following diabetic supplies upon **prescription** by a **physician**:

- Diabetic needles and syringes.
- Test strips for glucose monitoring and/or visual reading.
- Diabetic test agents.
- Lancets/lancing devices.
- Alcohol swabs.

Contraceptives

Covered expenses include charges made by a network **pharmacy** for the following contraceptive methods when prescribed by a **prescriber** and the **prescription** is submitted to the pharmacist for processing:

- Female oral and injectable contraceptives that are **generic prescription drugs** and **brand-name prescription drugs.**
- Female contraceptive devices.
- FDA-approved female generic emergency contraceptives; and.
- FDA-approved female generic over-the-counter (OTC) contraceptives.

Important Note:

This Plan does not cover all contraceptives. For a current listing, contact Member Services by logging onto the Aetna website at www.aetna.com or calling the toll-free number on the back of the ID card.

Contraceptives can be paid either under your medical plan or pharmacy plan depending on the type of expense and how and where the expense is incurred. Benefits are paid under your medical plan for female contraceptive prescription drugs and devices (including any related services and supplies) when they are provided, administered, or removed, by a physician during an office visit.

Refer to the *Copay and Deductible Waiver* section of your *Schedule of Benefits* for cost-sharing information.

Important Notes:

1. The Copay and Deductible Waiver does not apply to contraceptive methods that are:
   - **brand-name prescription drugs**;
   - FDA-approved female brand-name emergency contraceptives**.**
   - FDA–approved female brand-name over-the-counter (OTC) contraceptives.

   However, the Copay and Deductible Waiver does apply when:

   - such contraceptive methods are not available within the same **therapeutic drug class**; or
   - a generic equivalent, or generic alternative, within the same **therapeutic drug class** is not available; and
   - you are granted a medical exception. Refer to *Medical Exceptions* in the *Precertification* section for information on how you or your **prescriber** can obtain a medical exception.

2. A *generic equivalent* contains the identical amounts of the same active ingredients as the **brand-name prescription drug** or device. A *generic alternative* is used for the same purpose, but can have different ingredients or different amounts of ingredients.

Oral and Self-Injectable Infertility Drugs

The following **prescription drugs** used for the purpose of treating infertility including, but not limited to:

- Urofollitropin, menotropin, human chorionic gonadotropin and progesterone.

Lifestyle/Performance Drugs

The following lifestyle/performance drugs:

- Sildenafil Citrate, phentolamine, apomorphine and alprostadil in oral, injectable and topical (including but not limited to gels, creams, ointments and patches) forms or any other form used internally or externally. Expenses include any prescription drug in oral or topical form that is similar or identical class, has a similar or identical mode of action or exhibits similar or identical outcomes.
- Coverage is limited to 6 pills or other form, determined cumulatively among all forms, for unit amounts as determined by **Aetna** to be similar in cost to oral forms, per 30 day supply. Mail order and 60 to 90 day supplies are not covered.

Preventive Care Drugs and Supplements

Covered expenses include preventive care drugs and supplements (including over-the-counter drugs and supplements) obtained at a **network pharmacy**. They are covered when they are:

- prescribed by a **physician**;
- obtained at a **pharmacy**; and
- submitted to a pharmacist for processing.

The preventive care drugs and supplements covered under this Plan include, but may not be limited to:

- Aspirin: Benefits are available to adults.
- Oral Fluoride Supplements: Benefits are available to children whose primary water source is deficient in fluoride.
- Folic Acid Supplements: Benefits are available to adult females planning to become pregnant or capable of pregnancy.
- Iron Supplements: Benefits are available to children without symptoms of iron deficiency. Coverage is limited to children who are at increased risk for iron deficiency anemia.
- Vitamin D Supplements: Benefits are available to adults to promote calcium absorption and bone growth in their bodies.
- Risk-Reducing Breast Cancer **Prescription Drugs**: Covered medical expenses include charges incurred for generic **prescription drugs** prescribed by a **physician** for a woman who is at increased risk for breast cancer and is at low risk for adverse medication side effects.

Coverage of preventive care drugs and supplements will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force.

Important Note:
For details on the guidelines and the current list of covered preventive care drugs and supplements, contact your **physician** or Member Services by logging onto the Aetna website www.aetna.com and Aetna Navigator, or calling the number on the back of your ID card.

Tobacco Cessation Prescription and Over-the-Counter Drugs

Covered expenses include FDA-approved **prescription drugs** and over-the-counter (OTC) drugs to help stop the use of tobacco products, when prescribed by a prescriber and the **prescription** is submitted to the pharmacist for processing.

Refer to the *Schedule of Benefits* for the cost-sharing and supply limits that apply to these benefits.

Precertification

Precertification is required for certain outpatient **prescription drugs**. **Prescribers** must contact **Aetna** to request and obtain coverage for such **prescription drugs**. The list of drugs requiring **precertification** is subject to periodic review and change by **Aetna**. For the most up to date information, call the toll-free number on your member ID card or log on to your Aetna Navigator secure member website at www.aetna.com.

Benefits will be reduced or denied if **Aetna** does not **precertify** your **prescription drug**. So ask your **prescriber** or pharmacist if your **prescription drug** needs to be **precertified.**

How to Obtain Precertification

If an outpatient **prescription drug** requires **precertification** and you use a **network pharmacy** the **prescriber** is required to obtain **precertification** for you.

When you use an **out-of-network pharmacy**, you can begin the **precertification** process by having the **prescriber** call **Aetna** at the number on your ID card.

Aetna will let your **prescriber** know if the **prescription drug** is **precertified**.

If **precertification** is denied **Aetna** will notify you how the decision can be appealed.

Medical Exceptions:

Your **prescriber** may seek a medical exception to obtain coverage for drugs for which coverage is denied through **Precertification**. You or your **prescriber** must submit such exception requests to Aetna. Coverage granted as a result of a medical exception shall be based on an individual, case by case **medical necessity** determination and coverage will not apply or extend to other covered persons.

Pharmacy Benefit Limitations

A **network pharmacy** may refuse to fill a prescription order or refill when in the professional judgment of the pharmacist the prescription should not be filled.

The plan will not cover expenses for any **prescription drug** for which the actual charge to you is less than the required **copayment** or **deductible**, or for any **prescription drug** for which no charge is made to you.

You will be charged the **out-of-network prescription drug cost sharing** for **prescription drugs** recently approved by the FDA, but which have not yet been reviewed by the Aetna Health Pharmacy Management Department and Therapeutics Committee.

Aetna retains the right to review all requests for reimbursement and in its sole discretion make reimbursement determinations subject to the Complaint and Appeals section(s) of the Booklet.

Aetna reserves the right to include only one manufacturer's product on the **preferred drug list** when the same or similar drug (that, a drug with the same active ingredient), supply or equipment is made by two or more different manufacturers.

Aetna reserves the right to include only one dosage or form of a drug on the **preferred drug list** when the same drug (that is, a drug with the same active ingredient) is available in different dosages or forms from the same or different manufacturers. The product in the dosage or form that is listed on our **preferred drug list** will be covered at the applicable **copayment** or **coinsurance**.

The number of **copayments/deductibles** you are responsible for per vial of Depo-Provera, an injectable contraceptive, or similar type contraceptive dispensed for more than a 30 day supply, will be based on the 90 day supply level. Coverage is limited to a maximum of 5 vials per plan year.

The plan will not pay charges for any **prescription drug** dispensed by a **mail order pharmacy** for the treatment of erectile dysfunction, impotence or sexual dysfunction or inadequacy.

Some **prescription drugs** are subject to quantity limits. These quantity limits help your **prescriber** and pharmacist check that your **prescription drug** is used correctly and safely. **Aetna** relies on medical guidelines, FDA-approved recommendations from drug makers and other criteria developed by **Aetna** to set these quantity limits. The quantity limit may restrict either the amount dispensed per **prescription** order or refill.

Depending on the form and packing of the product, some **prescription drugs** are limited to a single commercially prepackaged item excluding insulin, diabetic supplies, test strips dispensed per **prescription** order or refill.

Depending on the form and packing of the product, some **prescription drugs** are limited to 100 units excluding insulin dispensed per **prescription** order or refill.

Any **prescription drug** that has duration of action extending beyond one (1) month shall require the number of **copayments** per prescribing unit that is equal to the anticipated duration of the medication. For example, a single injection of a drug that is effective for three (3) months would require three (3) **copayments**.

Specialty care prescription drugs may have limited access or distribution and are subject to supply limits.

Plan approved blood glucose meters, asthma holding chambers and peak flow meters are **eligible health services**, but are limited to one (1) **prescription** order per **contract year**.

Pharmacy Benefit Exclusions

Not every health care service or supply is covered by the plan. Even if prescribed, recommended, or approved by your **physician** or **dentist** it may not be covered. The plan covers only those services and supplies that are **medically necessary** and included in the *What the Plan Covers* section. Charges made for the following are not covered except to the extent listed under the *What the Plan Covers* section or by amendment attached to this *Booklet*. In addition, some services are specifically limited or excluded. This section describes expenses that are not covered or subject to special limitations.

These **prescription drug** exclusions are in addition to the exclusions listed under your medical coverage.

The plan does not cover the following expenses:

Abortion drugs.

Administration or injection of any drug.

Any charges in excess of the benefit, dollar, day, or supply limits stated in this *Booklet*.

Allergy sera and extracts.

Any non-emergency charges incurred outside of the United States if you traveled to such location to obtain **prescription drugs**, or supplies, even if otherwise covered under this *Booklet*. This also includes **prescription drugs** or supplies if:

- Such drugs or supplies are unavailable or illegal in the United States, or
- The purchase of such **prescription drugs** or supplies outside the United States is considered illegal.

Any drugs or medications, services and supplies that are not **medically necessary**, as determined by **Aetna**, for the diagnosis, care or treatment of the **illness** or **injury** involved. This applies even if they are prescribed, recommended or approved by your **physician** or **dentist**.

Biological sera, blood, blood plasma, blood products or substitutes or any other blood products.

Contraception:

- Over the counter contraceptive supplies including but not limited to:
  - condoms;
  - contraceptive foams;
  - jellies; and
  - ointments;
- Services associated with the prescribing, monitoring and/or administration of contraceptives.

Cosmetic drugs, medications or preparations used for **cosmetic** purposes or to promote hair growth or removal, including but not limited to:

- health and beauty aids;
- chemical peels;
- dermabrasion;
- treatments;
- bleaching;
- creams;
- ointments or other treatments or supplies, to remove tattoos, scars or to alter the appearance or texture of the skin.

Compounded **prescriptions**.

Devices and appliances that do not have the National Drug Code (NDC).

Dietary supplements including medical foods.

Drugs given or entirely consumed at the time and place it is prescribed or dispensed.

Drugs for which the cost is recoverable under any federal, state, or government agency or any medication for which there is no charge made to the recipient.

Drugs which do not, by federal or state law, require a **prescription** order (i.e. over-the-counter (OTC) drugs), even if a **prescription** is written (except as specifically covered in the *What the Pharmacy Plan Covers* section.

Drugs provided by, or while the person is an inpatient in, any healthcare facility; or for any drugs provided on an outpatient basis in any such institution to the extent benefits are payable for it.

Drugs that include vitamins and minerals, both over-the counter (OTC) and legend, except legend pre-natal vitamins for pregnant or nursing females, liquid or chewable legend pediatric vitamins for children under age 13, and potassium supplements to prevent/treat low potassium and legend vitamins that are medically necessary for the treatment of renal disease, hyperparathyroidism or other covered conditions with prior approval from us unless recommended by the United States Preventive Services Task Force (USPSTF).

Drugs used for methadone maintenance medications used for drug detoxification.

Drugs used for the purpose of weight gain or reduction, including but not limited to:

- stimulants;
- preparations;
- foods or diet supplements;
- dietary regimens and supplements;
- food or food supplements;
- appetite suppressants; and

- other medications.

Drugs used for the treatment of obesity.

All drugs or growth hormones used to stimulate growth and treat idiopathic short stature unless there is evidence that the member meets one or more clinical criteria detailed in our precertification and clinical policies.

Drugs or medications that include the same active ingredient or a modified version of an active ingredient.

Drug or medication that is therapeutically equivalent or therapeutically alternative to a covered **prescription drug**.

Drug or medication that is therapeutically equivalent or therapeutically alternative to an over-the-counter (OTC) product.

Duplicative drug therapy (e.g. two antihistamine drugs.

Durable medical equipment, monitors and other equipment.

Experimental or investigational drugs or devices, except as described in the *What the Plan Covers* section.

This exclusion will ***not*** apply with respect to drugs that:

- Have been granted treatment investigational new drug (IND); or Group c/treatment IND status; or
- Are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute; and
- **Aetna** determines, based on available scientific evidence, are effective or show promise of being effective for the **illness**.

Food items: Any food item, including:
- infant formulas;
- nutritional supplements;
- vitamins;
- medical foods and other nutritional items, even if it is the sole source of nutrition.

Genetics: Any treatment, device, drug, or supply to alter the body's genes, genetic make-up, or the expression of the body's genes except for the correction of congenital birth defects.

Immunization or immunological agents.

Implantable drugs and associated devices.

Injectables:

- Any charges for the administration or injection of **prescription drugs** or injectable insulin and other injectable drugs covered by the Plan;
- Needles and syringes, except for diabetic needles and syringes;
- Injectable drugs if an alternative oral drug is available;
- For any refill of a designated self-injectable drug not dispensed by or obtained through the **specialty pharmacy network**. An updated copy of the list of self-injectable drugs designated by this plan to be refilled by or obtained through the **specialty pharmacy network** is available upon request. You may also get a copy of the list on **Aetna's** website at www.aetna.com.
- For any drug, which due to its characteristics as determined by us must typically be administered or supervised by a qualified **provider** or licensed certified **health professional** in an outpatient setting. This exception does not apply to Depo Provera and other injectable drugs used for contraception.

Insulin pumps or tubing or other ancillary equipment and supplies for insulin pumps.

Prescription drugs for which there is an over-the-counter (OTC) product which has the same active ingredient and strength even if a **prescription** is written.

Prescription drugs, medications, injectables or supplies provided through a third party vendor contract with the contractholder.

Prescription drugs dispensed by a **mail order pharmacy** that include **prescription drugs** that cannot be shipped by mail due to state or federal laws or regulations, or when the plan considers shipment through the mail to be unsafe. Examples of these types of drugs include, but are not limited to, narcotics, amphetamines, DEA controlled substances and anticoagulants.

Prescription drugs that include an active metabolite, stereoisomer, prodrug (precursor) or altered formulation of another drug and is not clinically superior to that drug as determined by the plan.

Prescription drugs that are ordered by a **dentist** or prescribed by an oral surgeon in relation to the removal of teeth, or **prescription drugs** for the treatment of a dental condition.

Prescription drugs that are **non-preferred drugs**, unless **non-preferred drugs** are specifically covered as described in your schedule of benefits. However, a **non-preferred drug** will be covered if in the judgment of the **prescriber** there is no equivalent **prescription drug** on the **preferred drug guide** or the product on the **preferred drug guide** is ineffective in treating your disease or condition or has caused or is likely to cause an adverse reaction or harm you.

Prescription drugs that are being used or abused in a manner that is determined to be furthering an addiction to a habit-forming substance, the use of or intended use of which would be illegal, unethical, imprudent, abusive, not **medically necessary**, or otherwise improper; and drugs obtained for use by anyone other than the member identified on the ID card.

Prescription orders filled prior to the effective date or after the termination date of coverage under this Booklet.

Progesterone for the treatment of premenstrual syndrome (PMS) and compounded natural hormone therapy replacement.

Prophylactic drugs for travel.

Refills over the amount specified by the **prescription** order. Before recognizing charges, **Aetna** may require a new **prescription** or proof as to need, if a **prescription** or refill appears excessive under accepted medical practice standards.

Refills dispensed more than one year from the date the latest **prescription** order was written, or as otherwise allowed by applicable law of the jurisdiction in which the drug is dispensed.

Replacement of lost or stolen **prescription**s.

Drugs, services and supplies given in connection with treatment of an **occupational injury or occupational illness**.

Strength and performance: Drugs or preparations, devices or supplies to enhance strength, physical condition, endurance or physical performance, including performance enhancing steroids.

Sex change: Any treatment, drug or supply related to changing sex or sexual characteristics, including hormones and hormone therapy.

Supplies, devices or equipment of any type, except as specifically provided in the *What the Plan Covers* section.

Test agents except diabetic test agents.

When Coverage Ends

Coverage under your plan can end for a variety of reasons. In this section, you will find details on how and why coverage ends, and how you may still be able to continue coverage.

When Coverage Ends for Employees

Your **Aetna** health benefits coverage will end if:

- The **Aetna** health benefits plan is discontinued;
- You voluntarily stop your coverage;
- You are no longer eligible for coverage;
- You do not make any required contributions;
- You become covered under another plan offered by your employer;
- You have exhausted your overall maximum lifetime benefit under your health plan, if your plan contains such a maximum benefit; or
- Your employer notifies **Aetna** that your employment is ended.

It is your employer's responsibility to let **Aetna** know when your employment ends.

Your Proof of Prior Medical Coverage

Under the Health Insurance Portability and Accountability Act of 1996, your employer is required to give you a certificate of **creditable coverage** when your employment ends. This certificate proves that you were covered under this plan when you were employed. Ask your employer about the certificate of **creditable coverage**.

When Coverage Ends for Dependents

Coverage for your dependents will end if:

- You are no longer eligible for dependents' coverage;
- You do not make your contribution for the cost of dependents' coverage;
- Your own coverage ends for any of the reasons listed under *When Coverage Ends* for Employees. (This does not apply if you use up your overall lifetime maximum, if included);
- Your dependent is no longer eligible for coverage. Coverage ends at the end of the pay period when your dependent does not meet the plan's definition of a dependent; or
- As permitted under applicable federal and state law, your dependent becomes eligible for like benefits under this or any other group plan offered by your employer.

Coverage for dependents may continue for a period after your death. Coverage for handicapped dependents may continue after they reach any limiting age. See *Continuation of Coverage* for more information.

Continuation of Coverage

Continuing Health Care Benefits

Continuing Coverage for Dependent Students on Medical Leave of Absence

If your dependent child who is eligible for coverage and enrolled in this plan by reason of his or her status as a full-time student at a postsecondary educational institution ceases to be eligible due to:

- a medically necessary leave of absence from school; or
- a change in his or her status as a full-time student,

resulting from a serious **illness** or **injury**, such child's coverage under this plan may continue.

Coverage under this continuation provision will end when the first of the following occurs:

- The end of the 12 month period following the first day of your dependent child's leave of absence from school, or a change in his or her status as a full-time student;
- Your dependent child's coverage would otherwise end under the terms of this plan;
- Dependent coverage is discontinued under this plan; or
- You fail to make any required contribution toward the cost of this coverage.

To be eligible for this continuation, the dependent child must have been enrolled in this plan and attending school on a full-time basis immediately before the first day of the leave of absence.

To continue your dependent child's coverage under this provision you should notify your employer as soon as possible after your child's leave of absence begins or the change in his or her status as a full-time student. **Aetna** may require a written certification from the treating **physician** which states that the child is suffering from a serious **illness** or **injury** and that the resulting leave of absence (or change in full-time student status) is **medically necessary**.

Important Note
If at the end of this 12 month continuation period, your dependent child's leave of absence from school (or change in full-time student status) continues, such child may qualify for a further continuation of coverage under the Handicapped Dependent Children provision of this plan. Please see the section, *Handicapped Dependent Children*, for more information.

Handicapped Dependent Children

Health Expense Coverage for your fully handicapped dependent child may be continued past the maximum age for a dependent child. However, such coverage may not be continued if the child has been issued an individual medical conversion policy.

Your child is fully handicapped if:

- he or she is not able to earn his or her own living because of mental retardation or a physical handicap which started prior to the date he or she reaches the maximum age for dependent children under your plan; and
- he or she depends chiefly on you for support and maintenance.

Proof that your child is fully handicapped must be submitted to **Aetna** no later than 31 days after the date your child reaches the maximum age under your plan.

Coverage will cease on the first to occur of:

- Cessation of the handicap.
- Failure to give proof that the handicap continues.
- Failure to have any required exam.
- Termination of Dependent Coverage as to your child for any reason other than reaching the maximum age under your plan.

Aetna will have the right to require proof of the continuation of the handicap. **Aetna** also has the right to examine your child as often as needed while the handicap continues at its own expense. An exam will not be required more often than once each year after 2 years from the date your child reached the maximum age under your plan.

Coordination of Benefits - What Happens When There is More Than One Health Plan

Other Plans Not Including Medicare

Other Plans Not Including Medicare

Some persons have health coverage in addition to coverage under this Plan. Under these circumstances, it is not intended that a plan provide duplicate benefits. For this reason, many plans, including this Plan, have a "coordination of benefits" provision.

Under the coordination of benefits provision of this Plan, the amount normally reimbursed under this Plan is reduced to take into account payments made by "other plans".

When this and another health expenses coverage plan applies, the order in which the various plans will pay benefits must be figured. This will be done as follows using the first rule that applies:

1. A plan with no rules for coordination with other benefits will be deemed to pay its benefits before a plan which contains such rules.
2. A plan which covers a person other than as a dependent will be deemed to pay its benefits before a plan which covers the person as a dependent; except that if the person is also a Medicare beneficiary and as a result of the Social Security Act of 1965, as amended, Medicare is:
   - secondary to the plan covering the person as a dependent; and
   - primary to the plan covering the person as other than a dependent;

   The benefits of a plan which covers the person as a dependent will be determined before the benefits of a plan which:
   - covers the person as other than a dependent; and
   - is secondary to Medicare.
3. Except in the case of a dependent child whose parents are divorced or separated; the plan which covers the person as a dependent of a person whose birthday comes first in a calendar year will be primary to the plan which covers the person as a dependent of a person whose birthday comes later in that calendar year. If both parents have the same birthday, the benefits of a plan which covered one parent longer are determined before those of a plan which covered the other parent for a shorter period of time.

   If the other plan does not have the rule described in this provision (3) but instead has a rule based on the gender of the parent and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.
4. In the case of a dependent child whose parents are divorced or separated:

   a. If there is a court decree which states that the parents shall share joint custody of a dependent child, without stating that one of the parents is responsible for the health care expenses of the child, the order of benefit determination rules specified in (3) above will apply.
   b. If there is a court decree which makes one parent financially responsible for the medical, dental or other health care expenses of such child, the benefits of a plan which covers the child as a dependent of such parent will be determined before the benefits of any other plan which covers the child as a dependent child.

c. If there is not such a court decree:

- If the parent with custody of the child has not remarried, the benefits of a plan which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody.
- If the parent with custody of the child has remarried, the benefits of a plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a plan which covers that child as a dependent of the stepparent. The benefits of a plan which covers that child as a dependent of the stepparent will be determined before the benefits of a plan which covers that child as a dependent of the parent without custody.

5. If 1, 2, 3 and 4 above do not establish an order of payment, the plan under which the person has been covered for the longest will be deemed to pay its benefits first; except that:

The benefits of a plan which covers the person on whose expenses claim is based as a:
- laid-off or retired employee; or
- the dependent of such person.

Shall be determined after the benefits of any other plan which covers such person as:
- an employee who is not laid-off or retired; or
- dependent of such person.

If the other plan does not have a provision:
- regarding laid-off or retired employees; and
- as a result, each plan determines its benefits after the other;

then the above paragraph will not apply.

The benefits of a plan which covers the person on whose expenses claim is based under a right of continuation pursuant to federal or state law shall be determined after the benefits of any other plan which covers the person other than under such right of continuation.

If the other plan does not have a provision:
- regarding right of continuation pursuant to federal or state law; and
- as a result, each plan determines its benefits after the other;

then the above paragraph will not apply.

The general rule is that the benefits otherwise payable under this Plan for all expenses processed during a single "processed claim transaction" will be reduced by the total benefits payable under all "other plans" for the same expenses. An exception to this rule is that when the coordination of benefits rules of this Plan and any "other plan" both agree that this Plan is primary, the benefits of the other plan will be ignored in applying this rule. As used in this paragraph, a "processed claim transaction" is a group of actual or prospective charges submitted to Aetna for consideration, that have been grouped together for administrative purposes as a "claim transaction" in accordance with Aetna's then current rules. If the contract includes both medical and dental coverage, those coverages will be considered separate plans. The Medical/Pharmacy coverage will be coordinated with other Medical/Pharmacy plans. In turn, the dental coverage will be coordinated with other dental plans.

In order to administer this provision, Aetna can release or obtain data. Aetna can also make or recover payments.

Other Plan
This means any other plan of health expense coverage under:

- Group insurance.
- Any other type of coverage for persons in a group. This includes plans that are insured and those that are not.
- No-fault auto insurance required by law and provided on other than a group basis. Only the level of benefits required by the law will be counted.

When You Have Medicare Coverage

Effect of Medicare

Effect of Medicare

Health Expense Coverage under this Plan will be changed for any person while eligible for Medicare.

A person is "eligible for Medicare" if he or she:

- Is covered under it;
- Is not covered under it because of:
  - Having refused it;
  - Having dropped it;
  - Having failed to make proper request for it.

These are the changes:

- The total amount of "regular benefits" under all Health Expense Benefits will be figured. (This will be the amount that would be payable if there were no Medicare benefits.) If this is more than the amount Medicare provides for the expenses involved, this Plan will pay the difference. Otherwise, this Plan will pay no benefits. This will be done for each claim.
- Charges used to satisfy a person's Part B deductible under Medicare will be applied under this Plan in the order received by **Aetna**. Two or more charges received at the same time will be applied starting with the largest first.
- Medicare benefits will be taken into account for any person while he or she is eligible for Medicare. This will be done whether or not he or she is entitled to Medicare benefits.
- Any rule for coordinating "other plan" benefits with those under this Plan will be applied after this Plan's benefits have been figured under the above rules. Any benefits under Medicare will not be deemed to be an "Allowable Expense."

Coverage will not be changed at any time when your Employer's compliance with federal law requires this Plan's benefits for a person to be figured before benefits are figured under Medicare.

General Provisions

Type of Coverage

Coverage under the plan is **non-occupational**. Only **non-occupational** accidental **injuries** and **non-occupational illnesses** are covered. The plan covers charges made for services and supplies only while the person is covered under the plan.

Physical Examinations

Aetna will have the right and opportunity to examine and evaluate any person who is the basis of any claim at all reasonable times while a claim is pending or under review. This will be done at no cost to you.

Legal Action

No legal action can be brought to recover payment under any benefit after 3 years from the deadline for filing claims.

Additional Provisions

The following additional provisions apply to your coverage:

- This Booklet applies to coverage only, and does not restrict your ability to receive health care services that are not, or might not be, covered.
- You cannot receive multiple coverage under the plan because you are connected with more than one employer.
- In the event of a misstatement of any fact affecting your coverage under the plan, the true facts will be used to determine the coverage in force.
- This document describes the main features of the plan. If you have any questions about the terms of the plan or about the proper payment of benefits, contact your employer or **Aetna**.
- The plan may be changed or discontinued with respect to your coverage.

Assignments

Coverage and your rights under this plan may not be assigned. A direction to pay a provider is not an assignment of any right under this plan or of any legal or equitable right to institute any court proceeding.

Misstatements

Aetna's failure to implement or insist upon compliance with any provision of this plan at any given time or times, shall not constitute a waiver of **Aetna's** right to implement or insist upon compliance with that provision at any other time or times.

Fraudulent misstatements in connection with any claim or application for coverage may result in termination of all coverage under this plan.

Rescission of Coverage

Aetna may rescind your coverage if you, or the person seeking coverage on your behalf:

- Performs an act, practice or omission that constitutes fraud; or

- Makes an intentional misrepresentation of material fact.

You will be given 30 days advance written notice of any rescission of coverage.

As to medical and prescription drug coverage only, you have the right to an internal Appeal with **Aetna** and/or the right to a third party review conducted by an independent External Review Organization if your coverage under this Booklet is rescinded retroactive to its Effective Date.

Subrogation and Right of Recovery Provision

The provisions of this section apply to all current or former plan participants and also to the parents, guardian, or other representative of a dependent child who incurs claims and is or has been covered by the plan. The plan's right to recover (whether by subrogation or reimbursement) shall apply to the personal representative of your estate, your decedents, minors, and incompetent or disabled persons. "You" or "your" includes anyone on whose behalf the plan pays benefits. No adult covered person hereunder may assign any rights that it may have to recover medical expenses from any tortfeasor or other person or entity to any minor child or children of said adult covered person without the prior express written consent of the plan.

The plan's right of subrogation or reimbursement, as set forth below, extend to all insurance coverage available to you due to an **injury**, **illness** or condition for which the plan has paid medical claims (including, but not limited to, liability coverage, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers' compensation coverage, no-fault automobile coverage or any first party insurance coverage).

Your health plan is always secondary to automobile no-fault coverage, personal injury protection coverage, or medical payments coverage.

Subrogation
The right of subrogation means the plan is entitled to pursue any claims that you may have in order to recover the benefits paid by the plan. Immediately upon paying or providing any benefit under the plan, the plan shall be subrogated to (stand in the place of) all rights of recovery with respect to any claim or potential claim against any party, due to an **injury**, **illness** or condition to the full extent of benefits provided or to be provided by the plan. The plan may assert a claim or file suit in your name and take appropriate action to assert its subrogation claim, with or without your consent. The plan is not required to pay you part of any recovery it may obtain, even if it files suit in your name.

Reimbursement
If you receive any payment as a result of an **injury**, **illness** or condition, you agree to reimburse the plan first from such payment for all amounts the plan has paid and will pay as a result of that **injury**, **illness** or condition, up to and including the full amount of your recovery.

Constructive Trust
By accepting benefits (whether the payment of such benefits is made to you or made on your behalf to any provider) you agree that if you receive any payment as a result of an **injury**, **illness** or condition, you will serve as a constructive trustee over those funds. Failure to hold such funds in trust will be deemed a breach of your fiduciary duty to the plan.

Lien Rights
Further, the plan will automatically have a lien to the extent of benefits paid by the plan for the treatment of the **illness**, **injury** or condition upon any recovery whether by settlement, judgment, or otherwise, related to treatment for any **illness**, **injury** or condition for which the plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the plan including, but not limited to, you, your representative or agent, and/or any other source possessing funds representing the amount of benefits paid by the plan.

Assignment
In order to secure the plan's recovery rights, you agree to assign to the plan any benefits or claims or rights of recovery you have under any automobile policy or other coverage, to the full extent of the plan's subrogation and reimbursement claims. This assignment allows the plan to pursue any claim you may have, whether or not you choose to pursue the claim.

First-Priority Claim
By accepting benefits from the plan, you acknowledge that the plan's recovery rights are a first priority claim and are to be repaid to the plan before you receive any recovery for your damages. The plan shall be entitled to full reimbursement on a first-dollar basis from any payments, even if such payment to the plan will result in a recovery which is insufficient to make you whole or to compensate you in part or in whole for the damages sustained. The plan is not required to participate in or pay your court costs or attorney fees to any attorney you hire to pursue your damage claim.

Applicability to All Settlements and Judgments
The terms of this entire subrogation and right of recovery provision shall apply and the plan is entitled to full recovery regardless of whether any liability for payment is admitted and regardless of whether the settlement or judgment identifies the medical benefits the plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses. The plan is entitled to recover from *any and all* settlements or judgments, even those designated as pain and suffering, non-economic damages, and/or general damages only. The plan's claim will not be reduced due to your own negligence.

Cooperation
You agree to cooperate fully with the plan's efforts to recover benefits paid. It is your duty to notify the plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of your intention to pursue or investigate a claim to recover damages or obtain compensation due to your **injury**, **illness** or condition. You and your agents shall provide all information requested by the plan, the Claims Administrator or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the plan may reasonably request and all documents related to or filed in person injury litigation. Failure to provide this information, failure to assist the plan in pursuit of its subrogation rights, or failure to reimburse the plan from any settlement or recovery you receive may result in the termination of your health benefits or the institution of court proceedings against you.

You shall do nothing to prejudice the plan's subrogation or recovery interest or to prejudice the plan's ability to enforce the terms of this plan provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the plan. If you fail to cooperate with the plan in its efforts to recover such amounts or do anything to hinder or prevent such a recovery, you will cease to be entitled to any further plan benefits. The plan will also have the right to withhold or offset future benefit payments up to the amount of any settlement, judgment, or recovery you obtain, regardless of whether the settlement, judgment or recovery is designated to cover future medical benefits or expenses.

You acknowledge that the plan has the right to conduct an investigation regarding the **injury**, **illness** or condition to identify potential sources of recovery. The plan reserves the right to notify all parties and his/ her agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

You acknowledge that the plan has notified you that it has the right pursuant to the Health Insurance Portability & Accountability Act ("HIPAA"), 42 U.S.C. Section 1301 *et seq,* to share your personal health information in exercising its subrogation and reimbursement rights.

Interpretation
In the event that any claim is made that any part of this subrogation and right of recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the Claims Administrator for the plan shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

Jurisdiction
By accepting benefits from the plan, you agree that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the plan may elect. By accepting such benefits, you hereby submit to each such jurisdiction, waiving whatever rights may correspond by reason of your present or future domicile. By accepting such benefits, you also agree to pay all attorneys' fees the plan incurs in successful attempts to recover amounts the plan is entitled to under this section.

Workers' Compensation

If benefits are paid under the **Aetna** medical benefits plan and **Aetna** determines you received Workers' Compensation benefits for the same incident, **Aetna** has the right to recover as described under the *Subrogation and Right of Reimbursement* provision. **Aetna**, on behalf of the Plan, **w**ill exercise its right to recover against you.

The Recovery Rights will be applied even though:

- The Workers' Compensation benefits are in dispute or are made by means of settlement or compromise;
- No final determination is made that bodily **injury** or **illness** was sustained in the course of or resulted from your employment;
- The amount of Workers' Compensation due to medical or health care is not agreed upon or defined by you or the Workers' Compensation carrier; or
- The medical or health care benefits are specifically excluded from the Workers' Compensation settlement or compromise.

You hereby agree that, in consideration for the coverage provided by this **Aetna** medical benefits plan, you will notify **Aetna** of any Workers' Compensation claim you make, and that you agree to reimburse **Aetna**, on behalf of the Plan, as described above.

If benefits are paid under this **Aetna** medical benefits plan, and you or your covered dependent recover from a responsible party by settlement, judgment or otherwise, **Aetna**, on behalf of the Plan, has a right to recover from you or your covered dependent an amount equal to the amount the Plan paid.

Recovery of Overpayments

Health Coverage

If a benefit payment is made by the Plan, to or on your behalf, which exceeds the benefit amount that you are entitled to receive, the Plan has the right:

- To require the return of the overpayment; or
- To reduce by the amount of the overpayment, any future benefit payment made to or on behalf of that person or another person in his or her family.

Such right does not affect any other right of recovery the Plan may have with respect to such overpayment.

Reporting of Claims

A claim must be submitted to **Aetna** in writing. It must give proof of the nature and extent of the loss. Your employer has claim forms.

All claims should be reported promptly. The deadline for filing a claim is 90 days after the date of the loss.

If, through no fault of your own, you are not able to meet the deadline for filing claim, your claim will still be accepted if you file as soon as possible. Unless you are legally incapacitated, late claims for health benefits will not be covered if they are filed more than 2 years after the deadline.

Payment of Benefits

Benefits will be paid as soon as the necessary proof to support the claim is received. Written proof must be provided for all benefits.

All covered health benefits are payable to you. However, **Aetna** has the right to pay any health benefits to the service provider. This will be done unless you have told **Aetna** otherwise by the time you file the claim.

The Plan may pay up to $1,000 of any other benefit to any of your relatives whom it believes fairly entitled to it. This can be done if the benefit is payable to you and you are a minor or not able to give a valid release.

When a **PCP** provides care for you or a covered dependent, or care is provided by **a network provider** (**network services or supplies**), the **network provider** will take care of filing claims. However, when you seek care on your own (**out-of-network services and supplies**), you are responsible for filing your own claims.

Records of Expenses

Keep complete records of the expenses of each person. They will be required when a claim is made.

Very important are:

- Names of **physicians**, **dentists** and others who furnish services.
- Dates expenses are incurred.
- Copies of all bills and receipts.

Contacting Aetna

If you have questions, comments or concerns about your benefits or coverage, or if you are required to submit information to **Aetna**, you may contact **Aetna**'s Home Office at:

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156

You may also use **Aetna**'s toll free Member Services phone number on your ID card or visit **Aetna**'s web site at www.aetna.com.

Effect of Benefits Under Other Plans

Effect of A Health Maintenance Organization Plan (HMO Plan) On Coverage

If you are in an eligible class and have chosen coverage under an HMO Plan offered by your employer, you will be excluded from medical expense coverage (except Vision Care, if any,) on the date of your coverage under such HMO Plan.

If you are in an eligible class and are covered under an HMO Plan, you can choose to change to coverage for yourself and your covered dependents under this plan. If you:

- Live in an HMO Plan enrollment area and choose to change coverage during an open enrollment period, coverage will take effect on the group contract anniversary date after the open enrollment period. There will be no rules for waiting periods or preexisting conditions.
- Live in an HMO Plan enrollment area and choose to change coverage when there is not an open enrollment period, coverage will take effect only if and when **Aetna** gives its written consent.
- Move from an HMO Plan enrollment area or if the HMO discontinues and you choose to change coverage within 31 days of the move or the discontinuance, coverage will take effect on the date you elect such coverage. There will be no restrictions for waiting periods or preexisting conditions. If you choose to change coverage after 31 days, coverage will take effect only if and when **Aetna** gives its written consent.

No benefits will be paid for any charges for services rendered or supplies furnished under an HMO Plan.

Discount Programs

Discount Arrangements

From time to time, we may offer, provide, or arrange for discount arrangements or special rates from certain service providers such as pharmacies, optometrists, **dentists**, alternative medicine, wellness and healthy living providers to you under this plan. Some of these arrangements may be made available through third parties who may make payments to **Aetna** in exchange for making these services available.

The third party service providers are independent contractors and are solely responsible to you for the provision of any such goods and/or services. We reserve the right to modify or discontinue such arrangements at any time. These discount arrangements are not insurance. There are no benefits payable to you nor do we compensate providers for services they may render through discount arrangements.

Incentives

In order to encourage you to access certain medical services when deemed appropriate by you in consultation with your **physician** or other service providers, we may, from time to time, offer to waive or reduce a member's **copayment**, **payment percentage**, and/or a **deductible** otherwise required under the plan or offer coupons or other financial incentives. We have the right to determine the amount and duration of any waiver, reduction, coupon, or financial incentive and to limit the covered persons to whom these arrangements are available.

Claims, Appeals and External Review

Filing Health Claims under the Plan

Under the Plan, you may file claims for Plan benefits and appeal adverse claim determinations. Any reference to "you" in this Claims, Appeals and External Review section includes you and your Authorized Representative. An "Authorized Representative" is a person you authorize, in writing, to act on your behalf. The Plan will also recognize a court order giving a person authority to submit claims on your behalf. In the case of an urgent care claim, a health care professional with knowledge of your condition may always act as your Authorized Representative.

If your claim is denied in whole or in part, you will receive a written notice of the denial from Aetna Life Insurance Company (Aetna). The notice will explain the reason for the denial and the appeal procedures available under the Plan.

Urgent Care Claims
An "Urgent Care Claim" is any claim for medical care or treatment for which the application of the time periods for making non-urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function, or, in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

If the Plan requires advance approval of a service, supply or procedure before a benefit will be payable, and if Aetna or your physician determines that it is an Urgent Care Claim, you will be notified of the decision, whether adverse or not, as soon as possible but not later than 72 hours after the claim is received.

If there is not sufficient information to decide the claim, you will be notified of the information necessary to complete the claim as soon as possible, but not later than 24 hours after receipt of the claim. You will be given a reasonable additional amount of time, but not less than 48 hours, to provide the information, and you will be notified of the decision not later than 48 hours after the end of that additional time period (or after receipt of the information, if earlier).

Other Claims (Pre-Service and Post-Service)
If the Plan requires you to obtain advance approval of a non-urgent service, supply or procedure before a benefit will be payable, a request for advance approval is considered a pre-service claim. You will be notified of the decision not later than 15 days after receipt of the pre-service claim.

For other claims (post-service claims), you will be notified of the decision not later than 30 days after receipt of the claim.

For either a pre-service or a post-service claim, these time periods may be extended up to an additional 15 days due to circumstances outside Aetna's control. In that case, you will be notified of the extension before the end of the initial 15 or 30-day period. For example, they may be extended because you have not submitted sufficient information, in which case you will be notified of the specific information necessary and given an additional period of at least 45 days after receiving the notice to furnish that information. You will be notified of Aetna's claim decision no later than 15 days after the end of that additional period (or after receipt of the information, if earlier).

For pre-service claims which name a specific claimant, medical condition, and service or supply for which approval is requested, and which are submitted to an Aetna representative responsible for handling benefit matters, but which otherwise fail to follow the Plan's procedures for filing pre-service claims, you will be notified of the failure within 5 days (within 24 hours in the case of an urgent care claim) and of the proper procedures to be followed. The notice may be oral unless you request written notification.

Ongoing Course of Treatment
If you have received pre-authorization for an ongoing course of treatment, you will be notified in advance if the previously authorized course of treatment is intended to be terminated or reduced so that you will have an opportunity to appeal any decision to Aetna and receive a decision on that appeal before the termination or reduction takes effect. If the course of treatment involves urgent care, and you request an extension of the course of treatment at least 24 hours before its expiration, you will be notified of the decision within 24 hours after receipt of the request.

Health Claims – Standard Appeals
As an individual enrolled in the Plan, you have the right to file an appeal from an Adverse Benefit Determination relating to service(s) you have received or could have received from your health care provider under the Plan.

An "Adverse Benefit Determination" is defined as a denial, reduction, termination of, or failure to, provide or make payment (in whole or in part) for a service, supply or benefit. Such Adverse Benefit Determination may be based on:

- Your eligibility for coverage, including a retrospective termination of coverage (whether or not there is an adverse effect on any particular benefit);
- Coverage determinations, including plan limitations or exclusions;
- The results of any Utilization Review activities;
- A decision that the service or supply is **experimental or investigational**; or
- A decision that the service or supply is not **medically necessary**.

A "Final Internal Adverse Benefit Determination" is defined as an Adverse Benefit Determination that has been upheld by the appropriate named fiduciary (Aetna) at the completion of the internal appeals process, or an Adverse Benefit Determination for which the internal appeals process has been exhausted.

Exhaustion of Internal Appeals Process
Generally, you are required to complete all appeal processes of the Plan before being able to obtain External Review or bring an action in litigation. However, if Aetna, or the Plan or its designee, does not strictly adhere to all claim determination and appeal requirements under applicable federal law, you are considered to have exhausted the Plan's appeal requirements ("Deemed Exhaustion") and may proceed with External Review or may pursue any available remedies under §502(a) of ERISA or under state law, as applicable.

There is an exception to the Deemed Exhaustion rule. Your claim or internal appeal may not go straight to External Review if:

A rule violation was minor and is not likely to influence a decision or harm you; and
It was for a good cause or was beyond Aetna's or the Plan's or its designee's control; and
It was part of an ongoing good faith exchange between you and Aetna or the Plan.

This exception is not available if the rule violation is part of a pattern or practice of violations by Aetna or the Plan.

You may request a written explanation of the violation from the Plan or Aetna, and the Plan or Aetna must provide such explanation within 10 days, including a specific description of its bases, if any, for asserting that the violation should not cause the internal claims and appeals process to be deemed exhausted. If an External Reviewer or a court rejects your request for immediate review on the basis that the plan met the standards for the exception, you have the right to resubmit and pursue the internal appeal of the claim. In such a case, within a reasonable time after the External Reviewer or court rejects the claim for immediate review (not to exceed 10 days), you will receive notice of the opportunity to resubmit and pursue the internal appeal of the claim. Time periods for re-filing the claim shall begin to run upon your receipt of such notice.

Full and Fair Review of Claim Determinations and Appeals
Aetna will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by Aetna (or at the direction of Aetna), or any new or additional rationale as soon as possible and sufficiently in advance of the date on which the notice of Final Internal Adverse Benefit Determination is provided, to give you a reasonable opportunity to respond prior to that date.

You may file an appeal in writing to Aetna at the address provided in this booklet, or, if your appeal is of an urgent nature, you may call Aetna's Member Services Unit at the toll-free phone number on your ID card. Your request should include the group name (that is, your employer), your name, member ID, or other identifying information shown on the front of the Explanation of Benefits form, and any other comments, documents, records and other information you would like to have considered, whether or not submitted in connection with the initial claim.

An Aetna representative may call you or your health care provider to obtain medical records and/or other pertinent information in order to respond to your appeal.

You will have 180 days following receipt of an Adverse Benefit Determination to appeal the determination to Aetna. You will be notified of the decision not later than 15 days (for pre-service claims) or 30 days (for post-service claims) after the appeal is received. You may submit written comments, documents, records and other information relating to

your claim, whether or not the comments, documents, records or other information were submitted in connection with the initial claim. A copy of the specific rule, guideline or protocol relied upon in the Adverse Benefit Determination will be provided free of charge upon request by you or your Authorized Representative. You may also request that Aetna provide you, free of charge, copies of all documents, records and other information relevant to the claim.

If your claim involves urgent care, an expedited appeal may be initiated by a telephone call to the phone number included in your denial, or to Aetna's Member Services. Aetna's Member Services telephone number is on your Identification Card. You or your Authorized Representative may appeal urgent care claim denials either orally or in writing. All necessary information, including the appeal decision, will be communicated between you or your Authorized Representative and Aetna by telephone, facsimile, or other similar method. You will be notified of the decision not later than 36 hours after the appeal is received.

If you are dissatisfied with the appeal decision on an urgent care claim, you may file a second level appeal with Aetna. You will be notified of the decision not later than 36 hours after the appeal is received.

If you are dissatisfied with a pre-service or post-service appeal decision, you may file a second level appeal with Aetna within 60 days of receipt of the level one appeal decision. Aetna will notify you of the decision not later than 15 days (for pre-service claims) or 30 days (for post-service claims) after the appeal is received.

If you do not agree with the Final Internal Adverse Benefit Determination on review, you have the right to bring a civil action under Section 502(a) of ERISA, if applicable.

Health Claims – Voluntary Appeals

External Review

"External Review" is a review of an eligible Adverse Benefit Determination or a Final Internal Adverse Benefit Determination by an Independent Review Organization/External Review Organization (ERO) or by the State Insurance Commissioner, if applicable.

A "Final External Review Decision" is a determination by an ERO at the conclusion of an External Review.

You must complete all of the levels of standard appeal described above before you can request External Review, other than in a case of Deemed Exhaustion. Subject to verification procedures that the Plan may establish, your Authorized Representative may act on your behalf in filing and pursuing this voluntary appeal.

You may file a voluntary appeal for External Review of any Adverse Benefit Determination or any Final Internal Adverse Benefit Determination that qualifies as set forth below.

The notice of Adverse Benefit Determination or Final Internal Adverse Benefit Determination that you receive from Aetna will describe the process to follow if you wish to pursue an External Review, and will include a copy of the *Request for External Review Form*.

You must submit the *Request for External Review Form* to Aetna within 123 calendar days of the date you received the Adverse Benefit Determination or Final Internal Adverse Benefit Determination notice. If the last filing date would fall on a Saturday, Sunday or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday or Federal holiday. You also must include a copy of the notice and all other pertinent information that supports your request.

If you file a voluntary appeal, any applicable statute of limitations will be tolled while the appeal is pending. The filing of a claim will have no effect on your rights to any other benefits under the Plan. However, the appeal is voluntary and you are not required to undertake it before pursuing legal action.

If you choose not to file for voluntary review, the Plan will not assert that you have failed to exhaust your administrative remedies because of that choice.

Request for External Review
The External Review process under this Plan gives you the opportunity to receive review of an Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination) conducted pursuant to applicable law. Your request will be eligible for External Review if the claim decision involves medical judgment and the following are satisfied:

- Aetna, or the Plan or its designee, does not strictly adhere to all claim determination and appeal requirements under federal law (except for minor violations); or
- the standard levels of appeal have been exhausted; or
- the appeal relates to a rescission, defined as a cancellation or discontinuance of coverage which has retroactive effect.

An Adverse Benefit Determination based upon your eligibility is not eligible for External Review.

If upon the final standard level of appeal, the coverage denial is upheld and it is determined that you are eligible for External Review, you will be informed in writing of the steps necessary to request an External Review.

An independent review organization refers the case for review by a neutral, independent clinical reviewer with appropriate expertise in the area in question. The decision of the independent external expert reviewer is binding on you, Aetna and the Plan unless otherwise allowed by law.

Preliminary Review
Within 5 business days following the date of receipt of the request, Aetna must provide a preliminary review determining: you were covered under the Plan at the time the service was requested or provided, the determination does not relate to eligibility, you have exhausted the internal appeals process (unless Deemed Exhaustion applies), and you have provided all paperwork necessary to complete the External Review and you are eligible for external review.

Within one business day after completion of the preliminary review, Aetna must issue to you a notification in writing. If the request is complete but not eligible for External Review, such notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, such notification will describe the information or materials needed to make the request complete and Aetna must allow you to perfect the request for External Review within the 123 calendar days filing period or within the 48 hour period following the receipt of the notification, whichever is later.

Referral to ERO
Aetna will assign an ERO accredited as required under federal law, to conduct the External Review. The assigned ERO will timely notify you in writing of the request's eligibility and acceptance for External Review, and will provide an opportunity for you to submit in writing within 10 business days following the date of receipt, additional information that the ERO must consider when conducting the External Review. Within one (1) business day after making the decision, the ERO must notify you, Aetna and the Plan.

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

(i) Your medical records;
(ii) The attending health care professional's recommendation;
(iii) Reports from appropriate health care professionals and other documents submitted by the Plan or issuer, you, or your treating provider;
(iv) The terms of your Plan to ensure that the ERO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law;
(v) Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards,

and associations;
(vi) Any applicable clinical review criteria developed and used by Aetna, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and
(vii) The opinion of the ERO's clinical reviewer or reviewers after considering the information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

The assigned ERO must provide written notice of the Final External Review Decision within 45 days after the ERO receives the request for the External Review. The ERO must deliver the notice of Final External Review Decision to you, Aetna and the Plan.

After a Final External Review Decision, the ERO must maintain records of all claims and notices associated with the External Review process for six years. An ERO must make such records available for examination by the claimant, Plan, or State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws.

Upon receipt of a notice of a Final External Review Decision reversing the Adverse Benefit Determination or Final Internal Adverse Benefit Determination, the Plan immediately must provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

Expedited External Review
The Plan must allow you to request an expedited External Review at the time you receive:

(a) An Adverse Benefit Determination if the Adverse Benefit Determination involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or
(b) A Final Internal Adverse Benefit Determination, if you have a medical condition where the timeframe for completion of a standard External Review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the Final Internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but have not been discharged from a facility.

Immediately upon receipt of the request for expedited External Review, Aetna will determine whether the request meets the reviewability requirements set forth above for standard External Review. Aetna must immediately send you a notice of its eligibility determination.

Referral of Expedited Review to ERO
Upon a determination that a request is eligible for External Review following preliminary review, Aetna will assign an ERO. The ERO shall render a decision as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the ERO receives the request for an expedited External Review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned ERO must provide written confirmation of the decision to you, Aetna and the Plan.

Glossary

In this section, you will find definitions for the words and phrases that appear in **bold type** throughout the text of this Booklet.

A

Aetna
Aetna Life Insurance Company, an affiliate, or a third party vendor under contract with **Aetna**.

Ambulance
A vehicle that is staffed with medical personnel and equipped to transport an ill or injured person.

Average Wholesale Price (AWP)
The current **average wholesale price** of a **prescription drug** listed in the Facts and Comparisons weekly price updates (or any other similar publication designated by **Aetna**) on the day that a **pharmacy** claim is submitted for adjudication.

B

Behavioral Health Provider/Practitioner
A licensed organization or professional providing diagnostic, therapeutic or psychological services for behavioral health conditions.

Birthing Center
A freestanding facility that meets ***all*** of the following requirements:

- Meets licensing standards.
- Is set up, equipped and run to provide prenatal care, delivery and immediate postpartum care.
- Charges for its services.
- Is directed by at least one **physician** who is a **specialist** in obstetrics and gynecology.
- Has a **physician** or certified nurse midwife present at all births and during the immediate postpartum period.
- Extends staff privileges to **physicians** who practice obstetrics and gynecology in an area **hospital**.
- Has at least 2 beds or 2 birthing rooms for use by patients while in labor and during delivery.
- Provides, during labor, delivery and the immediate postpartum period, full-time **skilled nursing services** directed by an **R.N.** or certified nurse midwife.
- Provides, or arranges with a facility in the area for, diagnostic X-ray and lab services for the mother and child.
- Has the capacity to administer a local anesthetic and to perform minor surgery. This includes episiotomy and repair of perineal tear.
- Is equipped and has trained staff to handle **emergency medical conditions** and provide immediate support measures to sustain life if:
  - Complications arise during labor; or
  - A child is born with an abnormality which impairs function or threatens life.
- Accepts only patients with low-risk pregnancies.
- Has a written agreement with a **hospital** in the area for emergency transfer of a patient or a child. Written procedures for such a transfer must be displayed and the staff must be aware of them.
- Provides an ongoing quality assurance program. This includes reviews by **physicians** who do not own or direct the facility.
- Keeps a medical record on each patient and child.

Body Mass Index
This is a practical marker that is used to assess the degree of obesity and is calculated by dividing the weight in kilograms by the height in meters squared.

Brand-Name Prescription Drug
A **prescription drug** with a proprietary name assigned to it by the manufacturer or distributor and so indicated by Medi-Span or any other similar publication designated by **Aetna** or an affiliate.

C

Copay or Copayment
The specific dollar amount or percentage required to be paid by you or on your behalf. The plan includes various **copayments**, and these **copayment** amounts or percentages are specified in the *Schedule of Benefits*.

Cosmetic
Services or supplies that alter, improve or enhance appearance.

Covered Expenses
Medical, dental, vision or hearing services and supplies shown as covered under this Booklet.

Creditable Coverage
A person's prior medical coverage as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Such coverage includes:

- Health coverage issued on a group or individual basis;
- Medicare;
- Medicaid;
- Health care for members of the uniformed services;
- A program of the Indian Health Service;
- A state health benefits risk pool;
- The Federal Employees' Health Benefit Plan (FEHBP);
- A public health plan (any plan established by a State, the government of the United States, or any subdivision of a State or of the government of the United States, or a foreign country);
- Any health benefit plan under Section 5(e) of the Peace Corps Act; and
- The State Children's Health Insurance Program (S-Chip).

Custodial Care
Services and supplies that are primarily intended to help you meet personal needs. **Custodial care** can be prescribed by a **physician** or given by trained medical personnel. It may involve artificial methods such as feeding tubes, ventilators or catheters. Examples of **custodial care** include:

- Routine patient care such as changing dressings, periodic turning and positioning in bed, administering medications;
- Care of a stable tracheostomy (including intermittent suctioning);
- Care of a stable colostomy/ileostomy;
- Care of stable gastrostomy/jejunostomy/nasogastric tube (intermittent or continuous) feedings;
- Care of a stable indwelling bladder catheter (including emptying/changing containers and clamping tubing);
- Watching or protecting you;
- Respite care, adult (or child) day care, or convalescent care;
- Institutional care, including **room and board** for rest cures, adult day care and convalescent care;

- Help with the daily living activities, such as walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating or preparing foods;
- Any services that a person without medical or paramedical training could be trained to perform; and
- Any service that can be performed by a person without any medical or paramedical training.

D

Day Care Treatment

A **partial confinement treatment** program to provide treatment for you during the day. The **hospital**, **psychiatric hospital** or **residential treatment facility** does not make a room charge for **day care treatment.** Such treatment must be available for at least 4 hours, but not more than 12 hours in any 24-hour period.

Deductible

The part of your **covered expenses** you pay before the plan starts to pay benefits. Additional information regarding **deductibles** and **deductible** amounts can be found in the *Schedule of Benefits*.

Dentist

A legally qualified **dentist**, or a **physician** licensed to do the dental work he or she performs.

Detoxification

The process by which an alcohol-intoxicated or drug-intoxicated; or an alcohol-dependent or drug-dependent person is medically managed through the period of time necessary to eliminate, by metabolic or other means, the:

- Intoxicating alcohol or drug;
- Alcohol or drug-dependent factors; or
- Alcohol in combination with drugs;

as determined by a **physician**. The process must keep the physiological risk to the patient at a minimum, and take place in a facility that meets any applicable licensing standards established by the jurisdiction in which it is located.

Directory

A listing of all **network providers** serving the class of employees to which you belong. The contractholder will give you a copy of this **directory**. **Network provider** information is also available through **Aetna's** online provider **directory**, DocFind®.

Durable Medical and Surgical Equipment (DME)

Equipment, and the accessories needed to operate it, that is:

- Made to withstand prolonged use;
- Made for and mainly used in the treatment of an **illness** or **injury**;
- Suited for use in the home;
- Not normally of use to people who do not have an **illness** or **injury**;
- Not for use in altering air quality or temperature; and
- Not for exercise or training.

Durable medical and surgical equipment does not include equipment such as whirlpools, portable whirlpool pumps, sauna baths, massage devices, over bed tables, elevators, communication aids, vision aids and telephone alert systems.

E

E-visit

An **E-visit** is an online internet consultation between a network **physician** and an established patient about a non-emergency healthcare matter. This visit must be conducted through an **Aetna** authorized internet E-visit service vendor.

Effective Treatment of a Mental Disorder

This is a program that:

- Is prescribed; and supervised; by a **physician**; and
- Is for a **mental disorder** that can be favorably changed.

Emergency Care

This means the treatment given in a **hospital'**s emergency room to evaluate and treat an **emergency medical condition**.

Emergency Medical Condition

A recent and severe medical condition, including (but not limited to) severe pain, which would lead a prudent layperson possessing an average knowledge of medicine and health, to believe that his or her condition, **illness**, or **injury** is of such a nature that failure to get immediate medical care could result in:

- Placing your health in serious jeopardy; or
- Serious impairment to bodily function; or
- Serious dysfunction of a body part or organ; or
- In the case of a pregnant woman, serious jeopardy to the health of the fetus.

Experimental or Investigational

Except as provided for under the Clinical Trials benefit provision, a drug, a device, a procedure, or treatment will be determined to be **experimental or investigational** if:

- There is not enough outcomes data available from controlled clinical trials published in the peer-reviewed literature to substantiate its safety and effectiveness for the **illness** or **injury** involved; or
- Approval required by the U. S. Food and Drug Administration (FDA) has not been granted for marketing; or
- A recognized national medical or dental society or regulatory agency has determined, in writing, that it is **experimental or investigational**, or for research purposes; or
- It is a type of drug, device, procedure or treatment that is the subject of a Phase I or Phase II clinical trial or the experimental or research arm of a Phase III clinical trial, using the definition of "phases" indicated in regulations and other official actions and publications of the FDA and Department of Health and Human Services; or
- The written protocol or protocols used by the treating facility, or the protocol or protocols of any other facility studying substantially the same:
  - drug;
  - device;
  - procedure; or
  - treatment.

It also includes the written informed consent used by:

- the treating facility; or
- by another facility studying the same:
  - drug;
  - device;

- procedure; or
- treatment.

that states that it is **experimental or investigational**, or for research purposes.

G

Generic Prescription Drug

A **prescription drug**, that is identified by its:

- chemical;
- proprietary; or
- non-proprietary name; and
- is accepted by the U.S. Food and Drug Administration as therapeutically the same; and
- can be replaced with drugs with the same amount of active ingredient; and
- so stated by Medispan or any other publication named by **Aetna** or consort.

H

Homebound

This means that you are confined to your place of residence:

- Due to an **illness** or **injury** which makes leaving the home medically contraindicated; or
- Because the act of transport would be a serious risk to your life or health.

Situations where you would not be considered **homebound** include (but are not limited to) the following:

- You do not often travel from home because of feebleness or insecurity brought on by advanced age (or otherwise); or
- You are wheelchair bound but could safely be transported via wheelchair accessible transportation.

Home Health Care Agency

An agency that meets all of the following requirements.

- Mainly provides skilled nursing and other therapeutic services.
- Is associated with a professional group (of at least one **physician** and one **R.N.**) which makes policy.
- Has full-time supervision by a **physician** or an **R.N.**
- Keeps complete medical records on each person.
- Has an administrator.
- Meets licensing standards.

Home Health Care Plan

This is a plan that provides for continued care and treatment of an **illness** or **injury**. The care and treatment must be:

- Prescribed in writing by the attending **physician**; and
- An alternative to a **hospital** or **skilled nursing facility stay**.

Hospice Care

This is care given to a **terminally ill** person by or under arrangements with a **hospice care agency**. The care must be part of a **hospice care program**.

Hospice Care Agency

An agency or organization that meets all of the following requirements:

- Has **hospice care** available 24 hours a day.
- Meets any licensing or certification standards established by the jurisdiction where it is located.
- Provides:
  - **Skilled nursing services**;
  - Medical social services; and
  - Psychological and dietary counseling.
- Provides, or arranges for, other services which include:
  - **Physician** services;
  - Physical and occupational therapy;
  - Part-time home health aide services which mainly consist of caring for **terminally ill** people; and
  - Inpatient care in a facility when needed for pain control and acute and chronic symptom management.
- Has at least the following personnel:
  - One **physician**;
  - One **R.N.**; and
  - One licensed or certified social worker employed by the agency.
- Establishes policies about how **hospice care** is provided.
- Assesses the patient's medical and social needs.
- Develops a **hospice care program** to meet those needs.
- Provides an ongoing quality assurance program. This includes reviews by **physicians**, other than those who own or direct the agency.
- Permits all area medical personnel to utilize its services for their patients.
- Keeps a medical record on each patient.
- Uses volunteers trained in providing services for non-medical needs.
- Has a full-time administrator.

Hospice Care Program

This is a written plan of **hospice care**, which:

- Is established by and reviewed from time to time by a **physician** attending the person, and appropriate personnel of a **hospice care agency**;
- Is designed to provide palliative and supportive care to **terminally ill** persons, and supportive care to their families; and
- Includes an assessment of the person's medical and social needs; and a description of the care to be given to meet those needs.

Hospice Facility

A facility, or distinct part of one, that meets all of the following requirements:

- Mainly provides inpatient **hospice care** to **terminally ill** persons.
- Charges patients for its services.
- Meets any licensing or certification standards established by the jurisdiction where it is located.
- Keeps a medical record on each patient.
- Provides an ongoing quality assurance program including reviews by **physicians** other than those who own or direct the facility.
- Is run by a staff of **physicians**. At least one staff **physician** must be on call at all times.
- Provides 24-hour-a-day nursing services under the direction of an **R.N.**
- Has a full-time administrator.

Hospital
An institution that:

- Is primarily engaged in providing, on its premises, inpatient medical, surgical and diagnostic services;
- Is supervised by a staff of **physicians**;
- Provides twenty-four (24) hour-a-day **R.N.** service,
- Charges patients for its services;
- Is operating in accordance with the laws of the jurisdiction in which it is located; and
- Does not meet all of the requirements above, but does meet the requirements of the jurisdiction in which it operates for licensing as a **hospital** and is accredited as a **hospital** by the Joint Commission on the Accreditation of Healthcare Organizations.

In no event does **hospital** include a convalescent nursing home or any institution or part of one which is used principally as a convalescent facility, rest facility, nursing facility, facility for the aged, extended care facility, intermediate care facility, **skilled nursing facility**, hospice, rehabilitative **hospital** or facility primarily for rehabilitative or custodial services.

Hospitalization
A continuous confinement as an inpatient in a **hospital** for which a **room and board** charge is made.

I

Illness
A pathological condition of the body that presents a group of clinical signs and symptoms and laboratory findings peculiar to the findings set the condition apart as an abnormal entity differing from other normal or pathological body states.

Infertile or Infertility
The condition of a presumably healthy covered person who is unable to conceive or produce conception after:

- *For a* woman *who is under 35 years of age*: 1 year or more of timed, unprotected coitus, or 12 cycles of artificial insemination; or
- *For a* woman *who is 35 years of age or older*: 6 months or more of timed, unprotected coitus, or 6 cycles of artificial insemination.

Injury
An accidental bodily **injury** that is the sole and direct result of:

- An unexpected or reasonably unforeseen occurrence or event; or
- The reasonable unforeseeable consequences of a voluntary act by the person.
- An act or event must be definite as to time and place.

Institute of Excellence (IOE)
A **hospital** or other facility that has contracted with **Aetna** to give services or supplies to an **IOE** patient in connection with specific transplants, procedures at a **negotiated charge**. A facility is an **IOE** facility only for those types of transplants, procedures for which it has signed a contract.

J

Jaw Joint Disorder
This is:

- A Temporomandibular Joint (TMJ) dysfunction or any alike disorder of the jaw joint; or
- A Myofacial Pain Dysfunction (MPD); or
- Any alike disorder in the relationship of the jaw joint and the related muscles and nerves.

L

Late Enrollee
This is an employee in an Eligible Class who requests enrollment under this Plan after the Initial Enrollment Period. In addition, this is an eligible dependent for whom the employee did not elect coverage within the Initial Enrollment Period, but for whom coverage is elected at a later time.

However, an eligible employee or dependent may not be considered a **Late Enrollee** under certain circumstances. See the *Special Enrollment Periods* section of the Booklet.

L.P.N.
A licensed practical or vocational nurse.

M

Mail Order Pharmacy
An establishment where **prescription drugs** are legally given out by mail or other carrier.

Maintenance Care
Care made up of services and supplies that:

- Are given mainly to maintain, rather than to improve, a level of physical, or mental function; and
- Give a surrounding free from exposures that can worsen the person's physical or mental condition.

Maximum Out-of-Pocket Limit
Your plan has a **maximum out-of-pocket limit**. Your **deductibles**, **payment percentage, copays** and other eligible out-of-pocket expense apply to the **maximum out-of-pocket limit**. Once you satisfy the maximum amount the plan will pay 100% of **covered expenses** that apply toward the limit for the rest of the calendar year. **The maximum out-of-pocket limit** applies to both network and out-of-network out-of-pocket expenses.

Medically Necessary or Medical Necessity

These are health care or dental services, and supplies or **prescription drug**s that a **physician**, other health care provider or **dental provider**, exercising prudent clinical judgment, would give to a patient for the purpose of:

- preventing;
- evaluating;
- diagnosing; or
- treating:
  - an **illness**;
  - an **injury**;
  - a disease; or
  - its symptoms.

The provision of the service, supply or **prescription drug** must be:

a) In accordance with generally accepted standards of medical or dental practice;
b) Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's **illness**, **injury** or disease; and
c) Not mostly for the convenience of the patient, **physician**, other health care or **dental provider**; and
d) And do not cost more than an alternative service or sequence of services at least as likely to produce the same therapeutic or diagnostic results as to the diagnosis or treatment of that patient's **illness**, **injury**, or disease.

For these purposes "generally accepted standards of medical or dental practice" means standards that are based on credible scientific evidence published in peer-reviewed literature. They must be generally recognized by the relevant medical or dental community. Otherwise, the standards are consistent with **physician** or dental specialty society recommendations. They must be consistent with the views of **physicians** or **dentists** practicing in relevant clinical areas and any other relevant factors.

Mental Disorder

An **illness** commonly understood to be a **mental disorder**, whether or not it has a physiological basis, and for which treatment is generally provided by or under the direction of a **behavioral health provider** such as a **psychiatric physician**, a psychologist or a psychiatric social worker. A **mental disorder** includes; but is not limited to:

- Alcoholism and substance abuse.
- Bipolar disorder.
- Major depressive disorder.
- Obsessive compulsive disorder.
- Panic disorder.
- Pervasive developmental disorder (including Autism).
- Psychotic depression.
- Schizophrenia.

For the purposes of benefits under this plan, **mental disorder** will include alcoholism and substance abuse only if any separate benefit for a particular type of treatment does not apply to alcoholism and substance abuse.

Morbid Obesity

This means a **Body Mass Index** that is: greater than 40 kilograms per meter squared; or equal to or greater than 35 kilograms per meter squared with a comorbid medical condition, including: hypertension; a cardiopulmonary condition; sleep apnea; or diabetes.

N

Negotiated Charge

As to health expense coverage, other than Prescription Drug Expense Coverage:

The **negotiated charge** is the maximum charge a **network provider** has agreed to make as to any service or supply for the purpose of the benefits under this plan.

As to Prescription Drug Expense Coverage:
The **negotiated charge** is the amount **Aetna** has established for each **prescription drug** obtained from a **network pharmacy** under this plan. This **negotiated charge** may reflect amounts **Aetna** has agreed to pay directly to the **network pharmacy** or to a third party vendor for the **prescription drug**, and may include an additional service or risk charge set by **Aetna**.

The **negotiated charge** does not include or reflect any amount **Aetna**, an affiliate, or a third party vendor, may receive under a rebate arrangement between **Aetna,** an affiliate or a third party vendor and a drug manufacturer for any **prescription drug**, including **prescription drugs** on the **preferred drug guide**.

Based on its overall drug purchasing, **Aetna** may receive rebates from the manufacturers of **prescription drugs** and may receive or pay additional amounts from or to third parties under price guarantees. These amounts will not change the **negotiated charge** under this plan.

Network Advanced Reproductive Technology (ART) Specialist

A specialist **physician** who has entered into a contractual agreement with **Aetna** for the provision of covered **Advanced Reproductive Technology** (**ART**) services.

Network Provider

A health care provider, a **pharmacy** or **dental provider** who has contracted to furnish services or supplies for this plan; but only if the provider is, with **Aetna's** consent, included in the **directory** as a **network provider** for:

- The service or supply involved; and
- The class of employees to which you belong.

Network Service(s) or Supply(ies)

Health care service or supply that is:

- Furnished by a **network provider**; or
- Furnished or arranged by your **PCP**.

Night Care Treatment

A **partial confinement treatment** program provided when you need to be confined during the night. A room charge is made by the **hospital, psychiatric hospital** or **residential treatment facility**. Such treatment must be available at least:

- 8 hours in a row a night; and
- 5 nights a week.

Non-Occupational Illness
A **non-occupational illness** is an **illness** that does not:

- Arise out of (or in the course of) any work for pay or profit; or
- Result in any way from an **illness** that does.

An **illness** will be deemed to be non-occupational regardless of cause if proof is furnished that the person:

- Is covered under any type of workers' compensation law; and
- Is not covered for that **illness** under such law.

Non-Occupational Injury
A **non-occupational injury** is an accidental bodily **injury** that does not:

- Arise out of (or in the course of) any work for pay or profit; or
- Result in any way from an **injury** which does.

Non-Preferred Drug (Non-Formulary)
A **prescription drug** that is not listed in the **preferred drug guide**. This includes **prescription drugs** on the **preferred drug guide exclusions list** that are approved by medical exception.

Non-Specialist
A **physician** who is not a **specialist**.

Non-Urgent Admission
An inpatient admission that is not an **emergency admission** or an **urgent admission**.

O

Occupational Injury or Occupational Illness
An **injury** or **illness** that:

- Arises out of (or in the course of) any activity in connection with employment or self-employment whether or not on a full time basis; or
- Results in any way from an **injury** or **illness** that does.

Occurrence
This means a period of disease or **injury**. An **occurrence** ends when 60 consecutive days have passed during which the covered person:

- Receives no medical treatment; services; or supplies; for a disease or **injury**; and
- Neither takes any medication, nor has any medication prescribed, for a disease or **injury**.

Orthodontic Treatment
This is any:

- Medical service or supply; or
- Dental service or supply;

furnished to prevent or to diagnose or to correct a misalignment:

- Of the teeth; or
- Of the bite; or
- Of the jaws or jaw joint relationship;

whether or not for the purpose of relieving pain.

The following are not considered **orthodontic treatment**:

- The installation of a space maintainer; or
- A surgical procedure to correct malocclusion.

Out-of-Network Service(s) and Supply(ies)

Health care service or supply that is:

- Furnished by an **out-of network provider**; or
- Not furnished or arranged by your **PCP**.

Out-of-Network Provider

A health care provider or **pharmacy** who has not contracted with **Aetna**, an affiliate, or a third party vendor, to furnish services or supplies for this plan.

P

Partial Confinement Treatment

A plan of medical, psychiatric, nursing, counseling, or therapeutic services to treat alcoholism, substance abuse, or **mental disorders**. The plan must meet these tests:

- It is carried out in a **hospital**; **psychiatric hospital** or **residential treatment facility**; on less than a full-time inpatient basis.
- It is in accord with accepted medical practice for the condition of the person.
- It does not require full-time confinement.
- It is supervised by a **psychiatric physician** who weekly reviews and evaluates its effect.
- **Day care treatment** and **night care treatment** are considered **partial confinement treatment**.

Payment Percentage

Payment percentage is both the percentage of **covered expenses** that the plan pays, and the percentage of **covered expenses** that you pay. The percentage that the plan pays is referred to as the "plan **payment percentage**," and varies by the type of expense. Please refer to the *Schedule of Benefits* for specific information on **payment percentage** amounts.

Pharmacy

An establishment where **prescription drugs** are legally dispensed. **Pharmacy** includes a retail **pharmacy**, **mail order pharmacy** and **specialty pharmacy network pharmacy**.

Physician
A duly licensed member of a medical profession who:

- Has an M.D. or D.O. degree;
- Is properly licensed or certified to provide medical care under the laws of the jurisdiction where the individual practices; and
- Provides medical services which are within the scope of his or her license or certificate.

This also includes a health professional who:

- Is properly licensed or certified to provide medical care under the laws of the jurisdiction where he or she practices;
- Provides medical services which are within the scope of his or her license or certificate;
- Under applicable insurance law is considered a "physician" for purposes of this coverage;
- Has the medical training and clinical expertise suitable to treat your condition;
- Specializes in psychiatry, if your **illness** or **injury** is caused, to any extent, by alcohol abuse, substance abuse or a mental disorder; and
- A physician is not you or related to you.

Precertification or Precertify
A process where **Aetna** is contacted before certain services are provided, such as **hospitalization** or outpatient surgery, or **prescription drugs** are prescribed to determine whether the services being recommended or the drugs prescribed are considered **covered expenses** under the plan. It is not a guarantee that benefits will be payable.

Preferred Drug Guide
A listing of **prescription drugs** established by **Aetna** or an affiliate, which includes both **brand name prescription drugs** and **generic prescription drugs**. This list is subject to periodic review and modification by **Aetna** or an affiliate. A copy of the **preferred drug guide** will be available upon your request or may be accessed on the **Aetna** website at www.**Aetna**.com/formulary.

Preferred Drug Guide Exclusions List
A list of **prescription drugs** in the **preferred drug guide** that are identified as excluded under the plan. This list is subject to periodic review and modification by **Aetna**.

Preferred Network Pharmacy
A **network retail pharmacy** that has contracted with **Aetna**, an affiliate, or a third party vendor, to provide outpatient **prescription drugs** that we have identified as a **preferred network pharmacy**.

Prescriber
Any **physician** or **dentist**, acting within the scope of his or her license, who has the legal authority to write an order for a **prescription drug**.

Prescription
An order for the dispensing of a **prescription drug** by a **prescriber**. If it is an oral order, it must be promptly put in writing by the pharmacy.

Prescription Drug

A drug, biological, or compounded **prescription** which, by State and Federal Law, may be dispensed only by **prescription** and which is required to be labeled "Caution: Federal Law prohibits dispensing without prescription." This includes:

- An injectable drug prescribed to be self-administered or administered by any other person except one who is acting within his or her capacity as a paid healthcare professional. Covered injectable drugs include injectable insulin.

Primary Care Physician (PCP)

This is the **network provider** who:

- Is selected by a person from the list of **primary care physicians** in the **directory**;
- Supervises, coordinates and provides initial care and basic medical services to a person as a general or family care practitioner, or in some cases, as an internist or a pediatrician; and
- Is shown on **Aetna**'s records as the person's **PCP**.

Psychiatric Hospital

This is an institution that meets all of the following requirements.

- Mainly provides a program for the diagnosis, evaluation, and treatment of alcoholism, substance abuse or **mental disorders**.
- Is not mainly a school or a custodial, recreational or training institution.
- Provides infirmary-level medical services. Also, it provides, or arranges with a **hospital** in the area for, any other medical service that may be required.
- Is supervised full-time by a **psychiatric physician** who is responsible for patient care and is there regularly.
- Is staffed by **psychiatric physicians** involved in care and treatment.
- Has a **psychiatric physician** present during the whole treatment day.
- Provides, at all times, **psychiatric** social work and nursing services.
- Provides, at all times, **skilled nursing services** by licensed nurses who are supervised by a full-time **R.N.**
- Prepares and maintains a written plan of treatment for each patient based on medical, psychological and social needs. The plan must be supervised by a **psychiatric physician**.
- Makes charges.
- Meets licensing standards.

Psychiatric Physician

This is a **physician** who:

- Specializes in psychiatry; or
- Has the training or experience to do the required evaluation and treatment of alcoholism, substance abuse or **mental disorders**.

R

Recognized Charge

The **covered expense** is only that part of a charge which is the **recognized charge**.

As to medical, vision and hearing expenses, the **recognized charge** for each service or supply is the lesser of:

- What the provider bills or submits for that service or supply; and
- For professional services and other services or supplies not mentioned below:
  - the 80th percentile of the Prevailing Charge Rate;

  for the Geographic Area where the service is furnished.

As to **prescription drug** expenses, the **recognized charge** for each service or supply is the lesser of:

- What the provider bills or submits for that service or supply; and
- 110% of the **Average Wholesale Price (AWP)** or other similar resource. **Average Wholesale Price (AWP)** is the current average wholesale price of a **prescription drug** listed in the Medi-Span weekly price updates (or any other similar publication chosen by **Aetna**).

If **Aetna** has an agreement with a provider (directly, or indirectly through a third party) which sets the rate that **Aetna** will pay for a service or supply, then the **recognized charge** is the rate established in such agreement.

Aetna may also reduce the **recognized charge** by applying **Aetna** Reimbursement Policies. **Aetna** Reimbursement Policies address the appropriate billing of services, taking into account factors that are relevant to the cost of the service such as:

- the duration and complexity of a service;
- whether multiple procedures are billed at the same time, but no additional overhead is required;
- whether an assistant surgeon is involved and necessary for the service;
- if follow up care is included;
- whether there are any other characteristics that may modify or make a particular service unique; and
- when a charge includes more than one claim line, whether any services described by a claim line are part of or incidental to the primary service provided.

Aetna Reimbursement Policies are based on **Aetna's** review of: the policies developed for Medicare; the generally accepted standards of medical and dental practice, which are based on credible scientific evidence published in peer-reviewed literature generally recognized by the relevant medical or dental community or which is otherwise consistent with **physician** or dental specialty society recommendations; and the views of **physicians** and dentists practicing in the relevant clinical areas. **Aetna** uses a commercial software package to administer some of these policies.

As used above, Geographic Area and Prevailing Charge Rates are defined as follows:

- Geographic Area: This means an expense area grouping defined by the first three digits of the U.S. Postal Service zip codes. If the volume of charges in a single three digit zip code is sufficient to produce a statistically valid sample, an expense area is made up of a single three digit zip code. If the volume of charges is not sufficient to produce a statistically valid sample, two or more three digit zip codes are grouped to produce a statistically valid sample. When it is necessary to group three digit zip codes, the grouping never crosses state lines.
- Prevailing Charge Rates: These are rates reported by FAIR Health, a nonprofit company, in their database. FAIR Health reviews and, if necessary, changes these rates periodically. **Aetna** updates its systems with these changes within 180 days after receiving them from FAIR Health.

Important Note
Aetna periodically updates its systems with changes made to the Prevailing Charge Rates.

What this means to you is that the **recognized charge** is based on the version of the rates that is in use by **Aetna** on the date that the service or supply was provided.

Additional Information
Aetna's website aetna.com may contain additional information which may help you determine the cost of a service or supply. Log on to **Aetna** Navigator to access the "Estimate the Cost of Care" feature. Within this feature, view our "Cost of Care" and "Member Payment Estimator" tools, or contact our Customer Service Department for assistance.

Rehabilitation Facility
A facility, or a distinct part of a facility which provides **rehabilitative services**, meets any licensing or certification standards established by the jurisdiction where it is located, and makes charges for its services.

Rehabilitative Services
The combined and coordinated use of medical, social, educational and vocational measures for training or retraining if you are disabled by **illness** or **injury**.

Residential Treatment Facility (Mental Disorders)
This is an institution that meets all of the following requirements:

- Is accredited by one of the following agencies, commissions or committees for the services being provided: The Joint Commission (TJC), Committee on Accreditation of Rehabilitation Facilities (CARF), American Osteopathic Association's Healthcare Facilities Accreditation Program (HFAP) or the Council on Accreditation (COA); or is credentialed by **Aetna**;
- Meets all applicable licensing standards established by the jurisdiction in which it is located;
- Performs a comprehensive patient assessment preferably before admission, but at least upon admission;
- Creates individualized active treatment plans directed toward the alleviation of the impairment that caused the admission;
- Has the ability to involve family/support systems in the therapeutic process;
- Has the level of skilled intervention and provision of care must be consistent with the patient's **illness** and risk;
- Provides access to psychiatric care by a **psychiatrist** as necessary for the provision of such care;
- Provides treatment services that are managed by a **behavioral health provider** who functions under the direction/supervision of a medical director; and
- Is not a wilderness treatment program (whether or not the program is part of a licensed **residential treatment facility**, or otherwise licensed institution), educational services, schooling or any such related or similar program, including therapeutic programs within a school setting.

In addition to the above requirements, for Mental Health Residential Treatment Programs:

- A **behavioral health provider** must be actively on duty 24 hours per day for 7 days a week;
- The patient is treated by a **psychiatrist** at least once per week; and
- The medical director must be a **psychiatrist**.

Residential Treatment Facility (Substance Abuse)
This is an institution that meets all of the following requirements:

- Is accredited by one of the following agencies, commissions or committees for the services being provided: The Joint Commission (TJC), Committee on Accreditation of Rehabilitation Facilities (CARF), American Osteopathic Association's Healthcare Facilities Accreditation Program (HFAP), or the Council on Accreditation (COA); or is credentialed by **Aetna**;
- Meets all applicable licensing standards established by the jurisdiction in which it is located;
- Performs a comprehensive patient assessment preferably before admission, but at least upon admission;
- Creates individualized active treatment plans directed toward the alleviation of the impairment that caused the admission;
- Has the ability to involve family and/or support systems in the therapeutic process;
- Has the level of skilled intervention and provision of care that is consistent with the patient's **illness** and risk;

- Provides access to psychiatric care by a **psychiatrist** as necessary for the provision of such care;
- Provides treatment services that are managed by a **behavioral health provider** who functions under the direction/supervision of a medical director; and
- Is not a wilderness treatment program (whether or not the program is part of a licensed **residential treatment facility**, or otherwise licensed institution), educational services, schooling or any such related or similar program, including therapeutic programs within a school setting.

In addition to the above requirements, for Chemical Dependence Residential Treatment Programs:

- Is a **behavioral health provider** or an appropriately state certified professional (for example, CADC, CAC);
- Is actively on duty during the day and evening therapeutic programming; and
- The medical director must be a **physician** who is an addiction **specialist**.

In addition to the above requirements, for Chemical Dependence Detoxification Programs within a residential setting:

- An **R.N**. is onsite 24 hours per day for 7 days a week; and
- The care must be provided under the direct supervision of a **physician**.

R.N.
A registered nurse.

Room and Board
Charges made by an institution for **room and board** and other **medically necessary** services and supplies. The charges must be regularly made at a daily or weekly rate.

S

Self-injectable Drug(s)
Prescription drugs that are intended to be self-administered by injection to a specific part of the body to treat medical conditions.

Semi-Private Room Rate
The **room and board** charge that an institution applies to the most beds in its semi-private rooms with 2 or more beds. If there are no such rooms, **Aetna** will figure the rate based on the rate most commonly charged by similar institutions in the same geographic area.

Service Area
This is the geographic area, as determined by **Aetna**, in which **network providers** for this plan are located.

Skilled Nursing Facility
An institution that meets all of the following requirements:

- It is licensed to provide, and does provide, the following on an inpatient basis for persons convalescing from **illness** or **injury**:
  - Professional nursing care by an **R.N.**, or by a **L.P.N.** directed by a full-time **R.N.**; and
  - Physical restoration services to help patients to meet a goal of self-care in daily living activities.
- Provides 24 hour a day nursing care by licensed nurses directed by a full-time **R.N.**
- Is supervised full-time by a **physician** or an **R.N.**
- Keeps a complete medical record on each patient.
- Has a utilization review plan.

- Is not mainly a place for rest, for the aged, for drug addicts, for alcoholics, for mental retardates, for custodial or educational care, or for care of **mental disorder**s.
- Charges patients for its services.
- An institution or a distinct part of an institution that meets all of the following requirements:
  - It is licensed or approved under state or local law.
  - Is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons.
- Qualifies as a **skilled nursing facility** under Medicare or as an institution accredited by**:**
  - The Joint Commission on Accreditation of Health Care Organizations;
  - The Bureau of **Hospitals** of the American Osteopathic Association; or
  - The Commission on the Accreditation of Rehabilitative Facilities

Skilled nursing facilities also include rehabilitation **hospitals** (all levels of care, e.g. acute) and portions of a **hospital** designated for skilled or **rehabilitation services**.

Skilled nursing facility does not include:

- Institutions which provide only:
  - Minimal care;
  - Custodial care services;
  - Ambulatory; or
  - Part-time care services.
- Institutions which primarily provide for the care and treatment of alcoholism, **substance abuse** or **mental disorders**.

Skilled Nursing Services
Services that meet all of the following requirements:

- The services require medical or paramedical training.
- The services are rendered by an **R.N.** or **L.P.N.** within the scope of his or her license.
- The services are not custodial.

Specialist
A **physician** who practices in any generally accepted medical or surgical sub-specialty.

Specialty Care
Health care services or supplies that require the services of a **specialist**.

Specialty Care Drugs
Injectable, infusion and oral **prescription drugs** that are prescribed to address complex, chronic diseases with associated co-morbidities such as cancer, rheumatoid arthritis, hemophilia, multiple sclerosis.
You can access the list of these **specialty care prescription drugs** by calling the toll-free number on your Member ID card or by logging on to your Aetna Navigator® secure member website at www.aetna.com

Specialty Pharmacy Network
A network of pharmacies designated to fill **specialty care drugs**.

Stay
A full-time inpatient confinement for which a **room and board** charge is made.

Step Therapy

A form of **precertification** under which certain **prescription drugs** will be excluded from coverage, unless a first-line therapy drug(s) is used first by you. The list of step-therapy drugs is subject to change by **Aetna** or an affiliate. An updated copy of the list of drugs subject to **step therapy** shall be available upon request by you or may be accessed on the **Aetna** website at www.**Aetna**.com/formulary.

Substance Abuse

This is a physical or psychological dependency, or both, on a controlled substance or alcohol agent (These are defined on Axis I in the Diagnostic and Statistical Manual of **Mental Disorders** (DSM) published by the American Psychiatric Association which is current as of the date services are rendered to you or your covered dependents.) This term does not include conditions not attributable to a **mental disorder** that are a focus of attention or treatment (the V codes on Axis I of DSM); an addiction to nicotine products, food or caffeine intoxication.

Surgery Center

A freestanding ambulatory surgical facility that meets all of the following requirements:

- Meets licensing standards.
- Is set up, equipped and run to provide general surgery.
- Charges for its services.
- Is directed by a staff of **physicians**. At least one of them must be on the premises when surgery is performed and during the recovery period.
- Has at least one certified anesthesiologist at the site when surgery requiring general or spinal anesthesia is performed and during the recovery period.
- Extends surgical staff privileges to:
  - **Physicians** who practice surgery in an area **hospital**; and
  - **Dentists** who perform oral surgery.
- Has at least 2 operating rooms and one recovery room.
- Provides, or arranges with a medical facility in the area for, diagnostic x-ray and lab services needed in connection with surgery.
- Does not have a place for patients to **stay** overnight.
- Provides, in the operating and recovery rooms, full-time **skilled nursing services** directed by an **R.N.**
- Is equipped and has trained staff to handle **emergency medical conditions**.

Must have all of the following:

- A **physician** trained in cardiopulmonary resuscitation; and
- A defibrillator; and
- A tracheotomy set; and
- A blood volume expander.
- Has a written agreement with a **hospital** in the area for immediate emergency transfer of patients.
- Written procedures for such a transfer must be displayed and the staff must be aware of them.
- Provides an ongoing quality assurance program. The program must include reviews by **physicians** who do not own or direct the facility.
- Keeps a medical record on each patient.

T

Terminally Ill (Hospice Care)

Terminally ill means a medical prognosis of 12 months or less to live.

Therapeutic Drug Class
A group of drugs or medications that have a similar or identical mode of action or exhibit similar or identical outcomes for the treatment of a disease or **injury**.

U

Urgent Admission
A **hospital** admission by a **physician** due to:

- The onset of or change in an **illness**; or
- The diagnosis of an **illness**; or
- An **injury**.
- The condition, while not needing an **emergency admission**, is severe enough to require confinement as an inpatient in a **hospital** within 2 weeks from the date the need for the confinement becomes apparent.

Urgent Care Facility
A facility licensed as a freestanding medical facility by applicable state and federal laws to treat an **urgent condition.**

Urgent Care Provider
This is:

- A freestanding medical facility that meets all of the following requirements.
  - Provides unscheduled medical services to treat an **urgent condition** if the person's **physician** is not reasonably available.
  - Routinely provides ongoing unscheduled medical services for more than 8 consecutive hours.
  - Charges for its services and supplies.
  - Is licensed and certified as required by any state or federal law or regulation.
  - Keeps a medical record on each patient.
  - Provides an ongoing quality assurance program. This includes reviews by **physicians** other than those who own or direct the facility.
  - Is run by a staff of **physicians**. At least one **physician** must be on call at all times.
  - Has a full-time administrator who is a licensed **physician**.
- A **physician**'s office, but only one that:
  - Has contracted with **Aetna** to provide urgent care; and
  - Is, with **Aetna**'s consent, included in the **directory** as a network **urgent care provider**.

It is not the emergency room or outpatient department of a **hospital**.

Urgent Condition
This means a sudden **illness**; **injury**; or condition; that:

- Is severe enough to require prompt medical attention to avoid serious deterioration of your health;
- Includes a condition which would subject you to severe pain that could not be adequately managed without urgent care or treatment;
- Does not require the level of care provided in the emergency room of a hospital; and
- Requires immediate outpatient medical care that cannot be postponed until your physician becomes reasonably available.

W

Walk-in Clinic

Walk-in Clinics are free-standing health care facilities. They are an alternative to a **physician's** office visit for treatment of:

- Unscheduled, non-emergency **illnesses** and **injuries**;
- The administration of certain immunizations; and
- Individual screening and counseling services.

It is not an alternative for emergency room services or the ongoing care provided by a **physician**.

Neither:

- An emergency room; nor
- The outpatient department of a **hospital**;

shall be considered a **Walk-in Clinic**.

IMPORTANT HEALTH CARE REFORM NOTICES

CHOICE OF PROVIDER

If your Aetna plan generally requires or allows the designation of a primary care provider, you have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. If the plan or health insurance coverage designates a primary care provider automatically, then until you make this designation, Aetna designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your Employer or, if you are a current member, your Aetna contact number on the back of your ID card.

If your Aetna plan allows for the designation of a primary care provider for a child, you may designate a pediatrician as the primary care provider.

If your Aetna plan provides coverage for obstetric or gynecological care and requires the designation of a primary care provider then you do not need prior authorization from Aetna or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact your Employer or, if you are a current member, your Aetna contact number on the back of your ID card.

Statement of Rights under the Newborns' and Mothers' Health Protection Act

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

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

In addition, a plan or issuer may not, under federal law, require that you, your physician, or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, you may be required to obtain precertification for any days of confinement that exceed 48 hours (or 96 hours). For information on precertification, contact your plan administrator.

Notice Regarding Women's Health and Cancer Rights Act

Under this health plan, as required by the Women's Health and Cancer Rights Act of 1998, coverage will be provided to a person who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with the mastectomy for:

(1) all stages of reconstruction of the breast on which a mastectomy has been performed;
(2) surgery and reconstruction of the other breast to produce a symmetrical appearance;
(3) prostheses; and
(4) treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the attending physician and the patient, and will be provided in accordance with the plan design, limitations, copays, deductibles, and referral requirements, if any, as outlined in your plan documents.

If you have any questions about our coverage of mastectomies and reconstructive surgery, please contact the Member Services number on your ID card.

For more information, you can visit this U.S. Department of Health and Human Services website, http://www.cms.gov/home/regsguidance.asp, and this U.S. Department of Labor website, http://www.dol.gov/ebsa/consumer_info_health.html.

Continuation of Coverage During an Approved Leave of Absence Granted to Comply With Federal Law

This continuation of coverage section applies only for the period of any approved family or medical leave (approved FMLA leave) required by Family and Medical Leave Act of 1993 (FMLA). If your Employer grants you an approved FMLA leave for a period in excess of the period required by FMLA, any continuation of coverage during that excess period will be determined by your Employer.

If your Employer grants you an approved FMLA leave in accordance with FMLA, you may, during the continuance of such approved FMLA leave, continue Health Expense Benefits for you and your eligible dependents.

At the time you request the leave, you must agree to make any contributions required by your Employer to continue coverage.

If any coverage your Employer allows you to continue has reduction rules applicable by reason of age or retirement, the coverage will be subject to such rules while you are on FMLA leave.

Coverage will not be continued beyond the first to occur of:

- The date you are required to make any contribution and you fail to do so.
- The date your Employer determines your approved FMLA leave is terminated.
- The date the coverage involved discontinues as to your eligible class. However, coverage for health expenses may be available to you under another plan sponsored by your Employer.

Any coverage being continued for a dependent will not be continued beyond the date it would otherwise terminate.

If Health Expense Benefits terminate because your approved FMLA leave is deemed terminated by your Employer, you may, on the date of such termination, be eligible for Continuation Under Federal Law on the same terms as though your employment terminated, other than for gross misconduct, on such date. If this Plan provides any other continuation of coverage (for example, upon termination of employment, death, divorce or ceasing to be a defined dependent), you (or your eligible dependents) may be eligible for such continuation on the date your Employer determines your approved FMLA leave is terminated or the date of the event for which the continuation is available.

If you acquire a new dependent while your coverage is continued during an approved FMLA leave, the dependent will be eligible for the continued coverage on the same terms as would be applicable if you were actively at work, not on an approved FMLA leave.

If you return to work for your Employer following the date your Employer determines the approved FMLA leave is terminated, your coverage under this Plan will be in force as though you had continued in active employment rather than going on an approved FMLA leave provided you make request for such coverage within 31 days of the date your Employer determines the approved FMLA leave to be terminated. If you do not make such request within 31 days, coverage will again be effective under this Plan only if and when this Plan gives its written consent.

If any coverage being continued terminates because your Employer determines the approved FMLA leave is terminated, any Conversion Privilege will be available on the same terms as though your employment had terminated on the date your Employer determines the approved FMLA leave is terminated.

WILLIAMSON COUNTY BENEFITS FUND
Profit & Loss
October 2011 through September 2012

Wilco Claims Expense - FY 2012

Active & COBRA are combined.

	Oct 11	Nov 11	Dec 11	Jan 12
Income				
Expense				
004038 Retiree Vision Claims	847.25	2,154.40	1,237.00	1,440.00
004039 Retiree Dental				
004039 Retiree Dental High	3,480.10	2,238.80	3,100.25	2,833.60
Total 004039 Retiree Dental	3,480.10	2,238.80	3,100.25	2,833.60
004040 - Retiree Claims				
004040 Retiree Claims- Core	24,681.94	30,353.82	73,529.77	16,283.33
004040 Retiree Claims- Ded	21,060.77	8,437.40	5,483.23	57,388.53
004040 Retiree Claims- EPO	4,544.40	2,277.21	1,616.79	6,955.33
Total 004040 - Retiree Claims	50,287.11	41,068.43	80,629.79	80,627.19
004041 - Retiree Rx Claims Exp				
004041 Retiree Rx- Core	12,372.36	7,373.59	5,288.55	14,334.28
004041 Retiree Rx- Ded	5,420.40	7,014.48	5,736.96	9,261.75
004041 Retiree Rx- EPO	6,441.90	4,987.85	4,867.82	5,716.20
Total 004041 - Retiree Rx Claims Exp	24,234.66	19,375.92	15,893.33	29,312.23
004048 Vision Claim	19,615.98	30,495.64	36,412.41	24,566.78
004049 Dental Claims Paid				
004049 Dental Claims Paid - Hi	50,985.90	70,733.94	69,098.92	69,332.71
004049 Dental Claims Paid - Lo	6,489.60	12,075.40	6,703.10	7,543.80
Total 004049 Dental Claims Paid	57,475.50	82,809.34	75,802.02	76,876.51
004050 Med Claims Paid				
004050 Med Claims Paid- Core	189,498.03	207,398.32	209,262.32	300,136.44
004050 Med Claims Paid- Ded	360,704.52	303,833.44	299,386.69	430,840.34
004050 Med Claims Paid- EPO	121,163.74	170,335.52	237,539.44	87,174.96
004050 Med Claims Paid - Other	0.00	0.00	0.00	0.00
Total 004050 Med Claims Paid	671,366.29	681,567.28	746,188.45	818,151.74
004051 Prescrip Drugs				
004051 Prescrip Drugs- Core	64,486.46	56,501.13	58,278.36	100,908.49
004051 Prescrip Drugs- Ded	71,601.47	70,308.45	73,254.96	96,339.78
004051 Prescrip Drugs- EPO	40,839.38	36,512.60	33,013.93	53,529.58
Total 004051 Prescrip Drugs	176,927.31	163,322.18	164,547.25	250,777.85

WILLIAMSON COUNTY BENEFITS FUND
Profit & Loss
October 2011 through September 2012

Wilco Claims Expense - FY 2012 Source: Quick Books, Memorized Reports, "Profit and Lo

Active & COBRA are combined.

	Feb 12	Mar 12	Apr 12	May 12
Income				
Expense				
004038 Retiree Vision Claims	528.00	945.00	300.00	300.00
004039 Retiree Dental				
004039 Retiree Dental High	1,352.25	5,088.95	3,679.66	3,091.06
Total 004039 Retiree Dental	1,352.25	5,088.95	3,679.66	3,091.06
004040 - Retiree Claims				
004040 Retiree Claims- Core	20,915.02	13,476.26	50,945.25	88,576.28
004040 Retiree Claims- Ded	1,973.58	35,938.01	41,985.91	36,230.19
004040 Retiree Claims- EPO	49,615.93	22,858.37	-30,505.65	1,175.59
Total 004040 - Retiree Claims	72,504.53	72,272.64	62,425.51	125,982.06
004041 - Retiree Rx Claims Exp				
004041 Retiree Rx- Core	10,214.23	10,266.84	9,854.25	12,623.52
004041 Retiree Rx- Ded	6,347.09	5,182.65	7,018.90	5,223.38
004041 Retiree Rx- EPO	5,327.52	5,073.37	4,836.05	3,983.01
Total 004041 - Retiree Rx Claims Exp	21,888.84	20,522.86	21,709.20	21,829.91
004048 Vision Claim	21,393.91	25,131.83	16,108.01	17,960.13
004049 Dental Claims Paid				
004049 Dental Claims Paid - Hi	55,931.89	91,812.56	63,016.82	59,723.09
004049 Dental Claims Paid - Lo	6,279.70	12,350.28	9,150.40	7,384.10
Total 004049 Dental Claims Paid	62,211.59	104,162.84	72,167.22	67,107.19
004050 Med Claims Paid				
004050 Med Claims Paid- Core	359,814.67	337,563.04	351,235.95	629,365.23
004050 Med Claims Paid- Ded	402,024.39	306,479.94	222,689.21	279,450.67
004050 Med Claims Paid- EPO	82,906.70	291,584.77	95,472.70	77,680.38
004050 Med Claims Paid - Other	0.00	0.00	0.00	0.00
Total 004050 Med Claims Paid	844,745.76	935,627.75	669,397.86	986,496.28
004051 Prescrip Drugs				
004051 Prescrip Drugs- Core	76,811.77	79,515.52	72,403.18	86,909.04
004051 Prescrip Drugs- Ded	73,916.14	88,755.22	76,088.20	74,928.81
004051 Prescrip Drugs- EPO	26,757.22	38,329.77	31,428.88	31,430.45
Total 004051 Prescrip Drugs	177,485.13	206,600.51	179,920.26	193,268.30

WILLIAMSON COUNTY BENEFITS FUND
Profit & Loss
October 2011 through September 2012
Wilco Claims Expense - FY 2012ss FY by Month

Active & COBRA are combined.

	Jun 12	Jul 12	Aug 12	Sep 12
Income				
Expense				
004038 Retiree Vision Claims	738.00	916.00	1,542.00	1,784.95
004039 Retiree Dental				
004039 Retiree Dental High	3,654.66	1,127.16	3,651.06	2,873.06
Total 004039 Retiree Dental	3,654.66	1,127.16	3,651.06	2,873.06
004040 - Retiree Claims				
004040 Retiree Claims- Core	21,958.16	57,426.81	85,183.98	71,130.40
004040 Retiree Claims- Ded	15,916.02	7,711.95	19,350.78	10,260.08
004040 Retiree Claims- EPO	4,750.73	1,309.41	104.40	996.44
Total 004040 - Retiree Claims	42,624.91	66,448.17	104,639.16	82,386.92
004041 - Retiree Rx Claims Exp				
004041 Retiree Rx- Core	11,631.68	19,373.01	7,529.55	13,656.75
004041 Retiree Rx- Ded	7,694.22	10,710.36	7,458.53	6,926.78
004041 Retiree Rx- EPO	8,003.16	8,157.98	990.56	16,569.76
Total 004041 - Retiree Rx Claims Exp	27,329.06	38,241.35	15,978.64	37,153.29
004048 Vision Claim	19,256.45	20,336.45	29,529.07	32,804.79
004049 Dental Claims Paid				
004049 Dental Claims Paid - Hi	65,909.70	56,515.24	78,751.70	74,582.25
004049 Dental Claims Paid - Lo	8,664.50	8,327.40	19,461.74	10,396.70
Total 004049 Dental Claims Paid	74,574.20	64,842.64	98,213.44	84,978.95
004050 Med Claims Paid				
004050 Med Claims Paid- Core	294,282.76	244,547.81	282,138.76	-244,806.68
004050 Med Claims Paid- Ded	400,645.12	368,092.27	263,848.51	336,972.92
004050 Med Claims Paid- EPO	72,507.08	108,432.40	85,441.18	105,180.16
004050 Med Claims Paid - Other	0.00	0.00	0.00	333,182.75
Total 004050 Med Claims Paid	767,434.96	721,072.48	631,428.45	530,529.15
004051 Prescrip Drugs				
004051 Prescrip Drugs- Core	68,176.13	120,553.84	82,063.30	82,747.29
004051 Prescrip Drugs- Ded	78,289.21	118,138.77	74,779.45	80,007.76
004051 Prescrip Drugs- EPO	24,887.62	42,016.90	31,735.68	30,528.95
Total 004051 Prescrip Drugs	171,352.96	280,709.51	188,578.43	193,284.00

WILLIAMSON COUNTY BENEFITS FUND
Profit & Loss
October 2011 through September 2012
Wilco Claims Expense - FY 2012

Active & COBRA are combined.

	TOTAL
Income	
Expense	
004038 Retiree Vision Claims	12,732.60
004039 Retiree Dental	
004039 Retiree Dental High	36,170.61
Total 004039 Retiree Dental	36,170.61
004040 - Retiree Claims	
004040 Retiree Claims- Core	554,461.02
004040 Retiree Claims- Ded	261,736.45
004040 Retiree Claims- EPO	65,698.95
Total 004040 - Retiree Claims	881,896.42
004041 - Retiree Rx Claims Exp	
004041 Retiree Rx- Core	134,518.61
004041 Retiree Rx- Ded	83,995.50
004041 Retiree Rx- EPO	74,955.18
Total 004041 - Retiree Rx Claims Exp	293,469.29
004048 Vision Claim	293,611.45
004049 Dental Claims Paid	
004049 Dental Claims Paid - Hi	806,394.72
004049 Dental Claims Paid - Lo	114,826.72
Total 004049 Dental Claims Paid	921,221.44
004050 Med Claims Paid	
004050 Med Claims Paid- Core	3,160,436.65
004050 Med Claims Paid- Ded	3,974,968.02
004050 Med Claims Paid- EPO	1,535,419.03
004050 Med Claims Paid - Other	333,182.75
Total 004050 Med Claims Paid	9,004,006.45
004051 Prescrip Drugs	
004051 Prescrip Drugs- Core	949,354.51
004051 Prescrip Drugs- Ded	976,408.22
004051 Prescrip Drugs- EPO	421,010.96
Total 004051 Prescrip Drugs	2,346,773.69

WILLIAMSON COUNTY BENEFITS FUND
Profit & Loss
October 2012 through September 2013

Wilco Claims Expense - FY 2013

Active & COBRA are combined.

	Oct 12	Nov 12	Dec 12	Jan 13
Expense				
004038 Retiree Vision Claims	2,546.20	2,478.12	1,346.00	520.00
004039 Retiree Dental				
004039 Retiree Dental High	2,069.60	848.42	1,716.80	2,303.71
004039 Retiree Dental Low	0.00	133.00	145.10	0.00
Total 004039 Retiree Dental	2,069.60	981.42	1,861.90	2,303.71
004040 - Retiree Claims				
004040 Retiree Claims- Core	28,069.57	32,761.35	8,185.96	13,995.92
004040 Retiree Claims- Ded	17,647.83	18,333.28	7,382.14	4,107.78
004040 Retiree Claims- EPO	537.70	481.62	113.33	276.43
Total 004040 - Retiree Claims	46,255.10	51,576.25	15,681.43	18,380.13
004041 - Retiree Rx Claims Exp				
004041 Retiree Rx- Core	14,673.21	13,109.93	10,632.18	20,285.56
004041 Retiree Rx- Ded	8,644.38	9,066.21	5,824.72	14,752.36
004041 Retiree Rx- EPO	496.68	596.99	320.00	719.85
Total 004041 - Retiree Rx Claims Exp	23,814.27	22,773.13	16,776.90	35,757.77
004048 Vision Claim	25,746.65	30,641.70	19,935.00	17,928.38
004049 Dental Claims Paid				
004049 Dental Claims Paid - Hi	59,001.83	35,135.10	58,500.33	61,662.75
004049 Dental Claims Paid - Lo	10,260.60	2,952.60	6,359.90	4,255.60
Total 004049 Dental Claims Paid	69,262.43	38,087.70	64,860.23	65,918.35
004050 Med Claims Paid				
004050 Med Claims Paid- Core	1,002,905.28	175,065.81	114,124.19	250,270.15
004050 Med Claims Paid- Ded	455,085.29	316,691.88	144,246.11	219,631.75
004050 Med Claims Paid- EPO	150,223.97	58,793.05	17,243.23	32,615.07
004050 Med Claims Paid - Other	0.00	0.00	0.00	0.00
Total 004050 Med Claims Paid	1,608,214.54	550,550.74	275,613.53	502,516.97
004051 Prescrip Drugs				
004051 Prescrip Drugs- Core	88,149.09	74,423.22	54,636.83	75,556.13
004051 Prescrip Drugs- Ded	76,104.35	80,858.75	84,776.62	119,589.08
004051 Prescrip Drugs- EPO	35,345.15	33,174.01	24,712.31	36,118.69
Total 004051 Prescrip Drugs	199,598.59	188,455.98	164,125.76	231,263.90

WILLIAMSON COUNTY BENEFITS FUND
Profit & Loss
October 2012 through September 2013

Wilco Claims Expense - FY 2013 Source: Quick Books, Memorized Reports, "Profit and Lo

Active & COBRA are combined.

	Feb 13	Mar 13	Apr 13	May 13
Expense				
004038 Retiree Vision Claims	1,119.00	1,180.00	1,483.00	1,789.00
004039 Retiree Dental				
004039 Retiree Dental High	3,792.20	1,453.41	5,017.76	5,539.52
004039 Retiree Dental Low	233.70	435.50	335.00	888.40
Total 004039 Retiree Dental	4,025.90	1,888.91	5,352.76	6,427.92
004040 - Retiree Claims				
004040 Retiree Claims- Core	22,747.24	55,031.46	29,547.46	25,086.98
004040 Retiree Claims- Ded	18,870.08	29,293.65	68,889.16	5,322.69
004040 Retiree Claims- EPO	8,196.29	1,570.39	2,319.26	680.89
Total 004040 - Retiree Claims	49,813.61	85,895.50	100,755.88	31,090.56
004041 - Retiree Rx Claims Exp				
004041 Retiree Rx- Core	4,338.58	5,201.96	17,081.46	14,160.72
004041 Retiree Rx- Ded	1,692.18	4,906.48	12,355.79	9,955.88
004041 Retiree Rx- EPO	213.62	105.90	832.89	1,078.82
Total 004041 - Retiree Rx Claims Exp	6,244.38	10,214.34	30,270.14	25,195.42
004048 Vision Claim	21,335.69	31,041.64	25,674.34	15,878.66
004049 Dental Claims Paid				
004049 Dental Claims Paid - Hi	89,501.10	103,882.42	102,008.80	79,410.01
004049 Dental Claims Paid - Lo	11,931.91	11,474.92	10,489.74	7,450.73
Total 004049 Dental Claims Paid	101,433.01	115,357.34	112,498.54	86,860.74
004050 Med Claims Paid				
004050 Med Claims Paid- Core	387,381.30	434,308.71	331,453.29	428,106.36
004050 Med Claims Paid- Ded	713,870.80	762,619.78	445,851.37	314,458.01
004050 Med Claims Paid- EPO	70,030.89	171,587.58	96,672.34	93,028.37
004050 Med Claims Paid - Other	0.00	0.00	0.00	0.00
Total 004050 Med Claims Paid	1,171,282.99	1,368,516.07	873,977.00	835,592.74
004051 Prescrip Drugs				
004051 Prescrip Drugs- Core	19,066.31	15,777.12	89,112.90	46,731.79
004051 Prescrip Drugs- Ded	26,177.58	18,206.87	133,747.03	118,461.28
004051 Prescrip Drugs- EPO	10,827.45	5,569.55	42,836.78	33,384.99
Total 004051 Prescrip Drugs	56,071.34	39,553.54	265,696.71	198,578.06

WILLIAMSON COUNTY BENEFITS FUND
Profit & Loss
October 2012 through September 2013
Wilco Claims Expense - FY 2013ss FY by Month

Active & COBRA are combined.

	Jun 13	Jul 13	Aug 13	Sep 13
Expense				
004038 Retiree Vision Claims	1,194.93	1,642.00	1,752.88	1,862.60
004039 Retiree Dental				
004039 Retiree Dental High	1,333.20	3,358.05	4,497.24	3,464.11
004039 Retiree Dental Low	0.00	109.00	0.00	120.00
Total 004039 Retiree Dental	1,333.20	3,467.05	4,497.24	3,584.11
004040 - Retiree Claims				
004040 Retiree Claims- Core	61,341.81	51,270.36	75,122.70	28,874.26
004040 Retiree Claims- Ded	67,792.51	8,588.27	8,677.73	34,126.40
004040 Retiree Claims- EPO	1,207.39	1,745.18	2,338.24	11,238.29
Total 004040 - Retiree Claims	130,341.71	61,603.81	86,138.67	74,238.95
004041 - Retiree Rx Claims Exp				
004041 Retiree Rx- Core	12,764.03	15,562.56	19,459.28	24,027.20
004041 Retiree Rx- Ded	3,271.02	17,277.92	7,862.29	10,731.72
004041 Retiree Rx- EPO	560.30	1,218.75	1,284.25	2,594.89
Total 004041 - Retiree Rx Claims Exp	16,595.35	34,059.23	28,605.82	37,353.81
004048 Vision Claim	14,186.87	30,979.76	22,695.14	31,783.88
004049 Dental Claims Paid				
004049 Dental Claims Paid - Hi	67,536.20	81,784.45	70,851.14	71,629.72
004049 Dental Claims Paid - Lo	12,956.20	9,233.69	10,011.88	11,780.29
Total 004049 Dental Claims Paid	80,492.40	91,018.14	80,863.02	83,410.01
004050 Med Claims Paid				
004050 Med Claims Paid- Core	415,677.90	257,427.28	495,122.80	-941.88
004050 Med Claims Paid- Ded	678,901.59	341,053.98	357,977.31	352,979.69
004050 Med Claims Paid- EPO	39,943.77	73,467.60	64,166.29	99,507.30
004050 Med Claims Paid - Other	0.00	0.00	0.00	38,548.22
Total 004050 Med Claims Paid	1,134,523.26	671,948.86	917,266.40	490,093.33
004051 Prescrip Drugs				
004051 Prescrip Drugs- Core	47,012.59	106,272.16	80,207.13	107,695.89
004051 Prescrip Drugs- Ded	45,177.20	179,374.64	118,327.54	117,688.97
004051 Prescrip Drugs- EPO	15,512.38	59,013.65	27,202.91	43,147.49
Total 004051 Prescrip Drugs	107,702.17	344,660.45	225,737.58	268,532.35

WILLIAMSON COUNTY BENEFITS FUND
Profit & Loss
October 2012 through September 2013

Wilco Claims Expense - FY 2013

Active & COBRA are combined.

	TOTAL
Expense	
004038 Retiree Vision Claims	18,913.73
004039 Retiree Dental	
004039 Retiree Dental High	35,394.02
004039 Retiree Dental Low	2,399.70
Total 004039 Retiree Dental	37,793.72
004040 - Retiree Claims	
004040 Retiree Claims- Core	432,035.07
004040 Retiree Claims- Ded	289,031.52
004040 Retiree Claims- EPO	30,705.01
Total 004040 - Retiree Claims	751,771.60
004041 - Retiree Rx Claims Exp	
004041 Retiree Rx- Core	171,296.67
004041 Retiree Rx- Ded	106,340.95
004041 Retiree Rx- EPO	10,022.94
Total 004041 - Retiree Rx Claims Exp	287,660.56
004048 Vision Claim	287,827.71
004049 Dental Claims Paid	
004049 Dental Claims Paid - Hi	880,903.85
004049 Dental Claims Paid - Lo	109,158.06
Total 004049 Dental Claims Paid	990,061.91
004050 Med Claims Paid	
004050 Med Claims Paid- Core	4,290,901.19
004050 Med Claims Paid- Ded	5,103,367.56
004050 Med Claims Paid- EPO	967,279.46
004050 Med Claims Paid - Other	38,548.22
Total 004050 Med Claims Paid	10,400,096.43
004051 Prescrip Drugs	
004051 Prescrip Drugs- Core	804,641.16
004051 Prescrip Drugs- Ded	1,118,489.91
004051 Prescrip Drugs- EPO	366,845.36
Total 004051 Prescrip Drugs	2,289,976.43

Williamson County
Claims (Allegiance / Aetna)

Month	Allegiance	Aetna	Grand Total	Emps
Nov-14	$701,842	$186,487	$888,329	1,440
Dec-14	$298,097	$883,941	$1,182,037	1,440
Jan-15	$61,268	$748,726	$809,994	1,414
Feb-15	$321,112	$1,347,437	$1,668,549	1,423
Mar-15	$81,113	$1,848,100	$1,929,213	1,422
Apr-15	-$1,518	$1,388,838	$1,387,320	1,407
May-15	$0	$1,317,149	$1,317,149	1,411
Jun-15			$0	
Jul-15			$0	
Aug-15			$0	
Sep-15			$0	
Oct-15			$0	
Total	**$1,461,913**	**$7,720,677**	**$9,182,591**	**9,957**

	ACO High			ACO Low			POS High			POS Low			Actives	Retirees	COBRA						
	10-001	10-002	10-003	11-101	11-102	11-103	12-201	12-202	12-203	13-301	13-302	13-303	Total-001	Total 002	Total 003	Gr Total	High Dental	Low Dental	Gr Total	Vision	
Nov-14	$13,674	$839	$0	$72,513	$3,315	$1	$19,546	$543	$0	$42,889	$2,364	$1	$148,622	$7,061	$2	$155,685	$27,915	$2,886	$30,801	$1	$186,486
Dec-14	$89,394	$17,861	$0	$290,797	$29,594	$4,323	$94,847	$6,754	$0	$263,028	$15,349	$1,424	$738,066	$69,558	$5,747	$813,371	$63,414	$7,155	$70,569	$1	$883,940
Jan-15	$86,527	$13,774	$0	$231,984	$41,880	$2,776	$79,840	$1,843	$0	$191,234	$14,553	$223	$589,585	$72,050	$2,999	$664,634	$60,664	$7,008	$67,672	$16,420	$732,306
Feb-15	$181,511	$43,209	$0	$447,922	$38,823	$4,388	$117,480	$74,026	$0	$308,750	$26,456	$184	$1,055,663	$182,514	$4,572	$1,242,749	$72,091	$8,128	$80,219	$24,469	$1,322,968
Mar-15	$334,982	$47,614	$0	$728,355	$28,419	$20,867	$72,963	$5,493	$0	$469,007	$26,391	$279	$1,605,307	$107,917	$21,146	$1,734,370	$76,938	$14,498	$91,436	$22,294	$1,825,806
Apr-15	$242,106	$7,968	$0	$517,263	$16,385	$31,541	$155,128	$3,051	$0	$286,208	$20,347	$588	$1,200,705	$47,751	$32,129	$1,280,585	$80,494	$7,162	$87,656	$20,597	$1,368,241
May-15	$395,141	$10,218	$0	$401,484	$36,173	$1,758	$108,598	$5,110	$0	$255,047	$20,132	$889	$1,160,270	$71,633	$2,647	$1,234,550	$59,628	$4,209	$63,837	$18,757	$1,317,144
Jun-15																					
Jul-15																					
Aug-15																					
Sep-15																					
Oct-15																					
Totals	$1,343,335	$141,483	$0	$2,690,318	$194,589	$65,654	$648,402	$96,820	$0	$1,816,163	$125,592	$3,588	$6,498,218	$558,484	$69,242	$7,125,944	$349,815	$41,005	$390,820		

	ACO High			ACO Low			POS High			POS Low			Actives	Retirees	COBRA				
	10-001	10-002	10-003	11-101	11-102	11-103	12-201	12-202	12-203	13-301	13-302	13-303	Total-001	Total 002	Total 003	Gr Total	High Dental	Low Dental	Gr Total
Nov-14	138	14	0	917	39	1	65	7	0	215	29	1	1335	89	2	1426	963	320	1283
Dec-14	138	14	0	917	39	1	65	7	0	215	29	1	1335	89	2	1426	963	320	1283
Jan-15	136	15	0	912	39	2	64	7	0	211	29	1	1323	90	3	1416	958	318	1276
Feb-15	136	15	0	918	39	2	63	7	0	212	29	1	1329	90	3	1422	958	320	1278
Mar-15	136	14	0	912	41	2	62	7	0	214	29	1	1324	91	3	1418	955	322	1277
Apr-15	133	15	0	908	39	2	62	7	0	214	29	1	1317	90	3	1410	955	322	1277
May-15	131	15	0	910	39	2	63	7	0	216	27	1	1320	88	3	1411			
Jun-15																			
Jul-15																			
Aug-15																			
Sep-15																			
Oct-15																			
Totals	948	102	0	6394	275	12	444	49	0	1497	201	7	9283	627	19	9929			

04/30/15 Allegiance Benefit Plan Management, Inc. PAGE: 1
LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 03 11/01/2014 to 10/31/2015 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

GROUP: 2001025 SSN: ********** SEQ: ** DIV: 0001 RELAT: Child EFF: ********** DOB: ********** TERM: **********
LEVEL: na PLAN:

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	11-*	250000.00	14.22	35556.19	.00	.00	.00	.00

==========Diagnosis Recap==========

Amount	Code	Description
$29,413.77	355.3	09190001012015093OLESION OF LATERAL POPLITEAL NERVE
$1,335.53	459.9	09190001012015093OUNSPECIFIED CIRCULATORY SYSTEM DISORDER
$1,239.50	836.50	09190001012015093OCLOSED DISLOCATION OF KNEE, UNSPECIFIED
$786.91	736.79	09190001012015093OOTHER ACQUIRED DEFORMITIES OF ANKLE AND
$555.83	999	09190001012015093OCOMPLICATIONS OF MEDICAL CARE, NOT ELSEW
$486.32	354.9	09190001012015093OMONONEURITIS OF UPPER LIMB, UNSPECIFIED
$461.64	DRUGS	09190001012015093OPRESCRIPTION DRUGS
$380.80	782.0	09190001012015093ODISTURBANCE OF SKIN SENSATION
$308.63	718.43	09190001012015093OCONTRACTURE OF FOREARM JOINT
$226.02	821.00	09190001012015093OFRACTURE OF UNSPECIFIED PART OF FEMUR, C
$97.87	719.7	09190001012015093ODIFFICULTY IN WALKING
$95.04	789.07	09190001012015093OOTHER SYMPTOMS INVOLVING ABDOMEN AND
$59.50	296.89	09190001012015093OBIPOLAR DISORDER,OTHER
$51.25	891.1	09190001012015093OOPEN WOUND OF KNEE, LEG (EXCEPT THIGH),
$29.45	828.1	09190001012015093OMULTIPLE FRACTURES INVOLVING BOTH LOWER
$28.13	736.71	09190001012015093OACQUIRED EQUINOVARUS DEFORMITY

$35,556.19 Total Paid

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
836.50	CLOSED DISLOCATION OF KNEE, UNSPECIFIED	1239.50	10/07/2014
736.79	OTHER ACQUIRED DEFORMITIES OF ANKLE AND	786.91	10/06/2014
354.9	MONONEURITIS OF UPPER LIMB, UNSPECIFIED	486.32	10/27/2014
718.43	CONTRACTURE OF FOREARM JOINT	308.63	09/10/2014
999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEW	555.83	10/26/2014
891.1	OPEN WOUND OF KNEE, LEG (EXCEPT THIGH),	51.25	10/21/2014
958.8	OTHER EARLY COMPLICATIONS OF TRAUMA		10/21/2014
718.56	ANKYLOSIS OF LOWER LEG JOINT		10/21/2014
836.52	POSTERIOR DISLOCATION OF TIBIA, PROXIMAL		10/21/2014
DRUGS	PRESCRIPTION DRUGS	461.64	10/28/2014
789.07	OTHER SYMPTOMS INVOLVING ABDOMEN AND	95.04	10/24/2014
821.00	FRACTURE OF UNSPECIFIED PART OF FEMUR, C	226.02	10/25/2014
823.80	CLOSED FRACTURE OF UNSPECIFIED PART OF T		10/25/2014
728.87	MUSCLE WEAKNESS (GENERALIZED)		10/25/2014
719.7	DIFFICULTY IN WALKING	97.87	10/31/2014
736.71	ACQUIRED EQUINOVARUS DEFORMITY	28.13	10/10/2014
828.1	MULTIPLE FRACTURES INVOLVING BOTH LOWER	29.45	10/25/2014
296.89	BIPOLAR DISORDER,OTHER	59.50	09/11/2014
V71.09	OBSERVATION OF OTHER SUSPECTED MENTAL CO		09/11/2014

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 03 11/01/2014 to 10/31/2015 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
782.0	DISTURBANCE OF SKIN SENSATION	380.80	08/09/2014
459.9	UNSPECIFIED CIRCULATORY SYSTEM DISORDER	1335.53	08/09/2014
355.3	LESION OF LATERAL POPLITEAL NERVE	29413.77	10/10/2014
717.83	OLD DISRUPTION OF ANTERIOR CRUCIATE LIGA		10/10/2014
719.47	PAIN IN JOINT INVOLVING ANKLE AND FOOT		10/10/2014
719.58	STIFFNESS OF JOINT, NOT ELSEWHERE CLASSI		10/10/2014

GROUP: 2001025 SSN: ********** SEQ: ** DIV: 0001 RELAT: Child EFF: ********** DOB: ********** TERM: **********
LEVEL: na PLAN:

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	12-*	250000.00	65.60	163988.00	.00	.00	.00	.00

Diagnosis Recap

Amount	Code	Description
$127,006.27	996.59	09190001012015093OMECHANICAL COMPLICATION OF OTHER IMPLANT
$23,660.08	996.49	09190001012015093OOTHER MECHANICAL COMPLICATION OF OTHER
$10,177.33	738.4	09190001012015093OACQUIRED SPONDYLOLISTHESIS
$2,720.00	721.3	09190001012015093OLUMBOSACRAL SPONDYLOSIS WITHOUT MYELOPAT
$278.63	733.82	09190001012015093ONONUNION OF FRACTURE
$100.47	V72.83	09190001012015093OTH SPCF PREOP EXAM
$27.61	DRUGS	09190001012015093OPRESCRIPTION DRUGS
$17.61	V45.4	09190001012015093OPOSTSURGICAL ARTHRODESIS STATUS

$163,988.00 Total Paid

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
DRUGS	PRESCRIPTION DRUGS	27.61	10/27/2014
738.4	ACQUIRED SPONDYLOLISTHESIS	10177.33	10/30/2014
724.4	THORACIC OR LUMBOSACRAL NEURITIS OR RADI		10/30/2014
733.82	NONUNION OF FRACTURE	278.63	10/30/2014
V45.4	POSTSURGICAL ARTHRODESIS STATUS	17.61	10/30/2014
756.11	CONGENITAL SPONDYLOLYSIS, LUMBOSACRAL RE		10/27/2014
721.3	LUMBOSACRAL SPONDYLOSIS WITHOUT MYELOPAT	2720.00	10/22/2014
V72.83	OTH SPCF PREOP EXAM	100.47	10/17/2014
996.59	MECHANICAL COMPLICATION OF OTHER IMPLANT	127006.27	10/27/2014
996.41	MECHANICAL LOOSENING OF PROSTHETIC JOINT		10/22/2014
724.8	OTHER SYMPTOMS REFERABLE TO BACK		10/27/2014
996.49	OTHER MECHANICAL COMPLICATION OF OTHER	23660.08	10/22/2014

GROUP: 2001025 SSN: ********** SEQ: ** DIV: 0001 RELAT: Participant EFF: ********** DOB: ********** TERM: **********
LEVEL: na PLAN:

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	00-*	250000.00	11.79	29485.56	.00	.00	.00	.00

Diagnosis Recap

Amount	Code	Description
$26,648.31	473.9	09190001012015093OUNSPECIFIED SINUSITIS (CHRONIC)
$1,599.47	470	09190001012015093ODEVIATED NASAL SEPTUM
$380.38	478.0	09190001012015093OHYPERTROPHY OF NASAL TURBINATES
$288.40	999	09190001012015093OCOMPLICATIONS OF MEDICAL CARE, NOT ELSEW
$286.37	477.9	09190001012015093OALLERGIC RHINITIS, CAUSE UNSPECIFIED
$182.28	DRUGS	09190001012015093OPRESCRIPTION DRUGS
$101.35	V70.0	09190001012015093OROUTINE GENERAL MEDICAL EXAMINATION AT A

$29,486.56 Total Paid

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
DRUGS	PRESCRIPTION DRUGS	182.28	10/31/2014
477.9	ALLERGIC RHINITIS, CAUSE UNSPECIFIED	286.37	10/28/2014
473.9	UNSPECIFIED SINUSITIS (CHRONIC)	26648.31	10/31/2014
478.19	OTHER DISEASES OF UPPER RESPIRATORY		10/28/2014
470	DEVIATED NASAL SEPTUM	1599.47	10/31/2014
V70.0	ROUTINE GENERAL MEDICAL EXAMINATION AT A	101.35	10/22/2014
478.0	HYPERTROPHY OF NASAL TURBINATES	380.38	10/31/2014
999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEW	288.40	10/31/2014

GROUP: 2001025 SSN: ********** SEQ: ** DIV: 0001 RELAT: Spouse EFF: ********** DOB: ********** TERM: **********
LEVEL: na PLAN:

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	01-*	250000.00	33.43	83567.17	.00	.00	.00	.00

Diagnosis Recap

Amount	Code	Description
$65,229.30	530.81	09190001012015093OESOPHAGEAL REFLUX

$5,985.15	DRUGS	091900010120150930PRESCRIPTION DRUGS
$4,778.40	V55.3	091900010120150930ATTENTION TO COLOSTOMY
$2,387.38	787.20	091900010120150930DYSPHAGIA, UNSPECIFIED
$1,413.52	V58.44	091900010120150930AFTERCARE FOLLOWING ORGAN TRANSPLANT
$1,094.16	V42.6	091900010120150930LUNG REPLACED BY TRANSPLANT
$996.66	999	091900010120150930COMPLICATIONS OF MEDICAL CARE, NOT ELSEW
$765.00	478.30	091900010120150930UNSPECIFIED PARALYSIS OF VOCAL CORDS
$321.60	536.42	091900010120150930GASTROSTOMY COMPLICATIONS;MECHANICAL
$315.39	523.41	091900010120150930GINGIVAL AND PERIODONTAL DISEASES-
$169.01	496	091900010120150930CHRONIC AIRWAY OBSTRUCTION, NOT ELSEWHER
$83.40	787.23	091900010120150930DYSPHAGIA, PHARYNGEAL PHASE
$28.20	V58.81	091900010120150930FITTING AND ADJUSTMENT OF VASCULAR

$83,567.17 Total Paid

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
787.20	DYSPHAGIA, UNSPECIFIED	2387.38	09/26/2014
136.9	UNSPECIFIED INFECTIOUS AND PARASITIC DIS		09/26/2014
263.0	MALNUTRITION OF MODERATE DEGREE		10/08/2014
518.81	RESPIRATORY FAILURE		09/26/2014
DRUGS	PRESCRIPTION DRUGS	5985.15	10/30/2014
999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEW	996.66	10/30/2014
523.41	GINGIVAL AND PERIODONTAL DISEASES-	315.39	08/14/2014
496	CHRONIC AIRWAY OBSTRUCTION, NOT ELSEWHER	169.01	10/22/2014
560.9	UNSPECIFIED INTESTINAL OBSTRUCTION		10/22/2014
530.81	ESOPHAGEAL REFLUX	65229.30	10/08/2014
285.1	ACUTE POSTHEMORRHAGIC ANEMIA		09/30/2014
V42.6	LUNG REPLACED BY TRANSPLANT	1094.16	10/31/2014
V07.2	NEED FOR PROPHYLACTIC IMMUNOTHERAPY		10/24/2014
275.5	Hungry bone syndrome		10/31/2014

04/30/15 Allegiance Benefit Plan Management, Inc. PAGE: 4
LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 03 11/01/2014 to 10/31/2015 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
078.5	CYTOMEGALIC INCLUSION DISEASE		10/31/2014
V55.3	ATTENTION TO COLOSTOMY	4778.40	09/30/2014
V64.41	LAPAROSCOPIC SURG PROC CONVERTED TO		09/30/2014
V58.44	AFTERCARE FOLLOWING ORGAN TRANSPLANT	1413.52	10/31/2014
272.4	OTHER AND UNSPECIFIED HYPERLIPIDEMIA		10/31/2014
518.52	Othr pulmon insuff NOS fol tra/surg		10/08/2014
560.1	PARALYTIC ILEUS		10/08/2014
536.42	GASTROSTOMY COMPLICATIONS;MECHANICAL	321.60	08/24/2014
414.00	CORONARY ATHEROSCLEROSIS OF UNSPECIFIED		08/24/2014
V58.81	FITTING AND ADJUSTMENT OF VASCULAR	28.20	10/03/2014
V58.82	FITTING AND ADJUSTMENT OF NONVASCULAR		10/03/2014
478.30	UNSPECIFIED PARALYSIS OF VOCAL CORDS	765.00	09/15/2014
784.42	Symptom, dysphonia		09/15/2014
787.23	DYSPHAGIA, PHARYNGEAL PHASE	83.40	10/07/2014
786.02	ORTHOPNEA		10/20/2014

GROUP: 2001025 SSN: ********** SEQ: ** DIV: 0001 RELAT: Spouse EFF: ********** DOB: ********** TERM: **********
LEVEL: na PLAN:

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	01-*	250000.00	16.32	40789.74	.00	.00	.00	.00

==========Diagnosis Recap==========

Amount	Code	Description
$37,207.63	112.84	09190001012015093OCANDIDAL ESOPHAGITIS
$1,402.51	250.12	09190001012015093ODIABETES WITH KETOACIDOSIS,TYPE II OR
$557.52	789.07	09190001012015093OOTHER SYMPTOMS INVOLVING ABDOMEN AND
$385.62	789.06	09190001012015093OOTHER SYMPTOMS INVOLVING ABDOMEN AND
$255.50	211.3	09190001012015093OBENIGN NEOPLASM OF COLON
$193.93	DRUGS	09190001012015093OPRESCRIPTION DRUGS
$164.52	789.00	09190001012015093OOTHER SYMPTOMS INVOLVING ABDOMEN AND
$144.07	562.10	09190001012015093ODIVERTICULOSIS OF COLON
$140.65	787.03	09190001012015093OSYMPTOMS INVOLVING DIGESTIVE SYSTEM
$138.76	V72.60	09190001012015093OLaboratory examination, unspecified
$111.20	751.69	09190001012015093OOTHER CONGENITAL ANOMALIES OF GALLBLADDE
$60.25	787.01	09190001012015093OOTHER SYMPTOMS INVOLVING DIGESTIVE
$13.79	V58.81	09190001012015093OFITTING AND ADJUSTMENT OF VASCULAR
$13.79	780.79	09190001012015093OOTHER MALAISE AND FATIGUE

$40,789.74 Total Paid

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 03 11/01/2014 to 10/31/2015 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
V72.60	Laboratory examination, unspecified	138.76	10/23/2014
112.84	CANDIDAL ESOPHAGITIS	37207.63	10/23/2014
535.10	ATRPH GASTRTIS W/O HMRHG		10/22/2014
789.07	OTHER SYMPTOMS INVOLVING ABDOMEN AND	557.52	10/15/2014
787.01	OTHER SYMPTOMS INVOLVING DIGESTIVE	60.25	10/23/2014
787.91	OTHER SYMPTOMS INVOLVING DIGESTIVE		10/23/2014
DRUGS	PRESCRIPTION DRUGS	193.93	10/28/2014
787.03	SYMPTOMS INVOLVING DIGESTIVE SYSTEM	140.65	10/23/2014
789.00	OTHER SYMPTOMS INVOLVING ABDOMEN AND	164.52	10/23/2014
211.3	BENIGN NEOPLASM OF COLON	255.50	10/08/2014
562.10	DIVERTICULOSIS OF COLON	144.07	10/15/2014
250.00	DIABETES MELLITUS WITHOUT MENTION OF		10/23/2014
244.9	UNSPECIFIED ACQUIRED HYPOTHYROIDISM		10/08/2014
789.06	OTHER SYMPTOMS INVOLVING ABDOMEN AND	385.62	10/22/2014
780.79	OTHER MALAISE AND FATIGUE	13.79	10/15/2014
751.69	OTHER CONGENITAL ANOMALIES OF GALLBLADDE	111.20	10/21/2014
V58.81	FITTING AND ADJUSTMENT OF VASCULAR	13.79	10/18/2014
209.20	Malig tumor unkn primary site		10/23/2014
535.50	GSTR/DDNTS NOS W/O HMRHG		10/23/2014
272.4	OTHER AND UNSPECIFIED HYPERLIPIDEMIA		10/23/2014
250.12	DIABETES WITH KETOACIDOSIS,TYPE II OR	1402.51	09/04/2014
401.0	MALIGNANT ESSENTIAL HYPERTENSION		09/04/2014
530.81	ESOPHAGEAL REFLUX		09/04/2014
558.9	OTHER AND UNSPECIFIED NONINFECTIOUS GAST		09/04/2014

GROUP: 2001025 SSN: ********** SEQ: ** DIV: 0001 RELAT: Spouse EFF: ********** DOB: ********** TERM: **********
LEVEL: na PLAN:

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	01-*	250000.00	34.09	85215.78	.00	.00	.00	.00

==========Diagnosis Recap==========

Amount	Code	Description
$83,649.86	338.4	091900010120150930CHRONIC PAIN SYNDROME
$1,550.00	722.83	091900010120150930POSTLAMINECTOMY SYNDROME OF LUMBAR REGIO
$15.92	DRUGS	091900010120150930PRESCRIPTION DRUGS

$85,215.78 Total Paid

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
DRUGS	PRESCRIPTION DRUGS	15.92	10/24/2014
338.4	CHRONIC PAIN SYNDROME	83649.86	10/24/2014
722.83	POSTLAMINECTOMY SYNDROME OF LUMBAR REGIO	1550.00	10/24/2014
493.90	ASTHMA, UNSPECIFIED TYPE		10/24/2014

GROUP: 2001025 SSN: ********** SEQ: ** DIV: 0001 RELAT: Child EFF: ********** DOB: ********** TERM: **********
LEVEL: na PLAN:

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	12-*	250000.00	21.47	53685.76	.00	.00	.00	.00

==========Diagnosis Recap==========

Amount	Code	Description
$50,104.74	V44.0	091900010120150930TRACHEOSTOMY STATUS
$923.70	V44.1	091900010120150930GASTROSTOMY STATUS
$884.46	518.89	091900010120150930OTHER DISEASES OF LUNG, NOT ELSEWHERE CL
$590.25	578.9	091900010120150930HEMORRHAGE OF GASTROINTESTINAL TRACT, UN
$483.00	787.03	091900010120150930SYMPTOMS INVOLVING DIGESTIVE SYSTEM
$202.02	783.3	091900010120150930FEEDING DIFFICULTIES AND MISMANAGEMENT
$184.08	518.83	091900010120150930OTHER DISEASE OF LUNG / CHRONIC
$179.34	330.0	091900010120150930LEUKODYSTROPHY
$134.17	999	091900010120150930COMPLICATIONS OF MEDICAL CARE, NOT ELSEW

$53,685.76 Total Paid

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
330.0	LEUKODYSTROPHY	179.34	10/20/2014
999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEW	134.17	10/25/2014
V44.0	TRACHEOSTOMY STATUS	50104.74	10/31/2014
V44.1	GASTROSTOMY STATUS	923.70	10/31/2014
518.89	OTHER DISEASES OF LUNG, NOT ELSEWHERE CL	884.46	10/07/2014
496	CHRONIC AIRWAY OBSTRUCTION, NOT ELSEWHER		10/07/2014
578.9	HEMORRHAGE OF GASTROINTESTINAL TRACT, UN	590.25	08/19/2014
783.3	FEEDING DIFFICULTIES AND MISMANAGEMENT	202.02	09/08/2014
315.9	UNSPECIFIED DELAY IN DEVELOPMENT		08/19/2014
518.83	OTHER DISEASE OF LUNG / CHRONIC	184.08	09/18/2014
787.29	OTHER DYSPHAGIA		09/18/2014
491.1	MUCOPURULENT CHRONIC BRONCHITIS		09/18/2014
787.03	SYMPTOMS INVOLVING DIGESTIVE SYSTEM	483.00	09/08/2014
V66.7	ENCOUNTER FOR PALLIATIVE CARE;HOSPICE		08/19/2014
377.75	CORTICAL BLINDNESS		10/20/2014
379.51	CONGENITAL NYSTAGMUS		10/20/2014

********** GROUP TOTALS **********	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
	492288.20	.00	.00	.00	.00

TOTAL OF PRINTED CLAIM DETAIL: 492289.20

** TOTALS FOR ALL GROUPS **

**********	TOTALS	**********	492288.20	.00	.00	.00	.00

TOTAL OF PRINTED CLAIM DETAIL: 492289.20

Division Break Down

0001	7	$492,289.20
Total	7	$492,289.20

10/31/14 Allegiance Benefit Plan Management, Inc. PAGE: 1
LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 02 11/01/2013 to 10/31/2014 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

GROUP: 2001025 SSN: ********** SEQ: ** DIV: RETR RELAT: Participant EFF: ********** DOB: ********** TERM: **********
LEVEL: P00 PLAN: WILCO-MED-CORE

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	00-*	250000.00	25.41	63518.07	.00	.00	.00	.00

==========Diagnosis Recap==========

Amount	Code	Description
$45,301.02	715.16	OSTEOARTHROSIS, LOCALIZED, PRIMARY, INVOLVING LOWER LEG
$3,679.07	715.96	OSTEOARTHROSIS, UNSPECIFIED, INVOLVING LOWER LEG/KNEE
$3,294.62	V57.1	CARE INVOLVING OTHER PHYSICAL THERAPY
$2,147.18	V54.81	AFTERCARE FOLLOWING JOINT REPLACEMENT
$1,995.46	722.52	DEGENERATION OF LUMBAR OR LUMBOSACRAL INTERVERTEBRAL DISC
$1,879.94	724.4	THORACIC OR LUMBOSACRAL NEURITIS OR RADICULITIS
$911.71	724.2	LUMBAGO
$889.85	DRUGS	PRESCRIPTION DRUGS
$638.48	721.3	LUMBOSACRAL SPONDYLOSIS WITHOUT MYELOPATHY
$500.00	719.45	PAIN IN JOINT INVOLVING PELVIC REGION AND THIGH
$459.00	724.3	SCIATICA
$401.42	V58.69	LONG-TERM (CURRENT) USE OF OTHER MEDICATIONS
$385.67	999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEWHERE CLASSIFIED
$344.95	365.01	OPEN ANGLE WITH BORDERLINE GLAUCOMA FINDINGS
$234.17	722.10	DISPLACEMENT OF LUMBAR INTERVERTEBRAL DISC WITHOUT MYELOPATHY
$204.61	338.4	CHRONIC PAIN SYNDROME
$165.50	285.1	ACUTE POSTHEMORRHAGIC ANEMIA
$75.98	728.89	OTHER DISORDER OF MUSCLE, LIGAMENT, AND FASCIA
$9.44	V72.81	PREOP CARDIOVSCLR EXAM

$63,518.07 Total Paid

10/31/14 Allegiance Benefit Plan Management, Inc. PAGE: 2
LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 02 11/01/2013 to 10/31/2014 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
715.96	OSTEOARTHROSIS, UNSPECIFIED, INVOLVING	3679.07	03/07/2014
285.1	ACUTE POSTHEMORRHAGIC ANEMIA	165.50	12/06/2013
458.9	HYPOTENSION, UNSPECIFIED		12/06/2013
600.01	HYPERTROPHY (BENIGN) OF PROSTATE WITH		12/06/2013
DRUGS	PRESCRIPTION DRUGS	889.85	04/25/2014
V72.81	PREOP CARDIOVSCLR EXAM	9.44	11/27/2013
715.36	OSTEOARTHROSIS, LOCALIZED, INVOLVING		11/27/2013
715.16	OSTEOARTHROSIS, LOCALIZED, PRIMARY, INVO	45301.02	12/26/2013
458.0	ORTHOSTATIC HYPOTENSION		12/06/2013
401.9	UNSPECIFIED ESSENTIAL HYPERTENSION		12/20/2013
V43.65	JOINT;KNEE		01/24/2014
365.01	OPEN ANGLE WITH BORDERLINE GLAUCOMA FIND	344.95	05/27/2014
366.16	SENILE NUCLEAR SCLEROSIS		05/27/2014
V54.81	AFTERCARE FOLLOWING JOINT REPLACEMENT	2147.18	12/20/2013
311	DEPRESSIVE DISORDER, NOT ELSEWHERE CLASS		12/20/2013
999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEW	385.67	06/26/2014
V57.1	CARE INVOLVING OTHER PHYSICAL THERAPY	3294.62	04/22/2014
719.56	STIFFNESS OF JOINT, NOT ELSEWHERE CLASSI		01/24/2014
719.46	PAIN IN JOINT INVOLVING LOWER LEG		04/07/2014
728.87	MUSCLE WEAKNESS (GENERALIZED)		04/22/2014
722.10	DISPLACEMENT OF LUMBAR INTERVERTEBRAL DI	234.17	03/07/2014
724.2	LUMBAGO	911.71	06/27/2014
722.52	DEGENERATION OF LUMBAR OR LUMBOSACRAL IN	1995.46	04/21/2014
V67.00	FOLLOWING SURGERY, UNSPECIFIED		03/07/2014
721.3	LUMBOSACRAL SPONDYLOSIS WITHOUT MYELOPAT	638.48	03/21/2014
V58.69	LONG-TERM (CURRENT) USE OF OTHER	401.42	03/10/2014
338.4	CHRONIC PAIN SYNDROME	204.61	04/07/2014
724.4	THORACIC OR LUMBOSACRAL NEURITIS OR RADI	1879.94	06/24/2014
728.85	SPASM OF MUSCLE		04/21/2014
728.89	OTHER DISORDER OF MUSCLE, LIGAMENT, AND	75.98	04/21/2014
719.7	DIFFICULTY IN WALKING		04/22/2014
724.3	SCIATICA	459.00	06/24/2014
724.1	PAIN IN THORACIC SPINE		06/24/2014
375.15	TEAR FILM INSUFFICIENCY, UNSPECIFIED		05/27/2014
724.02	Stenosis, spinal, lmbr, no neuro cl		06/24/2014
719.45	PAIN IN JOINT INVOLVING PELVIC REGION AN	500.00	06/27/2014

GROUP: 2001025 SSN: ********** SEQ: ** DIV: RETR RELAT: Spouse EFF: ********** DOB: ********** TERM: **********
LEVEL: P99 PLAN: WILCO-MED-DED

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	01-*	250000.00	27.47	68684.85	.00	.00	.00	.00

==========Diagnosis Recap==========

Amount	Code	Description
$23,995.73	197.6	SECONDARY MALIGNANT NEOPLASM OF RETROPERITONEUM AND PERITONEUM
$12,197.57	153.3	MALIGNANT NEOPLASM OF SIGMOID COLON
$12,131.12	578.9	HEMORRHAGE OF GASTROINTESTINAL TRACT, UNSPECIFIED
$9,457.80	153.9	MALIGNANT NEOPLASM OF COLON, UNSPECIFIED
$2,835.99	560.9	UNSPECIFIED INTESTINAL OBSTRUCTION
$2,747.95	V10.05	Hx, prsnl, colonic malignancy
$1,439.92	DRUGS	PRESCRIPTION DRUGS
$1,245.83	999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEWHERE CLASSIFIED
$661.20	573.8	OTHER SPECIFIED DISORDERS OF LIVER
$499.62	789.00	OTHER SYMPTOMS INVOLVING ABDOMEN AND PELVIS
$473.00	564.89	OTHER SPECIFIED DISORDERS OF INTESTINE; OTHER
$218.32	793.4	NONSPECIFIC ABNORMAL FINDINGS ON RADIOLOGICAL AND OTHER EXAMINATION OF GASTROINT
$186.80	415.19	ACUTE PULMONARY HEART DISEASE
$183.64	560.89	OTHER SPECIFIED INTESTINAL OBSTRUCTION
$164.62	276.51	DEHYDRATION
$79.00	789.09	OTHER SYMPTOMS INVOLVING ABDOMEN AND PELVIS
$45.54	782.3	EDEMA
$32.94	518.81	RESPIRATORY FAILURE
$30.02	263.9	UNSPECIFIED PROTEIN-CALORIE MALNUTRITION
$28.82	728.87	MUSCLE WEAKNESS (GENERALIZED)
$15.01	787.3	FLATULENCE, ERUCTATION, AND GAS PAIN
$14.41	786.50	UNSPECIFIED CHEST PAIN

$68,684.85 Total Paid

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
153.3	MALIGNANT NEOPLASM OF SIGMOID COLON	12197.57	04/18/2014
V10.05	Hx, prsnl, colonic malignancy	2747.95	02/28/2014
564.00	CONSTIPATION, UNSPECIFIED		02/21/2014
493.90	ASTHMA, UNSPECIFIED TYPE		02/21/2014
305.1	TOBACCO USE DISORDER		03/14/2014
V45.72	ACQUIRED ABSENCE OF ORGAN;ACQUIRED		02/21/2014
153.9	MALIGNANT NEOPLASM OF COLON, UNSPECIFIED	9457.80	04/15/2014
197.7	MALIGNANT NEOPLASM OF LIVER, SPECIFIED A		04/17/2014
560.89	OTHER SPECIFIED INTESTINAL OBSTRUCTION	183.64	04/10/2014
197.6	SECONDARY MALIGNANT NEOPLASM OF RETROPER	23995.73	04/15/2014
584.9	Acute kidney failure, unspecified		03/01/2014
789.09	OTHER SYMPTOMS INVOLVING ABDOMEN AND	79.00	03/03/2014
564.89	OTHER SPECIFIED DISORDERS OF INTESTINE;	473.00	03/05/2014
789.00	OTHER SYMPTOMS INVOLVING ABDOMEN AND	499.62	03/29/2014
787.3	FLATULENCE, ERUCTATION, AND GAS PAIN	15.01	03/30/2014
573.8	OTHER SPECIFIED DISORDERS OF LIVER	661.20	03/06/2014
999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEW	1245.83	05/25/2014
DRUGS	PRESCRIPTION DRUGS	1439.92	04/02/2014
263.9	UNSPECIFIED PROTEIN-CALORIE MALNUTRITION	30.02	04/18/2014
783.3	FEEDING DIFFICULTIES AND MISMANAGEMENT		03/30/2014
V53.59	Fit/adjust other gastro appl/dev		03/30/2014
578.9	HEMORRHAGE OF GASTROINTESTINAL TRACT, UN	12131.12	04/08/2014
782.3	EDEMA	45.54	03/29/2014
560.9	UNSPECIFIED INTESTINAL OBSTRUCTION	2835.99	04/18/2014
415.19	ACUTE PULMONARY HEART DISEASE	186.80	04/08/2014
518.81	RESPIRATORY FAILURE	32.94	04/11/2014
573.9	DISORDER OF LIVER		04/10/2014
793.19	Othr nonspecfc abnorml finding/lung		04/10/2014
199.1	OTHER MALIGNANT NEOPLASM OF UNSPECIFIED		04/08/2014

10/31/14 Allegiance Benefit Plan Management, Inc. PAGE: 4
LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 02 11/01/2013 to 10/31/2014 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
V14.0	Hx, prsnl, penicillin allergy		03/26/2014
154.1	MALIGNANT NEOPLASM OF RECTUM		03/29/2014
285.1	ACUTE POSTHEMORRHAGIC ANEMIA		04/07/2014
276.8	HYPOPOTASSEMIA		03/07/2014
276.1	HYPOSMOLALITY AND/OR HYPONATREMIA		03/05/2014
788.99	Symptoms, other symptoms, urinary		03/02/2014
288.60	NEUTROPENIA-LEUKOCYTOSIS, UNSPECIFIED		03/07/2014
276.51	DEHYDRATION	164.62	04/18/2014
V12.79	Hx, prsnl, digestive disease NEC		04/11/2014
V12.55	Hx, prsnl, pulmonary embolism		04/11/2014
728.87	MUSCLE WEAKNESS (GENERALIZED)	28.82	04/12/2014
793.4	NONSPECIFIC ABNORMAL FINDINGS ON RADIOLO	218.32	03/21/2014
786.50	UNSPECIFIED CHEST PAIN	14.41	04/11/2014
557.9	UNSPECIFIED VASCULAR INSUFFICIENCY OF IN		04/11/2014
486	PNEUMONIA, ORGANISM UNSPECIFIED		04/10/2014
569.83	PERFORATION OF INTESTINE		04/10/2014
262	OTHER SEVERE PROTEIN-CALORIE MALNUTRITIO		04/10/2014
V58.69	LONG-TERM (CURRENT) USE OF OTHER		03/21/2014
787.01	OTHER SYMPTOMS INVOLVING DIGESTIVE		02/28/2014
787.91	OTHER SYMPTOMS INVOLVING DIGESTIVE		02/28/2014
275.2	DISORDERS OF MAGNESIUM METABOLISM		03/29/2014
780.79	OTHER MALAISE AND FATIGUE		04/17/2014

GROUP: 2001025 SSN: ********** SEQ: ** DIV: RET2 RELAT: Participant EFF: ********** DOB: ********** TERM: **********
LEVEL: F00 PLAN: WILCO-MED-CORE-DIAB

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	00-*	250000.00	90.72	226790.90	.00	.00	.00	.00

==========Diagnosis Recap==========

Amount	Code	Description
$143,112.24	996.49	OTHER MECHANICAL COMPLICATION OF OTHER INTERNAL ORTHOPEDIC DEVICE,IMPLANT,GRAFT
$52,675.66	721.1	CERVICAL SPONDYLOSIS WITH MYELOPATHY
$9,604.33	724.02	Stenosis, spinal, lmbr, no neuro cl
$7,310.41	DRUGS	PRESCRIPTION DRUGS
$5,724.80	780.4	DIZZINESS AND GIDDINESS
$2,804.38	738.4	ACQUIRED SPONDYLOLISTHESIS
$953.13	721.0	CERVICAL SPONDYLOSIS WITHOUT MYELOPATHY
$698.81	722.0	DISPLACEMENT OF CERVICAL INTERVERTEBRAL DISC WITHOUT MYELOPATHY
$632.87	999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEWHERE CLASSIFIED
$490.00	722.4	DEGENERATION OF CERVICAL INTERVERTEBRAL DISC
$452.41	722.10	DISPLACEMENT OF LUMBAR INTERVERTEBRAL DISC WITHOUT MYELOPATHY
$290.68	354.0	CARPAL TUNNEL SYNDROME
$234.70	250.00	DIABETES MELLITUS WITHOUT MENTION OF COMPLICATION, TYPE II
$229.83	V58.69	LONG-TERM (CURRENT) USE OF OTHER MEDICATIONS
$228.27	723.4	BRACHIAL NEURITIS OR RADICULITIS NOS
$175.58	724.03	Stenosis lumbar neurogen claudicati
$170.48	250.12	DIABETES WITH KETOACIDOSIS,TYPE II OR UNSPECIFIED TYPE,UNCONTROLLED
$124.84	724.2	LUMBAGO
$120.45	V70.0	ROUTINE GENERAL MEDICAL EXAMINATION AT AHEALTH CARE FACILITY
$118.31	722.52	DEGENERATION OF LUMBAR OR LUMBOSACRAL INTERVERTEBRAL DISC
$77.22	214.1	LIPOMA OF OTHER SKIN AND SUBCUTANEOUS TISSUE
$71.54	721.41	SPONDYLOSIS WITH MYELOPATHY, THORACIC REGION
$67.03	701.9	UNSPECIFIED HYPERTROPHIC AND ATROPHIC CONDITIONS OF SKIN
$66.43	266.2	OTHER B-COMPLEX DEFICIENCIES
$55.39	357.4	POLYNEUROPATHY IN OTHER DISEASES CLASSIFIED ELSEWHERE
$55.39	723.0	SPINAL STENOSIS IN CERVICAL REGION
$55.39	079.99	VIRAL INFECTION NOS
$55.39	214.9	LIPOMA, UNSPECIFIED SITE
$54.85	244.9	UNSPECIFIED ACQUIRED HYPOTHYROIDISM
$42.29	V04.81	NEED FOR PROPHYLACTIC VACCINATION/ INOCULATION AGAINST, INFLUENZA
$17.12	723.1	CERVICALGIA
$13.18	338.4	CHRONIC PAIN SYNDROME
$7.50	V72.81	PREOP CARDIOVSCLR EXAM

$226,790.90 Total Paid

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEW	632.87	08/08/2014
DRUGS	PRESCRIPTION DRUGS	7310.41	10/23/2014
250.00	DIABETES MELLITUS WITHOUT MENTION OF	234.70	10/07/2014
244.9	UNSPECIFIED ACQUIRED HYPOTHYROIDISM	54.85	08/11/2014
272.4	OTHER AND UNSPECIFIED HYPERLIPIDEMIA		08/11/2014
V04.81	NEED FOR PROPHYLACTIC VACCINATION/	42.29	10/30/2013
722.0	DISPLACEMENT OF CERVICAL INTERVERTEBRAL	698.81	10/23/2013
722.4	DEGENERATION OF CERVICAL INTERVERTEBRAL	490.00	07/18/2014
721.0	CERVICAL SPONDYLOSIS WITHOUT MYELOPATHY	953.13	07/14/2014
723.1	CERVICALGIA	17.12	08/05/2014
996.49	OTHER MECHANICAL COMPLICATION OF OTHER	143112.24	10/07/2013
349.31	Accid puncture of dura during procd		10/07/2013
722.52	DEGENERATION OF LUMBAR OR LUMBOSACRAL IN	118.31	11/11/2013
401.9	UNSPECIFIED ESSENTIAL HYPERTENSION		07/30/2014
250.02	DIABETES MELLITUS WITHOUT MENTION OF		12/10/2013
724.02	Stenosis, spinal, lmbr, no neuro cl	9604.33	10/01/2013
755.52	CONGENITAL ELEVATION OF SCAPULA		10/01/2013
V45.4	POSTSURGICAL ARTHRODESIS STATUS		08/05/2014
721.3	LUMBOSACRAL SPONDYLOSIS WITHOUT MYELOPAT		11/18/2013
729.2	NEURALGIA, NEURITIS, AND RADICULITIS, UN		12/23/2013

10/31/14 Allegiance Benefit Plan Management, Inc. PAGE: 6
LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 02 11/01/2013 to 10/31/2014 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

	Diagnosis Summary for **********	Amount Paid	Last D.O.S.
V58.69	LONG-TERM (CURRENT) USE OF OTHER	229.83	02/05/2014
338.4	CHRONIC PAIN SYNDROME	13.18	11/18/2013
402.10	BENIGN HYPERTENSIVE HEART DISEASE WITHOU		12/10/2013
214.9	LIPOMA, UNSPECIFIED SITE	55.39	01/16/2014
477.9	ALLERGIC RHINITIS, CAUSE UNSPECIFIED		08/07/2014
354.0	CARPAL TUNNEL SYNDROME	290.68	01/21/2014
782.0	DISTURBANCE OF SKIN SENSATION		08/05/2014
723.4	BRACHIAL NEURITIS OR RADICULITIS NOS	228.27	08/07/2014
729.5	PAIN IN LIMB		08/05/2014
V76.44	SPECIAL SCREENING FOR MALIGNANT NEOPLASM		02/05/2014
V70.0	ROUTINE GENERAL MEDICAL EXAMINATION AT A	120.45	02/05/2014
724.2	LUMBAGO	124.84	02/24/2014
079.99	VIRAL INFECTION NOS	55.39	02/13/2014
278.00	OBESITY, UNSPECIFIED		02/13/2014
721.1	CERVICAL SPONDYLOSIS WITH MYELOPATHY	52675.66	09/19/2014
724.03	Stenosis lumbar neurogen claudicati	175.58	02/10/2014
721.41	SPONDYLOSIS WITH MYELOPATHY, THORACIC RE	71.54	03/26/2014
214.1	LIPOMA OF OTHER SKIN AND SUBCUTANEOUS TI	77.22	01/21/2014
722.10	DISPLACEMENT OF LUMBAR INTERVERTEBRAL DI	452.41	01/08/2014
701.9	UNSPECIFIED HYPERTROPHIC AND ATROPHIC CO	67.03	03/11/2014
723.0	SPINAL STENOSIS IN CERVICAL REGION	55.39	08/06/2014
266.2	OTHER B-COMPLEX DEFICIENCIES	66.43	08/11/2014
357.4	POLYNEUROPATHY IN OTHER DISEASES CLASSIF	55.39	07/14/2014
V72.81	PREOP CARDIOVSCLR EXAM	7.50	07/30/2014
250.12	DIABETES WITH KETOACIDOSIS,TYPE II OR	170.48	08/06/2014
401.1	BENIGN ESSENTIAL HYPERTENSION		08/06/2014
327.23	OBSTRUCTIVE SLEEP APNEA (ADULT)		08/11/2014
738.4	ACQUIRED SPONDYLOLISTHESIS	2804.38	08/05/2014
780.4	DIZZINESS AND GIDDINESS	5724.80	10/07/2014
780.79	OTHER MALAISE AND FATIGUE		10/07/2014

GROUP: 2001025 SSN: ********** SEQ: ** DIV: RET2 RELAT: Participant EFF: ********** DOB: ********** TERM: **********
LEVEL: P00 PLAN: WILCO-MED-DED-DIAB

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	00-*	250000.00	11.72	29311.25	.00	.00	.00	.00

==========Diagnosis Recap==========

Amount	Code	Description
$28,065.81	DRUGS	PRESCRIPTION DRUGS
$1,193.42	042	HUMAN IMMUNODEFICIENCY VIRUS (HIV) INFECTION
$52.02	719.46	PAIN IN JOINT INVOLVING LOWER LEG

$29,311.25 Total Paid

	Diagnosis Summary for **********	Amount Paid	Last D.O.S.
DRUGS	PRESCRIPTION DRUGS	28065.81	10/01/2014
042	HUMAN IMMUNODEFICIENCY VIRUS (HIV) INFEC	1193.42	07/23/2014
250.02	DIABETES MELLITUS WITHOUT MENTION OF		04/08/2014
272.4	OTHER AND UNSPECIFIED HYPERLIPIDEMIA		07/23/2014
250.00	DIABETES MELLITUS WITHOUT MENTION OF		07/23/2014
844.9	SPRAIN OF UNSPECIFIED SITE OF KNEE AND L		07/23/2014
719.46	PAIN IN JOINT INVOLVING LOWER LEG	52.02	04/16/2014

GROUP: 2001025 SSN: ********** SEQ: ** DIV: RETR RELAT: Participant EFF: ********** DOB: ********** TERM: **********
LEVEL: P00 PLAN: WILCO-MED-CORE

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	00-*	250000.00	26.54	66344.50	.00	.00	.00	.00

==========Diagnosis Recap==========

Amount	Code	Description
$65,313.19	DRUGS	PRESCRIPTION DRUGS
$222.85	719.46	PAIN IN JOINT INVOLVING LOWER LEG
$169.94	627.2	MENOPAUSAL OR FEMALE CLIMACTERIC STATES
$165.24	272.4	OTHER AND UNSPECIFIED HYPERLIPIDEMIA
$154.25	V72.31	ROUTINE GYNECOLOGICAL EXAM
$143.62	340	MULTIPLE SCLEROSIS
$86.65	702.11	SEBORRHEIC KERATISIS;INFLAMED SEBORRHEICKERATOSIS
$47.87	216.5	BENIGN NEOPLASM OF SKIN OF TRUNK, EXCEPTSCROTUM
$40.89	V04.81	NEED FOR PROPHYLACTIC VACCINATION/ INOCULATION AGAINST, INFLUENZA

$66,344.50 Total Paid

10/31/14 Allegiance Benefit Plan Management, Inc. PAGE: 7
LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
DRUGS	PRESCRIPTION DRUGS	65313.19	10/07/2014
272.4	OTHER AND UNSPECIFIED HYPERLIPIDEMIA	165.24	07/28/2014
277.9	UNSPECIFIED DISORDER OF METABOLISM		01/27/2014
300.4	DYSTHYMIC DISORDER		01/27/2014
340	MULTIPLE SCLEROSIS	143.62	04/22/2014
729.89	OTHER MUSCULOSKELETAL SYMPTOMS REFERABLE		04/22/2014
781.2	ABNORMALITY OF GAIT		04/22/2014
719.46	PAIN IN JOINT INVOLVING LOWER LEG	222.85	03/18/2014
728.87	MUSCLE WEAKNESS (GENERALIZED)		03/18/2014
V72.31	ROUTINE GYNECOLOGICAL EXAM	154.25	05/07/2014
627.2	MENOPAUSAL OR FEMALE CLIMACTERIC STATES	169.94	05/14/2014
639.4	METABOLIC DISORDERS FOLLOWING ABORTION O		07/28/2014
216.5	BENIGN NEOPLASM OF SKIN OF TRUNK, EXCEPT	47.87	09/29/2014
702.19	OTHER DERMATOSES;OTHER SEBORRHEIC		09/29/2014
702.11	SEBORRHEIC KERATISIS;INFLAMED SEBORRHEIC	86.65	09/29/2014
V04.81	NEED FOR PROPHYLACTIC VACCINATION/	40.89	10/03/2014

GROUP: 2001025 SSN: ********** SEQ: ** DIV: RET2 RELAT: Spouse EFF: ********** DOB: ********** TERM: **********
LEVEL: F99 PLAN: WILCO-MED-DED-DIAB

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	01-*	250000.00	12.72	31794.11	.00	.00	.00	.00

==========Diagnosis Recap==========

Amount	Code	Description
$31,351.66	DRUGS	PRESCRIPTION DRUGS
$320.48	250.02	DIABETES MELLITUS WITHOUT MENTION OF COMPLICATION, TYPE II,UNCONTROLLED
$76.39	427.1	PAROXYSMAL VENTRICULAR TACHYCARDIA
$45.58	425.9	SECONDARY CARDIOMYOPATHY, UNSPECIFIED

$31,794.11 Total Paid

10/31/14 Allegiance Benefit Plan Management, Inc. PAGE: 8
LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 02 11/01/2013 to 10/31/2014 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

	Diagnosis Summary for **********	Amount Paid	Last D.O.S.
DRUGS	PRESCRIPTION DRUGS	31351.66	10/23/2014
250.02	DIABETES MELLITUS WITHOUT MENTION OF	320.48	07/15/2014
244.9	UNSPECIFIED ACQUIRED HYPOTHYROIDISM		07/15/2014
425.9	SECONDARY CARDIOMYOPATHY, UNSPECIFIED	45.58	12/05/2013
401.1	BENIGN ESSENTIAL HYPERTENSION		12/05/2013
745.9	UNSPECIFIED DEFECT OF SEPTAL CLOSURE		12/05/2013
427.1	PAROXYSMAL VENTRICULAR TACHYCARDIA	76.39	02/19/2014
V45.02	CARDIAC DEVICE IN SITU;AUTO IMPLANTABLE		02/19/2014
268.9	UNSPECIFIED VITAMIN D DEFICIENCY		07/15/2014
272.2	Hyperlipidemia, mixed		07/15/2014

GROUP: 2001025 SSN: ********** SEQ: ** DIV: 0001 RELAT: Participant EFF: ********** DOB: ********** TERM: **********
LEVEL: F00 PLAN: WILCO-MED-CORE

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	00-*	250000.00	14.21	35530.18	.00	.00	.00	.00

==========Diagnosis Recap==========

Amount	Code	Description
$33,817.69	DRUGS	PRESCRIPTION DRUGS
$605.00	309.0	ADJUSTMENT DISORDER WITH DEPRESSED MOOD
$392.76	714.0	RHEUMATOID ARTHRITIS
$220.00	300.02	GENERALIZED ANXIETY DISORDER
$159.36	V70.0	ROUTINE GENERAL MEDICAL EXAMINATION AT AHEALTH CARE FACILITY
$128.81	401.9	UNSPECIFIED ESSENTIAL HYPERTENSION
$76.61	V72.62	Lab exam ordered routine gen exam
$76.06	719.45	PAIN IN JOINT INVOLVING PELVIC REGION AND THIGH
$30.00	V04.81	NEED FOR PROPHYLACTIC VACCINATION/ INOCULATION AGAINST, INFLUENZA
$23.89	V58.69	LONG-TERM (CURRENT) USE OF OTHER MEDICATIONS

$35,530.18 Total Paid

	Diagnosis Summary for **********	Amount Paid	Last D.O.S.
DRUGS	PRESCRIPTION DRUGS	33817.69	10/20/2014
719.45	PAIN IN JOINT INVOLVING PELVIC REGION AN	76.06	10/26/2013
715.15	OSTEOARTHROSIS, LOCALIZED, PRIMARY, INVO		10/26/2013
V58.69	LONG-TERM (CURRENT) USE OF OTHER	23.89	01/29/2014
714.0	RHEUMATOID ARTHRITIS	392.76	08/18/2014
401.9	UNSPECIFIED ESSENTIAL HYPERTENSION	128.81	06/13/2014
429.3	CARDIOMEGALY		06/13/2014
426.4	RIGHT BUNDLE BRANCH BLOCK		06/13/2014
272.4	OTHER AND UNSPECIFIED HYPERLIPIDEMIA		06/13/2014
300.02	GENERALIZED ANXIETY DISORDER	220.00	05/29/2014
309.0	ADJUSTMENT DISORDER WITH DEPRESSED MOOD	605.00	09/11/2014
V70.0	ROUTINE GENERAL MEDICAL EXAMINATION AT A	159.36	09/17/2014
V72.62	Lab exam ordered routine gen exam	76.61	09/17/2014

10/31/14 Allegiance Benefit Plan Management, Inc. PAGE: 9
LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 02 11/01/2013 to 10/31/2014 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

Diagnosis Summary for **********	Amount Paid	Last D.O.S.
V04.81 NEED FOR PROPHYLACTIC VACCINATION/	30.00	09/17/2014

GROUP: 2001025 SSN: ********** SEQ: ** DIV: 0001 RELAT: Participant EFF: ********** DOB: ********** TERM: **********
LEVEL: P99 PLAN: WILCO-MED-DED

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	00-*	250000.00	14.50	36242.21	.00	.00	.00	.00

==========Diagnosis Recap==========

Amount	Code	Description
$22,184.13	189.0	MALIGNANT NEOPLASM OF KIDNEY, EXCEPT PELVIS
$7,662.42	236.91	NEOPLASM OF UNCERTAIN BEHAVIOR OF KIDNEYAND URETER
$3,349.10	DRUGS	PRESCRIPTION DRUGS
$796.76	V72.84	PREOP EXAM UNSPCF
$785.84	999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEWHERE CLASSIFIED
$490.49	593.9	UNSPECIFIED DISORDER OF KIDNEY AND URETER
$372.65	188.9	MALIGNANT NEOPLASM OF BLADDER, PART UNSPECIFIED
$196.24	401.1	BENIGN ESSENTIAL HYPERTENSION
$193.38	789.04	OTHER SYMPTOMS INVOLVING ABDOMEN AND PELVIS
$66.74	272.4	OTHER AND UNSPECIFIED HYPERLIPIDEMIA
$65.69	847.1	THORACIC SPRAIN
$50.00	794.31	NONSPECIFIC ABNORMAL ELECTROCARDIOGRAM (ECG) (EKG)
$18.76	V72.60	Laboratory examination, unspecified
$10.01	V72.82	PREOP RESPIRATORY EXAM

$36,242.21 Total Paid

10/31/14 Allegiance Benefit Plan Management, Inc. PAGE: 10
LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 02 11/01/2013 to 10/31/2014 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
DRUGS	PRESCRIPTION DRUGS	3349.10	10/23/2014
401.1	BENIGN ESSENTIAL HYPERTENSION	196.24	06/25/2014
789.04	OTHER SYMPTOMS INVOLVING ABDOMEN AND	193.38	02/13/2014
338.29	OTHER CHRONIC PAIN		02/11/2014
593.9	UNSPECIFIED DISORDER OF KIDNEY AND URETE	490.49	03/07/2014
236.91	NEOPLASM OF UNCERTAIN BEHAVIOR OF KIDNEY	7662.42	06/10/2014
V72.60	Laboratory examination, unspecified	18.76	03/07/2014
189.0	MALIGNANT NEOPLASM OF KIDNEY, EXCEPT PEL	22184.13	06/11/2014
272.4	OTHER AND UNSPECIFIED HYPERLIPIDEMIA	66.74	06/25/2014
999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEW	785.84	09/25/2014
285.1	ACUTE POSTHEMORRHAGIC ANEMIA		04/23/2014
V72.82	PREOP RESPIRATORY EXAM	10.01	04/18/2014
V72.84	PREOP EXAM UNSPCF	796.76	06/09/2014
787.02	OTHER SYMPTOMS OF THE DIGESTIVE SYSTEM;		04/22/2014
401.9	UNSPECIFIED ESSENTIAL HYPERTENSION		06/11/2014
272.0	PURE HYPERCHOLESTEROLEMIA		04/22/2014
188.9	MALIGNANT NEOPLASM OF BLADDER, PART UNSP	372.65	04/22/2014
794.31	NONSPECIFIC ABNORMAL ELECTROCARDIOGRAM (	50.00	04/18/2014
847.1	THORACIC SPRAIN	65.69	08/30/2014

GROUP: 2001025 SSN: ********** SEQ: ** DIV: 0001 RELAT: Spouse EFF: ********** DOB: ********** TERM: **********
LEVEL: F00 PLAN: WILCO-MED-CORE

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	01-*	250000.00	100.00	293800.38	43800.38	40228.59	1972.63	1599.16

==========Diagnosis Recap==========

Amount	Code	Description
$230,070.85	733.13	PATH FX VERTEBRAE
$27,590.38	718.88	OTHER JOINT DERANGEMENT, NOT ELSEWHERE CLASSIFIED, INVOLVING OTHER SPECIFIED SIT
$6,960.59	V57.89	CARE INVOLVING OTHER SPECIFIED REHABILITATION PROCEDURE
$6,598.14	724.02	Stenosis, spinal, lmbr, no neuro cl
$5,074.61	737.30	SCOLIOSIS (AND KYPHOSCOLIOSIS), IDIOPATHIC
$3,022.58	DRUGS	PRESCRIPTION DRUGS
$2,464.99	999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEWHERE CLASSIFIED
$2,241.63	401.9	UNSPECIFIED ESSENTIAL HYPERTENSION
$1,455.22	V58.69	LONG-TERM (CURRENT) USE OF OTHER MEDICATIONS
$1,393.20	781.2	ABNORMALITY OF GAIT
$1,073.35	V72.84	PREOP EXAM UNSPCF
$842.43	722.52	DEGENERATION OF LUMBAR OR LUMBOSACRAL INTERVERTEBRAL DISC
$590.50	327.23	OBSTRUCTIVE SLEEP APNEA (ADULT) (PEDIATRIC)
$557.61	724.5	BACKACHE, UNSPECIFIED
$530.00	722.72	INTERVERTEBRAL DISC DISORDER WITH MYELOPATHY, THORACIC REGION
$433.13	724.4	THORACIC OR LUMBOSACRAL NEURITIS OR RADICULITIS
$396.36	722.83	POSTLAMINECTOMY SYNDROME OF LUMBAR REGION
$341.34	426.4	RIGHT BUNDLE BRANCH BLOCK
$310.16	724.3	SCIATICA
$262.50	722.0	DISPLACEMENT OF CERVICAL INTERVERTEBRAL DISC WITHOUT MYELOPATHY
$240.77	727.03	TRIGGER FINGER (ACQUIRED)
$202.49	401.1	BENIGN ESSENTIAL HYPERTENSION
$181.45	433.30	OCL MLT BI ART WO INFRCT
$158.68	309.9	UNSPECIFIED ADJUSTMENT REACTION
$112.48	V72.85	OTH SPECIFIED EXAM
$106.74	V67.09	FOLLOWING OTHER SURGERY \
$92.47	429.3	CARDIOMEGALY
$69.54	465.9	ACUTE UPPER RESPIRATORY INFECTIONS OF UNSPECIFIED SITE
$69.54	381.01	ACUTE SEROUS OTITIS MEDIA
$62.63	719.95	UNSPECIFIED DISORDER OF JOINT OF PELVIC REGION AND THIGH
$59.15	285.9	ANEMIA, UNSPECIFIED
$40.00	V72.82	PREOP RESPIRATORY EXAM
$36.32	V45.4	POSTSURGICAL ARTHRODESIS STATUS
$34.24	V58.78	AFTERCARE FOLLOWING SURGERY OF THE MUSCULOSKELETAL SYSTEM, NEC
$31.35	425.4	PRIMARY CARDIOMYOPATHIES
$29.02	V76.44	SPECIAL SCREENING FOR MALIGNANT NEOPLASMOF THE PROSTATE
$25.54	272.4	OTHER AND UNSPECIFIED HYPERLIPIDEMIA
$13.79	518.0	PULMONARY COLLAPSE
$13.79	V58.81	FITTING AND ADJUSTMENT OF VASCULAR CATHETER
$10.82	786.05	SHORTNESS OF BREATH

$293,800.38 Total Paid

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
724.02	Stenosis, spinal, lmbr, no neuro cl	6598.14	02/12/2014
724.4	THORACIC OR LUMBOSACRAL NEURITIS OR RADI	433.13	12/18/2013
722.52	DEGENERATION OF LUMBAR OR LUMBOSACRAL IN	842.43	04/30/2014
737.30	SCOLIOSIS (AND KYPHOSCOLIOSIS), IDIOPATH	5074.61	02/24/2014
DRUGS	PRESCRIPTION DRUGS	3022.58	10/21/2014
401.1	BENIGN ESSENTIAL HYPERTENSION	202.49	05/05/2014
272.4	OTHER AND UNSPECIFIED HYPERLIPIDEMIA	25.54	05/05/2014

10/31/14 Allegiance Benefit Plan Management, Inc. PAGE: 12
LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 02 11/01/2013 to 10/31/2014 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
426.4	RIGHT BUNDLE BRANCH BLOCK	341.34	01/20/2014
724.3	SCIATICA	310.16	11/25/2013
381.01	ACUTE SEROUS OTITIS MEDIA	69.54	11/18/2013
733.13	PATH FX VERTEBRAE	230070.85	09/03/2014
V72.83	OTH SPCF PREOP EXAM		12/16/2013
433.30	OCL MLT BI ART WO INFRCT	181.45	12/12/2013
V72.85	OTH SPECIFIED EXAM	112.48	12/12/2013
722.0	DISPLACEMENT OF CERVICAL INTERVERTEBRAL	262.50	12/18/2013
724.5	BACKACHE, UNSPECIFIED	557.61	02/24/2014
729.5	PAIN IN LIMB		12/18/2013
786.05	SHORTNESS OF BREATH	10.82	12/16/2013
465.9	ACUTE UPPER RESPIRATORY INFECTIONS OF UN	69.54	12/27/2013
V72.82	PREOP RESPIRATORY EXAM	40.00	01/13/2014
429.3	CARDIOMEGALY	92.47	01/20/2014
327.23	OBSTRUCTIVE SLEEP APNEA (ADULT)	590.50	09/29/2014
V58.69	LONG-TERM (CURRENT) USE OF OTHER	1455.22	10/17/2014
V58.78	AFTERCARE FOLLOWING SURGERY OF THE	34.24	02/17/2014
V45.4	POSTSURGICAL ARTHRODESIS STATUS	36.32	04/30/2014
V58.81	FITTING AND ADJUSTMENT OF VASCULAR	13.79	02/04/2014
518.0	PULMONARY COLLAPSE	13.79	02/06/2014
799.02	HYPOXEMIA		02/06/2014
309.9	UNSPECIFIED ADJUSTMENT REACTION	158.68	02/18/2014
425.4	PRIMARY CARDIOMYOPATHIES	31.35	01/29/2014
737.10	KYPHOSIS (ACQUIRED) (POSTURAL)		02/09/2014
737.29	OTHER LORDOSIS, ACQUIRED		02/09/2014
401.9	UNSPECIFIED ESSENTIAL HYPERTENSION	2241.63	02/20/2014
780.51	INSOMNIA WITH SLEEP APNEA, UNSPECIFIED		02/13/2014
477.9	ALLERGIC RHINITIS, CAUSE UNSPECIFIED		02/20/2014
V57.89	CARE INVOLVING OTHER SPECIFIED REHABILIT	6960.59	02/24/2014
718.88	OTHER JOINT DERANGEMENT, NOT ELSEWHERE C	27590.38	04/30/2014
722.10	DISPLACEMENT OF LUMBAR INTERVERTEBRAL DI		02/04/2014
719.95	UNSPECIFIED DISORDER OF JOINT OF PELVIC	62.63	02/21/2014
781.2	ABNORMALITY OF GAIT	1393.20	02/24/2014
V67.09	FOLLOWING OTHER SURGERY	106.74	04/30/2014
V72.84	PREOP EXAM UNSPCF	1073.35	01/17/2014
999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEW	2464.99	07/25/2014
V76.44	SPECIAL SCREENING FOR MALIGNANT NEOPLASM	29.02	05/05/2014
780.57	UNSPECIFIED SLEEP APNEA		05/05/2014
724.2	LUMBAGO		05/05/2014
285.9	ANEMIA, UNSPECIFIED	59.15	05/19/2014
281.8	ANEMIA ASSOCIATED WITH OTHER SPECIFIED N		05/19/2014
285.1	ACUTE POSTHEMORRHAGIC ANEMIA		02/04/2014
458.9	HYPOTENSION, UNSPECIFIED		02/04/2014

10/31/14 Allegiance Benefit Plan Management, Inc. PAGE: 13
LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 02 11/01/2013 to 10/31/2014 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

	Diagnosis Summary for **********	Amount Paid	Last D.O.S.
276.1	HYPOSMOLALITY AND/OR HYPONATREMIA		02/04/2014
727.03	TRIGGER FINGER (ACQUIRED)	240.77	08/07/2014
722.83	POSTLAMINECTOMY SYNDROME OF LUMBAR REGIO	396.36	10/17/2014
722.82	POSTLAMINECTOMY SYNDROME OF THORACIC REG		10/17/2014
722.81	POSTLAMINECTOMY SYNDROME OF CERVICAL REG		10/17/2014
304.01	OPIOID TYPE DEPENDENCE, CONTINUOUS USE		09/17/2014
338.4	CHRONIC PAIN SYNDROME		09/17/2014
722.72	INTERVERTEBRAL DISC DISORDER WITH MYELOP	530.00	09/26/2014
722.73	INTERVERTEBRAL DISC DISORDER WITH MYELOP		09/26/2014
723.4	BRACHIAL NEURITIS OR RADICULITIS NOS		09/26/2014
728.85	SPASM OF MUSCLE		09/26/2014

GROUP: 2001025 SSN: ********** SEQ: ** DIV: 0001 RELAT: Participant EFF: ********** DOB: ********** TERM: **********
LEVEL: F00 PLAN: WILCO-MED-DED-DIAB

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	00-*	250000.00	12.52	31299.84	.00	.00	.00	.00

==========Diagnosis Recap==========

Amount	Code	Description
$11,052.16	726.12	BICIPITAL TENOSYNOVITIS
$5,705.63	V57.1	CARE INVOLVING OTHER PHYSICAL THERAPY
$3,318.10	840.4	ROTATOR CUFF (CAPSULE) SPRAIN
$3,221.14	454.8	VARICOSE VEINS OF LWR EXTREMITIES W/ OTHER COMPLICATIONS;EDEMA,PAIN,SWELLING
$1,899.75	338.18	OTHER ACUTE POSTOPERATIVE PAIN
$1,639.67	427.31	ATRIAL FIBRILLATION
$1,392.07	DRUGS	PRESCRIPTION DRUGS
$756.73	726.2	OTHER AFFECTIONS OF SHOULDER REGION, NOTELSEWHERE CLASSIFIED
$364.62	727.00	SYNOVITIS AND TENOSYNOVITIS, UNSPECIFIED
$340.98	V72.81	PREOP CARDIOVSCLR EXAM
$286.78	715.91	OSTEOARTHROSIS, UNSPECIFIED WHETHER GENERALIZED OR LOCALIZED, INVOLVING SHOULDER
$225.06	V70.0	ROUTINE GENERAL MEDICAL EXAMINATION AT AHEALTH CARE FACILITY
$223.32	V76.12	OTHER SCREENING MAMMOGRAM
$149.24	238.2	NEOPLASM OF UNCERTAIN BEHAVIOR OF SKIN
$111.27	V72.31	ROUTINE GYNECOLOGICAL EXAM
$111.00	701.9	UNSPECIFIED HYPERTROPHIC AND ATROPHIC CONDITIONS OF SKIN
$102.92	719.41	PAIN IN JOINT INVOLVING SHOULDER REGION
$102.90	424.0	MITRAL VALVE DISORDERS
$85.37	726.10	DISORDERS OF BURSAE AND TENDONS IN SHOULDER REGION, UNSPECIFIED
$62.56	462	ACUTE PHARYNGITIS
$47.33	379.24	OTHER VITREOUS OPACITIES
$40.89	V04.81	NEED FOR PROPHYLACTIC VACCINATION/ INOCULATION AGAINST, INFLUENZA
$22.16	727.61	COMPLETE RUPTURE OF ROTATOR CUFF
$17.12	V72.82	PREOP RESPIRATORY EXAM
$8.64	599.70	Hematuria, unspecified
$8.16	401.1	BENIGN ESSENTIAL HYPERTENSION
$2.50	V76.41	SCREENING FOR MALIGNANT NEOPLASMS OF THERECTUM
$1.77	V81.5	SCREENING FOR NEPHROPATHY

$31,299.84 Total Paid

10/31/14 Allegiance Benefit Plan Management, Inc. PAGE: 14
LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 02 11/01/2013 to 10/31/2014 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
V76.12	OTHER SCREENING MAMMOGRAM	223.32	11/13/2013
V81.5	SCREENING FOR NEPHROPATHY	1.77	11/21/2013
V76.41	SCREENING FOR MALIGNANT NEOPLASMS OF THE	2.50	11/27/2013
379.24	OTHER VITREOUS OPACITIES	47.33	12/03/2013
V72.31	ROUTINE GYNECOLOGICAL EXAM	111.27	11/21/2013
DRUGS	PRESCRIPTION DRUGS	1392.07	10/18/2014
715.91	OSTEOARTHROSIS, UNSPECIFIED WHETHER GENE	286.78	02/05/2014
719.41	PAIN IN JOINT INVOLVING SHOULDER REGION	102.92	09/18/2014
726.12	BICIPITAL TENOSYNOVITIS	11052.16	03/19/2014
726.10	DISORDERS OF BURSAE AND TENDONS IN SHOUL	85.37	09/18/2014
840.4	ROTATOR CUFF (CAPSULE) SPRAIN	3318.10	03/21/2014
726.0	ADHESIVE CAPSULITIS OF SHOULDER		03/21/2014
V72.81	PREOP CARDIOVSCLR EXAM	340.98	03/04/2014
V72.82	PREOP RESPIRATORY EXAM	17.12	03/04/2014
V72.83	OTH SPCF PREOP EXAM		03/04/2014
729.5	PAIN IN LIMB		07/11/2014
427.89	CARDIAC DYSRHYTHMIAS		03/04/2014
727.61	COMPLETE RUPTURE OF ROTATOR CUFF	22.16	02/24/2014
718.01	ARTICULAR CARTILAGE DISORDER INVOLVING S		03/19/2014
715.31	OSTEOARTHROSIS, LOCALIZED, NOT SPECIFIED		03/19/2014
726.2	OTHER AFFECTIONS OF SHOULDER REGION, NOT	756.73	03/21/2014
427.9	CARDIAC DYSRHYTHMIA		03/19/2014
338.18	OTHER ACUTE POSTOPERATIVE PAIN	1899.75	03/19/2014
727.00	SYNOVITIS AND TENOSYNOVITIS, UNSPECIFIED	364.62	03/19/2014
V57.1	CARE INVOLVING OTHER PHYSICAL THERAPY	5705.63	08/28/2014
V58.78	AFTERCARE FOLLOWING SURGERY OF THE		09/18/2014
728.87	MUSCLE WEAKNESS (GENERALIZED)		08/28/2014
V70.0	ROUTINE GENERAL MEDICAL EXAMINATION AT A	225.06	06/26/2014
244.9	UNSPECIFIED ACQUIRED HYPOTHYROIDISM		05/29/2014
272.4	OTHER AND UNSPECIFIED HYPERLIPIDEMIA		10/09/2014
278.00	OBESITY, UNSPECIFIED		05/29/2014
427.31	ATRIAL FIBRILLATION	1639.67	10/09/2014
729.81	SWELLING OF LIMB		08/28/2014
424.0	MITRAL VALVE DISORDERS	102.90	10/09/2014
599.70	Hematuria, unspecified	8.64	07/16/2014
401.1	BENIGN ESSENTIAL HYPERTENSION	8.16	10/16/2014
782.3	EDEMA		07/16/2014
V45.89	OTHER POSTSURGICAL STATUS		07/11/2014
781.92	ABNORMAL POSTURE		08/28/2014
728.2	MUSCULAR WASTING AND DISUSE ATROPHY, NOT		08/28/2014
701.9	UNSPECIFIED HYPERTROPHIC AND ATROPHIC CO	111.00	09/02/2014
216.9	BENIGN NEOPLASM OF SKIN, SITE UNSPECIFIE		09/02/2014
702.19	OTHER DERMATOSES;OTHER SEBORRHEIC		09/02/2014

10/31/14 Allegiance Benefit Plan Management, Inc. PAGE: 15
LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 02 11/01/2013 to 10/31/2014 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
238.2	NEOPLASM OF UNCERTAIN BEHAVIOR OF SKIN	149.24	09/02/2014
462	ACUTE PHARYNGITIS	62.56	09/16/2014
460	ACUTE NASOPHARYNGITIS (COMMON COLD)		09/16/2014
V04.81	NEED FOR PROPHYLACTIC VACCINATION/	40.89	09/16/2014
454.8	VARICOSE VEINS OF LWR EXTREMITIES W/	3221.14	10/16/2014
780.79	OTHER MALAISE AND FATIGUE		10/16/2014
454.1	VARICOSE VEINS OF LOWER EXTREMITIES WITH		10/16/2014

GROUP: 2001025 SSN: ********** SEQ: ** DIV: 0001 RELAT: Participant EFF: ********** DOB: ********** TERM: **********
LEVEL: P00 PLAN: WILCO-MED-DED

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	00-*	250000.00	26.88	67212.13	.00	.00	.00	.00

==========Diagnosis Recap==========

Amount	Code	Description
$49,056.46	722.0	DISPLACEMENT OF CERVICAL INTERVERTEBRAL DISC WITHOUT MYELOPATHY
$8,067.87	953.0	INJURY TO CERVICAL NERVE ROOT
$4,175.77	DRUGS	PRESCRIPTION DRUGS
$2,300.45	782.0	DISTURBANCE OF SKIN SENSATION
$1,775.72	723.4	BRACHIAL NEURITIS OR RADICULITIS NOS
$546.57	723.1	CERVICALGIA
$274.72	625.9	UNSPECIFIED SYMPTOM ASSOCIATED WITH FEMALE GENITAL ORGANS
$267.80	999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEWHERE CLASSIFIED
$225.00	346.90	Migraine NOS w/o migrain w/o status
$206.28	V70.0	ROUTINE GENERAL MEDICAL EXAMINATION AT AHEALTH CARE FACILITY
$152.48	V72.31	ROUTINE GYNECOLOGICAL EXAM
$103.56	401.1	BENIGN ESSENTIAL HYPERTENSION
$59.45	704.1	HIRSUTISM

$67,212.13 Total Paid

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
DRUGS	PRESCRIPTION DRUGS	4175.77	10/19/2014
346.90	Migraine NOS w/o migrain w/o status	225.00	07/16/2014
723.1	CERVICALGIA	546.57	05/27/2014

10/31/14 Allegiance Benefit Plan Management, Inc. PAGE: 16
LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 02 11/01/2013 to 10/31/2014 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

	Diagnosis Summary for **********	Amount Paid	Last D.O.S.
723.4	BRACHIAL NEURITIS OR RADICULITIS NOS	1775.72	06/18/2014
722.4	DEGENERATION OF CERVICAL INTERVERTEBRAL		06/18/2014
729.1	MYALGIA AND MYOSITIS, UNSPECIFIED		05/06/2014
999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEW	267.80	06/09/2014
V70.0	ROUTINE GENERAL MEDICAL EXAMINATION AT A	206.28	06/27/2014
722.0	DISPLACEMENT OF CERVICAL INTERVERTEBRAL	49056.46	06/18/2014
401.1	BENIGN ESSENTIAL HYPERTENSION	103.56	08/20/2014
272.0	PURE HYPERCHOLESTEROLEMIA		07/16/2014
244.9	UNSPECIFIED ACQUIRED HYPOTHYROIDISM		07/16/2014
722.81	POSTLAMINECTOMY SYNDROME OF CERVICAL REG		06/18/2014
953.0	INJURY TO CERVICAL NERVE ROOT	8067.87	06/18/2014
358.9	MYONEURAL DISORDERS, UNSPECIFIED		06/18/2014
704.1	HIRSUTISM	59.45	08/20/2014
V72.31	ROUTINE GYNECOLOGICAL EXAM	152.48	08/20/2014
625.0	DYSPAREUNIA		08/20/2014
278.00	OBESITY, UNSPECIFIED		08/20/2014
625.9	UNSPECIFIED SYMPTOM ASSOCIATED WITH FEMA	274.72	09/10/2014
782.0	DISTURBANCE OF SKIN SENSATION	2300.45	06/17/2014

GROUP: 2001025 SSN: ********** SEQ: ** DIV: 0001 RELAT: Participant EFF: ********** DOB: ********** TERM: **********
LEVEL: P00 PLAN: WILCO-MED-DED

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	00-*	250000.00	32.78	81962.44	.00	.00	.00	.00

==========Diagnosis Recap==========

Amount	Code	Description
$26,567.78	183.0	MALIGNANT NEOPLASM OF OVARY
$20,335.94	867.2	INJURY TO URETER WITHOUT MENTION OF OPENWOUND INTO CAVITY
$6,166.35	DRUGS	PRESCRIPTION DRUGS
$4,337.64	789.00	OTHER SYMPTOMS INVOLVING ABDOMEN AND PELVIS
$4,316.22	782.3	EDEMA
$2,313.24	338.3	NEOPLASM RELATED PAIN (ACUTE) (CHRONIC)
$2,295.00	625.8	OTHER SPECIFIED SYMPTOMS ASSOCIATED WITHFEMALE GENITAL ORGANS
$2,032.45	632	MISSED ABORTION
$2,025.61	729.5	PAIN IN LIMB
$1,725.36	999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEWHERE CLASSIFIED
$1,289.47	918.1	SUPERFICIAL INJURY OF CORNEA
$1,155.75	789.59	ASCITES;OTHER SPECIFIC SITE
$1,122.77	789.07	OTHER SYMPTOMS INVOLVING ABDOMEN AND PELVIS
$1,009.47	V23.0	Sprv preg, w/infertility history
$1,005.12	593.89	OTHER SPECIFIED DISORDERS OF KIDNEY AND URETER
$486.04	626.8	OTHER DISORDERS OF MENSTRUATION AND OTHER ABNORMAL BLEEDING FROM FEMALE GENITAL
$447.71	276.51	DEHYDRATION
$340.54	789.33	OTHER SYMPTOMS INVOLVING ABDOMEN AND PELVIS
$333.00	640.03	THREATENED ABORTION, ANTEPARTUM
$322.40	793.19	Othr nonspecfc abnorml finding/lung
$319.88	593.3	STRICTURE OR KINKING OF URETER
$295.33	V67.59	OTHER FOLLOW-UP EXAMINATION
$225.00	466.0	ACUTE BRONCHITIS
$190.71	180.8	MALIGNANT NEOPLASM OF OTHER SPECIFIED SITES OF CERVIX
$177.02	180.0	MALIGNANT NEOPLASM OF ENDOCERVIX
$154.67	112.5	DISSEMINATED CANDIDIASIS
$144.07	789.39	OTHER SYMPTOMS INVOLVING ABDOMEN AND PELVIS
$141.34	V58.11	ENCOUNTER FOR ANTINEOPLASTIC CHEMOTHERAPY
$132.89	626.4	IRREGULAR MENSTRUAL CYCLE
$120.34	V82.71	SPECIAL SCREENING FOR OTHER CONDITIONS- SCREENING FOR GENETIC DISEASE CARRIER
$101.44	625.9	UNSPECIFIED SYMPTOM ASSOCIATED WITH FEMALE GENITAL ORGANS
$73.13	V67.09	FOLLOWING OTHER SURGERY \
$64.51	696.1	OTHER PSORIASIS AND SIMILAR DISORDERS
$53.44	729.81	SWELLING OF LIMB
$52.80	V10.41	Hx, prsnl, cervical malignancy
$26.78	599.0	URINARY TRACT INFECTION, SITE NOT SPECIFIED
$25.54	V22.1	SUPERVISION OF OTHER NORMAL PREGNANCY
$22.47	180.9	MALIGNANT NEOPLASM OF CERVIX UTERI, UNSPECIFIED
$13.22	V72.40	PREGNANCY EXAMINATION OR TEST,PREGNANCY UNCONFIRMED

$81,962.44 Total Paid

10/31/14 Allegiance Benefit Plan Management, Inc. PAGE: 17
LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
112.5	DISSEMINATED CANDIDIASIS	154.67	10/02/2013
626.8	OTHER DISORDERS OF MENSTRUATION AND OTHE	486.04	12/19/2013
626.4	IRREGULAR MENSTRUAL CYCLE	132.89	11/07/2013
DRUGS	PRESCRIPTION DRUGS	6166.35	10/08/2014
696.1	OTHER PSORIASIS AND SIMILAR DISORDERS	64.51	12/16/2013
180.9	MALIGNANT NEOPLASM OF CERVIX UTERI, UNSP	22.47	08/08/2014
180.8	MALIGNANT NEOPLASM OF OTHER SPECIFIED SI	190.71	12/17/2013
V67.59	OTHER FOLLOW-UP EXAMINATION	295.33	12/17/2013
V72.40	PREGNANCY EXAMINATION OR TEST,PREGNANCY	13.22	01/10/2014
625.9	UNSPECIFIED SYMPTOM ASSOCIATED WITH FEMA	101.44	01/20/2014
640.03	THREATENED ABORTION, ANTEPARTUM	333.00	03/21/2014
V23.0	Sprv preg, w/infertility history	1009.47	04/08/2014
620.0	FOLLICULAR CYST OF OVARY		03/31/2014
632	MISSED ABORTION	2032.45	04/17/2014
V22.1	SUPERVISION OF OTHER NORMAL PREGNANCY	25.54	04/15/2014
466.0	ACUTE BRONCHITIS	225.00	04/18/2014
786.2	COUGH		04/18/2014

10/31/14 Allegiance Benefit Plan Management, Inc. PAGE: 18
LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 02 11/01/2013 to 10/31/2014 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
180.0	MALIGNANT NEOPLASM OF ENDOCERVIX	177.02	09/30/2014
V10.41	Hx, prsnl, cervical malignancy	52.80	08/08/2014
338.3	NEOPLASM RELATED PAIN (ACUTE) (CHRONIC)	2313.24	10/06/2014
789.37	OTHER SYMPTOMS INVOLVING ABDOMEN AND		10/06/2014
789.33	OTHER SYMPTOMS INVOLVING ABDOMEN AND	340.54	06/27/2014
789.00	OTHER SYMPTOMS INVOLVING ABDOMEN AND	4337.64	06/08/2014
338.19	OTHER ACUTE PAIN		06/08/2014
789.59	ASCITES;OTHER SPECIFIC SITE	1155.75	06/16/2014
511.9	UNSPECIFIED PLEURAL EFFUSION		06/08/2014
789.30	OTHER SYMPTOMS INVOLVING ABDOMEN AND		06/08/2014
793.19	Othr nonspecfc abnorml finding/lung	322.40	06/11/2014
789.39	OTHER SYMPTOMS INVOLVING ABDOMEN AND	144.07	06/07/2014
195.2	MALIGNANT NEOPLASM OF ABDOMEN		06/08/2014
195.3	MALIGNANT NEOPLASM OF PELVIS		06/07/2014
V67.09	FOLLOWING OTHER SURGERY	73.13	05/15/2014
V15.07	Hx, prsnl, allergy, latex		05/15/2014
V15.09	Hx, prsnl, alrgy not med agent NEC		05/15/2014
789.07	OTHER SYMPTOMS INVOLVING ABDOMEN AND	1122.77	06/07/2014
786.05	SHORTNESS OF BREATH		06/07/2014
782.3	EDEMA	4316.22	08/06/2014
729.81	SWELLING OF LIMB	53.44	06/08/2014
593.89	OTHER SPECIFIED DISORDERS OF KIDNEY AND	1005.12	06/16/2014
999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEW	1725.36	09/25/2014
V45.89	OTHER POSTSURGICAL STATUS		06/21/2014
867.2	INJURY TO URETER WITHOUT MENTION OF OPEN	20335.94	06/19/2014
183.0	MALIGNANT NEOPLASM OF OVARY	26567.78	10/18/2014
593.3	STRICTURE OR KINKING OF URETER	319.88	08/18/2014
918.1	SUPERFICIAL INJURY OF CORNEA	1289.47	07/11/2014
780.96	GENERALIZED PAIN		07/11/2014
E928.9	UNSPECIFIED ACCIDENT		07/11/2014
V58.11	ENCOUNTER FOR ANTINEOPLASTIC	141.34	10/08/2014
E928.8	OTHER ACCIDENTS		07/11/2014
E849.9	ACCIDENTS OCCURRING IN UNSPECIFIED PLACE		07/11/2014
V82.71	SPECIAL SCREENING FOR OTHER CONDITIONS-	120.34	07/30/2014
V16.49	GENITAL ORGANS;OTHER		07/28/2014
V10.43	Hx, prsnl, ovarian malignancy		08/08/2014
493.90	ASTHMA, UNSPECIFIED TYPE		07/11/2014
276.51	DEHYDRATION	447.71	10/14/2014
729.5	PAIN IN LIMB	2025.61	08/08/2014
V45.79	OTHER ACQUIRED ABSENCE OF ORGAN		08/08/2014
V88.01	Acquired abs of both cervix, uterus		08/08/2014
625.8	OTHER SPECIFIED SYMPTOMS ASSOCIATED WITH	2295.00	06/16/2014
599.0	URINARY TRACT INFECTION, SITE NOT SPECIF	26.78	08/29/2014

10/31/14 Allegiance Benefit Plan Management, Inc. PAGE: 19
LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 02 11/01/2013 to 10/31/2014 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

Diagnosis Summary for **********	Amount Paid	Last D.O.S.
V14.8 Hx, prsnl, drug allergy NEC		06/16/2014
692.9 CONTACT DERMATITIS AND OTHER ECZEMA, UNS		12/16/2013
V16.8 FAMILY HISTORY OF OTHER SPECIFIED MALIGN		07/30/2014

GROUP: 2001025 SSN: ********** SEQ: ** DIV: 0002 RELAT: Spouse EFF: ********** DOB: ********** TERM: **********
LEVEL: F99 PLAN: WILCO-MED-EPO-DIAB

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	01-*	250000.00	11.80	29499.93	.00	.00	.00	.00

Diagnosis Recap

Amount	Code	Description
$29,423.26	427.69	PREMATURE BEATS
$76.67	999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEWHERE CLASSIFIED
$29,499.93	Total Paid	

Diagnosis Summary for **********	Amount Paid	Last D.O.S.
427.69 PREMATURE BEATS	29423.26	01/22/2014
427.1 PAROXYSMAL VENTRICULAR TACHYCARDIA		12/10/2013
999 COMPLICATIONS OF MEDICAL CARE, NOT ELSEW	76.67	04/25/2014

GROUP: 2001025 SSN: ********** SEQ: ** DIV: 0002 RELAT: Participant EFF: ********** DOB: ********** TERM: **********
LEVEL: P00 PLAN: WILCO-MED-CORE-DIAB

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	00-*	250000.00	32.80	81993.32	.00	.00	.00	.00

Diagnosis Recap

Amount	Code	Description
$34,027.43	998.59	POSTOPERATIVE INFECTIONS;OTHER POSTOPERATIVE INFECTION
$19,196.46	722.10	DISPLACEMENT OF LUMBAR INTERVERTEBRAL DISC WITHOUT MYELOPATHY
$8,253.61	DRUGS	PRESCRIPTION DRUGS
$5,527.86	724.02	Stenosis, spinal, lmbr, no neuro cl
$4,280.53	722.52	DEGENERATION OF LUMBAR OR LUMBOSACRAL INTERVERTEBRAL DISC
$2,583.58	959.01	HEAD INJURY, UNSPECIFIED
$2,290.70	999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEWHERE CLASSIFIED
$1,180.28	722.83	POSTLAMINECTOMY SYNDROME OF LUMBAR REGION
$1,161.70	724.2	LUMBAGO
$485.80	724.3	SCIATICA
$473.70	V58.69	LONG-TERM (CURRENT) USE OF OTHER MEDICATIONS
$447.86	V25.12	Encounter for removal of IUD
$378.00	296.26	MAJOR DEPRESSIVE AFFECTIVE DISORDER, SINGLE EPISODE, IN FULL REMISSION
$318.99	716.45	TRANSIENT ARTHROPATHY INVOLVING PELVIC REGION AND THIGH
$264.49	V58.81	FITTING AND ADJUSTMENT OF VASCULAR CATHETER
$233.80	250.00	DIABETES MELLITUS WITHOUT MENTION OF COMPLICATION, TYPE II
$223.32	V76.12	OTHER SCREENING MAMMOGRAM
$191.74	729.5	PAIN IN LIMB
$126.36	V72.31	ROUTINE GYNECOLOGICAL EXAM
$63.51	719.45	PAIN IN JOINT INVOLVING PELVIC REGION AND THIGH
$56.55	724.5	BACKACHE, UNSPECIFIED
$50.33	465.9	ACUTE UPPER RESPIRATORY INFECTIONS OF UNSPECIFIED SITE
$46.00	784.0	HEADACHE
$40.60	V70.0	ROUTINE GENERAL MEDICAL EXAMINATION AT AHEALTH CARE FACILITY
$27.58	786.50	UNSPECIFIED CHEST PAIN
$25.00	429.3	CARDIOMEGALY
$13.79	V58.62	LONG-TERM (CURRENT) USE OF ANTIBIOTICS
$12.75	296.20	MAJOR DEPRESSIVE AFFECTIVE DISORDER, SINGLE EPISODE, UNSPECIFIED DEGREE
$11.00	V76.51	SPECIAL SCREENING FOR MALIG NEOPL;COLON
$81,993.32	Total Paid	

Diagnosis Summary for ********** Amount Paid Last D.O.S.

DRUGS	PRESCRIPTION DRUGS	8253.61	07/26/2014
724.2	LUMBAGO	1161.70	07/29/2014
724.3	SCIATICA	485.80	02/18/2014
724.4	THORACIC OR LUMBOSACRAL NEURITIS OR RADI		04/12/2014
722.10	DISPLACEMENT OF LUMBAR INTERVERTEBRAL DI	19196.46	07/29/2014
465.9	ACUTE UPPER RESPIRATORY INFECTIONS OF UN	50.33	12/27/2013
V70.0	ROUTINE GENERAL MEDICAL EXAMINATION AT A	40.60	01/20/2014
250.02	DIABETES MELLITUS WITHOUT MENTION OF		01/20/2014
V76.12	OTHER SCREENING MAMMOGRAM	223.32	01/20/2014
V72.31	ROUTINE GYNECOLOGICAL EXAM	126.36	01/20/2014
296.20	MAJOR DEPRESSIVE AFFECTIVE DISORDER, SIN	12.75	01/20/2014
401.1	BENIGN ESSENTIAL HYPERTENSION		07/18/2014
V76.51	SPECIAL SCREENING FOR MALIG NEOPL;COLON	11.00	01/20/2014
V85.41	BMI 40.0-44.9, adult		01/20/2014
719.45	PAIN IN JOINT INVOLVING PELVIC REGION AN	63.51	01/28/2014
727.3	OTHER BURSITIS DISORDERS		01/28/2014
250.00	DIABETES MELLITUS WITHOUT MENTION OF	233.80	07/18/2014
296.23	MAJOR DEPRESSIVE AFFECTIVE DISORDER, SIN		01/28/2014
724.5	BACKACHE, UNSPECIFIED	56.55	01/31/2014
733.6	TIETZE'S DISEASE		01/31/2014
716.45	TRANSIENT ARTHROPATHY INVOLVING PELVIC R	318.99	02/05/2014
272.4	OTHER AND UNSPECIFIED HYPERLIPIDEMIA		02/17/2014
401.9	UNSPECIFIED ESSENTIAL HYPERTENSION		04/29/2014
300.4	DYSTHYMIC DISORDER		02/17/2014
722.52	DEGENERATION OF LUMBAR OR LUMBOSACRAL IN	4280.53	06/03/2014
724.1	PAIN IN THORACIC SPINE		02/18/2014
722.11	DISPLACEMENT OF THORACIC INTERVERTEBRAL		02/18/2014

10/31/14 Allegiance Benefit Plan Management, Inc. PAGE: 21
LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 02 11/01/2013 to 10/31/2014 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
728.85	SPASM OF MUSCLE		02/19/2014
V58.69	LONG-TERM (CURRENT) USE OF OTHER	473.70	07/18/2014
959.01	HEAD INJURY, UNSPECIFIED	2583.58	02/23/2014
E888.9	UNSPECIFIED FALL		02/23/2014
E849.0	HOME ACCIDENTS		02/23/2014
784.0	HEADACHE	46.00	02/23/2014
724.02	Stenosis, spinal, lmbr, no neuro cl	5527.86	07/29/2014
999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEW	2290.70	07/25/2014
278.01	MORBID OBESITY		04/25/2014
998.59	POSTOPERATIVE INFECTIONS;OTHER	34027.43	05/29/2014
V58.81	FITTING AND ADJUSTMENT OF VASCULAR	264.49	05/03/2014
920	CONTUSION OF FACE, SCALP, AND NECK EXCEP		02/23/2014
E888.1	FALL RESULTING IN STRIKING AGAINST		02/23/2014
998.32	Disrupt, external oper surg wound		05/01/2014
E878.8	OTHER SPECIFIED SURGICAL OPERATIONS AND		05/01/2014
041.11	Infection, MSSA staph aureus		05/29/2014
V58.62	LONG-TERM (CURRENT) USE OF ANTIBIOTICS	13.79	05/03/2014
722.83	POSTLAMINECTOMY SYNDROME OF LUMBAR REGIO	1180.28	07/29/2014
285.9	ANEMIA, UNSPECIFIED		04/29/2014
787.91	OTHER SYMPTOMS INVOLVING DIGESTIVE		05/14/2014
786.50	UNSPECIFIED CHEST PAIN	27.58	05/02/2014
296.26	MAJOR DEPRESSIVE AFFECTIVE DISORDER, SIN	378.00	06/20/2014
729.5	PAIN IN LIMB	191.74	06/27/2014
311	DEPRESSIVE DISORDER, NOT ELSEWHERE CLASS		04/12/2014
041.12	Infection, MRSA staph aureus		05/02/2014
278.00	OBESITY, UNSPECIFIED		07/08/2014
429.3	CARDIOMEGALY	25.00	04/11/2014
410.10	ACUTE MYOCARDIAL INFARCTION OF OTHER ANT		04/11/2014
719.40	PAIN IN JOINT, SITE UNSPECIFIED		07/18/2014
V25.12	Encounter for removal of IUD	447.86	07/23/2014
272.2	Hyperlipidemia, mixed		07/18/2014
719.00	EFFUSION OF JOINT, SITE UNSPECIFIED		07/18/2014

GROUP: 2001025 SSN: ********** SEQ: ** DIV: 0002 RELAT: Participant EFF: ********** DOB: ********** TERM: **********
LEVEL: F99 PLAN: WILCO-MED-CORE-DIAB

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	00-*	250000.00	13.16	32901.03	.00	.00	.00	.00

==========Diagnosis Recap==========

Amount	Code	Description
$11,108.82	648.83	ABNORMAL GLUCOSE TOLERANCE OF MOTHER, ANTEPARTUM
$7,540.96	648.01	DIABETES MELLITUS OF MOTHER, WITH DELIVERY
$4,559.24	DRUGS	PRESCRIPTION DRUGS
$2,172.15	669.71	CESAREAN DELIVERY, WITHOUT MENTION OF INDICATION, DELIVERED, WITH OR WITHOUT MEN
$1,478.49	657.03	POLYHYDRAMNIOS, ANTEPARTUM COMPLICATION
$692.99	V72.42	PREGNANCY EXAMINATION OR TEST, POSITIVE RESULT
$611.25	659.63	OTH ADVNCD MTRNL AGE ANT
$528.37	719.45	PAIN IN JOINT INVOLVING PELVIC REGION AND THIGH
$512.07	648.80	ABNORMAL GLUCOSE TOLERANCE OF MOTHER, COMPLICATING PREGNANCY, CHILDBIRTH, OR THE
$509.43	V23.0	Sprv preg, w/infertility history
$492.85	V72.60	Laboratory examination, unspecified
$379.54	616.10	VAGINITIS AND VULVOVAGINITIS, UNSPECIFIED
$312.61	V23.9	SUPERVISION OF UNSPECIFIED HIGH-RISK PREGNANCY
$269.99	999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEWHERE CLASSIFIED
$204.87	250.02	DIABETES MELLITUS WITHOUT MENTION OF COMPLICATION, TYPE II,UNCONTROLLED
$191.45	626.0	ABSENCE OF MENSTRUATION
$181.71	659.53	ELDERLY PRIMIGRAVIDA, ANTEPARTUM
$151.61	659.61	OTH ADVNCD MTRNL AGE DEL
$145.51	655.93	UNSPECIFIED SUSPECTED FETAL ABNORMALITY,AFFECTING MANAGEMENT OF MOTHER, ANTEPAR
$131.63	640.00	THREATENED ABORTION, UNSPECIFIED AS TO EPISODE OF CARE
$121.94	241.9	UNSPECIFIED NONTOXIC NODULAR GOITER
$114.46	788.99	Symptoms, other symptoms, urinary
$111.49	244.9	UNSPECIFIED ACQUIRED HYPOTHYROIDISM
$93.15	461.9	ACUTE SINUSITIS, UNSPECIFIED
$75.08	646.83	OTHER SPECIFIED ANTEPARTUM COMPLICATIONS
$63.48	054.9	HERPES SIMPLEX WITHOUT MENTION OF COMPLICATION
$47.87	V43.64	JOINT;HIP
$31.51	791.5	GLYCOSURIA
$26.65	755.63	OTHER CONGENITAL DEFORMITY OF HIP (JOINT)
$21.31	788.1	DYSURIA
$18.55	790.29	OTHER ABNORMAL GLUCOSE

$32,901.03 Total Paid

10/31/14 Allegiance Benefit Plan Management, Inc. PAGE: 22
LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
250.02	DIABETES MELLITUS WITHOUT MENTION OF	204.87	11/08/2013
241.9	UNSPECIFIED NONTOXIC NODULAR GOITER	121.94	10/11/2013
DRUGS	PRESCRIPTION DRUGS	4559.24	10/16/2014
V43.64	JOINT;HIP	47.87	10/04/2014
719.45	PAIN IN JOINT INVOLVING PELVIC REGION AN	528.37	01/14/2014

10/31/14 Allegiance Benefit Plan Management, Inc. PAGE: 23
LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 02 11/01/2013 to 10/31/2014 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
V72.60	Laboratory examination, unspecified	492.85	12/07/2013
244.9	UNSPECIFIED ACQUIRED HYPOTHYROIDISM	111.49	12/18/2013
790.29	OTHER ABNORMAL GLUCOSE	18.55	12/13/2013
790.21	IMPAIRED FASTING GLUCOSE		12/18/2013
616.10	VAGINITIS AND VULVOVAGINITIS, UNSPECIFIE	379.54	09/25/2014
V72.42	PREGNANCY EXAMINATION OR TEST, POSITIVE	692.99	03/06/2014
648.80	ABNORMAL GLUCOSE TOLERANCE OF MOTHER, CO	512.07	08/26/2014
640.00	THREATENED ABORTION, UNSPECIFIED AS TO E	131.63	02/13/2014
V23.0	Sprv preg, w/infertility history	509.43	03/13/2014
626.0	ABSENCE OF MENSTRUATION	191.45	03/06/2014
V73.88	SCRN OTH SPCF CHLMYD DIS		03/06/2014
V77.99	OTHER AND UNSPECIFIED ENDOCRINE, NUTRITI		03/06/2014
659.61	OTH ADVNCD MTRNL AGE DEL	151.61	08/12/2014
788.1	DYSURIA	21.31	06/08/2014
659.53	ELDERLY PRIMIGRAVIDA, ANTEPARTUM	181.71	09/26/2014
655.93	UNSPECIFIED SUSPECTED FETAL ABNORMALITY,	145.51	06/30/2014
V23.9	SUPERVISION OF UNSPECIFIED HIGH-RISK PRE	312.61	09/30/2014
788.99	Symptoms, other symptoms, urinary	114.46	06/08/2014
648.90	OTHER CURRENT CONDITIONS CLASSIFIABLE EL		06/08/2014
659.63	OTH ADVNCD MTRNL AGE ANT	611.25	08/22/2014
461.9	ACUTE SINUSITIS, UNSPECIFIED	93.15	06/20/2014
465.9	ACUTE UPPER RESPIRATORY INFECTIONS OF UN		06/20/2014
V22.2	PREGNANT STATE, INCIDENTAL		06/20/2014
791.5	GLYCOSURIA	31.51	06/30/2014
V22.0	SUPERVISION OF NORMAL FIRST PREGNANCY		06/30/2014
648.83	ABNORMAL GLUCOSE TOLERANCE OF MOTHER, AN	11108.82	09/26/2014
649.13	OBESITY COMPLICATING PREGNANCY, CHILD-		07/16/2014
278.00	OBESITY, UNSPECIFIED		07/16/2014
V28.3	Enc routi scrg mthr antntl, ftl mal		07/16/2014
054.9	HERPES SIMPLEX WITHOUT MENTION OF COMPLI	63.48	07/16/2014
530.81	ESOPHAGEAL REFLUX		07/16/2014
564.1	IRRITABLE COLON		07/16/2014
647.63	OTHER ANTEPARTUM VIRAL DISEASES		08/01/2014
648.93	OTHER CURRENT CONDITIONS CLASSIFIABLE EL		08/29/2014
657.03	POLYHYDRAMNIOS, ANTEPARTUM COMPLICATION	1478.49	09/26/2014
646.83	OTHER SPECIFIED ANTEPARTUM COMPLICATIONS	75.08	08/20/2014
623.5	LEUKORRHEA, NOT SPECIFIED AS INFECTIVE		08/20/2014
999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEW	269.99	08/30/2014
648.01	DIABETES MELLITUS OF MOTHER, WITH DELIVE	7540.96	10/06/2014
648.61	OTHER CARDIOVASCULAR DISEASES OF MOTHER,		10/06/2014
250.00	DIABETES MELLITUS WITHOUT MENTION OF		10/06/2014
648.91	OTHER CURRENT CONDITIONS CLASSIFIABLE EL		10/06/2014
755.63	OTHER CONGENITAL DEFORMITY OF HIP (JOINT	26.65	10/06/2014

10/31/14 Allegiance Benefit Plan Management, Inc. PAGE: 24
LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 02 11/01/2013 to 10/31/2014 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

Diagnosis Summary for **********	Amount Paid	Last D.O.S.
669.71 CESAREAN DELIVERY, WITHOUT MENTION OF IN	2172.15	10/03/2014
V27.0 MOTHER WITH SINGLE LIVEBORN		10/04/2014
338.18 OTHER ACUTE POSTOPERATIVE PAIN		10/04/2014

GROUP: 2001025 SSN: ********** SEQ: ** DIV: 0001 RELAT: Spouse EFF: ********** DOB: ********** TERM: **********
LEVEL: F99 PLAN: WILCO-MED-CORE

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	01-*	250000.00	15.66	39156.94	.00	.00	.00	.00

==========Diagnosis Recap==========

Amount	Code	Description
$9,611.25	574.00	CALCULUS OF GALLBLADDER WITH ACUTE CHOLECYSTITIS, WITHOUT MENTION OF OBSTRUCTION
$8,589.82	664.01	FIRST-DEGREE PERINEAL LACERATION, WITH DELIVERY
$5,738.18	574.50	CALCULUS OF BILE DUCT WITHOUT MENTION OFCHOLECYSTITIS, WITHOUT MENTION OF OBSTR
$3,287.52	576.8	OTHER SPECIFIED DISORDERS OF BILIARY TRACT
$3,088.62	646.83	OTHER SPECIFIED ANTEPARTUM COMPLICATIONS
$2,603.41	574.20	CALCULUS OF GALLBLADDER WITHOUT MENTION OF CHOLECYSTITIS, WITHOUT MENTION OF OBS
$1,666.00	650	DELIVERY IN A COMPLETELY NORMAL CASE
$1,595.38	574.51	CALCULUS OF BILE DUCT WITHOUT MENTION OFCHOLECYSTITIS, WITH OBSTRUCTION
$1,456.50	789.00	OTHER SYMPTOMS INVOLVING ABDOMEN AND PELVIS
$1,015.95	789.01	OTHER SYMPTOMS INVOLVING ABDOMEN AND PELVIS
$144.07	787.01	OTHER SYMPTOMS INVOLVING DIGESTIVE SYSTEM;NAUSEA WITH VOMITING
$110.32	574.10	CALCULUS OF GALLBLADDER WITH OTHER CHOLECYSTITIS, WITHOUT MENTION OF OBSTRUCTION
$74.89	790.5	OTHER NONSPECIFIC ABNORMAL SERUM ENZYME LEVELS
$67.10	642.33	ANTEPARTUM TRANSIENT HYPERTENSION
$60.05	V24.2	ROUTINE POSTPARTUM FOLLOW-UP
$19.70	592.0	CALCULUS OF KIDNEY
$19.54	794.8	NONSPECIFIC ABNORMAL RESULTS OF FUNCTIONSTUDY OF LIVER
$5.09	V28.6	SCREENING FOR STREPTOCOCCUS B
$3.55	DRUGS	PRESCRIPTION DRUGS

$39,156.94 Total Paid

Diagnosis Summary for **********	Amount Paid	Last D.O.S.
646.83 OTHER SPECIFIED ANTEPARTUM COMPLICATIONS	3088.62	10/25/2013
796.2 ELEVATED BLOOD PRESSURE READING WITHOUT		10/25/2013
664.01 FIRST-DEGREE PERINEAL LACERATION, WITH D	8589.82	11/14/2013
642.41 MILD OR UNSPECIFIED PRE-ECLAMPSIA, WITH		11/14/2013
V85.43 BMI 50.0-59.9, adult		11/14/2013
649.11 OBESITY COMPLICATING PREGNANCY, CHILD-		11/14/2013
278.00 OBESITY, UNSPECIFIED		05/17/2014
V27.0 MOTHER WITH SINGLE LIVEBORN		11/12/2013
650 DELIVERY IN A COMPLETELY NORMAL CASE	1666.00	11/11/2013
V24.2 ROUTINE POSTPARTUM FOLLOW-UP	60.05	12/31/2013
795.01 PAPANICOLAOU SMEAR OF CERVIX WITH ATYPIC		12/31/2013
V28.6 SCREENING FOR STREPTOCOCCUS B	5.09	10/25/2013
789.00 OTHER SYMPTOMS INVOLVING ABDOMEN AND	1456.50	04/19/2014
574.20 CALCULUS OF GALLBLADDER WITHOUT MENTION	2603.41	05/18/2014
DRUGS PRESCRIPTION DRUGS	3.55	04/16/2014
574.00 CALCULUS OF GALLBLADDER WITH ACUTE CHOLE	9611.25	05/17/2014
574.10 CALCULUS OF GALLBLADDER WITH OTHER CHOLE	110.32	04/16/2014
401.9 UNSPECIFIED ESSENTIAL HYPERTENSION		04/14/2014
789.01 OTHER SYMPTOMS INVOLVING ABDOMEN AND	1015.95	05/17/2014
574.50 CALCULUS OF BILE DUCT WITHOUT MENTION OF	5738.18	05/18/2014
574.51 CALCULUS OF BILE DUCT WITHOUT MENTION OF	1595.38	05/18/2014
790.4 NONSPECIFIC ELEVATION OF LEVELS OF TRANS		04/19/2014

10/31/14 Allegiance Benefit Plan Management, Inc. PAGE: 25
LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 02 11/01/2013 to 10/31/2014 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
793.3	NONSPECIFIC ABNORMAL FINDINGS ON RADIOLO		04/19/2014
592.0	CALCULUS OF KIDNEY	19.70	04/16/2014
789.07	OTHER SYMPTOMS INVOLVING ABDOMEN AND		05/18/2014
276.8	HYPOPOTASSEMIA		05/18/2014
576.8	OTHER SPECIFIED DISORDERS OF BILIARY TRA	3287.52	05/18/2014
V45.79	OTHER ACQUIRED ABSENCE OF ORGAN		05/17/2014
V85.37	BODY MASS INDEX 37.0-37.9, ADULT		05/17/2014
V14.8	Hx, prsnl, drug allergy NEC		05/17/2014
794.8	NONSPECIFIC ABNORMAL RESULTS OF FUNCTION	19.54	05/28/2014
782.4	JAUNDICE, UNSPECIFIED, NOT OF NEWBORN		05/17/2014
790.5	OTHER NONSPECIFIC ABNORMAL SERUM ENZYME	74.89	05/23/2014
787.01	OTHER SYMPTOMS INVOLVING DIGESTIVE	144.07	05/17/2014
787.91	OTHER SYMPTOMS INVOLVING DIGESTIVE		05/17/2014
642.33	ANTEPARTUM TRANSIENT HYPERTENSION	67.10	10/25/2013

GROUP: 2001025 SSN: ********** SEQ: ** DIV: 0002 RELAT: Participant EFF: ********** DOB: ********** TERM: **********
LEVEL: F99 PLAN: WILCO-MED-CORE-DIAB

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	00-*	250000.00	44.63	111576.92	.00	.00	.00	.00

==========Diagnosis Recap==========

Amount	Code	Description
$40,711.56	038.9	UNSPECIFIED SEPTICEMIA
$17,010.74	345.90	EPILEPSY, UNSPECIFIED, WITHOUT MENTION OF INTRACTABLE EPILEPSY
$15,620.30	999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEWHERE CLASSIFIED
$5,649.32	DRUGS	PRESCRIPTION DRUGS
$4,797.74	780.39	CONVULSIONS;OTHER CONVULSIONS
$4,589.21	250.60	DIABETES WITH NEUROLOGICAL MANIFESTATIONS,TYPE II,UNSPECIFIED TYPE
$2,437.69	250.50	DIABETES WITH OPHTHALMIC MANIFESTATIONS,TYPE II OR UNSPECIFIED TYPE
$2,311.04	250.80	DIABETES WITH OTHER SPECIFIED MANIFESTATIONS,TYPE II OR UNSPECIFIED TYPE
$1,626.15	782.3	EDEMA
$1,549.16	780.09	OTHER ALTER CONSCIOUSNES
$1,190.50	780.97	ALTERED MENTAL STATUS
$1,175.51	518.81	RESPIRATORY FAILURE
$993.82	782.0	DISTURBANCE OF SKIN SENSATION
$840.06	707.14	Ulcer, heel and midfoot
$816.00	V57.1	CARE INVOLVING OTHER PHYSICAL THERAPY
$776.84	250.02	DIABETES MELLITUS WITHOUT MENTION OF COMPLICATION, TYPE II,UNCONTROLLED
$770.00	V72.60	Laboratory examination, unspecified
$717.51	250.20	DIABETES WITH HYPEROSMOLARITY,TYPE II ORUNSPECIFIED TYPE
$711.46	793.0	NONSPECIFIC ABNORMAL FINDINGS ON RADIOLOGICAL AND OTHER EXAMINATION OF SKULL AND
$678.36	507.0	PNEUMONITIS DUE TO INHALATION OF FOOD ORVOMITUS
$568.39	781.2	ABNORMALITY OF GAIT
$567.07	780.79	OTHER MALAISE AND FATIGUE
$560.64	584.9	Acute kidney failure, unspecified
$559.74	414.00	CORONARY ATHEROSCLEROSIS OF UNSPECIFIED TYPE OF VESSEL, NATIVE OR GRAFT
$499.77	356.9	UNSPECIFIED IDIOPATHIC PERIPHERAL NEUROPATHY
$487.28	405.19	OTHER BENIGN SECONDARY HYPERTENSION
$339.24	250.72	DIABETES WITH PERIPHERAL CIRCULATORY DISORDERS,TYPE II OR UNSPEC TYPE,UNCONTROLD
$296.94	955.2	INJURY TO ULNAR NERVE
$292.50	728.87	MUSCLE WEAKNESS (GENERALIZED)
$198.23	682.7	CELLULITIS AND ABSCESS OF FOOT, EXCEPT TOES
$197.75	365.04	OCULAR HYPERTENSION
$184.62	585.3	CHRONIC KIDNEY DISEASE, STAGE III (MODERATE)
$177.91	436	ACUTE, BUT ILL-DEFINED, CEREBROVASCULAR DISEASE
$152.02	780.60	Symptom, fever, unspecified
$149.28	780.93	SYMPTOM, MEMORY LOSS
$129.18	434.91	CRBL ART OCL NOS W INFRC
$128.56	585.4	CHRONIC KIDNEY DISEASE, STAGE IV (SEVERE)
$119.02	250.00	DIABETES MELLITUS WITHOUT MENTION OF COMPLICATION, TYPE II
$114.31	323.9	UNSPECIFIED CAUSE OF ENCEPHALITIS
$93.15	486	PNEUMONIA, ORGANISM UNSPECIFIED
$80.02	237.5	NEOPLASM OF UNCERTAIN BEHAVIOR OF BRAIN AND SPINAL CORD
$78.44	V58.83	ENCOUNTER/THERAPEUTIC DRUG MONITORING
$74.01	369.9	UNSPECIFIED VISUAL LOSS
$72.03	429.82	HYPERKINETIC HEART DISEASE
$68.38	459.81	VENOUS (PERIPHERAL) INSUFFICIENCY, UNSPECIFIED
$56.92	586	RENAL FAILURE, UNSPECIFIED
$53.44	729.81	SWELLING OF LIMB
$51.54	786.2	COUGH
$45.82	574.20	CALCULUS OF GALLBLADDER WITHOUT MENTION OF CHOLECYSTITIS, WITHOUT MENTION OF OBS
$41.37	V58.81	FITTING AND ADJUSTMENT OF VASCULAR CATHETER
$38.00	250.92	DIABETES WITH OTHER UNSPECIFIED COMPLICATION,TYPE II OR UNSPEC TYPE,UNCONTROLLED
$32.44	401.9	UNSPECIFIED ESSENTIAL HYPERTENSION
$28.88	780.2	SYNCOPE AND COLLAPSE
$18.16	904.8	INJURY TO UNSPECIFIED BLOOD VESSEL OF LOWER EXTREMITY
$16.00	724.02	Stenosis, spinal, lmbr, no neuro cl
$13.79	V58.82	FITTING AND ADJUSTMENT OF NONVASCULAR CATHETER, NEC
$8.67	V58.61	LONG-TERM (CURRENT) USE OF ANTICOAGULANT
$7.42	453.40	Acute emblsm/thrmb dp vsl lwr extrm
$3.02	721.3	LUMBOSACRAL SPONDYLOSIS WITHOUT MYELOPATHY

$111,576.92 Total Paid

10/31/14 Allegiance Benefit Plan Management, Inc. PAGE: 26
LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEW	15620.30	07/26/2014
DRUGS	PRESCRIPTION DRUGS	5649.32	07/27/2014
780.39	CONVULSIONS;OTHER CONVULSIONS	4797.74	06/28/2014
V58.61	LONG-TERM (CURRENT) USE OF ANTICOAGULANT	8.67	06/18/2014
780.2	SYNCOPE AND COLLAPSE	28.88	10/13/2013
904.8	INJURY TO UNSPECIFIED BLOOD VESSEL OF LO	18.16	10/11/2013
V57.1	CARE INVOLVING OTHER PHYSICAL THERAPY	816.00	10/30/2013
724.02	Stenosis, spinal, lmbr, no neuro cl	16.00	10/30/2013
348.0	CEREBRAL CYSTS		10/30/2013
728.87	MUSCLE WEAKNESS (GENERALIZED)	292.50	06/19/2014
781.2	ABNORMALITY OF GAIT	568.39	07/07/2014
782.3	EDEMA	1626.15	07/08/2014
250.02	DIABETES MELLITUS WITHOUT MENTION OF	776.84	06/28/2014
272.2	Hyperlipidemia, mixed		06/28/2014
401.1	BENIGN ESSENTIAL HYPERTENSION		05/28/2014
721.3	LUMBOSACRAL SPONDYLOSIS WITHOUT MYELOPAT	3.02	12/12/2013
780.60	Symptom, fever, unspecified	152.02	04/23/2014
486	PNEUMONIA, ORGANISM UNSPECIFIED	93.15	02/03/2014
285.9	ANEMIA, UNSPECIFIED		05/23/2014
250.92	DIABETES WITH OTHER UNSPECIFIED COMPLICA	38.00	02/03/2014
414.00	CORONARY ATHEROSCLEROSIS OF UNSPECIFIED	559.74	07/07/2014
401.9	UNSPECIFIED ESSENTIAL HYPERTENSION	32.44	07/08/2014
453.40	Acute emblsm/thrmb dp vsl lwr extrm	7.42	02/03/2014
414.9	CHRONIC ISCHEMIC HEART DISEASE, UNSPECIF		07/08/2014
272.4	OTHER AND UNSPECIFIED HYPERLIPIDEMIA		06/03/2014
786.2	COUGH	51.54	01/27/2014
250.00	DIABETES MELLITUS WITHOUT MENTION OF	119.02	06/23/2014
V43.1	LENS REPLACED BY OTHER MEANS		03/31/2014
369.9	UNSPECIFIED VISUAL LOSS	74.01	05/09/2014
368.40	VISUAL FIELD DEFECT, UNSPECIFIED		04/04/2014
365.04	OCULAR HYPERTENSION	197.75	06/06/2014
250.50	DIABETES WITH OPHTHALMIC MANIFESTATIONS,	2437.69	06/20/2014
362.01	BACKGROUND DIABETIC RETINOPATHY		04/04/2014

10/31/14 Allegiance Benefit Plan Management, Inc. PAGE: 27
LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 02 11/01/2013 to 10/31/2014 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
362.07	DIABETIC MACULAR EDEMA		04/04/2014
362.02	PROLIFERATIVE DIABETIC RETINOPATHY		06/06/2014
V72.60	Laboratory examination, unspecified	770.00	06/13/2014
780.97	ALTERED MENTAL STATUS	1190.50	04/29/2014
507.0	PNEUMONITIS DUE TO INHALATION OF FOOD OR	678.36	04/29/2014
584.9	Acute kidney failure, unspecified	560.64	05/28/2014
436	ACUTE, BUT ILL-DEFINED, CEREBROVASCULAR	177.91	04/28/2014
250.20	DIABETES WITH HYPEROSMOLARITY,TYPE II OR	717.51	05/16/2014
780.09	OTHER ALTER CONSCIOUSNES	1549.16	04/22/2014
518.81	RESPIRATORY FAILURE	1175.51	04/29/2014
250.21	DIABETES WITH HYPEROSMOLARITY,TYPE I,		04/27/2014
276.0	HYPEROSMOLALITY AND/OR HYPERNATREMIA		04/28/2014
780.79	OTHER MALAISE AND FATIGUE	567.07	04/22/2014
345.91	EPILEPSY, UNSPECIFIED, WITH INTRACTABLE		04/22/2014
V12.49	Hx, prsnl, nrv syst/sns org dsd NEC		04/24/2014
038.9	UNSPECIFIED SEPTICEMIA	40711.56	04/29/2014
434.91	CRBL ART OCL NOS W INFRC	129.18	07/03/2014
250.22	DIABETES WITH HYPEROSMOLARITY,TYPE II OR		05/24/2014
997.39	Other respiratory complications		04/29/2014
348.39	OTHER ENCEPHALOPATHY		04/29/2014
250.72	DIABETES WITH PERIPHERAL CIRCULATORY DIS	339.24	07/08/2014
429.82	HYPERKINETIC HEART DISEASE	72.03	04/25/2014
416.8	OTHER CHRONIC PULMONARY HEART DISEASES		04/25/2014
V58.81	FITTING AND ADJUSTMENT OF VASCULAR	41.37	04/25/2014
V58.82	FITTING AND ADJUSTMENT OF NONVASCULAR	13.79	04/23/2014
379.21	VITREOUS DEGENERATION		05/09/2014
586	RENAL FAILURE, UNSPECIFIED	56.92	04/24/2014
237.5	NEOPLASM OF UNCERTAIN BEHAVIOR OF BRAIN	80.02	04/24/2014
V58.83	ENCOUNTER/THERAPEUTIC DRUG MONITORING	78.44	06/18/2014
250.60	DIABETES WITH NEUROLOGICAL MANIFESTATION	4589.21	07/07/2014
440.23	ATHRSCL EXTRM ULCERATION		05/24/2014
707.19	Ulcer, oth prt of lwr limb		05/24/2014
682.7	CELLULITIS AND ABSCESS OF FOOT, EXCEPT T	198.23	06/30/2014
707.14	Ulcer, heel and midfoot	840.06	07/07/2014
357.2	POLYNEUROPATHY IN DIABETES		05/24/2014
250.80	DIABETES WITH OTHER SPECIFIED MANIFESTAT	2311.04	07/07/2014
707.15	Ulcer, other part of foot		05/30/2014
250.70	DIABETES WITH PERIPHERAL CIRCULATORY		05/24/2014
459.81	VENOUS (PERIPHERAL) INSUFFICIENCY, UNSPE	68.38	06/30/2014
707.07	Ulcer, pressure, heel		05/23/2014
585.9	CHRONIC KIDNEY DISEASE, UNSPECIFIED		05/23/2014
729.81	SWELLING OF LIMB	53.44	05/23/2014
719.7	DIFFICULTY IN WALKING		06/19/2014

10/31/14 Allegiance Benefit Plan Management, Inc. PAGE: 28
LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 02 11/01/2013 to 10/31/2014 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
V12.54	Hx, prsnl, TIA and cerebral infa		06/19/2014
585.3	CHRONIC KIDNEY DISEASE, STAGE III	184.62	06/20/2014
791.0	PROTEINURIA		06/30/2014
955.2	INJURY TO ULNAR NERVE	296.94	06/09/2014
405.19	OTHER BENIGN SECONDARY HYPERTENSION	487.28	06/27/2014
573.3	HEPATITIS, UNSPECIFIED		06/27/2014
250.10	DIABETES WITH KETOACIDOSIS,TYPE II OR		06/27/2014
401.0	MALIGNANT ESSENTIAL HYPERTENSION		06/28/2014
585.4	CHRONIC KIDNEY DISEASE, STAGE IV	128.56	06/30/2014
345.90	EPILEPSY, UNSPECIFIED, WITHOUT MENTION O	17010.74	06/27/2014
345.3	GRAND MAL STATUS, EPILEPTIC		06/23/2014
788.1	DYSURIA		06/23/2014
250.40	DIABETES WITH RENAL MANIFESTATION,TYPE		06/13/2014
348.1	ANOXIC BRAIN DAMAGE		06/13/2014
356.9	UNSPECIFIED IDIOPATHIC PERIPHERAL NEUROP	499.77	07/14/2014
780.93	SYMPTOM, MEMORY LOSS	149.28	07/03/2014
794.09	OTHER NONSPECIFIC ABNORMAL RESULTS OF FU		07/03/2014
793.0	NONSPECIFIC ABNORMAL FINDINGS ON RADIOLO	711.46	07/10/2014
782.0	DISTURBANCE OF SKIN SENSATION	993.82	07/14/2014
354.0	CARPAL TUNNEL SYNDROME		07/14/2014
574.20	CALCULUS OF GALLBLADDER WITHOUT MENTION	45.82	06/24/2014
794.8	NONSPECIFIC ABNORMAL RESULTS OF FUNCTION		06/24/2014
438.9	OTHER PARALYTIC SYNDROME;UNSPECIFIED		05/16/2014
362.10	BACKGROUND RETINOPATHY, UNSPECIFIED		07/07/2014

GROUP: 2001025 SSN: ********** SEQ: ** DIV: 0001 RELAT: Participant EFF: ********** DOB: ********** TERM: **********
LEVEL: P00 PLAN: WILCO-MED-CORE-DIAB

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	00-*	250000.00	11.07	27683.54	.00	.00	.00	.00

==========Diagnosis Recap==========

Amount	Code	Description
$8,894.17	DRUGS	PRESCRIPTION DRUGS
$7,052.28	574.20	CALCULUS OF GALLBLADDER WITHOUT MENTION OF CHOLECYSTITIS, WITHOUT MENTION OF OBS
$4,152.91	789.09	OTHER SYMPTOMS INVOLVING ABDOMEN AND PELVIS
$1,602.55	250.00	DIABETES MELLITUS WITHOUT MENTION OF COMPLICATION, TYPE II
$1,592.52	575.8	OTHER SPECIFIED DISORDERS OF GALLBLADDER
$1,354.92	250.02	DIABETES MELLITUS WITHOUT MENTION OF COMPLICATION, TYPE II,UNCONTROLLED
$1,115.63	575.0	ACUTE CHOLECYSTITIS
$824.13	575.11	OTHER CHOLECYSTITIS;CHRONIC
$313.71	789.00	OTHER SYMPTOMS INVOLVING ABDOMEN AND PELVIS
$185.50	487.1	INFLUENZA WITH OTHER RESPIRATORY MANIFESTATIONS
$161.43	564.00	CONSTIPATION, UNSPECIFIED
$100.78	789.05	OTHER SYMPTOMS INVOLVING ABDOMEN AND PELVIS
$68.48	787.02	OTHER SYMPTOMS OF THE DIGESTIVE SYSTEM; NAUSEA ALONE
$63.81	789.07	OTHER SYMPTOMS INVOLVING ABDOMEN AND PELVIS
$63.51	789.04	OTHER SYMPTOMS INVOLVING ABDOMEN AND PELVIS
$62.39	571.8	OTHER CHRONIC NONALCOHOLIC LIVER DISEASE
$42.17	461.9	ACUTE SINUSITIS, UNSPECIFIED
$32.65	V04.81	NEED FOR PROPHYLACTIC VACCINATION/ INOCULATION AGAINST, INFLUENZA

$27,683.54 Total Paid

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
250.02	DIABETES MELLITUS WITHOUT MENTION OF	1354.92	08/11/2014
272.0	PURE HYPERCHOLESTEROLEMIA		05/16/2014
V58.69	LONG-TERM (CURRENT) USE OF OTHER		05/16/2014
250.00	DIABETES MELLITUS WITHOUT MENTION OF	1602.55	09/01/2014
V04.81	NEED FOR PROPHYLACTIC VACCINATION/	32.65	10/11/2013
DRUGS	PRESCRIPTION DRUGS	8894.17	10/10/2014
461.9	ACUTE SINUSITIS, UNSPECIFIED	42.17	11/06/2013
466.0	ACUTE BRONCHITIS		11/06/2013
487.1	INFLUENZA WITH OTHER RESPIRATORY MANIFES	185.50	12/15/2013
724.2	LUMBAGO		05/16/2014
788.1	DYSURIA		06/18/2014

10/31/14 Allegiance Benefit Plan Management, Inc. PAGE: 29
LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 02 11/01/2013 to 10/31/2014 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
564.1	IRRITABLE COLON		09/01/2014
789.09	OTHER SYMPTOMS INVOLVING ABDOMEN AND	4152.91	09/23/2014
571.8	OTHER CHRONIC NONALCOHOLIC LIVER DISEASE	62.39	08/12/2014
787.02	OTHER SYMPTOMS OF THE DIGESTIVE SYSTEM;	68.48	08/28/2014
789.00	OTHER SYMPTOMS INVOLVING ABDOMEN AND	313.71	08/28/2014
787.01	OTHER SYMPTOMS INVOLVING DIGESTIVE		09/23/2014
789.04	OTHER SYMPTOMS INVOLVING ABDOMEN AND	63.51	08/11/2014
789.01	OTHER SYMPTOMS INVOLVING ABDOMEN AND		08/11/2014
574.20	CALCULUS OF GALLBLADDER WITHOUT MENTION	7052.28	08/21/2014
530.81	ESOPHAGEAL REFLUX		08/20/2014
780.57	UNSPECIFIED SLEEP APNEA		08/20/2014
575.8	OTHER SPECIFIED DISORDERS OF GALLBLADDER	1592.52	08/28/2014
575.11	OTHER CHOLECYSTITIS;CHRONIC	824.13	08/20/2014
575.6	CHOLESTEROLOSIS OF GALLBLADDER		08/20/2014
789.07	OTHER SYMPTOMS INVOLVING ABDOMEN AND	63.81	08/31/2014
564.00	CONSTIPATION, UNSPECIFIED	161.43	09/23/2014
414.4	Coronary atherosclerosis d/t lesion		08/28/2014
783.0	ANOREXIA		09/01/2014
278.00	OBESITY, UNSPECIFIED		09/01/2014
575.0	ACUTE CHOLECYSTITIS	1115.63	08/20/2014
787.3	FLATULENCE, ERUCTATION, AND GAS PAIN		09/23/2014
789.05	OTHER SYMPTOMS INVOLVING ABDOMEN AND	100.78	08/29/2014
789.06	OTHER SYMPTOMS INVOLVING ABDOMEN AND		08/29/2014
787.99	OTHER SYMPTOMS INVOLVING DIGESTIVE		08/29/2014
V45.89	OTHER POSTSURGICAL STATUS		08/28/2014

GROUP: 2001025 SSN: ********** SEQ: ** DIV: 0001 RELAT: Spouse EFF: ********** DOB: ********** TERM: **********
LEVEL: F99 PLAN: WILCO-MED-CORE-DIAB

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	01-*	250000.00	33.52	83789.78	.00	.00	.00	.00

==========Diagnosis Recap==========

Amount	Code	Description
$46,947.22	182.0	MALIGNANT NEOPLASM OF CORPUS UTERI, EXCEPT ISTHMUS
$10,840.28	158.8	MALIGNANT NEOPLASM OF SPECIFIED PARTS OFPERITONEUM
$5,474.69	574.20	CALCULUS OF GALLBLADDER WITHOUT MENTION OF CHOLECYSTITIS, WITHOUT MENTION OF OBS
$4,017.64	179	MALIGNANT NEOPLASM OF UTERUS, PART UNSPECIFIED
$3,903.78	DRUGS	PRESCRIPTION DRUGS
$2,520.05	999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEWHERE CLASSIFIED
$2,386.50	V76.51	SPECIAL SCREENING FOR MALIG NEOPL;COLON
$2,135.28	566	ABSCESS OF ANAL AND RECTAL REGIONS
$1,479.92	789.30	OTHER SYMPTOMS INVOLVING ABDOMEN AND PELVIS
$978.58	V58.81	FITTING AND ADJUSTMENT OF VASCULAR CATHETER
$680.76	V71.1	OBSERVATION FOR SUSPECTED MALIGNANT NEOPLASM
$460.87	569.9	UNSPECIFIED DISORDER OF INTESTINE
$372.38	782.3	EDEMA
$254.98	V58.61	LONG-TERM (CURRENT) USE OF ANTICOAGULANT
$223.32	V76.12	OTHER SCREENING MAMMOGRAM
$181.64	627.1	POSTMENOPAUSAL BLEEDING
$165.76	625.9	UNSPECIFIED SYMPTOM ASSOCIATED WITH FEMALE GENITAL ORGANS
$152.00	V57.1	CARE INVOLVING OTHER PHYSICAL THERAPY
$135.30	V72.83	OTH SPCF PREOP EXAM
$126.83	584.9	Acute kidney failure, unspecified
$79.13	786.2	COUGH
$68.38	706.2	SEBACEOUS CYST
$56.51	616.4	OTHER ABSCESS OF VULVA
$56.49	616.10	VAGINITIS AND VULVOVAGINITIS, UNSPECIFIED
$55.39	458.9	HYPOTENSION, UNSPECIFIED
$36.10	276.8	HYPOPOTASSEMIA

$83,789.78 Total Paid

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
V72.83	OTH SPCF PREOP EXAM	135.30	10/07/2013
782.3	EDEMA	372.38	12/31/2013
V58.81	FITTING AND ADJUSTMENT OF VASCULAR	978.58	10/30/2013
V76.51	SPECIAL SCREENING FOR MALIG NEOPL;COLON	2386.50	10/08/2013
289.81	PRIMARY HYPERCOAGULABLE STATE		10/09/2013
574.20	CALCULUS OF GALLBLADDER WITHOUT MENTION	5474.69	10/09/2013
401.9	UNSPECIFIED ESSENTIAL HYPERTENSION		10/09/2013
999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEW	2520.05	04/25/2014
182.0	MALIGNANT NEOPLASM OF CORPUS UTERI, EXCE	46947.22	09/30/2014
278.01	MORBID OBESITY		10/09/2013
V85.43	BMI 50.0-59.9, adult		10/09/2013
627.1	POSTMENOPAUSAL BLEEDING	181.64	11/21/2013
V58.61	LONG-TERM (CURRENT) USE OF ANTICOAGULANT	254.98	10/20/2014
569.9	UNSPECIFIED DISORDER OF INTESTINE	460.87	10/08/2013
211.3	BENIGN NEOPLASM OF COLON		10/08/2013
569.89	OTHER SPECIFIED DISORDERS OF INTESTINES		10/08/2013
625.8	OTHER SPECIFIED SYMPTOMS ASSOCIATED WITH		10/08/2013
DRUGS	PRESCRIPTION DRUGS	3903.78	10/17/2014
V57.1	CARE INVOLVING OTHER PHYSICAL THERAPY	152.00	10/22/2013
682.5	CELLULITIS AND ABSCESS OF BUTTOCK		10/22/2013

10/31/14 Allegiance Benefit Plan Management, Inc. PAGE: 30
LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 02 11/01/2013 to 10/31/2014 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
179	MALIGNANT NEOPLASM OF UTERUS, PART UNSPE	4017.64	10/09/2013
617.1	ENDOMETRIOSIS OF OVARY		10/09/2013
616.0	CERVICITIS AND ENDOCERVICITIS		10/09/2013
574.10	CALCULUS OF GALLBLADDER WITH OTHER CHOLE		10/09/2013
584.9	Acute kidney failure, unspecified	126.83	11/22/2013
997.49	Othr digestive system complications		10/09/2013
560.1	PARALYTIC ILEUS		10/09/2013
158.8	MALIGNANT NEOPLASM OF SPECIFIED PARTS OF	10840.28	08/22/2014
625.9	UNSPECIFIED SYMPTOM ASSOCIATED WITH FEMA	165.76	11/13/2013
276.8	HYPOPOTASSEMIA	36.10	11/22/2013
616.10	VAGINITIS AND VULVOVAGINITIS, UNSPECIFIE	56.49	11/21/2013
V58.11	ENCOUNTER FOR ANTINEOPLASTIC		02/10/2014
566	ABSCESS OF ANAL AND RECTAL REGIONS	2135.28	08/28/2013
701.1	KERATODERMA, ACQUIRED		08/28/2013
458.9	HYPOTENSION, UNSPECIFIED	55.39	12/02/2013
401.1	BENIGN ESSENTIAL HYPERTENSION		12/02/2013
451.9	PHLEBITIS AND THROMBOPHLEBITIS OF UNSPEC		12/02/2013
V71.1	OBSERVATION FOR SUSPECTED MALIGNANT NEOP	680.76	12/27/2013
275.2	DISORDERS OF MAGNESIUM METABOLISM		11/22/2013
789.30	OTHER SYMPTOMS INVOLVING ABDOMEN AND	1479.92	10/09/2013
786.2	COUGH	79.13	08/18/2014
724.2	LUMBAGO		08/18/2014
724.3	SCIATICA		08/18/2014
616.4	OTHER ABSCESS OF VULVA	56.51	03/14/2014
706.2	SEBACEOUS CYST	68.38	09/17/2014
V76.12	OTHER SCREENING MAMMOGRAM	223.32	10/20/2014

GROUP: 2001025 SSN: ********** SEQ: ** DIV: 0001 RELAT: Participant EFF: ********** DOB: ********** TERM: **********
LEVEL: F99 PLAN: WILCO-MED-DED

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	00-*	250000.00	21.89	54731.24	.00	.00	.00	.00

==========Diagnosis Recap==========

Amount	Code	Description
$32,440.75	871.2	RUPTURE OF EYE WITH PARTIAL LOSS OF INTRAOCULAR TISSUE
$3,978.25	371.03	CENTRAL OPACITY OF CORNEA
$3,845.06	379.23	VITREOUS HEMORRHAGE
$3,124.94	812.00	FRACTURE OF UNSPECIFIED PART OF UPPER END OF HUMERUS, CLOSED
$3,066.77	V57.1	CARE INVOLVING OTHER PHYSICAL THERAPY
$1,639.02	372.64	SCARRING OF CONJUNCTIVA
$1,496.00	870.1	LACERATION OF EYELID, FULL-THICKNESS, NOT INVOLVING LACRIMAL PASSAGES
$1,096.12	959.8	OTHER AND UNSPECIFIED INJURY TO OTHER SPECIFIED SITES, INCLUDING MULTIPLE
$1,042.00	847.0	NECK SPRAIN
$890.70	812.01	FRACTURE OF SURGICAL NECK OF HUMERUS, CLOSED
$363.36	DRUGS	PRESCRIPTION DRUGS
$318.64	401.9	UNSPECIFIED ESSENTIAL HYPERTENSION
$205.56	V76.12	OTHER SCREENING MAMMOGRAM
$188.07	719.41	PAIN IN JOINT INVOLVING SHOULDER REGION
$168.19	V45.69	STATES FOLLOWING SURGERY OF EYE/ADNEXA OTHER STATES FOLLOWING SURGERY
$152.48	V72.31	ROUTINE GYNECOLOGICAL EXAM
$144.07	959.12	OTHER INJURY OF ABDOMEN
$112.16	959.11	OTHER INJURY OF CHEST WALL
$89.50	959.09	INJURY OF FACE AND NECK
$76.67	999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEWHERE CLASSIFIED
$71.82	V70.0	ROUTINE GENERAL MEDICAL EXAMINATION AT AHEALTH CARE FACILITY
$65.72	959.01	HEAD INJURY, UNSPECIFIED
$54.45	V04.81	NEED FOR PROPHYLACTIC VACCINATION/ INOCULATION AGAINST, INFLUENZA
$49.10	362.53	CYSTOID MACULAR DEGENERATION OF RETINA
$26.48	V54.11	AFTERCARE FOR HEALING TRAUMATIC FRACTURE OF UPPER ARM
$13.79	861.21	CONTUSION OF LUNG WITHOUT OPEN WOUND INTO THORAX
$11.57	812.09	OTHER CLOSED FRACTURES OF UPPER END OF HUMERUS

$54,731.24 Total Paid

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
959.11	OTHER INJURY OF CHEST WALL	112.16	01/16/2014
847.0	NECK SPRAIN	1042.00	11/06/2013
922.1	CONTUSION OF CHEST WALL		11/06/2013
V70.0	ROUTINE GENERAL MEDICAL EXAMINATION AT A	71.82	12/18/2013
V72.31	ROUTINE GYNECOLOGICAL EXAM	152.48	12/18/2013
DRUGS	PRESCRIPTION DRUGS	363.36	10/07/2014
871.2	RUPTURE OF EYE WITH PARTIAL LOSS OF INTR	32440.75	06/24/2014
870.0	LACERATION OF SKIN OF EYELID AND PERIOCU		01/16/2014
921.9	UNSPECIFIED CONTUSION OF EYE		04/03/2014
379.23	VITREOUS HEMORRHAGE	3845.06	06/24/2014
379.31	APHAKIA		06/24/2014
743.45	ANIRIDIA		01/22/2014
401.9	UNSPECIFIED ESSENTIAL HYPERTENSION	318.64	10/20/2014
530.81	ESOPHAGEAL REFLUX		01/22/2014
V76.12	OTHER SCREENING MAMMOGRAM	205.56	09/30/2014
V54.11	AFTERCARE FOR HEALING TRAUMATIC	26.48	06/11/2014
812.00	FRACTURE OF UNSPECIFIED PART OF UPPER EN	3124.94	01/19/2014
861.21	CONTUSION OF LUNG WITHOUT OPEN WOUND INT	13.79	01/19/2014
376.40	DEFORMITY OF ORBIT, UNSPECIFIED		01/16/2014
E812.0	OTHER MOTOR VEHICLE TRAFFIC ACCIDENT INV		01/19/2014
959.12	OTHER INJURY OF ABDOMEN	144.07	01/16/2014
870.1	LACERATION OF EYELID, FULL-THICKNESS, NO	1496.00	01/17/2014

10/31/14 Allegiance Benefit Plan Management, Inc. PAGE: 31
LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

812.09	OTHER CLOSED FRACTURES OF UPPER END OF H	11.57	01/16/2014
959.09	INJURY OF FACE AND NECK	89.50	01/16/2014
959.01	HEAD INJURY, UNSPECIFIED	65.72	01/16/2014
338.18	OTHER ACUTE POSTOPERATIVE PAIN		01/19/2014
V45.69	STATES FOLLOWING SURGERY OF EYE/ADNEXA	168.19	06/24/2014

10/31/14 Allegiance Benefit Plan Management, Inc. PAGE: 32
LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 02 11/01/2013 to 10/31/2014 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
807.01	CLOSED FRACTURE OF ONE RIB		01/19/2014
813.01	FRACTURE OF OLECRANON PROCESS OF ULNA, C		01/17/2014
959.8	OTHER AND UNSPECIFIED INJURY TO OTHER SP	1096.12	01/16/2014
812.01	FRACTURE OF SURGICAL NECK OF HUMERUS, CL	890.70	07/10/2014
719.41	PAIN IN JOINT INVOLVING SHOULDER REGION	188.07	07/10/2014
999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEW	76.67	02/06/2014
244.9	UNSPECIFIED ACQUIRED HYPOTHYROIDISM		10/20/2014
553.3	DIAPHRAGMATIC HERNIA WITHOUT MENTION OF		04/03/2014
272.4	OTHER AND UNSPECIFIED HYPERLIPIDEMIA		10/20/2014
268.9	UNSPECIFIED VITAMIN D DEFICIENCY		05/09/2014
362.53	CYSTOID MACULAR DEGENERATION OF RETINA	49.10	05/23/2014
371.03	CENTRAL OPACITY OF CORNEA	3978.25	08/13/2014
372.64	SCARRING OF CONJUNCTIVA	1639.02	08/13/2014
V57.1	CARE INVOLVING OTHER PHYSICAL THERAPY	3066.77	06/11/2014
719.51	STIFFNESS OF JOINT, NOT ELSEWHERE CLASSI		06/11/2014
V04.81	NEED FOR PROPHYLACTIC VACCINATION/	54.45	10/20/2014

GROUP: 2001025 SSN: ********** SEQ: ** DIV: RETR RELAT: Participant EFF: ********** DOB: ********** TERM: **********
LEVEL: F99 PLAN: WILCO-MED-CORE

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	00-*	250000.00	12.91	32286.66	.00	.00	.00	.00

==========Diagnosis Recap==========

Amount	Code	Description
$22,309.78	715.35	OSTEOARTHROSIS, LOCALIZED, INVOLVING PELVIC REGION/HIP
$3,343.20	DRUGS	PRESCRIPTION DRUGS
$1,917.96	715.95	OSTEOARTHROSIS, UNSPECIFIED, INVOLVING PELVIC REGION/HIP
$1,617.09	715.15	OSTEOARTHROSIS, LOCALIZED, PRIMARY, INVOLVING PELVIC REGION AND THIGH
$1,242.53	781.2	ABNORMALITY OF GAIT
$603.97	719.45	PAIN IN JOINT INVOLVING PELVIC REGION AND THIGH
$575.00	999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEWHERE CLASSIFIED
$316.99	715.90	OSTEOARTHROSIS, UNSPECIFIED WHETHER GENERALIZED OR LOCALIZED, INVOLVING UNSPECIF
$142.71	401.1	BENIGN ESSENTIAL HYPERTENSION
$102.59	346.10	Mgn w/o aura not intrac w/o status
$63.48	680.0	CARBUNCLE AND FURUNCLE OF FACE
$34.24	V54.81	AFTERCARE FOLLOWING JOINT REPLACEMENT
$17.12	V72.82	PREOP RESPIRATORY EXAM

$32,286.66 Total Paid

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
DRUGS	PRESCRIPTION DRUGS	3343.20	10/14/2014
401.1	BENIGN ESSENTIAL HYPERTENSION	142.71	12/19/2013
493.90	ASTHMA, UNSPECIFIED TYPE		02/20/2014
715.15	OSTEOARTHROSIS, LOCALIZED, PRIMARY, INVO	1617.09	03/13/2014
680.0	CARBUNCLE AND FURUNCLE OF FACE	63.48	02/10/2014
715.95	OSTEOARTHROSIS, UNSPECIFIED, INVOLVING	1917.96	02/20/2014
V43.64	JOINT;HIP		07/02/2014
715.90	OSTEOARTHROSIS, UNSPECIFIED WHETHER GENE	316.99	02/20/2014
401.9	UNSPECIFIED ESSENTIAL HYPERTENSION		02/20/2014
296.40	BIPOLAR AFFECTIVE DISORDER, MANIC, UNSPE		02/20/2014
715.35	OSTEOARTHROSIS, LOCALIZED, INVOLVING	22309.78	02/20/2014
296.80	BIPOLAR DISORDER,UNSPECIFIED		02/20/2014
V72.82	PREOP RESPIRATORY EXAM	17.12	02/11/2014
V54.81	AFTERCARE FOLLOWING JOINT REPLACEMENT	34.24	02/18/2014
719.45	PAIN IN JOINT INVOLVING PELVIC REGION AN	603.97	07/02/2014
999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEW	575.00	04/25/2014
781.2	ABNORMALITY OF GAIT	1242.53	03/13/2014
346.10	Mgn w/o aura not intrac w/o status	102.59	05/13/2014
722.10	DISPLACEMENT OF LUMBAR INTERVERTEBRAL DI		05/13/2014
323.9	UNSPECIFIED CAUSE OF ENCEPHALITIS		05/13/2014

GROUP: 2001025 SSN: ********** SEQ: ** DIV: 0001 RELAT: Child EFF: ********** DOB: ********** TERM: **********
LEVEL: P99 PLAN: WILCO-MED-CORE

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	11-*	250000.00	10.85	27127.11	.00	.00	.00	.00

==========Diagnosis Recap==========

Amount	Code	Description
$23,520.34	540.9	ACUTE APPENDICITIS WITHOUT MENTION OF PERITONITIS
$1,785.05	541	APPENDICITIS, UNQUALIFIED
$1,345.50	540.0	ACUTE APPENDICITIS WITH GENERALIZED PERITONITIS
$265.20	789.03	OTHER SYMPTOMS INVOLVING ABDOMEN AND PELVIS
$102.02	784.1	THROAT PAIN
$56.56	789.09	OTHER SYMPTOMS INVOLVING ABDOMEN AND PELVIS
$45.82	789.00	OTHER SYMPTOMS INVOLVING ABDOMEN AND PELVIS
$6.62	462	ACUTE PHARYNGITIS

$27,127.11 Total Paid

10/31/14 Allegiance Benefit Plan Management, Inc. PAGE: 33
LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
784.1	THROAT PAIN	102.02	03/07/2014
462	ACUTE PHARYNGITIS	6.62	05/20/2014
789.09	OTHER SYMPTOMS INVOLVING ABDOMEN AND	56.56	05/20/2014
540.9	ACUTE APPENDICITIS WITHOUT MENTION OF PE	23520.34	05/21/2014
V14.0	Hx, prsnl, penicillin allergy		05/21/2014
789.00	OTHER SYMPTOMS INVOLVING ABDOMEN AND	45.82	05/20/2014

10/31/14 Allegiance Benefit Plan Management, Inc. PAGE: 34
LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 02 11/01/2013 to 10/31/2014 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
541	APPENDICITIS, UNQUALIFIED	1785.05	05/20/2014
789.03	OTHER SYMPTOMS INVOLVING ABDOMEN AND	265.20	05/20/2014
540.0	ACUTE APPENDICITIS WITH GENERALIZED PERI	1345.50	05/20/2014

GROUP: 2001025 SSN: ********** SEQ: ** DIV: 0001 RELAT: Participant EFF: ********** DOB: ********** TERM: **********
LEVEL: P00 PLAN: WILCO-MED-DED-DIAB

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	00-*	250000.00	11.21	28030.26	.00	.00	.00	.00

Diagnosis Recap

Amount	Code	Description
$26,125.69	DRUGS	PRESCRIPTION DRUGS
$603.65	250.00	DIABETES MELLITUS WITHOUT MENTION OF COMPLICATION, TYPE II
$337.01	715.96	OSTEOARTHROSIS, UNSPECIFIED, INVOLVING LOWER LEG/KNEE
$225.00	784.2	Symptom, swelling in head/neck
$205.56	V76.12	OTHER SCREENING MAMMOGRAM
$185.50	250.02	DIABETES MELLITUS WITHOUT MENTION OF COMPLICATION, TYPE II,UNCONTROLLED
$179.45	V72.31	ROUTINE GYNECOLOGICAL EXAM
$100.88	719.46	PAIN IN JOINT INVOLVING LOWER LEG
$35.24	959.7	OTHER AND UNSPECIFIED INJURY TO KNEE, LEG, ANKLE, AND FOOT
$24.28	723.4	BRACHIAL NEURITIS OR RADICULITIS NOS
$8.00	796.2	ELEVATED BLOOD PRESSURE READING WITHOUT DIAGNOSIS OF HYPERTENSION

$28,030.26 Total Paid

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
723.4	BRACHIAL NEURITIS OR RADICULITIS NOS	24.28	10/15/2013
DRUGS	PRESCRIPTION DRUGS	26125.69	10/21/2014
250.02	DIABETES MELLITUS WITHOUT MENTION OF	185.50	07/24/2014
401.1	BENIGN ESSENTIAL HYPERTENSION		07/24/2014
272.4	OTHER AND UNSPECIFIED HYPERLIPIDEMIA		08/27/2014
796.2	ELEVATED BLOOD PRESSURE READING WITHOUT	8.00	11/24/2013
784.2	Symptom, swelling in head/neck	225.00	11/24/2013
250.00	DIABETES MELLITUS WITHOUT MENTION OF	603.65	08/27/2014
244.8	OTHER SPECIFIED ACQUIRED HYPOTHYROIDISM		08/27/2014
401.9	UNSPECIFIED ESSENTIAL HYPERTENSION		08/28/2013
V76.12	OTHER SCREENING MAMMOGRAM	205.56	03/25/2014
V72.31	ROUTINE GYNECOLOGICAL EXAM	179.45	03/25/2014
719.46	PAIN IN JOINT INVOLVING LOWER LEG	100.88	03/26/2014
715.96	OSTEOARTHROSIS, UNSPECIFIED, INVOLVING	337.01	03/26/2014
959.7	OTHER AND UNSPECIFIED INJURY TO KNEE, LE	35.24	08/21/2014

GROUP: 2001025 SSN: ********** SEQ: ** DIV: 0001 RELAT: Participant EFF: ********** DOB: ********** TERM: **********
LEVEL: P99 PLAN: WILCO-MED-DED-DIAB

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	00-*	250000.00	15.30	38254.33	.00	.00	.00	.00

Diagnosis Recap

Amount	Code	Description
$21,494.90	473.9	UNSPECIFIED SINUSITIS (CHRONIC)
$3,547.79	DRUGS	PRESCRIPTION DRUGS
$3,422.45	530.12	ACUTE ESOPHAGITIS
$2,381.23	787.91	OTHER SYMPTOMS INVOLVING DIGESTIVE SYSTEM; DIARRHEA
$1,261.56	569.89	OTHER SPECIFIED DISORDERS OF INTESTINES
$1,227.00	535.10	ATRPH GASTRTIS W/O HMRHG
$1,151.26	789.00	OTHER SYMPTOMS INVOLVING ABDOMEN AND PELVIS
$906.02	478.19	OTHER DISEASES OF UPPER RESPIRATORY TRACT-OTHER DISEASES OF NASAL CAVITY
$714.79	555.0	REGIONAL ENTERITIS OF SMALL INTESTINE
$406.65	473.8	OTHER CHRONIC SINUSITIS
$397.16	535.60	DUODENITIS W/O HMRHG
$227.26	470	DEVIATED NASAL SEPTUM
$185.45	789.02	OTHER SYMPTOMS INVOLVING ABDOMEN AND PELVIS
$151.40	789.07	OTHER SYMPTOMS INVOLVING ABDOMEN AND PELVIS
$148.41	530.81	ESOPHAGEAL REFLUX
$116.35	474.12	HYPERTROPHY OF ADENOIDS ALONE
$82.15	490	BRONCHITIS, NOT SPECIFIED AS ACUTE OR CHRONIC
$77.59	382.00	ACUTE SUPPURATIVE OTITIS MEDIA WITHOUT SPONTANEOUS RUPTURE OF EARDRUM
$71.28	487.8	INFLUENZA WITH OTHER MANIFESTATIONS
$65.63	V72.60	Laboratory examination, unspecified
$59.63	558.9	OTHER AND UNSPECIFIED NONINFECTIOUS GASTROENTERITIS AND COLITIS
$58.68	787.20	DYSPHAGIA, UNSPECIFIED
$30.84	783.21	LOSS OF WEIGHT
$30.76	789.09	OTHER SYMPTOMS INVOLVING ABDOMEN AND PELVIS
$30.16	626.0	ABSENCE OF MENSTRUATION
$7.93	794.8	NONSPECIFIC ABNORMAL RESULTS OF FUNCTIONSTUDY OF LIVER

$38,254.33 Total Paid

Diagnosis Summary for ********** Amount Paid Last D.O.S.

DRUGS	PRESCRIPTION DRUGS	3547.79	10/22/2014
535.60	DUODENITIS W/O HMRHG	397.16	11/07/2013
535.50	GSTR/DDNTS NOS W/O HMRHG		11/07/2013
530.81	ESOPHAGEAL REFLUX	148.41	02/20/2014
789.06	OTHER SYMPTOMS INVOLVING ABDOMEN AND		11/07/2013
787.20	DYSPHAGIA, UNSPECIFIED	58.68	11/07/2013
789.00	OTHER SYMPTOMS INVOLVING ABDOMEN AND	1151.26	05/16/2014
787.91	OTHER SYMPTOMS INVOLVING DIGESTIVE	2381.23	02/07/2014
787.02	OTHER SYMPTOMS OF THE DIGESTIVE SYSTEM;		01/20/2014
530.12	ACUTE ESOPHAGITIS	3422.45	11/06/2013
789.09	OTHER SYMPTOMS INVOLVING ABDOMEN AND	30.76	11/06/2013
569.89	OTHER SPECIFIED DISORDERS OF INTESTINES	1261.56	11/18/2013

10/31/14 Allegiance Benefit Plan Management, Inc. PAGE: 36
LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 02 11/01/2013 to 10/31/2014 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
789.02	OTHER SYMPTOMS INVOLVING ABDOMEN AND	185.45	11/18/2013
535.10	ATRPH GASTRTIS W/O HMRHG	1227.00	11/07/2013
530.19	OTHER ESOPHAGITIS		11/07/2013
783.21	LOSS OF WEIGHT	30.84	02/07/2014
346.90	Migraine NOS w/o migrain w/o status		11/18/2013
487.8	INFLUENZA WITH OTHER MANIFESTATIONS	71.28	12/09/2013
555.0	REGIONAL ENTERITIS OF SMALL INTESTINE	714.79	12/30/2013
382.00	ACUTE SUPPURATIVE OTITIS MEDIA WITHOUT S	77.59	12/27/2013
466.0	ACUTE BRONCHITIS		12/27/2013
462	ACUTE PHARYNGITIS		12/27/2013
490	BRONCHITIS, NOT SPECIFIED AS ACUTE OR CH	82.15	10/10/2013
786.2	COUGH		10/10/2013
558.9	OTHER AND UNSPECIFIED NONINFECTIOUS GAST	59.63	02/07/2014
564.1	IRRITABLE COLON		02/20/2014
008.5	BACTERIAL ENTERITIS, UNSPECIFIED		02/20/2014
473.9	UNSPECIFIED SINUSITIS (CHRONIC)	21494.90	10/13/2014
053.9	HERPES ZOSTER WITHOUT MENTION OF COMPLIC		03/03/2014
V72.60	Laboratory examination, unspecified	65.63	01/27/2014
305.1	TOBACCO USE DISORDER		06/13/2014
794.8	NONSPECIFIC ABNORMAL RESULTS OF FUNCTION	7.93	07/03/2014
337.00	Idpth priph autonom neuro, unspec		10/01/2014
470	DEVIATED NASAL SEPTUM	227.26	09/18/2014
478.19	OTHER DISEASES OF UPPER RESPIRATORY	906.02	10/01/2014
789.07	OTHER SYMPTOMS INVOLVING ABDOMEN AND	151.40	08/11/2014
784.0	HEADACHE		09/18/2014
626.0	ABSENCE OF MENSTRUATION	30.16	08/13/2014
473.8	OTHER CHRONIC SINUSITIS	406.65	09/18/2014
474.12	HYPERTROPHY OF ADENOIDS ALONE	116.35	09/18/2014
327.20	ORGANIC SLEEP APNEA, UNSPECIFIED		10/01/2014

GROUP: 2001025 SSN: ********** SEQ: ** DIV: 0001 RELAT: Participant EFF: ********** DOB: ********** TERM: **********
LEVEL: P00 PLAN: WILCO-MED-DED-DIAB

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	00-*	250000.00	21.32	53307.04	.00	.00	.00	.00

==========Diagnosis Recap==========

Amount	Code	Description
$21,818.52	786.59	OTHER CHEST PAIN
$15,996.11	428.0	CONGESTIVE HEART FAILURE
$6,175.47	DRUGS	PRESCRIPTION DRUGS
$2,622.21	327.23	OBSTRUCTIVE SLEEP APNEA (ADULT) (PEDIATRIC)
$2,384.51	786.50	UNSPECIFIED CHEST PAIN
$1,774.27	789.09	OTHER SYMPTOMS INVOLVING ABDOMEN AND PELVIS
$726.15	428.30	DIASTOLIC HEART FAILURE UNSPECIFIED
$584.89	518.4	ACUTE EDEMA OF LUNG, UNSPECIFIED
$381.36	428.41	COMBINED SYSTOLIC AND DIASTOLIC HEART FAILURE ACUTE
$308.91	784.0	HEADACHE
$266.43	747.81	CONGENITAL ANOMALIES OF CEREBROVASCULAR SYSTEM
$77.59	272.0	PURE HYPERCHOLESTEROLEMIA
$77.59	401.1	BENIGN ESSENTIAL HYPERTENSION
$53.44	729.81	SWELLING OF LIMB
$45.80	250.00	DIABETES MELLITUS WITHOUT MENTION OF COMPLICATION, TYPE II
$13.79	514	PULMONARY CONGESTION AND HYPOSTASIS

$53,307.04 Total Paid

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
428.30	DIASTOLIC HEART FAILURE UNSPECIFIED	726.15	09/10/2013
403.90	HYPERTENSIVE KIDNEY DISEASE, UNSPECIFIED		09/10/2013
414.00	CORONARY ATHEROSCLEROSIS OF UNSPECIFIED		09/10/2013
278.00	OBESITY, UNSPECIFIED		09/10/2013

10/31/14 Allegiance Benefit Plan Management, Inc. PAGE: 37
LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 02 11/01/2013 to 10/31/2014 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
585.9	CHRONIC KIDNEY DISEASE, UNSPECIFIED		10/13/2014
327.23	OBSTRUCTIVE SLEEP APNEA (ADULT)	2622.21	09/27/2014
416.8	OTHER CHRONIC PULMONARY HEART DISEASES		09/27/2014
DRUGS	PRESCRIPTION DRUGS	6175.47	10/15/2014
401.1	BENIGN ESSENTIAL HYPERTENSION	77.59	03/27/2014
250.00	DIABETES MELLITUS WITHOUT MENTION OF	45.80	10/14/2014
272.0	PURE HYPERCHOLESTEROLEMIA	77.59	03/27/2014
300.02	GENERALIZED ANXIETY DISORDER		03/27/2014
311	DEPRESSIVE DISORDER, NOT ELSEWHERE CLASS		03/27/2014
786.50	UNSPECIFIED CHEST PAIN	2384.51	05/06/2014
428.23	SYSTOLIC HEART FAILURE ACUTE ON CHRONIC		05/06/2014
784.0	HEADACHE	308.91	05/04/2014
428.0	CONGESTIVE HEART FAILURE	15996.11	10/14/2014
786.59	OTHER CHEST PAIN	21818.52	05/06/2014
786.05	SHORTNESS OF BREATH		10/10/2014
514	PULMONARY CONGESTION AND HYPOSTASIS	13.79	10/11/2014
412	OLD MYOCARDIAL INFARCTION		05/06/2014
747.81	CONGENITAL ANOMALIES OF CEREBROVASCULAR	266.43	05/06/2014
276.69	Other fluid overload		05/06/2014
729.81	SWELLING OF LIMB	53.44	05/01/2014
789.09	OTHER SYMPTOMS INVOLVING ABDOMEN AND	1774.27	06/03/2014
599.0	URINARY TRACT INFECTION, SITE NOT SPECIF		06/03/2014
401.9	UNSPECIFIED ESSENTIAL HYPERTENSION		10/14/2014
786.09	OTHER DYSPNEA AND RESPIRATORY ABNORMALIT		05/01/2014
428.41	COMBINED SYSTOLIC AND DIASTOLIC HEART	381.36	10/14/2014
782.3	EDEMA		10/14/2014
584.9	Acute kidney failure, unspecified		10/14/2014
427.31	ATRIAL FIBRILLATION		10/14/2014
V85.42	BMI 45.0-49.9, adult		10/14/2014
403.10	HYPERTENSIVE KIDNEY DISEASE, BENIGN,		10/14/2014
518.4	ACUTE EDEMA OF LUNG, UNSPECIFIED	584.89	10/10/2014

GROUP: 2001025 SSN: ********** SEQ: ** DIV: 0001 RELAT: Child EFF: ********** DOB: ********** TERM: **********
LEVEL: F99 PLAN: WILCO-MED-DED

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	12-*	250000.00	16.77	41936.08	.00	.00	.00	.00

==========Diagnosis Recap==========

Amount	Code	Description
$29,917.74	359.1	HEREDITARY PROGRESSIVE MUSCULAR DYSTROPHY
$7,756.12	359.0	CONGENITAL HEREDITARY MUSCULAR DYSTROPHY
$4,262.22	999.9	OTHER AND UNSPECIFIED COMPLICATIONS OF MEDICAL CARE, NOT ELSEWHERE CLASSIFIED

$41,936.08 Total Paid

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
359.1	HEREDITARY PROGRESSIVE MUSCULAR DYSTROPH	29917.74	09/29/2014
327.23	OBSTRUCTIVE SLEEP APNEA (ADULT)		09/29/2014
359.0	CONGENITAL HEREDITARY MUSCULAR DYSTROPHY	7756.12	04/11/2014
999.9	OTHER AND UNSPECIFIED COMPLICATIONS OF M	4262.22	04/11/2014

GROUP: 2001025 SSN: ********** SEQ: ** DIV: 0001 RELAT: Spouse EFF: ********** DOB: ********** TERM: **********
LEVEL: F00 PLAN: WILCO-MED-CORE

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	01-*	250000.00	18.68	46691.08	.00	.00	.00	.00

==========Diagnosis Recap==========

Amount	Code	Description
$34,226.63	486	PNEUMONIA, ORGANISM UNSPECIFIED
$9,970.99	562.11	DIVERTICULITIS OF COLON
$1,287.00	DRUGS	PRESCRIPTION DRUGS
$423.00	562.10	DIVERTICULOSIS OF COLON
$205.56	V76.12	OTHER SCREENING MAMMOGRAM
$171.23	789.00	OTHER SYMPTOMS INVOLVING ABDOMEN AND PELVIS
$170.11	V72.31	ROUTINE GYNECOLOGICAL EXAM
$127.52	V72.60	Laboratory examination, unspecified
$47.91	780.79	OTHER MALAISE AND FATIGUE
$33.76	789.04	OTHER SYMPTOMS INVOLVING ABDOMEN AND PELVIS
$27.37	786.05	SHORTNESS OF BREATH

$46,691.08 Total Paid

Diagnosis Summary for ********** Amount Paid Last D.O.S.

DRUGS	PRESCRIPTION DRUGS	1287.00	10/21/2014
V72.31	ROUTINE GYNECOLOGICAL EXAM	170.11	03/26/2014
627.2	MENOPAUSAL OR FEMALE CLIMACTERIC STATES		03/24/2014
V76.12	OTHER SCREENING MAMMOGRAM	205.56	03/24/2014
V77.91	SCREENING FOR LIPOID DISORDERS		03/26/2014
789.00	OTHER SYMPTOMS INVOLVING ABDOMEN AND	171.23	09/16/2014
562.11	DIVERTICULITIS OF COLON	9970.99	09/18/2014
789.04	OTHER SYMPTOMS INVOLVING ABDOMEN AND	33.76	09/17/2014
V72.60	Laboratory examination, unspecified	127.52	09/28/2014
562.10	DIVERTICULOSIS OF COLON	423.00	09/17/2014
486	PNEUMONIA, ORGANISM UNSPECIFIED	34226.63	10/20/2014
799.02	HYPOXEMIA		09/30/2014
560.81	INTESTINAL OR PERITONEAL ADHESIONS WITH		09/16/2014
288.60	NEUTROPENIA-LEUKOCYTOSIS, UNSPECIFIED		09/30/2014
305.1	TOBACCO USE DISORDER		09/30/2014
V45.89	OTHER POSTSURGICAL STATUS		09/30/2014
786.05	SHORTNESS OF BREATH	27.37	09/24/2014
786.07	DYSPNEA AND RESPIRATORY ABNORMALITIES;		09/24/2014

10/31/14 Allegiance Benefit Plan Management, Inc. PAGE: 39
LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 02 11/01/2013 to 10/31/2014 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

Diagnosis Summary for **********	Amount Paid	Last D.O.S.
780.79 OTHER MALAISE AND FATIGUE	47.91	10/07/2014
272.4 OTHER AND UNSPECIFIED HYPERLIPIDEMIA		10/07/2014

GROUP: 2001025 SSN: ********** SEQ: ** DIV: 0001 RELAT: Participant EFF: ********** DOB: ********** TERM: **********
LEVEL: F00 PLAN: WILCO-MED-CORE

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	00-*	250000.00	94.73	236837.49	.00	.00	.00	.00

Diagnosis Recap

Amount	Code	Description
$108,498.70	996.77	OTHER COMPLICATIONS DUE TO INTERNAL JOINT PROSTHESIS
$101,050.59	996.42	DISLOCATION OF PROSTHETIC JOINT
$6,387.57	DRUGS	PRESCRIPTION DRUGS
$4,918.20	V57.1	CARE INVOLVING OTHER PHYSICAL THERAPY
$3,523.08	338.18	OTHER ACUTE POSTOPERATIVE PAIN
$2,930.97	V54.81	AFTERCARE FOLLOWING JOINT REPLACEMENT
$2,488.16	V58.78	AFTERCARE FOLLOWING SURGERY OF THE MUSCULOSKELETAL SYSTEM, NEC
$2,095.35	996.66	INFECTION AND INFLAMMATORY REACTION DUE TO INTERNAL JOINT PROSTHESIS
$1,536.51	924.10	CONTUSION OF LOWER LEG
$805.00	999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEWHERE CLASSIFIED
$573.00	692.9	CONTACT DERMATITIS AND OTHER ECZEMA, UNSPECIFIED CAUSE
$569.71	427.31	ATRIAL FIBRILLATION
$559.63	719.46	PAIN IN JOINT INVOLVING LOWER LEG
$365.12	924.9	CONTUSION OF UNSPECIFIED SITE
$229.90	786.50	UNSPECIFIED CHEST PAIN
$152.23	719.41	PAIN IN JOINT INVOLVING SHOULDER REGION
$102.59	996.47	OTHER MECHANICAL COMPLICATION OF PROSTHETIC JOINT IMPLANT
$24.70	729.81	SWELLING OF LIMB
$13.24	823.00	CLOSED FRACTURE OF UPPER END OF TIBIA
$13.24	V54.16	AFTERCARE FOR HEALING TRAUMATIC FRACTUREOF LOWER LEG

$236,837.49 Total Paid

Diagnosis Summary for **********	Amount Paid	Last D.O.S.
719.46 PAIN IN JOINT INVOLVING LOWER LEG	559.63	09/19/2014
V43.65 JOINT;KNEE		09/19/2014
786.50 UNSPECIFIED CHEST PAIN	229.90	08/03/2013
DRUGS PRESCRIPTION DRUGS	6387.57	10/22/2014
719.41 PAIN IN JOINT INVOLVING SHOULDER REGION	152.23	11/19/2013
427.31 ATRIAL FIBRILLATION	569.71	07/11/2014
401.1 BENIGN ESSENTIAL HYPERTENSION		12/04/2013
996.42 DISLOCATION OF PROSTHETIC JOINT	101050.59	12/04/2013
729.81 SWELLING OF LIMB	24.70	12/08/2013
999 COMPLICATIONS OF MEDICAL CARE, NOT ELSEW	805.00	02/03/2014
338.18 OTHER ACUTE POSTOPERATIVE PAIN	3523.08	09/19/2014
V58.78 AFTERCARE FOLLOWING SURGERY OF THE	2488.16	06/18/2014
V54.81 AFTERCARE FOLLOWING JOINT REPLACEMENT	2930.97	08/25/2014
715.16 OSTEOARTHROSIS, LOCALIZED, PRIMARY, INVO		03/25/2014
717.84 OLD DISRUPTION OF POSTERIOR CRUCIATE LIG		12/04/2013
427.69 PREMATURE BEATS		12/04/2013
924.10 CONTUSION OF LOWER LEG	1536.51	12/08/2013
V45.89 OTHER POSTSURGICAL STATUS		12/08/2013
924.9 CONTUSION OF UNSPECIFIED SITE	365.12	12/08/2013
729.5 PAIN IN LIMB		12/08/2013
E928.9 UNSPECIFIED ACCIDENT		12/08/2013
E849.9 ACCIDENTS OCCURRING IN UNSPECIFIED PLACE		12/08/2013
996.47 OTHER MECHANICAL COMPLICATION OF	102.59	05/14/2014
V87.02 Cont w/+ susp expos uranium		06/04/2014
692.9 CONTACT DERMATITIS AND OTHER ECZEMA, UNS	573.00	03/25/2014
995.3 ALLERGY, UNSPECIFIED, NOT ELSEWHERE CLAS		03/25/2014
996.66 INFECTION AND INFLAMMATORY REACTION DUE	2095.35	05/21/2014
996.77 OTHER COMPLICATIONS DUE TO INTERNAL JOIN	108498.70	05/24/2014
327.23 OBSTRUCTIVE SLEEP APNEA (ADULT)		05/23/2014
V54.16 AFTERCARE FOR HEALING TRAUMATIC FRACTURE	13.24	05/21/2014
823.00 CLOSED FRACTURE OF UPPER END OF TIBIA	13.24	05/21/2014
285.1 ACUTE POSTHEMORRHAGIC ANEMIA		05/24/2014
V85.43 BMI 50.0-59.9, adult		05/24/2014
998.89 OTHER COMPLICATIONS OF PROCEDURES NOT		05/24/2014
996.67 INFECTION AND INFLAMMATORY REACTION DUE		06/18/2014
V58.49 OTHER SPECIFIED AFTERCARE FOLLOWING		06/18/2014
V57.1 CARE INVOLVING OTHER PHYSICAL THERAPY	4918.20	09/19/2014
719.7 DIFFICULTY IN WALKING		07/18/2014

10/31/14 Allegiance Benefit Plan Management, Inc. PAGE: 40
LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 02 11/01/2013 to 10/31/2014 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

Diagnosis Summary for **********	Amount Paid	Last D.O.S.
719.56 STIFFNESS OF JOINT, NOT ELSEWHERE CLASSI		07/18/2014
781.2 ABNORMALITY OF GAIT		07/18/2014
781.3 LACK OF COORDINATION		09/19/2014

GROUP: 2001025 SSN: ********** SEQ: ** DIV: 0001 RELAT: Participant EFF: ********** DOB: ********** TERM: **********
LEVEL: P99 PLAN: WILCO-MED-CORE-DIAB

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	00-*	250000.00	100.00	311963.52	61963.52	.00	50369.56	11593.96

Diagnosis Recap

Amount	Code	Description
$168,826.20	585.6	END STAGE RENAL DISEASE
$58,449.76	428.23	SYSTOLIC HEART FAILURE ACUTE ON CHRONIC
$28,861.44	414.01	CORONARY ATHEROSCLEROSIS;OF NATIVE CORONARY ARTERY
$19,691.58	V57.89	CARE INVOLVING OTHER SPECIFIED REHABILITATION PROCEDURE
$8,545.45	DRUGS	PRESCRIPTION DRUGS
$7,215.03	V72.83	OTH SPCF PREOP EXAM
$3,121.77	996.1	MECHANICAL COMPLICATION OF OTHER VASCULAR DEVICE, IMPLANT, AND GRAFT
$2,969.70	584.9	Acute kidney failure, unspecified
$2,516.56	403.91	HYPERTENSIVE KIDNEY DISEASE, UNSPECIFIEDWITH CHRONIC KIDNEY DISEASE
$2,329.04	998.11	HEMATOMA;SEROMA COMPLICATING A PROCEDUREHEMORRHAGE COMPLICATING A PROCEDURE
$1,609.99	999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEWHERE CLASSIFIED
$1,488.68	586	RENAL FAILURE, UNSPECIFIED
$869.72	780.60	Symptom, fever, unspecified
$760.41	996.73	OTHER COMPLICATIONS DUE TO RENAL DIALYSIS DEVICE, IMPLANT, AND GRAFT
$712.36	348.31	METABOLIC ENCEPHALOPATHY
$620.43	250.00	DIABETES MELLITUS WITHOUT MENTION OF COMPLICATION, TYPE II
$610.35	403.90	HYPERTENSIVE KIDNEY DISEASE, UNSPECIFIEDWITHOUT CHRONIC KIDNEY DISEASE
$485.80	996.74	OTHER COMPLICATIONS DUE TO OTHER VASCULAR DEVICE, IMPLANT, AND GRAFT
$378.29	401.9	UNSPECIFIED ESSENTIAL HYPERTENSION
$282.59	280.9	IRON DEFICIENCY ANEMIA, UNSPECIFIED
$273.62	995.91	SIRS-DUE TO INFECTIOUS PROCESS WITHOUT ORGAN DYSFUNCTION
$259.36	487.1	INFLUENZA WITH OTHER RESPIRATORY MANIFESTATIONS
$170.80	564.00	CONSTIPATION, UNSPECIFIED
$170.70	428.30	DIASTOLIC HEART FAILURE UNSPECIFIED
$148.14	401.0	MALIGNANT ESSENTIAL HYPERTENSION
$117.35	707.05	Ulcer, pressure, buttock
$106.42	428.0	CONGESTIVE HEART FAILURE
$62.63	588.89	OTHER SPECIFIED DISORDERS RESULTING FROMIMPAIRED RENAL FUNCTION
$56.92	593.9	UNSPECIFIED DISORDER OF KIDNEY AND URETER
$56.16	780.99	OTHER GENERAL SYMPTOMS:CHILLS, GENERALZDPAIN,HYPOTHERMIA,NOT ASSOC W/ LOW ENVIRO
$46.00	404.01	MALIGNANT HYPERTENSIVE HEART AND RENAL DISEASE, WITH CONGESTIVE HEART FAILURE
$40.14	272.4	OTHER AND UNSPECIFIED HYPERLIPIDEMIA
$27.58	V58.82	FITTING AND ADJUSTMENT OF NONVASCULAR CATHETER, NEC
$27.58	429.3	CARDIOMEGALY
$17.12	786.7	ABNORMAL CHEST SOUNDS
$14.41	427.31	ATRIAL FIBRILLATION
$13.79	V53.31	CARDIAC DEVICE;CARDIAC PACEMAKER
$9.65	786.2	COUGH
$311,963.52	Total Paid	

Diagnosis Summary for **********	Amount Paid	Last D.O.S.
DRUGS PRESCRIPTION DRUGS	8545.45	10/23/2014
487.1 INFLUENZA WITH OTHER RESPIRATORY MANIFES	259.36	01/27/2014
401.0 MALIGNANT ESSENTIAL HYPERTENSION	148.14	02/19/2014
586 RENAL FAILURE, UNSPECIFIED	1488.68	05/05/2014
786.2 COUGH	9.65	01/25/2014
348.31 METABOLIC ENCEPHALOPATHY	712.36	02/27/2014
585.6 END STAGE RENAL DISEASE	168826.20	10/18/2014
429.3 CARDIOMEGALY	27.58	01/28/2014
V53.31 CARDIAC DEVICE;CARDIAC PACEMAKER	13.79	01/29/2014
428.30 DIASTOLIC HEART FAILURE UNSPECIFIED	170.70	01/26/2014
790.5 OTHER NONSPECIFIC ABNORMAL SERUM ENZYME		01/26/2014
401.9 UNSPECIFIED ESSENTIAL HYPERTENSION	378.29	08/29/2014
V58.82 FITTING AND ADJUSTMENT OF NONVASCULAR	27.58	01/31/2014
428.0 CONGESTIVE HEART FAILURE	106.42	08/01/2014
584.9 Acute kidney failure, unspecified	2969.70	02/19/2014
403.90 HYPERTENSIVE KIDNEY DISEASE, UNSPECIFIED	610.35	02/20/2014
404.01 MALIGNANT HYPERTENSIVE HEART AND RENAL D	46.00	01/31/2014
593.9 UNSPECIFIED DISORDER OF KIDNEY AND URETE	56.92	01/30/2014
280.9 IRON DEFICIENCY ANEMIA, UNSPECIFIED	282.59	04/05/2014
428.23 SYSTOLIC HEART FAILURE ACUTE ON CHRONIC	58449.76	02/20/2014
414.01 CORONARY ATHEROSCLEROSIS;OF NATIVE	28861.44	09/08/2014
402.01 MALIGNANT HYPERTENSIVE HEART DISEASE WIT		02/20/2014
038.9 UNSPECIFIED SEPTICEMIA		01/30/2014
995.91 SIRS-DUE TO INFECTIOUS PROCESS WITHOUT	273.62	03/06/2014
780.99 OTHER GENERAL SYMPTOMS:CHILLS, GENERALZD	56.16	01/30/2014

10/31/14 Allegiance Benefit Plan Management, Inc. PAGE: 41
LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 02 11/01/2013 to 10/31/2014 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
V57.89	CARE INVOLVING OTHER SPECIFIED REHABILIT	19691.58	02/19/2014
588.89	OTHER SPECIFIED DISORDERS RESULTING FROM	62.63	02/20/2014
707.05	Ulcer, pressure, buttock	117.35	02/26/2014
250.00	DIABETES MELLITUS WITHOUT MENTION OF	620.43	09/08/2014
786.7	ABNORMAL CHEST SOUNDS	17.12	02/16/2014
V45.11	Renal dialysis status		08/21/2014
V56.0	AFTERCARE INVOLVING EXTRACORPOREAL DIALY		08/26/2014
286.9	COAGULATION DEFECTS		10/18/2014
285.21	ANEMIA IN CHRONIC KIDNEY DISEASE		10/18/2014
403.10	HYPERTENSIVE KIDNEY DISEASE, BENIGN,		02/19/2014
999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEW	1609.99	09/25/2014
459.81	VENOUS (PERIPHERAL) INSUFFICIENCY, UNSPE		01/29/2014
780.60	Symptom, fever, unspecified	869.72	01/28/2014
466.0	ACUTE BRONCHITIS		01/25/2014
782.3	EDEMA		01/25/2014
588.0	RENAL OSTEODYSTROPHY		05/20/2014
272.0	PURE HYPERCHOLESTEROLEMIA		08/01/2014
244.9	UNSPECIFIED ACQUIRED HYPOTHYROIDISM		08/01/2014
403.91	HYPERTENSIVE KIDNEY DISEASE, UNSPECIFIED	2516.56	09/09/2014
305.1	TOBACCO USE DISORDER		07/21/2014
564.00	CONSTIPATION, UNSPECIFIED	170.80	06/14/2014
996.1	MECHANICAL COMPLICATION OF OTHER VASCULA	3121.77	07/21/2014
996.73	OTHER COMPLICATIONS DUE TO RENAL DIALYSI	760.41	07/21/2014
272.4	OTHER AND UNSPECIFIED HYPERLIPIDEMIA	40.14	08/01/2014
V67.51	FOLLOW-UP EXAMINATION FOLLOWING TREATMEN		09/08/2014
V72.83	OTH SPCF PREOP EXAM	7215.03	09/08/2014
588.81	SECONDARY HYPERPARATHYROIDISM(OF RENAL		08/29/2014
250.40	DIABETES WITH RENAL MANIFESTATION,TYPE		08/29/2014
404.10	HYPERTENSIVE HEART AND KIDNEY DISEASE,		08/29/2014
998.11	HEMATOMA;SEROMA COMPLICATING A PROCEDURE	2329.04	09/09/2014
996.72	OTHER COMPLICATIONS DUE TO OTHER CARDIAC		09/09/2014
V45.82	OTHER POSTSURGICAL STATUS;PERCUTANEOUS		09/09/2014
V45.09	CARDIAC DEVICE IN SITU;OTHER SPECIFIED		09/09/2014
996.74	OTHER COMPLICATIONS DUE TO OTHER VASCULA	485.80	09/09/2014
427.31	ATRIAL FIBRILLATION	14.41	09/08/2014
V72.81	PREOP CARDIOVSCLR EXAM		09/08/2014
V06.6	STREPTOCOCCUS PNEUMONIAE AND INFLUENZA		10/18/2014

GROUP: 2001025 SSN: ********** SEQ: ** DIV: 0002 RELAT: Participant EFF: ********** DOB: ********** TERM: **********
LEVEL: F00 PLAN: WILCO-MED-DED-DIAB

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	00-*	250000.00	17.67	44182.01	.00	.00	.00	.00

==========Diagnosis Recap==========

Amount	Code	Description
$17,546.91	DRUGS	PRESCRIPTION DRUGS
$9,479.80	433.10	OCL CRTD ART WO INFRCT
$4,014.09	250.02	DIABETES MELLITUS WITHOUT MENTION OF COMPLICATION, TYPE II,UNCONTROLLED
$3,942.58	707.15	Ulcer, other part of foot
$2,417.74	250.60	DIABETES WITH NEUROLOGICAL MANIFESTATIONS,TYPE II,UNSPECIFIED TYPE
$1,929.70	707.14	Ulcer, heel and midfoot
$1,630.29	401.1	BENIGN ESSENTIAL HYPERTENSION
$1,273.19	730.10	CHRONIC OSTEOMYELITIS, SITE UNSPECIFIED
$513.02	257.2	OTHER TESTICULAR HYPOFUNCTION
$460.66	250.92	DIABETES WITH OTHER UNSPECIFIED COMPLICATION,TYPE II OR UNSPEC TYPE,UNCONTROLLED
$317.09	402.10	BENIGN HYPERTENSIVE HEART DISEASE WITHOUT CONGESTIVE HEART FAILURE
$133.26	250.00	DIABETES MELLITUS WITHOUT MENTION OF COMPLICATION, TYPE II
$109.05	730.27	UNSPECIFIED OSTEOMYELITIS INVOLVING ANKLE AND FOOT
$103.88	786.50	UNSPECIFIED CHEST PAIN
$75.98	518.89	OTHER DISEASES OF LUNG, NOT ELSEWHERE CLASSIFIED
$66.83	443.9	PERIPHERAL VASCULAR DISEASE, UNSPECIFIED
$54.13	462	ACUTE PHARYNGITIS
$54.13	473.9	UNSPECIFIED SINUSITIS (CHRONIC)
$34.79	401.9	UNSPECIFIED ESSENTIAL HYPERTENSION
$8.57	V72.81	PREOP CARDIOVSCLR EXAM
$8.16	414.01	CORONARY ATHEROSCLEROSIS;OF NATIVE CORONARY ARTERY
$8.16	272.0	PURE HYPERCHOLESTEROLEMIA

$44,182.01 Total Paid

10/31/14 Allegiance Benefit Plan Management, Inc. PAGE: 43
LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 02 11/01/2013 to 10/31/2014 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
257.2	OTHER TESTICULAR HYPOFUNCTION	513.02	12/10/2013
250.00	DIABETES MELLITUS WITHOUT MENTION OF	133.26	06/23/2014
401.1	BENIGN ESSENTIAL HYPERTENSION	1630.29	02/25/2014
V58.69	LONG-TERM (CURRENT) USE OF OTHER		10/30/2013
402.10	BENIGN HYPERTENSIVE HEART DISEASE WITHOU	317.09	06/23/2014
433.10	OCL CRTD ART WO INFRCT	9479.80	08/01/2014
272.0	PURE HYPERCHOLESTEROLEMIA	8.16	06/23/2014
278.02	OVERWEIGHT		06/23/2014
401.9	UNSPECIFIED ESSENTIAL HYPERTENSION	34.79	01/29/2014
272.4	OTHER AND UNSPECIFIED HYPERLIPIDEMIA		02/25/2014
707.15	Ulcer, other part of foot	3942.58	02/17/2014
440.20	ATHERSCLR EXTREMITES NOS		11/13/2013
250.60	DIABETES WITH NEUROLOGICAL MANIFESTATION	2417.74	06/23/2014
518.89	OTHER DISEASES OF LUNG, NOT ELSEWHERE CL	75.98	08/01/2014
730.27	UNSPECIFIED OSTEOMYELITIS INVOLVING ANKL	109.05	11/25/2013
250.92	DIABETES WITH OTHER UNSPECIFIED COMPLICA	460.66	08/01/2014
356.9	UNSPECIFIED IDIOPATHIC PERIPHERAL NEUROP		08/01/2014
DRUGS	PRESCRIPTION DRUGS	17546.91	10/06/2014
786.05	SHORTNESS OF BREATH		12/12/2013
786.50	UNSPECIFIED CHEST PAIN	103.88	12/13/2013
278.01	MORBID OBESITY		01/07/2014
730.10	CHRONIC OSTEOMYELITIS, SITE UNSPECIFIED	1273.19	12/06/2013
250.02	DIABETES MELLITUS WITHOUT MENTION OF	4014.09	07/31/2014
443.9	PERIPHERAL VASCULAR DISEASE, UNSPECIFIED	66.83	02/20/2014
433.30	OCL MLT BI ART WO INFRCT		01/29/2014
414.01	CORONARY ATHEROSCLEROSIS;OF NATIVE	8.16	02/13/2014
427.89	CARDIAC DYSRHYTHMIAS		02/20/2014
593.9	UNSPECIFIED DISORDER OF KIDNEY AND URETE		02/20/2014
V72.81	PREOP CARDIOVSCLR EXAM	8.57	01/29/2014
414.00	CORONARY ATHEROSCLEROSIS OF UNSPECIFIED		01/29/2014
707.14	Ulcer, heel and midfoot	1929.70	06/23/2014
473.9	UNSPECIFIED SINUSITIS (CHRONIC)	54.13	04/08/2014
784.7	EPISTAXIS		04/08/2014
462	ACUTE PHARYNGITIS	54.13	05/30/2014

GROUP: 2001025 SSN: ********** SEQ: ** DIV: 0001 RELAT: Child EFF: ********** DOB: ********** TERM: **********
LEVEL: F99 PLAN: WILCO-MED-DED

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	12-*	250000.00	100.00	399520.40	149520.40	148075.58	.00	1444.82

==========Diagnosis Recap==========

Amount	Code	Description
$151,907.91	V58.11	ENCOUNTER FOR ANTINEOPLASTIC CHEMOTHERAPY
$113,502.00	V58.12	ENCOUNTER FOR ANTINEOPLASTIC IMMUNOTHERAPY
$66,360.56	191.9	MALIGNANT NEOPLASM OF BRAIN
$42,362.03	191.7	MALIGNANT NEOPLASM OF BRAIN STEM
$19,017.06	DRUGS	PRESCRIPTION DRUGS
$1,850.95	191.8	MALIGNANT NEOPLASM OF OTHER PARTS OF BRAIN
$1,341.67	999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEWHERE CLASSIFIED
$660.10	V45.89	OTHER POSTSURGICAL STATUS
$545.18	723.1	CERVICALGIA
$380.11	239.6	NEOPLASM OF UNSPECIFIED NATURE OF BRAIN
$354.92	V58.42	AFTERCARE FOLLOWING SURGERY FOR NEOPLASM
$341.94	729.89	OTHER MUSCULOSKELETAL SYMPTOMS REFERABLETO LIMBS
$245.00	781.3	LACK OF COORDINATION
$245.00	780.79	OTHER MALAISE AND FATIGUE
$219.94	728.87	MUSCLE WEAKNESS (GENERALIZED)
$181.77	348.89	Other conditions of brain
$4.26	V01.1	CONTACT WITH OR EXPOSURE TO TUBERCULOSIS

$399,520.40 Total Paid

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEW	1341.67	07/26/2014
191.9	MALIGNANT NEOPLASM OF BRAIN	66360.56	08/06/2014
V58.11	ENCOUNTER FOR ANTINEOPLASTIC	151907.91	06/04/2014
279.9	UNSPECIFIED DISORDER OF IMMUNE MECHANISM		06/18/2014
783.0	ANOREXIA		06/18/2014
564.00	CONSTIPATION, UNSPECIFIED		11/21/2013
DRUGS	PRESCRIPTION DRUGS	19017.06	07/30/2014
191.7	MALIGNANT NEOPLASM OF BRAIN STEM	42362.03	07/23/2014
279.8	OTHER SPECIFIED DISORDERS INVOLVING THE		07/21/2014
V58.65	LONG-TERM (CURRENT) USE OF STEROIDS		12/04/2013
E933.1	ANTINEOPLASTIC AND IMMUNOSUPPRESSIVE DRU		05/07/2014
283.0	AUTOIMMUNE HEMOLYTIC ANEMIAS		10/02/2013

10/31/14 Allegiance Benefit Plan Management, Inc. PAGE: 44
LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 02 11/01/2013 to 10/31/2014 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
780.79	OTHER MALAISE AND FATIGUE	245.00	07/23/2014
729.89	OTHER MUSCULOSKELETAL SYMPTOMS REFERABLE	341.94	07/17/2014
V45.89	OTHER POSTSURGICAL STATUS	660.10	07/17/2014
V58.69	LONG-TERM (CURRENT) USE OF OTHER		06/30/2014
V58.12	ENCOUNTER FOR ANTINEOPLASTIC	113502.00	06/18/2014
781.3	LACK OF COORDINATION	245.00	11/18/2013
V57.21	CARE INVOLVING REHABILITATION PROCEDURES		02/10/2014
V57.1	CARE INVOLVING OTHER PHYSICAL THERAPY		07/17/2014
V15.3	Hx, prsnl, irradiation		03/24/2014
V14.1	Hx, prsnl, antibiotic allergy NEC		01/03/2014
V01.1	CONTACT WITH OR EXPOSURE TO TUBERCULOSIS	4.26	06/18/2014
V58.42	AFTERCARE FOLLOWING SURGERY FOR NEOPLASM	354.92	02/10/2014
287.5	THROMBOCYTOPENIA, UNSPECIFIED		10/10/2013
239.6	NEOPLASM OF UNSPECIFIED NATURE OF BRAIN	380.11	01/22/2014
V87.41	Personal hx antineoplastic chemo		07/23/2014
728.87	MUSCLE WEAKNESS (GENERALIZED)	219.94	04/15/2014
736.79	OTHER ACQUIRED DEFORMITIES OF ANKLE AND		04/15/2014
V10.85	Hx, prsnl, brain malignancy		07/17/2014
287.49	Other secondary thrombocytopenia		06/04/2014
V14.5	Hx, prsnl, narcotic allergy		06/30/2014
V14.8	Hx, prsnl, drug allergy NEC		06/30/2014
V14.3	Hx, prsnl, anti-infective allergy		06/30/2014
191.8	MALIGNANT NEOPLASM OF OTHER PARTS OF BRA	1850.95	07/23/2014
787.01	OTHER SYMPTOMS INVOLVING DIGESTIVE		07/15/2014
780.52	INSOMNIA, UNSPECIFIED		07/23/2014
728.85	SPASM OF MUSCLE		07/23/2014
348.89	Other conditions of brain	181.77	07/22/2014
723.1	CERVICALGIA	545.18	07/23/2014
V66.7	ENCOUNTER FOR PALLIATIVE CARE;HOSPICE		07/23/2014
V61.9	UNSPECIFIED FAMILY CIRCUMSTANCE		07/23/2014

GROUP: 2001025 SSN: ********** SEQ: ** DIV: 0001 RELAT: Child EFF: ********** DOB: ********** TERM: **********
LEVEL: F99 PLAN: WILCO-MED-CORE

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	11-*	250000.00	100.00	374408.07	124408.07	114612.23	10026.41	-230.57

==========Diagnosis Recap==========

Amount	Code	Description
$188,615.53	953.4	INJURY TO BRACHIAL PLEXUS
$30,026.62	DRUGS	PRESCRIPTION DRUGS
$25,476.72	998.83	OTHER SPECIFIED COMPLICATIONS OF PROCED-URES/ NON-HEALING SURGICAL WOUND
$16,915.34	904.41	INJURY TO POPLITEAL ARTERY
$15,215.34	V55.3	ATTENTION TO COLOSTOMY
$12,207.02	V57.89	CARE INVOLVING OTHER SPECIFIED REHABILITATION PROCEDURE
$6,897.24	276.51	DEHYDRATION
$5,100.03	736.71	ACQUIRED EQUINOVARUS DEFORMITY
$5,068.09	891.1	OPEN WOUND OF KNEE, LEG (EXCEPT THIGH), AND ANKLE, COMPLICATED
$4,887.85	805.4	CLOSED FRACTURE OF LUMBAR VERTEBRA WITHOUT MENTION OF SPINAL CORD INJURY
$4,326.07	999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEWHERE CLASSIFIED
$3,504.30	884.1	MULTIPLE AND UNSPECIFIED OPEN WOUND OF UPPER LIMB, COMPLICATED
$3,459.50	891.2	OPEN WOUND OF KNEE, LEG (EXCEPT THIGH), AND ANKLE, WITH TENDON INVOLVEMENT
$3,268.99	729.5	PAIN IN LIMB
$3,030.30	459.9	UNSPECIFIED CIRCULATORY SYSTEM DISORDER
$2,747.50	728.87	MUSCLE WEAKNESS (GENERALIZED)
$2,737.00	844.2	SPRAIN OF CRUCIATE LIGAMENT OF KNEE
$2,238.52	863.54	INJURY TO SIGMOID COLON WITH OPEN WOUND INTO CAVITY
$2,212.00	718.47	CONTRACTURE OF ANKLE AND FOOT JOINT
$2,040.27	569.69	COLOSTOMY/ENTEROSTOMY COMPLICATIONS; OTHER
$1,950.02	736.79	OTHER ACQUIRED DEFORMITIES OF ANKLE AND FOOT
$1,727.72	354.9	MONONEURITIS OF UPPER LIMB, UNSPECIFIED
$1,718.60	518.81	RESPIRATORY FAILURE
$1,697.00	953.9	INJURY TO UNSPECIFIED SITE OF NERVE ROOTS AND SPINAL PLEXUS
$1,560.88	959.8	OTHER AND UNSPECIFIED INJURY TO OTHER SPECIFIED SITES, INCLUDING MULTIPLE
$1,466.04	V54.89	OTHER ORTHOPEDIC AFTERCARE;AFTERCARE FORHEALING FRACTURE
$1,356.36	785.0	TACHYCARDIA, UNSPECIFIED
$1,349.77	V58.30	ENCOUNTER FOR OTHER AND UNSPECIFIED PROCEDURES AND AFTERCARE-ENCOUNTER
$1,202.20	443.9	PERIPHERAL VASCULAR DISEASE, UNSPECIFIED
$1,122.00	891.0	OPEN WOUND OF KNEE, LEG (EXCEPT THIGH), AND ANKLE, WITHOUT MENTION OF COMPLICATI
$1,072.53	433.00	OCL BSLR ART WO INFRCT
$922.66	863.99	INJURY TO OTHER AND UNSPECIFIED GASTROINTESTINAL SITES WITH OPEN WOUND INTO CAVI
$879.75	996.79	OTHER COMPLICATIONS DUE TO OTHER INTERNAL PROSTHETIC DEVICE, IMPLANT, AND GRAFT
$835.00	719.46	PAIN IN JOINT INVOLVING LOWER LEG
$801.84	821.00	FRACTURE OF UNSPECIFIED PART OF FEMUR, CLOSED
$787.05	908.9	LATE EFFECT OF UNSPECIFIED INJURY
$775.18	V72.60	Laboratory examination, unspecified
$766.94	998.30	Disruption of wound, unspecified
$737.00	296.90	UNSPECIFIED EPISODIC MOOD DISORDER
$724.00	296.89	BIPOLAR DISORDER,OTHER
$684.25	353.4	LUMBOSACRAL ROOT LESIONS, NOT ELSEWHERE CLASSIFIED
$652.17	996.49	OTHER MECHANICAL COMPLICATION OF OTHER INTERNAL ORTHOPEDIC DEVICE,IMPLANT,GRAFT
$648.24	338.11	ACUTE PAIN DUE TO TRAUMA
$633.60	996.78	OTHER COMPLICATIONS DUE TO OTHER INTERNAL ORTHOPEDIC DEVICE, IMPLANT, AND GRAFT
$597.64	V58.69	LONG-TERM (CURRENT) USE OF OTHER MEDICATIONS
$596.76	285.1	ACUTE POSTHEMORRHAGIC ANEMIA
$584.89	787.03	SYMPTOMS INVOLVING DIGESTIVE SYSTEM VOMITING ALONE
$512.40	558.9	OTHER AND UNSPECIFIED NONINFECTIOUS GASTROENTERITIS AND COLITIS
$475.30	724.2	LUMBAGO
$449.56	823.80	CLOSED FRACTURE OF UNSPECIFIED PART OF TIBIA
$372.35	996.1	MECHANICAL COMPLICATION OF OTHER VASCULAR DEVICE, IMPLANT, AND GRAFT
$326.78	338.19	OTHER ACUTE PAIN

$284.25	557.9	UNSPECIFIED VASCULAR INSUFFICIENCY OF INTESTINE
$251.30	296.22	MAJOR DEPRESSIVE AFFECTIVE DISORDER, SINGLE EPISODE, MODERATE DEGREE
$237.50	959.19	OTHER INJURY OF OTHER SITES OF TRUNK
$226.39	309.28	ADJUSTMENT DISORDER WITH MIXED ANXIETY AND DEPRESSED MOOD
$220.00	718.56	ANKYLOSIS OF LOWER LEG JOINT
$212.91	338.21	CHRONIC PAIN DUE TO TRAUMA
$212.91	337.21	RFLX SYM DYSTRPH UP LIMB
$188.00	690.10	SEBORRHEIC DERMATITIS,UNSPECIFIED
$187.60	701.4	KELOID SCAR
$176.80	507.0	PNEUMONITIS DUE TO INHALATION OF FOOD ORVOMITUS
$176.80	288.60	NEUTROPENIA-LEUKOCYTOSIS, UNSPECIFIED
$175.20	374.30	PTOSIS OF EYELID, UNSPECIFIED
$150.48	444.22	ARTERIAL EMBOLISM AND THROMBOSIS OF LOWER EXTREMITY
$145.29	729.81	SWELLING OF LIMB
$145.11	338.18	OTHER ACUTE POSTOPERATIVE PAIN
$145.11	723.4	BRACHIAL NEURITIS OR RADICULITIS NOS
$138.75	569.60	COLOSTOMY/ENTEROSTOMY COMPLICATIONS; UNSPECIFIED
$128.10	V44.3	COLOSTOMY STATUS
$123.19	959.09	INJURY OF FACE AND NECK
$117.80	828.1	MULTIPLE FRACTURES INVOLVING BOTH LOWER LIMBS, LOWER WITH UPPER LIMB, AND LOWER
$114.68	823.00	CLOSED FRACTURE OF UPPER END OF TIBIA
$102.88	719.06	EFFUSION OF LOWER LEG JOINT
$98.48	904.8	INJURY TO UNSPECIFIED BLOOD VESSEL OF LOWER EXTREMITY
$95.04	787.91	OTHER SYMPTOMS INVOLVING DIGESTIVE SYSTEM; DIARRHEA
$71.98	276.8	HYPOPOTASSEMIA
$71.98	375.15	TEAR FILM INSUFFICIENCY, UNSPECIFIED
$52.18	296.33	MAJOR DEPRESSIVE AFFECTIVE DISORDER, RECURRENT EPISODE, SEVERE DEGREE, WITHOUT M
$41.37	786.05	SHORTNESS OF BREATH
$35.63	V14.0	Hx, prsnl, penicillin allergy
$19.92	881.10	OPEN WOUND OF FOREARM, COMPLICATED
$17.61	V45.4	POSTSURGICAL ARTHRODESIS STATUS
$13.79	959.11	OTHER INJURY OF CHEST WALL
$13.79	780.60	Symptom, fever, unspecified
$13.79	518.0	PULMONARY COLLAPSE
$13.79	512.89	Other pneumothorax
$13.72	727.81	CONTRACTURE OF TENDON (SHEATH)
$13.24	959.4	OTHER AND UNSPECIFIED INJURY TO HAND, EXCEPT FINGER

$374,408.07 Total Paid

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEW	4326.07	09/11/2014
288.60	NEUTROPENIA-LEUKOCYTOSIS, UNSPECIFIED	176.80	10/18/2013
507.0	PNEUMONITIS DUE TO INHALATION OF FOOD OR	176.80	10/29/2013
959.8	OTHER AND UNSPECIFIED INJURY TO OTHER SP	1560.88	11/11/2013

10/31/14 Allegiance Benefit Plan Management, Inc. PAGE: 46
LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 02 11/01/2013 to 10/31/2014 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
786.05	SHORTNESS OF BREATH	41.37	10/15/2013
374.30	PTOSIS OF EYELID, UNSPECIFIED	175.20	10/25/2013
375.15	TEAR FILM INSUFFICIENCY, UNSPECIFIED	71.98	10/25/2013
372.72	CONJUNCTIVAL HEMORRHAGE		10/25/2013
512.89	Other pneumothorax	13.79	10/09/2013
863.44	INJURY TO SIGMOID COLON WITHOUT OPEN WOU		10/17/2013
861.21	CONTUSION OF LUNG WITHOUT OPEN WOUND INT		10/17/2013
518.81	RESPIRATORY FAILURE	1718.60	10/29/2013
V46.13	ENCOUNTER FOR WEANING FROM RESPIRATOR		10/13/2013
511.9	UNSPECIFIED PLEURAL EFFUSION		10/11/2013
287.5	THROMBOCYTOPENIA, UNSPECIFIED		10/11/2013
805.4	CLOSED FRACTURE OF LUMBAR VERTEBRA WITHO	4887.85	01/14/2014
953.4	INJURY TO BRACHIAL PLEXUS	188615.53	07/07/2014
557.9	UNSPECIFIED VASCULAR INSUFFICIENCY OF IN	284.25	10/07/2013
V72.60	Laboratory examination, unspecified	775.18	10/28/2013
V45.4	POSTSURGICAL ARTHRODESIS STATUS	17.61	10/23/2013
891.1	OPEN WOUND OF KNEE, LEG (EXCEPT THIGH),	5068.09	09/26/2014
823.80	CLOSED FRACTURE OF UNSPECIFIED PART OF T	449.56	09/25/2014
959.4	OTHER AND UNSPECIFIED INJURY TO HAND, EX	13.24	10/12/2013
518.0	PULMONARY COLLAPSE	13.79	10/13/2013
285.9	ANEMIA, UNSPECIFIED		10/21/2013
959.09	INJURY OF FACE AND NECK	123.19	10/08/2013
959.19	OTHER INJURY OF OTHER SITES OF TRUNK	237.50	10/08/2013
891.0	OPEN WOUND OF KNEE, LEG (EXCEPT THIGH),	1122.00	10/14/2013
808.0	CLOSED FRACTURE OF ACETABULUM		10/27/2013
780.60	Symptom, fever, unspecified	13.79	10/18/2013
891.2	OPEN WOUND OF KNEE, LEG (EXCEPT THIGH),	3459.50	10/21/2013
296.33	MAJOR DEPRESSIVE AFFECTIVE DISORDER, REC	52.18	10/22/2013
300.00	ANXIETY STATE, UNSPECIFIED		07/07/2014
823.00	CLOSED FRACTURE OF UPPER END OF TIBIA	114.68	10/29/2013
296.22	MAJOR DEPRESSIVE AFFECTIVE DISORDER, SIN	251.30	12/11/2013
DRUGS	PRESCRIPTION DRUGS	30026.62	10/23/2014
V44.3	COLOSTOMY STATUS	128.10	11/18/2013
905.4	LATE EFFECT OF FRACTURE OF LOWER EXTREMI		10/23/2013
863.54	INJURY TO SIGMOID COLON WITH OPEN WOUND	2238.52	10/07/2013
822.1	OPEN FRACTURE OF PATELLA		10/07/2013
E819.0	MOTOR VEHICLE TRAFFIC ACCIDENT OF UNSPEC		10/07/2013
863.99	INJURY TO OTHER AND UNSPECIFIED GASTROIN	922.66	10/07/2013
V57.89	CARE INVOLVING OTHER SPECIFIED REHABILIT	12207.02	11/12/2013
V54.19	AFTERCARE FOR HEALING TRAUMATIC FRACTURE		11/12/2013
V58.43	AFTERCARE FOLLOWING SURGERY FOR INJURY		11/12/2013
V54.17	AFTERCARE FOR HEALING TRAUMATIC		11/12/2013
V54.16	AFTERCARE FOR HEALING TRAUMATIC FRACTURE		11/12/2013

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LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 02 11/01/2013 to 10/31/2014 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
781.2	ABNORMALITY OF GAIT		04/29/2014
V54.89	OTHER ORTHOPEDIC AFTERCARE;AFTERCARE FOR	1466.04	12/06/2013
719.56	STIFFNESS OF JOINT, NOT ELSEWHERE CLASSI		12/06/2013
727.81	CONTRACTURE OF TENDON (SHEATH)	13.72	12/06/2013
311	DEPRESSIVE DISORDER, NOT ELSEWHERE CLASS		07/07/2014
729.5	PAIN IN LIMB	3268.99	05/21/2014
996.78	OTHER COMPLICATIONS DUE TO OTHER INTERNA	633.60	12/05/2013
996.1	MECHANICAL COMPLICATION OF OTHER VASCULA	372.35	12/10/2013
338.18	OTHER ACUTE POSTOPERATIVE PAIN	145.11	10/10/2014
V45.89	OTHER POSTSURGICAL STATUS		12/10/2013
309.28	ADJUSTMENT DISORDER WITH MIXED ANXIETY	226.39	11/11/2013
729.81	SWELLING OF LIMB	145.29	11/03/2013
564.1	IRRITABLE COLON		11/12/2013
998.83	OTHER SPECIFIED COMPLICATIONS OF PROCED-	25476.72	07/07/2014
953.0	INJURY TO CERVICAL NERVE ROOT		01/02/2014
338.28	OTHER CHRONIC POSTOPERATIVE PAIN		01/02/2014
836.52	POSTERIOR DISLOCATION OF TIBIA, PROXIMAL		09/26/2014
958.8	OTHER EARLY COMPLICATIONS OF TRAUMA		09/26/2014
996.49	OTHER MECHANICAL COMPLICATION OF OTHER	652.17	06/30/2014
718.56	ANKYLOSIS OF LOWER LEG JOINT	220.00	09/26/2014
904.41	INJURY TO POPLITEAL ARTERY	16915.34	10/29/2013
958.4	TRAUMATIC SHOCK		10/29/2013
823.12	OPEN FRACTURE OF UPPER END OF FIBULA WIT		10/29/2013
338.19	OTHER ACUTE PAIN	326.78	11/22/2013
353.0	BRACHIAL PLEXUS LESIONS		04/29/2014
338.11	ACUTE PAIN DUE TO TRAUMA	648.24	02/12/2014
904.8	INJURY TO UNSPECIFIED BLOOD VESSEL OF LO	98.48	12/10/2013
569.69	COLOSTOMY/ENTEROSTOMY COMPLICATIONS;	2040.27	01/08/2014
569.60	COLOSTOMY/ENTEROSTOMY COMPLICATIONS;	138.75	01/08/2014
V55.3	ATTENTION TO COLOSTOMY	15215.34	01/12/2014
799.4	CACHEXIA		01/12/2014
V58.69	LONG-TERM (CURRENT) USE OF OTHER	597.64	04/29/2014
V15.82	Hx, prsnl, tobacco use		01/12/2014
V85.1	BODY MASS INDEX BETWEEN 19-24, ADULT		01/12/2014
719.06	EFFUSION OF LOWER LEG JOINT	102.88	10/08/2013
782.3	EDEMA		10/08/2013
924.9	CONTUSION OF UNSPECIFIED SITE		10/08/2013
558.9	OTHER AND UNSPECIFIED NONINFECTIOUS GAST	512.40	01/27/2014
300.4	DYSTHYMIC DISORDER		01/27/2014
338.29	OTHER CHRONIC PAIN		01/27/2014
276.51	DEHYDRATION	6897.24	01/25/2014
584.9	Acute kidney failure, unspecified		01/25/2014
V14.0	Hx, prsnl, penicillin allergy	35.63	01/26/2014

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LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 02 11/01/2013 to 10/31/2014 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

Diagnosis Summary for **********	Amount Paid	Last D.O.S.
V45.72 ACQUIRED ABSENCE OF ORGAN;ACQUIRED		01/26/2014
959.11 OTHER INJURY OF CHEST WALL	13.79	10/08/2013
953.9 INJURY TO UNSPECIFIED SITE OF NERVE ROOT	1697.00	01/30/2014
349.2 DISORDERS OF MENINGES, NOT ELSEWHERE CLA		01/30/2014
354.9 MONONEURITIS OF UPPER LIMB, UNSPECIFIED	1727.72	09/29/2014
354.5 MONONEURITIS MULTIPLEX		04/28/2014
723.4 BRACHIAL NEURITIS OR RADICULITIS NOS	145.11	04/28/2014
728.87 MUSCLE WEAKNESS (GENERALIZED)	2747.50	09/25/2014
296.89 BIPOLAR DISORDER,OTHER	724.00	07/21/2014
296.90 UNSPECIFIED EPISODIC MOOD DISORDER	737.00	09/24/2014

GROUP: 2001025 SSN: ********** SEQ: ** DIV: 0001 RELAT: Participant EFF: ********** DOB: ********** TERM: **********
LEVEL: F00 PLAN: WILCO-MED-EPO-DIAB

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	00-*	250000.00	15.30	38244.67	.00	.00	.00	.00

==========Diagnosis Recap==========

Amount	Code	Description
$8,663.28	840.8	SPRAIN OF OTHER SPECIFIED SITES OF SHOULDER AND UPPER ARM
$8,344.70	723.0	SPINAL STENOSIS IN CERVICAL REGION
$7,059.71	DRUGS	PRESCRIPTION DRUGS
$3,084.81	721.3	LUMBOSACRAL SPONDYLOSIS WITHOUT MYELOPATHY
$1,565.28	173.89	Othr spec malg neop othr sites skin
$1,564.41	721.0	CERVICAL SPONDYLOSIS WITHOUT MYELOPATHY
$1,514.70	721.1	CERVICAL SPONDYLOSIS WITH MYELOPATHY
$1,358.55	999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEWHERE CLASSIFIED
$1,024.88	727.62	NONTRAUMATIC RUPTURE OF TENDONS OF BICEPS (LONG HEAD)
$589.75	V72.84	PREOP EXAM UNSPCF
$509.09	250.00	DIABETES MELLITUS WITHOUT MENTION OF COMPLICATION, TYPE II
$395.51	723.1	CERVICALGIA
$345.91	289.0	POLYCYTHEMIA, SECONDARY
$337.50	786.50	UNSPECIFIED CHEST PAIN
$318.61	327.23	OBSTRUCTIVE SLEEP APNEA (ADULT) (PEDIATRIC)
$316.74	702.0	ACTINIC KERATOSIS
$289.88	719.42	PAIN IN JOINT INVOLVING UPPER ARM
$156.07	238.2	NEOPLASM OF UNCERTAIN BEHAVIOR OF SKIN
$125.00	250.02	DIABETES MELLITUS WITHOUT MENTION OF COMPLICATION, TYPE II,UNCONTROLLED
$100.50	232.9	CARCINOMA IN SITU OF SKIN, SITE UNSPECIFIED
$96.41	272.4	OTHER AND UNSPECIFIED HYPERLIPIDEMIA
$92.28	257.2	OTHER TESTICULAR HYPOFUNCTION
$90.17	V10.83	Hx, prsnl, skin malignancy NEC
$73.69	720.0	ANKYLOSING SPONDYLITIS
$62.59	709.09	DYSCHROMIA;OTHER
$43.58	401.1	BENIGN ESSENTIAL HYPERTENSION
$40.00	380.4	IMPACTED CERUMEN
$28.27	275.09	Hemochromatosis NEC
$25.00	V04.81	NEED FOR PROPHYLACTIC VACCINATION/ INOCULATION AGAINST, INFLUENZA
$16.23	276.1	HYPOSMOLALITY AND/OR HYPONATREMIA
$11.57	841.9	SPRAIN OF UNSPECIFIED SITE OF ELBOW AND FOREARM

$38,244.67 Total Paid

10/31/14 Allegiance Benefit Plan Management, Inc. PAGE: 49
LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 02 11/01/2013 to 10/31/2014 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
721.0	CERVICAL SPONDYLOSIS WITHOUT MYELOPATHY	1564.41	10/21/2013
723.0	SPINAL STENOSIS IN CERVICAL REGION	8344.70	01/21/2014
DRUGS	PRESCRIPTION DRUGS	7059.71	10/15/2014
999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEW	1358.55	01/16/2014
V04.81	NEED FOR PROPHYLACTIC VACCINATION/	25.00	11/09/2013
723.1	CERVICALGIA	395.51	01/20/2014
327.23	OBSTRUCTIVE SLEEP APNEA (ADULT)	318.61	08/07/2014
250.00	DIABETES MELLITUS WITHOUT MENTION OF	509.09	06/26/2014
272.4	OTHER AND UNSPECIFIED HYPERLIPIDEMIA	96.41	06/24/2014
401.1	BENIGN ESSENTIAL HYPERTENSION	43.58	06/24/2014
257.2	OTHER TESTICULAR HYPOFUNCTION	92.28	08/13/2014
232.9	CARCINOMA IN SITU OF SKIN, SITE UNSPECIF	100.50	11/07/2013
702.11	SEBORRHEIC KERATISIS;INFLAMED SEBORRHEIC		11/07/2013
721.3	LUMBOSACRAL SPONDYLOSIS WITHOUT MYELOPAT	3084.81	10/22/2013
401.9	UNSPECIFIED ESSENTIAL HYPERTENSION		06/26/2014
289.0	POLYCYTHEMIA, SECONDARY	345.91	08/13/2014
250.02	DIABETES MELLITUS WITHOUT MENTION OF	125.00	11/26/2013
720.0	ANKYLOSING SPONDYLITIS	73.69	12/23/2013
276.1	HYPOSMOLALITY AND/OR HYPONATREMIA	16.23	12/30/2013
275.09	Hemochromatosis NEC	28.27	04/09/2014
V54.09	OTHER AFTERCARE INVOLVING INTERNAL		10/21/2013
786.50	UNSPECIFIED CHEST PAIN	337.50	12/18/2013
530.81	ESOPHAGEAL REFLUX		01/21/2014
721.1	CERVICAL SPONDYLOSIS WITH MYELOPATHY	1514.70	01/20/2014
173.89	Othr spec malg neop othr sites skin	1565.28	12/04/2013
278.00	OBESITY, UNSPECIFIED		01/21/2014
702.0	ACTINIC KERATOSIS	316.74	05/13/2014
V10.83	Hx, prsnl, skin malignancy NEC	90.17	05/13/2014
216.5	BENIGN NEOPLASM OF SKIN OF TRUNK, EXCEPT		03/17/2014
702.19	OTHER DERMATOSES;OTHER SEBORRHEIC		03/17/2014
780.4	DIZZINESS AND GIDDINESS		03/25/2014
V72.84	PREOP EXAM UNSPCF	589.75	10/17/2013
380.4	IMPACTED CERUMEN	40.00	04/27/2014
381.4	NONSUPPURATIVE OTITIS MEDIA, NOT SPECIFI		04/27/2014
709.09	DYSCHROMIA;OTHER	62.59	11/07/2013
228.01	HEMANGIOMA OF SKIN AND SUBCUTANEOUS TISS		11/07/2013
238.2	NEOPLASM OF UNCERTAIN BEHAVIOR OF SKIN	156.07	11/07/2013
719.42	PAIN IN JOINT INVOLVING UPPER ARM	289.88	06/23/2014
727.62	NONTRAUMATIC RUPTURE OF TENDONS OF BICEP	1024.88	10/06/2014
840.8	SPRAIN OF OTHER SPECIFIED SITES OF SHOUL	8663.28	06/26/2014
E927.0	Overextension from sudden strenuous		06/26/2014
841.9	SPRAIN OF UNSPECIFIED SITE OF ELBOW AND	11.57	06/26/2014

10/31/14 Allegiance Benefit Plan Management, Inc. PAGE: 50
LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 02 11/01/2013 to 10/31/2014 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

GROUP: 2001025 SSN: ********** SEQ: ** DIV: 0001 RELAT: Spouse EFF: ********** DOB: ********** TERM: **********
LEVEL: F00 PLAN: WILCO-MED-EPO-DIAB

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	01-*	250000.00	13.88	34687.65	.00	.00	.00	.00

==========Diagnosis Recap==========

Amount	Code	Description
$7,457.59	786.59	OTHER CHEST PAIN
$7,049.51	220	BENIGN NEOPLASM OF OVARY
$4,871.13	540.9	ACUTE APPENDICITIS WITHOUT MENTION OF PERITONITIS
$3,533.10	620.2	OTHER AND UNSPECIFIED OVARIAN CYST
$2,779.99	824.8	UNSPECIFIED FRACTURE OF ANKLE, CLOSED
$2,078.75	DRUGS	PRESCRIPTION DRUGS
$1,840.45	540.0	ACUTE APPENDICITIS WITH GENERALIZED PERITONITIS
$1,271.33	719.47	PAIN IN JOINT INVOLVING ANKLE AND FOOT
$1,190.15	824.2	FRACTURE OF LATERAL MALLEOLUS, CLOSED
$1,026.40	959.8	OTHER AND UNSPECIFIED INJURY TO OTHER SPECIFIED SITES, INCLUDING MULTIPLE
$320.88	272.4	OTHER AND UNSPECIFIED HYPERLIPIDEMIA
$285.25	786.50	UNSPECIFIED CHEST PAIN
$197.91	786.52	PAINFUL RESPIRATION
$189.89	789.00	OTHER SYMPTOMS INVOLVING ABDOMEN AND PELVIS
$177.48	V72.31	ROUTINE GYNECOLOGICAL EXAM
$157.91	V72.60	Laboratory examination, unspecified
$104.69	780.4	DIZZINESS AND GIDDINESS
$78.50	789.03	OTHER SYMPTOMS INVOLVING ABDOMEN AND PELVIS
$31.99	V04.81	NEED FOR PROPHYLACTIC VACCINATION/ INOCULATION AGAINST, INFLUENZA
$31.51	244.9	UNSPECIFIED ACQUIRED HYPOTHYROIDISM
$13.24	729.5	PAIN IN LIMB

$34,687.65 Total Paid

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
DRUGS	PRESCRIPTION DRUGS	2078.75	08/22/2014
780.4	DIZZINESS AND GIDDINESS	104.69	11/16/2013
V04.81	NEED FOR PROPHYLACTIC VACCINATION/	31.99	11/09/2013
272.4	OTHER AND UNSPECIFIED HYPERLIPIDEMIA	320.88	08/22/2014
244.9	UNSPECIFIED ACQUIRED HYPOTHYROIDISM	31.51	08/22/2014
824.2	FRACTURE OF LATERAL MALLEOLUS, CLOSED	1190.15	05/16/2014
824.8	UNSPECIFIED FRACTURE OF ANKLE, CLOSED	2779.99	02/22/2014
719.47	PAIN IN JOINT INVOLVING ANKLE AND FOOT	1271.33	08/12/2014
729.5	PAIN IN LIMB	13.24	01/28/2014
V72.31	ROUTINE GYNECOLOGICAL EXAM	177.48	11/12/2013
959.8	OTHER AND UNSPECIFIED INJURY TO OTHER SP	1026.40	01/28/2014
E885.9	FALL FROM OTHER,TRIPPIN,SLIPPING,OR		01/28/2014

10/31/14 Allegiance Benefit Plan Management, Inc. PAGE: 51
LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 02 11/01/2013 to 10/31/2014 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
E000.8	Other external cause status		01/28/2014
786.50	UNSPECIFIED CHEST PAIN	285.25	02/22/2014
786.52	PAINFUL RESPIRATION	197.91	02/22/2014
272.2	Hyperlipidemia, mixed		02/22/2014
789.00	OTHER SYMPTOMS INVOLVING ABDOMEN AND	189.89	05/04/2014
786.59	OTHER CHEST PAIN	7457.59	02/22/2014
789.06	OTHER SYMPTOMS INVOLVING ABDOMEN AND		02/21/2014
787.01	OTHER SYMPTOMS INVOLVING DIGESTIVE		05/04/2014
V72.60	Laboratory examination, unspecified	157.91	05/04/2014
V15.88	Hx, prsnl, fall		02/22/2014
540.0	ACUTE APPENDICITIS WITH GENERALIZED PERI	1840.45	05/04/2014
620.2	OTHER AND UNSPECIFIED OVARIAN CYST	3533.10	06/02/2014
789.03	OTHER SYMPTOMS INVOLVING ABDOMEN AND	78.50	05/04/2014
794.9	NONSPECIFIC ABNORMAL RESULTS OF OTHER SP		05/04/2014
543.9	OTHER AND UNSPECIFIED DISEASES OF APPEND		05/04/2014
540.9	ACUTE APPENDICITIS WITHOUT MENTION OF PE	4871.13	05/04/2014
220	BENIGN NEOPLASM OF OVARY	7049.51	06/02/2014
629.89	OTHER SPECIFIED DISORDERS OF FEMALE		06/02/2014
V10.43	Hx, prsnl, ovarian malignancy		06/02/2014
530.81	ESOPHAGEAL REFLUX		08/22/2014

GROUP: 2001025 SSN: ********** SEQ: ** DIV: 0002 RELAT: Participant EFF: ********** DOB: ********** TERM: **********
LEVEL: P00 PLAN: WILCO-MED-CORE-DIAB

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	00-*	250000.00	22.44	56110.36	.00	.00	.00	.00

==========Diagnosis Recap==========

Amount	Code	Description
$39,076.05	410.71	SUBENDOCARDIAL INFARCTION, INITIAL EPISODE OF CARE
$7,386.45	DRUGS	PRESCRIPTION DRUGS
$3,154.12	V57.89	CARE INVOLVING OTHER SPECIFIED REHABILITATION PROCEDURE
$1,130.82	999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEWHERE CLASSIFIED
$732.69	682.9	CELLULITIS AND ABSCESS OF UNSPECIFIED SITES
$724.16	250.90	DIABETES WITH UNSPECIFIED COMPLICATION, TYPE II OR UNSPECIFIED TYPE
$628.07	250.02	DIABETES MELLITUS WITHOUT MENTION OF COMPLICATION, TYPE II,UNCONTROLLED
$451.50	411.1	INTERMEDIATE CORONARY SYNDROME
$439.34	787.91	OTHER SYMPTOMS INVOLVING DIGESTIVE SYSTEM; DIARRHEA
$412.64	365.10	OPEN-ANGLE GLAUCOMA, UNSPECIFIED
$342.13	410.70	SUBENDOCARDIAL INFARCTION, EPISODE OF CARE UNSPECIFIED
$265.00	692.9	CONTACT DERMATITIS AND OTHER ECZEMA, UNSPECIFIED CAUSE
$213.74	410.72	SUBENDOCARDIAL INFARCTION, SUBSEQUENT EPISODE OF CARE
$194.06	414.00	CORONARY ATHEROSCLEROSIS OF UNSPECIFIED TYPE OF VESSEL, NATIVE OR GRAFT
$172.66	272.0	PURE HYPERCHOLESTEROLEMIA
$163.62	724.5	BACKACHE, UNSPECIFIED
$142.63	786.2	COUGH
$137.92	558.9	OTHER AND UNSPECIFIED NONINFECTIOUS GASTROENTERITIS AND COLITIS
$130.64	786.09	OTHER DYSPNEA AND RESPIRATORY ABNORMALITY
$77.50	724.3	SCIATICA
$76.85	410.80	ACUTE MYOCARDIAL INFARCTION OF OTHER SPECIFIED SITES, EPISODE OF CARE UNSPECIFIE
$27.50	724.6	DISORDERS OF SACRUM
$10.09	794.31	NONSPECIFIC ABNORMAL ELECTROCARDIOGRAM (ECG) (EKG)
$10.09	786.50	UNSPECIFIED CHEST PAIN
$10.09	401.1	BENIGN ESSENTIAL HYPERTENSION

$56,110.36 Total Paid

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
250.02	DIABETES MELLITUS WITHOUT MENTION OF	628.07	03/18/2014
401.1	BENIGN ESSENTIAL HYPERTENSION	10.09	10/01/2014
272.0	PURE HYPERCHOLESTEROLEMIA	172.66	10/01/2014
DRUGS	PRESCRIPTION DRUGS	7386.45	10/18/2014
786.2	COUGH	142.63	10/31/2013
365.10	OPEN-ANGLE GLAUCOMA, UNSPECIFIED	412.64	07/18/2014
250.90	DIABETES WITH UNSPECIFIED COMPLICATION,	724.16	08/18/2014
311	DEPRESSIVE DISORDER, NOT ELSEWHERE CLASS		08/18/2014
375.15	TEAR FILM INSUFFICIENCY, UNSPECIFIED		03/04/2014
381.81	DYSFUNCTION OF EUSTACHIAN TUBE		03/18/2014
724.3	SCIATICA	77.50	04/15/2014
724.6	DISORDERS OF SACRUM	27.50	05/22/2014
724.1	PAIN IN THORACIC SPINE		04/15/2014
718.56	ANKYLOSIS OF LOWER LEG JOINT		05/22/2014
724.5	BACKACHE, UNSPECIFIED	163.62	06/16/2014
411.1	INTERMEDIATE CORONARY SYNDROME	451.50	06/10/2014
794.39	OTHER NONSPECIFIC ABNORMAL FUNCTION STUD		06/06/2014
790.6	OTHER ABNORMAL BLOOD CHEMISTRY		06/06/2014
410.70	SUBENDOCARDIAL INFARCTION, EPISODE OF CA	342.13	09/22/2014
410.80	ACUTE MYOCARDIAL INFARCTION OF OTHER SPE	76.85	06/09/2014

10/31/14 Allegiance Benefit Plan Management, Inc. PAGE: 52
LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 02 11/01/2013 to 10/31/2014 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
786.50	UNSPECIFIED CHEST PAIN	10.09	06/06/2014
285.9	ANEMIA, UNSPECIFIED		06/12/2014
794.31	NONSPECIFIC ABNORMAL ELECTROCARDIOGRAM (	10.09	06/09/2014
410.71	SUBENDOCARDIAL INFARCTION, INITIAL EPISO	39076.05	06/10/2014
401.0	MALIGNANT ESSENTIAL HYPERTENSION		06/09/2014
V85.43	BMI 50.0-59.9, adult		06/06/2014
414.01	CORONARY ATHEROSCLEROSIS;OF NATIVE		06/09/2014
558.9	OTHER AND UNSPECIFIED NONINFECTIOUS GAST	137.92	06/16/2014
530.81	ESOPHAGEAL REFLUX		06/16/2014
780.79	OTHER MALAISE AND FATIGUE		06/16/2014
786.09	OTHER DYSPNEA AND RESPIRATORY ABNORMALIT	130.64	06/06/2014
786.00	RESPIRATORY ABNORMALITY, UNSPECIFIED		06/06/2014
250.00	DIABETES MELLITUS WITHOUT MENTION OF		06/14/2014
787.91	OTHER SYMPTOMS INVOLVING DIGESTIVE	439.34	06/14/2014
787.02	OTHER SYMPTOMS OF THE DIGESTIVE SYSTEM;		06/14/2014
401.9	UNSPECIFIED ESSENTIAL HYPERTENSION		06/14/2014
272.4	OTHER AND UNSPECIFIED HYPERLIPIDEMIA		06/14/2014
410.72	SUBENDOCARDIAL INFARCTION, SUBSEQUENT EP	213.74	06/19/2014
414.00	CORONARY ATHEROSCLEROSIS OF UNSPECIFIED	194.06	10/01/2014
999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEW	1130.82	09/25/2014
278.01	MORBID OBESITY		06/10/2014
V57.89	CARE INVOLVING OTHER SPECIFIED REHABILIT	3154.12	09/22/2014
682.9	CELLULITIS AND ABSCESS OF UNSPECIFIED SI	732.69	08/13/2014
366.16	SENILE NUCLEAR SCLEROSIS		07/18/2014
692.9	CONTACT DERMATITIS AND OTHER ECZEMA, UNS	265.00	08/08/2014
708.9	UNSPECIFIED URTICARIA		08/08/2014

GROUP: 2001025 SSN: ********** SEQ: ** DIV: 0001 RELAT: Participant EFF: ********** DOB: ********** TERM: **********
LEVEL: F99 PLAN: WILCO-MED-DED

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	00-*	250000.00	26.32	65792.92	.00	.00	.00	.00

==========Diagnosis Recap==========

Amount	Code	Description
$50,192.48	540.0	ACUTE APPENDICITIS WITH GENERALIZED PERITONITIS
$9,281.66	682.2	CELLULITIS AND ABSCESS OF TRUNK
$1,874.60	789.59	ASCITES;OTHER SPECIFIC SITE
$1,732.64	540.9	ACUTE APPENDICITIS WITHOUT MENTION OF PERITONITIS
$1,233.88	998.59	POSTOPERATIVE INFECTIONS;OTHER POSTOPERATIVE INFECTION
$747.49	999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEWHERE CLASSIFIED
$144.07	789.2	SPLENOMEGALY
$144.07	567.22	PERITONEAL ABSCESS
$144.07	789.03	OTHER SYMPTOMS INVOLVING ABDOMEN AND PELVIS
$113.04	789.00	OTHER SYMPTOMS INVOLVING ABDOMEN AND PELVIS
$74.34	558.9	OTHER AND UNSPECIFIED NONINFECTIOUS GASTROENTERITIS AND COLITIS
$41.69	DRUGS	PRESCRIPTION DRUGS
$35.28	729.81	SWELLING OF LIMB
$19.82	V58.62	LONG-TERM (CURRENT) USE OF ANTIBIOTICS
$13.79	V58.81	FITTING AND ADJUSTMENT OF VASCULAR CATHETER

$65,792.92 Total Paid

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
DRUGS	PRESCRIPTION DRUGS	41.69	01/13/2014
558.9	OTHER AND UNSPECIFIED NONINFECTIOUS GAST	74.34	12/27/2013
789.00	OTHER SYMPTOMS INVOLVING ABDOMEN AND	113.04	01/02/2014
V15.9	Hx, prsnl, health hazard NOS		12/29/2013
540.9	ACUTE APPENDICITIS WITHOUT MENTION OF PE	1732.64	01/13/2014
789.03	OTHER SYMPTOMS INVOLVING ABDOMEN AND	144.07	12/30/2013
787.91	OTHER SYMPTOMS INVOLVING DIGESTIVE		12/29/2013
V58.62	LONG-TERM (CURRENT) USE OF ANTIBIOTICS	19.82	01/20/2014
995.20	UNSPECIFIED ADVERSE EFFECT OF UNSPEC-		01/20/2014
540.0	ACUTE APPENDICITIS WITH GENERALIZED PERI	50192.48	01/13/2014
560.1	PARALYTIC ILEUS		01/13/2014
584.9	Acute kidney failure, unspecified		01/13/2014
V58.81	FITTING AND ADJUSTMENT OF VASCULAR	13.79	01/08/2014
997.49	Othr digestive system complications		12/30/2013
511.9	UNSPECIFIED PLEURAL EFFUSION		12/30/2013
789.59	ASCITES;OTHER SPECIFIC SITE	1874.60	01/09/2014
729.81	SWELLING OF LIMB	35.28	01/07/2014
567.22	PERITONEAL ABSCESS	144.07	01/13/2014
999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEW	747.49	05/25/2014
682.2	CELLULITIS AND ABSCESS OF TRUNK	9281.66	01/23/2014
998.59	POSTOPERATIVE INFECTIONS;OTHER	1233.88	01/22/2014
E878.6	REMOVAL OF OTHER ORGAN (PARTIAL) (TOTAL)		01/22/2014
789.2	SPLENOMEGALY	144.07	01/22/2014

10/31/14 Allegiance Benefit Plan Management, Inc. PAGE: 53
LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 02 11/01/2013 to 10/31/2014 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

Diagnosis Summary for ********** Amount Paid Last D.O.S.

GROUP: 2001025 SSN: ********** SEQ: ** DIV: 0001 RELAT: Child EFF: ********** DOB: ********** TERM: **********
LEVEL: F99 PLAN: WILCO-MED-DED

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	11-*	250000.00	12.64	31598.06	.00	.00	.00	.00

==========Diagnosis Recap==========

Amount	Code	Description
$8,729.55	780.60	Symptom, fever, unspecified
$5,687.42	204.00	ACT LYM LEUK W/O RMSION
$4,910.38	V58.11	ENCOUNTER FOR ANTINEOPLASTIC CHEMOTHERAPY
$3,609.18	DRUGS	PRESCRIPTION DRUGS
$3,483.09	204.01	ACT LYM LEUK W RMSION
$1,817.69	V20.2	ROUTINE INFANT OR CHILD HEALTH CHECK
$536.51	V67.2	FOLLOW-UP EXAMINATION FOLLOWING CHEMOTHERAPY
$478.32	V45.89	OTHER POSTSURGICAL STATUS
$471.89	V57.21	CARE INVOLVING REHABILITATION PROCEDURESENCOUNTER FOR OCCUPATIONAL THERAPY
$313.60	204.11	CHR LYM LEUK W RMSION
$222.21	462	ACUTE PHARYNGITIS
$214.91	782.1	RASH AND OTHER NONSPECIFIC SKIN ERUPTION
$189.57	780.61	Symptom, fever prest w/ cond elsewh
$189.57	208.90	LEUKEMIA NOS W/O REMISSION
$152.50	372.30	CONJUNCTIVITIS, UNSPECIFIED
$130.56	691.8	OTHER ATOPIC DERMATITIS AND RELATED CONDITIONS
$77.59	786.2	COUGH
$73.76	373.00	BLEPHARITIS, UNSPECIFIED
$73.76	372.00	ACUTE CONJUNCTIVITIS, UNSPECIFIED
$57.51	999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEWHERE CLASSIFIED
$53.09	752.52	UNDESCENDED/RETRACTILE TESTICLE
$26.46	692.9	CONTACT DERMATITIS AND OTHER ECZEMA, UNSPECIFIED CAUSE
$25.17	V72.5	RADIOLOGICAL EXAMINATION, NOT ELSEWHERE CLASSIFIED
$17.93	786.05	SHORTNESS OF BREATH
$17.93	793.19	Othr nonspecfc abnorml finding/lung
$17.93	786.50	UNSPECIFIED CHEST PAIN
$17.38	780.79	OTHER MALAISE AND FATIGUE
$2.60	V72.0	EXAMINATION OF EYES AND VISION

$31,598.06 Total Paid

Diagnosis Summary for ********** Amount Paid Last D.O.S.

204.00	ACT LYM LEUK W/O RMSION	5687.42	07/24/2014
462	ACUTE PHARYNGITIS	222.21	01/18/2014
780.60	Symptom, fever, unspecified	8729.55	09/04/2014
478.19	OTHER DISEASES OF UPPER RESPIRATORY		08/27/2014
786.2	COUGH	77.59	09/03/2014
493.90	ASTHMA, UNSPECIFIED TYPE		09/04/2014
DRUGS	PRESCRIPTION DRUGS	3609.18	10/13/2014
208.90	LEUKEMIA NOS W/O REMISSION	189.57	08/27/2014
780.61	Symptom, fever prest w/ cond elsewh	189.57	01/31/2014
465.9	ACUTE UPPER RESPIRATORY INFECTIONS OF UN		12/23/2013
079.99	VIRAL INFECTION NOS		10/24/2013
786.50	UNSPECIFIED CHEST PAIN	17.93	11/12/2013
204.01	ACT LYM LEUK W RMSION	3483.09	09/16/2014
382.9	UNSPECIFIED OTITIS MEDIA		11/13/2013
V15.83	Hx, prsnl, underimmunization status		11/23/2013
V58.69	LONG-TERM (CURRENT) USE OF OTHER		08/07/2014
782.1	RASH AND OTHER NONSPECIFIC SKIN ERUPTION	214.91	10/03/2014
V58.11	ENCOUNTER FOR ANTINEOPLASTIC	4910.38	09/04/2014
793.19	Othr nonspecfc abnorml finding/lung	17.93	11/12/2013
V10.60	Hx, prsnl, leukemia NOS		11/23/2013
V20.2	ROUTINE INFANT OR CHILD HEALTH CHECK	1817.69	07/24/2014
V72.5	RADIOLOGICAL EXAMINATION, NOT ELSEWHERE	25.17	01/21/2014
372.00	ACUTE CONJUNCTIVITIS, UNSPECIFIED	73.76	01/08/2014
780.79	OTHER MALAISE AND FATIGUE	17.38	06/30/2014
V72.0	EXAMINATION OF EYES AND VISION	2.60	01/29/2014
787.03	SYMPTOMS INVOLVING DIGESTIVE SYSTEM		01/31/2014

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LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 02 11/01/2013 to 10/31/2014 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
786.05	SHORTNESS OF BREATH	17.93	01/31/2014
V45.89	OTHER POSTSURGICAL STATUS	478.32	10/02/2014
V15.09	Hx, prsnl, alrgy not med agent NEC		02/06/2014
692.9	CONTACT DERMATITIS AND OTHER ECZEMA, UNS	26.46	10/13/2014
372.30	CONJUNCTIVITIS, UNSPECIFIED	152.50	02/17/2014
375.15	TEAR FILM INSUFFICIENCY, UNSPECIFIED		02/17/2014
V67.2	FOLLOW-UP EXAMINATION FOLLOWING CHEMOTHE	536.51	09/04/2014
357.6	POLYNEUROPATHY DUE TO DRUGS		06/30/2014
999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEW	57.51	07/25/2014
V07.39	OTHER PROPHYLACTIC CHEMOTHERAPY; OTHER		08/21/2014
780.96	GENERALIZED PAIN		03/18/2014
477.9	ALLERGIC RHINITIS, CAUSE UNSPECIFIED		08/27/2014
201.01	HODGKIN'S PARAGRANULOMA INVOLVING LYMPH		05/13/2014
V57.21	CARE INVOLVING REHABILITATION PROCEDURES	471.89	06/30/2014
691.8	OTHER ATOPIC DERMATITIS AND RELATED COND	130.56	06/04/2014
752.51	UNDESCENDED/RETRACTILE TESTICLE		07/24/2014
752.52	UNDESCENDED/RETRACTILE TESTICLE	53.09	07/24/2014
V06.1	NEED FOR PROPHYLACTIC VACCINATION WITH C		07/24/2014
V05.3	NEED PRPHYL VC VRL HEPAT		07/24/2014
V58.65	LONG-TERM (CURRENT) USE OF STEROIDS		08/07/2014
V87.41	Personal hx antineoplastic chemo		09/03/2014
079.3	RHINOVIRUS INFECTION IN CONDITIONS CLASS		09/04/2014
204.11	CHR LYM LEUK W RMSION	313.60	05/13/2014
373.00	BLEPHARITIS, UNSPECIFIED	73.76	09/16/2014
684	IMPETIGO		10/13/2014
V04.81	NEED FOR PROPHYLACTIC VACCINATION/		10/13/2014

GROUP: 2001025 SSN: ********** SEQ: ** DIV: 0002 RELAT: Participant EFF: ********** DOB: ********** TERM: **********
LEVEL: F00 PLAN: WILCO-MED-DED-DIAB

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	00-*	250000.00	20.31	50768.35	.00	.00	.00	.00

==========Diagnosis Recap==========

Amount	Code	Description
$43,910.01	DRUGS	PRESCRIPTION DRUGS
$5,151.25	723.4	BRACHIAL NEURITIS OR RADICULITIS NOS
$612.26	729.5	PAIN IN LIMB
$286.27	V76.12	OTHER SCREENING MAMMOGRAM
$183.24	388.30	TINNITUS, UNSPECIFIED
$160.94	347.01	NARCOLEPSY,WITH CATAPLEXY
$159.36	V70.0	ROUTINE GENERAL MEDICAL EXAMINATION AT AHEALTH CARE FACILITY
$155.22	782.0	DISTURBANCE OF SKIN SENSATION
$76.67	999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEWHERE CLASSIFIED
$59.34	702.19	OTHER DERMATOSES;OTHER SEBORRHEIC KERATOSIS
$13.79	786.50	UNSPECIFIED CHEST PAIN

$50,768.35 Total Paid

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
DRUGS	PRESCRIPTION DRUGS	43910.01	06/26/2014
388.30	TINNITUS, UNSPECIFIED	183.24	11/05/2013
347.01	NARCOLEPSY,WITH CATAPLEXY	160.94	05/27/2014
V76.12	OTHER SCREENING MAMMOGRAM	286.27	01/31/2014
V70.0	ROUTINE GENERAL MEDICAL EXAMINATION AT A	159.36	01/31/2014
723.4	BRACHIAL NEURITIS OR RADICULITIS NOS	5151.25	04/01/2014
724.5	BACKACHE, UNSPECIFIED		03/03/2014
782.0	DISTURBANCE OF SKIN SENSATION	155.22	03/03/2014
722.4	DEGENERATION OF CERVICAL INTERVERTEBRAL		03/03/2014
794.31	NONSPECIFIC ABNORMAL ELECTROCARDIOGRAM (		03/03/2014
729.5	PAIN IN LIMB	612.26	03/03/2014
723.1	CERVICALGIA		03/03/2014
786.50	UNSPECIFIED CHEST PAIN	13.79	03/03/2014
702.19	OTHER DERMATOSES;OTHER SEBORRHEIC	59.34	04/03/2014
706.2	SEBACEOUS CYST		04/03/2014
110.1	DERMATOPHYTOSIS OF NAIL		04/03/2014
216.9	BENIGN NEOPLASM OF SKIN, SITE UNSPECIFIE		04/03/2014
999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEW	76.67	06/25/2014

GROUP: 2001025 SSN: ********** SEQ: ** DIV: 0001 RELAT: Child EFF: ********** DOB: ********** TERM: **********
LEVEL: F99 PLAN: WILCO-MED-EPO-DIAB

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	11-*	250000.00	22.86	57157.33	.00	.00	.00	.00

==========Diagnosis Recap==========

Amount	Code	Description
$15,401.67	DRUGS	PRESCRIPTION DRUGS
$7,682.58	296.33	MAJOR DEPRESSIVE AFFECTIVE DISORDER, RECURRENT EPISODE, SEVERE DEGREE, WITHOUT M
$5,129.15	470	DEVIATED NASAL SEPTUM
$4,500.32	784.0	HEADACHE
$4,454.04	307.1	ANOREXIA NERVOSA
$4,069.80	296.34	MAJOR DEPRESSIVE AFFECTIVE DISORDER, RECURRENT EPISODE, SEVERE DEGREE, SPECIFIED
$3,503.87	599.0	URINARY TRACT INFECTION, SITE NOT SPECIFIED

10/31/14 Allegiance Benefit Plan Management, Inc. PAGE: 55
LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

$3,062.33	465.9	ACUTE UPPER RESPIRATORY INFECTIONS OF UNSPECIFIED SITE
$2,621.12	346.90	Migraine NOS w/o migrain w/o status
$2,078.37	307.51	BULIMIA NERVOSA
$936.67	999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEWHERE CLASSIFIED
$559.76	295.70	SCHIZO-AFFECTIVE TYPE SCHIZOPHRENIA, UNSPECIFIED STATE
$360.16	623.5	LEUKORRHEA, NOT SPECIFIED AS INFECTIVE
$358.52	V70.0	ROUTINE GENERAL MEDICAL EXAMINATION AT AHEALTH CARE FACILITY
$332.78	478.0	HYPERTROPHY OF NASAL TURBINATES
$325.78	462	ACUTE PHARYNGITIS
$260.07	473.9	UNSPECIFIED SINUSITIS (CHRONIC)
$227.79	564.1	IRRITABLE COLON
$202.13	296.80	BIPOLAR DISORDER,UNSPECIFIED
$157.30	401.1	BENIGN ESSENTIAL HYPERTENSION
$128.68	111.8	OTHER SPECIFIED DERMATOMYCOSES
$124.53	703.0	INGROWING NAIL
$94.20	789.02	OTHER SYMPTOMS INVOLVING ABDOMEN AND PELVIS
$84.56	785.0	TACHYCARDIA, UNSPECIFIED
$77.16	307.50	EATING DISORDER, UNSPECIFIED
$61.79	690.10	SEBORRHEIC DERMATITIS,UNSPECIFIED
$59.81	296.51	BIPOLAR AFFECTIVE DISORDER, DEPRESSED, MILD DEGREE
$55.04	530.81	ESOPHAGEAL REFLUX
$45.48	789.09	OTHER SYMPTOMS INVOLVING ABDOMEN AND PELVIS
$43.95	788.43	NOCTURIA
$28.38	380.10	INFECTIVE OTITIS EXTERNA, UNSPECIFIED
$27.88	787.01	OTHER SYMPTOMS INVOLVING DIGESTIVE SYSTEM;NAUSEA WITH VOMITING
$25.90	256.4	POLYCYSTIC OVARIES
$24.79	780.79	OTHER MALAISE AND FATIGUE
$17.93	272.4	OTHER AND UNSPECIFIED HYPERLIPIDEMIA
$15.52	626.6	METRORRHAGIA
$13.79	786.05	SHORTNESS OF BREATH
$3.73	V74.1	SCREENING EXAMINATION FOR PULMONARY TUBERCULOSIS

$57,157.33 Total Paid

10/31/14 Allegiance Benefit Plan Management, Inc. PAGE: 56
LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 02 11/01/2013 to 10/31/2014 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

Diagnosis	Summary for **********	Amount Paid	Last D.O.S.
296.34	MAJOR DEPRESSIVE AFFECTIVE DISORDER, REC	4069.80	10/03/2013
799.9	UNKNOWN/UNSPECIFIED CAUSE OF MORBIDITY		10/03/2013
256.4	POLYCYSTIC OVARIES	25.90	03/11/2014
564.1	IRRITABLE COLON	227.79	10/20/2014
595.1	CHRONIC INTERSTITIAL CYSTITIS		10/03/2013
788.43	NOCTURIA	43.95	10/14/2013
788.41	URINARY FREQUENCY		10/14/2013
788.63	SYMPTOM, URGENCY OF URINATION		10/14/2013
295.70	SCHIZO-AFFECTIVE TYPE SCHIZOPHRENIA, UNS	559.76	07/24/2014
307.51	BULIMIA NERVOSA	2078.37	10/06/2014
DRUGS	PRESCRIPTION DRUGS	15401.67	10/14/2014
462	ACUTE PHARYNGITIS	325.78	12/03/2013
787.01	OTHER SYMPTOMS INVOLVING DIGESTIVE	27.88	01/09/2014
465.9	ACUTE UPPER RESPIRATORY INFECTIONS OF UN	3062.33	12/04/2013
111.8	OTHER SPECIFIED DERMATOMYCOSES	128.68	11/05/2013
780.79	OTHER MALAISE AND FATIGUE	24.79	11/05/2013
009.1	COLITIS, ENTERITIS, AND GASTROENTERITIS		11/05/2013
530.81	ESOPHAGEAL REFLUX	55.04	10/20/2014
296.80	BIPOLAR DISORDER,UNSPECIFIED	202.13	10/06/2014
296.51	BIPOLAR AFFECTIVE DISORDER, DEPRESSED, M	59.81	09/12/2013
599.0	URINARY TRACT INFECTION, SITE NOT SPECIF	3503.87	09/27/2014
789.09	OTHER SYMPTOMS INVOLVING ABDOMEN AND	45.48	12/20/2013
625.9	UNSPECIFIED SYMPTOM ASSOCIATED WITH FEMA		12/20/2013
380.10	INFECTIVE OTITIS EXTERNA, UNSPECIFIED	28.38	12/30/2013
789.02	OTHER SYMPTOMS INVOLVING ABDOMEN AND	94.20	12/13/2013
346.90	Migraine NOS w/o migrain w/o status	2621.12	01/08/2014
784.0	HEADACHE	4500.32	01/15/2014
787.02	OTHER SYMPTOMS OF THE DIGESTIVE SYSTEM;		01/12/2014
780.4	DIZZINESS AND GIDDINESS		01/12/2014
690.10	SEBORRHEIC DERMATITIS,UNSPECIFIED	61.79	12/30/2013
216.3	BENIGN NEOPLASM OF SKIN OF OTHER AND UNS		12/30/2013
216.6	BENIGN NEOPLASM OF SKIN OF UPPER LIMB, I		12/30/2013
786.05	SHORTNESS OF BREATH	13.79	12/04/2013
272.4	OTHER AND UNSPECIFIED HYPERLIPIDEMIA	17.93	05/13/2014
V70.5	HEALTH EXAMINATION OF DEFINED SUBPOPULAT		01/24/2014
785.0	TACHYCARDIA, UNSPECIFIED	84.56	01/28/2014
401.9	UNSPECIFIED ESSENTIAL HYPERTENSION		01/28/2014
388.70	OTALGIA, UNSPECIFIED		01/15/2014
296.33	MAJOR DEPRESSIVE AFFECTIVE DISORDER, REC	7682.58	02/03/2014
279.49	Autoimmune disease NOS		01/29/2014
401.1	BENIGN ESSENTIAL HYPERTENSION	157.30	02/07/2014
272.0	PURE HYPERCHOLESTEROLEMIA		02/07/2014
427.9	CARDIAC DYSRHYTHMIA		02/07/2014

10/31/14 Allegiance Benefit Plan Management, Inc. PAGE: 57
LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 02 11/01/2013 to 10/31/2014 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
301.83	BORDERLINE PERSONALITY DISORDER		02/03/2014
595.9	CYSTITIS, UNSPECIFIED		02/03/2014
530.11	REFLUX ESOPHAGITIS		01/23/2014
V70.0	ROUTINE GENERAL MEDICAL EXAMINATION AT A	358.52	08/06/2014
307.50	EATING DISORDER, UNSPECIFIED	77.16	10/02/2014
470	DEVIATED NASAL SEPTUM	5129.15	10/13/2014
478.0	HYPERTROPHY OF NASAL TURBINATES	332.78	05/14/2014
478.19	OTHER DISEASES OF UPPER RESPIRATORY		05/14/2014
473.9	UNSPECIFIED SINUSITIS (CHRONIC)	260.07	10/13/2014
213.0	BENIGN NEOPLASM OF BONES OF SKULL AND FA		05/14/2014
626.6	METRORRHAGIA	15.52	06/30/2014
V58.69	LONG-TERM (CURRENT) USE OF OTHER		10/06/2014
V74.1	SCREENING EXAMINATION FOR PULMONARY TUBE	3.73	08/06/2014
999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEW	936.67	09/25/2014
786.50	UNSPECIFIED CHEST PAIN		08/17/2014
782.3	EDEMA		08/17/2014
703.0	INGROWING NAIL	124.53	08/15/2014
692.9	CONTACT DERMATITIS AND OTHER ECZEMA, UNS		09/27/2014
307.1	ANOREXIA NERVOSA	4454.04	09/18/2014
V72.41	PREGNANCY EXAMINATION OR TEST,NEGATIVE		09/27/2014
278.00	OBESITY, UNSPECIFIED		10/02/2014
623.5	LEUKORRHEA, NOT SPECIFIED AS INFECTIVE	360.16	10/10/2014

GROUP: 2001025 SSN: ********** SEQ: ** DIV: 0001 RELAT: Participant EFF: ********** DOB: ********** TERM: **********
LEVEL: F99 PLAN: WILCO-MED-DED

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	00-*	250000.00	23.91	59769.98	.00	.00	.00	.00

==========Diagnosis Recap==========

Amount	Code	Description
$58,987.61	DRUGS	PRESCRIPTION DRUGS
$264.28	796.2	ELEVATED BLOOD PRESSURE READING WITHOUT DIAGNOSIS OF HYPERTENSION
$179.41	340	MULTIPLE SCLEROSIS
$150.93	V67.9	UNSPECIFIED FOLLOW-UP EXAMINATION
$107.89	401.9	UNSPECIFIED ESSENTIAL HYPERTENSION
$49.89	V04.81	NEED FOR PROPHYLACTIC VACCINATION/ INOCULATION AGAINST, INFLUENZA
$29.97	785.1	PALPITATIONS

$59,769.98 Total Paid

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
DRUGS	PRESCRIPTION DRUGS	58987.61	10/06/2014
340	MULTIPLE SCLEROSIS	179.41	08/19/2014
780.4	DIZZINESS AND GIDDINESS		07/16/2014
796.2	ELEVATED BLOOD PRESSURE READING WITHOUT	264.28	07/18/2014
V04.81	NEED FOR PROPHYLACTIC VACCINATION/	49.89	12/06/2013
783.1	ABNORMAL WEIGHT GAIN		12/06/2013
V67.9	UNSPECIFIED FOLLOW-UP EXAMINATION	150.93	08/18/2014
268.9	UNSPECIFIED VITAMIN D DEFICIENCY		07/16/2014
785.1	PALPITATIONS	29.97	07/18/2014
386.11	BENIGN PAROXYSMAL POSITIONAL VERTIGO		07/18/2014
401.9	UNSPECIFIED ESSENTIAL HYPERTENSION	107.89	08/18/2014

10/31/14 Allegiance Benefit Plan Management, Inc. PAGE: 58
LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 02 11/01/2013 to 10/31/2014 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

Diagnosis Summary for **********	Amount Paid	Last D.O.S.
784.0 HEADACHE		08/18/2014
787.02 OTHER SYMPTOMS OF THE DIGESTIVE SYSTEM;		08/18/2014

GROUP: 2001025 SSN: ********** SEQ: ** DIV: 0001 RELAT: Child EFF: ********** DOB: ********** TERM: **********
LEVEL: F99 PLAN: WILCO-MED-DED

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	12-*	250000.00	12.34	30850.97	.00	.00	.00	.00

==========Diagnosis Recap==========

Amount	Code	Description
$29,220.36	850.0	CONCUSSION WITH NO LOSS OF CONSCIOUSNESS
$952.00	919.0	ABRASION OR FRICTION BURN OF OTHER, MULTIPLE, AND UNSPECIFIED SITES, WITHOUT MEN
$231.90	V20.2	ROUTINE INFANT OR CHILD HEALTH CHECK
$167.70	850.11	CONCUSSION WITH LOSS OF CONSCIOUSNESS OF30 MINUTES OR LESS
$110.00	382.9	UNSPECIFIED OTITIS MEDIA
$89.50	959.09	INJURY OF FACE AND NECK
$65.72	959.01	HEAD INJURY, UNSPECIFIED
$13.79	959.11	OTHER INJURY OF CHEST WALL

$30,850.97 Total Paid

Diagnosis Summary for **********	Amount Paid	Last D.O.S.
850.0 CONCUSSION WITH NO LOSS OF CONSCIOUSNESS	29220.36	12/03/2013
916.0 ABRASION OR FRICTION BURN OF HIP, THIGH,		12/03/2013
E882 ACCIDENTAL FALL FROM OR OUT OF BUILDING		12/03/2013
E849.0 HOME ACCIDENTS		12/03/2013
959.01 HEAD INJURY, UNSPECIFIED	65.72	12/02/2013
959.09 INJURY OF FACE AND NECK	89.50	12/02/2013
959.11 OTHER INJURY OF CHEST WALL	13.79	12/02/2013
850.11 CONCUSSION WITH LOSS OF CONSCIOUSNESS OF	167.70	12/03/2013
E888.8 OTHER FALL		12/03/2013
919.0 ABRASION OR FRICTION BURN OF OTHER, MULT	952.00	12/02/2013
789.00 OTHER SYMPTOMS INVOLVING ABDOMEN AND		12/02/2013
E884.9 OTHER ACCIDENTAL FALL FROM ONE LEVEL TO		12/02/2013
V20.2 ROUTINE INFANT OR CHILD HEALTH CHECK	231.90	05/06/2014
382.9 UNSPECIFIED OTITIS MEDIA	110.00	09/20/2014

GROUP: 2001025 SSN: ********** SEQ: ** DIV: 0001 RELAT: Spouse EFF: ********** DOB: ********** TERM: **********
LEVEL: F00 PLAN: WILCO-MED-CORE-DIAB

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	01-*	250000.00	11.06	27637.65	.00	.00	.00	.00

==========Diagnosis Recap==========

Amount	Code	Description
$16,263.90	530.85	BARRETT'S ESOPHAGUS
$3,178.63	DRUGS	PRESCRIPTION DRUGS
$1,879.93	787.20	DYSPHAGIA, UNSPECIFIED
$1,324.53	173.21	Basal cell carcinoma of ear/canal
$1,115.67	935.1	FOREIGN BODY IN ESOPHAGUS
$837.73	327.23	OBSTRUCTIVE SLEEP APNEA (ADULT) (PEDIATRIC)
$474.13	702.0	ACTINIC KERATOSIS
$470.53	173.81	Basal cell carcinma othr sites skin
$457.36	427.31	ATRIAL FIBRILLATION
$436.66	250.00	DIABETES MELLITUS WITHOUT MENTION OF COMPLICATION, TYPE II
$272.57	211.0	BENIGN NEOPLASM OF ESOPHAGUS
$206.36	V04.89	NEED FOR PROPHYLACTIC VACCINATION/ INOCULATION AGAINST, OTHER VIRAL DISEASE
$168.71	600.21	BENIGN LOCALIZED HYPERPLASIA OF PROSTATEW/URINARY OBSTRUCTION
$125.08	238.2	NEOPLASM OF UNCERTAIN BEHAVIOR OF SKIN
$116.25	216.5	BENIGN NEOPLASM OF SKIN OF TRUNK, EXCEPTSCROTUM
$93.71	553.3	DIAPHRAGMATIC HERNIA WITHOUT MENTION OF OBSTRUCTION OR GANGRENE
$68.38	V10.82	Hx, prsnl, malignant skin melanoma
$53.23	427.81	SINOATRIAL NODE DYSFUNCTION
$43.46	780.57	UNSPECIFIED SLEEP APNEA
$43.33	702.11	SEBORRHEIC KERATISIS;INFLAMED SEBORRHEICKERATOSIS
$7.50	V72.81	PREOP CARDIOVSCLR EXAM

$27,637.65 Total Paid

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
702.0	ACTINIC KERATOSIS	474.13	10/08/2014
V10.82	Hx, prsnl, malignant skin melanoma	68.38	10/14/2013
216.5	BENIGN NEOPLASM OF SKIN OF TRUNK, EXCEPT	116.25	10/08/2014
V04.89	NEED FOR PROPHYLACTIC VACCINATION/	206.36	10/18/2013
DRUGS	PRESCRIPTION DRUGS	3178.63	10/23/2014
427.31	ATRIAL FIBRILLATION	457.36	09/24/2014
V45.01	CARDIAC DEVICE IN SITU;CARDIAC PACE-		07/30/2014
427.81	SINOATRIAL NODE DYSFUNCTION	53.23	04/22/2014
780.57	UNSPECIFIED SLEEP APNEA	43.46	09/24/2014
401.9	UNSPECIFIED ESSENTIAL HYPERTENSION		09/24/2014
272.4	OTHER AND UNSPECIFIED HYPERLIPIDEMIA		08/29/2014
327.23	OBSTRUCTIVE SLEEP APNEA (ADULT)	837.73	12/13/2013
401.1	BENIGN ESSENTIAL HYPERTENSION		01/10/2014
250.00	DIABETES MELLITUS WITHOUT MENTION OF	436.66	09/24/2014
600.21	BENIGN LOCALIZED HYPERPLASIA OF PROSTATE	168.71	09/17/2014
935.1	FOREIGN BODY IN ESOPHAGUS	1115.67	03/22/2014
E915	FOREIGN BODY ACCIDENTALLY ENTERING OTHER		03/22/2014
E849.9	ACCIDENTS OCCURRING IN UNSPECIFIED PLACE		03/22/2014
787.20	DYSPHAGIA, UNSPECIFIED	1879.93	07/30/2014

10/31/14 Allegiance Benefit Plan Management, Inc. PAGE: 60
LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 02 11/01/2013 to 10/31/2014 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
702.19	OTHER DERMATOSES;OTHER SEBORRHEIC		10/08/2014
V10.83	Hx, prsnl, skin malignancy NEC		10/08/2014
238.2	NEOPLASM OF UNCERTAIN BEHAVIOR OF SKIN	125.08	04/16/2014
173.81	Basal cell carcinma othr sites skin	470.53	04/16/2014
427.9	CARDIAC DYSRHYTHMIA		03/28/2014
530.85	BARRETT'S ESOPHAGUS	16263.90	09/24/2014
041.86	OTHER SPECIFIED BACTERIAL INFECTIONS /		04/30/2014
535.10	ATRPH GASTRTIS W/O HMRHG		06/11/2014
173.21	Basal cell carcinoma of ear/canal	1324.53	05/07/2014
702.11	SEBORRHEIC KERATISIS;INFLAMED SEBORRHEIC	43.33	05/07/2014
530.81	ESOPHAGEAL REFLUX		06/11/2014
553.3	DIAPHRAGMATIC HERNIA WITHOUT MENTION OF	93.71	06/11/2014
V72.81	PREOP CARDIOVSCLR EXAM	7.50	06/11/2014
427.89	CARDIAC DYSRHYTHMIAS		06/11/2014
211.0	BENIGN NEOPLASM OF ESOPHAGUS	272.57	07/30/2014
414.00	CORONARY ATHEROSCLEROSIS OF UNSPECIFIED		07/30/2014

GROUP: 2001025 SSN: ********** SEQ: ** DIV: 0001 RELAT: Participant EFF: ********** DOB: ********** TERM: **********
LEVEL: P00 PLAN: WILCO-MED-DED

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	00-*	250000.00	24.95	62371.73	.00	.00	.00	.00

==========Diagnosis Recap==========

Amount	Code	Description
$39,006.90	340	MULTIPLE SCLEROSIS
$18,456.54	DRUGS	PRESCRIPTION DRUGS
$1,449.86	956.0	INJURY TO SCIATIC NERVE
$1,084.26	355.8	MONONEURITIS OF LOWER LIMB, UNSPECIFIED
$674.66	721.90	SPONDYLOSIS OF UNSPECIFIED SITE WITHOUT MENTION OF MYELOPATHY
$654.52	729.5	PAIN IN LIMB
$500.67	999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEWHERE CLASSIFIED
$196.90	473.9	UNSPECIFIED SINUSITIS (CHRONIC)
$109.82	461.8	OTHER ACUTE SINUSITIS
$62.62	786.2	COUGH
$55.06	305.50	OPIOID ABUSE, UNSPECIFIED USE
$51.54	473.8	OTHER CHRONIC SINUSITIS
$40.00	V58.69	LONG-TERM (CURRENT) USE OF OTHER MEDICATIONS
$28.38	338.4	CHRONIC PAIN SYNDROME

$62,371.73 Total Paid

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
DRUGS	PRESCRIPTION DRUGS	18456.54	10/12/2014
340	MULTIPLE SCLEROSIS	39006.90	09/30/2014
999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEW	500.67	05/02/2014
461.8	OTHER ACUTE SINUSITIS	109.82	11/27/2013
473.8	OTHER CHRONIC SINUSITIS	51.54	11/27/2013
786.2	COUGH	62.62	11/27/2013
466.0	ACUTE BRONCHITIS		11/27/2013
054.9	HERPES SIMPLEX WITHOUT MENTION OF COMPLI		11/27/2013
323.9	UNSPECIFIED CAUSE OF ENCEPHALITIS		07/23/2014
729.2	NEURALGIA, NEURITIS, AND RADICULITIS, UN		07/23/2014
729.5	PAIN IN LIMB	654.52	02/05/2014
V58.69	LONG-TERM (CURRENT) USE OF OTHER	40.00	07/01/2014
304.00	OPIOID TYPE DEPENDENCE, UNSPECIFIED USE		02/05/2014
473.9	UNSPECIFIED SINUSITIS (CHRONIC)	196.90	03/18/2014
470	DEVIATED NASAL SEPTUM		02/18/2014
478.19	OTHER DISEASES OF UPPER RESPIRATORY		03/18/2014
327.20	ORGANIC SLEEP APNEA, UNSPECIFIED		02/18/2014
338.4	CHRONIC PAIN SYNDROME	28.38	09/30/2014
722.83	POSTLAMINECTOMY SYNDROME OF LUMBAR REGIO		08/29/2014
305.50	OPIOID ABUSE, UNSPECIFIED USE	55.06	02/21/2014
474.10	HYPERTROPHY OF TONSIL WITH ADENOIDS		03/18/2014
382.00	ACUTE SUPPURATIVE OTITIS MEDIA WITHOUT S		03/18/2014
721.90	SPONDYLOSIS OF UNSPECIFIED SITE WITHOUT	674.66	08/29/2014
355.8	MONONEURITIS OF LOWER LIMB, UNSPECIFIED	1084.26	09/30/2014
780.79	OTHER MALAISE AND FATIGUE		07/23/2014
956.0	INJURY TO SCIATIC NERVE	1449.86	09/16/2014
780.57	UNSPECIFIED SLEEP APNEA		09/16/2014

10/31/14 Allegiance Benefit Plan Management, Inc. PAGE: 61
LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 02 11/01/2013 to 10/31/2014 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

GROUP: 2001025 SSN: ********** SEQ: ** DIV: 0001 RELAT: Child EFF: ********** DOB: ********** TERM: **********
LEVEL: P99 PLAN: WILCO-MED-CORE

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	11-*	250000.00	13.04	32605.59	.00	.00	.00	.00

==========Diagnosis Recap==========

Amount	Code	Description
$16,788.68	210.4	BENIGN NEOPLASM OF OTHER AND UNSPECIFIEDPARTS OF MOUTH
$6,333.79	DRUGS	PRESCRIPTION DRUGS
$2,430.32	814.00	CLOSED FRACTURE OF CARPAL BONE, UNSPECIFIED
$1,506.85	528.9	OTHER AND UNSPECIFIED DISEASES OF THE ORAL SOFT TISSUES
$1,159.05	784.2	Symptom, swelling in head/neck
$906.82	842.00	SPRAIN OF UNSPECIFIED SITE OF WRIST
$852.58	348.30	ENCEPHALOPATHY, UNSPECIFIED
$412.30	299.80	OTHER SPECIFIED EARLY CHILDHOOD PSYCHOSES, CURRENT OR ACTIVE STATE
$364.70	202.80	OTHER MALIGNANT LYMPHOMAS
$319.46	239.0	NEOPLASM OF UNSPECIFIED NATURE OF DIGESTIVE SYSTEM
$314.73	314.01	ATTENTION DEFICIT DISORDER OF CHILDHOOD WITH HYPERACTIVITY
$262.07	V20.2	ROUTINE INFANT OR CHILD HEALTH CHECK
$164.46	V15.29	Hx, prsnl surgery to other organs
$127.12	780.4	DIZZINESS AND GIDDINESS
$118.62	235.1	NEOPLASM OF UNCERTAIN BEHAVIOR OF LIP, ORAL CAVITY, AND PHARYNX
$98.81	813.42	OTHER CLOSED FRACTURES OF DISTAL END OF RADIUS (ALONE)
$91.77	462	ACUTE PHARYNGITIS
$82.09	238.79	NEOPLASM OF UNCERTAIN BEHAVIOR-OTHER LYMPHATIC AND HEMATOPOIETIC TISSUES
$62.99	719.43	PAIN IN JOINT INVOLVING FOREARM
$57.18	461.9	ACUTE SINUSITIS, UNSPECIFIED
$44.60	525.9	UNSPECIFIED DISORDER OF THE TEETH AND SUPPORTING STRUCTURES
$41.00	518.81	RESPIRATORY FAILURE
$24.61	314.00	ATTENTION DEFICIT DISORDER OF CHILDHOOD WITHOUT MENTION OF HYPERACTIVITY
$14.41	842.09	OTHER WRIST SPRAIN
$13.41	733.99	OTHER DISORDERS OF BONE AND CARTILAGE
$13.17	959.3	OTHER AND UNSPECIFIED INJURY TO ELBOW, FOREARM, AND WRIST

$32,605.59 Total Paid

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
784.2	Symptom, swelling in head/neck	1159.05	03/11/2014
V10.79	Hx, prsnl, lymphatic malignancy NEC		11/21/2013
348.30	ENCEPHALOPATHY, UNSPECIFIED	852.58	09/02/2014
314.01	ATTENTION DEFICIT DISORDER OF CHILDHOOD	314.73	09/02/2014
299.00	INFANTILE AUTISM, CURRENT OR ACTIVE STAT		07/29/2014
315.4	DEVELOPMENTAL COORDINATION DISORDER		11/04/2013
528.9	OTHER AND UNSPECIFIED DISEASES OF THE OR	1506.85	03/06/2014
296.90	UNSPECIFIED EPISODIC MOOD DISORDER		03/11/2014
202.80	OTHER MALIGNANT LYMPHOMAS	364.70	06/24/2014
299.80	OTHER SPECIFIED EARLY CHILDHOOD PSYCHOSE	412.30	06/05/2014

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LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 02 11/01/2013 to 10/31/2014 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
210.4	BENIGN NEOPLASM OF OTHER AND UNSPECIFIED	16788.68	03/11/2014
DRUGS	PRESCRIPTION DRUGS	6333.79	10/14/2014
733.90	DISORDER OF BONE AND CARTILAGE, UNSPECIF		11/21/2013
235.1	NEOPLASM OF UNCERTAIN BEHAVIOR OF LIP, O	118.62	10/22/2013
239.0	NEOPLASM OF UNSPECIFIED NATURE OF DIGEST	319.46	03/19/2014
462	ACUTE PHARYNGITIS	91.77	01/30/2014
461.9	ACUTE SINUSITIS, UNSPECIFIED	57.18	07/09/2014
034.0	STREPTOCOCCAL SORE THROAT		01/30/2014
314.00	ATTENTION DEFICIT DISORDER OF CHILDHOOD	24.61	12/02/2013
300.00	ANXIETY STATE, UNSPECIFIED		09/02/2014
V58.69	LONG-TERM (CURRENT) USE OF OTHER		04/29/2014
787.01	OTHER SYMPTOMS INVOLVING DIGESTIVE		01/30/2014
784.0	HEADACHE		01/30/2014
238.79	NEOPLASM OF UNCERTAIN BEHAVIOR-OTHER	82.09	01/02/2014
V20.2	ROUTINE INFANT OR CHILD HEALTH CHECK	262.07	09/12/2014
518.81	RESPIRATORY FAILURE	41.00	03/10/2014
V15.29	Hx, prsnl surgery to other organs	164.46	06/13/2014
814.00	CLOSED FRACTURE OF CARPAL BONE, UNSPECIF	2430.32	05/27/2014
780.4	DIZZINESS AND GIDDINESS	127.12	04/24/2014
719.43	PAIN IN JOINT INVOLVING FOREARM	62.99	04/29/2014
729.81	SWELLING OF LIMB		04/29/2014
V54.19	AFTERCARE FOR HEALING TRAUMATIC FRACTURE		04/29/2014
E888.9	UNSPECIFIED FALL		04/24/2014
202.00	NODULAR LYMPHOMA		03/11/2014
813.42	OTHER CLOSED FRACTURES OF DISTAL END OF	98.81	05/27/2014
V54.12	AFTERCARE FOR HEALING TRAUMATIC		05/27/2014
E928.9	UNSPECIFIED ACCIDENT		05/27/2014
525.9	UNSPECIFIED DISORDER OF THE TEETH AND SU	44.60	03/10/2014
733.99	OTHER DISORDERS OF BONE AND CARTILAGE	13.41	03/10/2014
842.00	SPRAIN OF UNSPECIFIED SITE OF WRIST	906.82	07/29/2014
E885.9	FALL FROM OTHER,TRIPPIN,SLIPPING,OR		07/29/2014
959.3	OTHER AND UNSPECIFIED INJURY TO ELBOW, F	13.17	07/29/2014
313.81	OPPOSITIONAL DEFIANT DISORDER		09/02/2014
787.02	OTHER SYMPTOMS OF THE DIGESTIVE SYSTEM;		04/24/2014
842.09	OTHER WRIST SPRAIN	14.41	08/14/2014
756.52	OSTEOPETROSIS		08/14/2014

GROUP: 2001025 SSN: ********** SEQ: ** DIV: 0001 RELAT: Spouse EFF: ********** DOB: ********** TERM: **********
LEVEL: F00 PLAN: WILCO-MED-DED

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	01-*	250000.00	14.23	35580.66	.00	.00	.00	.00

==========Diagnosis Recap==========

Amount	Code	Description
$14,077.56	218.2	SUBSEROUS LEIOMYOMA OF UTERUS
$11,546.75	617.1	ENDOMETRIOSIS OF OVARY
$2,231.25	621.0	POLYP OF CORPUS UTERI
$1,400.44	614.6	PELVIC PERITONEAL ADHESIONS, FEMALE
$1,255.95	620.0	FOLLICULAR CYST OF OVARY
$1,140.24	218.0	SUBMUCOUS LEIOMYOMA OF UTERUS
$877.00	296.80	BIPOLAR DISORDER,UNSPECIFIED
$781.80	218.1	INTRAMURAL LEIOMYOMA OF UTERUS
$682.00	309.28	ADJUSTMENT DISORDER WITH MIXED ANXIETY AND DEPRESSED MOOD
$666.09	789.00	OTHER SYMPTOMS INVOLVING ABDOMEN AND PELVIS
$336.21	DRUGS	PRESCRIPTION DRUGS
$314.06	218.9	LEIOMYOMA OF UTERUS, UNSPECIFIED
$163.57	V72.31	ROUTINE GYNECOLOGICAL EXAM
$48.70	300.4	DYSTHYMIC DISORDER
$45.82	789.01	OTHER SYMPTOMS INVOLVING ABDOMEN AND PELVIS
$13.22	V72.40	PREGNANCY EXAMINATION OR TEST,PREGNANCY UNCONFIRMED

$35,580.66 Total Paid

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
V72.31	ROUTINE GYNECOLOGICAL EXAM	163.57	12/10/2013
218.1	INTRAMURAL LEIOMYOMA OF UTERUS	781.80	04/17/2014
218.2	SUBSEROUS LEIOMYOMA OF UTERUS	14077.56	04/17/2014
218.9	LEIOMYOMA OF UTERUS, UNSPECIFIED	314.06	04/17/2014

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LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 02 11/01/2013 to 10/31/2014 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
DRUGS	PRESCRIPTION DRUGS	336.21	07/25/2014
300.4	DYSTHYMIC DISORDER	48.70	02/17/2014
296.89	BIPOLAR DISORDER,OTHER		02/17/2014
218.0	SUBMUCOUS LEIOMYOMA OF UTERUS	1140.24	02/28/2014
620.8	OTHER NONINFLAMMATORY DISORDERS OF OVARY		02/28/2014
617.1	ENDOMETRIOSIS OF OVARY	11546.75	04/17/2014
620.0	FOLLICULAR CYST OF OVARY	1255.95	02/28/2014
296.80	BIPOLAR DISORDER,UNSPECIFIED	877.00	10/03/2014
621.0	POLYP OF CORPUS UTERI	2231.25	02/28/2014
789.00	OTHER SYMPTOMS INVOLVING ABDOMEN AND	666.09	09/05/2014
309.28	ADJUSTMENT DISORDER WITH MIXED ANXIETY	682.00	08/18/2014
300.02	GENERALIZED ANXIETY DISORDER		10/03/2014
300.23	SOCIAL PHOBIA		10/03/2014
614.6	PELVIC PERITONEAL ADHESIONS, FEMALE	1400.44	04/17/2014
621.8	OTHER SPECIFIED DISORDERS OF UTERUS, NOT		04/17/2014
617.3	ENDOMETRIOSIS OF PELVIC PERITONEUM		04/17/2014
V72.40	PREGNANCY EXAMINATION OR TEST,PREGNANCY	13.22	09/05/2014
789.01	OTHER SYMPTOMS INVOLVING ABDOMEN AND	45.82	09/05/2014

GROUP: 2001025 SSN: ********** SEQ: ** DIV: 0001 RELAT: Participant EFF: ********** DOB: ********** TERM: **********
LEVEL: F99 PLAN: WILCO-MED-CORE

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	00-*	250000.00	13.66	34146.53	.00	.00	.00	.00

==========Diagnosis Recap==========

Amount	Code	Description
$7,915.00	592.0	CALCULUS OF KIDNEY
$6,432.45	473.9	UNSPECIFIED SINUSITIS (CHRONIC)
$5,827.77	DRUGS	PRESCRIPTION DRUGS
$5,311.27	592.1	CALCULUS OF URETER
$3,843.66	780.53	HYPERSOMNIA WITH SLEEP APNEA, UNSPECIFIED
$851.82	470	DEVIATED NASAL SEPTUM
$669.90	789.09	OTHER SYMPTOMS INVOLVING ABDOMEN AND PELVIS
$629.61	473.1	CHRONIC FRONTAL SINUSITIS
$493.00	478.0	HYPERTROPHY OF NASAL TURBINATES
$488.53	V72.82	PREOP RESPIRATORY EXAM
$245.62	473.2	CHRONIC ETHMOIDAL SINUSITIS
$220.24	238.2	NEOPLASM OF UNCERTAIN BEHAVIOR OF SKIN
$217.94	V05.8	NEED FOR PROPHYLACTIC VACCINATION AND INOCULATION AGAINST OTHER SPECIFIED DISEAS
$194.34	473.0	CHRONIC MAXILLARY SINUSITIS
$193.08	V70.0	ROUTINE GENERAL MEDICAL EXAMINATION AT AHEALTH CARE FACILITY
$174.00	216.6	BENIGN NEOPLASM OF SKIN OF UPPER LIMB, INCLUDING SHOULDER
$104.80	365.02	ANATOMICAL NARROW ANGLE BORDERLINE GLAUCOMA
$96.29	702.0	ACTINIC KERATOSIS
$96.19	593.5	HYDROURETER
$63.59	078.10	VIRAL WARTS NOS
$47.87	558.9	OTHER AND UNSPECIFIED NONINFECTIOUS GASTROENTERITIS AND COLITIS
$17.81	V04.81	NEED FOR PROPHYLACTIC VACCINATION/ INOCULATION AGAINST, INFLUENZA
$9.44	V72.81	PREOP CARDIOVSCLR EXAM
$2.31	600.00	HYPERTROPHY (BENIGN) OF PROSTATE W/O URINARY OBSTRUCTION

$34,146.53 Total Paid

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
DRUGS	PRESCRIPTION DRUGS	5827.77	08/11/2014
592.0	CALCULUS OF KIDNEY	7915.00	01/20/2014
593.5	HYDROURETER	96.19	12/29/2013
592.1	CALCULUS OF URETER	5311.27	01/20/2014
591	HYDRONEPHROSIS		12/29/2013
604.90	ORCHITIS AND EPIDIDYMITIS, UNSPECIFIED		01/02/2014
558.9	OTHER AND UNSPECIFIED NONINFECTIOUS GAST	47.87	01/09/2014
593.3	STRICTURE OR KINKING OF URETER		01/03/2014
401.9	UNSPECIFIED ESSENTIAL HYPERTENSION		01/03/2014
V72.81	PREOP CARDIOVSCLR EXAM	9.44	06/25/2014
600.00	HYPERTROPHY (BENIGN) OF PROSTATE W/O	2.31	02/03/2014
789.09	OTHER SYMPTOMS INVOLVING ABDOMEN AND	669.90	12/29/2013
078.10	VIRAL WARTS NOS	63.59	05/20/2014
470	DEVIATED NASAL SEPTUM	851.82	07/01/2014
478.0	HYPERTROPHY OF NASAL TURBINATES	493.00	07/01/2014
780.53	HYPERSOMNIA WITH SLEEP APNEA,	3843.66	08/28/2014
473.9	UNSPECIFIED SINUSITIS (CHRONIC)	6432.45	08/28/2014
V72.82	PREOP RESPIRATORY EXAM	488.53	06/25/2014
V72.84	PREOP EXAM UNSPCF		06/25/2014
238.2	NEOPLASM OF UNCERTAIN BEHAVIOR OF SKIN	220.24	07/10/2014
702.0	ACTINIC KERATOSIS	96.29	07/10/2014
216.5	BENIGN NEOPLASM OF SKIN OF TRUNK, EXCEPT		07/10/2014
709.09	DYSCHROMIA;OTHER		07/10/2014

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LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 02 11/01/2013 to 10/31/2014 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
210.4	BENIGN NEOPLASM OF OTHER AND UNSPECIFIED		07/01/2014
473.1	CHRONIC FRONTAL SINUSITIS	629.61	07/01/2014
473.2	CHRONIC ETHMOIDAL SINUSITIS	245.62	07/01/2014
473.0	CHRONIC MAXILLARY SINUSITIS	194.34	07/01/2014
216.6	BENIGN NEOPLASM OF SKIN OF UPPER LIMB, I	174.00	07/10/2014
365.02	ANATOMICAL NARROW ANGLE BORDERLINE GLAUC	104.80	07/30/2014
V70.0	ROUTINE GENERAL MEDICAL EXAMINATION AT A	193.08	09/15/2014
V05.8	NEED FOR PROPHYLACTIC VACCINATION AND IN	217.94	09/15/2014
V04.81	NEED FOR PROPHYLACTIC VACCINATION/	17.81	09/15/2014
780.79	OTHER MALAISE AND FATIGUE		09/15/2014
V76.44	SPECIAL SCREENING FOR MALIGNANT NEOPLASM		09/15/2014

GROUP: 2001025 SSN: ********** SEQ: ** DIV: 0001 RELAT: Participant EFF: ********** DOB: ********** TERM: **********
LEVEL: F00 PLAN: WILCO-MED-CORE

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	00-*	250000.00	27.81	69519.77	.00	.00	.00	.00

==========Diagnosis Recap==========

Amount	Code	Description
$52,637.77	715.36	OSTEOARTHROSIS, LOCALIZED, INVOLVING LOWER LEG/KNEE
$6,049.95	715.96	OSTEOARTHROSIS, UNSPECIFIED, INVOLVING LOWER LEG/KNEE
$3,006.77	V43.65	JOINT;KNEE
$1,796.12	DRUGS	PRESCRIPTION DRUGS
$1,779.17	V76.51	SPECIAL SCREENING FOR MALIG NEOPL;COLON
$730.33	V49.81	POSTMENOPAUSAL STATUS (AGE RELATED)
$555.83	999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEWHERE CLASSIFIED
$509.94	719.46	PAIN IN JOINT INVOLVING LOWER LEG
$452.73	781.2	ABNORMALITY OF GAIT
$372.64	716.96	UNSPECIFIED ARTHROPATHY INVOLVING LOWER LEG
$271.49	477.0	ALLERGIC RHINITIS DUE TO POLLEN
$223.32	V76.12	OTHER SCREENING MAMMOGRAM
$206.60	V04.89	NEED FOR PROPHYLACTIC VACCINATION/ INOCULATION AGAINST, OTHER VIRAL DISEASE
$182.46	493.90	ASTHMA, UNSPECIFIED TYPE
$168.00	285.1	ACUTE POSTHEMORRHAGIC ANEMIA
$136.05	285.9	ANEMIA, UNSPECIFIED
$94.88	727.1	BUNION
$66.43	719.96	UNSPECIFIED DISORDER OF LOWER LEG JOINT
$49.83	272.0	PURE HYPERCHOLESTEROLEMIA
$47.87	401.9	UNSPECIFIED ESSENTIAL HYPERTENSION
$47.87	754.62	TALIPES CALCANEOVALGUS
$47.87	477.9	ALLERGIC RHINITIS, CAUSE UNSPECIFIED
$36.95	V72.83	OTH SPCF PREOP EXAM
$25.74	272.4	OTHER AND UNSPECIFIED HYPERLIPIDEMIA
$13.72	V54.81	AFTERCARE FOLLOWING JOINT REPLACEMENT
$9.44	V72.81	PREOP CARDIOVSCLR EXAM

$69,519.77 Total Paid

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
DRUGS	PRESCRIPTION DRUGS	1796.12	10/20/2014
272.0	PURE HYPERCHOLESTEROLEMIA	49.83	05/12/2014
272.4	OTHER AND UNSPECIFIED HYPERLIPIDEMIA	25.74	07/08/2014
790.6	OTHER ABNORMAL BLOOD CHEMISTRY		02/10/2014
278.00	OBESITY, UNSPECIFIED		06/20/2014
477.9	ALLERGIC RHINITIS, CAUSE UNSPECIFIED	47.87	05/12/2014
V49.81	POSTMENOPAUSAL STATUS (AGE RELATED)	730.33	11/14/2013
716.96	UNSPECIFIED ARTHROPATHY INVOLVING LOWER	372.64	11/20/2013
726.2	OTHER AFFECTIONS OF SHOULDER REGION, NOT		11/20/2013
845.00	UNSPECIFIED SITE OF ANKLE SPRAIN		11/20/2013
726.10	DISORDERS OF BURSAE AND TENDONS IN SHOUL		11/20/2013
715.96	OSTEOARTHROSIS, UNSPECIFIED, INVOLVING	6049.95	08/29/2014
V72.83	OTH SPCF PREOP EXAM	36.95	11/25/2013
V76.51	SPECIAL SCREENING FOR MALIG NEOPL;COLON	1779.17	12/10/2013
562.10	DIVERTICULOSIS OF COLON		12/10/2013
493.90	ASTHMA, UNSPECIFIED TYPE	182.46	06/20/2014
754.62	TALIPES CALCANEOVALGUS	47.87	01/07/2014
110.1	DERMATOPHYTOSIS OF NAIL		01/07/2014
356.9	UNSPECIFIED IDIOPATHIC PERIPHERAL NEUROP		01/07/2014
401.9	UNSPECIFIED ESSENTIAL HYPERTENSION	47.87	05/07/2014

10/31/14 Allegiance Benefit Plan Management, Inc. PAGE: 65
LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 02 11/01/2013 to 10/31/2014 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
V04.89	NEED FOR PROPHYLACTIC VACCINATION/	206.60	02/10/2014
780.79	OTHER MALAISE AND FATIGUE		02/10/2014
477.0	ALLERGIC RHINITIS DUE TO POLLEN	271.49	05/23/2014
477.8	ALLERGIC RHINITIS DUE TO OTHER ALLERGEN		05/23/2014
372.14	OTHER CHRONIC ALLERGIC CONJUNCTIVITIS		05/23/2014
727.1	BUNION	94.88	04/10/2014
718.77	DEVELOPMENTAL DISLOCATION OF JOINT,		04/10/2014
719.96	UNSPECIFIED DISORDER OF LOWER LEG JOINT	66.43	05/21/2014
V72.81	PREOP CARDIOVSCLR EXAM	9.44	06/10/2014
715.36	OSTEOARTHROSIS, LOCALIZED, INVOLVING	52637.77	06/20/2014
999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEW	555.83	08/25/2014
V54.81	AFTERCARE FOLLOWING JOINT REPLACEMENT	13.72	07/08/2014
V43.65	JOINT;KNEE	3006.77	07/08/2014
285.9	ANEMIA, UNSPECIFIED	136.05	06/20/2014
715.09	OSTEOARTHROSIS, GENERALIZED, INVOLVING M		06/20/2014
781.2	ABNORMALITY OF GAIT	452.73	07/08/2014
998.83	OTHER SPECIFIED COMPLICATIONS OF PROCED-		07/08/2014
V57.89	CARE INVOLVING OTHER SPECIFIED REHABILIT		06/20/2014
280.0	IRON DEFICIENCY ANEMIA SECONDARY TO BLOO		06/20/2014
V85.39	BODY MASS INDEX 39.0-39.9, ADULT		06/20/2014
719.46	PAIN IN JOINT INVOLVING LOWER LEG	509.94	07/21/2014
719.56	STIFFNESS OF JOINT, NOT ELSEWHERE CLASSI		07/21/2014
715.16	OSTEOARTHROSIS, LOCALIZED, PRIMARY, INVO		07/08/2014
285.1	ACUTE POSTHEMORRHAGIC ANEMIA	168.00	06/23/2014
278.01	MORBID OBESITY		06/23/2014
V76.12	OTHER SCREENING MAMMOGRAM	223.32	10/13/2014
V58.69	LONG-TERM (CURRENT) USE OF OTHER		05/07/2014

GROUP: 2001025 SSN: ********** SEQ: ** DIV: 0001 RELAT: Participant EFF: ********** DOB: ********** TERM: **********
LEVEL: F00 PLAN: WILCO-MED-DED-DIAB

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	00-*	250000.00	54.01	135020.06	.00	.00	.00	.00

==========Diagnosis Recap==========

Amount	Code	Description
$64,698.85	DRUGS	PRESCRIPTION DRUGS
$34,625.82	V58.0	RADIOTHERAPY SESSION
$21,097.48	185	MALIGNANT NEOPLASM OF PROSTATE
$3,732.51	198.5	SECONDARY MALIGNANT NEOPLASM OF BONE ANDBONE MARROW
$3,146.80	427.0	PAROXYSMAL SUPRAVENTRICULAR TACHYCARDIA
$2,754.00	V12.72	Hx, prsnl, colonic polyps
$1,863.74	211.3	BENIGN NEOPLASM OF COLON
$811.84	V67.59	OTHER FOLLOW-UP EXAMINATION
$612.26	786.05	SHORTNESS OF BREATH
$374.13	785.1	PALPITATIONS
$263.77	250.00	DIABETES MELLITUS WITHOUT MENTION OF COMPLICATION, TYPE II
$259.39	733.13	PATH FX VERTEBRAE
$231.78	V70.0	ROUTINE GENERAL MEDICAL EXAMINATION AT AHEALTH CARE FACILITY
$159.88	401.1	BENIGN ESSENTIAL HYPERTENSION
$131.90	790.93	ELVTD PRSTATE SPCF ANTGN
$103.66	V58.69	LONG-TERM (CURRENT) USE OF OTHER MEDICATIONS
$92.25	401.9	UNSPECIFIED ESSENTIAL HYPERTENSION
$60.00	530.11	REFLUX ESOPHAGITIS

$135,020.06 Total Paid

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
185	MALIGNANT NEOPLASM OF PROSTATE	21097.48	10/07/2014
211.3	BENIGN NEOPLASM OF COLON	1863.74	10/22/2013
V12.72	Hx, prsnl, colonic polyps	2754.00	10/22/2013
455.0	INTERNAL HEMORRHOIDS WITHOUT MENTION OF		10/22/2013
562.10	DIVERTICULOSIS OF COLON		10/22/2013
569.89	OTHER SPECIFIED DISORDERS OF INTESTINES		10/22/2013

10/31/14 Allegiance Benefit Plan Management, Inc. PAGE: 66
LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 02 11/01/2013 to 10/31/2014 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
198.5	SECONDARY MALIGNANT NEOPLASM OF BONE AND	3732.51	08/07/2014
790.93	ELVTD PRSTATE SPCF ANTGN	131.90	02/06/2014
V10.46	Hx, prsnl, prostatic malignancy		12/09/2013
DRUGS	PRESCRIPTION DRUGS	64698.85	10/22/2014
V58.0	RADIOTHERAPY SESSION	34625.82	12/09/2013
250.00	DIABETES MELLITUS WITHOUT MENTION OF	263.77	10/07/2014
427.0	PAROXYSMAL SUPRAVENTRICULAR TACHYCARDIA	3146.80	02/11/2014
401.9	UNSPECIFIED ESSENTIAL HYPERTENSION	92.25	02/27/2014
785.1	PALPITATIONS	374.13	02/13/2014
786.05	SHORTNESS OF BREATH	612.26	02/11/2014
530.11	REFLUX ESOPHAGITIS	60.00	02/21/2014
427.89	CARDIAC DYSRHYTHMIAS		02/27/2014
V67.59	OTHER FOLLOW-UP EXAMINATION	811.84	02/06/2014
V58.69	LONG-TERM (CURRENT) USE OF OTHER	103.66	06/23/2014
733.13	PATH FX VERTEBRAE	259.39	03/10/2014
V07.59	Use of othr agnts affec estrogen		05/08/2014
V72.60	Laboratory examination, unspecified		05/08/2014
401.1	BENIGN ESSENTIAL HYPERTENSION	159.88	10/07/2014
V45.77	ACQUIRED ABSENCE OF GENITAL ORGAN		05/22/2014
V15.3	Hx, prsnl, irradiation		08/07/2014
738.5	OTHER ACQUIRED DEFORMITY OF BACK OR SPIN		08/07/2014
V70.0	ROUTINE GENERAL MEDICAL EXAMINATION AT A	231.78	09/29/2014
244.9	UNSPECIFIED ACQUIRED HYPOTHYROIDISM		10/07/2014

GROUP: 2001025 SSN: ********** SEQ: ** DIV: 0001 RELAT: Child EFF: ********** DOB: ********** TERM: **********
LEVEL: P99 PLAN: WILCO-MED-DED

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	11-*	250000.00	13.63	34073.96	.00	.00	.00	.00

==========Diagnosis Recap==========

Amount	Code	Description
$25,056.68	DRUGS	PRESCRIPTION DRUGS
$8,369.31	259.1	PRECOCIOUS SEXUAL DEVELOPMENT AND PUBERTY, NOT ELSEWHERE CLASSIFIED
$504.45	999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEWHERE CLASSIFIED
$143.52	785.0	TACHYCARDIA, UNSPECIFIED

$34,073.96 Total Paid

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
259.1	PRECOCIOUS SEXUAL DEVELOPMENT AND PUBERT	8369.31	04/11/2014
999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEW	504.45	12/14/2013
DRUGS	PRESCRIPTION DRUGS	25056.68	05/05/2014
785.0	TACHYCARDIA, UNSPECIFIED	143.52	01/31/2014

GROUP: 2001025 SSN: ********** SEQ: ** DIV: 0001 RELAT: Participant EFF: ********** DOB: ********** TERM: **********
LEVEL: P99 PLAN: WILCO-MED-DED

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	00-*	250000.00	12.52	31294.44	.00	.00	.00	.00

==========Diagnosis Recap==========

Amount	Code	Description
$14,540.36	V57.89	CARE INVOLVING OTHER SPECIFIED REHABILITATION PROCEDURE
$10,948.37	434.91	CRBL ART OCL NOS W INFRC
$2,952.97	780.79	OTHER MALAISE AND FATIGUE
$1,500.00	429.9	HEART DISEASE, UNSPECIFIED
$402.50	999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEWHERE CLASSIFIED
$370.40	796.2	ELEVATED BLOOD PRESSURE READING WITHOUT DIAGNOSIS OF HYPERTENSION
$154.66	401.9	UNSPECIFIED ESSENTIAL HYPERTENSION
$145.42	729.89	OTHER MUSCULOSKELETAL SYMPTOMS REFERABLETO LIMBS
$132.67	434.90	CRBL ART OC NOS WO INFRC
$74.92	496	CHRONIC AIRWAY OBSTRUCTION, NOT ELSEWHERE CLASSIFIED
$50.31	V67.9	UNSPECIFIED FOLLOW-UP EXAMINATION
$21.86	DRUGS	PRESCRIPTION DRUGS

$31,294.44 Total Paid

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
434.91	CRBL ART OCL NOS W INFRC	10948.37	09/11/2014
401.0	MALIGNANT ESSENTIAL HYPERTENSION		09/18/2014
428.30	DIASTOLIC HEART FAILURE UNSPECIFIED		09/11/2014
334.3	OTHER CEREBELLAR ATAXIA		09/11/2014
272.4	OTHER AND UNSPECIFIED HYPERLIPIDEMIA		09/11/2014
796.2	ELEVATED BLOOD PRESSURE READING WITHOUT	370.40	09/09/2014
344.9	PARALYSIS, UNSPECIFIED		09/09/2014
DRUGS	PRESCRIPTION DRUGS	21.86	09/18/2014
729.89	OTHER MUSCULOSKELETAL SYMPTOMS REFERABLE	145.42	09/09/2014
V57.89	CARE INVOLVING OTHER SPECIFIED REHABILIT	14540.36	10/03/2014
438.20	HEMOPLEGIA/HEMIPARESIS AFFECTING		09/18/2014
438.84	ATAXIA		09/18/2014
V15.52	Hx, prsnl, traumatic brain injury		09/18/2014
780.79	OTHER MALAISE AND FATIGUE	2952.97	09/09/2014

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LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 02 11/01/2013 to 10/31/2014 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEW	402.50	09/25/2014
429.9	HEART DISEASE, UNSPECIFIED	1500.00	09/10/2014
496	CHRONIC AIRWAY OBSTRUCTION, NOT ELSEWHER	74.92	09/08/2014
434.90	CRBL ART OC NOS WO INFRC	132.67	09/07/2014
401.9	UNSPECIFIED ESSENTIAL HYPERTENSION	154.66	10/02/2014
272.9	UNSPECIFIED DISORDER OF LIPOID METABOLIS		10/02/2014
959.01	HEAD INJURY, UNSPECIFIED		10/02/2014
V67.9	UNSPECIFIED FOLLOW-UP EXAMINATION	50.31	10/02/2014
719.7	DIFFICULTY IN WALKING		10/03/2014
719.57	STIFFNESS OF JOINT, NOT ELSEWHERE CLASSI		10/03/2014
781.2	ABNORMALITY OF GAIT		10/03/2014
781.3	LACK OF COORDINATION		10/03/2014

GROUP: 2001025 SSN: ********** SEQ: ** DIV: RETR RELAT: Participant EFF: ********** DOB: ********** TERM: **********
LEVEL: P00 PLAN: WILCO-MED-CORE

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	00-*	250000.00	64.90	162248.36	.00	.00	.00	.00

==========Diagnosis Recap==========

Amount	Code	Description
$139,955.24	174.4	MALIGNANT NEOPLASM OF UPPER-OUTER QUADRANT OF FEMALE BREAST
$6,557.38	174.9	MALIGNANT NEOPLASM OF BREAST (FEMALE), UNSPECIFIED
$4,888.42	DRUGS	PRESCRIPTION DRUGS
$2,078.92	V57.21	CARE INVOLVING REHABILITATION PROCEDURESENCOUNTER FOR OCCUPATIONAL THERAPY
$1,488.75	999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEWHERE CLASSIFIED
$1,223.50	V57.89	CARE INVOLVING OTHER SPECIFIED REHABILITATION PROCEDURE
$1,203.01	998.51	POSTOPERATIVE INFECTION;INFECTED POST- OPERATIVE SEROMA
$963.34	V10.3	Hx, prsnl, breast malignancy
$884.11	784.7	EPISTAXIS
$743.72	V58.11	ENCOUNTER FOR ANTINEOPLASTIC CHEMOTHERAPY
$357.00	V57.1	CARE INVOLVING OTHER PHYSICAL THERAPY
$338.76	244.0	POSTSURGICAL HYPOTHYROIDISM
$265.00	V58.32	ENCOUNTER FOR OTHER AND UNSPECIFIED PROCEDURES AND AFTERCARE-ENCOUNTER
$265.00	879.8	OPEN WOUND(S) (MULTIPLE) OF UNSPECIFIED SITE(S), WITHOUT MENTION OF COMPLICATION
$206.78	174.8	MALIGNANT NEOPLASM OF OTHER SPECIFIED SITES OF FEMALE BREAST
$186.60	233.0	CARCINOMA IN SITU OF BREAST
$147.24	414.02	CORONARY ATHEROSCLEROSIS;OF AUTOLOGOUS VEIN BYPASS GRAFT
$113.35	366.16	SENILE NUCLEAR SCLEROSIS
$101.79	110.1	DERMATOPHYTOSIS OF NAIL
$75.58	782.3	EDEMA
$66.72	V04.81	NEED FOR PROPHYLACTIC VACCINATION/ INOCULATION AGAINST, INFLUENZA
$56.05	272.2	Hyperlipidemia, mixed
$52.67	V58.69	LONG-TERM (CURRENT) USE OF OTHER MEDICATIONS
$21.49	V10.87	Hx, prsnl, thyroid malignancy
$7.94	V02.61	VIRAL HEPATITIS;HEPATITIS B CARRIER

$162,248.36 Total Paid

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
998.51	POSTOPERATIVE INFECTION;INFECTED POST-	1203.01	10/10/2013
996.69	INFECTION AND INFLAMMATORY REACTION DUE		10/10/2013
611.0	INFLAMMATORY DISEASE OF BREAST		10/10/2013
E878.1	SURGICAL OPERATION WITH IMPLANT OF ARTIF		10/10/2013
233.0	CARCINOMA IN SITU OF BREAST	186.60	05/15/2014
999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEW	1488.75	09/25/2014
V04.81	NEED FOR PROPHYLACTIC VACCINATION/	66.72	10/13/2014
V10.87	Hx, prsnl, thyroid malignancy	21.49	06/18/2014
244.0	POSTSURGICAL HYPOTHYROIDISM	338.76	06/24/2014
252.1	HYPOPARATHYROIDISM		02/06/2014
266.2	OTHER B-COMPLEX DEFICIENCIES		10/29/2013
V10.3	Hx, prsnl, breast malignancy	963.34	10/10/2013
V45.71	Pstprcd state acq absce of brst/nip		03/26/2014
611.83	Capsular contracture breast implant		10/10/2013
174.9	MALIGNANT NEOPLASM OF BREAST (FEMALE), U	6557.38	07/29/2014
611.3	FAT NECROSIS OF BREAST		08/16/2013
V86.0	ESTROGEN RECEPTOR POSITIVE STATUS (ER+)		08/16/2013
174.4	MALIGNANT NEOPLASM OF UPPER-OUTER QUADRA	139955.24	10/13/2014
DRUGS	PRESCRIPTION DRUGS	4888.42	10/14/2014
V58.11	ENCOUNTER FOR ANTINEOPLASTIC	743.72	10/13/2014
V57.1	CARE INVOLVING OTHER PHYSICAL THERAPY	357.00	07/29/2014
719.41	PAIN IN JOINT INVOLVING SHOULDER REGION		11/11/2013
719.51	STIFFNESS OF JOINT, NOT ELSEWHERE CLASSI		11/11/2013
728.87	MUSCLE WEAKNESS (GENERALIZED)		11/11/2013
796.2	ELEVATED BLOOD PRESSURE READING WITHOUT		11/11/2013
174.8	MALIGNANT NEOPLASM OF OTHER SPECIFIED SI	206.78	09/25/2014

10/31/14 Allegiance Benefit Plan Management, Inc. PAGE: 69
LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 02 11/01/2013 to 10/31/2014 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
V02.61	VIRAL HEPATITIS;HEPATITIS B CARRIER	7.94	01/02/2014
784.7	EPISTAXIS	884.11	01/27/2014
V58.69	LONG-TERM (CURRENT) USE OF OTHER	52.67	01/17/2014
285.9	ANEMIA, UNSPECIFIED		01/17/2014
272.2	Hyperlipidemia, mixed	56.05	06/24/2014
V58.12	ENCOUNTER FOR ANTINEOPLASTIC		10/13/2014
592.0	CALCULUS OF KIDNEY		03/18/2014
268.9	UNSPECIFIED VITAMIN D DEFICIENCY		06/18/2014
193	MALIGNANT NEOPLASM OF THYROID GLAND		06/24/2014
790.21	IMPAIRED FASTING GLUCOSE		06/24/2014
V57.89	CARE INVOLVING OTHER SPECIFIED REHABILIT	1223.50	04/09/2014
729.81	SWELLING OF LIMB		07/29/2014
729.5	PAIN IN LIMB		06/19/2014
V57.21	CARE INVOLVING REHABILITATION PROCEDURES	2078.92	06/24/2014
110.1	DERMATOPHYTOSIS OF NAIL	101.79	06/19/2014
457.1	OTHER LYMPHEDEMA		06/24/2014
366.16	SENILE NUCLEAR SCLEROSIS	113.35	08/06/2014
457.0	POSTMASTECTOMY LYMPHEDEMA SYNDROME		07/09/2014
782.3	EDEMA	75.58	07/09/2014
879.8	OPEN WOUND(S) (MULTIPLE) OF UNSPECIFIED	265.00	09/24/2014
V58.32	ENCOUNTER FOR OTHER AND UNSPECIFIED	265.00	10/04/2014
414.02	CORONARY ATHEROSCLEROSIS;OF AUTOLOGOUS	147.24	09/16/2014
424.1	AORTIC VALVE DISORDERS		09/16/2014
272.0	PURE HYPERCHOLESTEROLEMIA		09/16/2014

GROUP: 2001025 SSN: ********** SEQ: ** DIV: 0001 RELAT: Participant EFF: ********** DOB: ********** TERM: **********
LEVEL: P99 PLAN: WILCO-MED-EPO

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	00-*	250000.00	10.26	25651.96	.00	.00	.00	.00

==========Diagnosis Recap==========

Amount	Code	Description
$12,207.32	530.81	ESOPHAGEAL REFLUX
$4,669.86	789.09	OTHER SYMPTOMS INVOLVING ABDOMEN AND PELVIS
$4,019.96	V16.3	FAMILY HISTORY OF MALIGNANT NEOPLASM OF BREAST
$1,341.78	786.50	UNSPECIFIED CHEST PAIN
$612.00	787.20	DYSPHAGIA, UNSPECIFIED
$555.00	535.10	ATRPH GASTRTIS W/O HMRHG
$401.57	787.01	OTHER SYMPTOMS INVOLVING DIGESTIVE SYSTEM;NAUSEA WITH VOMITING
$364.17	999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEWHERE CLASSIFIED
$268.71	789.01	OTHER SYMPTOMS INVOLVING ABDOMEN AND PELVIS
$144.07	562.10	DIVERTICULOSIS OF COLON
$137.36	V64.1	SURGICAL OR OTHER PROCEDURE NOT CARRIED OUT BECAUSE OF CONTRAINDICATION
$115.37	236.2	NEOPLASM OF UNCERTAIN BEHAVIOR OF OVARY
$112.66	553.3	DIAPHRAGMATIC HERNIA WITHOUT MENTION OF OBSTRUCTION OR GANGRENE
$112.02	611.72	LUMP OR MASS IN BREAST
$92.35	780.79	OTHER MALAISE AND FATIGUE
$90.38	DRUGS	PRESCRIPTION DRUGS
$83.97	V16.41	GENITAL ORGANS, OVARY
$80.42	272.4	OTHER AND UNSPECIFIED HYPERLIPIDEMIA
$59.66	620.1	CORPUS LUTEUM CYST OR HEMATOMA
$59.63	787.02	OTHER SYMPTOMS OF THE DIGESTIVE SYSTEM; NAUSEA ALONE
$59.63	564.1	IRRITABLE COLON
$17.61	724.2	LUMBAGO
$17.12	959.19	OTHER INJURY OF OTHER SITES OF TRUNK
$13.79	786.09	OTHER DYSPNEA AND RESPIRATORY ABNORMALITY
$8.05	789.00	OTHER SYMPTOMS INVOLVING ABDOMEN AND PELVIS
$7.50	786.59	OTHER CHEST PAIN

$25,651.96 Total Paid

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
V16.3	FAMILY HISTORY OF MALIGNANT NEOPLASM OF	4019.96	01/20/2014
V16.42	GENITAL ORGANS;PROSTATE		01/20/2014
236.2	NEOPLASM OF UNCERTAIN BEHAVIOR OF OVARY	115.37	10/21/2013
625.9	UNSPECIFIED SYMPTOM ASSOCIATED WITH FEMA		10/21/2013
V16.41	GENITAL ORGANS, OVARY	83.97	01/20/2014
786.50	UNSPECIFIED CHEST PAIN	1341.78	10/01/2013
530.81	ESOPHAGEAL REFLUX	12207.32	04/15/2014
530.3	STRICTURE AND STENOSIS OF ESOPHAGUS		03/24/2014
611.72	LUMP OR MASS IN BREAST	112.02	09/06/2013
V64.1	SURGICAL OR OTHER PROCEDURE NOT CARRIED	137.36	11/11/2013
553.3	DIAPHRAGMATIC HERNIA WITHOUT MENTION OF	112.66	04/15/2014
787.20	DYSPHAGIA, UNSPECIFIED	612.00	11/11/2013
564.1	IRRITABLE COLON	59.63	01/13/2014
787.01	OTHER SYMPTOMS INVOLVING DIGESTIVE	401.57	01/16/2014
535.10	ATRPH GASTRTIS W/O HMRHG	555.00	10/07/2013
535.60	DUODENITIS W/O HMRHG		10/07/2013
786.59	OTHER CHEST PAIN	7.50	10/02/2013
V12.54	Hx, prsnl, TIA and cerebral infa		10/02/2013
V45.72	ACQUIRED ABSENCE OF ORGAN;ACQUIRED		10/02/2013
278.01	MORBID OBESITY		11/11/2013
611.71	MASTODYNIA		09/23/2013
793.80	ABNORMAL MAMMOGRAM, UNSPECIFIED		09/23/2013
620.1	CORPUS LUTEUM CYST OR HEMATOMA	59.66	10/21/2013
789.09	OTHER SYMPTOMS INVOLVING ABDOMEN AND	4669.86	01/16/2014
338.19	OTHER ACUTE PAIN		01/16/2014

623.8	OTHER SPECIFIED NONINFLAMMATORY DISORDER			01/15/2014
562.10	DIVERTICULOSIS OF COLON		144.07	01/16/2014
571.8	OTHER CHRONIC NONALCOHOLIC LIVER DISEASE			01/16/2014
478.29	OTHER DISEASES OF PHARYNX OR NASOPHARYNX			02/28/2014
DRUGS	PRESCRIPTION DRUGS		90.38	09/24/2014
V85.41	BMI 40.0-44.9, adult			04/15/2014
278.00	OBESITY, UNSPECIFIED			04/15/2014
228.09	HEMANGIOMA OF OTHER SITES			04/15/2014
999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEW		364.17	05/25/2014
959.19	OTHER INJURY OF OTHER SITES OF TRUNK		17.12	04/18/2014
724.1	PAIN IN THORACIC SPINE			04/18/2014
786.09	OTHER DYSPNEA AND RESPIRATORY ABNORMALIT		13.79	04/16/2014
724.2	LUMBAGO		17.61	04/18/2014
780.79	OTHER MALAISE AND FATIGUE		92.35	07/25/2014

10/31/14 Allegiance Benefit Plan Management, Inc. PAGE: 71
LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 02 11/01/2013 to 10/31/2014 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
789.00	OTHER SYMPTOMS INVOLVING ABDOMEN AND	8.05	07/25/2014
787.02	OTHER SYMPTOMS OF THE DIGESTIVE SYSTEM;	59.63	10/03/2014
573.9	DISORDER OF LIVER		07/25/2014
272.4	OTHER AND UNSPECIFIED HYPERLIPIDEMIA	80.42	07/25/2014
789.01	OTHER SYMPTOMS INVOLVING ABDOMEN AND	268.71	10/03/2014
564.00	CONSTIPATION, UNSPECIFIED		09/29/2014
V12.72	Hx, prsnl, colonic polyps		09/29/2014

GROUP: 2001025 SSN: ********** SEQ: ** DIV: 0001 RELAT: Spouse EFF: ********** DOB: ********** TERM: **********
LEVEL: F99 PLAN: WILCO-MED-CORE

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	01-*	250000.00	53.59	133967.26	.00	.00	.00	.00

==========Diagnosis Recap==========

Amount	Code	Description
$102,402.08	996.2	MECHANICAL COMPLICATION OF NERVOUS SYSTEM DEVICE, IMPLANT, AND GRAFT
$15,183.27	332.0	PARALYSIS AGITANS
$13,931.62	DRUGS	PRESCRIPTION DRUGS
$783.86	999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEWHERE CLASSIFIED
$304.11	719.41	PAIN IN JOINT INVOLVING SHOULDER REGION
$251.00	333.1	ESSENTIAL AND OTHER SPECIFIED FORMS OF TREMOR
$237.26	726.2	OTHER AFFECTIONS OF SHOULDER REGION, NOTELSEWHERE CLASSIFIED
$158.24	272.4	OTHER AND UNSPECIFIED HYPERLIPIDEMIA
$131.81	257.2	OTHER TESTICULAR HYPOFUNCTION
$131.06	333.99	OTHER EXTRAPYRAMIDAL DISEASES AND ABNORMAL MOVEMENT DISORDERS
$131.05	255.2	ADRENOGENITAL DISORDERS
$120.45	V70.0	ROUTINE GENERAL MEDICAL EXAMINATION AT AHEALTH CARE FACILITY
$96.67	V71.9	OBSERVATION FOR UNSPECIFIED SUSPECTED CONDITION
$68.24	477.9	ALLERGIC RHINITIS, CAUSE UNSPECIFIED
$19.42	V72.81	PREOP CARDIOVSCLR EXAM
$17.12	V72.82	PREOP RESPIRATORY EXAM
$133,967.26	Total Paid	

10/31/14 Allegiance Benefit Plan Management, Inc. PAGE: 72
LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 02 11/01/2013 to 10/31/2014 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
332.0	PARALYSIS AGITANS	15183.27	10/02/2014
333.99	OTHER EXTRAPYRAMIDAL DISEASES AND ABNORM	131.06	10/02/2014
333.89	OTHER FRAGMENTS OF TORSION DYSTONIA		10/02/2014
268.9	UNSPECIFIED VITAMIN D DEFICIENCY		09/02/2014
DRUGS	PRESCRIPTION DRUGS	13931.62	10/21/2014
V72.81	PREOP CARDIOVSCLR EXAM	19.42	07/17/2014
V71.9	OBSERVATION FOR UNSPECIFIED SUSPECTED CO	96.67	12/09/2013
255.2	ADRENOGENITAL DISORDERS	131.05	10/20/2014
272.4	OTHER AND UNSPECIFIED HYPERLIPIDEMIA	158.24	10/20/2014
V70.0	ROUTINE GENERAL MEDICAL EXAMINATION AT A	120.45	01/20/2014
477.9	ALLERGIC RHINITIS, CAUSE UNSPECIFIED	68.24	10/15/2014
302.72	HYPOACTIVE SEXUAL DESIRE DISORDER,WITH		10/15/2014
719.41	PAIN IN JOINT INVOLVING SHOULDER REGION	304.11	04/21/2014
727.62	NONTRAUMATIC RUPTURE OF TENDONS OF BICEP		02/13/2014
999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEW	783.86	08/25/2014
726.2	OTHER AFFECTIONS OF SHOULDER REGION, NOT	237.26	04/21/2014
333.1	ESSENTIAL AND OTHER SPECIFIED FORMS OF T	251.00	04/03/2014
996.2	MECHANICAL COMPLICATION OF NERVOUS SYSTE	102402.08	07/19/2014
785.0	TACHYCARDIA, UNSPECIFIED		07/17/2014
V72.82	PREOP RESPIRATORY EXAM	17.12	07/17/2014
257.2	OTHER TESTICULAR HYPOFUNCTION	131.81	10/20/2014
270.4	DISTURBANCES OF SULPHUR-BEARING AMINO-AC		07/19/2014
305.1	TOBACCO USE DISORDER		07/19/2014
V04.81	NEED FOR PROPHYLACTIC VACCINATION/		10/15/2014

GROUP: 2001025 SSN: ********** SEQ: ** DIV: 0001 RELAT: Child EFF: ********** DOB: ********** TERM: **********
LEVEL: F99 PLAN: WILCO-MED-EPO

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	12-*	250000.00	16.40	41011.60	.00	.00	.00	.00

==========Diagnosis Recap==========

Amount	Code	Description
$26,036.80	155.0	MALIGNANT NEOPLASM OF LIVER, PRIMARY
$5,413.65	155.2	MALIGNANT NEOPLASM OF LIVER, NOT SPECIFIED AS PRIMARY OR SECONDARY
$1,957.67	620.2	OTHER AND UNSPECIFIED OVARIAN CYST
$1,938.62	237.3	NEOPLASM OF UNCERTAIN BEHAVIOR OF PARAGANGLIA
$1,315.42	401.0	MALIGNANT ESSENTIAL HYPERTENSION
$1,289.75	238.5	NEOPLASM OF UNCERTAIN BEHAVIOR OF HISTIOCYTIC AND MAST CELLS
$544.18	171.5	MALIGNANT NEOPLASM OF CONNECTIVE AND OTHER SOFT TISSUE OF ABDOMEN
$457.80	620.8	OTHER NONINFLAMMATORY DISORDERS OF OVARY, FALLOPIAN TUBE, AND BROAD LIGAMENT
$402.52	999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEWHERE CLASSIFIED
$337.50	786.6	SWELLING, MASS, OR LUMP IN CHEST
$212.55	171.4	MALIGNANT NEOPLASM OF CONNECTIVE AND OTHER SOFT TISSUE OF THORAX
$205.08	235.3	NEOPLASM OF UNCERTAIN BEHAVIOR OF LIVER AND BILIARY PASSAGES
$203.78	573.8	OTHER SPECIFIED DISORDERS OF LIVER
$202.22	785.2	FUNCTIONAL AND UNDIAGNOSED CARDIAC MURMURS
$170.20	401.1	BENIGN ESSENTIAL HYPERTENSION
$154.49	238.1	NEOPLASM OF UNCERTAIN BEHAVIOR OF CONNECTIVE AND OTHER SOFT TISSUE
$99.23	402.00	MALIGNANT HYPERTENSIVE HEART DISEASE WITHOUT CONGESTIVE HEART FAILURE
$43.38	692.6	CONTACT DERMATITIS AND OTHER ECZEMA DUE TO PLANTS (EXCEPT FOOD)
$17.12	V72.82	PREOP RESPIRATORY EXAM
$9.64	V72.81	PREOP CARDIOVSCLR EXAM

$41,011.60 Total Paid

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
155.0	MALIGNANT NEOPLASM OF LIVER, PRIMARY	26036.80	06/10/2014
568.0	PERITONEAL ADHESIONS		10/08/2013
401.9	UNSPECIFIED ESSENTIAL HYPERTENSION		06/10/2014
999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEW	402.52	09/25/2014
238.5	NEOPLASM OF UNCERTAIN BEHAVIOR OF HISTIO	1289.75	10/22/2013
620.8	OTHER NONINFLAMMATORY DISORDERS OF OVARY	457.80	10/08/2013
789.59	ASCITES;OTHER SPECIFIC SITE		10/07/2013
786.6	SWELLING, MASS, OR LUMP IN CHEST	337.50	10/22/2013
171.4	MALIGNANT NEOPLASM OF CONNECTIVE AND OTH	212.55	10/18/2013
V72.82	PREOP RESPIRATORY EXAM	17.12	10/03/2013
237.3	NEOPLASM OF UNCERTAIN BEHAVIOR OF PARAGA	1938.62	10/31/2013
238.1	NEOPLASM OF UNCERTAIN BEHAVIOR OF CONNEC	154.49	01/16/2014
155.2	MALIGNANT NEOPLASM OF LIVER, NOT SPECIFI	5413.65	10/07/2013
620.2	OTHER AND UNSPECIFIED OVARIAN CYST	1957.67	10/07/2013
235.3	NEOPLASM OF UNCERTAIN BEHAVIOR OF LIVER	205.08	11/18/2013

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LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 02 11/01/2013 to 10/31/2014 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
V72.81	PREOP CARDIOVSCLR EXAM	9.64	10/03/2013
171.5	MALIGNANT NEOPLASM OF CONNECTIVE AND OTH	544.18	06/10/2014
493.90	ASTHMA, UNSPECIFIED TYPE		01/16/2014
692.6	CONTACT DERMATITIS AND OTHER ECZEMA DUE	43.38	02/27/2014
401.1	BENIGN ESSENTIAL HYPERTENSION	170.20	10/17/2014
405.99	OTHER UNSPECIFIED SECONDARY HYPERTENSION		06/10/2014
573.8	OTHER SPECIFIED DISORDERS OF LIVER	203.78	06/10/2014
V45.89	OTHER POSTSURGICAL STATUS		06/10/2014
719.41	PAIN IN JOINT INVOLVING SHOULDER REGION		06/10/2014
724.2	LUMBAGO		06/10/2014
V58.69	LONG-TERM (CURRENT) USE OF OTHER		06/10/2014
785.2	FUNCTIONAL AND UNDIAGNOSED CARDIAC MURMU	202.22	06/24/2014
401.0	MALIGNANT ESSENTIAL HYPERTENSION	1315.42	06/24/2014
593.9	UNSPECIFIED DISORDER OF KIDNEY AND URETE		06/24/2014
402.00	MALIGNANT HYPERTENSIVE HEART DISEASE WIT	99.23	06/24/2014

GROUP: 2001025 SSN: ********** SEQ: ** DIV: 0001 RELAT: Child EFF: ********** DOB: ********** TERM: **********
LEVEL: P99 PLAN: WILCO-MED-DED

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	11-*	250000.00	10.42	26051.48	.00	.00	.00	.00

==========Diagnosis Recap==========

Amount	Code	Description
$25,670.78	DRUGS	PRESCRIPTION DRUGS
$90.73	300.02	GENERALIZED ANXIETY DISORDER
$90.34	V70.0	ROUTINE GENERAL MEDICAL EXAMINATION AT AHEALTH CARE FACILITY
$65.73	923.21	CONTUSION OF WRIST
$64.01	696.1	OTHER PSORIASIS AND SIMILAR DISORDERS
$29.46	719.43	PAIN IN JOINT INVOLVING FOREARM
$22.34	719.45	PAIN IN JOINT INVOLVING PELVIC REGION AND THIGH
$18.09	780.79	OTHER MALAISE AND FATIGUE

$26,051.48 Total Paid

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
V70.0	ROUTINE GENERAL MEDICAL EXAMINATION AT A	90.34	08/22/2013
625.3	DYSMENORRHEA		08/22/2013
300.02	GENERALIZED ANXIETY DISORDER	90.73	03/10/2014
696.1	OTHER PSORIASIS AND SIMILAR DISORDERS	64.01	09/10/2014
DRUGS	PRESCRIPTION DRUGS	25670.78	10/16/2014
923.21	CONTUSION OF WRIST	65.73	12/17/2013
719.43	PAIN IN JOINT INVOLVING FOREARM	29.46	12/17/2013
296.20	MAJOR DEPRESSIVE AFFECTIVE DISORDER, SIN		12/17/2013
780.79	OTHER MALAISE AND FATIGUE	18.09	12/17/2013
296.30	MAJOR DEPRESSIVE AFFECTIVE DISORDER, REC		03/10/2014
V65.42	COUNSELING ON SUBSTANCE USE AND ABUSE		03/10/2014
719.45	PAIN IN JOINT INVOLVING PELVIC REGION AN	22.34	08/12/2014

GROUP: 2001025 SSN: ********** SEQ: ** DIV: 0002 RELAT: Participant EFF: ********** DOB: ********** TERM: **********
LEVEL: P00 PLAN: WILCO-MED-DED-DIAB

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	00-*	250000.00	98.09	245235.71	.00	.00	.00	.00

==========Diagnosis Recap==========

Amount	Code	Description
$161,050.73	482.9	BACTERIAL PNEUMONIA, UNSPECIFIED
$23,844.48	DRUGS	PRESCRIPTION DRUGS
$14,666.18	799.3	DEBILITY, UNSPECIFIED
$10,662.17	V58.69	LONG-TERM (CURRENT) USE OF OTHER MEDICATIONS
$5,981.81	722.52	DEGENERATION OF LUMBAR OR LUMBOSACRAL INTERVERTEBRAL DISC
$5,458.33	338.4	CHRONIC PAIN SYNDROME
$3,368.19	721.3	LUMBOSACRAL SPONDYLOSIS WITHOUT MYELOPATHY
$2,799.75	518.81	RESPIRATORY FAILURE
$2,245.74	999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEWHERE CLASSIFIED
$2,189.77	724.4	THORACIC OR LUMBOSACRAL NEURITIS OR RADICULITIS
$1,777.92	724.2	LUMBAGO
$1,648.92	786.03	DYSPNEA AND RESPIRATORY ABNORMALITIES; APNEA
$1,453.71	327.23	OBSTRUCTIVE SLEEP APNEA (ADULT) (PEDIATRIC)
$1,391.51	506.1	ACUTE PULMONARY EDEMA DUE TO FUMES AND VAPORS
$1,248.92	V46.2	SUPPLEMENTAL OXYGEN; LONG TERM O2 THERAPY
$770.00	722.10	DISPLACEMENT OF LUMBAR INTERVERTEBRAL DISC WITHOUT MYELOPATHY
$675.41	250.00	DIABETES MELLITUS WITHOUT MENTION OF COMPLICATION, TYPE II
$642.72	338.19	OTHER ACUTE PAIN
$632.32	518.84	OTHER DISEASES OF LUNG/ ACUTE & CHRONIC RESIPIRATORY FAILURE
$555.20	724.3	SCIATICA
$503.70	V85.43	BMI 50.0-59.9, adult
$491.55	716.98	UNSPECIFIED ARTHROPATHY INVOLVING OTHER UNSPECIFIED SITES
$293.28	493.92	ASTHMA UNSPECIFIED W/ ACUTE EXACERBATION
$228.79	786.05	SHORTNESS OF BREATH
$71.60	782.3	EDEMA
$67.14	424.2	TRICUSPID VALVE DISORDERS, SPECIFIED AS NONRHEUMATIC
$62.00	309.0	ADJUSTMENT DISORDER WITH DEPRESSED MOOD

$60.76	V85.44	BMI 60.0-69.9, adult
$60.44	756.12	SPONDYLOLISTHESIS, CONGENITAL
$58.95	724.5	BACKACHE, UNSPECIFIED
$58.95	372.30	CONJUNCTIVITIS, UNSPECIFIED
$57.58	719.48	PAIN IN JOINT INVOLVING OTHER SPECIFIED SITES
$42.74	729.5	PAIN IN LIMB
$28.38	338.28	OTHER CHRONIC POSTOPERATIVE PAIN
$27.58	486	PNEUMONIA, ORGANISM UNSPECIFIED
$17.12	429.3	CARDIOMEGALY
$13.79	518.89	OTHER DISEASES OF LUNG, NOT ELSEWHERE CLASSIFIED
$13.79	786.09	OTHER DYSPNEA AND RESPIRATORY ABNORMALITY
$13.79	V58.82	FITTING AND ADJUSTMENT OF NONVASCULAR CATHETER, NEC

$245,235.71 Total Paid

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
729.5	PAIN IN LIMB	42.74	02/19/2014
722.52	DEGENERATION OF LUMBAR OR LUMBOSACRAL IN	5981.81	09/25/2014
DRUGS	PRESCRIPTION DRUGS	23844.48	09/26/2014
722.10	DISPLACEMENT OF LUMBAR INTERVERTEBRAL DI	770.00	11/13/2013
214.8	LIPOMA OF OTHER SPECIFIED SITES		11/13/2013
721.3	LUMBOSACRAL SPONDYLOSIS WITHOUT MYELOPAT	3368.19	06/03/2014
V58.69	LONG-TERM (CURRENT) USE OF OTHER	10662.17	09/25/2014
V58.83	ENCOUNTER/THERAPEUTIC DRUG MONITORING		09/25/2014
250.00	DIABETES MELLITUS WITHOUT MENTION OF	675.41	06/20/2014
372.30	CONJUNCTIVITIS, UNSPECIFIED	58.95	12/20/2013

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LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 02 11/01/2013 to 10/31/2014 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
724.4	THORACIC OR LUMBOSACRAL NEURITIS OR RADI	2189.77	09/25/2014
401.9	UNSPECIFIED ESSENTIAL HYPERTENSION		09/05/2014
493.90	ASTHMA, UNSPECIFIED TYPE		04/11/2014
327.23	OBSTRUCTIVE SLEEP APNEA (ADULT)	1453.71	09/12/2014
716.98	UNSPECIFIED ARTHROPATHY INVOLVING OTHER	491.55	09/25/2014
724.2	LUMBAGO	1777.92	09/25/2014
724.5	BACKACHE, UNSPECIFIED	58.95	05/09/2014
783.1	ABNORMAL WEIGHT GAIN		12/17/2013
338.19	OTHER ACUTE PAIN	642.72	02/27/2014
338.29	OTHER CHRONIC PAIN		06/20/2014
719.45	PAIN IN JOINT INVOLVING PELVIC REGION AN		02/27/2014
V45.89	OTHER POSTSURGICAL STATUS		02/27/2014
724.3	SCIATICA	555.20	02/27/2014
719.48	PAIN IN JOINT INVOLVING OTHER SPECIFIED	57.58	09/25/2014
424.2	TRICUSPID VALVE DISORDERS, SPECIFIED AS	67.14	03/26/2014
782.3	EDEMA	71.60	03/26/2014
999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEW	2245.74	08/25/2014
518.81	RESPIRATORY FAILURE	2799.75	04/11/2014
493.92	ASTHMA UNSPECIFIED W/ ACUTE EXACERBATION	293.28	03/26/2014
486	PNEUMONIA, ORGANISM UNSPECIFIED	27.58	04/11/2014
786.07	DYSPNEA AND RESPIRATORY ABNORMALITIES;		03/25/2014
482.9	BACTERIAL PNEUMONIA, UNSPECIFIED	161050.73	07/02/2014
786.2	COUGH		03/25/2014
786.03	DYSPNEA AND RESPIRATORY ABNORMALITIES;	1648.92	07/25/2014
799.02	HYPOXEMIA		03/30/2014
278.00	OBESITY, UNSPECIFIED		03/28/2014
250.02	DIABETES MELLITUS WITHOUT MENTION OF		04/09/2014
518.84	OTHER DISEASES OF LUNG/ ACUTE & CHRONIC	632.32	03/31/2014
V58.82	FITTING AND ADJUSTMENT OF NONVASCULAR	13.79	07/24/2014
786.09	OTHER DYSPNEA AND RESPIRATORY ABNORMALIT	13.79	04/04/2014
506.1	ACUTE PULMONARY EDEMA DUE TO FUMES AND V	1391.51	04/03/2014
276.8	HYPOPOTASSEMIA		04/06/2014
278.01	MORBID OBESITY		06/20/2014
285.9	ANEMIA, UNSPECIFIED		04/08/2014
786.05	SHORTNESS OF BREATH	228.79	07/25/2014
V85.43	BMI 50.0-59.9, adult	503.70	04/11/2014
V45.82	OTHER POSTSURGICAL STATUS;PERCUTANEOUS		07/24/2014
518.4	ACUTE EDEMA OF LUNG, UNSPECIFIED		04/10/2014
799.3	DEBILITY, UNSPECIFIED	14666.18	04/11/2014
272.4	OTHER AND UNSPECIFIED HYPERLIPIDEMIA		09/05/2014
357.2	POLYNEUROPATHY IN DIABETES		03/25/2014
309.0	ADJUSTMENT DISORDER WITH DEPRESSED MOOD	62.00	05/21/2014
311	DEPRESSIVE DISORDER, NOT ELSEWHERE CLASS		05/06/2014

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LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 02 11/01/2013 to 10/31/2014 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
338.28	OTHER CHRONIC POSTOPERATIVE PAIN	28.38	06/04/2014
722.83	POSTLAMINECTOMY SYNDROME OF LUMBAR REGIO		09/25/2014
V85.44	BMI 60.0-69.9, adult	60.76	07/25/2014
V64.1	SURGICAL OR OTHER PROCEDURE NOT CARRIED		07/25/2014
V12.61	Hx, prsnl, pneumonia		07/25/2014
780.51	INSOMNIA WITH SLEEP APNEA, UNSPECIFIED		07/25/2014
414.9	CHRONIC ISCHEMIC HEART DISEASE, UNSPECIF		07/25/2014
V46.2	SUPPLEMENTAL OXYGEN; LONG TERM O2	1248.92	04/11/2014
756.12	SPONDYLOLISTHESIS, CONGENITAL	60.44	07/25/2014
429.3	CARDIOMEGALY	17.12	07/24/2014
518.89	OTHER DISEASES OF LUNG, NOT ELSEWHERE CL	13.79	07/24/2014
278.03	Obesity hypoventilation syndrome		08/12/2014
728.87	MUSCLE WEAKNESS (GENERALIZED)		09/25/2014
719.7	DIFFICULTY IN WALKING		09/25/2014
338.4	CHRONIC PAIN SYNDROME	5458.33	09/25/2014
780.52	INSOMNIA, UNSPECIFIED		09/05/2014

GROUP: 2001025 SSN: ********** SEQ: ** DIV: 0001 RELAT: Participant EFF: ********** DOB: ********** TERM: **********
LEVEL: P00 PLAN: WILCO-MED-DED

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	00-*	250000.00	25.02	62544.05	.00	.00	.00	.00

==========Diagnosis Recap==========

Amount	Code	Description
$60,755.25	DRUGS	PRESCRIPTION DRUGS
$575.00	999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEWHERE CLASSIFIED
$342.74	V70.0	ROUTINE GENERAL MEDICAL EXAMINATION AT AHEALTH CARE FACILITY
$274.72	626.2	EXCESSIVE OR FREQUENT MENSTRUATION
$223.32	V76.12	OTHER SCREENING MAMMOGRAM
$199.26	696.1	OTHER PSORIASIS AND SIMILAR DISORDERS
$108.07	780.4	DIZZINESS AND GIDDINESS
$65.69	372.30	CONJUNCTIVITIS, UNSPECIFIED

$62,544.05 Total Paid

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
DRUGS	PRESCRIPTION DRUGS	60755.25	10/03/2014
696.1	OTHER PSORIASIS AND SIMILAR DISORDERS	199.26	04/08/2014
V58.69	LONG-TERM (CURRENT) USE OF OTHER		03/07/2014
716.90	UNSPECIFIED ARTHROPATHY, SITE UNSPECIFIE		03/07/2014
V70.0	ROUTINE GENERAL MEDICAL EXAMINATION AT A	342.74	04/08/2014
626.2	EXCESSIVE OR FREQUENT MENSTRUATION	274.72	04/11/2014
V76.12	OTHER SCREENING MAMMOGRAM	223.32	04/11/2014
999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEW	575.00	05/25/2014
372.30	CONJUNCTIVITIS, UNSPECIFIED	65.69	08/11/2014
780.4	DIZZINESS AND GIDDINESS	108.07	10/03/2014
784.0	HEADACHE		10/03/2014

GROUP: 2001025 SSN: ********** SEQ: ** DIV: 0001 RELAT: Participant EFF: ********** DOB: ********** TERM: **********
LEVEL: P99 PLAN: WILCO-MED-DED-DIAB

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	00-*	250000.00	11.06	27640.42	.00	.00	.00	.00

==========Diagnosis Recap==========

Amount	Code	Description
$21,149.63	DRUGS	PRESCRIPTION DRUGS
$4,268.50	786.09	OTHER DYSPNEA AND RESPIRATORY ABNORMALITY
$844.47	840.9	SPRAIN OF UNSPECIFIED SITE OF SHOULDER AND UPPER ARM
$553.67	250.02	DIABETES MELLITUS WITHOUT MENTION OF COMPLICATION, TYPE II,UNCONTROLLED
$184.52	714.0	RHEUMATOID ARTHRITIS
$165.93	786.05	SHORTNESS OF BREATH
$102.06	401.1	BENIGN ESSENTIAL HYPERTENSION
$79.02	366.16	SENILE NUCLEAR SCLEROSIS
$77.59	465.9	ACUTE UPPER RESPIRATORY INFECTIONS OF UNSPECIFIED SITE
$68.38	250.00	DIABETES MELLITUS WITHOUT MENTION OF COMPLICATION, TYPE II
$43.38	784.0	HEADACHE
$43.38	493.10	INTRINSIC ASTHMA WITHOUT MENTION OF STATUS ASTHMATICUS
$43.38	719.41	PAIN IN JOINT INVOLVING SHOULDER REGION
$16.51	715.91	OSTEOARTHROSIS, UNSPECIFIED WHETHER GENERALIZED OR LOCALIZED, INVOLVING SHOULDER

$27,640.42 Total Paid

10/31/14 Allegiance Benefit Plan Management, Inc. PAGE: 78
LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 02 11/01/2013 to 10/31/2014 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
714.0	RHEUMATOID ARTHRITIS	184.52	03/19/2014
DRUGS	PRESCRIPTION DRUGS	21149.63	09/30/2014
250.00	DIABETES MELLITUS WITHOUT MENTION OF	68.38	06/06/2014
300.00	ANXIETY STATE, UNSPECIFIED		09/26/2014
719.41	PAIN IN JOINT INVOLVING SHOULDER REGION	43.38	01/02/2014
715.91	OSTEOARTHROSIS, UNSPECIFIED WHETHER GENE	16.51	01/02/2014
840.9	SPRAIN OF UNSPECIFIED SITE OF SHOULDER A	844.47	01/02/2014
250.80	DIABETES WITH OTHER SPECIFIED MANIFESTAT		01/02/2014
401.9	UNSPECIFIED ESSENTIAL HYPERTENSION		01/02/2014
244.9	UNSPECIFIED ACQUIRED HYPOTHYROIDISM		09/24/2014
250.02	DIABETES MELLITUS WITHOUT MENTION OF	553.67	09/24/2014
272.4	OTHER AND UNSPECIFIED HYPERLIPIDEMIA		09/24/2014
465.9	ACUTE UPPER RESPIRATORY INFECTIONS OF UN	77.59	03/19/2014
493.90	ASTHMA, UNSPECIFIED TYPE		03/19/2014
366.16	SENILE NUCLEAR SCLEROSIS	79.02	05/02/2014
268.9	UNSPECIFIED VITAMIN D DEFICIENCY		05/21/2014
493.10	INTRINSIC ASTHMA WITHOUT MENTION OF STAT	43.38	06/09/2014
300.01	PANIC DISORDER WITHOUT AGORAPHOBIA		06/09/2014
786.05	SHORTNESS OF BREATH	165.93	06/06/2014
786.09	OTHER DYSPNEA AND RESPIRATORY ABNORMALIT	4268.50	06/06/2014
786.07	DYSPNEA AND RESPIRATORY ABNORMALITIES;		06/06/2014
278.00	OBESITY, UNSPECIFIED		06/06/2014
729.81	SWELLING OF LIMB		06/06/2014
784.0	HEADACHE	43.38	08/11/2014
300.02	GENERALIZED ANXIETY DISORDER		09/24/2014
401.1	BENIGN ESSENTIAL HYPERTENSION	102.06	09/26/2014
272.0	PURE HYPERCHOLESTEROLEMIA		09/26/2014
V04.81	NEED FOR PROPHYLACTIC VACCINATION/		09/26/2014
715.90	OSTEOARTHROSIS, UNSPECIFIED WHETHER GENE		01/02/2014
V58.67	LONG-TERM (CURRENT) USE OF INSULIN		01/02/2014

GROUP: 2001025 SSN: ********** SEQ: ** DIV: 0002 RELAT: Spouse EFF: ********** DOB: ********** TERM: **********
LEVEL: PLAN:

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	01-*	250000.00	18.42	46041.83	.00	.00	.00	.00

==========Diagnosis Recap==========

Amount	Code	Description
$24,323.63	250.82	DIABETES WITH OTHER SPECIFIED MANIFESTATIONS,TYPE II OR UNSPEC TYPE,UNCONTROLLED
$11,298.03	V58.69	LONG-TERM (CURRENT) USE OF OTHER MEDICATIONS
$2,291.10	250.00	DIABETES MELLITUS WITHOUT MENTION OF COMPLICATION, TYPE II
$1,877.99	DRUGS	PRESCRIPTION DRUGS
$1,753.87	V58.83	ENCOUNTER/THERAPEUTIC DRUG MONITORING
$1,156.16	785.4	GANGRENE
$850.00	892.0	OPEN WOUND OF FOOT EXCEPT TOE(S) ALONE, WITHOUT MENTION OF COMPLICATION
$850.00	250.80	DIABETES WITH OTHER SPECIFIED MANIFESTATIONS,TYPE II OR UNSPECIFIED TYPE
$516.04	893.1	OPEN WOUND OF TOE(S), COMPLICATED
$498.33	999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEWHERE CLASSIFIED
$124.00	V58.81	FITTING AND ADJUSTMENT OF VASCULAR CATHETER
$113.72	893.2	OPEN WOUND OF TOE(S), WITH TENDON INVOLVEMENT
$106.71	V70.0	ROUTINE GENERAL MEDICAL EXAMINATION AT AHEALTH CARE FACILITY
$65.88	724.4	THORACIC OR LUMBOSACRAL NEURITIS OR RADICULITIS
$56.76	722.52	DEGENERATION OF LUMBAR OR LUMBOSACRAL INTERVERTEBRAL DISC
$44.32	250.60	DIABETES WITH NEUROLOGICAL MANIFESTATIONS,TYPE II,UNSPECIFIED TYPE
$43.38	789.02	OTHER SYMPTOMS INVOLVING ABDOMEN AND PELVIS
$41.00	365.01	OPEN ANGLE WITH BORDERLINE GLAUCOMA FINDINGS
$17.12	786.2	COUGH
$13.79	730.28	UNSPECIFIED OSTEOMYELITIS INVOLVING OTHER SPECIFIED SITES

$46,041.83 Total Paid

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
DRUGS	PRESCRIPTION DRUGS	1877.99	09/02/2014
250.00	DIABETES MELLITUS WITHOUT MENTION OF	2291.10	08/21/2014
V72.0	EXAMINATION OF EYES AND VISION		10/30/2013
365.01	OPEN ANGLE WITH BORDERLINE GLAUCOMA FIND	41.00	10/30/2013
V58.69	LONG-TERM (CURRENT) USE OF OTHER	11298.03	07/23/2014
V58.83	ENCOUNTER/THERAPEUTIC DRUG MONITORING	1753.87	07/23/2014
789.02	OTHER SYMPTOMS INVOLVING ABDOMEN AND	43.38	10/30/2013
722.52	DEGENERATION OF LUMBAR OR LUMBOSACRAL IN	56.76	02/19/2014
719.48	PAIN IN JOINT INVOLVING OTHER SPECIFIED		06/11/2014

10/31/14 Allegiance Benefit Plan Management, Inc. PAGE: 79
LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 02 11/01/2013 to 10/31/2014 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
724.4	THORACIC OR LUMBOSACRAL NEURITIS OR RADI	65.88	06/11/2014
272.4	OTHER AND UNSPECIFIED HYPERLIPIDEMIA		09/26/2013
401.1	BENIGN ESSENTIAL HYPERTENSION		08/21/2014
716.98	UNSPECIFIED ARTHROPATHY INVOLVING OTHER		06/11/2014
722.4	DEGENERATION OF CERVICAL INTERVERTEBRAL		06/11/2014
893.2	OPEN WOUND OF TOE(S), WITH TENDON INVOLV	113.72	08/21/2014
785.4	GANGRENE	1156.16	08/18/2014
250.60	DIABETES WITH NEUROLOGICAL MANIFESTATION	44.32	07/11/2014
995.20	UNSPECIFIED ADVERSE EFFECT OF UNSPEC-		07/11/2014
V70.0	ROUTINE GENERAL MEDICAL EXAMINATION AT A	106.71	08/21/2014
999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEW	498.33	08/26/2014
786.2	COUGH	17.12	08/14/2014
250.82	DIABETES WITH OTHER SPECIFIED MANIFESTAT	24323.63	08/18/2014
730.07	ACUTE OSTEOMYELITIS INVOLVING ANKLE AND		08/18/2014
730.17	CHRONIC OSTEOMYELITIS INVOLVING ANKLE AN		08/18/2014
730.28	UNSPECIFIED OSTEOMYELITIS INVOLVING OTHE	13.79	08/15/2014
401.0	MALIGNANT ESSENTIAL HYPERTENSION		08/18/2014
893.1	OPEN WOUND OF TOE(S), COMPLICATED	516.04	08/16/2014
250.80	DIABETES WITH OTHER SPECIFIED MANIFESTAT	850.00	08/13/2014
892.0	OPEN WOUND OF FOOT EXCEPT TOE(S) ALONE,	850.00	08/16/2014
401.9	UNSPECIFIED ESSENTIAL HYPERTENSION		08/16/2014
V58.81	FITTING AND ADJUSTMENT OF VASCULAR	124.00	08/25/2014

GROUP: 2001025 SSN: ********** SEQ: ** DIV: 0001 RELAT: Participant EFF: ********** DOB: ********** TERM: **********
LEVEL: P00 PLAN: WILCO-MED-EPO

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	00-*	250000.00	15.49	38729.83	.00	.00	.00	.00

==========Diagnosis Recap==========

Amount	Code	Description
$16,239.28	162.5	MALIGNANT NEOPLASM OF LOWER LOBE, BRONCHUS OR LUNG
$6,987.21	162.9	MALIGNANT NEOPLASM OF BRONCHUS AND LUNG
$3,972.61	DRUGS	PRESCRIPTION DRUGS
$3,720.23	162.2	MALIGNANT NEOPLASM OF MAIN BRONCHUS
$2,137.12	793.11	Solitary pulmonary nodule
$1,759.29	786.6	SWELLING, MASS, OR LUMP IN CHEST
$398.25	999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEWHERE CLASSIFIED
$375.64	V70.0	ROUTINE GENERAL MEDICAL EXAMINATION AT AHEALTH CARE FACILITY
$274.02	786.2	COUGH
$266.20	365.01	OPEN ANGLE WITH BORDERLINE GLAUCOMA FINDINGS
$262.91	784.0	HEADACHE
$255.46	493.00	EXTRINSIC ASTHMA, UNSPECIFIED
$247.13	V72.31	ROUTINE GYNECOLOGICAL EXAM
$241.21	V04.89	NEED FOR PROPHYLACTIC VACCINATION/ INOCULATION AGAINST, OTHER VIRAL DISEASE
$237.76	V76.10	BREAST SCREENING UNSPECIFIED
$223.32	V76.12	OTHER SCREENING MAMMOGRAM
$191.02	780.60	Symptom, fever, unspecified
$173.76	401.9	UNSPECIFIED ESSENTIAL HYPERTENSION
$163.37	V82.81	OSTEOPOROSIS
$108.04	365.12	LOW TENSION GLAUCOMA
$106.80	786.07	DYSPNEA AND RESPIRATORY ABNORMALITIES; WHEEZING
$90.37	785.6	ENLARGEMENT OF LYMPH NODES
$88.47	199.1	OTHER MALIGNANT NEOPLASM OF UNSPECIFIED SITE
$77.59	V58.11	ENCOUNTER FOR ANTINEOPLASTIC CHEMOTHERAPY
$34.26	786.05	SHORTNESS OF BREATH
$33.36	V04.81	NEED FOR PROPHYLACTIC VACCINATION/ INOCULATION AGAINST, INFLUENZA
$28.38	477.0	ALLERGIC RHINITIS DUE TO POLLEN
$28.38	472.0	CHRONIC RHINITIS
$6.02	788.41	URINARY FREQUENCY
$2.37	401.1	BENIGN ESSENTIAL HYPERTENSION

$38,729.83 Total Paid

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
365.01	OPEN ANGLE WITH BORDERLINE GLAUCOMA FIND	266.20	05/14/2014
365.12	LOW TENSION GLAUCOMA	108.04	08/13/2014
366.16	SENILE NUCLEAR SCLEROSIS		04/23/2014
DRUGS	PRESCRIPTION DRUGS	3972.61	10/18/2014
V76.10	BREAST SCREENING UNSPECIFIED	237.76	07/18/2014
401.9	UNSPECIFIED ESSENTIAL HYPERTENSION	173.76	10/13/2014
596.51	HYPERTONICITY OF BLADDER		06/26/2014
786.07	DYSPNEA AND RESPIRATORY ABNORMALITIES;	106.80	07/10/2014
786.2	COUGH	274.02	09/15/2014
786.05	SHORTNESS OF BREATH	34.26	10/11/2014
477.9	ALLERGIC RHINITIS, CAUSE UNSPECIFIED		07/23/2014
V72.31	ROUTINE GYNECOLOGICAL EXAM	247.13	07/18/2014
627.3	POSTMENOPAUSAL ATROPHIC VAGINITIS		07/18/2014
627.2	MENOPAUSAL OR FEMALE CLIMACTERIC STATES		07/18/2014
472.0	CHRONIC RHINITIS	28.38	07/23/2014
493.00	EXTRINSIC ASTHMA, UNSPECIFIED	255.46	09/11/2014
493.90	ASTHMA, UNSPECIFIED TYPE		10/13/2014
V76.12	OTHER SCREENING MAMMOGRAM	223.32	08/07/2014
V82.81	OSTEOPOROSIS	163.37	08/07/2014
V70.0	ROUTINE GENERAL MEDICAL EXAMINATION AT A	375.64	09/03/2014
401.1	BENIGN ESSENTIAL HYPERTENSION	2.37	09/03/2014
V04.89	NEED FOR PROPHYLACTIC VACCINATION/	241.21	09/03/2014
786.6	SWELLING, MASS, OR LUMP IN CHEST	1759.29	09/30/2014

477.0	ALLERGIC RHINITIS DUE TO POLLEN	28.38	09/11/2014
477.8	ALLERGIC RHINITIS DUE TO OTHER ALLERGEN		09/11/2014
V14.8	Hx, prsnl, drug allergy NEC		09/11/2014
788.41	URINARY FREQUENCY	6.02	09/10/2014
780.60	Symptom, fever, unspecified	191.02	09/15/2014
599.0	URINARY TRACT INFECTION, SITE NOT SPECIF		09/15/2014
793.11	Solitary pulmonary nodule	2137.12	09/26/2014
999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEW	398.25	10/07/2014
784.0	HEADACHE	262.91	10/01/2014
199.1	OTHER MALIGNANT NEOPLASM OF UNSPECIFIED	88.47	10/01/2014
162.2	MALIGNANT NEOPLASM OF MAIN BRONCHUS	3720.23	09/30/2014
162.5	MALIGNANT NEOPLASM OF LOWER LOBE, BRONCH	16239.28	10/21/2014
162.9	MALIGNANT NEOPLASM OF BRONCHUS AND LUNG	6987.21	10/22/2014

10/31/14 Allegiance Benefit Plan Management, Inc. PAGE: 81
LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 02 11/01/2013 to 10/31/2014 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
785.6	ENLARGEMENT OF LYMPH NODES	90.37	09/26/2014
196.1	SECONDARY AND UNSPECIFIED MALIGNANT NEOP		09/30/2014
V14.6	Hx, prsnl, analgesic allergy		09/30/2014
V07.8	Prophylactic/treatment measures NEC		10/15/2014
V58.11	ENCOUNTER FOR ANTINEOPLASTIC	77.59	10/15/2014
250.00	DIABETES MELLITUS WITHOUT MENTION OF		10/13/2014
278.00	OBESITY, UNSPECIFIED		10/13/2014
V04.81	NEED FOR PROPHYLACTIC VACCINATION/	33.36	10/15/2014

GROUP: 2001025 SSN: ********** SEQ: ** DIV: 0002 RELAT: Participant EFF: ********** DOB: ********** TERM: **********
LEVEL: F00 PLAN: WILCO-MED-CORE-DIAB

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	00-*	250000.00	10.51	26285.11	.00	.00	.00	.00

==========Diagnosis Recap==========

Amount	Code	Description
$10,196.29	592.1	CALCULUS OF URETER
$3,527.12	211.3	BENIGN NEOPLASM OF COLON
$3,404.50	153.9	MALIGNANT NEOPLASM OF COLON, UNSPECIFIED
$3,165.29	592.0	CALCULUS OF KIDNEY
$1,583.26	DRUGS	PRESCRIPTION DRUGS
$1,383.07	562.11	DIVERTICULITIS OF COLON
$970.56	715.96	OSTEOARTHROSIS, UNSPECIFIED, INVOLVING LOWER LEG/KNEE
$513.68	272.4	OTHER AND UNSPECIFIED HYPERLIPIDEMIA
$453.57	250.00	DIABETES MELLITUS WITHOUT MENTION OF COMPLICATION, TYPE II
$256.03	716.96	UNSPECIFIED ARTHROPATHY INVOLVING LOWER LEG
$239.78	603.8	OTHER SPECIFIED TYPES OF HYDROCELE
$183.76	608.86	EDEMA OF MALE GENITAL ORGANS
$176.05	V10.05	Hx, prsnl, colonic malignancy
$103.01	719.46	PAIN IN JOINT INVOLVING LOWER LEG
$99.12	591	HYDRONEPHROSIS
$15.01	787.3	FLATULENCE, ERUCTATION, AND GAS PAIN
$15.01	786.2	COUGH

$26,285.11 Total Paid

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
DRUGS	PRESCRIPTION DRUGS	1583.26	10/16/2014
211.3	BENIGN NEOPLASM OF COLON	3527.12	11/26/2013
592.0	CALCULUS OF KIDNEY	3165.29	09/26/2014
719.46	PAIN IN JOINT INVOLVING LOWER LEG	103.01	03/20/2014
592.1	CALCULUS OF URETER	10196.29	01/27/2014
591	HYDRONEPHROSIS	99.12	12/01/2013
305.1	TOBACCO USE DISORDER		12/11/2013
401.9	UNSPECIFIED ESSENTIAL HYPERTENSION		10/14/2014
272.4	OTHER AND UNSPECIFIED HYPERLIPIDEMIA	513.68	09/12/2014
250.00	DIABETES MELLITUS WITHOUT MENTION OF	453.57	10/14/2014
V70.0	ROUTINE GENERAL MEDICAL EXAMINATION AT A		12/13/2013
153.9	MALIGNANT NEOPLASM OF COLON, UNSPECIFIED	3404.50	10/03/2014
593.9	UNSPECIFIED DISORDER OF KIDNEY AND URETE		12/01/2013

10/31/14 Allegiance Benefit Plan Management, Inc. PAGE: 82
LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 02 11/01/2013 to 10/31/2014 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
276.51	DEHYDRATION		12/01/2013
455.0	INTERNAL HEMORRHOIDS WITHOUT MENTION OF		11/26/2013
V10.05	Hx, prsnl, colonic malignancy	176.05	10/14/2014
V45.89	OTHER POSTSURGICAL STATUS		11/26/2013
786.2	COUGH	15.01	12/01/2013
278.00	OBESITY, UNSPECIFIED		12/23/2013
608.86	EDEMA OF MALE GENITAL ORGANS	183.76	02/06/2014
603.8	OTHER SPECIFIED TYPES OF HYDROCELE	239.78	02/05/2014
716.96	UNSPECIFIED ARTHROPATHY INVOLVING LOWER	256.03	03/25/2014
715.96	OSTEOARTHROSIS, UNSPECIFIED, INVOLVING	970.56	09/25/2014
787.3	FLATULENCE, ERUCTATION, AND GAS PAIN	15.01	10/14/2014
564.89	OTHER SPECIFIED DISORDERS OF INTESTINE;		10/14/2014
562.11	DIVERTICULITIS OF COLON	1383.07	10/14/2014
V13.01	Hx, prsnl, urinary calculi		10/14/2014

GROUP: 2001025 SSN: ********** SEQ: ** DIV: 0001 RELAT: Participant EFF: ********** DOB: ********** TERM: **********
LEVEL: P00 PLAN: WILCO-MED-CORE

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	00-*	250000.00	62.62	156550.52	.00	.00	.00	.00

==========Diagnosis Recap==========

Amount	Code	Description
$51,958.39	510.9	EMPYEMA WITHOUT MENTION OF FISTULA
$25,121.49	038.9	UNSPECIFIED SEPTICEMIA
$19,011.58	158.0	MALIGNANT NEOPLASM OF RETROPERITONEUM
$15,361.03	780.79	OTHER MALAISE AND FATIGUE
$7,200.00	716.90	UNSPECIFIED ARTHROPATHY, SITE UNSPECIFIED
$5,345.29	999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEWHERE CLASSIFIED
$4,216.13	511.9	UNSPECIFIED PLEURAL EFFUSION
$3,897.84	V49.84	BED CONFINEMENT STATUS
$2,816.17	780.97	ALTERED MENTAL STATUS
$2,597.29	789.00	OTHER SYMPTOMS INVOLVING ABDOMEN AND PELVIS
$2,048.00	V58.81	FITTING AND ADJUSTMENT OF VASCULAR CATHETER
$1,976.60	V58.11	ENCOUNTER FOR ANTINEOPLASTIC CHEMOTHERAPY
$1,680.00	783.7	ADULT FAILURE TO THRIVE
$1,565.05	781.2	ABNORMALITY OF GAIT
$1,396.47	200.10	LYMPHOSARCOMA, UNSPECIFIED SITE
$1,309.38	285.9	ANEMIA, UNSPECIFIED
$1,113.90	280.9	IRON DEFICIENCY ANEMIA, UNSPECIFIED
$927.51	276.51	DEHYDRATION
$831.40	239.0	NEOPLASM OF UNSPECIFIED NATURE OF DIGESTIVE SYSTEM
$572.24	276.50	VOLUME DEPLETION, UNSPECIFIED
$517.00	518.81	RESPIRATORY FAILURE
$444.26	171.9	MALIGNANT NEOPLASM OF CONNECTIVE AND OTHER SOFT TISSUE, SITE UNSPECIFIED
$429.48	789.32	OTHER SYMPTOMS INVOLVING THE ABDOMEN ANDPELVIS
$414.50	DRUGS	PRESCRIPTION DRUGS
$411.00	783.0	ANOREXIA
$400.00	799.3	DEBILITY, UNSPECIFIED
$309.60	789.39	OTHER SYMPTOMS INVOLVING ABDOMEN AND PELVIS
$301.54	V57.1	CARE INVOLVING OTHER PHYSICAL THERAPY
$284.45	V85.35	BODY MASS INDEX 35.0-35.9, ADULT
$268.55	292.81	DRUG-INDUCED DELIRIUM
$254.65	486	PNEUMONIA, ORGANISM UNSPECIFIED
$183.82	787.01	OTHER SYMPTOMS INVOLVING DIGESTIVE SYSTEM;NAUSEA WITH VOMITING
$166.40	274.9	GOUT, UNSPECIFIED
$137.00	599.0	URINARY TRACT INFECTION, SITE NOT SPECIFIED
$137.00	477.9	ALLERGIC RHINITIS, CAUSE UNSPECIFIED
$137.00	787.03	SYMPTOMS INVOLVING DIGESTIVE SYSTEM VOMITING ALONE
$106.93	786.50	UNSPECIFIED CHEST PAIN
$79.51	298.9	UNSPECIFIED PSYCHOSIS
$78.46	786.6	SWELLING, MASS, OR LUMP IN CHEST
$72.03	424.2	TRICUSPID VALVE DISORDERS, SPECIFIED AS NONRHEUMATIC
$71.98	482.9	BACTERIAL PNEUMONIA, UNSPECIFIED
$71.51	276.52	HYPOVOLEMIA
$71.51	458.9	HYPOTENSION, UNSPECIFIED
$54.81	996.74	OTHER COMPLICATIONS DUE TO OTHER VASCULAR DEVICE, IMPLANT, AND GRAFT
$48.30	238.71	NEOPLASM OF UNCERTAIN BEHAVIOR-ESSENTIALTHROMBOCYTHEMIA
$26.57	995.27	CERTAIN ADVERSE EFFECTS NOT ELSEWHERE CLASSIFIED-OTHER DRUG ALLERGY
$19.46	780.60	Symptom, fever, unspecified
$13.79	518.89	OTHER DISEASES OF LUNG, NOT ELSEWHERE CLASSIFIED
$13.79	512.89	Other pneumothorax
$13.79	518.0	PULMONARY COLLAPSE
$13.79	786.7	ABNORMAL CHEST SOUNDS
$13.79	786.2	COUGH
$13.79	239.9	NEOPLASM OF UNSPECIFIED NATURE, SITE UNSPECIFIED
$12.35	158.8	MALIGNANT NEOPLASM OF SPECIFIED PARTS OFPERITONEUM
$7.07	285.29	ANEMIA OF OTHER CHRONIC ILLNESS
$5.28	285.3	Antineoplastic chemo induced anemia

$156,550.52 Total Paid

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
274.9	GOUT, UNSPECIFIED	166.40	05/23/2014
780.60	Symptom, fever, unspecified	19.46	01/17/2014
786.50	UNSPECIFIED CHEST PAIN	106.93	12/11/2013
786.6	SWELLING, MASS, OR LUMP IN CHEST	78.46	01/20/2014
789.39	OTHER SYMPTOMS INVOLVING ABDOMEN AND	309.60	06/08/2014
DRUGS	PRESCRIPTION DRUGS	414.50	06/30/2014
789.00	OTHER SYMPTOMS INVOLVING ABDOMEN AND	2597.29	12/09/2013
599.72	Microscopic hematuria		12/02/2013
285.9	ANEMIA, UNSPECIFIED	1309.38	05/06/2014
238.71	NEOPLASM OF UNCERTAIN BEHAVIOR-ESSENTIAL	48.30	12/16/2013
288.2	GENETIC ANOMALIES OF LEUKOCYTES		12/16/2013
288.3	EOSINOPHILIA		12/16/2013
158.0	MALIGNANT NEOPLASM OF RETROPERITONEUM	19011.58	06/13/2014
511.9	UNSPECIFIED PLEURAL EFFUSION	4216.13	06/13/2014

10/31/14 Allegiance Benefit Plan Management, Inc. PAGE: 84
LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 02 11/01/2013 to 10/31/2014 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
429.3	CARDIOMEGALY		01/02/2014
789.32	OTHER SYMPTOMS INVOLVING THE ABDOMEN AND	429.48	12/04/2013
574.20	CALCULUS OF GALLBLADDER WITHOUT MENTION		01/17/2014
158.8	MALIGNANT NEOPLASM OF SPECIFIED PARTS OF	12.35	04/15/2014
424.2	TRICUSPID VALVE DISORDERS, SPECIFIED AS	72.03	01/03/2014
239.9	NEOPLASM OF UNSPECIFIED NATURE, SITE UNS	13.79	01/06/2014
V58.11	ENCOUNTER FOR ANTINEOPLASTIC	1976.60	02/27/2014
995.27	CERTAIN ADVERSE EFFECTS NOT ELSEWHERE	26.57	01/14/2014
276.51	DEHYDRATION	927.51	04/29/2014
292.81	DRUG-INDUCED DELIRIUM	268.55	01/16/2014
239.0	NEOPLASM OF UNSPECIFIED NATURE OF DIGEST	831.40	05/05/2014
786.2	COUGH	13.79	01/16/2014
786.05	SHORTNESS OF BREATH		01/16/2014
999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEW	5345.29	07/03/2014
298.9	UNSPECIFIED PSYCHOSIS	79.51	01/15/2014
780.97	ALTERED MENTAL STATUS	2816.17	01/17/2014
280.9	IRON DEFICIENCY ANEMIA, UNSPECIFIED	1113.90	01/23/2014
786.7	ABNORMAL CHEST SOUNDS	13.79	01/19/2014
038.9	UNSPECIFIED SEPTICEMIA	25121.49	01/21/2014
486	PNEUMONIA, ORGANISM UNSPECIFIED	254.65	01/21/2014
349.82	TOXIC ENCEPHALOPATHY		01/21/2014
584.9	Acute kidney failure, unspecified		01/21/2014
V58.81	FITTING AND ADJUSTMENT OF VASCULAR	2048.00	01/06/2014
995.92	SIRS-DUE TO INFECTIOUS PROCESS WITH		01/17/2014
482.9	BACTERIAL PNEUMONIA, UNSPECIFIED	71.98	01/20/2014
279.3	UNSPECIFIED IMMUNITY DEFICIENCY		01/20/2014
162.9	MALIGNANT NEOPLASM OF BRONCHUS AND LUNG		01/20/2014
996.74	OTHER COMPLICATIONS DUE TO OTHER VASCULA	54.81	02/28/2014
783.21	LOSS OF WEIGHT		05/22/2014
285.3	Antineoplastic chemo induced anemia	5.28	04/08/2014
455.6	UNSPECIFIED HEMORRHOIDS WITHOUT MENTION		04/08/2014
458.9	HYPOTENSION, UNSPECIFIED	71.51	06/13/2014
285.29	ANEMIA OF OTHER CHRONIC ILLNESS	7.07	05/21/2014
780.79	OTHER MALAISE AND FATIGUE	15361.03	05/05/2014
276.52	HYPOVOLEMIA	71.51	03/21/2014
276.50	VOLUME DEPLETION, UNSPECIFIED	572.24	05/05/2014
783.7	ADULT FAILURE TO THRIVE	1680.00	07/02/2014
787.01	OTHER SYMPTOMS INVOLVING DIGESTIVE	183.82	05/05/2014
V57.1	CARE INVOLVING OTHER PHYSICAL THERAPY	301.54	04/21/2014
728.87	MUSCLE WEAKNESS (GENERALIZED)		04/21/2014
173.92	Squam cell carcnma skin,site unsp		04/21/2014
401.9	UNSPECIFIED ESSENTIAL HYPERTENSION		05/23/2014
787.03	SYMPTOMS INVOLVING DIGESTIVE SYSTEM	137.00	05/23/2014

10/31/14 Allegiance Benefit Plan Management, Inc. PAGE: 85
LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 02 11/01/2013 to 10/31/2014 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
171.9	MALIGNANT NEOPLASM OF CONNECTIVE AND OTH	444.26	06/13/2014
781.2	ABNORMALITY OF GAIT	1565.05	04/28/2014
716.90	UNSPECIFIED ARTHROPATHY, SITE UNSPECIFIE	7200.00	05/23/2014
V57.89	CARE INVOLVING OTHER SPECIFIED REHABILIT		05/23/2014
200.10	LYMPHOSARCOMA, UNSPECIFIED SITE	1396.47	06/13/2014
518.81	RESPIRATORY FAILURE	517.00	06/13/2014
785.52	SEPTIC SHOCK		06/13/2014
518.0	PULMONARY COLLAPSE	13.79	06/11/2014
V58.82	FITTING AND ADJUSTMENT OF NONVASCULAR		06/11/2014
V49.84	BED CONFINEMENT STATUS	3897.84	06/13/2014
512.89	Other pneumothorax	13.79	06/10/2014
518.89	OTHER DISEASES OF LUNG, NOT ELSEWHERE CL	13.79	06/06/2014
799.3	DEBILITY, UNSPECIFIED	400.00	05/23/2014
272.0	PURE HYPERCHOLESTEROLEMIA		05/05/2014
V85.35	BODY MASS INDEX 35.0-35.9, ADULT	284.45	06/14/2014
V15.3	Hx, prsnl, irradiation		06/14/2014
V58.69	LONG-TERM (CURRENT) USE OF OTHER		06/14/2014
V87.41	Personal hx antineoplastic chemo		06/14/2014
783.0	ANOREXIA	411.00	05/23/2014
477.9	ALLERGIC RHINITIS, CAUSE UNSPECIFIED	137.00	05/15/2014
564.00	CONSTIPATION, UNSPECIFIED		05/19/2014
599.0	URINARY TRACT INFECTION, SITE NOT SPECIF	137.00	05/23/2014
783.9	OTHER SYMPTOMS CONCERNING NUTRITION, MET		07/02/2014
510.9	EMPYEMA WITHOUT MENTION OF FISTULA	51958.39	06/13/2014
518.51	Acute resp fail follw truma/surgey		06/13/2014

GROUP: 2001025 SSN: ********** SEQ: ** DIV: 0001 RELAT: Participant EFF: ********** DOB: ********** TERM: **********
LEVEL: F99 PLAN: WILCO-MED-CORE

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	00-*	250000.00	12.63	31578.88	.00	.00	.00	.00

==========Diagnosis Recap==========

Amount	Code	Description
$13,286.58	840.4	ROTATOR CUFF (CAPSULE) SPRAIN
$5,845.01	DRUGS	PRESCRIPTION DRUGS
$3,708.85	719.41	PAIN IN JOINT INVOLVING SHOULDER REGION
$3,700.72	735.4	OTHER HAMMER TOE (ACQUIRED)
$1,405.82	338.18	OTHER ACUTE POSTOPERATIVE PAIN
$952.53	840.6	SUPRASPINATUS (MUSCLE) (TENDON) SPRAIN
$596.96	715.17	OSTEOARTHROSIS, LOCALIZED, PRIMARY, INVOLVING ANKLE AND FOOT
$387.97	726.2	OTHER AFFECTIONS OF SHOULDER REGION, NOTELSEWHERE CLASSIFIED
$256.50	840.7	SPRAINS & STRAINS OF SHOULDER & UPPER ARSUPERIOR GLENOID LABRUM LESION
$237.36	728.71	PLANTAR FASCIAL FIBROMATOSIS
$212.16	625.6	STRESS INCONTINENCE, FEMALE
$180.31	726.12	BICIPITAL TENOSYNOVITIS
$166.94	736.79	OTHER ACQUIRED DEFORMITIES OF ANKLE AND FOOT
$106.08	728.85	SPASM OF MUSCLE
$101.79	705.83	HIDRADENITIS
$84.64	840.9	SPRAIN OF UNSPECIFIED SITE OF SHOULDER AND UPPER ARM
$71.81	726.10	DISORDERS OF BURSAE AND TENDONS IN SHOULDER REGION, UNSPECIFIED
$68.38	726.33	OLECRANON BURSITIS
$53.67	682.9	CELLULITIS AND ABSCESS OF UNSPECIFIED SITES
$47.87	706.1	OTHER ACNE
$42.17	382.9	UNSPECIFIED OTITIS MEDIA
$22.78	V58.78	AFTERCARE FOLLOWING SURGERY OF THE MUSCULOSKELETAL SYSTEM, NEC
$21.76	729.5	PAIN IN LIMB
$20.22	726.91	EXOSTOSIS OF UNSPECIFIED SITE

$31,578.88 Total Paid

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
DRUGS	PRESCRIPTION DRUGS	5845.01	10/22/2014
706.1	OTHER ACNE	47.87	11/20/2013
216.5	BENIGN NEOPLASM OF SKIN OF TRUNK, EXCEPT		06/20/2014
382.9	UNSPECIFIED OTITIS MEDIA	42.17	11/14/2013
461.9	ACUTE SINUSITIS, UNSPECIFIED		11/14/2013
719.41	PAIN IN JOINT INVOLVING SHOULDER REGION	3708.85	10/07/2014
726.10	DISORDERS OF BURSAE AND TENDONS IN SHOUL	71.81	03/07/2014
840.7	SPRAINS & STRAINS OF SHOULDER & UPPER AR	256.50	04/21/2014
726.2	OTHER AFFECTIONS OF SHOULDER REGION, NOT	387.97	04/16/2014
726.12	BICIPITAL TENOSYNOVITIS	180.31	04/21/2014

10/31/14 Allegiance Benefit Plan Management, Inc. PAGE: 86
LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 02 11/01/2013 to 10/31/2014 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
840.4	ROTATOR CUFF (CAPSULE) SPRAIN	13286.58	04/21/2014
729.5	PAIN IN LIMB	21.76	04/02/2014
V72.83	OTH SPCF PREOP EXAM		04/02/2014
726.19	OTHER SPECIFIED DISORDERS OF BURSAE AND		04/16/2014
338.18	OTHER ACUTE POSTOPERATIVE PAIN	1405.82	04/16/2014
840.9	SPRAIN OF UNSPECIFIED SITE OF SHOULDER A	84.64	04/01/2014
V72.84	PREOP EXAM UNSPCF		04/01/2014
V58.78	AFTERCARE FOLLOWING SURGERY OF THE	22.78	10/07/2014
V58.32	ENCOUNTER FOR OTHER AND UNSPECIFIED		04/29/2014
278.00	OBESITY, UNSPECIFIED		04/16/2014
840.6	SUPRASPINATUS (MUSCLE) (TENDON) SPRAIN	952.53	03/03/2014
682.9	CELLULITIS AND ABSCESS OF UNSPECIFIED SI	53.67	06/20/2014
705.83	HIDRADENITIS	101.79	06/20/2014
709.09	DYSCHROMIA;OTHER		06/20/2014
228.01	HEMANGIOMA OF SKIN AND SUBCUTANEOUS TISS		06/20/2014
682.6	CELLULITIS AND ABSCESS OF LEG, EXCEPT FO		06/20/2014
726.33	OLECRANON BURSITIS	68.38	06/06/2014
736.79	OTHER ACQUIRED DEFORMITIES OF ANKLE AND	166.94	09/15/2014
728.71	PLANTAR FASCIAL FIBROMATOSIS	237.36	09/15/2014
735.4	OTHER HAMMER TOE (ACQUIRED)	3700.72	10/20/2014
726.91	EXOSTOSIS OF UNSPECIFIED SITE	20.22	10/20/2014
728.85	SPASM OF MUSCLE	106.08	03/20/2014
625.6	STRESS INCONTINENCE, FEMALE	212.16	05/14/2014
724.2	LUMBAGO		05/14/2014
715.17	OSTEOARTHROSIS, LOCALIZED, PRIMARY, INVO	596.96	10/08/2014

GROUP: 2001025 SSN: ********** SEQ: ** DIV: 0001 RELAT: Spouse EFF: ********** DOB: ********** TERM: **********
LEVEL: F99 PLAN: WILCO-MED-EPO-DIAB

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	01-*	250000.00	11.95	29880.64	.00	.00	.00	.00

==========Diagnosis Recap==========

Amount	Code	Description
$16,218.91	DRUGS	PRESCRIPTION DRUGS
$8,753.01	556.6	ULCERATIVE COLITIS;UNIVERSAL CHRONIC COLITIS
$2,661.93	525.9	UNSPECIFIED DISORDER OF THE TEETH AND SUPPORTING STRUCTURES
$399.09	558.9	OTHER AND UNSPECIFIED NONINFECTIOUS GASTROENTERITIS AND COLITIS
$390.51	250.02	DIABETES MELLITUS WITHOUT MENTION OF COMPLICATION, TYPE II,UNCONTROLLED
$345.90	571.5	CIRRHOSIS OF LIVER WITHOUT MENTION OF ALCOHOL
$225.00	719.43	PAIN IN JOINT INVOLVING FOREARM
$212.93	365.01	OPEN ANGLE WITH BORDERLINE GLAUCOMA FINDINGS
$173.02	782.3	EDEMA
$171.36	250.00	DIABETES MELLITUS WITHOUT MENTION OF COMPLICATION, TYPE II
$123.15	287.5	THROMBOCYTOPENIA, UNSPECIFIED
$106.37	241.0	NONTOXIC UNINODULAR GOITER
$99.46	787.91	OTHER SYMPTOMS INVOLVING DIGESTIVE SYSTEM; DIARRHEA

$29,880.64 Total Paid

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
250.02	DIABETES MELLITUS WITHOUT MENTION OF	390.51	10/12/2014
272.4	OTHER AND UNSPECIFIED HYPERLIPIDEMIA		08/15/2014
DRUGS	PRESCRIPTION DRUGS	16218.91	10/06/2014
250.00	DIABETES MELLITUS WITHOUT MENTION OF	171.36	10/20/2014
365.01	OPEN ANGLE WITH BORDERLINE GLAUCOMA FIND	212.93	10/20/2014
V43.1	LENS REPLACED BY OTHER MEANS		04/21/2014
241.0	NONTOXIC UNINODULAR GOITER	106.37	02/27/2014
571.5	CIRRHOSIS OF LIVER WITHOUT MENTION OF AL	345.90	10/21/2014
456.0	Varices, esophageal w/bleeding		10/21/2014
719.43	PAIN IN JOINT INVOLVING FOREARM	225.00	01/08/2014
782.3	EDEMA	173.02	08/15/2014
414.00	CORONARY ATHEROSCLEROSIS OF UNSPECIFIED		08/15/2014
287.5	THROMBOCYTOPENIA, UNSPECIFIED	123.15	09/24/2014
525.9	UNSPECIFIED DISORDER OF THE TEETH AND SU	2661.93	09/24/2014
521.00	DENTAL CARIES, UNSPECIFIED		09/24/2014
266.2	OTHER B-COMPLEX DEFICIENCIES		09/24/2014
572.3	PORTAL HYPERTENSION		10/09/2014
558.9	OTHER AND UNSPECIFIED NONINFECTIOUS GAST	399.09	10/12/2014
780.61	Symptom, fever prest w/ cond elsewh		10/12/2014
556.6	ULCERATIVE COLITIS;UNIVERSAL CHRONIC	8753.01	10/12/2014
401.9	UNSPECIFIED ESSENTIAL HYPERTENSION		10/12/2014
571.8	OTHER CHRONIC NONALCOHOLIC LIVER DISEASE		10/12/2014
560.1	PARALYTIC ILEUS		10/09/2014
787.91	OTHER SYMPTOMS INVOLVING DIGESTIVE	99.46	10/21/2014
789.07	OTHER SYMPTOMS INVOLVING ABDOMEN AND		10/21/2014

GROUP: 2001025 SSN: ********** SEQ: ** DIV: 0001 RELAT: Participant EFF: ********** DOB: ********** TERM: **********
LEVEL: F99 PLAN: WILCO-MED-CORE

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	00-*	250000.00	22.62	56544.33	.00	.00	.00	.00

==========Diagnosis Recap==========

Amount	Code	Description

10/31/14 Allegiance Benefit Plan Management, Inc. PAGE: 87
LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

$28,906.58	DRUGS	PRESCRIPTION DRUGS
$16,918.50	592.0	CALCULUS OF KIDNEY
$5,587.22	733.20	CYST OF BONE (LOCALIZED), UNSPECIFIED
$1,500.00	724.8	OTHER SYMPTOMS REFERABLE TO BACK
$979.65	723.4	BRACHIAL NEURITIS OR RADICULITIS NOS
$500.00	720.2	SACROILIITIS, NOT ELSEWHERE CLASSIFIED
$355.55	274.11	URIC ACID NEPHROLITHIASIS
$287.10	788.0	RENAL COLIC
$237.15	099.3	REITER'S DISEASE
$215.56	716.99	UNSPECIFIED ARTHROPATHY INVOLVING MULTIPLE SITES
$167.04	477.9	ALLERGIC RHINITIS, CAUSE UNSPECIFIED
$158.76	009.3	DIARRHEA OF PRESUMED INFECTIOUS ORIGIN
$158.76	518.82	OTHER PULMONARY INSUFFICIENCY, NOT ELSEWHERE CLASSIFIED
$155.85	592.1	CALCULUS OF URETER
$119.00	338.4	CHRONIC PAIN SYNDROME
$93.68	V03.82	OTHER VACCINATIONS/SINGLE BACTERIAL DISEASE;STREPTOCOCCUS PNEUMONIA
$71.06	714.0	RHEUMATOID ARTHRITIS
$69.41	V58.69	LONG-TERM (CURRENT) USE OF OTHER MEDICATIONS
$41.67	275.42	DISORDERS OF CALCIUM METABOLISM / HYPERCALCEMIA
$21.79	720.0	ANKYLOSING SPONDYLITIS

$56,544.33 Total Paid

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
275.42	DISORDERS OF CALCIUM METABOLISM /	41.67	10/16/2013
592.0	CALCULUS OF KIDNEY	16918.50	10/16/2013
592.1	CALCULUS OF URETER	155.85	10/09/2013
493.20	CHRONIC OBSTRUCTIVE ASTHMA (WITH OBSTRUC		10/09/2013
715.98	OSTEOARTHROSIS, UNSPECIFIED WHETHER GENE		10/09/2013
714.0	RHEUMATOID ARTHRITIS	71.06	01/03/2014
V58.65	LONG-TERM (CURRENT) USE OF STEROIDS		10/22/2013
564.00	CONSTIPATION, UNSPECIFIED		10/14/2013
599.70	Hematuria, unspecified		10/14/2013
V58.69	LONG-TERM (CURRENT) USE OF OTHER	69.41	09/19/2014
477.9	ALLERGIC RHINITIS, CAUSE UNSPECIFIED	167.04	07/08/2014
DRUGS	PRESCRIPTION DRUGS	28906.58	10/23/2014
733.20	CYST OF BONE (LOCALIZED), UNSPECIFIED	5587.22	08/07/2013
719.02	EFFUSION OF UPPER ARM JOINT		08/07/2013
727.00	SYNOVITIS AND TENOSYNOVITIS, UNSPECIFIED		08/07/2013
099.3	REITER'S DISEASE	237.15	07/08/2014
788.0	RENAL COLIC	287.10	10/10/2013
274.11	URIC ACID NEPHROLITHIASIS	355.55	10/13/2013
789.00	OTHER SYMPTOMS INVOLVING ABDOMEN AND		10/13/2013
720.0	ANKYLOSING SPONDYLITIS	21.79	04/08/2014
716.99	UNSPECIFIED ARTHROPATHY INVOLVING MULTIP	215.56	09/19/2014

10/31/14 Allegiance Benefit Plan Management, Inc. PAGE: 88
LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 02 11/01/2013 to 10/31/2014 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
518.82	OTHER PULMONARY INSUFFICIENCY, NOT ELSEW	158.76	06/19/2014
003.1	SALMONELLA SEPTICEMIA		06/19/2014
314.00	ATTENTION DEFICIT DISORDER OF CHILDHOOD		07/08/2014
V03.82	OTHER VACCINATIONS/SINGLE BACTERIAL	93.68	07/08/2014
723.4	BRACHIAL NEURITIS OR RADICULITIS NOS	979.65	08/29/2014
338.4	CHRONIC PAIN SYNDROME	119.00	08/05/2014
719.47	PAIN IN JOINT INVOLVING ANKLE AND FOOT		08/05/2014
724.8	OTHER SYMPTOMS REFERABLE TO BACK	1500.00	08/26/2014
724.2	LUMBAGO		08/26/2014
720.2	SACROILIITIS, NOT ELSEWHERE CLASSIFIED	500.00	08/29/2014
721.3	LUMBOSACRAL SPONDYLOSIS WITHOUT MYELOPAT		08/29/2014
723.8	OTHER SYNDROMES AFFECTING CERVICAL REGIO		08/29/2014
795.51	Nonspec reactn TB skn tst w/o activ		09/19/2014
009.3	DIARRHEA OF PRESUMED INFECTIOUS ORIGIN	158.76	09/18/2014

GROUP: 2001025 SSN: ********** SEQ: ** DIV: 0001 RELAT: Spouse EFF: ********** DOB: ********** TERM: **********
LEVEL: F99 PLAN: WILCO-MED-CORE

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	01-*	250000.00	22.77	56926.48	.00	.00	.00	.00

==========Diagnosis Recap==========

Amount	Code	Description
$30,082.59	DRUGS	PRESCRIPTION DRUGS
$18,108.93	922.1	CONTUSION OF CHEST WALL
$1,022.06	719.47	PAIN IN JOINT INVOLVING ANKLE AND FOOT
$801.29	720.2	SACROILIITIS, NOT ELSEWHERE CLASSIFIED
$794.55	727.06	TENOSYNOVITIS OF FOOT AND ANKLE
$740.98	715.97	OSTEOARTHROSIS, UNSPECIFIED WHETHER GENERALIZED OR LOCALIZED, INVOLVING ANKLE AN
$698.81	722.4	DEGENERATION OF CERVICAL INTERVERTEBRAL DISC
$698.81	722.52	DEGENERATION OF LUMBAR OR LUMBOSACRAL INTERVERTEBRAL DISC
$576.80	999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEWHERE CLASSIFIED
$472.50	724.4	THORACIC OR LUMBOSACRAL NEURITIS OR RADICULITIS
$406.65	216.9	BENIGN NEOPLASM OF SKIN, SITE UNSPECIFIED
$341.64	355.5	TARSAL TUNNEL SYNDROME
$294.96	719.40	PAIN IN JOINT, SITE UNSPECIFIED
$242.46	716.17	TRAUMATIC ARTHROPATHY INVOLVING ANKLE AND FOOT
$223.92	453.40	Acute emblsm/thrmb dp vsl lwr extrm
$192.24	959.19	OTHER INJURY OF OTHER SITES OF TRUNK
$144.07	959.12	OTHER INJURY OF ABDOMEN
$109.25	238.2	NEOPLASM OF UNCERTAIN BEHAVIOR OF SKIN
$108.83	959.11	OTHER INJURY OF CHEST WALL
$107.50	723.4	BRACHIAL NEURITIS OR RADICULITIS NOS
$107.50	724.8	OTHER SYMPTOMS REFERABLE TO BACK
$97.67	V72.31	ROUTINE GYNECOLOGICAL EXAM
$89.50	959.09	INJURY OF FACE AND NECK
$66.60	V12.51	Hx, prsnl, vens thrombosis/embolism
$66.43	729.1	MYALGIA AND MYOSITIS, UNSPECIFIED
$65.72	959.01	HEAD INJURY, UNSPECIFIED
$58.17	739.3	NONALLOPATHIC LESIONS OF LUMBAR REGION, NOT ELSEWHERE CLASSIFIED
$47.87	216.5	BENIGN NEOPLASM OF SKIN OF TRUNK, EXCEPTSCROTUM
$37.21	465.9	ACUTE UPPER RESPIRATORY INFECTIONS OF UNSPECIFIED SITE
$25.50	314.00	ATTENTION DEFICIT DISORDER OF CHILDHOOD WITHOUT MENTION OF HYPERACTIVITY
$24.70	729.81	SWELLING OF LIMB
$23.49	477.9	ALLERGIC RHINITIS, CAUSE UNSPECIFIED
$20.84	780.79	OTHER MALAISE AND FATIGUE
$15.18	V58.61	LONG-TERM (CURRENT) USE OF ANTICOAGULANT
$11.26	V58.83	ENCOUNTER/THERAPEUTIC DRUG MONITORING

$56,926.48 Total Paid

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
V58.83	ENCOUNTER/THERAPEUTIC DRUG MONITORING	11.26	04/07/2014
453.40	Acute emblsm/thrmb dp vsl lwr extrm	223.92	04/07/2014
719.47	PAIN IN JOINT INVOLVING ANKLE AND FOOT	1022.06	12/11/2013
DRUGS	PRESCRIPTION DRUGS	30082.59	10/21/2014
V58.61	LONG-TERM (CURRENT) USE OF ANTICOAGULANT	15.18	04/07/2014
462	ACUTE PHARYNGITIS		11/06/2013
780.79	OTHER MALAISE AND FATIGUE	20.84	11/06/2013
465.9	ACUTE UPPER RESPIRATORY INFECTIONS OF UN	37.21	11/06/2013
355.5	TARSAL TUNNEL SYNDROME	341.64	04/30/2014
716.17	TRAUMATIC ARTHROPATHY INVOLVING ANKLE AN	242.46	06/27/2014
V72.31	ROUTINE GYNECOLOGICAL EXAM	97.67	01/10/2014
727.06	TENOSYNOVITIS OF FOOT AND ANKLE	794.55	07/17/2014
782.3	EDEMA		12/20/2013
719.07	EFFUSION OF ANKLE AND FOOT JOINT		12/20/2013
719.40	PAIN IN JOINT, SITE UNSPECIFIED	294.96	03/26/2014
477.9	ALLERGIC RHINITIS, CAUSE UNSPECIFIED	23.49	02/11/2014

10/31/14 Allegiance Benefit Plan Management, Inc. PAGE: 89
LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 02 11/01/2013 to 10/31/2014 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

Diagnosis	Summary for **********	Amount Paid	Last D.O.S.
714.9	UNSPECIFIED INFLAMMATORY POLYARTHROPATHY		03/26/2014
789.09	OTHER SYMPTOMS INVOLVING ABDOMEN AND		04/07/2014
V12.51	Hx, prsnl, vens thrombosis/embolism	66.60	04/07/2014
729.81	SWELLING OF LIMB	24.70	04/07/2014
739.3	NONALLOPATHIC LESIONS OF LUMBAR REGION,	58.17	05/24/2014
715.97	OSTEOARTHROSIS, UNSPECIFIED WHETHER GENE	740.98	07/17/2014
847.2	LUMBAR SPRAIN		05/22/2014
314.00	ATTENTION DEFICIT DISORDER OF CHILDHOOD	25.50	08/21/2014
724.4	THORACIC OR LUMBOSACRAL NEURITIS OR RADI	472.50	06/24/2014
846.0	LUMBOSACRAL (JOINT) (LIGAMENT) SPRAIN		06/24/2014
728.85	SPASM OF MUSCLE		06/24/2014
729.1	MYALGIA AND MYOSITIS, UNSPECIFIED	66.43	10/21/2014
722.52	DEGENERATION OF LUMBAR OR LUMBOSACRAL IN	698.81	07/17/2014
722.10	DISPLACEMENT OF LUMBAR INTERVERTEBRAL DI		07/17/2014
216.9	BENIGN NEOPLASM OF SKIN, SITE UNSPECIFIE	406.65	07/21/2014
722.4	DEGENERATION OF CERVICAL INTERVERTEBRAL	698.81	08/11/2014
722.0	DISPLACEMENT OF CERVICAL INTERVERTEBRAL		08/11/2014
782.0	DISTURBANCE OF SKIN SENSATION		08/11/2014
216.5	BENIGN NEOPLASM OF SKIN OF TRUNK, EXCEPT	47.87	07/21/2014
702.19	OTHER DERMATOSES;OTHER SEBORRHEIC		07/21/2014
238.2	NEOPLASM OF UNCERTAIN BEHAVIOR OF SKIN	109.25	07/21/2014
724.8	OTHER SYMPTOMS REFERABLE TO BACK	107.50	09/23/2014
721.3	LUMBOSACRAL SPONDYLOSIS WITHOUT MYELOPAT		09/23/2014
723.8	OTHER SYNDROMES AFFECTING CERVICAL REGIO		10/21/2014
922.1	CONTUSION OF CHEST WALL	18108.93	08/05/2014
308.9	UNSPECIFIED ACUTE REACTION TO STRESS		08/05/2014
E812.0	OTHER MOTOR VEHICLE TRAFFIC ACCIDENT INV		08/05/2014
720.2	SACROILIITIS, NOT ELSEWHERE CLASSIFIED	801.29	08/26/2014
999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEW	576.80	09/19/2014
924.10	CONTUSION OF LOWER LEG		08/05/2014
E812.1	OTHER MOTOR VEHICLE TRAFFIC ACCIDENT INV		08/05/2014
959.19	OTHER INJURY OF OTHER SITES OF TRUNK	192.24	08/05/2014
959.12	OTHER INJURY OF ABDOMEN	144.07	08/05/2014
V45.79	OTHER ACQUIRED ABSENCE OF ORGAN		08/05/2014
959.11	OTHER INJURY OF CHEST WALL	108.83	08/05/2014
959.09	INJURY OF FACE AND NECK	89.50	08/05/2014
959.01	HEAD INJURY, UNSPECIFIED	65.72	08/05/2014
723.4	BRACHIAL NEURITIS OR RADICULITIS NOS	107.50	10/21/2014
338.4	CHRONIC PAIN SYNDROME		10/21/2014

10/31/14 Allegiance Benefit Plan Management, Inc. PAGE: 90
LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 02 11/01/2013 to 10/31/2014 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

GROUP: 2001025 SSN: ********** SEQ: ** DIV: 0001 RELAT: Participant EFF: ********** DOB: ********** TERM: **********
LEVEL: P99 PLAN: WILCO-MED-CORE

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	00-*	250000.00	14.53	36330.41	.00	.00	.00	.00

==========Diagnosis Recap==========

Amount	Code	Description
$35,054.36	DRUGS	PRESCRIPTION DRUGS
$937.27	340	MULTIPLE SCLEROSIS
$170.56	V76.12	OTHER SCREENING MAMMOGRAM
$152.48	V72.31	ROUTINE GYNECOLOGICAL EXAM
$15.74	300.00	ANXIETY STATE, UNSPECIFIED

$36,330.41 Total Paid

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
DRUGS	PRESCRIPTION DRUGS	35054.36	10/17/2014
340	MULTIPLE SCLEROSIS	937.27	09/11/2014
733.90	DISORDER OF BONE AND CARTILAGE, UNSPECIF		06/06/2014
787.29	OTHER DYSPHAGIA		11/18/2013
782.0	DISTURBANCE OF SKIN SENSATION		06/06/2014
300.00	ANXIETY STATE, UNSPECIFIED	15.74	11/18/2013

10/31/14 Allegiance Benefit Plan Management, Inc. PAGE: 91
LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 02 11/01/2013 to 10/31/2014 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
V72.31	ROUTINE GYNECOLOGICAL EXAM	152.48	11/25/2013
788.31	URGE INCONTINENCE		11/25/2013
V76.12	OTHER SCREENING MAMMOGRAM	170.56	01/03/2014
780.79	OTHER MALAISE AND FATIGUE		09/11/2014
781.2	ABNORMALITY OF GAIT		09/11/2014
564.01	SLOW TRANSIT CONSTIPATION		09/11/2014

GROUP: 2001025 SSN: ********** SEQ: ** DIV: 0001 RELAT: Participant EFF: ********** DOB: ********** TERM: **********
LEVEL: P00 PLAN: WILCO-MED-CORE-DIAB

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	00-*	250000.00	15.31	38263.45	.00	.00	.00	.00

==========Diagnosis Recap==========

Amount	Code	Description
$26,028.33	716.91	UNSPECIFIED ARTHROPATHY INVOLVING SHOULDER REGION
$4,947.89	715.91	OSTEOARTHROSIS, UNSPECIFIED WHETHER GENERALIZED OR LOCALIZED, INVOLVING SHOULDER
$3,352.86	715.11	OSTEOARTHROSIS, LOCALIZED, PRIMARY, INVOLVING SHOULDER REGION
$1,200.00	338.18	OTHER ACUTE POSTOPERATIVE PAIN
$547.21	715.12	OSTEOARTHROSIS, LOCALIZED, PRIMARY, INVOLVING UPPER ARM
$536.66	999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEWHERE CLASSIFIED
$501.79	DRUGS	PRESCRIPTION DRUGS
$449.44	V54.81	AFTERCARE FOLLOWING JOINT REPLACEMENT
$262.50	719.50	STIFFNESS OF JOINT, NOT ELSEWHERE CLASSIFIED, INVOLVING UNSPECIFIED SITE
$196.48	401.9	UNSPECIFIED ESSENTIAL HYPERTENSION
$172.60	719.41	PAIN IN JOINT INVOLVING SHOULDER REGION
$44.46	250.00	DIABETES MELLITUS WITHOUT MENTION OF COMPLICATION, TYPE II
$13.79	V43.61	JOINT;SHOULDER
$9.44	V72.81	PREOP CARDIOVSCLR EXAM

$38,263.45 Total Paid

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
715.12	OSTEOARTHROSIS, LOCALIZED, PRIMARY, INVO	547.21	12/18/2013
719.41	PAIN IN JOINT INVOLVING SHOULDER REGION	172.60	02/05/2014
719.50	STIFFNESS OF JOINT, NOT ELSEWHERE CLASSI	262.50	12/06/2013
DRUGS	PRESCRIPTION DRUGS	501.79	09/24/2014
715.11	OSTEOARTHROSIS, LOCALIZED, PRIMARY, INVO	3352.86	08/08/2014
V72.81	PREOP CARDIOVSCLR EXAM	9.44	02/04/2014
716.91	UNSPECIFIED ARTHROPATHY INVOLVING SHOULD	26028.33	02/07/2014
401.9	UNSPECIFIED ESSENTIAL HYPERTENSION	196.48	08/08/2014
V45.79	OTHER ACQUIRED ABSENCE OF ORGAN		02/07/2014
V43.65	JOINT;KNEE		02/07/2014
V58.69	LONG-TERM (CURRENT) USE OF OTHER		02/07/2014

10/31/14 Allegiance Benefit Plan Management, Inc. PAGE: 92
LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 02 11/01/2013 to 10/31/2014 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
715.91	OSTEOARTHROSIS, UNSPECIFIED WHETHER GENE	4947.89	04/23/2014
338.18	OTHER ACUTE POSTOPERATIVE PAIN	1200.00	03/21/2014
V43.61	JOINT;SHOULDER	13.79	03/21/2014
250.00	DIABETES MELLITUS WITHOUT MENTION OF	44.46	08/08/2014
272.0	PURE HYPERCHOLESTEROLEMIA		08/08/2014
278.00	OBESITY, UNSPECIFIED		08/08/2014
999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEW	536.66	05/25/2014
V54.81	AFTERCARE FOLLOWING JOINT REPLACEMENT	449.44	03/21/2014
V67.00	FOLLOWING SURGERY, UNSPECIFIED		05/07/2014

GROUP: 2001025 SSN: ********** SEQ: ** DIV: 0001 RELAT: Child EFF: ********** DOB: ********** TERM: **********
LEVEL: F99 PLAN: WILCO-MED-EPO

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	11-*	250000.00	19.82	49541.95	.00	.00	.00	.00

==========Diagnosis Recap==========

Amount	Code	Description
$42,200.54	427.89	CARDIAC DYSRHYTHMIAS
$4,181.23	427.0	PAROXYSMAL SUPRAVENTRICULAR TACHYCARDIA
$1,198.96	427.42	VENTRICULAR FLUTTER
$491.00	DRUGS	PRESCRIPTION DRUGS
$471.67	785.1	PALPITATIONS
$375.15	794.5	NONSPECIFIC ABNORMAL RESULTS OF FUNCTIONSTUDY OF THYROID
$154.29	V04.81	NEED FOR PROPHYLACTIC VACCINATION/ INOCULATION AGAINST, INFLUENZA
$126.71	246.2	CYST OF THYROID
$121.94	246.9	UNSPECIFIED DISORDER OF THYROID
$87.94	V72.5	RADIOLOGICAL EXAMINATION, NOT ELSEWHERE CLASSIFIED
$74.39	477.9	ALLERGIC RHINITIS, CAUSE UNSPECIFIED
$34.51	242.00	TOXIC DIFFUSE GOITER WITHOUT MENTION OF THYROTOXIC CRISIS OR STORM
$12.91	242.90	THYROTOXICOSIS WITHOUT MENTION OF GOITEROR OTHER CAUSE, AND WITHOUT MENTION OF
$10.71	V72.81	PREOP CARDIOVSCLR EXAM

$49,541.95 Total Paid

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
794.5	NONSPECIFIC ABNORMAL RESULTS OF FUNCTION	375.15	04/02/2014
246.2	CYST OF THYROID	126.71	04/02/2014
V72.5	RADIOLOGICAL EXAMINATION, NOT ELSEWHERE	87.94	02/04/2014
246.9	UNSPECIFIED DISORDER OF THYROID	121.94	02/03/2014
V04.81	NEED FOR PROPHYLACTIC VACCINATION/	154.29	03/03/2014
V20.2	ROUTINE INFANT OR CHILD HEALTH CHECK		03/03/2014
DRUGS	PRESCRIPTION DRUGS	491.00	10/17/2014
242.90	THYROTOXICOSIS WITHOUT MENTION OF GOITER	12.91	07/04/2014
427.0	PAROXYSMAL SUPRAVENTRICULAR TACHYCARDIA	4181.23	08/01/2014

10/31/14 Allegiance Benefit Plan Management, Inc. PAGE: 93
LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 02 11/01/2013 to 10/31/2014 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
785.1	PALPITATIONS	471.67	06/03/2014
242.00	TOXIC DIFFUSE GOITER WITHOUT MENTION OF	34.51	08/06/2014
427.1	PAROXYSMAL VENTRICULAR TACHYCARDIA		04/26/2014
477.9	ALLERGIC RHINITIS, CAUSE UNSPECIFIED	74.39	05/13/2014
784.0	HEADACHE		05/13/2014
314.00	ATTENTION DEFICIT DISORDER OF CHILDHOOD		05/13/2014
427.42	VENTRICULAR FLUTTER	1198.96	06/02/2014
427.89	CARDIAC DYSRHYTHMIAS	42200.54	07/04/2014
314.01	ATTENTION DEFICIT DISORDER OF CHILDHOOD		07/04/2014
V72.81	PREOP CARDIOVSCLR EXAM	10.71	07/03/2014

GROUP: 2001025 SSN: ********** SEQ: ** DIV: RETR RELAT: Spouse EFF: ********** DOB: ********** TERM: **********
LEVEL: F99 PLAN: WILCO-MED-CORE

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	01-*	250000.00	15.90	39755.79	.00	.00	.00	.00

==========Diagnosis Recap==========

Amount	Code	Description
$19,365.65	189.0	MALIGNANT NEOPLASM OF KIDNEY, EXCEPT PELVIS
$12,574.42	593.9	UNSPECIFIED DISORDER OF KIDNEY AND URETER
$4,278.56	V67.59	OTHER FOLLOW-UP EXAMINATION
$1,407.89	DRUGS	PRESCRIPTION DRUGS
$646.63	555.9	REGIONAL ENTERITIS OF UNSPECIFIED SITE
$575.00	999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEWHERE CLASSIFIED
$241.02	338.29	OTHER CHRONIC PAIN
$204.09	787.01	OTHER SYMPTOMS INVOLVING DIGESTIVE SYSTEM;NAUSEA WITH VOMITING
$180.96	555.2	REGIONAL ENTERITIS OF SMALL INTESTINE WITH LARGE INTESTINE
$145.56	789.00	OTHER SYMPTOMS INVOLVING ABDOMEN AND PELVIS
$44.60	556.9	ULCERATIVE COLITIS;UNSPECIFIED
$44.60	555.0	REGIONAL ENTERITIS OF SMALL INTESTINE
$31.80	787.03	SYMPTOMS INVOLVING DIGESTIVE SYSTEM VOMITING ALONE
$15.01	786.05	SHORTNESS OF BREATH

$39,755.79 Total Paid

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
189.0	MALIGNANT NEOPLASM OF KIDNEY, EXCEPT PEL	19365.65	01/08/2014
DRUGS	PRESCRIPTION DRUGS	1407.89	10/19/2014
593.9	UNSPECIFIED DISORDER OF KIDNEY AND URETE	12574.42	01/14/2014
V45.89	OTHER POSTSURGICAL STATUS		10/21/2013
V67.59	OTHER FOLLOW-UP EXAMINATION	4278.56	10/21/2013
555.9	REGIONAL ENTERITIS OF UNSPECIFIED SITE	646.63	01/08/2014
555.2	REGIONAL ENTERITIS OF SMALL INTESTINE WI	180.96	11/08/2013
338.29	OTHER CHRONIC PAIN	241.02	10/03/2014
455.6	UNSPECIFIED HEMORRHOIDS WITHOUT MENTION		12/03/2013
789.00	OTHER SYMPTOMS INVOLVING ABDOMEN AND	145.56	01/14/2014

10/31/14 Allegiance Benefit Plan Management, Inc. PAGE: 94
LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 02 11/01/2013 to 10/31/2014 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
787.03	SYMPTOMS INVOLVING DIGESTIVE SYSTEM	31.80	01/14/2014
577.2	CYST AND PSEUDOCYST OF PANCREAS		10/07/2013
401.0	MALIGNANT ESSENTIAL HYPERTENSION		10/07/2013
V58.69	LONG-TERM (CURRENT) USE OF OTHER		10/07/2013
555.0	REGIONAL ENTERITIS OF SMALL INTESTINE	44.60	10/07/2013
556.9	ULCERATIVE COLITIS;UNSPECIFIED	44.60	10/07/2013
V10.52	Hx, prsnl, kidney malignancy		01/14/2014
780.57	UNSPECIFIED SLEEP APNEA		01/08/2014
724.5	BACKACHE, UNSPECIFIED		01/14/2014
787.01	OTHER SYMPTOMS INVOLVING DIGESTIVE	204.09	01/12/2014
789.07	OTHER SYMPTOMS INVOLVING ABDOMEN AND		01/12/2014
564.00	CONSTIPATION, UNSPECIFIED		01/12/2014
V72.83	OTH SPCF PREOP EXAM		01/06/2014
427.81	SINOATRIAL NODE DYSFUNCTION		01/06/2014
999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEW	575.00	02/19/2014
560.1	PARALYTIC ILEUS		01/14/2014
786.05	SHORTNESS OF BREATH	15.01	10/04/2013
724.2	LUMBAGO		10/03/2014
477.9	ALLERGIC RHINITIS, CAUSE UNSPECIFIED		10/03/2014
257.2	OTHER TESTICULAR HYPOFUNCTION		10/03/2014

GROUP: 2001025 SSN: ********** SEQ: ** DIV: 0001 RELAT: Child EFF: ********** DOB: ********** TERM: **********
LEVEL: F99 PLAN: WILCO-MED-DED

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	11-*	250000.00	100.00	250000.00	.00	.00	.00	-41569.01

==========Diagnosis Recap==========

Amount	Code	Description
$98,487.30	557.1	CHRONIC VASCULAR INSUFFICIENCY OF INTESTINE
$92,217.13	787.03	SYMPTOMS INVOLVING DIGESTIVE SYSTEM VOMITING ALONE
$4,162.88	DRUGS	PRESCRIPTION DRUGS
$2,432.94	789.05	OTHER SYMPTOMS INVOLVING ABDOMEN AND PELVIS
$2,074.40	555.1	REGIONAL ENTERITIS OF LARGE INTESTINE
$1,957.04	569.9	UNSPECIFIED DISORDER OF INTESTINE
$1,122.00	578.1	MELENA
$856.53	276.51	DEHYDRATION
$844.74	787.01	OTHER SYMPTOMS INVOLVING DIGESTIVE SYSTEM;NAUSEA WITH VOMITING
$728.16	493.00	EXTRINSIC ASTHMA, UNSPECIFIED
$679.12	729.5	PAIN IN LIMB
$651.67	999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEWHERE CLASSIFIED
$504.00	783.3	FEEDING DIFFICULTIES AND MISMANAGEMENT
$329.36	477.0	ALLERGIC RHINITIS DUE TO POLLEN
$270.66	789.07	OTHER SYMPTOMS INVOLVING ABDOMEN AND PELVIS
$243.50	786.2	COUGH
$148.66	V20.2	ROUTINE INFANT OR CHILD HEALTH CHECK
$74.34	382.9	UNSPECIFIED OTITIS MEDIA
$74.34	490	BRONCHITIS, NOT SPECIFIED AS ACUTE OR CHRONIC
$74.34	727.00	SYNOVITIS AND TENOSYNOVITIS, UNSPECIFIED
$71.32	789.00	OTHER SYMPTOMS INVOLVING ABDOMEN AND PELVIS
$70.16	530.81	ESOPHAGEAL REFLUX
$61.68	V55.4	ATTENTION TO OTHER ARTIFICIAL OPENING OFDIGESTIVE TRACT
$46.75	786.50	UNSPECIFIED CHEST PAIN
$45.11	719.41	PAIN IN JOINT INVOLVING SHOULDER REGION
$37.92	780.60	Symptom, fever, unspecified
$35.73	491.9	UNSPECIFIED CHRONIC BRONCHITIS
$32.81	V04.81	NEED FOR PROPHYLACTIC VACCINATION/ INOCULATION AGAINST, INFLUENZA
$32.06	536.2	PERSISTENT VOMITING
$23.44	556.2	ULCERATIVE COLITIS;CHRONIC PROCTITS
$20.45	788.20	RETENTION URINE NOS
$20.45	560.9	UNSPECIFIED INTESTINAL OBSTRUCTION

$208,430.99 Total Paid

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
789.05	OTHER SYMPTOMS INVOLVING ABDOMEN AND	2432.94	06/10/2014
536.2	PERSISTENT VOMITING	32.06	06/10/2014
DRUGS	PRESCRIPTION DRUGS	4162.88	10/15/2014
555.1	REGIONAL ENTERITIS OF LARGE INTESTINE	2074.40	11/04/2013
535.10	ATRPH GASTRTIS W/O HMRHG		11/04/2013
530.19	OTHER ESOPHAGITIS		11/04/2013
786.50	UNSPECIFIED CHEST PAIN	46.75	08/25/2013
787.03	SYMPTOMS INVOLVING DIGESTIVE SYSTEM	92217.13	05/16/2014
569.9	UNSPECIFIED DISORDER OF INTESTINE	1957.04	11/04/2013
557.1	CHRONIC VASCULAR INSUFFICIENCY OF INTEST	98487.30	11/13/2013
556.2	ULCERATIVE COLITIS;CHRONIC PROCTITS	23.44	07/25/2014
578.1	MELENA	1122.00	01/30/2014
999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEW	651.67	05/25/2014
V55.4	ATTENTION TO OTHER ARTIFICIAL OPENING OF	61.68	11/13/2013
276.51	DEHYDRATION	856.53	02/22/2014
783.3	FEEDING DIFFICULTIES AND MISMANAGEMENT	504.00	11/13/2013
789.00	OTHER SYMPTOMS INVOLVING ABDOMEN AND	71.32	02/21/2014
787.01	OTHER SYMPTOMS INVOLVING DIGESTIVE	844.74	02/22/2014
560.9	UNSPECIFIED INTESTINAL OBSTRUCTION	20.45	11/07/2013
535.50	GSTR/DDNTS NOS W/O HMRHG		11/08/2013
569.49	OTHER SPECIFIED DISORDERS OF RECTUM AND		11/13/2013
V04.81	NEED FOR PROPHYLACTIC VACCINATION/	32.81	12/31/2013
719.41	PAIN IN JOINT INVOLVING SHOULDER REGION	45.11	02/03/2014

727.00	SYNOVITIS AND TENOSYNOVITIS, UNSPECIFIED	74.34	02/03/2014
493.00	EXTRINSIC ASTHMA, UNSPECIFIED	728.16	08/22/2014
789.09	OTHER SYMPTOMS INVOLVING ABDOMEN AND		02/17/2014
490	BRONCHITIS, NOT SPECIFIED AS ACUTE OR CH	74.34	03/19/2014
556.9	ULCERATIVE COLITIS;UNSPECIFIED		09/30/2014
530.81	ESOPHAGEAL REFLUX	70.16	02/19/2014
788.20	RETENTION URINE NOS	20.45	02/17/2014
789.07	OTHER SYMPTOMS INVOLVING ABDOMEN AND	270.66	02/22/2014
780.60	Symptom, fever, unspecified	37.92	04/27/2014
382.9	UNSPECIFIED OTITIS MEDIA	74.34	04/27/2014
V12.79	Hx, prsnl, digestive disease NEC		02/17/2014
V20.2	ROUTINE INFANT OR CHILD HEALTH CHECK	148.66	05/08/2014
477.9	ALLERGIC RHINITIS, CAUSE UNSPECIFIED		05/16/2014
491.9	UNSPECIFIED CHRONIC BRONCHITIS	35.73	06/10/2014
786.2	COUGH	243.50	08/22/2014
477.0	ALLERGIC RHINITIS DUE TO POLLEN	329.36	10/15/2014
477.8	ALLERGIC RHINITIS DUE TO OTHER ALLERGEN		10/15/2014

10/31/14 Allegiance Benefit Plan Management, Inc. PAGE: 96
LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 02 11/01/2013 to 10/31/2014 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

Diagnosis Summary for **********	Amount Paid	Last D.O.S.
729.5 PAIN IN LIMB	679.12	10/02/2014

GROUP: 2001025 SSN: ********** SEQ: ** DIV: 0001 RELAT: Participant EFF: ********** DOB: ********** TERM: **********
LEVEL: P99 PLAN: WILCO-MED-EPO

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	00-*	250000.00	10.86	27151.99	.00	.00	.00	.00

Diagnosis Recap

Amount	Code	Description
$24,544.84	DRUGS	PRESCRIPTION DRUGS
$630.00	722.52	DEGENERATION OF LUMBAR OR LUMBOSACRAL INTERVERTEBRAL DISC
$554.33	724.4	THORACIC OR LUMBOSACRAL NEURITIS OR RADICULITIS
$360.00	737.39	OTHER KYPHOSCOLIOSIS AND SCOLIOSIS
$272.47	042	HUMAN IMMUNODEFICIENCY VIRUS (HIV) INFECTION
$251.97	401.1	BENIGN ESSENTIAL HYPERTENSION
$176.94	365.01	OPEN ANGLE WITH BORDERLINE GLAUCOMA FINDINGS
$127.95	724.5	BACKACHE, UNSPECIFIED
$113.35	616.2	CYST OF BARTHOLIN'S GLAND
$56.76	737.30	SCOLIOSIS (AND KYPHOSCOLIOSIS), IDIOPATHIC
$43.38	V82.89	OTHER SPECIFIED CONDITIONS
$20.00	V58.69	LONG-TERM (CURRENT) USE OF OTHER MEDICATIONS

$27,151.99 Total Paid

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
DRUGS	PRESCRIPTION DRUGS	24544.84	10/22/2014
042	HUMAN IMMUNODEFICIENCY VIRUS (HIV) INFEC	272.47	06/17/2014
724.5	BACKACHE, UNSPECIFIED	127.95	01/27/2014
796.2	ELEVATED BLOOD PRESSURE READING WITHOUT		11/27/2013
365.9	UNSPECIFIED GLAUCOMA		11/27/2013
365.01	OPEN ANGLE WITH BORDERLINE GLAUCOMA FIND	176.94	12/13/2013
401.1	BENIGN ESSENTIAL HYPERTENSION	251.97	06/17/2014
724.4	THORACIC OR LUMBOSACRAL NEURITIS OR RADI	554.33	05/02/2014
847.1	THORACIC SPRAIN		05/02/2014
V58.69	LONG-TERM (CURRENT) USE OF OTHER	20.00	02/07/2014
304.00	OPIOID TYPE DEPENDENCE, UNSPECIFIED USE		02/07/2014
737.39	OTHER KYPHOSCOLIOSIS AND SCOLIOSIS	360.00	02/17/2014
722.52	DEGENERATION OF LUMBAR OR LUMBOSACRAL IN	630.00	02/17/2014
737.30	SCOLIOSIS (AND KYPHOSCOLIOSIS), IDIOPATH	56.76	05/02/2014
721.2	THORACIC SPONDYLOSIS WITHOUT MYELOPATHY		05/02/2014
616.2	CYST OF BARTHOLIN'S GLAND	113.35	07/28/2014
V82.89	OTHER SPECIFIED CONDITIONS	43.38	08/25/2014

GROUP: 2001025 SSN: ********** SEQ: ** DIV: RET2 RELAT: Spouse EFF: ********** DOB: ********** TERM: **********
LEVEL: F99 PLAN: WILCO-MED-CORE-DIAB

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	01-*	250000.00	11.33	28333.94	.00	.00	.00	.00

Diagnosis Recap

Amount	Code	Description
$13,133.55	DRUGS	PRESCRIPTION DRUGS
$7,190.00	221.8	BENIGN NEOPLASM OF OTHER SPECIFIED SITESOF FEMALE GENITAL ORGANS
$2,628.42	211.3	BENIGN NEOPLASM OF COLON
$1,547.61	789.30	OTHER SYMPTOMS INVOLVING ABDOMEN AND PELVIS
$546.34	620.2	OTHER AND UNSPECIFIED OVARIAN CYST
$527.99	625.9	UNSPECIFIED SYMPTOM ASSOCIATED WITH FEMALE GENITAL ORGANS
$445.95	789.00	OTHER SYMPTOMS INVOLVING ABDOMEN AND PELVIS
$306.33	789.07	OTHER SYMPTOMS INVOLVING ABDOMEN AND PELVIS
$223.32	V76.12	OTHER SCREENING MAMMOGRAM
$191.34	V72.31	ROUTINE GYNECOLOGICAL EXAM
$163.37	V49.81	POSTMENOPAUSAL STATUS (AGE RELATED)
$146.91	250.00	DIABETES MELLITUS WITHOUT MENTION OF COMPLICATION, TYPE II
$143.99	362.76	DYSTROPHIES PRIMARILY INVOLVING THE RETINAL PIGMENT EPITHELIUM
$136.76	789.35	OTHER SYMPTOMS INVOLVING ABDOMEN AND PELVIS
$122.50	362.51	NONEXUDATIVE SENILE MACULAR DEGENERATIONOF RETINA
$119.68	789.03	OTHER SYMPTOMS INVOLVING ABDOMEN AND PELVIS
$119.68	536.3	GASTROPARESIS
$110.95	389.18	SENSORINEURAL HEARING LOSS OF COMBINED TYPES
$102.59	250.01	DIABETES MELLITUS WITHOUT MENTION OF COMPLICATION,TYPE I,JUVENILE TYPE
$100.18	362.70	HEREDITARY RETINAL DYSTROPHY, UNSPECIFIED
$66.53	789.01	OTHER SYMPTOMS INVOLVING ABDOMEN AND PELVIS
$66.00	V04.81	NEED FOR PROPHYLACTIC VACCINATION/ INOCULATION AGAINST, INFLUENZA
$47.87	599.0	URINARY TRACT INFECTION, SITE NOT SPECIFIED
$47.87	787.01	OTHER SYMPTOMS INVOLVING DIGESTIVE SYSTEM;NAUSEA WITH VOMITING
$47.87	488.09	Influenza d/t avian w/manifestation
$42.70	729.5	PAIN IN LIMB
$7.64	477.0	ALLERGIC RHINITIS DUE TO POLLEN

$28,333.94 Total Paid

Diagnosis Summary for **********	**********	Amount Paid	Last D.O.S.
250.01	DIABETES MELLITUS WITHOUT MENTION OF	102.59	02/13/2014
244.0	POSTSURGICAL HYPOTHYROIDISM		06/04/2014
536.3	GASTROPARESIS	119.68	04/11/2014
593.9	UNSPECIFIED DISORDER OF KIDNEY AND URETE		09/08/2014
250.00	DIABETES MELLITUS WITHOUT MENTION OF	146.91	10/23/2014
DRUGS	PRESCRIPTION DRUGS	13133.55	10/23/2014
488.09	Influenza d/t avian w/manifestation	47.87	12/19/2013
715.09	OSTEOARTHROSIS, GENERALIZED, INVOLVING M		12/19/2013
V04.81	NEED FOR PROPHYLACTIC VACCINATION/	66.00	10/23/2014
477.0	ALLERGIC RHINITIS DUE TO POLLEN	7.64	09/08/2014
787.01	OTHER SYMPTOMS INVOLVING DIGESTIVE	47.87	02/26/2014
782.0	DISTURBANCE OF SKIN SENSATION		04/11/2014
333.94	OTHER EXTRAPHYRAMIDAL DISEASE AND		04/11/2014
799.81	DECREASED LIBIDO		04/11/2014
362.76	DYSTROPHIES PRIMARILY INVOLVING THE RETI	143.99	02/13/2014
366.16	SENILE NUCLEAR SCLEROSIS		02/13/2014
729.5	PAIN IN LIMB	42.70	03/14/2014
V72.31	ROUTINE GYNECOLOGICAL EXAM	191.34	05/16/2014
625.0	DYSPAREUNIA		05/16/2014

10/31/14 Allegiance Benefit Plan Management, Inc. PAGE: 98
LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 02 11/01/2013 to 10/31/2014 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
789.00	OTHER SYMPTOMS INVOLVING ABDOMEN AND	445.95	05/28/2014
V76.12	OTHER SCREENING MAMMOGRAM	223.32	05/28/2014
272.4	OTHER AND UNSPECIFIED HYPERLIPIDEMIA		06/04/2014
789.07	OTHER SYMPTOMS INVOLVING ABDOMEN AND	306.33	08/27/2014
789.35	OTHER SYMPTOMS INVOLVING ABDOMEN AND	136.76	06/18/2014
V49.81	POSTMENOPAUSAL STATUS (AGE RELATED)	163.37	06/10/2014
625.9	UNSPECIFIED SYMPTOM ASSOCIATED WITH FEMA	527.99	07/14/2014
362.51	NONEXUDATIVE SENILE MACULAR DEGENERATION	122.50	08/16/2013
620.2	OTHER AND UNSPECIFIED OVARIAN CYST	546.34	07/14/2014
221.8	BENIGN NEOPLASM OF OTHER SPECIFIED SITES	7190.00	07/14/2014
246.9	UNSPECIFIED DISORDER OF THYROID		07/14/2014
305.1	TOBACCO USE DISORDER		07/14/2014
789.30	OTHER SYMPTOMS INVOLVING ABDOMEN AND	1547.61	07/14/2014
789.03	OTHER SYMPTOMS INVOLVING ABDOMEN AND	119.68	09/08/2014
369.4	LEGAL BLINDNESS, AS DEFINED IN U.S.A.		08/01/2014
564.00	CONSTIPATION, UNSPECIFIED		08/19/2014
787.91	OTHER SYMPTOMS INVOLVING DIGESTIVE		08/19/2014
787.3	FLATULENCE, ERUCTATION, AND GAS PAIN		08/19/2014
211.3	BENIGN NEOPLASM OF COLON	2628.42	08/27/2014
536.8	DYSPEPSIA AND OTHER SPECIFIED DISORDERS		08/27/2014
789.01	OTHER SYMPTOMS INVOLVING ABDOMEN AND	66.53	09/18/2014
389.18	SENSORINEURAL HEARING LOSS OF COMBINED T	110.95	10/06/2014
478.19	OTHER DISEASES OF UPPER RESPIRATORY		10/06/2014
362.70	HEREDITARY RETINAL DYSTROPHY, UNSPECIFIE	100.18	10/09/2014
599.0	URINARY TRACT INFECTION, SITE NOT SPECIF	47.87	10/23/2014
729.1	MYALGIA AND MYOSITIS, UNSPECIFIED		10/23/2014
715.89	OSTEOARTHROSIS INVOLVING OR WITH MENTION		10/23/2014

GROUP: 2001025 SSN: ********** SEQ: ** DIV: 0001 RELAT: Child EFF: ********** DOB: ********** TERM: **********
LEVEL: P99 PLAN: WILCO-MED-CORE

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	12-*	250000.00	17.74	44337.56	.00	.00	.00	.00

==========Diagnosis Recap==========

Amount	Code	Description
$22,643.34	749.23	CLEFT PALATE WITH CLEFT LIP, BILATERAL, COMPLETE
$16,529.84	996.59	MECHANICAL COMPLICATION OF OTHER IMPLANTAND INTERNAL DEVICE, NOT ELSEWHERE CLAS
$1,952.47	749.20	CLEFT PALATE WITH CLEFT LIP, UNSPECIFIED
$1,250.37	748.1	OTHER CONGENITAL ANOMALIES OF NOSE
$1,050.70	384.20	PERFORATION OF TYMPANIC MEMBRANE, UNSPECIFIED
$174.72	385.83	RETAINED FOREIGN BODY OF MIDDLE EAR
$114.40	749.24	CLEFT PALATE WITH CLEFT LIP, BILATERAL, INCOMPLETE
$114.40	V58.49	OTHER SPECIFIED AFTERCARE FOLLOWING SURGERY
$103.68	V04.81	NEED FOR PROPHYLACTIC VACCINATION/ INOCULATION AGAINST, INFLUENZA
$102.96	V67.09	FOLLOWING OTHER SURGERY \
$102.96	V72.2	DENTAL EXAMINATION
$86.24	057.0	ERYTHEMA INFECTIOSUM (FIFTH DISEASE)
$86.24	382.00	ACUTE SUPPURATIVE OTITIS MEDIA WITHOUT SPONTANEOUS RUPTURE OF EARDRUM
$25.24	V06.1	NEED FOR PROPHYLACTIC VACCINATION WITH COMBINED DIPHTHERIA-TETANUS-PERTUSSIS (DT
$0.00	DRUGS	PRESCRIPTION DRUGS

$44,337.56 Total Paid

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
749.23	CLEFT PALATE WITH CLEFT LIP, BILATERAL,	22643.34	07/09/2014
V45.89	OTHER POSTSURGICAL STATUS		08/18/2014
V72.2	DENTAL EXAMINATION	102.96	10/07/2013
749.20	CLEFT PALATE WITH CLEFT LIP, UNSPECIFIED	1952.47	08/14/2014
520.1	SUPERNUMERARY TEETH		10/07/2013
526.89	OTHER SPECIFIED DISEASES OF THE JAWS		10/07/2013
DRUGS	PRESCRIPTION DRUGS		01/25/2014

10/31/14 Allegiance Benefit Plan Management, Inc. PAGE: 99
LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 02 11/01/2013 to 10/31/2014 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
382.00	ACUTE SUPPURATIVE OTITIS MEDIA WITHOUT S	86.24	05/20/2014
465.9	ACUTE UPPER RESPIRATORY INFECTIONS OF UN		01/25/2014
V04.81	NEED FOR PROPHYLACTIC VACCINATION/	103.68	10/09/2013
V03.82	OTHER VACCINATIONS/SINGLE BACTERIAL		10/09/2013
V06.1	NEED FOR PROPHYLACTIC VACCINATION WITH C	25.24	10/09/2013
V03.81	OTHER VACCINATIONS/SINGLE BACTERIAL		10/09/2013
748.1	OTHER CONGENITAL ANOMALIES OF NOSE	1250.37	04/22/2014
V13.64	Hx, prsnl, correctd malfo face/neck		04/09/2014
709.2	SCAR CONDITIONS AND FIBROSIS OF SKIN		04/09/2014
525.8	OTHER SPECIFIED DISORDERS OF THE TEETH A		04/22/2014
315.39	OTHER DEVELOPMENTAL SPEECH OR LANGUAGE		04/22/2014
385.83	RETAINED FOREIGN BODY OF MIDDLE EAR	174.72	04/22/2014
384.20	PERFORATION OF TYMPANIC MEMBRANE, UNSPEC	1050.70	04/22/2014
738.0	ACQUIRED DEFORMITY OF NOSE		04/22/2014
V67.09	FOLLOWING OTHER SURGERY	102.96	04/30/2014
057.0	ERYTHEMA INFECTIOSUM (FIFTH DISEASE)	86.24	05/20/2014
521.00	DENTAL CARIES, UNSPECIFIED		04/22/2014
996.59	MECHANICAL COMPLICATION OF OTHER IMPLANT	16529.84	07/09/2014
E878.4	OTHER RESTORATIVE SURGERY CAUSING ABNORM		07/09/2014
V58.49	OTHER SPECIFIED AFTERCARE FOLLOWING	114.40	07/23/2014
749.24	CLEFT PALATE WITH CLEFT LIP, BILATERAL,	114.40	08/18/2014

GROUP: 2001025 SSN: ********** SEQ: ** DIV: 0001 RELAT: Child EFF: ********** DOB: ********** TERM: **********
LEVEL: P99 PLAN: WILCO-MED-CORE

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	13-*	250000.00	39.35	98366.37	.00	.00	.00	.00

==========Diagnosis Recap==========

Amount	Code	Description
$64,573.20	V30.01	SINGLE LIVEBORN, BORN IN HOSPITAL, DELIVERED BY CESAREAN SECTION
$9,904.43	769	RESPIRATORY DISTRESS SYNDROME IN NEWBORN
$5,258.55	770.81	PRIMARY APNEA OF NEWBORN
$4,589.87	765.27	SHORT GESTATION 33-34 COMPLETED WEEKS OFGESTATION
$4,573.34	765.19	PRETERM NEC 2500+G
$4,572.50	999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEWHERE CLASSIFIED
$3,783.35	770.89	OTHER RESPIRATORY PROBLEMS AFTER BIRTH
$520.38	V20.2	ROUTINE INFANT OR CHILD HEALTH CHECK
$398.48	V50.2	ROUTINE OR RITUAL CIRCUMCISION
$76.79	765.10	PRETERM INFANT NEC WTNOS
$47.87	464.4	CROUP
$43.38	478.19	OTHER DISEASES OF UPPER RESPIRATORY TRACT-OTHER DISEASES OF NASAL CAVITY
$24.23	V04.82	NEED FOR PROPHYLACTIC VACCINATION/ INOCULATION AGAINST, RESP SYNCTIAL VIRUS

$98,366.37 Total Paid

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
765.10	PRETERM INFANT NEC WTNOS	76.79	11/11/2013
770.89	OTHER RESPIRATORY PROBLEMS AFTER BIRTH	3783.35	09/26/2013
770.81	PRIMARY APNEA OF NEWBORN	5258.55	09/26/2013
765.19	PRETERM NEC 2500+G	4573.34	09/20/2013
V72.19	SPECIAL INVESTIGATIONS AND EXAMINATIONS-		09/13/2013
478.19	OTHER DISEASES OF UPPER RESPIRATORY	43.38	10/18/2013
V20.2	ROUTINE INFANT OR CHILD HEALTH CHECK	520.38	11/11/2013
999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEW	4572.50	12/19/2013
779.31	Disord stomach feeding prob NB		09/17/2013
V50.2	ROUTINE OR RITUAL CIRCUMCISION	398.48	09/16/2013
769	RESPIRATORY DISTRESS SYNDROME IN NEWBORN	9904.43	09/05/2013
765.27	SHORT GESTATION 33-34 COMPLETED WEEKS OF	4589.87	11/26/2013
464.4	CROUP	47.87	12/14/2013
V04.82	NEED FOR PROPHYLACTIC VACCINATION/	24.23	11/11/2013
V30.01	SINGLE LIVEBORN, BORN IN HOSPITAL, DELIV	64573.20	09/26/2013

GROUP: 2001025 SSN: ********** SEQ: ** DIV: 0001 RELAT: Participant EFF: ********** DOB: ********** TERM: **********
LEVEL: P99 PLAN: WILCO-MED-DED

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	00-*	250000.00	15.56	38894.07	.00	.00	.00	.00

==========Diagnosis Recap==========

Amount	Code	Description
$32,120.01	DRUGS	PRESCRIPTION DRUGS
$5,011.27	592.1	CALCULUS OF URETER
$400.22	V58.69	LONG-TERM (CURRENT) USE OF OTHER MEDICATIONS
$394.74	696.1	OTHER PSORIASIS AND SIMILAR DISORDERS
$174.04	571.8	OTHER CHRONIC NONALCOHOLIC LIVER DISEASE
$150.00	078.10	VIRAL WARTS NOS
$144.03	V70.0	ROUTINE GENERAL MEDICAL EXAMINATION AT AHEALTH CARE FACILITY
$140.53	238.2	NEOPLASM OF UNCERTAIN BEHAVIOR OF SKIN
$137.83	592.0	CALCULUS OF KIDNEY
$110.00	692.9	CONTACT DERMATITIS AND OTHER ECZEMA, UNSPECIFIED CAUSE
$41.90	V04.81	NEED FOR PROPHYLACTIC VACCINATION/ INOCULATION AGAINST, INFLUENZA
$28.63	272.4	OTHER AND UNSPECIFIED HYPERLIPIDEMIA
$23.95	477.9	ALLERGIC RHINITIS, CAUSE UNSPECIFIED

$16.92 790.4 NONSPECIFIC ELEVATION OF LEVELS OF TRANSAMINASE OR LACTIC ACID DEHYDROGENASE (LD

$38,894.07 Total Paid

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
DRUGS	PRESCRIPTION DRUGS	32120.01	10/21/2014
592.1	CALCULUS OF URETER	5011.27	11/22/2013
591	HYDRONEPHROSIS		10/23/2013
592.0	CALCULUS OF KIDNEY	137.83	03/05/2014
692.9	CONTACT DERMATITIS AND OTHER ECZEMA, UNS	110.00	03/10/2014
078.10	VIRAL WARTS NOS	150.00	12/30/2013
V58.69	LONG-TERM (CURRENT) USE OF OTHER	400.22	10/15/2014
696.1	OTHER PSORIASIS AND SIMILAR DISORDERS	394.74	10/15/2014
V70.0	ROUTINE GENERAL MEDICAL EXAMINATION AT A	144.03	01/14/2014
272.4	OTHER AND UNSPECIFIED HYPERLIPIDEMIA	28.63	01/14/2014
477.9	ALLERGIC RHINITIS, CAUSE UNSPECIFIED	23.95	01/14/2014
238.2	NEOPLASM OF UNCERTAIN BEHAVIOR OF SKIN	140.53	10/15/2014
790.4	NONSPECIFIC ELEVATION OF LEVELS OF TRANS	16.92	09/22/2014
571.8	OTHER CHRONIC NONALCOHOLIC LIVER DISEASE	174.04	09/26/2014
V04.81	NEED FOR PROPHYLACTIC VACCINATION/	41.90	10/21/2014

GROUP: 2001025 SSN: ********** SEQ: ** DIV: 0001 RELAT: Participant EFF: ********** DOB: ********** TERM: **********
LEVEL: F99 PLAN: WILCO-MED-DED

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	00-*	250000.00	21.93	54813.92	.00	.00	.00	.00

==========Diagnosis Recap==========

Amount	Code	Description
$31,787.86	180.0	MALIGNANT NEOPLASM OF ENDOCERVIX
$17,946.74	180.9	MALIGNANT NEOPLASM OF CERVIX UTERI, UNSPECIFIED
$1,723.12	DRUGS	PRESCRIPTION DRUGS
$1,204.08	441.2	THORACIC ANEURYSM WITHOUT MENTION OF RUPTURE
$1,090.53	999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEWHERE CLASSIFIED
$223.32	V76.12	OTHER SCREENING MAMMOGRAM
$180.09	272.4	OTHER AND UNSPECIFIED HYPERLIPIDEMIA
$175.35	787.91	OTHER SYMPTOMS INVOLVING DIGESTIVE SYSTEM; DIARRHEA
$128.70	780.79	OTHER MALAISE AND FATIGUE
$120.34	599.0	URINARY TRACT INFECTION, SITE NOT SPECIFIED
$58.97	V58.11	ENCOUNTER FOR ANTINEOPLASTIC CHEMOTHERAPY
$55.30	724.2	LUMBAGO
$42.02	182.0	MALIGNANT NEOPLASM OF CORPUS UTERI, EXCEPT ISTHMUS
$35.24	233.2	CARCINOMA IN SITU OF OTHER AND UNSPECIFIED PARTS OF UTERUS
$31.99	V04.81	NEED FOR PROPHYLACTIC VACCINATION/ INOCULATION AGAINST, INFLUENZA
$10.27	788.1	DYSURIA

$54,813.92 Total Paid

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
233.2	CARCINOMA IN SITU OF OTHER AND UNSPECIFI	35.24	10/23/2013
180.9	MALIGNANT NEOPLASM OF CERVIX UTERI, UNSP	17946.74	08/01/2014
182.0	MALIGNANT NEOPLASM OF CORPUS UTERI, EXCE	42.02	02/25/2014
724.2	LUMBAGO	55.30	11/13/2013
441.2	THORACIC ANEURYSM WITHOUT MENTION OF RUP	1204.08	11/18/2013
401.1	BENIGN ESSENTIAL HYPERTENSION		11/14/2013
427.89	CARDIAC DYSRHYTHMIAS		11/14/2013
180.0	MALIGNANT NEOPLASM OF ENDOCERVIX	31787.86	03/26/2014
V04.81	NEED FOR PROPHYLACTIC VACCINATION/	31.99	12/09/2013
DRUGS	PRESCRIPTION DRUGS	1723.12	03/26/2014
401.9	UNSPECIFIED ESSENTIAL HYPERTENSION		01/13/2014
530.81	ESOPHAGEAL REFLUX		01/13/2014
272.0	PURE HYPERCHOLESTEROLEMIA		01/13/2014
999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEW	1090.53	05/25/2014
788.1	DYSURIA	10.27	02/06/2014
V58.11	ENCOUNTER FOR ANTINEOPLASTIC	58.97	03/25/2014
787.91	OTHER SYMPTOMS INVOLVING DIGESTIVE	175.35	04/17/2014
780.79	OTHER MALAISE AND FATIGUE	128.70	04/17/2014
599.0	URINARY TRACT INFECTION, SITE NOT SPECIF	120.34	02/06/2014
V65.49	OTHER SPECIFIED COUNSELING		02/06/2014
272.4	OTHER AND UNSPECIFIED HYPERLIPIDEMIA	180.09	08/28/2014
796.2	ELEVATED BLOOD PRESSURE READING WITHOUT		08/28/2014
278.02	OVERWEIGHT		08/01/2014
278.00	OBESITY, UNSPECIFIED		08/28/2014
V76.12	OTHER SCREENING MAMMOGRAM	223.32	09/02/2014

10/31/14 Allegiance Benefit Plan Management, Inc. PAGE: 101
LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 02 11/01/2013 to 10/31/2014 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

GROUP: 2001025 SSN: ********** SEQ: ** DIV: 0001 RELAT: Participant EFF: ********** DOB: ********** TERM: **********
LEVEL: P00 PLAN: WILCO-MED-CORE-DIAB

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	00-*	250000.00	11.53	28824.23	.00	.00	.00	.00

==========Diagnosis Recap==========

Amount	Code	Description
$13,147.95	710.4	POLYMYOSITIS
$10,359.63	DRUGS	PRESCRIPTION DRUGS
$1,924.84	V57.1	CARE INVOLVING OTHER PHYSICAL THERAPY
$1,133.52	999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEWHERE CLASSIFIED
$506.97	789.04	OTHER SYMPTOMS INVOLVING ABDOMEN AND PELVIS
$250.70	249.00	Sec DM w/o ment of comp
$223.32	V76.12	OTHER SCREENING MAMMOGRAM
$202.90	518.89	OTHER DISEASES OF LUNG, NOT ELSEWHERE CLASSIFIED
$181.11	790.6	OTHER ABNORMAL BLOOD CHEMISTRY
$179.81	790.21	IMPAIRED FASTING GLUCOSE
$178.50	728.87	MUSCLE WEAKNESS (GENERALIZED)
$127.07	V72.31	ROUTINE GYNECOLOGICAL EXAM
$123.79	702.11	SEBORRHEIC KERATISIS;INFLAMED SEBORRHEICKERATOSIS
$101.79	228.01	HEMANGIOMA OF SKIN AND SUBCUTANEOUS TISSUE
$63.51	562.11	DIVERTICULITIS OF COLON
$51.54	793.11	Solitary pulmonary nodule
$51.54	786.50	UNSPECIFIED CHEST PAIN
$15.74	527.1	HYPERTROPHY OF SALIVARY GLAND

$28,824.23 Total Paid

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
DRUGS	PRESCRIPTION DRUGS	10359.63	10/23/2014
728.87	MUSCLE WEAKNESS (GENERALIZED)	178.50	08/06/2013
790.21	IMPAIRED FASTING GLUCOSE	179.81	03/13/2014
272.1	PURE HYPERGLYCERIDEMIA		09/18/2014
268.9	UNSPECIFIED VITAMIN D DEFICIENCY		06/17/2014
710.4	POLYMYOSITIS	13147.95	10/22/2014
V58.69	LONG-TERM (CURRENT) USE OF OTHER		10/22/2014
789.04	OTHER SYMPTOMS INVOLVING ABDOMEN AND	506.97	12/17/2013
527.1	HYPERTROPHY OF SALIVARY GLAND	15.74	12/20/2013

10/31/14 Allegiance Benefit Plan Management, Inc. PAGE: 102
LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 02 11/01/2013 to 10/31/2014 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
562.11	DIVERTICULITIS OF COLON	63.51	12/20/2013
787.02	OTHER SYMPTOMS OF THE DIGESTIVE SYSTEM;		12/20/2013
527.5	SIALOLITHIASIS		12/20/2013
V72.31	ROUTINE GYNECOLOGICAL EXAM	127.07	02/12/2014
999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEW	1133.52	05/28/2014
790.6	OTHER ABNORMAL BLOOD CHEMISTRY	181.11	09/16/2014
V76.12	OTHER SCREENING MAMMOGRAM	223.32	03/18/2014
249.00	Sec DM w/o ment of comp	250.70	09/18/2014
786.50	UNSPECIFIED CHEST PAIN	51.54	06/24/2014
793.11	Solitary pulmonary nodule	51.54	06/23/2014
518.89	OTHER DISEASES OF LUNG, NOT ELSEWHERE CL	202.90	07/23/2014
228.01	HEMANGIOMA OF SKIN AND SUBCUTANEOUS TISS	101.79	09/18/2014
216.5	BENIGN NEOPLASM OF SKIN OF TRUNK, EXCEPT		09/18/2014
702.19	OTHER DERMATOSES;OTHER SEBORRHEIC		09/18/2014
702.11	SEBORRHEIC KERATISIS;INFLAMED SEBORRHEIC	123.79	09/18/2014
V57.1	CARE INVOLVING OTHER PHYSICAL THERAPY	1924.84	09/24/2014
728.2	MUSCULAR WASTING AND DISUSE ATROPHY, NOT		09/24/2014
729.89	OTHER MUSCULOSKELETAL SYMPTOMS REFERABLE		09/24/2014
733.90	DISORDER OF BONE AND CARTILAGE, UNSPECIF		10/22/2014

GROUP: 2001025 SSN: ********** SEQ: ** DIV: RET2 RELAT: Participant EFF: ********** DOB: ********** TERM: **********
LEVEL: P00 PLAN: WILCO-MED-CORE-DIAB

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	00-*	250000.00	12.58	31448.79	.00	.00	.00	.00

==========Diagnosis Recap==========

Amount	Code	Description
$28,664.06	DRUGS	PRESCRIPTION DRUGS
$692.15	414.00	CORONARY ATHEROSCLEROSIS OF UNSPECIFIED TYPE OF VESSEL, NATIVE OR GRAFT
$485.04	724.2	LUMBAGO
$426.85	250.00	DIABETES MELLITUS WITHOUT MENTION OF COMPLICATION, TYPE II
$339.42	V58.69	LONG-TERM (CURRENT) USE OF OTHER MEDICATIONS
$207.86	724.4	THORACIC OR LUMBOSACRAL NEURITIS OR RADICULITIS
$159.36	V70.0	ROUTINE GENERAL MEDICAL EXAMINATION AT AHEALTH CARE FACILITY
$144.49	724.5	BACKACHE, UNSPECIFIED
$104.50	719.46	PAIN IN JOINT INVOLVING LOWER LEG
$83.31	366.16	SENILE NUCLEAR SCLEROSIS
$80.02	722.10	DISPLACEMENT OF LUMBAR INTERVERTEBRAL DISC WITHOUT MYELOPATHY
$44.12	272.2	Hyperlipidemia, mixed
$17.61	733.90	DISORDER OF BONE AND CARTILAGE, UNSPECIFIED

$31,448.79 Total Paid

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
DRUGS	PRESCRIPTION DRUGS	28664.06	10/13/2014
V58.69	LONG-TERM (CURRENT) USE OF OTHER	339.42	07/29/2014
696.0	PSORIATIC ARTHROPATHY		07/29/2014
V70.0	ROUTINE GENERAL MEDICAL EXAMINATION AT A	159.36	11/15/2013
250.00	DIABETES MELLITUS WITHOUT MENTION OF	426.85	09/22/2014
414.00	CORONARY ATHEROSCLEROSIS OF UNSPECIFIED	692.15	09/22/2014
401.9	UNSPECIFIED ESSENTIAL HYPERTENSION		09/22/2014
785.2	FUNCTIONAL AND UNDIAGNOSED CARDIAC MURMU		11/21/2013
272.2	Hyperlipidemia, mixed	44.12	09/22/2014
733.90	DISORDER OF BONE AND CARTILAGE, UNSPECIF	17.61	03/12/2014
724.5	BACKACHE, UNSPECIFIED	144.49	03/12/2014
724.4	THORACIC OR LUMBOSACRAL NEURITIS OR RADI	207.86	03/25/2014
729.5	PAIN IN LIMB		03/25/2014
724.2	LUMBAGO	485.04	03/28/2014
722.10	DISPLACEMENT OF LUMBAR INTERVERTEBRAL DI	80.02	03/28/2014
719.46	PAIN IN JOINT INVOLVING LOWER LEG	104.50	05/14/2014
366.16	SENILE NUCLEAR SCLEROSIS	83.31	06/12/2014

GROUP: 2001025 SSN: ********** SEQ: ** DIV: 0001 RELAT: Spouse EFF: ********** DOB: ********** TERM: **********
LEVEL: F99 PLAN: WILCO-MED-DED-DIAB

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	01-*	250000.00	12.60	31493.66	.00	.00	.00	.00

==========Diagnosis Recap==========

Amount	Code	Description
$14,944.18	726.12	BICIPITAL TENOSYNOVITIS
$5,344.18	726.2	OTHER AFFECTIONS OF SHOULDER REGION, NOTELSEWHERE CLASSIFIED
$5,098.89	DRUGS	PRESCRIPTION DRUGS
$3,951.54	719.41	PAIN IN JOINT INVOLVING SHOULDER REGION
$584.89	786.05	SHORTNESS OF BREATH
$384.41	599.71	Gross hematuria
$356.39	250.00	DIABETES MELLITUS WITHOUT MENTION OF COMPLICATION, TYPE II
$234.53	787.91	OTHER SYMPTOMS INVOLVING DIGESTIVE SYSTEM; DIARRHEA
$152.14	799.02	HYPOXEMIA
$121.94	793.99	OTHER NONSPECIFIC ABNORMAL FINDINGS ON RADIOLOGICAL AND OTHER EXAMINATIONS
$80.60	368.2	DIPLOPIA
$80.27	599.70	Hematuria, unspecified
$67.18	V76.44	SPECIAL SCREENING FOR MALIGNANT NEOPLASMOF THE PROSTATE

$28.86	401.9	UNSPECIFIED ESSENTIAL HYPERTENSION
$28.38	216.5	BENIGN NEOPLASM OF SKIN OF TRUNK, EXCEPTSCROTUM
$21.49	257.2	OTHER TESTICULAR HYPOFUNCTION
$13.79	786.2	COUGH

$31,493.66 Total Paid

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
DRUGS	PRESCRIPTION DRUGS	5098.89	10/17/2014
401.9	UNSPECIFIED ESSENTIAL HYPERTENSION	28.86	01/02/2014
250.00	DIABETES MELLITUS WITHOUT MENTION OF	356.39	05/13/2014
V04.81	NEED FOR PROPHYLACTIC VACCINATION/		09/23/2013
719.41	PAIN IN JOINT INVOLVING SHOULDER REGION	3951.54	09/18/2014
786.05	SHORTNESS OF BREATH	584.89	02/10/2014
257.2	OTHER TESTICULAR HYPOFUNCTION	21.49	02/21/2014
V76.44	SPECIAL SCREENING FOR MALIGNANT NEOPLASM	67.18	12/18/2013
787.91	OTHER SYMPTOMS INVOLVING DIGESTIVE	234.53	12/02/2013
799.02	HYPOXEMIA	152.14	02/10/2014
786.09	OTHER DYSPNEA AND RESPIRATORY ABNORMALIT		02/10/2014
786.2	COUGH	13.79	02/10/2014
599.70	Hematuria, unspecified	80.27	03/25/2014
593.2	CYST OF KIDNEY, ACQUIRED		03/25/2014
599.71	Gross hematuria	384.41	04/01/2014
607.84	IMPOTENCE OF ORGANIC ORIGIN		04/01/2014
793.99	OTHER NONSPECIFIC ABNORMAL FINDINGS ON	121.94	05/07/2014
216.5	BENIGN NEOPLASM OF SKIN OF TRUNK, EXCEPT	28.38	05/15/2014
726.2	OTHER AFFECTIONS OF SHOULDER REGION, NOT	5344.18	09/18/2014
726.32	LATERAL EPICONDYLITIS		06/11/2014
840.7	SPRAINS & STRAINS OF SHOULDER & UPPER AR		09/18/2014
368.2	DIPLOPIA	80.60	06/23/2014
726.12	BICIPITAL TENOSYNOVITIS	14944.18	09/18/2014
718.01	ARTICULAR CARTILAGE DISORDER INVOLVING S		08/06/2014

10/31/14 Allegiance Benefit Plan Management, Inc. PAGE: 104
LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 02 11/01/2013 to 10/31/2014 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

GROUP: 2001025 SSN: ********** SEQ: ** DIV: 0002 RELAT: Spouse EFF: ********** DOB: ********** TERM: **********
LEVEL: F99 PLAN: WILCO-MED-CORE-DIAB

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	01-*	250000.00	12.52	31301.47	.00	.00	.00	.00

==========Diagnosis Recap==========

Amount	Code	Description
$26,813.93	DRUGS	PRESCRIPTION DRUGS
$1,214.13	250.00	DIABETES MELLITUS WITHOUT MENTION OF COMPLICATION, TYPE II
$993.08	V58.69	LONG-TERM (CURRENT) USE OF OTHER MEDICATIONS
$700.66	244.0	POSTSURGICAL HYPOTHYROIDISM
$333.99	611.71	MASTODYNIA
$170.67	372.14	OTHER CHRONIC ALLERGIC CONJUNCTIVITIS
$158.39	723.1	CERVICALGIA
$109.84	338.4	CHRONIC PAIN SYNDROME
$105.68	461.9	ACUTE SINUSITIS, UNSPECIFIED
$89.57	682.2	CELLULITIS AND ABSCESS OF TRUNK
$71.81	244.9	UNSPECIFIED ACQUIRED HYPOTHYROIDISM
$71.81	785.6	ENLARGEMENT OF LYMPH NODES
$70.02	V04.81	NEED FOR PROPHYLACTIC VACCINATION/ INOCULATION AGAINST, INFLUENZA
$65.66	477.9	ALLERGIC RHINITIS, CAUSE UNSPECIFIED
$58.49	465.9	ACUTE UPPER RESPIRATORY INFECTIONS OF UNSPECIFIED SITE
$47.87	721.0	CERVICAL SPONDYLOSIS WITHOUT MYELOPATHY
$47.87	729.2	NEURALGIA, NEURITIS, AND RADICULITIS, UNSPECIFIED
$42.17	611.72	LUMP OR MASS IN BREAST
$42.17	704.8	OTHER SPECIFIED DISEASES OF HAIR AND HAIR FOLLICLES
$42.17	382.9	UNSPECIFIED OTITIS MEDIA
$40.60	V70.0	ROUTINE GENERAL MEDICAL EXAMINATION AT AHEALTH CARE FACILITY
$10.89	V72.62	Lab exam ordered routine gen exam

$31,301.47 Total Paid

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
DRUGS	PRESCRIPTION DRUGS	26813.93	10/21/2014
244.0	POSTSURGICAL HYPOTHYROIDISM	700.66	07/11/2014
250.00	DIABETES MELLITUS WITHOUT MENTION OF	1214.13	10/02/2014
461.9	ACUTE SINUSITIS, UNSPECIFIED	105.68	05/29/2014
338.4	CHRONIC PAIN SYNDROME	109.84	10/10/2014
V04.81	NEED FOR PROPHYLACTIC VACCINATION/	70.02	09/29/2014
785.6	ENLARGEMENT OF LYMPH NODES	71.81	04/08/2014
V10.87	Hx, prsnl, thyroid malignancy		08/06/2014
193	MALIGNANT NEOPLASM OF THYROID GLAND		07/11/2014
477.9	ALLERGIC RHINITIS, CAUSE UNSPECIFIED	65.66	05/29/2014
382.9	UNSPECIFIED OTITIS MEDIA	42.17	12/24/2013
381.81	DYSFUNCTION OF EUSTACHIAN TUBE		12/24/2013
465.9	ACUTE UPPER RESPIRATORY INFECTIONS OF UN	58.49	01/27/2014
V85.39	BODY MASS INDEX 39.0-39.9, ADULT		01/27/2014
704.8	OTHER SPECIFIED DISEASES OF HAIR AND HAI	42.17	03/03/2014
723.1	CERVICALGIA	158.39	06/26/2014
356.9	UNSPECIFIED IDIOPATHIC PERIPHERAL NEUROP		06/26/2014
V58.69	LONG-TERM (CURRENT) USE OF OTHER	993.08	10/12/2014
372.14	OTHER CHRONIC ALLERGIC CONJUNCTIVITIS	170.67	06/11/2014
375.15	TEAR FILM INSUFFICIENCY, UNSPECIFIED		06/11/2014
611.71	MASTODYNIA	333.99	07/30/2014
611.72	LUMP OR MASS IN BREAST	42.17	07/30/2014
682.2	CELLULITIS AND ABSCESS OF TRUNK	89.57	08/11/2014
244.9	UNSPECIFIED ACQUIRED HYPOTHYROIDISM	71.81	10/02/2014
729.2	NEURALGIA, NEURITIS, AND RADICULITIS, UN	47.87	08/21/2014
729.1	MYALGIA AND MYOSITIS, UNSPECIFIED		08/21/2014
V70.0	ROUTINE GENERAL MEDICAL EXAMINATION AT A	40.60	10/02/2014

10/31/14 Allegiance Benefit Plan Management, Inc. PAGE: 105
LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 02 11/01/2013 to 10/31/2014 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

Diagnosis Summary for **********	Amount Paid	Last D.O.S.
401.1 BENIGN ESSENTIAL HYPERTENSION		10/02/2014
721.0 CERVICAL SPONDYLOSIS WITHOUT MYELOPATHY	47.87	10/10/2014
V72.62 Lab exam ordered routine gen exam	10.89	10/02/2014

GROUP: 2001025 SSN: ********** SEQ: ** DIV: 0001 RELAT: Participant EFF: ********** DOB: ********** TERM: **********
LEVEL: P00 PLAN: WILCO-MED-DED

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	00-*	250000.00	10.90	27241.87	.00	.00	.00	.00

==========Diagnosis Recap==========

Amount	Code	Description
$26,272.59	DRUGS	PRESCRIPTION DRUGS
$268.58	692.75	DISSEMINATED SUPERFICIAL ACTINIC POROKERATOSIS (DSAP)
$177.52	556.9	ULCERATIVE COLITIS;UNSPECIFIED
$148.32	883.0	OPEN WOUND OF FINGERS, WITHOUT MENTION OF COMPLICATION
$143.52	486	PNEUMONIA, ORGANISM UNSPECIFIED
$97.98	556.5	ULCERATIVE COLITIS;LEFT SIDED CHRONIC COLITIS
$88.76	995.3	ALLERGY, UNSPECIFIED, NOT ELSEWHERE CLASSIFIED
$44.60	757.39	OTHER SPECIFIED CONGENITAL ANOMALIES OF SKIN

$27,241.87 Total Paid

10/31/14 Allegiance Benefit Plan Management, Inc. PAGE: 106
LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 02 11/01/2013 to 10/31/2014 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
DRUGS	PRESCRIPTION DRUGS	26272.59	10/06/2014
995.3	ALLERGY, UNSPECIFIED, NOT ELSEWHERE CLAS	88.76	12/30/2013
477.9	ALLERGIC RHINITIS, CAUSE UNSPECIFIED		12/30/2013
486	PNEUMONIA, ORGANISM UNSPECIFIED	143.52	03/25/2014
558.9	OTHER AND UNSPECIFIED NONINFECTIOUS GAST		03/25/2014
883.0	OPEN WOUND OF FINGERS, WITHOUT MENTION O	148.32	04/10/2014
556.9	ULCERATIVE COLITIS;UNSPECIFIED	177.52	06/10/2014
556.5	ULCERATIVE COLITIS;LEFT SIDED CHRONIC	97.98	06/04/2014
569.3	HEMORRHAGE OF RECTUM AND ANUS		06/04/2014
787.91	OTHER SYMPTOMS INVOLVING DIGESTIVE		06/04/2014
V74.1	SCREENING EXAMINATION FOR PULMONARY TUBE		06/10/2014
692.75	DISSEMINATED SUPERFICIAL ACTINIC	268.58	07/28/2014
238.2	NEOPLASM OF UNCERTAIN BEHAVIOR OF SKIN		07/28/2014
704.8	OTHER SPECIFIED DISEASES OF HAIR AND HAI		07/28/2014
V58.65	LONG-TERM (CURRENT) USE OF STEROIDS		07/28/2014
757.39	OTHER SPECIFIED CONGENITAL ANOMALIES OF	44.60	07/28/2014

GROUP: 2001025 SSN: ********** SEQ: ** DIV: 0001 RELAT: Participant EFF: ********** DOB: ********** TERM: **********
LEVEL: P00 PLAN: WILCO-MED-EPO

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	00-*	250000.00	10.48	26208.82	.00	.00	.00	.00

==========Diagnosis Recap==========

Amount	Code	Description
$18,048.99	DRUGS	PRESCRIPTION DRUGS
$5,094.51	786.50	UNSPECIFIED CHEST PAIN
$841.50	836.0	TEAR OF MEDIAL CARTILAGE OR MENISCUS OF KNEE, CURRENT
$607.02	786.52	PAINFUL RESPIRATION
$392.15	401.1	BENIGN ESSENTIAL HYPERTENSION
$225.00	382.9	UNSPECIFIED OTITIS MEDIA
$214.99	478.19	OTHER DISEASES OF UPPER RESPIRATORY TRACT-OTHER DISEASES OF NASAL CAVITY
$135.71	276.8	HYPOPOTASSEMIA
$120.02	389.05	CONDUCTIVE HEARING LOSS, UNILATERAL
$92.85	780.52	INSOMNIA, UNSPECIFIED
$92.61	424.2	TRICUSPID VALVE DISORDERS, SPECIFIED AS NONRHEUMATIC
$77.30	780.4	DIZZINESS AND GIDDINESS
$77.30	493.10	INTRINSIC ASTHMA WITHOUT MENTION OF STATUS ASTHMATICUS
$77.30	780.79	OTHER MALAISE AND FATIGUE
$37.37	595.9	CYSTITIS, UNSPECIFIED
$35.24	465.9	ACUTE UPPER RESPIRATORY INFECTIONS OF UNSPECIFIED SITE
$29.46	842.00	SPRAIN OF UNSPECIFIED SITE OF WRIST
$9.50	780.60	Symptom, fever, unspecified

$26,208.82 Total Paid

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
DRUGS	PRESCRIPTION DRUGS	18048.99	10/21/2014
401.1	BENIGN ESSENTIAL HYPERTENSION	392.15	09/15/2014
278.02	OVERWEIGHT		02/19/2014
780.79	OTHER MALAISE AND FATIGUE	77.30	11/11/2013
786.50	UNSPECIFIED CHEST PAIN	5094.51	12/18/2013
278.01	MORBID OBESITY		12/18/2013
V85.41	BMI 40.0-44.9, adult		12/18/2013
401.9	UNSPECIFIED ESSENTIAL HYPERTENSION		12/18/2013
276.8	HYPOPOTASSEMIA	135.71	02/20/2014
461.0	ACUTE MAXILLARY SINUSITIS		12/27/2013
493.10	INTRINSIC ASTHMA WITHOUT MENTION OF STAT	77.30	12/13/2013
780.60	Symptom, fever, unspecified	9.50	12/27/2013
424.2	TRICUSPID VALVE DISORDERS, SPECIFIED AS	92.61	12/17/2013
429.3	CARDIOMEGALY		12/17/2013
278.00	OBESITY, UNSPECIFIED		03/24/2014
780.4	DIZZINESS AND GIDDINESS	77.30	01/07/2014
786.52	PAINFUL RESPIRATION	607.02	12/18/2013
780.52	INSOMNIA, UNSPECIFIED	92.85	02/19/2014
715.90	OSTEOARTHROSIS, UNSPECIFIED WHETHER GENE		09/15/2014
465.9	ACUTE UPPER RESPIRATORY INFECTIONS OF UN	35.24	04/11/2014
V85.38	BODY MASS INDEX 38.0-38.9, ADULT		04/11/2014
842.00	SPRAIN OF UNSPECIFIED SITE OF WRIST	29.46	05/20/2014
836.0	TEAR OF MEDIAL CARTILAGE OR MENISCUS OF	841.50	09/11/2013
382.9	UNSPECIFIED OTITIS MEDIA	225.00	05/30/2014
381.81	DYSFUNCTION OF EUSTACHIAN TUBE		06/12/2014
389.05	CONDUCTIVE HEARING LOSS, UNILATERAL	120.02	06/12/2014
388.30	TINNITUS, UNSPECIFIED		06/12/2014
478.19	OTHER DISEASES OF UPPER RESPIRATORY	214.99	06/12/2014
723.3	CERVICOBRACHIAL SYNDROME (DIFFUSE)		08/13/2014

10/31/14 Allegiance Benefit Plan Management, Inc. PAGE: 107
LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 02 11/01/2013 to 10/31/2014 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

Diagnosis Summary for **********	Amount Paid	Last D.O.S.
723.4 BRACHIAL NEURITIS OR RADICULITIS NOS		08/13/2014
595.9 CYSTITIS, UNSPECIFIED	37.37	09/15/2014

GROUP: 2001025 SSN: ********** SEQ: ** DIV: 0001 RELAT: Spouse EFF: ********** DOB: ********** TERM: **********
LEVEL: F00 PLAN: WILCO-MED-DED

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	01-*	250000.00	100.00	1007964.21	757964.21	309803.68	396503.41	51657.12

==========Diagnosis Recap==========

Amount	Code	Description
$272,689.17	038.9	UNSPECIFIED SEPTICEMIA
$218,706.88	496	CHRONIC AIRWAY OBSTRUCTION, NOT ELSEWHERE CLASSIFIED
$173,531.49	996.84	COMPLICATIONS OF TRANSPLANTED LUNG
$87,193.90	DRUGS	PRESCRIPTION DRUGS
$63,926.08	V58.44	AFTERCARE FOLLOWING ORGAN TRANSPLANT
$56,738.83	V72.83	OTH SPCF PREOP EXAM
$20,937.95	518.81	RESPIRATORY FAILURE
$17,841.48	V42.6	LUNG REPLACED BY TRANSPLANT
$10,117.95	478.31	PARTIAL UNILATERAL PARALYSIS OF VOCAL CORDS
$9,113.34	530.81	ESOPHAGEAL REFLUX
$8,468.53	569.69	COLOSTOMY/ENTEROSTOMY COMPLICATIONS; OTHER
$8,329.79	V67.59	OTHER FOLLOW-UP EXAMINATION
$8,127.54	999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEWHERE CLASSIFIED
$4,550.92	V07.2	NEED FOR PROPHYLACTIC IMMUNOTHERAPY
$4,305.98	787.20	DYSPHAGIA, UNSPECIFIED
$4,176.00	799.02	HYPOXEMIA
$3,759.68	V58.83	ENCOUNTER/THERAPEUTIC DRUG MONITORING
$3,382.20	786.09	OTHER DYSPNEA AND RESPIRATORY ABNORMALITY
$2,916.82	V44.3	COLOSTOMY STATUS
$2,796.41	786.05	SHORTNESS OF BREATH
$2,562.25	136.9	UNSPECIFIED INFECTIOUS AND PARASITIC DISEASES
$2,476.04	784.0	HEADACHE
$2,079.93	786.02	ORTHOPNEA
$1,724.40	486	PNEUMONIA, ORGANISM UNSPECIFIED
$1,708.20	478.30	UNSPECIFIED PARALYSIS OF VOCAL CORDS
$1,704.75	536.49	GASTROSTOMY COMPLICATIONS;OTHER
$1,308.85	518.89	OTHER DISEASES OF LUNG, NOT ELSEWHERE CLASSIFIED
$1,185.00	519.19	OTHER DISEASES OF RESPIRATORY SYSTEM- OTHER DISEASES OF TRACHEA AND BRONCHUS
$1,002.87	V72.60	Laboratory examination, unspecified
$830.40	536.42	GASTROSTOMY COMPLICATIONS;MECHANICAL COMPLICATION OF GASTROSTOMY
$817.11	275.5	Hungry bone syndrome
$717.00	781.2	ABNORMALITY OF GAIT
$660.60	536.40	GASTROSTOMY COMPLICATIONS;UNSPECIFIED
$633.71	V55.4	ATTENTION TO OTHER ARTIFICIAL OPENING OFDIGESTIVE TRACT
$568.20	V72.81	PREOP CARDIOVSCLR EXAM
$420.60	518.0	PULMONARY COLLAPSE
$381.00	V55.6	ATTENTION TO OTHER ARTIFICIAL OPENING OFURINARY TRACT
$364.80	296.33	MAJOR DEPRESSIVE AFFECTIVE DISORDER, RECURRENT EPISODE, SEVERE DEGREE, WITHOUT M
$363.60	511.9	UNSPECIFIED PLEURAL EFFUSION
$362.40	480.0	PNEUMONIA DUE TO ADENOVIRUS
$355.30	401.9	UNSPECIFIED ESSENTIAL HYPERTENSION
$336.00	592.0	CALCULUS OF KIDNEY
$316.40	440.0	ATHEROSCLEROSIS OF AORTA
$303.00	279.8	OTHER SPECIFIED DISORDERS INVOLVING THE IMMUNE MECHANISM
$234.00	787.03	SYMPTOMS INVOLVING DIGESTIVE SYSTEM VOMITING ALONE
$213.60	466.0	ACUTE BRONCHITIS
$213.60	792.9	OTHER NONSPECIFIC ABNORMAL FINDINGS IN BODY SUBSTANCES
$193.80	078.5	CYTOMEGALIC INCLUSION DISEASE
$188.67	786.2	COUGH
$171.60	V71.89	OTHER SPECIFIED SUSPECTED CONDITION
$148.00	293.83	MOOD DISORDER IN CONDITIONS CLASSIFIED ELSEWHERE
$141.00	V58.82	FITTING AND ADJUSTMENT OF NONVASCULAR CATHETER, NEC
$138.00	482.1	PNEUMONIA DUE TO PSEUDOMONAS
$121.06	714.0	RHEUMATOID ARTHRITIS
$112.80	786.7	ABNORMAL CHEST SOUNDS
$112.43	805.2	CLOSED FRACTURE OF DORSAL (THORACIC) VERTEBRA WITHOUT MENTION OF SPINAL CORD INJ
$104.40	786.1	STRIDOR
$102.52	733.13	PATH FX VERTEBRAE
$91.80	416.0	PRIMARY PULMONARY HYPERTENSION
$84.60	V45.89	OTHER POSTSURGICAL STATUS
$83.41	780.79	OTHER MALAISE AND FATIGUE
$66.90	311	DEPRESSIVE DISORDER, NOT ELSEWHERE CLASSIFIED
$63.80	V05.3	NEED PRPHYL VC VRL HEPAT
$59.40	V72.82	PREOP RESPIRATORY EXAM
$56.98	998.33	Disrupt traumat injury wound repair
$56.40	793.19	Othr nonspecfc abnorml finding/lung
$56.40	V58.81	FITTING AND ADJUSTMENT OF VASCULAR CATHETER
$56.40	786.07	DYSPNEA AND RESPIRATORY ABNORMALITIES; WHEEZING
$45.00	733.00	OSTEOPOROSIS, UNSPECIFIED
$42.70	719.43	PAIN IN JOINT INVOLVING FOREARM
$33.60	492.8	OTHER EMPHYSEMA
$33.03	V72.84	PREOP EXAM UNSPCF
$30.00	427.89	CARDIAC DYSRHYTHMIAS
$28.38	842.00	SPRAIN OF UNSPECIFIED SITE OF WRIST
$28.20	787.3	FLATULENCE, ERUCTATION, AND GAS PAIN
$25.99	V04.81	NEED FOR PROPHYLACTIC VACCINATION/ INOCULATION AGAINST, INFLUENZA
$17.22	427.9	CARDIAC DYSRHYTHMIA
$14.65	789.00	OTHER SYMPTOMS INVOLVING ABDOMEN AND PELVIS
$0.52	724.01	SPINAL STENOSIS OF THORACIC REGION

$1,007,964.21 Total Paid

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
733.13	PATH FX VERTEBRAE	102.52	08/22/2013
V44.3	COLOSTOMY STATUS	2916.82	07/25/2014
999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEW	8127.54	09/25/2014
DRUGS	PRESCRIPTION DRUGS	87193.90	10/20/2014
724.01	SPINAL STENOSIS OF THORACIC REGION	.52	12/20/2013
496	CHRONIC AIRWAY OBSTRUCTION, NOT ELSEWHER	218706.88	09/22/2014
733.00	OSTEOPOROSIS, UNSPECIFIED	45.00	08/24/2014
805.2	CLOSED FRACTURE OF DORSAL (THORACIC) VER	112.43	10/28/2013
724.1	PAIN IN THORACIC SPINE		10/28/2013
786.2	COUGH	188.67	02/11/2014
518.89	OTHER DISEASES OF LUNG, NOT ELSEWHERE CL	1308.85	06/13/2014
440.0	ATHEROSCLEROSIS OF AORTA	316.40	12/02/2013

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LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 02 11/01/2013 to 10/31/2014 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
714.0	RHEUMATOID ARTHRITIS	121.06	09/15/2014
V58.69	LONG-TERM (CURRENT) USE OF OTHER		05/21/2014
733.01	SENILE OSTEOPOROSIS		10/29/2013
311	DEPRESSIVE DISORDER, NOT ELSEWHERE CLASS	66.90	08/14/2013
300.00	ANXIETY STATE, UNSPECIFIED		08/14/2013
793.19	Othr nonspecfc abnorml finding/lung	56.40	06/07/2014
293.83	MOOD DISORDER IN CONDITIONS CLASSIFIED	148.00	10/22/2013
719.43	PAIN IN JOINT INVOLVING FOREARM	42.70	11/20/2013
V04.81	NEED FOR PROPHYLACTIC VACCINATION/	25.99	12/04/2013
V05.3	NEED PRPHYL VC VRL HEPAT	63.80	12/04/2013
842.00	SPRAIN OF UNSPECIFIED SITE OF WRIST	28.38	12/20/2013
799.02	HYPOXEMIA	4176.00	06/04/2014
276.4	MIXED ACID-BASE BALANCE DISORDER		11/14/2013
V72.81	PREOP CARDIOVSCLR EXAM	568.20	09/26/2014
519.9	UNSPECIFIED DISEASE OF RESPIRATORY SYSTE		08/06/2013
V72.83	OTH SPCF PREOP EXAM	56738.83	01/17/2014
525.10	ACQUIRED ABSENCE OF TEETH (EXTRACTION)		08/06/2013
V71.89	OTHER SPECIFIED SUSPECTED CONDITION	171.60	08/06/2013
V42.6	LUNG REPLACED BY TRANSPLANT	17841.48	10/20/2014
V49.81	POSTMENOPAUSAL STATUS (AGE RELATED)		08/06/2013
V72.82	PREOP RESPIRATORY EXAM	59.40	08/06/2013
592.0	CALCULUS OF KIDNEY	336.00	08/06/2013
V45.89	OTHER POSTSURGICAL STATUS	84.60	06/09/2014
786.05	SHORTNESS OF BREATH	2796.41	06/11/2014
780.52	INSOMNIA, UNSPECIFIED		10/30/2013
799.24	Signs/sympt emot state emot labilty		10/30/2013
477.0	ALLERGIC RHINITIS DUE TO POLLEN		10/30/2013
518.81	RESPIRATORY FAILURE	20937.95	09/26/2014
V58.83	ENCOUNTER/THERAPEUTIC DRUG MONITORING	3759.68	05/12/2014
V07.2	NEED FOR PROPHYLACTIC IMMUNOTHERAPY	4550.92	10/20/2014
078.5	CYTOMEGALIC INCLUSION DISEASE	193.80	10/15/2014
272.2	Hyperlipidemia, mixed		09/17/2014
V58.44	AFTERCARE FOLLOWING ORGAN TRANSPLANT	63926.08	10/20/2014
275.5	Hungry bone syndrome	817.11	10/15/2014
518.83	OTHER DISEASE OF LUNG / CHRONIC		08/24/2014
276.2	ACIDOSIS		01/30/2014
V46.2	SUPPLEMENTAL OXYGEN; LONG TERM O2		01/30/2014
079.6	RESPIRATORY SYNCYTIAL VIRUS (RSV)		01/30/2014
V49.83	AWAITING ORGAN TRANSPLANT STATUS		01/16/2014
250.00	DIABETES MELLITUS WITHOUT MENTION OF		07/09/2014
996.84	COMPLICATIONS OF TRANSPLANTED LUNG	173531.49	07/02/2014
136.9	UNSPECIFIED INFECTIOUS AND PARASITIC DIS	2562.25	09/26/2014
272.4	OTHER AND UNSPECIFIED HYPERLIPIDEMIA		07/23/2014

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LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 02 11/01/2013 to 10/31/2014 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
492.8	OTHER EMPHYSEMA	33.60	05/21/2014
733.90	DISORDER OF BONE AND CARTILAGE, UNSPECIF		01/16/2014
786.02	ORTHOPNEA	2079.93	10/20/2014
414.01	CORONARY ATHEROSCLEROSIS;OF NATIVE		02/26/2014
V45.82	OTHER POSTSURGICAL STATUS;PERCUTANEOUS		02/26/2014
401.9	UNSPECIFIED ESSENTIAL HYPERTENSION	355.30	07/02/2014
786.1	STRIDOR	104.40	10/20/2014
560.9	UNSPECIFIED INTESTINAL OBSTRUCTION		09/22/2014
482.1	PNEUMONIA DUE TO PSEUDOMONAS	138.00	04/21/2014
996.1	MECHANICAL COMPLICATION OF OTHER VASCULA		04/21/2014
786.07	DYSPNEA AND RESPIRATORY ABNORMALITIES;	56.40	06/10/2014
V58.65	LONG-TERM (CURRENT) USE OF STEROIDS		04/22/2014
781.0	ABNORMAL INVOLUNTARY MOVEMENTS		04/22/2014
998.33	Disrupt traumat injury wound repair	56.98	03/10/2014
511.9	UNSPECIFIED PLEURAL EFFUSION	363.60	06/03/2014
518.0	PULMONARY COLLAPSE	420.60	06/12/2014
V72.60	Laboratory examination, unspecified	1002.87	07/16/2014
285.9	ANEMIA, UNSPECIFIED		07/02/2014
287.5	THROMBOCYTOPENIA, UNSPECIFIED		06/03/2014
785.52	SEPTIC SHOCK		06/12/2014
518.82	OTHER PULMONARY INSUFFICIENCY, NOT ELSEW		06/12/2014
288.50	NEUTROPENIA-LEUKOCYTOPENIA, UNSPECIFIED		06/02/2014
785.50	SHOCK, UNSPECIFIED		06/01/2014
416.0	PRIMARY PULMONARY HYPERTENSION	91.80	06/01/2014
507.0	PNEUMONITIS DUE TO INHALATION OF FOOD OR		06/22/2014
038.9	UNSPECIFIED SEPTICEMIA	272689.17	06/12/2014
263.9	UNSPECIFIED PROTEIN-CALORIE MALNUTRITION		06/09/2014
427.9	CARDIAC DYSRHYTHMIA	17.22	07/02/2014
427.89	CARDIAC DYSRHYTHMIAS	30.00	06/02/2014
786.09	OTHER DYSPNEA AND RESPIRATORY ABNORMALIT	3382.20	09/17/2014
530.81	ESOPHAGEAL REFLUX	9113.34	10/16/2014
789.00	OTHER SYMPTOMS INVOLVING ABDOMEN AND	14.65	06/13/2014
V58.82	FITTING AND ADJUSTMENT OF NONVASCULAR	141.00	06/27/2014
786.7	ABNORMAL CHEST SOUNDS	112.80	06/10/2014
V58.81	FITTING AND ADJUSTMENT OF VASCULAR	56.40	06/27/2014
787.3	FLATULENCE, ERUCTATION, AND GAS PAIN	28.20	06/02/2014
786.50	UNSPECIFIED CHEST PAIN		06/02/2014
781.2	ABNORMALITY OF GAIT	717.00	07/01/2014
799.3	DEBILITY, UNSPECIFIED		07/02/2014
486	PNEUMONIA, ORGANISM UNSPECIFIED	1724.40	07/02/2014
514	PULMONARY CONGESTION AND HYPOSTASIS		06/09/2014
518.84	OTHER DISEASES OF LUNG/ ACUTE & CHRONIC		07/02/2014
263.0	MALNUTRITION OF MODERATE DEGREE		09/26/2014

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LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 02 11/01/2013 to 10/31/2014 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

Diagnosis Summary for **********	Amount Paid	Last D.O.S.
V55.1 ATTENTION TO GASTROSTOMY		07/02/2014
516.8 OTHER SPECIFIED ALVEOLAR AND PARIETOALVE		07/02/2014

GROUP: 2001025 SSN: ********** SEQ: ** DIV: 0001 RELAT: Participant EFF: ********** DOB: ********** TERM: **********
LEVEL: P00 PLAN: WILCO-MED-DED

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	00-*	250000.00	27.25	68127.05	.00	.00	.00	.00

==========Diagnosis Recap==========

Amount	Code	Description
$67,750.43	DRUGS	PRESCRIPTION DRUGS
$210.93	V70.0	ROUTINE GENERAL MEDICAL EXAMINATION AT AHEALTH CARE FACILITY
$83.18	V04.81	NEED FOR PROPHYLACTIC VACCINATION/ INOCULATION AGAINST, INFLUENZA
$54.13	401.1	BENIGN ESSENTIAL HYPERTENSION
$28.38	340	MULTIPLE SCLEROSIS

$68,127.05 Total Paid

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LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 02 11/01/2013 to 10/31/2014 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
V04.81	NEED FOR PROPHYLACTIC VACCINATION/	83.18	10/02/2014
DRUGS	PRESCRIPTION DRUGS	67750.43	10/23/2014
340	MULTIPLE SCLEROSIS	28.38	01/16/2014
782.0	DISTURBANCE OF SKIN SENSATION		01/16/2014
V70.0	ROUTINE GENERAL MEDICAL EXAMINATION AT A	210.93	04/03/2014
401.1	BENIGN ESSENTIAL HYPERTENSION	54.13	10/02/2014
600.20	BENIGN LOCALIZED HYPERPLASIA OF PROSTATE		10/02/2014

GROUP: 2001025 SSN: ********** SEQ: ** DIV: 0001 RELAT: Spouse EFF: ********** DOB: ********** TERM: **********
LEVEL: F00 PLAN: WILCO-MED-DED-DIAB

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	01-*	250000.00	60.86	152149.54	.00	.00	.00	.00

==========Diagnosis Recap==========

Amount	Code	Description
$73,769.39	427.31	ATRIAL FIBRILLATION
$26,266.34	491.21	OBSTRUCTIVE CHRONIC BRONCHITIS WITH (ACUTE) EXACERBATION
$18,781.21	410.71	SUBENDOCARDIAL INFARCTION, INITIAL EPISODE OF CARE
$9,725.16	493.22	CHRONIC OBSTRUCTIVE ASTHMA WITH ACUTE EXACERBATION
$7,150.98	DRUGS	PRESCRIPTION DRUGS
$5,783.60	786.50	UNSPECIFIED CHEST PAIN
$2,617.26	327.23	OBSTRUCTIVE SLEEP APNEA (ADULT) (PEDIATRIC)
$1,858.24	786.09	OTHER DYSPNEA AND RESPIRATORY ABNORMALITY
$1,250.00	780.57	UNSPECIFIED SLEEP APNEA
$1,039.81	428.0	CONGESTIVE HEART FAILURE
$1,017.39	428.23	SYSTOLIC HEART FAILURE ACUTE ON CHRONIC
$853.41	401.1	BENIGN ESSENTIAL HYPERTENSION
$498.33	999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEWHERE CLASSIFIED
$411.63	414.01	CORONARY ATHEROSCLEROSIS;OF NATIVE CORONARY ARTERY
$341.69	427.1	PAROXYSMAL VENTRICULAR TACHYCARDIA
$206.27	496	CHRONIC AIRWAY OBSTRUCTION, NOT ELSEWHERE CLASSIFIED
$179.28	250.02	DIABETES MELLITUS WITHOUT MENTION OF COMPLICATION, TYPE II,UNCONTROLLED
$107.24	780.79	OTHER MALAISE AND FATIGUE
$92.76	790.21	IMPAIRED FASTING GLUCOSE
$92.32	458.9	HYPOTENSION, UNSPECIFIED
$25.00	380.4	IMPACTED CERUMEN
$22.00	959.11	OTHER INJURY OF CHEST WALL
$18.50	786.05	SHORTNESS OF BREATH
$17.43	272.0	PURE HYPERCHOLESTEROLEMIA
$17.12	511.9	UNSPECIFIED PLEURAL EFFUSION
$7.18	250.00	DIABETES MELLITUS WITHOUT MENTION OF COMPLICATION, TYPE II

$152,149.54 Total Paid

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
DRUGS	PRESCRIPTION DRUGS	7150.98	10/16/2014
414.01	CORONARY ATHEROSCLEROSIS;OF NATIVE	411.63	10/15/2014
428.1	LEFT HEART FAILURE		07/10/2014
402.10	BENIGN HYPERTENSIVE HEART DISEASE WITHOU		11/13/2013
V58.69	LONG-TERM (CURRENT) USE OF OTHER		03/18/2014
427.1	PAROXYSMAL VENTRICULAR TACHYCARDIA	341.69	08/21/2014
427.31	ATRIAL FIBRILLATION	73769.39	10/23/2014
790.21	IMPAIRED FASTING GLUCOSE	92.76	12/14/2013
466.0	ACUTE BRONCHITIS		12/14/2013
786.09	OTHER DYSPNEA AND RESPIRATORY ABNORMALIT	1858.24	06/22/2014
496	CHRONIC AIRWAY OBSTRUCTION, NOT ELSEWHER	206.27	08/13/2014
786.05	SHORTNESS OF BREATH	18.50	06/10/2014
511.9	UNSPECIFIED PLEURAL EFFUSION	17.12	01/03/2014
786.50	UNSPECIFIED CHEST PAIN	5783.60	10/15/2014
491.21	OBSTRUCTIVE CHRONIC BRONCHITIS WITH	26266.34	04/11/2014
250.00	DIABETES MELLITUS WITHOUT MENTION OF	7.18	07/11/2014
401.9	UNSPECIFIED ESSENTIAL HYPERTENSION		07/11/2014

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LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 02 11/01/2013 to 10/31/2014 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
272.4	OTHER AND UNSPECIFIED HYPERLIPIDEMIA		09/14/2014
428.0	CONGESTIVE HEART FAILURE	1039.81	09/14/2014
959.11	OTHER INJURY OF CHEST WALL	22.00	12/27/2013
401.1	BENIGN ESSENTIAL HYPERTENSION	853.41	02/05/2014
428.23	SYSTOLIC HEART FAILURE ACUTE ON CHRONIC	1017.39	04/11/2014
250.62	DIABETES WITH NEUROLOGICAL MANIFESTATION		02/01/2014
414.8	OTHER SPECIFIED FORMS OF CHRONIC ISCHEMI		10/15/2014
410.71	SUBENDOCARDIAL INFARCTION, INITIAL EPISO	18781.21	10/15/2014
799.02	HYPOXEMIA		01/02/2014
424.0	MITRAL VALVE DISORDERS		02/04/2014
V45.02	CARDIAC DEVICE IN SITU;AUTO IMPLANTABLE		10/15/2014
428.21	SYSTOLIC HEART FAILURE - ACUTE		02/05/2014
250.02	DIABETES MELLITUS WITHOUT MENTION OF	179.28	08/11/2014
V45.01	CARDIAC DEVICE IN SITU;CARDIAC PACE-		04/08/2014
V45.82	OTHER POSTSURGICAL STATUS;PERCUTANEOUS		02/01/2014
794.4	NONSPECIFIC ABNORMAL RESULTS OF FUNCTION		02/17/2014
402.11	BENIGN HYPERTENSIVE HEART DISEASE WITH C		03/26/2014
380.4	IMPACTED CERUMEN	25.00	03/01/2014
999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEW	498.33	05/25/2014
427.9	CARDIAC DYSRHYTHMIA		01/02/2014
250.12	DIABETES WITH KETOACIDOSIS,TYPE II OR		04/11/2014
493.22	CHRONIC OBSTRUCTIVE ASTHMA WITH ACUTE	9725.16	04/11/2014
491.22	OBSTRUCTIVE BRONCHITIS,WITH ACUTE BRONCH		04/11/2014
584.9	Acute kidney failure, unspecified		10/15/2014
866.00	UNSPECIFIED INJURY TO KIDNEY WITHOUT MEN		04/08/2014
458.9	HYPOTENSION, UNSPECIFIED	92.32	04/08/2014
780.79	OTHER MALAISE AND FATIGUE	107.24	05/08/2014
327.23	OBSTRUCTIVE SLEEP APNEA (ADULT)	2617.26	10/13/2014
272.0	PURE HYPERCHOLESTEROLEMIA	17.43	07/11/2014
593.9	UNSPECIFIED DISORDER OF KIDNEY AND URETE		06/09/2014
780.57	UNSPECIFIED SLEEP APNEA	1250.00	06/22/2014
305.1	TOBACCO USE DISORDER		12/27/2013
070.54	VIRAL HEPATITIS W/O MENTION HEPATIC COMA		09/14/2014
427.32	ATRIAL FLUTTER		10/15/2014
425.4	PRIMARY CARDIOMYOPATHIES		10/12/2014
428.33	DIASTOLIC HEART FAILURE ACUTE ON CHRONIC		10/13/2014
414.02	CORONARY ATHEROSCLEROSIS;OF AUTOLOGOUS		10/15/2014
428.22	SYSTOLIC HEART FAILURE - CHRONIC		10/15/2014

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LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 02 11/01/2013 to 10/31/2014 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

GROUP: 2001025 SSN: ********** SEQ: ** DIV: 0001 RELAT: Participant EFF: ********** DOB: ********** TERM: **********
LEVEL: P00 PLAN: WILCO-MED-DED

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	00-*	250000.00	45.41	113519.84	.00	.00	.00	.00

==========Diagnosis Recap==========

Amount	Code	Description
$54,706.44	V58.11	ENCOUNTER FOR ANTINEOPLASTIC CHEMOTHERAPY
$26,536.08	174.2	MALIGNANT NEOPLASM OF UPPER-INNER QUADRANT OF FEMALE BREAST
$19,226.37	V66.2	CONVALESCENCE FOLLOWING CHEMOTHERAPY
$6,544.73	174.9	MALIGNANT NEOPLASM OF BREAST (FEMALE), UNSPECIFIED
$3,333.80	999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEWHERE CLASSIFIED
$1,224.37	174.8	MALIGNANT NEOPLASM OF OTHER SPECIFIED SITES OF FEMALE BREAST
$625.39	DRUGS	PRESCRIPTION DRUGS
$457.31	996.74	OTHER COMPLICATIONS DUE TO OTHER VASCULAR DEVICE, IMPLANT, AND GRAFT
$233.76	V10.3	Hx, prsnl, breast malignancy
$175.60	V70.0	ROUTINE GENERAL MEDICAL EXAMINATION AT AHEALTH CARE FACILITY
$163.37	733.90	DISORDER OF BONE AND CARTILAGE, UNSPECIFIED
$130.01	611.72	LUMP OR MASS IN BREAST
$74.92	423.9	UNSPECIFIED DISEASE OF PERICARDIUM
$54.13	401.9	UNSPECIFIED ESSENTIAL HYPERTENSION
$19.77	272.0	PURE HYPERCHOLESTEROLEMIA
$13.79	V58.81	FITTING AND ADJUSTMENT OF VASCULAR CATHETER

$113,519.84 Total Paid

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
174.2	MALIGNANT NEOPLASM OF UPPER-INNER QUADRA	26536.08	10/07/2014
174.8	MALIGNANT NEOPLASM OF OTHER SPECIFIED SI	1224.37	09/12/2014
V86.0	ESTROGEN RECEPTOR POSITIVE STATUS (ER+)		06/02/2014
174.9	MALIGNANT NEOPLASM OF BREAST (FEMALE), U	6544.73	04/28/2014
999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEW	3333.80	08/25/2014
611.72	LUMP OR MASS IN BREAST	130.01	11/19/2013
V58.81	FITTING AND ADJUSTMENT OF VASCULAR	13.79	11/19/2013
401.9	UNSPECIFIED ESSENTIAL HYPERTENSION	54.13	02/05/2014
DRUGS	PRESCRIPTION DRUGS	625.39	10/02/2014
V58.11	ENCOUNTER FOR ANTINEOPLASTIC	54706.44	10/07/2014
268.9	UNSPECIFIED VITAMIN D DEFICIENCY		12/17/2013
V66.2	CONVALESCENCE FOLLOWING CHEMOTHERAPY	19226.37	06/02/2014
996.74	OTHER COMPLICATIONS DUE TO OTHER VASCULA	457.31	05/12/2014
272.0	PURE HYPERCHOLESTEROLEMIA	19.77	02/05/2014
285.3	Antineoplastic chemo induced anemia		02/17/2014
780.79	OTHER MALAISE AND FATIGUE		02/10/2014
733.90	DISORDER OF BONE AND CARTILAGE, UNSPECIF	163.37	06/19/2014
V10.3	Hx, prsnl, breast malignancy	233.76	08/07/2014
V70.0	ROUTINE GENERAL MEDICAL EXAMINATION AT A	175.60	08/11/2014
272.2	Hyperlipidemia, mixed		08/11/2014
397.0	DISEASES OF TRICUSPID VALVE		08/11/2014
429.9	HEART DISEASE, UNSPECIFIED		08/11/2014
423.9	UNSPECIFIED DISEASE OF PERICARDIUM	74.92	08/11/2014

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LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 02 11/01/2013 to 10/31/2014 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

GROUP: 2001025 SSN: ********** SEQ: ** DIV: 0001 RELAT: Child EFF: ********** DOB: ********** TERM: **********
LEVEL: P99 PLAN: WILCO-MED-CORE

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	12-*	250000.00	37.30	93256.06	.00	.00	.00	.00

==========Diagnosis Recap==========

Amount	Code	Description
$83,444.14	466.11	ACUTE BRONCHIOLITIS/ DUE TO RESPIRATORY SYNCYTIAL VIRUS (RSV)
$4,664.40	518.81	RESPIRATORY FAILURE
$1,829.32	786.09	OTHER DYSPNEA AND RESPIRATORY ABNORMALITY
$1,633.54	V30.00	SINGLE LIVEBORN, BORN IN HOSPITAL, DELIVERED WITHOUT MENTION OF CESAREAN SECTION
$742.19	V20.2	ROUTINE INFANT OR CHILD HEALTH CHECK
$603.33	079.6	RESPIRATORY SYNCYTIAL VIRUS (RSV)
$153.33	999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEWHERE CLASSIFIED
$84.34	466.19	ACUTE BRONCHIOLITIS / DUE TO OTHER INFECTIOUS ORGANISMS
$42.17	774.6	UNSPECIFIED FETAL AND NEONATAL JAUNDICE
$41.37	V58.82	FITTING AND ADJUSTMENT OF NONVASCULAR CATHETER, NEC
$17.93	DRUGS	PRESCRIPTION DRUGS

$93,256.06 Total Paid

Diagnosis Summary for **********	Amount Paid	Last D.O.S.
774.6 UNSPECIFIED FETAL AND NEONATAL JAUNDICE	42.17	12/31/2013
466.19 ACUTE BRONCHIOLITIS / DUE TO OTHER	84.34	02/05/2014
786.2 COUGH		02/05/2014
466.11 ACUTE BRONCHIOLITIS/ DUE TO RESPIRATORY	83444.14	02/04/2014
799.02 HYPOXEMIA		02/03/2014
V30.00 SINGLE LIVEBORN, BORN IN HOSPITAL, DELIV	1633.54	12/29/2013
794.15 NONSPECIFIC ABNORMAL AUDITORY FUNCTION S		12/29/2013
V29.0 NB OBSRV SUSPCT INFECT		12/29/2013
V64.05 VACCINATION NOT CARRIED OUT BECAUSE OF		12/29/2013
V20.2 ROUTINE INFANT OR CHILD HEALTH CHECK	742.19	02/27/2014
V72.19 SPECIAL INVESTIGATIONS AND EXAMINATIONS-		12/28/2013
786.09 OTHER DYSPNEA AND RESPIRATORY ABNORMALIT	1829.32	01/29/2014
V58.82 FITTING AND ADJUSTMENT OF NONVASCULAR	41.37	01/31/2014
751.3 HIRSCHSPRUNG'S DISEASE AND OTHER CONGENI		01/31/2014
DRUGS PRESCRIPTION DRUGS	17.93	03/12/2014
999 COMPLICATIONS OF MEDICAL CARE, NOT ELSEW	153.33	02/12/2014
079.6 RESPIRATORY SYNCYTIAL VIRUS (RSV)	603.33	01/29/2014
518.81 RESPIRATORY FAILURE	4664.40	02/04/2014
530.81 ESOPHAGEAL REFLUX		02/04/2014

GROUP: 2001025 SSN: ********** SEQ: ** DIV: 0001 RELAT: Spouse EFF: ********** DOB: ********** TERM: **********
LEVEL: F00 PLAN: WILCO-MED-CORE

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	01-*	250000.00	23.80	59498.05	.00	.00	.00	.00

==========Diagnosis Recap==========

Amount	Code	Description
$53,472.09	DRUGS	PRESCRIPTION DRUGS
$2,742.60	V58.69	LONG-TERM (CURRENT) USE OF OTHER MEDICATIONS
$1,581.24	720.2	SACROILIITIS, NOT ELSEWHERE CLASSIFIED
$539.57	723.1	CERVICALGIA
$449.31	724.2	LUMBAGO
$325.85	V72.31	ROUTINE GYNECOLOGICAL EXAM
$262.50	724.9	OTHER UNSPECIFIED BACK DISORDERS
$63.48	918.1	SUPERFICIAL INJURY OF CORNEA
$61.41	461.9	ACUTE SINUSITIS, UNSPECIFIED

$59,498.05 Total Paid

10/31/14 Allegiance Benefit Plan Management, Inc. PAGE: 116
LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 02 11/01/2013 to 10/31/2014 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
DRUGS	PRESCRIPTION DRUGS	53472.09	10/22/2014
720.2	SACROILIITIS, NOT ELSEWHERE CLASSIFIED	1581.24	10/24/2014
723.1	CERVICALGIA	539.57	06/05/2014
724.2	LUMBAGO	449.31	10/24/2014
724.8	OTHER SYMPTOMS REFERABLE TO BACK		10/24/2014
738.4	ACQUIRED SPONDYLOLISTHESIS		10/24/2014
461.9	ACUTE SINUSITIS, UNSPECIFIED	61.41	11/25/2013
477.8	ALLERGIC RHINITIS DUE TO OTHER ALLERGEN		11/25/2013
466.0	ACUTE BRONCHITIS		11/25/2013
724.9	OTHER UNSPECIFIED BACK DISORDERS	262.50	10/07/2013
719.46	PAIN IN JOINT INVOLVING LOWER LEG		12/11/2013
338.11	ACUTE PAIN DUE TO TRAUMA		12/11/2013
338.18	OTHER ACUTE POSTOPERATIVE PAIN		12/11/2013
V72.31	ROUTINE GYNECOLOGICAL EXAM	325.85	02/25/2014
256.31	OTHER OVARIAN FAILURE;PREMATURE MENOPAUS		02/25/2014
V58.69	LONG-TERM (CURRENT) USE OF OTHER	2742.60	08/29/2014
918.1	SUPERFICIAL INJURY OF CORNEA	63.48	03/28/2014

GROUP: 2001025 SSN: ********** SEQ: ** DIV: 0001 RELAT: Participant EFF: ********** DOB: ********** TERM: **********
LEVEL: F00 PLAN: WILCO-MED-DED-DIAB

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	00-*	250000.00	10.97	27433.75	.00	.00	.00	.00

==========Diagnosis Recap==========

Amount	Code	Description
$24,904.75	DRUGS	PRESCRIPTION DRUGS
$540.03	696.0	PSORIATIC ARTHROPATHY
$505.18	268.9	UNSPECIFIED VITAMIN D DEFICIENCY
$379.96	V76.12	OTHER SCREENING MAMMOGRAM
$285.35	715.90	OSTEOARTHROSIS, UNSPECIFIED WHETHER GENERALIZED OR LOCALIZED, INVOLVING UNSPECIF
$173.51	696.1	OTHER PSORIASIS AND SIMILAR DISORDERS
$146.48	473.9	UNSPECIFIED SINUSITIS (CHRONIC)
$128.52	728.89	OTHER DISORDER OF MUSCLE, LIGAMENT, AND FASCIA
$128.52	721.7	TRAUMATIC SPONDYLOPATHY
$98.00	V58.69	LONG-TERM (CURRENT) USE OF OTHER MEDICATIONS
$60.94	799.81	DECREASED LIBIDO
$54.13	477.0	ALLERGIC RHINITIS DUE TO POLLEN
$28.38	727.06	TENOSYNOVITIS OF FOOT AND ANKLE

$27,433.75 Total Paid

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
DRUGS	PRESCRIPTION DRUGS	24904.75	10/12/2014
727.06	TENOSYNOVITIS OF FOOT AND ANKLE	28.38	10/24/2013
696.1	OTHER PSORIASIS AND SIMILAR DISORDERS	173.51	05/29/2014
703.8	OTHER SPECIFIED DISEASES OF NAIL		10/24/2013
721.7	TRAUMATIC SPONDYLOPATHY	128.52	12/05/2013
268.9	UNSPECIFIED VITAMIN D DEFICIENCY	505.18	02/26/2014
780.79	OTHER MALAISE AND FATIGUE		11/21/2013
627.2	MENOPAUSAL OR FEMALE CLIMACTERIC STATES		02/26/2014

10/31/14 Allegiance Benefit Plan Management, Inc. PAGE: 117
LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 02 11/01/2013 to 10/31/2014 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
272.1	PURE HYPERGLYCERIDEMIA		11/21/2013
715.90	OSTEOARTHROSIS, UNSPECIFIED WHETHER GENE	285.35	12/24/2013
799.81	DECREASED LIBIDO	60.94	02/26/2014
401.1	BENIGN ESSENTIAL HYPERTENSION		01/14/2014
473.9	UNSPECIFIED SINUSITIS (CHRONIC)	146.48	02/12/2014
V58.69	LONG-TERM (CURRENT) USE OF OTHER	98.00	09/25/2014
477.0	ALLERGIC RHINITIS DUE TO POLLEN	54.13	05/14/2014
728.89	OTHER DISORDER OF MUSCLE, LIGAMENT, AND	128.52	04/10/2014
696.0	PSORIATIC ARTHROPATHY	540.03	10/09/2014
V76.12	OTHER SCREENING MAMMOGRAM	379.96	10/02/2014

GROUP: 2001025 SSN: ********** SEQ: ** DIV: 0001 RELAT: Spouse EFF: ********** DOB: ********** TERM: **********
LEVEL: F99 PLAN: WILCO-MED-EPO-DIAB

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	01-*	250000.00	12.25	30636.02	.00	.00	.00	.00

==========Diagnosis Recap==========

Amount	Code	Description
$17,091.31	626.8	OTHER DISORDERS OF MENSTRUATION AND OTHER ABNORMAL BLEEDING FROM FEMALE GENITAL
$5,859.75	V58.69	LONG-TERM (CURRENT) USE OF OTHER MEDICATIONS
$3,683.63	346.90	Migraine NOS w/o migrain w/o status
$2,172.73	DRUGS	PRESCRIPTION DRUGS
$416.00	627.0	PREMENOPAUSAL MENORRHAGIA
$319.32	626.2	EXCESSIVE OR FREQUENT MENSTRUATION
$255.27	338.4	CHRONIC PAIN SYNDROME
$221.06	724.1	PAIN IN THORACIC SPINE
$153.28	346.10	Mgn w/o aura not intrac w/o status
$125.18	723.1	CERVICALGIA
$90.57	553.20	UNSPECIFIED VENTRAL HERNIA WITHOUT MENTION OF OBSTRUCTION OR GANGRENE
$85.09	784.0	HEADACHE
$85.09	724.2	LUMBAGO
$62.73	626.9	UNSPECIFIED DISORDERS OF MENSTRUATION AND OTHER ABNORMAL BLEEDING FROM FEMALE GE
$15.01	786.2	COUGH

$30,636.02 Total Paid

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
DRUGS	PRESCRIPTION DRUGS	2172.73	10/16/2014
V58.69	LONG-TERM (CURRENT) USE OF OTHER	5859.75	08/22/2014
724.1	PAIN IN THORACIC SPINE	221.06	05/13/2014
721.2	THORACIC SPONDYLOSIS WITHOUT MYELOPATHY		05/13/2014
723.1	CERVICALGIA	125.18	03/18/2014
721.3	LUMBOSACRAL SPONDYLOSIS WITHOUT MYELOPAT		08/22/2014
724.2	LUMBAGO	85.09	08/22/2014
626.2	EXCESSIVE OR FREQUENT MENSTRUATION	319.32	12/30/2013
488.82	Flu d/t iden nov influ A othr resp		12/20/2013
346.90	Migraine NOS w/o migrain w/o status	3683.63	12/23/2013
338.29	OTHER CHRONIC PAIN		02/18/2014
724.5	BACKACHE, UNSPECIFIED		12/23/2013
296.90	UNSPECIFIED EPISODIC MOOD DISORDER		12/23/2013
338.4	CHRONIC PAIN SYNDROME	255.27	08/22/2014
304.01	OPIOID TYPE DEPENDENCE, CONTINUOUS USE		08/22/2014
626.9	UNSPECIFIED DISORDERS OF MENSTRUATION AN	62.73	12/30/2013
487.1	INFLUENZA WITH OTHER RESPIRATORY MANIFES		12/20/2013
786.2	COUGH	15.01	12/17/2013
786.50	UNSPECIFIED CHEST PAIN		12/17/2013
553.20	UNSPECIFIED VENTRAL HERNIA WITHOUT MENTI	90.57	08/02/2013
346.10	Mgn w/o aura not intrac w/o status	153.28	01/16/2014
626.8	OTHER DISORDERS OF MENSTRUATION AND OTHE	17091.31	02/20/2014
625.9	UNSPECIFIED SYMPTOM ASSOCIATED WITH FEMA		02/18/2014
338.18	OTHER ACUTE POSTOPERATIVE PAIN		02/20/2014
627.0	PREMENOPAUSAL MENORRHAGIA	416.00	02/18/2014
218.9	LEIOMYOMA OF UTERUS, UNSPECIFIED		02/18/2014
625.3	DYSMENORRHEA		02/18/2014
300.00	ANXIETY STATE, UNSPECIFIED		02/18/2014
346.71	Chronic migraine w/o aura		01/06/2014
784.0	HEADACHE	85.09	05/13/2014
780.60	Symptom, fever, unspecified		12/17/2013

10/31/14 Allegiance Benefit Plan Management, Inc. PAGE: 118
LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 02 11/01/2013 to 10/31/2014 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

GROUP: 2001025 SSN: ********** SEQ: ** DIV: 0001 RELAT: Spouse EFF: ********** DOB: ********** TERM: **********
LEVEL: F99 PLAN: WILCO-MED-CORE-DIAB

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	01-*	250000.00	11.23	28072.45	.00	.00	.00	.00

==========Diagnosis Recap==========

Amount	Code	Description
$18,124.09	DRUGS	PRESCRIPTION DRUGS
$6,150.47	250.02	DIABETES MELLITUS WITHOUT MENTION OF COMPLICATION, TYPE II,UNCONTROLLED
$1,330.48	V76.51	SPECIAL SCREENING FOR MALIG NEOPL;COLON
$631.45	250.43	DIABETES WITH RENAL MANIFESTATIONS,TYPE I,JUVENILE TYPE,UNCONTROLLED
$258.36	250.90	DIABETES WITH UNSPECIFIED COMPLICATION, TYPE II OR UNSPECIFIED TYPE
$247.91	574.20	CALCULUS OF GALLBLADDER WITHOUT MENTION OF CHOLECYSTITIS, WITHOUT MENTION OF OBS
$203.33	564.9	UNSPECIFIED FUNCTIONAL DISORDER OF INTESTINE
$178.85	V18.51	Hx, family, dgstv ds colonic polyp
$161.08	789.02	OTHER SYMPTOMS INVOLVING ABDOMEN AND PELVIS
$147.00	780.60	Symptom, fever, unspecified
$131.59	250.03	DIABETES MELLITUS WITHOUT MENTION OF COMPLICATION,TYPE I,JUVENILE,UNCONTROLD
$126.83	401.1	BENIGN ESSENTIAL HYPERTENSION
$121.94	241.0	NONTOXIC UNINODULAR GOITER
$99.87	789.04	OTHER SYMPTOMS INVOLVING ABDOMEN AND PELVIS
$59.50	462	ACUTE PHARYNGITIS
$50.40	466.0	ACUTE BRONCHITIS
$32.65	V04.81	NEED FOR PROPHYLACTIC VACCINATION/ INOCULATION AGAINST, INFLUENZA
$16.65	327.23	OBSTRUCTIVE SLEEP APNEA (ADULT) (PEDIATRIC)

$28,072.45 Total Paid

10/31/14 Allegiance Benefit Plan Management, Inc. PAGE: 119
LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 02 11/01/2013 to 10/31/2014 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
250.43	DIABETES WITH RENAL MANIFESTATIONS,TYPE	631.45	10/20/2014
583.81	NEPHRITIS AND NEPHROPATHY, NOT SPECIFIED		10/20/2014
272.4	OTHER AND UNSPECIFIED HYPERLIPIDEMIA		10/20/2014
401.1	BENIGN ESSENTIAL HYPERTENSION	126.83	12/27/2013
DRUGS	PRESCRIPTION DRUGS	18124.09	10/20/2014
250.03	DIABETES MELLITUS WITHOUT MENTION OF	131.59	10/20/2014
241.0	NONTOXIC UNINODULAR GOITER	121.94	04/08/2014
250.90	DIABETES WITH UNSPECIFIED COMPLICATION,	258.36	02/25/2014
327.23	OBSTRUCTIVE SLEEP APNEA (ADULT)	16.65	12/04/2013
268.9	UNSPECIFIED VITAMIN D DEFICIENCY		10/20/2014
250.02	DIABETES MELLITUS WITHOUT MENTION OF	6150.47	09/30/2014
780.60	Symptom, fever, unspecified	147.00	12/19/2013
784.1	THROAT PAIN		12/19/2013
487.1	INFLUENZA WITH OTHER RESPIRATORY MANIFES		12/19/2013
466.0	ACUTE BRONCHITIS	50.40	06/06/2014
796.2	ELEVATED BLOOD PRESSURE READING WITHOUT		06/06/2014
462	ACUTE PHARYNGITIS	59.50	06/10/2014
574.20	CALCULUS OF GALLBLADDER WITHOUT MENTION	247.91	07/30/2014
789.04	OTHER SYMPTOMS INVOLVING ABDOMEN AND	99.87	07/24/2014
789.02	OTHER SYMPTOMS INVOLVING ABDOMEN AND	161.08	07/30/2014
733.6	TIETZE'S DISEASE		07/30/2014
V18.51	Hx, family, dgstv ds colonic polyp	178.85	07/31/2014
V76.51	SPECIAL SCREENING FOR MALIG NEOPL;COLON	1330.48	07/31/2014
V18.61	KIDNEY DISEASE;POLYCYSTIC KIDNEY		07/31/2014
564.9	UNSPECIFIED FUNCTIONAL DISORDER OF INTES	203.33	07/31/2014
250.00	DIABETES MELLITUS WITHOUT MENTION OF		07/31/2014
278.01	MORBID OBESITY		07/31/2014
V04.81	NEED FOR PROPHYLACTIC VACCINATION/	32.65	10/03/2014

GROUP: 2001025 SSN: ********** SEQ: ** DIV: 0001 RELAT: Spouse EFF: ********** DOB: ********** TERM: **********
LEVEL: F99 PLAN: WILCO-MED-DED-DIAB

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	01-*	250000.00	10.85	27137.42	.00	.00	.00	.00

==========Diagnosis Recap==========

Amount	Code	Description
$23,599.98	DRUGS	PRESCRIPTION DRUGS
$2,943.13	340	MULTIPLE SCLEROSIS
$216.22	V72.31	ROUTINE GYNECOLOGICAL EXAM
$171.23	789.01	OTHER SYMPTOMS INVOLVING ABDOMEN AND PELVIS
$170.00	959.3	OTHER AND UNSPECIFIED INJURY TO ELBOW, FOREARM, AND WRIST
$36.86	627.2	MENOPAUSAL OR FEMALE CLIMACTERIC STATES

$27,137.42 Total Paid

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
789.01	OTHER SYMPTOMS INVOLVING ABDOMEN AND	171.23	11/11/2013
340	MULTIPLE SCLEROSIS	2943.13	08/05/2014
782.0	DISTURBANCE OF SKIN SENSATION		05/07/2014
268.9	UNSPECIFIED VITAMIN D DEFICIENCY		08/05/2014
DRUGS	PRESCRIPTION DRUGS	23599.98	10/17/2014
V72.31	ROUTINE GYNECOLOGICAL EXAM	216.22	03/18/2014
733.00	OSTEOPOROSIS, UNSPECIFIED		08/05/2014
627.2	MENOPAUSAL OR FEMALE CLIMACTERIC STATES	36.86	08/05/2014
959.3	OTHER AND UNSPECIFIED INJURY TO ELBOW, F	170.00	09/16/2014
842.00	SPRAIN OF UNSPECIFIED SITE OF WRIST		09/16/2014

10/31/14 Allegiance Benefit Plan Management, Inc. PAGE: 120
LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 02 11/01/2013 to 10/31/2014 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

GROUP: 2001025 SSN: ********** SEQ: ** DIV: 0001 RELAT: Spouse EFF: ********** DOB: ********** TERM: **********
LEVEL: F00 PLAN: WILCO-MED-CORE-DIAB

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	01-*	250000.00	15.01	37528.31	.00	.00	.00	.00

==========Diagnosis Recap==========

Amount	Code	Description
$20,567.22	250.12	DIABETES WITH KETOACIDOSIS,TYPE II OR UNSPECIFIED TYPE,UNCONTROLLED
$3,887.34	DRUGS	PRESCRIPTION DRUGS
$3,525.15	789.06	OTHER SYMPTOMS INVOLVING ABDOMEN AND PELVIS
$2,751.32	211.3	BENIGN NEOPLASM OF COLON
$1,761.51	789.00	OTHER SYMPTOMS INVOLVING ABDOMEN AND PELVIS
$625.90	789.07	OTHER SYMPTOMS INVOLVING ABDOMEN AND PELVIS
$592.21	V72.60	Laboratory examination, unspecified
$534.07	787.03	SYMPTOMS INVOLVING DIGESTIVE SYSTEM VOMITING ALONE
$525.36	250.00	DIABETES MELLITUS WITHOUT MENTION OF COMPLICATION, TYPE II
$475.61	250.10	DIABETES WITH KETOACIDOSIS,TYPE II OR UNSPECIFIED TYPE
$441.00	722.52	DEGENERATION OF LUMBAR OR LUMBOSACRAL INTERVERTEBRAL DISC
$437.61	787.01	OTHER SYMPTOMS INVOLVING DIGESTIVE SYSTEM;NAUSEA WITH VOMITING
$390.26	250.11	DIABETES WITH KETOACIDOSIS,TYPE I,JUVENILE TYPE
$223.32	V76.12	OTHER SCREENING MAMMOGRAM
$163.37	V82.81	OSTEOPOROSIS
$106.71	V70.0	ROUTINE GENERAL MEDICAL EXAMINATION AT AHEALTH CARE FACILITY
$103.54	782.3	EDEMA
$102.59	530.81	ESOPHAGEAL REFLUX
$75.51	078.19	OTH SPECFD VIRAL WARTS
$74.73	719.45	PAIN IN JOINT INVOLVING PELVIC REGION AND THIGH
$71.81	250.01	DIABETES MELLITUS WITHOUT MENTION OF COMPLICATION,TYPE I,JUVENILE TYPE
$71.81	724.03	Stenosis lumbar neurogen claudicati
$20.36	V72.31	ROUTINE GYNECOLOGICAL EXAM

$37,528.31 Total Paid

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
DRUGS	PRESCRIPTION DRUGS	3887.34	10/14/2014
250.00	DIABETES MELLITUS WITHOUT MENTION OF	525.36	10/14/2014
244.8	OTHER SPECIFIED ACQUIRED HYPOTHYROIDISM		04/02/2014
530.81	ESOPHAGEAL REFLUX	102.59	10/01/2014
799.24	Signs/sympt emot state emot labilty		12/10/2013
780.52	INSOMNIA, UNSPECIFIED		04/02/2014
715.04	OSTEOARTHROSIS, GENERALIZED, INVOLVING H		01/27/2014
307.81	TENSION HEADACHE		04/02/2014
722.52	DEGENERATION OF LUMBAR OR LUMBOSACRAL IN	441.00	08/08/2014
739.3	NONALLOPATHIC LESIONS OF LUMBAR REGION,		08/08/2014
739.5	NONALLOPATHIC LESIONS OF PELVIC REGION,		08/08/2014
724.2	LUMBAGO		08/08/2014
724.03	Stenosis lumbar neurogen claudicati	71.81	08/13/2014
616.11	VAGINITIS AND VULVOVAGINITIS IN DISEASES		08/13/2014
V70.0	ROUTINE GENERAL MEDICAL EXAMINATION AT A	106.71	08/18/2014
V72.31	ROUTINE GYNECOLOGICAL EXAM	20.36	08/18/2014
627.3	POSTMENOPAUSAL ATROPHIC VAGINITIS		08/18/2014

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LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 02 11/01/2013 to 10/31/2014 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
719.45	PAIN IN JOINT INVOLVING PELVIC REGION AN	74.73	08/13/2014
724.3	SCIATICA		08/13/2014
V82.81	OSTEOPOROSIS	163.37	08/25/2014
V76.12	OTHER SCREENING MAMMOGRAM	223.32	08/25/2014
782.3	EDEMA	103.54	09/08/2014
562.13	DVRTCLI COLON W HMRHG		09/05/2014
V72.60	Laboratory examination, unspecified	592.21	10/19/2014
536.3	GASTROPARESIS		10/03/2014
276.51	DEHYDRATION		10/15/2014
250.11	DIABETES WITH KETOACIDOSIS,TYPE I,JUVENI	390.26	08/31/2014
789.07	OTHER SYMPTOMS INVOLVING ABDOMEN AND	625.90	10/15/2014
787.01	OTHER SYMPTOMS INVOLVING DIGESTIVE	437.61	10/21/2014
250.10	DIABETES WITH KETOACIDOSIS,TYPE II OR	475.61	09/04/2014
530.11	REFLUX ESOPHAGITIS		09/04/2014
311	DEPRESSIVE DISORDER, NOT ELSEWHERE CLASS		10/14/2014
078.19	OTH SPECFD VIRAL WARTS	75.51	09/17/2014
250.12	DIABETES WITH KETOACIDOSIS,TYPE II OR	20567.22	09/04/2014
401.0	MALIGNANT ESSENTIAL HYPERTENSION		09/04/2014
558.9	OTHER AND UNSPECIFIED NONINFECTIOUS GAST		09/04/2014
250.01	DIABETES MELLITUS WITHOUT MENTION OF	71.81	10/01/2014
780.79	OTHER MALAISE AND FATIGUE		09/17/2014
009.1	COLITIS, ENTERITIS, AND GASTROENTERITIS		09/17/2014
787.99	OTHER SYMPTOMS INVOLVING DIGESTIVE		10/21/2014
793.6	NONSPECIFIC ABNORMAL FINDINGS ON RADIOLO		09/26/2014
789.06	OTHER SYMPTOMS INVOLVING ABDOMEN AND	3525.15	10/21/2014
211.3	BENIGN NEOPLASM OF COLON	2751.32	10/08/2014
789.00	OTHER SYMPTOMS INVOLVING ABDOMEN AND	1761.51	10/22/2014
562.10	DIVERTICULOSIS OF COLON		10/08/2014
780.60	Symptom, fever, unspecified		10/15/2014
536.8	DYSPEPSIA AND OTHER SPECIFIED DISORDERS		10/08/2014
787.03	SYMPTOMS INVOLVING DIGESTIVE SYSTEM	534.07	10/22/2014
787.91	OTHER SYMPTOMS INVOLVING DIGESTIVE		10/22/2014
112.84	CANDIDAL ESOPHAGITIS		10/22/2014
790.29	OTHER ABNORMAL GLUCOSE		10/14/2014

GROUP: 2001025 SSN: ********** SEQ: ** DIV: RETR RELAT: Participant EFF: ********** DOB: ********** TERM: **********
LEVEL: P00 PLAN: WILCO-MED-CORE

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	00-*	250000.00	25.74	64344.91	.00	.00	.00	.00

==========Diagnosis Recap==========

Amount	Code	Description
$31,650.81	715.36	OSTEOARTHROSIS, LOCALIZED, INVOLVING LOWER LEG/KNEE
$10,510.78	715.16	OSTEOARTHROSIS, LOCALIZED, PRIMARY, INVOLVING LOWER LEG
$5,364.42	DRUGS	PRESCRIPTION DRUGS
$4,821.92	V57.1	CARE INVOLVING OTHER PHYSICAL THERAPY
$3,257.66	715.96	OSTEOARTHROSIS, UNSPECIFIED, INVOLVING LOWER LEG/KNEE
$2,337.94	780.79	OTHER MALAISE AND FATIGUE
$1,667.51	999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEWHERE CLASSIFIED
$1,596.40	719.46	PAIN IN JOINT INVOLVING LOWER LEG
$1,080.25	V70.0	ROUTINE GENERAL MEDICAL EXAMINATION AT AHEALTH CARE FACILITY
$577.20	433.10	OCL CRTD ART WO INFRCT
$393.72	V43.65	JOINT;KNEE
$229.50	268.9	UNSPECIFIED VITAMIN D DEFICIENCY
$223.32	V76.12	OTHER SCREENING MAMMOGRAM
$196.31	786.2	COUGH
$118.47	788.41	URINARY FREQUENCY
$117.35	V70.3	OTHER GENERAL MEDICAL EXAMINATION FOR ADMINISTRATIVE PURPOSES
$62.27	V72.84	PREOP EXAM UNSPCF
$56.25	733.90	DISORDER OF BONE AND CARTILAGE, UNSPECIFIED
$42.29	V04.81	NEED FOR PROPHYLACTIC VACCINATION/ INOCULATION AGAINST, INFLUENZA
$26.26	V72.60	Laboratory examination, unspecified
$14.28	719.06	EFFUSION OF LOWER LEG JOINT

$64,344.91 Total Paid

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
719.46	PAIN IN JOINT INVOLVING LOWER LEG	1596.40	08/08/2014
780.79	OTHER MALAISE AND FATIGUE	2337.94	09/17/2014
268.9	UNSPECIFIED VITAMIN D DEFICIENCY	229.50	09/17/2014
259.9	UNSPECIFIED ENDOCRINE DISORDER		09/17/2014
715.96	OSTEOARTHROSIS, UNSPECIFIED, INVOLVING	3257.66	01/16/2014
DRUGS	PRESCRIPTION DRUGS	5364.42	09/30/2014
786.2	COUGH	196.31	10/30/2013
530.81	ESOPHAGEAL REFLUX		01/17/2014
V04.81	NEED FOR PROPHYLACTIC VACCINATION/	42.29	10/30/2013
715.16	OSTEOARTHROSIS, LOCALIZED, PRIMARY, INVO	10510.78	08/08/2014
V70.3	OTHER GENERAL MEDICAL EXAMINATION FOR AD	117.35	12/11/2013
716.90	UNSPECIFIED ARTHROPATHY, SITE UNSPECIFIE		12/11/2013
272.0	PURE HYPERCHOLESTEROLEMIA		12/11/2013
V72.83	OTH SPCF PREOP EXAM		12/09/2013
V72.84	PREOP EXAM UNSPCF	62.27	01/14/2014
V72.60	Laboratory examination, unspecified	26.26	01/17/2014
269.3	MINERAL DEFICIENCY, NOT ELSEWHERE CLASSI		01/13/2014
733.90	DISORDER OF BONE AND CARTILAGE, UNSPECIF	56.25	01/15/2014
V43.65	JOINT;KNEE	393.72	04/30/2014
338.18	OTHER ACUTE POSTOPERATIVE PAIN		01/16/2014

715.36	OSTEOARTHROSIS, LOCALIZED, INVOLVING	31650.81	01/17/2014
781.2	ABNORMALITY OF GAIT		02/06/2014
V54.81	AFTERCARE FOLLOWING JOINT REPLACEMENT		04/30/2014
272.4	OTHER AND UNSPECIFIED HYPERLIPIDEMIA		06/18/2014
V64.06	VACCINATION NOT CARRIED OUT BECAUSE OF		01/17/2014
999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEW	1667.51	05/25/2014
V57.1	CARE INVOLVING OTHER PHYSICAL THERAPY	4821.92	04/30/2014
728.87	MUSCLE WEAKNESS (GENERALIZED)		04/08/2014
719.56	STIFFNESS OF JOINT, NOT ELSEWHERE CLASSI		04/08/2014
719.40	PAIN IN JOINT, SITE UNSPECIFIED		04/30/2014
729.90	Disorders of soft tissue, unspec		04/30/2014
788.41	URINARY FREQUENCY	118.47	05/15/2014
V70.0	ROUTINE GENERAL MEDICAL EXAMINATION AT A	1080.25	05/21/2014
433.10	OCL CRTD ART WO INFRCT	577.20	07/09/2014
719.06	EFFUSION OF LOWER LEG JOINT	14.28	07/18/2014
V76.12	OTHER SCREENING MAMMOGRAM	223.32	08/18/2014
780.52	INSOMNIA, UNSPECIFIED		09/17/2014

10/31/14 Allegiance Benefit Plan Management, Inc. PAGE: 123
LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 02 11/01/2013 to 10/31/2014 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

Diagnosis Summary for ********** Amount Paid Last D.O.S.

GROUP: 2001025 SSN: ********** SEQ: ** DIV: 0001 RELAT: Child EFF: ********** DOB: ********** TERM: **********
LEVEL: F99 PLAN: WILCO-MED-DED

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	11-*	250000.00	13.87	34672.54	.00	.00	.00	.00

==========Diagnosis Recap==========

Amount	Code	Description
$21,236.65	250.13	DIABETES WITH KETOACIDOSIS,TYPE I,JUVENILE TYPE,UNCONTROLLED
$5,934.88	DRUGS	PRESCRIPTION DRUGS
$2,520.00	787.01	OTHER SYMPTOMS INVOLVING DIGESTIVE SYSTEM;NAUSEA WITH VOMITING
$1,655.48	250.03	DIABETES MELLITUS WITHOUT MENTION OF COMPLICATION,TYPE I,JUVENILE,UNCONTROLD
$884.57	279.06	COMMON VARIABLE IMMUNODEFICIENCY
$750.89	250.21	DIABETES WITH HYPEROSMOLARITY,TYPE I, JUVENILE TYPE
$614.06	250.01	DIABETES MELLITUS WITHOUT MENTION OF COMPLICATION,TYPE I,JUVENILE TYPE
$321.92	250.33	DIABETES WITH OTHER COMA,TYPE I,JUVENILETYPE,UNCONTROLLED
$207.64	279.3	UNSPECIFIED IMMUNITY DEFICIENCY
$176.85	683	ACUTE LYMPHADENITIS
$76.67	999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEWHERE CLASSIFIED
$72.17	245.2	CHRONIC LYMPHOCYTIC THYROIDITIS
$67.30	079.99	VIRAL INFECTION NOS
$58.95	528.5	DISEASES OF LIPS
$43.84	V18.19	OTHER ENDOCRINE & METABOLIC DISEASES
$25.99	V04.81	NEED FOR PROPHYLACTIC VACCINATION/ INOCULATION AGAINST, INFLUENZA
$22.98	462	ACUTE PHARYNGITIS
$1.70	788.1	DYSURIA

$34,672.54 Total Paid

Diagnosis Summary for ********** Amount Paid Last D.O.S.

DRUGS	PRESCRIPTION DRUGS	5934.88	10/05/2014
683	ACUTE LYMPHADENITIS	176.85	04/16/2014
462	ACUTE PHARYNGITIS	22.98	04/16/2014
788.1	DYSURIA	1.70	10/15/2013
245.2	CHRONIC LYMPHOCYTIC THYROIDITIS	72.17	09/10/2014
268.9	UNSPECIFIED VITAMIN D DEFICIENCY		03/26/2014
079.99	VIRAL INFECTION NOS	67.30	11/12/2013
V04.81	NEED FOR PROPHYLACTIC VACCINATION/	25.99	12/20/2013
279.06	COMMON VARIABLE IMMUNODEFICIENCY	884.57	04/01/2014
279.10	IMMUNODEFICIENCY WITH PREDOMINANT T-CELL		04/01/2014
279.00	HYPOGAMMAGLOBULINEMIA, UNSPECIFIED		04/01/2014
279.01	SELECTIVE IGA IMMUNODEFICIENCY		09/02/2014
528.5	DISEASES OF LIPS	58.95	12/20/2013
250.01	DIABETES MELLITUS WITHOUT MENTION OF	614.06	03/26/2014
009.3	DIARRHEA OF PRESUMED INFECTIOUS ORIGIN		04/16/2014
250.03	DIABETES MELLITUS WITHOUT MENTION OF	1655.48	09/29/2014
250.13	DIABETES WITH KETOACIDOSIS,TYPE I,JUVENI	21236.65	07/17/2014
276.51	DEHYDRATION		07/17/2014
V58.67	LONG-TERM (CURRENT) USE OF INSULIN		07/16/2014
250.21	DIABETES WITH HYPEROSMOLARITY,TYPE I,	750.89	07/16/2014
250.33	DIABETES WITH OTHER COMA,TYPE I,JUVENILE	321.92	07/24/2014
V18.19	OTHER ENDOCRINE & METABOLIC DISEASES	43.84	07/18/2014
999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEW	76.67	08/25/2014
787.01	OTHER SYMPTOMS INVOLVING DIGESTIVE	2520.00	07/17/2014
244.9	UNSPECIFIED ACQUIRED HYPOTHYROIDISM		07/17/2014
785.0	TACHYCARDIA, UNSPECIFIED		07/16/2014
279.3	UNSPECIFIED IMMUNITY DEFICIENCY	207.64	09/02/2014
279.9	UNSPECIFIED DISORDER OF IMMUNE MECHANISM		09/02/2014

10/31/14 Allegiance Benefit Plan Management, Inc. PAGE: 124
LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 02 11/01/2013 to 10/31/2014 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

GROUP: 2001025 SSN: ********** SEQ: ** DIV: 0001 RELAT: Spouse EFF: ********** DOB: ********** TERM: **********
LEVEL: F99 PLAN: WILCO-MED-CORE

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	01-*	250000.00	26.65	66633.72	.00	.00	.00	.00

==========Diagnosis Recap==========

Amount	Code	Description
$57,715.66	427.69	PREMATURE BEATS
$2,363.38	DRUGS	PRESCRIPTION DRUGS
$897.88	786.50	UNSPECIFIED CHEST PAIN
$894.39	794.31	NONSPECIFIC ABNORMAL ELECTROCARDIOGRAM (ECG) (EKG)
$647.98	257.2	OTHER TESTICULAR HYPOFUNCTION
$531.91	790.6	OTHER ABNORMAL BLOOD CHEMISTRY
$420.23	780.79	OTHER MALAISE AND FATIGUE
$405.93	608.20	OTHER DISORDERS OF MALE GENITAL ORGANS- TORSION OF TESTIS, UNSPECIFIED
$366.77	401.9	UNSPECIFIED ESSENTIAL HYPERTENSION
$364.97	253.3	PITUITARY DWARFISM
$302.57	327.23	OBSTRUCTIVE SLEEP APNEA (ADULT) (PEDIATRIC)
$248.68	785.1	PALPITATIONS
$212.02	V58.69	LONG-TERM (CURRENT) USE OF OTHER MEDICATIONS
$182.06	280.9	IRON DEFICIENCY ANEMIA, UNSPECIFIED
$138.57	280.8	OTHER SPECIFIED IRON DEFICIENCY ANEMIAS
$106.50	793.19	Othr nonspecfc abnorml finding/lung
$100.40	786.05	SHORTNESS OF BREATH
$97.58	782.1	RASH AND OTHER NONSPECIFIC SKIN ERUPTION
$95.74	719.44	PAIN IN JOINT INVOLVING HAND
$93.10	604.90	ORCHITIS AND EPIDIDYMITIS, UNSPECIFIED
$86.65	272.2	Hyperlipidemia, mixed
$86.47	786.59	OTHER CHEST PAIN
$77.23	715.90	OSTEOARTHROSIS, UNSPECIFIED WHETHER GENERALIZED OR LOCALIZED, INVOLVING UNSPECIF
$49.15	216.3	BENIGN NEOPLASM OF SKIN OF OTHER AND UNSPECIFIED PARTS OF FACE
$47.87	729.2	NEURALGIA, NEURITIS, AND RADICULITIS, UNSPECIFIED
$42.17	608.9	UNSPECIFIED DISORDER OF MALE GENITAL ORGANS
$18.27	288.00	NETUROPENIA, UNSPECIFIED
$16.76	604.99	OTHER ORCHITIS, EPIDIDYMITIS, AND EPIDIDYMO-ORCHITIS, WITHOUT MENTION OF ABSCESS
$13.18	338.4	CHRONIC PAIN SYNDROME
$9.65	786.09	OTHER DYSPNEA AND RESPIRATORY ABNORMALITY

$66,633.72 Total Paid

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
DRUGS	PRESCRIPTION DRUGS	2363.38	10/06/2014
719.44	PAIN IN JOINT INVOLVING HAND	95.74	02/12/2014
729.2	NEURALGIA, NEURITIS, AND RADICULITIS, UN	47.87	05/27/2014
327.23	OBSTRUCTIVE SLEEP APNEA (ADULT)	302.57	02/06/2014
307.42	PERSISTENT DISORDER OF INITIATING OR MAI		12/30/2013
338.29	OTHER CHRONIC PAIN		08/15/2014
530.81	ESOPHAGEAL REFLUX		12/30/2013
216.3	BENIGN NEOPLASM OF SKIN OF OTHER AND UNS	49.15	01/20/2014
706.9	UNSPECIFIED DISEASE OF SEBACEOUS GLANDS		01/20/2014
702.19	OTHER DERMATOSES;OTHER SEBORRHEIC		01/20/2014
272.2	Hyperlipidemia, mixed	86.65	01/20/2014
V58.69	LONG-TERM (CURRENT) USE OF OTHER	212.02	06/01/2014
257.2	OTHER TESTICULAR HYPOFUNCTION	647.98	10/06/2014
600.00	HYPERTROPHY (BENIGN) OF PROSTATE W/O		02/10/2014
338.4	CHRONIC PAIN SYNDROME	13.18	02/12/2014
719.40	PAIN IN JOINT, SITE UNSPECIFIED		05/27/2014
794.31	NONSPECIFIC ABNORMAL ELECTROCARDIOGRAM (	894.39	07/11/2014
401.9	UNSPECIFIED ESSENTIAL HYPERTENSION	366.77	09/23/2014
790.6	OTHER ABNORMAL BLOOD CHEMISTRY	531.91	08/29/2014
715.90	OSTEOARTHROSIS, UNSPECIFIED WHETHER GENE	77.23	07/21/2014

10/31/14 Allegiance Benefit Plan Management, Inc. PAGE: 125
LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 02 11/01/2013 to 10/31/2014 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
729.5	PAIN IN LIMB		08/15/2014
723.1	CERVICALGIA		07/11/2014
288.00	NETUROPENIA, UNSPECIFIED	18.27	08/15/2014
722.6	DEGENERATION OF INTERVERTEBRAL DISC, SIT		07/18/2014
785.0	TACHYCARDIA, UNSPECIFIED		07/25/2014
786.50	UNSPECIFIED CHEST PAIN	897.88	08/04/2014
785.1	PALPITATIONS	248.68	09/05/2014
786.05	SHORTNESS OF BREATH	100.40	08/04/2014
427.69	PREMATURE BEATS	57715.66	09/23/2014
786.59	OTHER CHEST PAIN	86.47	08/14/2014
401.0	MALIGNANT ESSENTIAL HYPERTENSION		08/14/2014
272.0	PURE HYPERCHOLESTEROLEMIA		08/14/2014
793.19	Othr nonspecfc abnorml finding/lung	106.50	07/21/2014
305.1	TOBACCO USE DISORDER		07/21/2014
786.09	OTHER DYSPNEA AND RESPIRATORY ABNORMALIT	9.65	07/21/2014
280.9	IRON DEFICIENCY ANEMIA, UNSPECIFIED	182.06	08/15/2014
280.8	OTHER SPECIFIED IRON DEFICIENCY ANEMIAS	138.57	07/31/2014
780.52	INSOMNIA, UNSPECIFIED		08/15/2014
780.79	OTHER MALAISE AND FATIGUE	420.23	09/05/2014
253.3	PITUITARY DWARFISM	364.97	09/16/2014
268.9	UNSPECIFIED VITAMIN D DEFICIENCY		10/06/2014
266.2	OTHER B-COMPLEX DEFICIENCIES		10/06/2014
608.9	UNSPECIFIED DISORDER OF MALE GENITAL ORG	42.17	10/21/2014
604.99	OTHER ORCHITIS, EPIDIDYMITIS, AND EPIDID	16.76	09/18/2014
427.0	PAROXYSMAL SUPRAVENTRICULAR TACHYCARDIA		09/23/2014
530.85	BARRETT'S ESOPHAGUS		09/23/2014
604.90	ORCHITIS AND EPIDIDYMITIS, UNSPECIFIED	93.10	10/06/2014
608.20	OTHER DISORDERS OF MALE GENITAL ORGANS-	405.93	10/06/2014
251.8	OTHER SPECIFIED DISORDERS OF PANCREATIC		10/06/2014
782.1	RASH AND OTHER NONSPECIFIC SKIN ERUPTION	97.58	10/21/2014

GROUP: 2001025 SSN: ********** SEQ: ** DIV: 0001 RELAT: Participant EFF: ********** DOB: ********** TERM: **********
LEVEL: F99 PLAN: WILCO-MED-CORE

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	00-*	250000.00	33.34	83340.28	.00	.00	.00	.00

==========Diagnosis Recap==========

Amount	Code	Description
$59,418.22	721.3	LUMBOSACRAL SPONDYLOSIS WITHOUT MYELOPATHY
$8,373.78	DRUGS	PRESCRIPTION DRUGS
$6,468.14	722.52	DEGENERATION OF LUMBAR OR LUMBOSACRAL INTERVERTEBRAL DISC
$4,254.62	V58.83	ENCOUNTER/THERAPEUTIC DRUG MONITORING
$1,614.36	999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEWHERE CLASSIFIED
$1,330.49	V76.51	SPECIAL SCREENING FOR MALIG NEOPL;COLON
$828.91	V72.84	PREOP EXAM UNSPCF
$437.36	V76.12	OTHER SCREENING MAMMOGRAM
$204.20	724.2	LUMBAGO
$135.23	794.31	NONSPECIFIC ABNORMAL ELECTROCARDIOGRAM (ECG) (EKG)
$106.71	V72.31	ROUTINE GYNECOLOGICAL EXAM
$71.25	627.4	STATES ASSOCIATED WITH ARTIFICIAL MENOPAUSE
$50.00	V72.81	PREOP CARDIOVSCLR EXAM
$37.00	722.83	POSTLAMINECTOMY SYNDROME OF LUMBAR REGION
$10.01	V72.82	PREOP RESPIRATORY EXAM

$83,340.28 Total Paid

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
V76.51	SPECIAL SCREENING FOR MALIG NEOPL;COLON	1330.49	10/17/2013
722.52	DEGENERATION OF LUMBAR OR LUMBOSACRAL IN	6468.14	10/03/2014
724.9	OTHER UNSPECIFIED BACK DISORDERS		12/02/2013
724.2	LUMBAGO	204.20	01/30/2014
724.02	Stenosis, spinal, lmbr, no neuro cl		12/02/2013
DRUGS	PRESCRIPTION DRUGS	8373.78	10/02/2014
V72.82	PREOP RESPIRATORY EXAM	10.01	02/03/2014
V72.81	PREOP CARDIOVSCLR EXAM	50.00	06/30/2014
794.31	NONSPECIFIC ABNORMAL ELECTROCARDIOGRAM (	135.23	02/04/2014
273.8	OTHER DISORDERS OF PLASMA PROTEIN METABO		02/04/2014
999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEW	1614.36	03/18/2014
V72.84	PREOP EXAM UNSPCF	828.91	06/30/2014
627.4	STATES ASSOCIATED WITH ARTIFICIAL MENOPA	71.25	06/09/2014
722.10	DISPLACEMENT OF LUMBAR INTERVERTEBRAL DI		06/30/2014
721.3	LUMBOSACRAL SPONDYLOSIS WITHOUT MYELOPAT	59418.22	07/02/2014
722.51	DEGENERATION OF THORACIC OR THORACOLUMBA		07/01/2014
729.2	NEURALGIA, NEURITIS, AND RADICULITIS, UN		07/01/2014
V58.83	ENCOUNTER/THERAPEUTIC DRUG MONITORING	4254.62	06/30/2014
V58.69	LONG-TERM (CURRENT) USE OF OTHER		06/30/2014
722.83	POSTLAMINECTOMY SYNDROME OF LUMBAR REGIO	37.00	07/01/2014
V45.4	POSTSURGICAL ARTHRODESIS STATUS		07/01/2014
738.4	ACQUIRED SPONDYLOLISTHESIS		10/03/2014
338.4	CHRONIC PAIN SYNDROME		06/30/2014
715.90	OSTEOARTHROSIS, UNSPECIFIED WHETHER GENE		06/30/2014
564.00	CONSTIPATION, UNSPECIFIED		07/02/2014
V72.31	ROUTINE GYNECOLOGICAL EXAM	106.71	08/26/2014
627.2	MENOPAUSAL OR FEMALE CLIMACTERIC STATES		08/26/2014

10/31/14 Allegiance Benefit Plan Management, Inc. PAGE: 126
LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 02 11/01/2013 to 10/31/2014 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

Diagnosis Summary for **********	Amount Paid	Last D.O.S.
V76.12 OTHER SCREENING MAMMOGRAM	437.36	09/15/2014

GROUP: 2001025 SSN: ********** SEQ: ** DIV: 0001 RELAT: Spouse EFF: ********** DOB: ********** TERM: **********
LEVEL: F00 PLAN: WILCO-MED-EPO

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	01-*	250000.00	25.78	64453.51	.00	.00	.00	.00

==========Diagnosis Recap==========

Amount	Code	Description
$45,376.45	715.36	OSTEOARTHROSIS, LOCALIZED, INVOLVING LOWER LEG/KNEE
$8,945.00	351.0	BELL'S PALSY
$2,159.52	715.16	OSTEOARTHROSIS, LOCALIZED, PRIMARY, INVOLVING LOWER LEG
$2,097.60	DRUGS	PRESCRIPTION DRUGS
$1,823.76	338.18	OTHER ACUTE POSTOPERATIVE PAIN
$1,050.76	729.5	PAIN IN LIMB
$909.57	V43.65	JOINT;KNEE
$884.00	999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEWHERE CLASSIFIED
$632.89	724.2	LUMBAGO
$191.98	V70.0	ROUTINE GENERAL MEDICAL EXAMINATION AT AHEALTH CARE FACILITY
$182.23	715.95	OSTEOARTHROSIS, UNSPECIFIED, INVOLVING PELVIC REGION/HIP
$66.04	436	ACUTE, BUT ILL-DEFINED, CEREBROVASCULAR DISEASE
$51.54	786.50	UNSPECIFIED CHEST PAIN
$40.19	719.46	PAIN IN JOINT INVOLVING LOWER LEG
$28.19	719.45	PAIN IN JOINT INVOLVING PELVIC REGION AND THIGH
$13.79	V72.82	PREOP RESPIRATORY EXAM

$64,453.51 Total Paid

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
436	ACUTE, BUT ILL-DEFINED, CEREBROVASCULAR	66.04	09/15/2014
780.39	CONVULSIONS;OTHER CONVULSIONS		09/15/2014
351.0	BELL'S PALSY	8945.00	09/27/2013
345.90	EPILEPSY, UNSPECIFIED, WITHOUT MENTION O		02/27/2014
V12.54	Hx, prsnl, TIA and cerebral infa		09/27/2013
V58.66	LONG-TERM (CURRENT) USE OF ASPIRIN		09/27/2013
786.50	UNSPECIFIED CHEST PAIN	51.54	11/07/2013
DRUGS	PRESCRIPTION DRUGS	2097.60	10/19/2014
715.16	OSTEOARTHROSIS, LOCALIZED, PRIMARY, INVO	2159.52	03/19/2014
V72.82	PREOP RESPIRATORY EXAM	13.79	02/20/2014
715.36	OSTEOARTHROSIS, LOCALIZED, INVOLVING	45376.45	02/27/2014
719.46	PAIN IN JOINT INVOLVING LOWER LEG	40.19	04/08/2014
338.18	OTHER ACUTE POSTOPERATIVE PAIN	1823.76	02/26/2014
719.45	PAIN IN JOINT INVOLVING PELVIC REGION AN	28.19	08/29/2014
999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEW	884.00	09/12/2014
715.95	OSTEOARTHROSIS, UNSPECIFIED, INVOLVING	182.23	02/24/2014
V43.65	JOINT;KNEE	909.57	04/08/2014
729.5	PAIN IN LIMB	1050.76	05/06/2014

10/31/14 Allegiance Benefit Plan Management, Inc. PAGE: 127
LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 02 11/01/2013 to 10/31/2014 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
724.2	LUMBAGO	632.89	08/29/2014
724.4	THORACIC OR LUMBOSACRAL NEURITIS OR RADI		08/29/2014
722.10	DISPLACEMENT OF LUMBAR INTERVERTEBRAL DI		08/29/2014
V70.0	ROUTINE GENERAL MEDICAL EXAMINATION AT A	191.98	09/15/2014
724.5	BACKACHE, UNSPECIFIED		09/15/2014
784.0	HEADACHE		09/15/2014
272.0	PURE HYPERCHOLESTEROLEMIA		09/15/2014
285.9	ANEMIA, UNSPECIFIED		09/15/2014

GROUP: 2001025 SSN: ********** SEQ: ** DIV: 0001 RELAT: Participant EFF: ********** DOB: ********** TERM: **********
LEVEL: P00 PLAN: WILCO-MED-DED

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	00-*	250000.00	26.95	67378.94	.00	.00	.00	.00

==========Diagnosis Recap==========

Amount	Code	Description
$66,493.02	DRUGS	PRESCRIPTION DRUGS
$233.00	466.0	ACUTE BRONCHITIS
$209.35	V70.0	ROUTINE GENERAL MEDICAL EXAMINATION AT AHEALTH CARE FACILITY
$160.00	V76.12	OTHER SCREENING MAMMOGRAM
$146.97	401.1	BENIGN ESSENTIAL HYPERTENSION
$60.00	692.9	CONTACT DERMATITIS AND OTHER ECZEMA, UNSPECIFIED CAUSE
$48.60	826.0	CLOSED FRACTURE OF ONE OR MORE PHALANGESOF FOOT
$28.00	910.5	INSECT BITE, NONVENOMOUS OF FACE, NECK, AND SCALP EXCEPT EYE, INFECTED

$67,378.94 Total Paid

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
DRUGS	PRESCRIPTION DRUGS	66493.02	10/03/2014
910.5	INSECT BITE, NONVENOMOUS OF FACE, NECK,	28.00	06/24/2014
692.9	CONTACT DERMATITIS AND OTHER ECZEMA, UNS	60.00	06/25/2014
466.0	ACUTE BRONCHITIS	233.00	07/03/2014
493.90	ASTHMA, UNSPECIFIED TYPE		07/03/2014
V70.0	ROUTINE GENERAL MEDICAL EXAMINATION AT A	209.35	07/22/2014
401.1	BENIGN ESSENTIAL HYPERTENSION	146.97	07/30/2014
272.0	PURE HYPERCHOLESTEROLEMIA		07/30/2014
244.9	UNSPECIFIED ACQUIRED HYPOTHYROIDISM		07/30/2014
530.81	ESOPHAGEAL REFLUX		07/30/2014
V76.12	OTHER SCREENING MAMMOGRAM	160.00	08/13/2014
826.0	CLOSED FRACTURE OF ONE OR MORE PHALANGES	48.60	09/16/2014

GROUP: 2001025 SSN: ********** SEQ: ** DIV: 0001 RELAT: Participant EFF: ********** DOB: ********** TERM: **********
LEVEL: F99 PLAN: WILCO-MED-EPO-DIAB

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	00-*	250000.00	10.01	25021.01	.00	.00	.00	.00

==========Diagnosis Recap==========

Amount	Code	Description
$9,629.29	435.9	TRANSIENT CEREBRAL ISCHEMIA
$4,211.58	437.3	CEREBRAL ANEURYSM, NONRUPTURED
$3,739.73	DRUGS	PRESCRIPTION DRUGS
$1,743.84	434.91	CRBL ART OCL NOS W INFRC
$630.00	722.11	DISPLACEMENT OF THORACIC INTERVERTEBRAL DISC WITHOUT MYELOPATHY
$630.00	723.4	BRACHIAL NEURITIS OR RADICULITIS NOS
$630.00	722.10	DISPLACEMENT OF LUMBAR INTERVERTEBRAL DISC WITHOUT MYELOPATHY
$447.96	427.31	ATRIAL FIBRILLATION
$417.60	784.0	HEADACHE
$322.20	436	ACUTE, BUT ILL-DEFINED, CEREBROVASCULAR DISEASE
$291.67	327.23	OBSTRUCTIVE SLEEP APNEA (ADULT) (PEDIATRIC)
$225.00	462	ACUTE PHARYNGITIS
$218.66	216.5	BENIGN NEOPLASM OF SKIN OF TRUNK, EXCEPTSCROTUM
$210.80	401.9	UNSPECIFIED ESSENTIAL HYPERTENSION
$202.93	739.2	NONALLOPATHIC LESIONS OF THORACIC REGION, NOT ELSEWHERE CLASSIFIED
$177.37	337.9	UNSPECIFIED DISORDER OF AUTONOMIC NERVOUS SYSTEM
$171.23	789.00	OTHER SYMPTOMS INVOLVING ABDOMEN AND PELVIS
$155.58	216.3	BENIGN NEOPLASM OF SKIN OF OTHER AND UNSPECIFIED PARTS OF FACE
$155.18	780.52	INSOMNIA, UNSPECIFIED
$145.28	V72.81	PREOP CARDIOVSCLR EXAM
$100.50	238.2	NEOPLASM OF UNCERTAIN BEHAVIOR OF SKIN
$92.61	429.3	CARDIOMEGALY
$77.59	530.81	ESOPHAGEAL REFLUX
$77.59	716.90	UNSPECIFIED ARTHROPATHY, SITE UNSPECIFIED
$59.34	726.10	DISORDERS OF BURSAE AND TENDONS IN SHOULDER REGION, UNSPECIFIED
$55.06	790.4	NONSPECIFIC ELEVATION OF LEVELS OF TRANSAMINASE OR LACTIC ACID DEHYDROGENASE (LD
$50.54	780.39	CONVULSIONS;OTHER CONVULSIONS
$37.04	414.00	CORONARY ATHEROSCLEROSIS OF UNSPECIFIED TYPE OF VESSEL, NATIVE OR GRAFT
$35.24	372.30	CONJUNCTIVITIS, UNSPECIFIED
$30.69	592.0	CALCULUS OF KIDNEY
$29.06	373.11	HORDEOLUM EXTERNUM
$19.85	V15.82	Hx, prsnl, tobacco use

$25,021.01 Total Paid

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
327.23	OBSTRUCTIVE SLEEP APNEA (ADULT)	291.67	11/17/2013
739.2	NONALLOPATHIC LESIONS OF THORACIC REGION	202.93	05/01/2014
DRUGS	PRESCRIPTION DRUGS	3739.73	10/17/2014
401.9	UNSPECIFIED ESSENTIAL HYPERTENSION	210.80	09/04/2014
V58.69	LONG-TERM (CURRENT) USE OF OTHER		11/22/2013
V77.91	SCREENING FOR LIPOID DISORDERS		11/22/2013
V76.44	SPECIAL SCREENING FOR MALIGNANT NEOPLASM		11/22/2013
530.81	ESOPHAGEAL REFLUX	77.59	09/04/2014
780.52	INSOMNIA, UNSPECIFIED	155.18	09/04/2014
427.31	ATRIAL FIBRILLATION	447.96	06/26/2014
535.50	GSTR/DDNTS NOS W/O HMRHG		02/20/2014
780.57	UNSPECIFIED SLEEP APNEA		05/28/2014
790.4	NONSPECIFIC ELEVATION OF LEVELS OF TRANS	55.06	12/02/2013
790.21	IMPAIRED FASTING GLUCOSE		12/02/2013
337.9	UNSPECIFIED DISORDER OF AUTONOMIC NERVOU	177.37	11/14/2013
785.0	TACHYCARDIA, UNSPECIFIED		11/14/2013
530.11	REFLUX ESOPHAGITIS		11/14/2013
716.90	UNSPECIFIED ARTHROPATHY, SITE UNSPECIFIE	77.59	10/11/2013
110.3	DERMATOPHYTOSIS OF GROIN AND PERIANAL AR		10/11/2013
716.50	UNSPECIFIED POLYARTHROPATHY OR POLYARTHR		10/11/2013
726.10	DISORDERS OF BURSAE AND TENDONS IN SHOUL	59.34	12/16/2013

10/31/14 Allegiance Benefit Plan Management, Inc. PAGE: 129
LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 02 11/01/2013 to 10/31/2014 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
719.50	STIFFNESS OF JOINT, NOT ELSEWHERE CLASSI		12/16/2013
372.30	CONJUNCTIVITIS, UNSPECIFIED	35.24	12/26/2013
373.11	HORDEOLUM EXTERNUM	29.06	01/08/2014
785.1	PALPITATIONS		01/14/2014
401.1	BENIGN ESSENTIAL HYPERTENSION		01/31/2014
272.0	PURE HYPERCHOLESTEROLEMIA		01/31/2014
414.00	CORONARY ATHEROSCLEROSIS OF UNSPECIFIED	37.04	01/28/2014
434.91	CRBL ART OCL NOS W INFRC	1743.84	02/13/2014
278.00	OBESITY, UNSPECIFIED		02/13/2014
435.9	TRANSIENT CEREBRAL ISCHEMIA	9629.29	06/26/2014
780.4	DIZZINESS AND GIDDINESS		02/13/2014
272.4	OTHER AND UNSPECIFIED HYPERLIPIDEMIA		05/28/2014
437.3	CEREBRAL ANEURYSM, NONRUPTURED	4211.58	02/13/2014
368.9	UNSPECIFIED VISUAL DISTURBANCE		02/13/2014
780.2	SYNCOPE AND COLLAPSE		02/13/2014
436	ACUTE, BUT ILL-DEFINED, CEREBROVASCULAR	322.20	02/12/2014
V67.59	OTHER FOLLOW-UP EXAMINATION		02/12/2014
573.9	DISORDER OF LIVER		02/20/2014
429.3	CARDIOMEGALY	92.61	02/12/2014
780.39	CONVULSIONS;OTHER CONVULSIONS	50.54	02/12/2014
722.10	DISPLACEMENT OF LUMBAR INTERVERTEBRAL DI	630.00	04/30/2014
784.0	HEADACHE	417.60	02/12/2014
780.79	OTHER MALAISE AND FATIGUE		02/12/2014
600.20	BENIGN LOCALIZED HYPERPLASIA OF PROSTATE		05/28/2014
462	ACUTE PHARYNGITIS	225.00	06/04/2014
V72.81	PREOP CARDIOVSCLR EXAM	145.28	06/26/2014
522.5	PERIAPICAL ABSCESS WITHOUT SINUS		06/26/2014
V15.82	Hx, prsnl, tobacco use	19.85	09/04/2014
782.3	EDEMA		09/04/2014
789.00	OTHER SYMPTOMS INVOLVING ABDOMEN AND	171.23	09/23/2014
723.4	BRACHIAL NEURITIS OR RADICULITIS NOS	630.00	09/30/2014
722.11	DISPLACEMENT OF THORACIC INTERVERTEBRAL	630.00	09/30/2014
216.5	BENIGN NEOPLASM OF SKIN OF TRUNK, EXCEPT	218.66	10/02/2014
216.3	BENIGN NEOPLASM OF SKIN OF OTHER AND UNS	155.58	10/02/2014
216.6	BENIGN NEOPLASM OF SKIN OF UPPER LIMB, I		10/02/2014
216.7	BENIGN NEOPLASM OF SKIN OF LOWER LIMB, I		10/02/2014
592.0	CALCULUS OF KIDNEY	30.69	10/10/2014
238.2	NEOPLASM OF UNCERTAIN BEHAVIOR OF SKIN	100.50	10/02/2014

10/31/14 Allegiance Benefit Plan Management, Inc. PAGE: 130
LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 02 11/01/2013 to 10/31/2014 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

GROUP: 2001025 SSN: ********** SEQ: ** DIV: 0001 RELAT: Participant EFF: ********** DOB: ********** TERM: **********
LEVEL: P00 PLAN: WILCO-MED-EPO

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	00-*	250000.00	33.85	84634.06	.00	.00	.00	.00

==========Diagnosis Recap==========

Amount	Code	Description
$77,613.70	427.31	ATRIAL FIBRILLATION
$4,382.72	327.23	OBSTRUCTIVE SLEEP APNEA (ADULT) (PEDIATRIC)
$2,167.49	DRUGS	PRESCRIPTION DRUGS
$156.07	401.9	UNSPECIFIED ESSENTIAL HYPERTENSION
$97.96	173.20	Unspec malignt neoplsm ear/canal
$97.20	V58.61	LONG-TERM (CURRENT) USE OF ANTICOAGULANT
$67.00	427.81	SINOATRIAL NODE DYSFUNCTION
$35.63	V72.60	Laboratory examination, unspecified
$9.64	V72.81	PREOP CARDIOVSCLR EXAM
$6.65	790.29	OTHER ABNORMAL GLUCOSE

$84,634.06 Total Paid

Diagnosis Summary for **********	Amount Paid	Last D.O.S.
327.23 OBSTRUCTIVE SLEEP APNEA (ADULT)	4382.72	09/02/2014
DRUGS PRESCRIPTION DRUGS	2167.49	10/22/2014
427.31 ATRIAL FIBRILLATION	77613.70	04/24/2014
401.1 BENIGN ESSENTIAL HYPERTENSION		04/22/2014
272.2 Hyperlipidemia, mixed		10/01/2013
401.9 UNSPECIFIED ESSENTIAL HYPERTENSION	156.07	12/19/2013
V72.60 Laboratory examination, unspecified	35.63	11/04/2013
780.57 UNSPECIFIED SLEEP APNEA		12/19/2013
272.4 OTHER AND UNSPECIFIED HYPERLIPIDEMIA		12/19/2013
790.29 OTHER ABNORMAL GLUCOSE	6.65	12/03/2013
424.0 MITRAL VALVE DISORDERS		12/18/2013
173.20 Unspec malignt neoplsm ear/canal	97.96	10/02/2013
427.89 CARDIAC DYSRHYTHMIAS		12/19/2013
V72.81 PREOP CARDIOVSCLR EXAM	9.64	12/29/2013
V58.61 LONG-TERM (CURRENT) USE OF ANTICOAGULANT	97.20	01/29/2014
429.3 CARDIOMEGALY		12/19/2013
427.81 SINOATRIAL NODE DYSFUNCTION	67.00	03/06/2014

GROUP: 2001025 SSN: ********** SEQ: ** DIV: 0001 RELAT: Participant EFF: ********** DOB: ********** TERM: **********
LEVEL: F99 PLAN: WILCO-MED-EPO

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	00-*	250000.00	13.86	34637.79	.00	.00	.00	.00

==========Diagnosis Recap==========

Amount	Code	Description
$27,083.35	DRUGS	PRESCRIPTION DRUGS
$2,418.46	786.39	Symptom, other hemoptysis
$1,299.88	714.0	RHEUMATOID ARTHRITIS
$995.55	031.0	PULMONARY DISEASES DUE TO OTHER MYCOBACTERIA
$330.63	238.2	NEOPLASM OF UNCERTAIN BEHAVIOR OF SKIN
$330.41	727.1	BUNION
$317.29	793.19	Othr nonspecfc abnorml finding/lung
$254.71	V58.69	LONG-TERM (CURRENT) USE OF OTHER MEDICATIONS
$228.87	V76.12	OTHER SCREENING MAMMOGRAM
$159.36	V70.0	ROUTINE GENERAL MEDICAL EXAMINATION AT AHEALTH CARE FACILITY
$149.80	799.81	DECREASED LIBIDO
$135.37	V58.65	LONG-TERM (CURRENT) USE OF STEROIDS
$124.28	V07.4	HORMONE REPLACEMENT THERAPY (POSTMENOPAUSAL)
$118.10	729.5	PAIN IN LIMB
$111.15	448.1	NEVUS, NON-NEOPLASTIC
$106.74	786.2	COUGH
$102.34	727.3	OTHER BURSITIS DISORDERS
$90.28	355.6	LESION OF PLANTAR NERVE
$62.59	728.6	CONTRACTURE OF PALMAR FASCIA
$59.34	726.70	ENTHESOPATHY OF ANKLE AND TARSUS, UNSPECIFIED
$46.82	268.9	UNSPECIFIED VITAMIN D DEFICIENCY
$30.00	V04.81	NEED FOR PROPHYLACTIC VACCINATION/ INOCULATION AGAINST, INFLUENZA
$25.54	272.0	PURE HYPERCHOLESTEROLEMIA
$24.07	V76.51	SPECIAL SCREENING FOR MALIG NEOPL;COLON
$17.12	518.89	OTHER DISEASES OF LUNG, NOT ELSEWHERE CLASSIFIED
$15.74	995.20	UNSPECIFIED ADVERSE EFFECT OF UNSPEC- IFIED DRUG, MEDICINAL AND BIOLOGICAL SUB

$34,637.79 Total Paid

10/31/14 Allegiance Benefit Plan Management, Inc. PAGE: 131
LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
714.0	RHEUMATOID ARTHRITIS	1299.88	09/03/2014
V58.69	LONG-TERM (CURRENT) USE OF OTHER	254.71	09/03/2014
786.39	Symptom, other hemoptysis	2418.46	10/03/2013
793.19	Othr nonspecfc abnorml finding/lung	317.29	10/16/2014
518.89	OTHER DISEASES OF LUNG, NOT ELSEWHERE CL	17.12	02/13/2014
DRUGS	PRESCRIPTION DRUGS	27083.35	10/23/2014
031.0	PULMONARY DISEASES DUE TO OTHER MYCOBACT	995.55	10/09/2014
995.20	UNSPECIFIED ADVERSE EFFECT OF UNSPEC-	15.74	01/22/2014
727.1	BUNION	330.41	11/05/2013
355.6	LESION OF PLANTAR NERVE	90.28	01/20/2014
726.72	TIBIALIS TENDINITIS		12/09/2013
726.70	ENTHESOPATHY OF ANKLE AND TARSUS, UNSPEC	59.34	01/20/2014
V70.0	ROUTINE GENERAL MEDICAL EXAMINATION AT A	159.36	11/05/2013
272.4	OTHER AND UNSPECIFIED HYPERLIPIDEMIA		11/05/2013
244.9	UNSPECIFIED ACQUIRED HYPOTHYROIDISM		11/26/2013

10/31/14 Allegiance Benefit Plan Management, Inc. PAGE: 132
LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 02 11/01/2013 to 10/31/2014 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
780.52	INSOMNIA, UNSPECIFIED		11/05/2013
729.5	PAIN IN LIMB	118.10	01/20/2014
735.4	OTHER HAMMER TOE (ACQUIRED)		12/09/2013
E930.6	ANTIMYCOBACTERIAL ANTIBIOTICS CAUSING AD		11/18/2013
V76.51	SPECIAL SCREENING FOR MALIG NEOPL;COLON	24.07	11/26/2013
788.1	DYSURIA		11/26/2013
727.3	OTHER BURSITIS DISORDERS	102.34	01/20/2014
786.2	COUGH	106.74	02/13/2014
466.0	ACUTE BRONCHITIS		02/13/2014
E931.8	OTHER ANTIMYCOBACTERIAL DRUGS CAUSING AD		02/17/2014
238.2	NEOPLASM OF UNCERTAIN BEHAVIOR OF SKIN	330.63	03/05/2014
448.1	NEVUS, NON-NEOPLASTIC	111.15	03/05/2014
702.19	OTHER DERMATOSES;OTHER SEBORRHEIC		03/05/2014
V07.4	HORMONE REPLACEMENT THERAPY (POSTMENOPAU	124.28	03/05/2014
799.81	DECREASED LIBIDO	149.80	09/03/2014
728.6	CONTRACTURE OF PALMAR FASCIA	62.59	02/24/2014
V58.65	LONG-TERM (CURRENT) USE OF STEROIDS	135.37	02/17/2014
268.9	UNSPECIFIED VITAMIN D DEFICIENCY	46.82	09/03/2014
272.0	PURE HYPERCHOLESTEROLEMIA	25.54	09/03/2014
V76.12	OTHER SCREENING MAMMOGRAM	228.87	10/09/2014
V04.81	NEED FOR PROPHYLACTIC VACCINATION/	30.00	10/14/2014

GROUP: 2001025 SSN: ********** SEQ: ** DIV: 0001 RELAT: Participant EFF: ********** DOB: ********** TERM: **********
LEVEL: P00 PLAN: WILCO-MED-CORE

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	00-*	250000.00	18.05	45114.94	.00	.00	.00	.00

==========Diagnosis Recap==========

Amount	Code	Description
$23,583.43	730.08	ACUTE OSTEOMYELITIS INVOLVING OTHER SPECIFIED SITES
$8,293.26	724.2	LUMBAGO
$2,419.66	DRUGS	PRESCRIPTION DRUGS
$1,967.24	793.7	NONSPECIFIC ABNORMAL FINDINGS ON RADIOLOGICAL AND OTHER EXAMINATION OF MUSCULOSK
$1,447.85	722.93	OTHER AND UNSPECIFIED DISC DISORDER OF LUMBAR REGION
$1,120.37	847.2	LUMBAR SPRAIN
$1,017.32	724.5	BACKACHE, UNSPECIFIED
$713.30	728.85	SPASM OF MUSCLE
$689.99	999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEWHERE CLASSIFIED
$622.11	V76.12	OTHER SCREENING MAMMOGRAM
$517.66	722.6	DEGENERATION OF INTERVERTEBRAL DISC, SITE UNSPECIFIED
$320.94	780.60	Symptom, fever, unspecified
$297.32	627.2	MENOPAUSAL OR FEMALE CLIMACTERIC STATES
$226.93	702.11	SEBORRHEIC KERATISIS;INFLAMED SEBORRHEICKERATOSIS
$198.34	721.0	CERVICAL SPONDYLOSIS WITHOUT MYELOPATHY
$197.78	721.3	LUMBOSACRAL SPONDYLOSIS WITHOUT MYELOPATHY
$165.00	780.79	OTHER MALAISE AND FATIGUE
$158.28	V14.0	Hx, prsnl, penicillin allergy
$153.34	373.2	CHALAZION
$117.35	053.9	HERPES ZOSTER WITHOUT MENTION OF COMPLICATION
$116.25	216.5	BENIGN NEOPLASM OF SKIN OF TRUNK, EXCEPTSCROTUM
$106.31	V72.31	ROUTINE GYNECOLOGICAL EXAM
$98.77	424.90	ENDOCARDITIS, VALVE UNSPECIFIED, UNSPECIFIED CAUSE
$85.10	730.20	UNSPECIFIED OSTEOMYELITIS, SITE UNSPECIFIED
$68.38	307.42	PERSISTENT DISORDER OF INITIATING OR MAINTAINING SLEEP
$66.88	V04.81	NEED FOR PROPHYLACTIC VACCINATION/ INOCULATION AGAINST, INFLUENZA
$62.65	722.52	DEGENERATION OF LUMBAR OR LUMBOSACRAL INTERVERTEBRAL DISC
$55.39	311	DEPRESSIVE DISORDER, NOT ELSEWHERE CLASSIFIED
$48.34	373.11	HORDEOLUM EXTERNUM
$47.87	702.19	OTHER DERMATOSES;OTHER SEBORRHEIC KERATOSIS
$46.56	216.1	BENIGN NEOPLASM OF EYELID, INCLUDING CANTHUS
$42.17	733.02	IDIOPATHIC OSTEOPOROSIS
$27.33	730.03	ACUTE OSTEOMYELITIS INVOLVING FOREARM
$15.47	733.00	OSTEOPOROSIS, UNSPECIFIED

$45,114.94 Total Paid

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
V04.81	NEED FOR PROPHYLACTIC VACCINATION/	66.88	10/03/2014
627.2	MENOPAUSAL OR FEMALE CLIMACTERIC STATES	297.32	03/04/2014
DRUGS	PRESCRIPTION DRUGS	2419.66	10/17/2014
V72.31	ROUTINE GYNECOLOGICAL EXAM	106.31	03/04/2014
733.02	IDIOPATHIC OSTEOPOROSIS	42.17	03/20/2014
268.9	UNSPECIFIED VITAMIN D DEFICIENCY		03/20/2014
216.5	BENIGN NEOPLASM OF SKIN OF TRUNK, EXCEPT	116.25	08/19/2014
702.19	OTHER DERMATOSES;OTHER SEBORRHEIC	47.87	08/19/2014
V10.82	Hx, prsnl, malignant skin melanoma		08/19/2014
702.11	SEBORRHEIC KERATISIS;INFLAMED SEBORRHEIC	226.93	06/10/2014
V76.12	OTHER SCREENING MAMMOGRAM	622.11	03/04/2014
733.00	OSTEOPOROSIS, UNSPECIFIED	15.47	07/16/2014
780.79	OTHER MALAISE AND FATIGUE	165.00	03/04/2014
733.90	DISORDER OF BONE AND CARTILAGE, UNSPECIF		03/04/2014
373.11	HORDEOLUM EXTERNUM	48.34	03/11/2014
379.93	REDNESS OR DISCHARGE OF EYE		03/11/2014
379.91	PAIN IN OR AROUND EYE		03/11/2014
216.1	BENIGN NEOPLASM OF EYELID, INCLUDING CAN	46.56	03/28/2014
311	DEPRESSIVE DISORDER, NOT ELSEWHERE CLASS	55.39	04/09/2014
373.2	CHALAZION	153.34	05/09/2014

373.00	BLEPHARITIS, UNSPECIFIED		04/16/2014
724.5	BACKACHE, UNSPECIFIED	1017.32	07/16/2014
847.2	LUMBAR SPRAIN	1120.37	07/03/2014
E927.3	CUMULATIVE TRAUMA FROM REPETITIVE MOTION		07/03/2014
724.2	LUMBAGO	8293.26	08/29/2014
722.52	DEGENERATION OF LUMBAR OR LUMBOSACRAL IN	62.65	07/04/2014
737.30	SCOLIOSIS (AND KYPHOSCOLIOSIS), IDIOPATH		07/04/2014
730.08	ACUTE OSTEOMYELITIS INVOLVING OTHER SPEC	23583.43	08/19/2014
784.0	HEADACHE		07/16/2014
793.7	NONSPECIFIC ABNORMAL FINDINGS ON RADIOLO	1967.24	07/11/2014
722.10	DISPLACEMENT OF LUMBAR INTERVERTEBRAL DI		07/11/2014
721.3	LUMBOSACRAL SPONDYLOSIS WITHOUT MYELOPAT	197.78	07/12/2014
276.1	HYPOSMOLALITY AND/OR HYPONATREMIA		07/16/2014
238.4	POLYCYTHEMIA VERA		07/16/2014
300.00	ANXIETY STATE, UNSPECIFIED		10/08/2014

10/31/14 Allegiance Benefit Plan Management, Inc. PAGE: 134
LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 02 11/01/2013 to 10/31/2014 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
728.85	SPASM OF MUSCLE	713.30	07/10/2014
722.90	OTHER AND UNSPECIFIED DISC DISORDER OF U		07/16/2014
722.6	DEGENERATION OF INTERVERTEBRAL DISC, SIT	517.66	07/12/2014
V11.1	Hx, prsnl, affective disorders		07/04/2014
722.93	OTHER AND UNSPECIFIED DISC DISORDER OF L	1447.85	08/17/2014
V14.0	Hx, prsnl, penicillin allergy	158.28	07/18/2014
V14.2	Hx, prsnl, sulfonamides allergy		07/18/2014
V14.5	Hx, prsnl, narcotic allergy		07/18/2014
999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEW	689.99	09/25/2014
E928.9	UNSPECIFIED ACCIDENT		07/03/2014
E849.9	ACCIDENTS OCCURRING IN UNSPECIFIED PLACE		07/03/2014
730.20	UNSPECIFIED OSTEOMYELITIS, SITE UNSPECIF	85.10	08/29/2014
424.90	ENDOCARDITIS, VALVE UNSPECIFIED, UNSPECI	98.77	07/14/2014
780.60	Symptom, fever, unspecified	320.94	07/15/2014
288.60	NEUTROPENIA-LEUKOCYTOSIS, UNSPECIFIED		07/16/2014
721.0	CERVICAL SPONDYLOSIS WITHOUT MYELOPATHY	198.34	07/12/2014
730.03	ACUTE OSTEOMYELITIS INVOLVING FOREARM	27.33	08/11/2014
307.42	PERSISTENT DISORDER OF INITIATING OR MAI	68.38	10/08/2014
053.9	HERPES ZOSTER WITHOUT MENTION OF COMPLIC	117.35	10/17/2014

GROUP: 2001025 SSN: ********** SEQ: ** DIV: 0001 RELAT: Participant EFF: ********** DOB: ********** TERM: **********
LEVEL: F99 PLAN: WILCO-MED-DED

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	00-*	250000.00	17.40	43503.47	.00	.00	.00	.00

==========Diagnosis Recap==========

Amount	Code	Description
$42,365.05	DRUGS	PRESCRIPTION DRUGS
$495.69	257.2	OTHER TESTICULAR HYPOFUNCTION
$155.18	719.46	PAIN IN JOINT INVOLVING LOWER LEG
$148.32	607.85	PEYRONIE'S DISEASE
$110.00	842.11	SPRAIN OF CARPOMETACARPAL (JOINT) OF HAND
$103.26	717.3	OTHER AND UNSPECIFIED DERANGEMENT OF MEDIAL MENISCUS
$90.97	696.1	OTHER PSORIASIS AND SIMILAR DISORDERS
$35.00	463	ACUTE TONSILLITIS

$43,503.47 Total Paid

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
DRUGS	PRESCRIPTION DRUGS	42365.05	10/21/2014
607.85	PEYRONIE'S DISEASE	148.32	01/23/2014
257.2	OTHER TESTICULAR HYPOFUNCTION	495.69	06/23/2014
696.1	OTHER PSORIASIS AND SIMILAR DISORDERS	90.97	10/24/2014
V58.69	LONG-TERM (CURRENT) USE OF OTHER		04/04/2014
842.11	SPRAIN OF CARPOMETACARPAL (JOINT) OF HAN	110.00	04/05/2014
463	ACUTE TONSILLITIS	35.00	04/30/2014
717.3	OTHER AND UNSPECIFIED DERANGEMENT OF MED	103.26	07/09/2014
719.46	PAIN IN JOINT INVOLVING LOWER LEG	155.18	09/16/2014

GROUP: 2001025 SSN: ********** SEQ: ** DIV: 0001 RELAT: Spouse EFF: ********** DOB: ********** TERM: **********
LEVEL: F00 PLAN: WILCO-MED-EPO-DIAB

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	01-*	250000.00	39.12	97790.54	.00	.00	.00	.00

==========Diagnosis Recap==========

Amount	Code	Description
$81,247.69	338.4	CHRONIC PAIN SYNDROME
$8,500.37	V58.69	LONG-TERM (CURRENT) USE OF OTHER MEDICATIONS
$4,885.06	DRUGS	PRESCRIPTION DRUGS
$1,525.91	722.52	DEGENERATION OF LUMBAR OR LUMBOSACRAL INTERVERTEBRAL DISC
$597.40	999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEWHERE CLASSIFIED
$365.88	722.83	POSTLAMINECTOMY SYNDROME OF LUMBAR REGION
$340.20	296.32	MAJOR DEPRESSIVE AFFECTIVE DISORDER, RECURRENT EPISODE, MODERATE DEGREE
$164.39	721.3	LUMBOSACRAL SPONDYLOSIS WITHOUT MYELOPATHY
$85.09	346.71	Chronic migraine w/o aura
$78.55	244.9	UNSPECIFIED ACQUIRED HYPOTHYROIDISM

$97,790.54 Total Paid

10/31/14 Allegiance Benefit Plan Management, Inc. PAGE: 135
LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
V58.69	LONG-TERM (CURRENT) USE OF OTHER	8500.37	09/18/2014
304.01	OPIOID TYPE DEPENDENCE, CONTINUOUS USE		09/18/2014
338.4	CHRONIC PAIN SYNDROME	81247.69	10/16/2014
DRUGS	PRESCRIPTION DRUGS	4885.06	10/22/2014
722.83	POSTLAMINECTOMY SYNDROME OF LUMBAR REGIO	365.88	10/16/2014
722.93	OTHER AND UNSPECIFIED DISC DISORDER OF L		11/22/2013
724.2	LUMBAGO		10/25/2013
721.3	LUMBOSACRAL SPONDYLOSIS WITHOUT MYELOPAT	164.39	05/14/2014
722.52	DEGENERATION OF LUMBAR OR LUMBOSACRAL IN	1525.91	05/14/2014
724.4	THORACIC OR LUMBOSACRAL NEURITIS OR RADI		05/14/2014
296.32	MAJOR DEPRESSIVE AFFECTIVE DISORDER, REC	340.20	06/20/2014
244.9	UNSPECIFIED ACQUIRED HYPOTHYROIDISM	78.55	07/09/2014
346.71	Chronic migraine w/o aura	85.09	02/25/2014
346.90	Migraine NOS w/o migrain w/o status		07/09/2014
681.02	ONYCHIA AND PARONYCHIA OF FINGER		07/09/2014
311	DEPRESSIVE DISORDER, NOT ELSEWHERE CLASS		07/09/2014
999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEW	597.40	10/13/2014
493.90	ASTHMA, UNSPECIFIED TYPE		08/01/2014

GROUP: 2001025 SSN: ********** SEQ: ** DIV: 0001 RELAT: Spouse EFF: ********** DOB: ********** TERM: **********
LEVEL: F99 PLAN: WILCO-MED-CORE

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	01-*	250000.00	10.52	26305.08	.00	.00	.00	.00

==========Diagnosis Recap==========

Amount	Code	Description
$13,985.17	DRUGS	PRESCRIPTION DRUGS
$6,501.75	650	DELIVERY IN A COMPLETELY NORMAL CASE
$3,332.86	655.23	HEREDITARY DISEASE IN FAMILY POSSIBLY AFFECTING FETUS, AFFECTING MANAGEMENT OF M
$1,327.36	784.0	HEADACHE
$766.27	644.13	OTHER THREATENED LABOR, ANTEPARTUM
$184.39	V28.81	Encounter for fetal anatomic survey
$95.02	V22.1	SUPERVISION OF OTHER NORMAL PREGNANCY
$84.24	V04.81	NEED FOR PROPHYLACTIC VACCINATION/ INOCULATION AGAINST, INFLUENZA
$28.02	V23.41	Sprv preg w/hx of pre-term labor

$26,305.08 Total Paid

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
V22.1	SUPERVISION OF OTHER NORMAL PREGNANCY	95.02	04/10/2014
V28.89	Other specified antenatal screening		10/22/2013
V04.81	NEED FOR PROPHYLACTIC VACCINATION/	84.24	10/15/2013
655.23	HEREDITARY DISEASE IN FAMILY POSSIBLY AF	3332.86	12/17/2013
V23.41	Sprv preg w/hx of pre-term labor	28.02	04/10/2014
784.0	HEADACHE	1327.36	11/23/2013
787.01	OTHER SYMPTOMS INVOLVING DIGESTIVE		11/23/2013
338.19	OTHER ACUTE PAIN		11/23/2013
DRUGS	PRESCRIPTION DRUGS	13985.17	09/20/2014
V28.81	Encounter for fetal anatomic survey	184.39	12/18/2013
644.13	OTHER THREATENED LABOR, ANTEPARTUM	766.27	03/12/2014
650	DELIVERY IN A COMPLETELY NORMAL CASE	6501.75	04/14/2014
V27.0	MOTHER WITH SINGLE LIVEBORN		04/14/2014

GROUP: 2001025 SSN: ********** SEQ: ** DIV: 0001 RELAT: Child EFF: ********** DOB: ********** TERM: **********
LEVEL: F99 PLAN: WILCO-MED-CORE

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	12-*	750000.00	100.00	841379.29	91379.29	.00	90511.81	867.48

==========Diagnosis Recap==========

Amount	Code	Description
$660,732.21	V44.0	TRACHEOSTOMY STATUS
$33,626.15	330.0	LEUKODYSTROPHY
$31,968.18	569.69	COLOSTOMY/ENTEROSTOMY COMPLICATIONS; OTHER
$30,522.30	535.51	GSTR/DDNTS NOS W HMRHG
$23,717.44	V44.1	GASTROSTOMY STATUS
$10,689.26	783.3	FEEDING DIFFICULTIES AND MISMANAGEMENT
$9,554.21	518.89	OTHER DISEASES OF LUNG, NOT ELSEWHERE CLASSIFIED
$6,911.85	474.12	HYPERTROPHY OF ADENOIDS ALONE
$6,556.96	330.9	UNSPECIFIED CEREBRAL DEGENERATION IN CHILDHOOD
$6,204.30	781.3	LACK OF COORDINATION
$3,169.87	999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEWHERE CLASSIFIED
$3,070.24	518.83	OTHER DISEASE OF LUNG / CHRONIC RESPIRATORY FAILURE
$1,905.78	999.9	OTHER AND UNSPECIFIED COMPLICATIONS OF MEDICAL CARE, NOT ELSEWHERE CLASSIFIED
$1,422.02	787.20	DYSPHAGIA, UNSPECIFIED
$1,399.23	578.0	HEMATEMESIS
$1,347.84	754.79	OTHER CONGENITAL DEFORMITIES OF FEET
$1,156.85	341.8	OTHER DEMYELINATING DISEASES OF CENTRAL NERVOUS SYSTEM
$1,105.72	315.32	MIXED RECEPTIVE-EXPRESSIVE LANGUAGE DIS RDER
$971.25	DRUGS	PRESCRIPTION DRUGS
$886.08	578.9	HEMORRHAGE OF GASTROINTESTINAL TRACT, UNSPECIFIED
$813.30	564.9	UNSPECIFIED FUNCTIONAL DISORDER OF INTESTINE
$775.01	341.9	DEMYELINATING DISEASE OF CENTRAL NERVOUSSYSTEM, UNSPECIFIED
$518.70	V20.2	ROUTINE INFANT OR CHILD HEALTH CHECK
$455.78	718.44	CONTRACTURE OF HAND JOINT
$405.42	786.7	ABNORMAL CHEST SOUNDS
$304.20	728.85	SPASM OF MUSCLE
$229.02	527.7	DISTURBANCE OF SALIVARY SECRETION
$203.97	536.49	GASTROSTOMY COMPLICATIONS;OTHER
$182.52	345.41	PARTIAL EPILEPSY, WITH IMTRACTABLE EPILEPSY

10/31/14 Allegiance Benefit Plan Management, Inc. PAGE: 136
LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

$170.00	783.42	DELAYED MILESTONE (LATE WALKER, TALKER)
$144.07	536.42	GASTROSTOMY COMPLICATIONS;MECHANICAL COMPLICATION OF GASTROSTOMY
$97.50	V03.82	OTHER VACCINATIONS/SINGLE BACTERIAL DISEASE;STREPTOCOCCUS PNEUMONIA
$50.70	V03.81	OTHER VACCINATIONS/SINGLE BACTERIAL DISEASES;HEMOPHILIUS INFLUENZA, TYPE B
$39.00	V06.1	NEED FOR PROPHYLACTIC VACCINATION WITH COMBINED DIPHTHERIA-TETANUS-PERTUSSIS (DT
$24.33	787.03	SYMPTOMS INVOLVING DIGESTIVE SYSTEM VOMITING ALONE
$17.12	786.2	COUGH
$17.12	V58.82	FITTING AND ADJUSTMENT OF NONVASCULAR CATHETER, NEC
$13.79	562.10	DIVERTICULOSIS OF COLON

$841,379.29 Total Paid

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
V44.0	TRACHEOSTOMY STATUS	660732.21	09/30/2014
V44.1	GASTROSTOMY STATUS	23717.44	09/30/2014
496	CHRONIC AIRWAY OBSTRUCTION, NOT ELSEWHER		09/11/2014
518.89	OTHER DISEASES OF LUNG, NOT ELSEWHERE CL	9554.21	09/11/2014
330.0	LEUKODYSTROPHY	33626.15	08/23/2014
999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEW	3169.87	10/07/2014
DRUGS	PRESCRIPTION DRUGS	971.25	12/20/2013
728.85	SPASM OF MUSCLE	304.20	03/03/2014
527.7	DISTURBANCE OF SALIVARY SECRETION	229.02	03/26/2014
V03.81	OTHER VACCINATIONS/SINGLE BACTERIAL	50.70	10/15/2013
V03.82	OTHER VACCINATIONS/SINGLE BACTERIAL	97.50	10/15/2013
V06.1	NEED FOR PROPHYLACTIC VACCINATION WITH C	39.00	10/15/2013
783.42	DELAYED MILESTONE (LATE WALKER, TALKER)	170.00	10/08/2014
V04.82	NEED FOR PROPHYLACTIC VACCINATION/		11/15/2013
V04.81	NEED FOR PROPHYLACTIC VACCINATION/		11/15/2013
518.83	OTHER DISEASE OF LUNG / CHRONIC	3070.24	08/23/2014
359.0	CONGENITAL HEREDITARY MUSCULAR DYSTROPHY		03/26/2014
787.29	OTHER DYSPHAGIA		03/26/2014
783.3	FEEDING DIFFICULTIES AND MISMANAGEMENT	10689.26	08/22/2014
787.20	DYSPHAGIA, UNSPECIFIED	1422.02	08/11/2014
783.40	LACK OF NORMAL PHYSIOLOGICAL DEVELOPMENT		08/11/2014
478.30	UNSPECIFIED PARALYSIS OF VOCAL CORDS		10/08/2013
341.8	OTHER DEMYELINATING DISEASES OF CENTRAL	1156.85	11/21/2013
478.33	PARTIAL BILATERAL PARALYSIS OF VOCAL COR		11/21/2013
474.12	HYPERTROPHY OF ADENOIDS ALONE	6911.85	11/27/2013
747.0	PATENT DUCTUS ARTERIOSUS		11/27/2013

10/31/14 Allegiance Benefit Plan Management, Inc. PAGE: 137
LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 02 11/01/2013 to 10/31/2014 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
345.90	EPILEPSY, UNSPECIFIED, WITHOUT MENTION O		11/27/2013
330.9	UNSPECIFIED CEREBRAL DEGENERATION IN CHI	6556.96	02/07/2014
781.3	LACK OF COORDINATION	6204.30	09/18/2014
786.7	ABNORMAL CHEST SOUNDS	405.42	11/13/2013
315.9	UNSPECIFIED DELAY IN DEVELOPMENT		11/16/2013
718.44	CONTRACTURE OF HAND JOINT	455.78	09/19/2013
V58.82	FITTING AND ADJUSTMENT OF NONVASCULAR	17.12	08/21/2014
999.9	OTHER AND UNSPECIFIED COMPLICATIONS OF M	1905.78	08/23/2014
345.41	PARTIAL EPILEPSY, WITH IMTRACTABLE EPILE	182.52	06/17/2014
343.9	INFANTILE CEREBRAL PALSY,		06/17/2014
348.30	ENCEPHALOPATHY, UNSPECIFIED		06/17/2014
315.32	MIXED RECEPTIVE-EXPRESSIVE LANGUAGE DIS	1105.72	08/07/2014
315.39	OTHER DEVELOPMENTAL SPEECH OR LANGUAGE		08/11/2014
536.49	GASTROSTOMY COMPLICATIONS;OTHER	203.97	08/18/2014
536.42	GASTROSTOMY COMPLICATIONS;MECHANICAL	144.07	08/17/2014
998.11	HEMATOMA;SEROMA COMPLICATING A PROCEDURE		08/17/2014
754.79	OTHER CONGENITAL DEFORMITIES OF FEET	1347.84	08/14/2014
754.60	CONGENITAL TALIPES VALGUS		08/14/2014
786.2	COUGH	17.12	08/21/2014
562.10	DIVERTICULOSIS OF COLON	13.79	08/21/2014
787.03	SYMPTOMS INVOLVING DIGESTIVE SYSTEM	24.33	08/21/2014
569.69	COLOSTOMY/ENTEROSTOMY COMPLICATIONS;	31968.18	08/19/2014
578.9	HEMORRHAGE OF GASTROINTESTINAL TRACT, UN	886.08	08/19/2014
287.5	THROMBOCYTOPENIA, UNSPECIFIED		08/19/2014
377.75	CORTICAL BLINDNESS		08/23/2014
V55.4	ATTENTION TO OTHER ARTIFICIAL OPENING OF		08/22/2014
564.9	UNSPECIFIED FUNCTIONAL DISORDER OF INTES	813.30	08/22/2014
535.50	GSTR/DDNTS NOS W/O HMRHG		08/22/2014
578.0	HEMATEMESIS	1399.23	08/22/2014
535.51	GSTR/DDNTS NOS W HMRHG	30522.30	08/23/2014
V20.2	ROUTINE INFANT OR CHILD HEALTH CHECK	518.70	07/22/2014
787.01	OTHER SYMPTOMS INVOLVING DIGESTIVE		07/22/2014
341.9	DEMYELINATING DISEASE OF CENTRAL NERVOUS	775.01	09/18/2014
786.09	OTHER DYSPNEA AND RESPIRATORY ABNORMALIT		09/18/2014
933.1	FOREIGN BODY IN LARYNX		09/18/2014

GROUP: 2001025 SSN: ********** SEQ: ** DIV: 0001 RELAT: Participant EFF: ********** DOB: ********** TERM: **********
LEVEL: P99 PLAN: WILCO-MED-DED-DIAB

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	00-*	250000.00	16.78	41958.88	.00	.00	.00	.00

==========Diagnosis Recap==========

Amount	Code	Description
$14,252.90	311	DEPRESSIVE DISORDER, NOT ELSEWHERE CLASSIFIED
$5,044.58	780.2	SYNCOPE AND COLLAPSE
$3,107.53	620.2	OTHER AND UNSPECIFIED OVARIAN CYST
$2,746.70	296.50	BIPOLAR AFFECTIVE DISORDER, DEPRESSED, UNSPECIFIED DEGREE
$2,639.51	296.20	MAJOR DEPRESSIVE AFFECTIVE DISORDER, SINGLE EPISODE, UNSPECIFIED DEGREE
$2,390.02	719.43	PAIN IN JOINT INVOLVING FOREARM
$1,576.90	300.00	ANXIETY STATE, UNSPECIFIED
$1,388.34	DRUGS	PRESCRIPTION DRUGS
$1,320.74	296.33	MAJOR DEPRESSIVE AFFECTIVE DISORDER, RECURRENT EPISODE, SEVERE DEGREE, WITHOUT M
$1,283.74	300.9	UNSPECIFIED NONPSYCHOTIC MENTAL DISORDER
$1,088.94	781.2	ABNORMALITY OF GAIT
$799.92	296.80	BIPOLAR DISORDER,UNSPECIFIED
$750.30	625.9	UNSPECIFIED SYMPTOM ASSOCIATED WITH FEMALE GENITAL ORGANS
$584.89	992.5	HEAT EXHAUSTION, UNSPECIFIED
$421.96	786.05	SHORTNESS OF BREATH
$329.99	296.30	MAJOR DEPRESSIVE AFFECTIVE DISORDER, RECURRENT EPISODE, UNSPECIFIED DEGREE
$263.19	V72.31	ROUTINE GYNECOLOGICAL EXAM
$217.68	V25.11	Encounter for insertion of IUD
$201.53	296.53	BIPOLAR AFFECTIVE DISORDER, DEPRESSED, SEVERE DEGREE, WITHOUT MENTION OF PSYCHOT
$199.92	789.04	OTHER SYMPTOMS INVOLVING ABDOMEN AND PELVIS
$171.46	783.1	ABNORMAL WEIGHT GAIN
$147.73	465.9	ACUTE UPPER RESPIRATORY INFECTIONS OF UNSPECIFIED SITE
$141.48	V03.89	OTHER VACCINATIONS/SINGLE BACTERIAL DISEASE;OTHER SPECIFIED VACCINATION
$111.87	842.00	SPRAIN OF UNSPECIFIED SITE OF WRIST
$108.07	V01.89	OTHER COMMUNICABLE DISEASES
$104.69	682.3	CELLULITIS AND ABSCESS OF UPPER ARM AND FOREARM
$89.50	723.1	CERVICALGIA
$84.52	788.1	DYSURIA
$84.23	V58.69	LONG-TERM (CURRENT) USE OF OTHER MEDICATIONS
$81.85	729.5	PAIN IN LIMB
$72.55	300.02	GENERALIZED ANXIETY DISORDER
$65.72	784.0	HEADACHE
$29.00	V70.0	ROUTINE GENERAL MEDICAL EXAMINATION AT AHEALTH CARE FACILITY
$25.93	959.3	OTHER AND UNSPECIFIED INJURY TO ELBOW, FOREARM, AND WRIST
$20.45	789.00	OTHER SYMPTOMS INVOLVING ABDOMEN AND PELVIS
$10.55	V74.1	SCREENING EXAMINATION FOR PULMONARY TUBERCULOSIS

$41,958.88 Total Paid

10/31/14 Allegiance Benefit Plan Management, Inc. PAGE: 138
LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
788.1	DYSURIA	84.52	10/21/2013
599.0	URINARY TRACT INFECTION, SITE NOT SPECIF		10/21/2013
DRUGS	PRESCRIPTION DRUGS	1388.34	10/05/2014
682.3	CELLULITIS AND ABSCESS OF UPPER ARM AND	104.69	10/30/2013
V74.1	SCREENING EXAMINATION FOR PULMONARY TUBE	10.55	10/30/2013
296.50	BIPOLAR AFFECTIVE DISORDER, DEPRESSED, U	2746.70	10/28/2013
799.9	UNKNOWN/UNSPECIFIED CAUSE OF MORBIDITY		08/19/2014
V15.41	Hx, prsnl, physical abuse		10/28/2013
620.2	OTHER AND UNSPECIFIED OVARIAN CYST	3107.53	12/22/2013
614.9	UNSPECIFIED INFLAMMATORY DISEASE OF FEMA		12/22/2013
616.0	CERVICITIS AND ENDOCERVICITIS		12/22/2013
625.9	UNSPECIFIED SYMPTOM ASSOCIATED WITH FEMA	750.30	12/22/2013
623.8	OTHER SPECIFIED NONINFLAMMATORY DISORDER		12/22/2013
338.19	OTHER ACUTE PAIN		12/22/2013
789.00	OTHER SYMPTOMS INVOLVING ABDOMEN AND	20.45	12/22/2013
V70.0	ROUTINE GENERAL MEDICAL EXAMINATION AT A	29.00	12/11/2013
V03.89	OTHER VACCINATIONS/SINGLE BACTERIAL	141.48	12/11/2013
789.04	OTHER SYMPTOMS INVOLVING ABDOMEN AND	199.92	12/22/2013
627.1	POSTMENOPAUSAL BLEEDING		12/22/2013
626.4	IRREGULAR MENSTRUAL CYCLE		12/22/2013
V72.31	ROUTINE GYNECOLOGICAL EXAM	263.19	01/24/2014
V25.9	UNSPECIFIED CONTRACEPTIVE MANAGEMENT		01/24/2014
625.6	STRESS INCONTINENCE, FEMALE		01/24/2014
788.31	URGE INCONTINENCE		01/24/2014
V25.11	Encounter for insertion of IUD	217.68	02/13/2014
296.53	BIPOLAR AFFECTIVE DISORDER, DEPRESSED, S	201.53	06/26/2014
300.00	ANXIETY STATE, UNSPECIFIED	1576.90	08/05/2014
719.43	PAIN IN JOINT INVOLVING FOREARM	2390.02	02/24/2014
729.5	PAIN IN LIMB	81.85	02/21/2014
296.20	MAJOR DEPRESSIVE AFFECTIVE DISORDER, SIN	2639.51	12/04/2013
V71.09	OBSERVATION OF OTHER SUSPECTED MENTAL CO		12/04/2013
E888.8	OTHER FALL		02/22/2014
338.11	ACUTE PAIN DUE TO TRAUMA		02/22/2014

10/31/14 Allegiance Benefit Plan Management, Inc. PAGE: 139
LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 02 11/01/2013 to 10/31/2014 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
V15.59	Hx, prsnl, other injury		02/22/2014
V01.89	OTHER COMMUNICABLE DISEASES	108.07	02/24/2014
959.3	OTHER AND UNSPECIFIED INJURY TO ELBOW, F	25.93	02/22/2014
842.00	SPRAIN OF UNSPECIFIED SITE OF WRIST	111.87	02/24/2014
465.9	ACUTE UPPER RESPIRATORY INFECTIONS OF UN	147.73	05/22/2014
786.2	COUGH		05/22/2014
784.0	HEADACHE	65.72	06/18/2014
723.1	CERVICALGIA	89.50	06/18/2014
780.2	SYNCOPE AND COLLAPSE	5044.58	06/18/2014
847.0	NECK SPRAIN		06/18/2014
992.5	HEAT EXHAUSTION, UNSPECIFIED	584.89	06/18/2014
E900.0	ACCIDENT CAUSED BY EXCESSIVE HEAT DUE TO		06/18/2014
V72.41	PREGNANCY EXAMINATION OR TEST,NEGATIVE		06/18/2014
306.1	RESPIRATORY MALFUNCTION ARISING FROM MEN		06/22/2014
311	DEPRESSIVE DISORDER, NOT ELSEWHERE CLASS	14252.90	08/20/2014
296.90	UNSPECIFIED EPISODIC MOOD DISORDER		06/30/2014
300.02	GENERALIZED ANXIETY DISORDER	72.55	06/25/2014
300.01	PANIC DISORDER WITHOUT AGORAPHOBIA		06/25/2014
781.2	ABNORMALITY OF GAIT	1088.94	06/18/2014
780.97	ALTERED MENTAL STATUS		06/18/2014
786.05	SHORTNESS OF BREATH	421.96	06/22/2014
785.0	TACHYCARDIA, UNSPECIFIED		06/22/2014
300.9	UNSPECIFIED NONPSYCHOTIC MENTAL DISORDER	1283.74	07/01/2014
293.1	SUBACUTE DELIRIUM		07/01/2014
296.80	BIPOLAR DISORDER,UNSPECIFIED	799.92	07/02/2014
V58.69	LONG-TERM (CURRENT) USE OF OTHER	84.23	09/26/2014
V62.84	SUICIDAL IDEATION		08/05/2014
783.1	ABNORMAL WEIGHT GAIN	171.46	07/01/2014
V70.5	HEALTH EXAMINATION OF DEFINED SUBPOPULAT		07/01/2014
285.9	ANEMIA, UNSPECIFIED		07/02/2014
296.30	MAJOR DEPRESSIVE AFFECTIVE DISORDER, REC	329.99	09/26/2014
309.81	POSTTRAUMATIC STRESS DISORDER		09/26/2014
301.83	BORDERLINE PERSONALITY DISORDER		09/26/2014
296.33	MAJOR DEPRESSIVE AFFECTIVE DISORDER, REC	1320.74	08/20/2014
304.23	COCAINE DEPENDENCE, IN REMISSION		08/20/2014
307.47	OTHER DYSFUNCTIONS OF SLEEP STAGES OR AR		08/05/2014

GROUP: 2001025 SSN: ********** SEQ: ** DIV: 0001 RELAT: Spouse EFF: ********** DOB: ********** TERM: **********
LEVEL: F99 PLAN: WILCO-MED-DED

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	01-*	250000.00	100.00	367077.92	117077.92	115671.48	.00	1406.44

==========Diagnosis Recap==========

Amount	Code	Description
$317,006.05	721.1	CERVICAL SPONDYLOSIS WITH MYELOPATHY
$11,424.74	723.0	SPINAL STENOSIS IN CERVICAL REGION
$8,152.85	999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEWHERE CLASSIFIED
$6,321.37	V58.78	AFTERCARE FOLLOWING SURGERY OF THE MUSCULOSKELETAL SYSTEM, NEC
$4,696.25	354.0	CARPAL TUNNEL SYNDROME
$4,200.08	DRUGS	PRESCRIPTION DRUGS
$3,566.50	518.81	RESPIRATORY FAILURE
$2,577.28	519.8	OTHER DISEASES OF RESPIRATORY SYSTEM, NOT ELSEWHERE CLASSIFIED
$2,107.29	V64.1	SURGICAL OR OTHER PROCEDURE NOT CARRIED OUT BECAUSE OF CONTRAINDICATION
$1,323.02	723.1	CERVICALGIA
$1,007.02	724.9	OTHER UNSPECIFIED BACK DISORDERS
$813.68	438.20	HEMOPLEGIA/HEMIPARESIS AFFECTING UNSPECIFIED SIDE
$627.62	787.20	DYSPHAGIA, UNSPECIFIED
$418.46	250.00	DIABETES MELLITUS WITHOUT MENTION OF COMPLICATION, TYPE II
$363.15	782.3	EDEMA
$304.23	721.0	CERVICAL SPONDYLOSIS WITHOUT MYELOPATHY
$288.26	401.0	MALIGNANT ESSENTIAL HYPERTENSION
$198.34	722.4	DEGENERATION OF CERVICAL INTERVERTEBRAL DISC
$193.70	288.60	NEUTROPENIA-LEUKOCYTOSIS, UNSPECIFIED
$159.16	V58.82	FITTING AND ADJUSTMENT OF NONVASCULAR CATHETER, NEC
$145.42	311	DEPRESSIVE DISORDER, NOT ELSEWHERE CLASSIFIED
$145.28	V72.81	PREOP CARDIOVSCLR EXAM
$112.59	786.05	SHORTNESS OF BREATH
$106.54	478.6	EDEMA OF LARYNX
$101.54	780.79	OTHER MALAISE AND FATIGUE
$98.55	723.4	BRACHIAL NEURITIS OR RADICULITIS NOS
$97.92	309.0	ADJUSTMENT DISORDER WITH DEPRESSED MOOD
$92.93	784.49	Symptom othr voice resonance disodr
$72.07	786.2	COUGH
$70.20	518.84	OTHER DISEASES OF LUNG/ ACUTE & CHRONIC RESIPIRATORY FAILURE
$57.50	724.00	SPINAL STENOSIS OF UNSPECIFIED REGION
$51.36	V45.4	POSTSURGICAL ARTHRODESIS STATUS
$42.25	372.72	CONJUNCTIVAL HEMORRHAGE
$31.53	272.0	PURE HYPERCHOLESTEROLEMIA
$27.58	786.09	OTHER DYSPNEA AND RESPIRATORY ABNORMALITY
$17.12	511.9	UNSPECIFIED PLEURAL EFFUSION
$17.12	V72.82	PREOP RESPIRATORY EXAM
$13.79	793.19	Othr nonspecfc abnorml finding/lung
$13.79	780.60	Symptom, fever, unspecified
$13.79	514	PULMONARY CONGESTION AND HYPOSTASIS

$367,077.92 Total Paid

10/31/14 Allegiance Benefit Plan Management, Inc. PAGE: 141
LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 02 11/01/2013 to 10/31/2014 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
723.1	CERVICALGIA	1323.02	08/15/2014
724.2	LUMBAGO		11/05/2013
DRUGS	PRESCRIPTION DRUGS	4200.08	10/21/2014
354.0	CARPAL TUNNEL SYNDROME	4696.25	12/09/2013
780.79	OTHER MALAISE AND FATIGUE	101.54	11/08/2013
272.0	PURE HYPERCHOLESTEROLEMIA	31.53	11/08/2013
250.00	DIABETES MELLITUS WITHOUT MENTION OF	418.46	07/10/2014
724.00	SPINAL STENOSIS OF UNSPECIFIED REGION	57.50	02/14/2014
721.0	CERVICAL SPONDYLOSIS WITHOUT MYELOPATHY	304.23	03/28/2014
327.23	OBSTRUCTIVE SLEEP APNEA (ADULT)		12/09/2013
V72.81	PREOP CARDIOVSCLR EXAM	145.28	12/27/2013
721.1	CERVICAL SPONDYLOSIS WITH MYELOPATHY	317006.05	02/14/2014
414.01	CORONARY ATHEROSCLEROSIS;OF NATIVE		12/27/2013
401.1	BENIGN ESSENTIAL HYPERTENSION		01/27/2014
722.71	INTERVERTEBRAL DISC DISORDER WITH MYELOP		01/15/2014
722.4	DEGENERATION OF CERVICAL INTERVERTEBRAL	198.34	02/12/2014
723.0	SPINAL STENOSIS IN CERVICAL REGION	11424.74	08/15/2014
999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEW	8152.85	08/25/2014
401.0	MALIGNANT ESSENTIAL HYPERTENSION	288.26	02/09/2014
785.0	TACHYCARDIA, UNSPECIFIED		01/17/2014
724.9	OTHER UNSPECIFIED BACK DISORDERS	1007.02	02/09/2014
518.81	RESPIRATORY FAILURE	3566.50	02/21/2014
478.6	EDEMA OF LARYNX	106.54	02/14/2014
518.4	ACUTE EDEMA OF LUNG, UNSPECIFIED		02/14/2014
V46.13	ENCOUNTER FOR WEANING FROM RESPIRATOR		01/22/2014
519.8	OTHER DISEASES OF RESPIRATORY SYSTEM, NO	2577.28	02/21/2014
401.9	UNSPECIFIED ESSENTIAL HYPERTENSION		01/19/2014
414.00	CORONARY ATHEROSCLEROSIS OF UNSPECIFIED		02/21/2014
V72.82	PREOP RESPIRATORY EXAM	17.12	01/08/2014
723.4	BRACHIAL NEURITIS OR RADICULITIS NOS	98.55	02/18/2014
514	PULMONARY CONGESTION AND HYPOSTASIS	13.79	01/15/2014
V64.1	SURGICAL OR OTHER PROCEDURE NOT CARRIED	2107.29	02/14/2014
788.1	DYSURIA		01/28/2014
786.2	COUGH	72.07	01/22/2014
784.49	Symptom othr voice resonance disodr	92.93	01/22/2014
V45.4	POSTSURGICAL ARTHRODESIS STATUS	51.36	02/12/2014
786.05	SHORTNESS OF BREATH	112.59	01/27/2014
V44.0	TRACHEOSTOMY STATUS		02/13/2014
309.0	ADJUSTMENT DISORDER WITH DEPRESSED MOOD	97.92	01/29/2014
786.09	OTHER DYSPNEA AND RESPIRATORY ABNORMALIT	27.58	01/23/2014
V58.82	FITTING AND ADJUSTMENT OF NONVASCULAR	159.16	02/07/2014
414.9	CHRONIC ISCHEMIC HEART DISEASE, UNSPECIF		02/16/2014
288.60	NEUTROPENIA-LEUKOCYTOSIS, UNSPECIFIED	193.70	02/03/2014

10/31/14 Allegiance Benefit Plan Management, Inc. PAGE: 142
LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 02 11/01/2013 to 10/31/2014 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
490	BRONCHITIS, NOT SPECIFIED AS ACUTE OR CH		02/02/2014
999.9	OTHER AND UNSPECIFIED COMPLICATIONS OF M		02/08/2014
782.3	EDEMA	363.15	02/12/2014
787.20	DYSPHAGIA, UNSPECIFIED	627.62	04/16/2014
780.60	Symptom, fever, unspecified	13.79	01/31/2014
518.84	OTHER DISEASES OF LUNG/ ACUTE & CHRONIC	70.20	02/13/2014
507.0	PNEUMONITIS DUE TO INHALATION OF FOOD OR		01/31/2014
V41.6	PROBLEMS WITH SWALLOWING AND MASTICATION		02/14/2014
793.19	Othr nonspecfc abnorml finding/lung	13.79	01/21/2014
511.9	UNSPECIFIED PLEURAL EFFUSION	17.12	02/04/2014
909.3	LATE EFFECT OF COMPLICATIONS OF SURGICAL		02/14/2014
V58.78	AFTERCARE FOLLOWING SURGERY OF THE	6321.37	02/18/2014
276.1	HYPOSMOLALITY AND/OR HYPONATREMIA		02/18/2014
263.9	UNSPECIFIED PROTEIN-CALORIE MALNUTRITION		02/18/2014
586	RENAL FAILURE, UNSPECIFIED		02/11/2014
783.3	FEEDING DIFFICULTIES AND MISMANAGEMENT		02/14/2014
438.20	HEMOPLEGIA/HEMIPARESIS AFFECTING	813.68	02/14/2014
781.2	ABNORMALITY OF GAIT		02/21/2014
458.9	HYPOTENSION, UNSPECIFIED		02/14/2014
276.3	ALKALOSIS		02/14/2014
372.72	CONJUNCTIVAL HEMORRHAGE	42.25	04/03/2014
482.42	Methclln rest pneu d/t Staph aureus		02/16/2014
250.90	DIABETES WITH UNSPECIFIED COMPLICATION,		02/16/2014
311	DEPRESSIVE DISORDER, NOT ELSEWHERE CLASS	145.42	07/02/2014
791.9	OTHER NONSPECIFIC FINDINGS ON EXAMINATIO		05/07/2014
366.16	SENILE NUCLEAR SCLEROSIS		07/10/2014
363.32	OTHER MACULAR SCARS OF RETINA		07/10/2014

GROUP: 2001025 SSN: ********** SEQ: ** DIV: 0001 RELAT: Spouse EFF: ********** DOB: ********** TERM: **********
LEVEL: F99 PLAN: WILCO-MED-DED

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	01-*	250000.00	11.41	28519.38	.00	.00	.00	.00

==========Diagnosis Recap==========

Amount	Code	Description
$13,606.10	415.19	ACUTE PULMONARY HEART DISEASE
$4,955.03	664.11	SECOND-DEGREE PERINEAL LACERATION, WITH DELIVERY
$2,025.56	DRUGS	PRESCRIPTION DRUGS
$1,700.00	650	DELIVERY IN A COMPLETELY NORMAL CASE
$1,591.60	646.83	OTHER SPECIFIED ANTEPARTUM COMPLICATIONS
$1,484.11	V22.1	SUPERVISION OF OTHER NORMAL PREGNANCY
$1,053.60	786.09	OTHER DYSPNEA AND RESPIRATORY ABNORMALITY
$412.04	427.81	SINOATRIAL NODE DYSFUNCTION
$393.51	427.89	CARDIAC DYSRHYTHMIAS
$318.23	786.05	SHORTNESS OF BREATH
$216.72	656.63	EXCESSIVE FETAL GROWTH, AFFECTING MANAGEMENT OF MOTHER, ANTEPARTUM
$188.42	648.93	OTHER CURRENT CONDITIONS CLASSIFIABLE ELSEWHERE OF MOTHER, ANTEPARTUM
$156.46	626.0	ABSENCE OF MENSTRUATION
$139.32	V28.81	Encounter for fetal anatomic survey
$92.35	473.9	UNSPECIFIED SINUSITIS (CHRONIC)
$54.13	892.0	OPEN WOUND OF FOOT EXCEPT TOE(S) ALONE, WITHOUT MENTION OF COMPLICATION
$53.44	729.81	SWELLING OF LIMB
$38.19	V06.1	NEED FOR PROPHYLACTIC VACCINATION WITH COMBINED DIPHTHERIA-TETANUS-PERTUSSIS (DT
$37.87	V58.61	LONG-TERM (CURRENT) USE OF ANTICOAGULANT
$2.70	V58.83	ENCOUNTER/THERAPEUTIC DRUG MONITORING

$28,519.38 Total Paid

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
V22.1	SUPERVISION OF OTHER NORMAL PREGNANCY	1484.11	09/15/2014
626.0	ABSENCE OF MENSTRUATION	156.46	02/06/2014
656.53	POOR FETAL GROWTH, AFFECTING MANAGEMENT		02/06/2014
473.9	UNSPECIFIED SINUSITIS (CHRONIC)	92.35	04/09/2014
V06.1	NEED FOR PROPHYLACTIC VACCINATION WITH C	38.19	04/15/2014
V28.81	Encounter for fetal anatomic survey	139.32	04/17/2014
892.0	OPEN WOUND OF FOOT EXCEPT TOE(S) ALONE,	54.13	04/15/2014
DRUGS	PRESCRIPTION DRUGS	2025.56	10/21/2014
648.93	OTHER CURRENT CONDITIONS CLASSIFIABLE EL	188.42	05/30/2014
789.00	OTHER SYMPTOMS INVOLVING ABDOMEN AND		05/30/2014
656.63	EXCESSIVE FETAL GROWTH, AFFECTING MANAGE	216.72	08/11/2014
646.83	OTHER SPECIFIED ANTEPARTUM COMPLICATIONS	1591.60	09/20/2014
664.11	SECOND-DEGREE PERINEAL LACERATION, WITH	4955.03	09/24/2014
V27.0	MOTHER WITH SINGLE LIVEBORN		09/24/2014
663.31	OTHER AND UNSPECIFIED CORD ENTANGLEMENT,		09/24/2014
786.09	OTHER DYSPNEA AND RESPIRATORY ABNORMALIT	1053.60	09/28/2014
786.05	SHORTNESS OF BREATH	318.23	09/29/2014
427.89	CARDIAC DYSRHYTHMIAS	393.51	10/07/2014
650	DELIVERY IN A COMPLETELY NORMAL CASE	1700.00	09/22/2014
427.81	SINOATRIAL NODE DYSFUNCTION	412.04	10/07/2014
415.19	ACUTE PULMONARY HEART DISEASE	13606.10	10/17/2014
V58.61	LONG-TERM (CURRENT) USE OF ANTICOAGULANT	37.87	10/17/2014
V58.83	ENCOUNTER/THERAPEUTIC DRUG MONITORING	2.70	10/17/2014
285.9	ANEMIA, UNSPECIFIED		10/02/2014
785.6	ENLARGEMENT OF LYMPH NODES		10/02/2014
511.9	UNSPECIFIED PLEURAL EFFUSION		09/28/2014
789.2	SPLENOMEGALY		09/28/2014
729.81	SWELLING OF LIMB	53.44	09/28/2014

10/31/14 Allegiance Benefit Plan Management, Inc. PAGE: 143
LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP: 2001025 SSN: ********** SEQ: ** DIV: 0001 RELAT: Participant EFF: ********** DOB: ********** TERM: **********
LEVEL: P00 PLAN: WILCO-MED-CORE

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	00-*	250000.00	12.02	30045.30	.00	.00	.00	.00

==========Diagnosis Recap==========

Amount	Code	Description
$16,082.52	DRUGS	PRESCRIPTION DRUGS
$5,952.30	556.6	ULCERATIVE COLITIS;UNIVERSAL CHRONIC COLITIS
$1,986.70	556.9	ULCERATIVE COLITIS;UNSPECIFIED
$1,879.64	362.07	DIABETIC MACULAR EDEMA
$1,313.70	558.42	Eosinophilic colitis
$1,312.39	362.01	BACKGROUND DIABETIC RETINOPATHY
$673.97	556.5	ULCERATIVE COLITIS;LEFT SIDED CHRONIC COLITIS
$206.09	280.0	IRON DEFICIENCY ANEMIA SECONDARY TO BLOOD LOSS (CHRONIC)
$184.85	250.00	DIABETES MELLITUS WITHOUT MENTION OF COMPLICATION, TYPE II
$100.85	789.00	OTHER SYMPTOMS INVOLVING ABDOMEN AND PELVIS
$93.15	250.02	DIABETES MELLITUS WITHOUT MENTION OF COMPLICATION, TYPE II,UNCONTROLLED
$57.50	999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEWHERE CLASSIFIED
$45.05	794.9	NONSPECIFIC ABNORMAL RESULTS OF OTHER SPECIFIED FUNCTION STUDY
$45.05	285.9	ANEMIA, UNSPECIFIED
$42.99	V04.81	NEED FOR PROPHYLACTIC VACCINATION/ INOCULATION AGAINST, INFLUENZA
$36.11	V58.65	LONG-TERM (CURRENT) USE OF STEROIDS
$32.44	272.4	OTHER AND UNSPECIFIED HYPERLIPIDEMIA

$30,045.30 Total Paid

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
362.07	DIABETIC MACULAR EDEMA	1879.64	03/14/2014
DRUGS	PRESCRIPTION DRUGS	16082.52	10/21/2014
362.01	BACKGROUND DIABETIC RETINOPATHY	1312.39	03/14/2014
V04.81	NEED FOR PROPHYLACTIC VACCINATION/	42.99	11/19/2013
250.00	DIABETES MELLITUS WITHOUT MENTION OF	184.85	09/18/2014
272.4	OTHER AND UNSPECIFIED HYPERLIPIDEMIA	32.44	01/22/2014
401.1	BENIGN ESSENTIAL HYPERTENSION		11/19/2013
728.87	MUSCLE WEAKNESS (GENERALIZED)		11/19/2013
V70.0	ROUTINE GENERAL MEDICAL EXAMINATION AT A		01/22/2014
556.5	ULCERATIVE COLITIS;LEFT SIDED CHRONIC	673.97	10/21/2014
556.9	ULCERATIVE COLITIS;UNSPECIFIED	1986.70	03/27/2014
285.9	ANEMIA, UNSPECIFIED	45.05	08/12/2014
794.9	NONSPECIFIC ABNORMAL RESULTS OF OTHER SP	45.05	08/12/2014
556.6	ULCERATIVE COLITIS;UNIVERSAL CHRONIC	5952.30	05/28/2014
401.9	UNSPECIFIED ESSENTIAL HYPERTENSION		03/25/2014
276.50	VOLUME DEPLETION, UNSPECIFIED		03/25/2014
362.83	RETINAL EDEMA		03/25/2014
250.02	DIABETES MELLITUS WITHOUT MENTION OF	93.15	04/01/2014
V58.65	LONG-TERM (CURRENT) USE OF STEROIDS	36.11	04/01/2014
789.00	OTHER SYMPTOMS INVOLVING ABDOMEN AND	100.85	03/25/2014
787.91	OTHER SYMPTOMS INVOLVING DIGESTIVE		03/25/2014
280.0	IRON DEFICIENCY ANEMIA SECONDARY TO BLOO	206.09	09/18/2014

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LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 02 11/01/2013 to 10/31/2014 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEW	57.50	04/25/2014
556.3	ULCERATIVE COLITIS;CHRONIC PROCTOSIG-		05/19/2014
569.3	HEMORRHAGE OF RECTUM AND ANUS		08/12/2014
V58.67	LONG-TERM (CURRENT) USE OF INSULIN		03/26/2014
V74.1	SCREENING EXAMINATION FOR PULMONARY TUBE		08/14/2014
558.9	OTHER AND UNSPECIFIED NONINFECTIOUS GAST		09/18/2014
558.42	Eosinophilic colitis	1313.70	10/17/2014
569.82	ULCERATION OF INTESTINE		10/17/2014

GROUP: 2001025 SSN: ********** SEQ: ** DIV: 0001 RELAT: Child EFF: ********** DOB: ********** TERM: **********
LEVEL: F99 PLAN: WILCO-MED-CORE

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	12-*	250000.00	34.71	86763.38	.00	.00	.00	.00

==========Diagnosis Recap==========

Amount	Code	Description
$58,469.71	V30.01	SINGLE LIVEBORN, BORN IN HOSPITAL, DELIVERED BY CESAREAN SECTION
$11,980.18	769	RESPIRATORY DISTRESS SYNDROME IN NEWBORN
$7,288.77	770.81	PRIMARY APNEA OF NEWBORN
$3,734.61	DRUGS	PRESCRIPTION DRUGS
$2,267.07	V20.2	ROUTINE INFANT OR CHILD HEALTH CHECK
$814.17	578.1	MELENA
$606.06	558.3	ALLERGIC GASTROENTERITIS AND COLITIS
$498.33	999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEWHERE CLASSIFIED
$362.10	775.0	SYNDROME OF 'INFANT OF A DIABETIC MOTHER'
$277.10	765.19	PRETERM NEC 2500+G
$219.17	V50.2	ROUTINE OR RITUAL CIRCUMCISION
$122.00	739.2	NONALLOPATHIC LESIONS OF THORACIC REGION, NOT ELSEWHERE CLASSIFIED
$82.74	765.10	PRETERM INFANT NEC WTNOS
$41.37	770.89	OTHER RESPIRATORY PROBLEMS AFTER BIRTH

$86,763.38 Total Paid

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
769	RESPIRATORY DISTRESS SYNDROME IN NEWBORN	11980.18	12/12/2013
779.31	Disord stomach feeding prob NB		12/23/2013
775.0	SYNDROME OF 'INFANT OF A DIABETIC MOTHER	362.10	12/24/2013
765.19	PRETERM NEC 2500+G	277.10	12/24/2013
774.2	NEONATAL JAUNDICE ASSOCIATED WITH PRETER		12/11/2013
770.81	PRIMARY APNEA OF NEWBORN	7288.77	12/23/2013
V72.19	SPECIAL INVESTIGATIONS AND EXAMINATIONS-		12/13/2013
765.10	PRETERM INFANT NEC WTNOS	82.74	08/21/2014
765.20	SHORT GESTATION-UNSPEC WEEKS OF GESTATIO		12/18/2013
578.1	MELENA	814.17	01/23/2014
787.7	ABNORMAL FECES		02/20/2014
765.27	SHORT GESTATION 33-34 COMPLETED WEEKS OF		05/29/2014
770.89	OTHER RESPIRATORY PROBLEMS AFTER BIRTH	41.37	12/09/2013
DRUGS	PRESCRIPTION DRUGS	3734.61	09/02/2014
V30.01	SINGLE LIVEBORN, BORN IN HOSPITAL, DELIV	58469.71	12/29/2013
777.50	Necrot enterocol in newborn unspec		12/09/2013
771.81	SEPTICEMIA IN NEWBORN		12/09/2013
V50.2	ROUTINE OR RITUAL CIRCUMCISION	219.17	12/23/2013
V20.2	ROUTINE INFANT OR CHILD HEALTH CHECK	2267.07	10/17/2014
V15.02	Hx, prsnl, allergy, milk product		01/13/2014
530.81	ESOPHAGEAL REFLUX		05/29/2014
558.3	ALLERGIC GASTROENTERITIS AND COLITIS	606.06	08/21/2014
999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEW	498.33	02/25/2014
739.2	NONALLOPATHIC LESIONS OF THORACIC REGION	122.00	02/05/2014
739.1	NONALLOPATHIC LESIONS OF CERVICAL REGION		02/05/2014
739.3	NONALLOPATHIC LESIONS OF LUMBAR REGION,		02/05/2014

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LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 02 11/01/2013 to 10/31/2014 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

GROUP: 2001025 SSN: ********** SEQ: ** DIV: 0001 RELAT: Participant EFF: ********** DOB: ********** TERM: **********
LEVEL: P99 PLAN: WILCO-MED-EPO

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	00-*	250000.00	12.07	30168.92	.00	.00	.00	.00

==========Diagnosis Recap==========

Amount	Code	Description
$6,590.00	V16.3	FAMILY HISTORY OF MALIGNANT NEOPLASM OF BREAST
$4,448.98	611.1	HYPERTROPHY OF BREAST
$3,951.01	228.09	HEMANGIOMA OF OTHER SITES
$1,438.25	535.40	OTH SPF GSTRT W/O HMRHG
$1,425.94	DRUGS	PRESCRIPTION DRUGS
$1,406.81	719.46	PAIN IN JOINT INVOLVING LOWER LEG
$1,346.91	787.03	SYMPTOMS INVOLVING DIGESTIVE SYSTEM VOMITING ALONE
$1,133.83	786.50	UNSPECIFIED CHEST PAIN
$982.50	535.10	ATRPH GASTRTIS W/O HMRHG
$891.69	787.60	Symptom, full incontinence feces
$853.03	724.5	BACKACHE, UNSPECIFIED
$803.20	386.11	BENIGN PAROXYSMAL POSITIONAL VERTIGO
$669.00	715.16	OSTEOARTHROSIS, LOCALIZED, PRIMARY, INVOLVING LOWER LEG
$630.00	724.4	THORACIC OR LUMBOSACRAL NEURITIS OR RADICULITIS
$516.28	844.9	SPRAIN OF UNSPECIFIED SITE OF KNEE AND LEG
$493.09	724.1	PAIN IN THORACIC SPINE
$439.24	V82.71	SPECIAL SCREENING FOR OTHER CONDITIONS- SCREENING FOR GENETIC DISEASE CARRIER
$382.35	729.2	NEURALGIA, NEURITIS, AND RADICULITIS, UNSPECIFIED
$327.28	729.1	MYALGIA AND MYOSITIS, UNSPECIFIED
$250.37	789.00	OTHER SYMPTOMS INVOLVING ABDOMEN AND PELVIS
$233.45	336.9	UNSPECIFIED DISEASE OF SPINAL CORD
$157.65	789.02	OTHER SYMPTOMS INVOLVING ABDOMEN AND PELVIS
$153.28	722.51	DEGENERATION OF THORACIC OR THORACOLUMBAR INTERVERTEBRAL DISC
$153.28	787.3	FLATULENCE, ERUCTATION, AND GAS PAIN
$92.35	787.62	Symptom, fecal smearing
$90.37	721.1	CERVICAL SPONDYLOSIS WITH MYELOPATHY
$74.16	V70.0	ROUTINE GENERAL MEDICAL EXAMINATION AT AHEALTH CARE FACILITY
$65.72	780.4	DIZZINESS AND GIDDINESS
$62.59	228.00	HEMANGIOMA OF UNSPECIFIED SITE
$43.38	401.1	BENIGN ESSENTIAL HYPERTENSION
$30.21	706.1	OTHER ACNE
$24.79	780.79	OTHER MALAISE AND FATIGUE
$7.93	599.0	URINARY TRACT INFECTION, SITE NOT SPECIFIED

$30,168.92 Total Paid

Diagnosis Summary for **********	Amount Paid	Last D.O.S.
780.4 DIZZINESS AND GIDDINESS	65.72	04/11/2014
DRUGS PRESCRIPTION DRUGS	1425.94	10/10/2014
706.1 OTHER ACNE	30.21	12/30/2013
709.9 UNSPECIFIED DISORDER OF SKIN AND SUBCUTA		12/30/2013
709.00 DYSCHROMIA;UNSPECIFIED		12/30/2013
386.11 BENIGN PAROXYSMAL POSITIONAL VERTIGO	803.20	10/07/2013
401.9 UNSPECIFIED ESSENTIAL HYPERTENSION		06/04/2014
401.1 BENIGN ESSENTIAL HYPERTENSION	43.38	10/14/2013
780.79 OTHER MALAISE AND FATIGUE	24.79	02/19/2014
787.3 FLATULENCE, ERUCTATION, AND GAS PAIN	153.28	03/14/2014
787.99 OTHER SYMPTOMS INVOLVING DIGESTIVE		03/03/2014
787.60 Symptom, full incontinence feces	891.69	06/09/2014
787.02 OTHER SYMPTOMS OF THE DIGESTIVE SYSTEM;		03/14/2014
787.62 Symptom, fecal smearing	92.35	02/19/2014
783.1 ABNORMAL WEIGHT GAIN		02/19/2014
692.9 CONTACT DERMATITIS AND OTHER ECZEMA, UNS		02/19/2014
789.02 OTHER SYMPTOMS INVOLVING ABDOMEN AND	157.65	03/14/2014
535.40 OTH SPF GSTRT W/O HMRHG	1438.25	03/03/2014
455.0 INTERNAL HEMORRHOIDS WITHOUT MENTION OF		03/03/2014
553.3 DIAPHRAGMATIC HERNIA WITHOUT MENTION OF		03/03/2014
530.19 OTHER ESOPHAGITIS		03/03/2014
530.11 REFLUX ESOPHAGITIS		03/03/2014

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LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 02 11/01/2013 to 10/31/2014 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
535.10	ATRPH GASTRTIS W/O HMRHG	982.50	03/03/2014
789.00	OTHER SYMPTOMS INVOLVING ABDOMEN AND	250.37	03/25/2014
724.1	PAIN IN THORACIC SPINE	493.09	08/02/2014
724.4	THORACIC OR LUMBOSACRAL NEURITIS OR RADI	630.00	03/21/2014
793.99	OTHER NONSPECIFIC ABNORMAL FINDINGS ON		03/25/2014
336.9	UNSPECIFIED DISEASE OF SPINAL CORD	233.45	04/12/2014
724.5	BACKACHE, UNSPECIFIED	853.03	06/10/2014
228.09	HEMANGIOMA OF OTHER SITES	3951.01	07/10/2014
611.79	OTHER SIGNS AND SYMPTOMS IN BREAST		04/25/2014
729.1	MYALGIA AND MYOSITIS, UNSPECIFIED	327.28	04/11/2014
729.2	NEURALGIA, NEURITIS, AND RADICULITIS, UN	382.35	04/11/2014
721.1	CERVICAL SPONDYLOSIS WITH MYELOPATHY	90.37	03/26/2014
784.0	HEADACHE		04/11/2014
787.01	OTHER SYMPTOMS INVOLVING DIGESTIVE		05/01/2014
V70.0	ROUTINE GENERAL MEDICAL EXAMINATION AT A	74.16	04/25/2014
268.9	UNSPECIFIED VITAMIN D DEFICIENCY		04/25/2014
786.50	UNSPECIFIED CHEST PAIN	1133.83	04/14/2014
722.51	DEGENERATION OF THORACIC OR THORACOLUMBA	153.28	04/16/2014
847.1	THORACIC SPRAIN		04/16/2014
V82.71	SPECIAL SCREENING FOR OTHER CONDITIONS-	439.24	05/17/2014
V16.3	FAMILY HISTORY OF MALIGNANT NEOPLASM OF	6590.00	05/17/2014
787.03	SYMPTOMS INVOLVING DIGESTIVE SYSTEM	1346.91	05/15/2014
V58.69	LONG-TERM (CURRENT) USE OF OTHER		05/15/2014
305.50	OPIOID ABUSE, UNSPECIFIED USE		05/15/2014
719.46	PAIN IN JOINT INVOLVING LOWER LEG	1406.81	06/25/2014
338.19	OTHER ACUTE PAIN		06/18/2014
715.16	OSTEOARTHROSIS, LOCALIZED, PRIMARY, INVO	669.00	07/01/2014
278.00	OBESITY, UNSPECIFIED		09/24/2014
844.9	SPRAIN OF UNSPECIFIED SITE OF KNEE AND L	516.28	06/04/2014
401.0	MALIGNANT ESSENTIAL HYPERTENSION		06/04/2014
E927.0	Overextension from sudden strenuous		06/04/2014
724.2	LUMBAGO		06/09/2014
611.1	HYPERTROPHY OF BREAST	4448.98	09/24/2014
228.00	HEMANGIOMA OF UNSPECIFIED SITE	62.59	05/01/2014
610.3	FIBROSCLEROSIS OF BREAST		09/23/2014
V85.36	BODY MASS INDEX 36.0-36.9, ADULT		09/24/2014
V15.07	Hx, prsnl, allergy, latex		09/24/2014
599.0	URINARY TRACT INFECTION, SITE NOT SPECIF	7.93	10/08/2014

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LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 02 11/01/2013 to 10/31/2014 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

GROUP: 2001025 SSN: ********** SEQ: ** DIV: 0001 RELAT: Child EFF: ********** DOB: ********** TERM: **********
LEVEL: P99 PLAN: WILCO-MED-DED

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	11-*	250000.00	14.42	36041.12	.00	.00	.00	.00

==========Diagnosis Recap==========

Amount	Code	Description
$24,767.88	236.4	NEOPLASM OF UNCERTAIN BEHAVIOR OF TESTIS
$3,296.15	381.4	NONSUPPURATIVE OTITIS MEDIA, NOT SPECIFIED AS ACUTE OR CHRONIC
$2,876.50	608.89	OTHER SPECIFIED DISORDERS OF MALE GENITAL ORGANS
$1,071.37	V30.00	SINGLE LIVEBORN, BORN IN HOSPITAL, DELIVERED WITHOUT MENTION OF CESAREAN SECTION
$654.08	V20.2	ROUTINE INFANT OR CHILD HEALTH CHECK
$498.10	V50.2	ROUTINE OR RITUAL CIRCUMCISION
$446.08	V03.82	OTHER VACCINATIONS/SINGLE BACTERIAL DISEASE;STREPTOCOCCUS PNEUMONIA
$415.76	V06.3	NEED FOR PROPHYLACTIC VACCINATION WITH DIPTHERIA-TETANUS- PERTUSSIS WITH POLIOMY
$392.00	784.2	Symptom, swelling in head/neck
$287.46	381.3	OTHER AND UNSPECIFIED CHRONIC NONSUPPURATIVE OTITIS MEDIA
$276.59	V04.89	NEED FOR PROPHYLACTIC VACCINATION/ INOCULATION AGAINST, OTHER VIRAL DISEASE
$164.50	756.10	CONGENITAL ANOMALY OF SPINE, UNSPECIFIED
$121.94	782.2	LOCALIZED SUPERFICIAL SWELLING, MASS, ORLUMP
$120.17	381.01	ACUTE SEROUS OTITIS MEDIA
$109.59	V20.32	Health super, N/B 8-28 days old
$94.59	V20.31	Health super, N/B under 8 day old
$86.76	478.19	OTHER DISEASES OF UPPER RESPIRATORY TRACT-OTHER DISEASES OF NASAL CAVITY
$86.28	780.60	Symptom, fever, unspecified
$77.59	382.00	ACUTE SUPPURATIVE OTITIS MEDIA WITHOUT SPONTANEOUS RUPTURE OF EARDRUM
$47.19	V04.81	NEED FOR PROPHYLACTIC VACCINATION/ INOCULATION AGAINST, INFLUENZA
$43.38	608.9	UNSPECIFIED DISORDER OF MALE GENITAL ORGANS
$43.38	057.9	VIRAL EXANTHEM, UNSPECIFIED
$31.16	DRUGS	PRESCRIPTION DRUGS
$23.93	V05.3	NEED PRPHYL VC VRL HEPAT
$8.69	786.2	COUGH

$36,041.12 Total Paid

Diagnosis Summary for **********	Amount Paid	Last D.O.S.
V30.00 SINGLE LIVEBORN, BORN IN HOSPITAL, DELIV	1071.37	11/26/2013
V05.3 NEED PRPHYL VC VRL HEPAT	23.93	01/24/2014
V20.32 Health super, N/B 8-28 days old	109.59	12/09/2013
V20.31 Health super, N/B under 8 day old	94.59	11/29/2013
V72.19 SPECIAL INVESTIGATIONS AND EXAMINATIONS-		11/26/2013
V50.2 ROUTINE OR RITUAL CIRCUMCISION	498.10	11/26/2013
782.2 LOCALIZED SUPERFICIAL SWELLING, MASS, OR	121.94	12/18/2013
756.10 CONGENITAL ANOMALY OF SPINE, UNSPECIFIED	164.50	12/18/2013
784.2 Symptom, swelling in head/neck	392.00	12/20/2013
V20.2 ROUTINE INFANT OR CHILD HEALTH CHECK	654.08	08/29/2014
V06.3 NEED FOR PROPHYLACTIC VACCINATION WITH D	415.76	05/23/2014
V03.82 OTHER VACCINATIONS/SINGLE BACTERIAL	446.08	05/23/2014
V04.89 NEED FOR PROPHYLACTIC VACCINATION/	276.59	05/23/2014
478.19 OTHER DISEASES OF UPPER RESPIRATORY	86.76	06/28/2014
786.2 COUGH	8.69	03/03/2014
382.00 ACUTE SUPPURATIVE OTITIS MEDIA WITHOUT S	77.59	06/07/2014
372.00 ACUTE CONJUNCTIVITIS, UNSPECIFIED		05/12/2014
DRUGS PRESCRIPTION DRUGS	31.16	10/17/2014
780.60 Symptom, fever, unspecified	86.28	06/28/2014
057.9 VIRAL EXANTHEM, UNSPECIFIED	43.38	06/16/2014
462 ACUTE PHARYNGITIS		06/28/2014
381.01 ACUTE SEROUS OTITIS MEDIA	120.17	09/29/2014
381.4 NONSUPPURATIVE OTITIS MEDIA, NOT SPECIFI	3296.15	10/17/2014
236.4 NEOPLASM OF UNCERTAIN BEHAVIOR OF TESTIS	24767.88	09/11/2014
608.9 UNSPECIFIED DISORDER OF MALE GENITAL ORG	43.38	09/10/2014
465.9 ACUTE UPPER RESPIRATORY INFECTIONS OF UN		09/10/2014
608.89 OTHER SPECIFIED DISORDERS OF MALE GENITA	2876.50	09/11/2014
787.03 SYMPTOMS INVOLVING DIGESTIVE SYSTEM		09/11/2014
757.39 OTHER SPECIFIED CONGENITAL ANOMALIES OF		09/11/2014
338.18 OTHER ACUTE POSTOPERATIVE PAIN		09/11/2014
V04.81 NEED FOR PROPHYLACTIC VACCINATION/	47.19	09/29/2014

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LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 02 11/01/2013 to 10/31/2014 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

Diagnosis Summary for **********	Amount Paid	Last D.O.S.
381.3 OTHER AND UNSPECIFIED CHRONIC NONSUPPURA	287.46	10/17/2014

GROUP: 2001025 SSN: ********** SEQ: ** DIV: 0001 RELAT: Child EFF: ********** DOB: ********** TERM: **********
LEVEL: F99 PLAN: WILCO-MED-DED

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	11-*	250000.00	26.97	67430.86	.00	.00	.00	.00

Diagnosis Recap

Amount	Code	Description
$40,711.50	801.26	CLOSED FRACTURE OF BASE OF SKULL WITH SUBARACHNOID, SUBDURAL, AND EXTRADURAL HEM
$13,735.24	V57.89	CARE INVOLVING OTHER SPECIFIED REHABILITATION PROCEDURE
$3,584.49	852.20	SUBDURAL HEMORRHAGE FOLLOWING INJURY, WITHOUT MENTION OF OPEN INTRACRANIAL WOUND
$1,989.81	431	INTRACEREBRAL HEMORRHAGE
$1,440.27	V57.3	Speech-language therapy
$1,024.95	852.26	SUBDURAL HEMORRHAGE FOLLOWING INJURY, WITHOUT MENTION OF OPEN INTRACRANIAL WOUND
$920.00	853.01	OTHER AND UNSPECIFIED INTRACRANIAL HEMORRHAGE FOLLOWING INJURY, WITHOUT MENTION
$613.33	999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEWHERE CLASSIFIED
$510.50	860.4	TRAUMATIC PNEUMOHEMOTHORAX WITHOUT MENTION OF OPEN WOUND INTO THORAX
$502.28	780.60	Symptom, fever, unspecified
$385.09	518.81	RESPIRATORY FAILURE
$252.74	310.2	POSTCONCUSSION SYNDROME
$240.24	507.0	PNEUMONITIS DUE TO INHALATION OF FOOD ORVOMITUS
$199.52	854.00	INTRACRANIAL INJURY OF OTHER AND UNSPECIFIED NATURE, WITHOUT MENTION OF OPEN INT
$197.16	959.01	HEAD INJURY, UNSPECIFIED
$188.05	959.09	INJURY OF FACE AND NECK
$184.61	966.0	POISONING BY OXAZOLIDINE DERIVATIVES
$179.00	959.19	OTHER INJURY OF OTHER SITES OF TRUNK
$145.83	959.11	OTHER INJURY OF CHEST WALL
$144.07	959.12	OTHER INJURY OF ABDOMEN
$99.47	802.4	CLOSED FRACTURE OF MALAR AND MAXILLARY BONES
$88.76	V58.89	OTHER SPECIFIED AFTERCARE
$52.58	432.9	UNSPECIFIED INTRACRANIAL HEMORRHAGE
$13.79	V58.81	FITTING AND ADJUSTMENT OF VASCULAR CATHETER
$13.79	V58.82	FITTING AND ADJUSTMENT OF NONVASCULAR CATHETER, NEC
$13.79	511.9	UNSPECIFIED PLEURAL EFFUSION

$67,430.86 Total Paid

Diagnosis Summary for **********	Amount Paid	Last D.O.S.
431 INTRACEREBRAL HEMORRHAGE	1989.81	12/21/2013
852.20 SUBDURAL HEMORRHAGE FOLLOWING INJURY, WI	3584.49	04/08/2014
518.81 RESPIRATORY FAILURE	385.09	12/26/2013
511.9 UNSPECIFIED PLEURAL EFFUSION	13.79	12/24/2013
999 COMPLICATIONS OF MEDICAL CARE, NOT ELSEW	613.33	02/25/2014
959.09 INJURY OF FACE AND NECK	188.05	12/24/2013
959.01 HEAD INJURY, UNSPECIFIED	197.16	12/31/2013
959.19 OTHER INJURY OF OTHER SITES OF TRUNK	179.00	12/21/2013
507.0 PNEUMONITIS DUE TO INHALATION OF FOOD OR	240.24	01/02/2014
432.1 SUBDURAL HEMORRHAGE		12/25/2013
288.60 NEUTROPENIA-LEUKOCYTOSIS, UNSPECIFIED		12/22/2013
310.2 POSTCONCUSSION SYNDROME	252.74	12/28/2013

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LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 02 11/01/2013 to 10/31/2014 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
486	PNEUMONIA, ORGANISM UNSPECIFIED		12/28/2013
285.9	ANEMIA, UNSPECIFIED		12/28/2013
787.20	DYSPHAGIA, UNSPECIFIED		12/28/2013
780.60	Symptom, fever, unspecified	502.28	12/27/2013
518.0	PULMONARY COLLAPSE		12/24/2013
807.09	CLOSED FRACTURE OF MULTIPLE RIBS, UNSPEC		12/25/2013
959.12	OTHER INJURY OF ABDOMEN	144.07	12/21/2013
959.11	OTHER INJURY OF CHEST WALL	145.83	12/22/2013
432.9	UNSPECIFIED INTRACRANIAL HEMORRHAGE	52.58	12/22/2013
V58.82	FITTING AND ADJUSTMENT OF NONVASCULAR	13.79	12/21/2013
V58.81	FITTING AND ADJUSTMENT OF VASCULAR	13.79	12/21/2013
854.00	INTRACRANIAL INJURY OF OTHER AND UNSPECI	199.52	01/23/2014
799.52	Signs/cognitive communicat deficit		08/08/2014
477.9	ALLERGIC RHINITIS, CAUSE UNSPECIFIED		01/23/2014
372.14	OTHER CHRONIC ALLERGIC CONJUNCTIVITIS		01/23/2014
801.26	CLOSED FRACTURE OF BASE OF SKULL WITH SU	40711.50	12/27/2013
866.02	LACERATION OF KIDNEY WITHOUT MENTION OF		12/27/2013
E826.1	PEDAL CYCLE ACCIDENT INJURING PEDAL CYCL		12/26/2013
372.30	CONJUNCTIVITIS, UNSPECIFIED		01/23/2014
852.40	EXTRADURAL HEMORRHAGE FOLLOWING INJURY,		12/21/2013
E819.9	MOTOR VEHICLE TRAFFIC ACCIDENT OF UNSPEC		12/21/2013
E816.1	MOTOR VEHICLE TRAFFIC ACCIDENT DUE TO LO		12/21/2013
853.01	OTHER AND UNSPECIFIED INTRACRANIAL HEMOR	920.00	01/27/2014
852.26	SUBDURAL HEMORRHAGE FOLLOWING INJURY, WI	1024.95	12/21/2013
860.4	TRAUMATIC PNEUMOHEMOTHORAX WITHOUT MENTI	510.50	01/02/2014
861.21	CONTUSION OF LUNG WITHOUT OPEN WOUND INT		12/21/2013
V57.3	Speech-language therapy	1440.27	02/13/2014
784.40	Symptom voice resonance disordr NOS		02/13/2014
V54.19	AFTERCARE FOR HEALING TRAUMATIC FRACTURE		02/13/2014
V58.43	AFTERCARE FOLLOWING SURGERY FOR INJURY		02/13/2014
V57.89	CARE INVOLVING OTHER SPECIFIED REHABILIT	13735.24	01/02/2014
803.20	OTHER CLOSED SKULL FRACTURE WITH SUBARAC		01/02/2014
865.03	LACERATION OF SPLEEN EXTENDING INTO PARE		01/02/2014
518.51	Acute resp fail follw truma/surgey		12/27/2013
966.0	POISONING BY OXAZOLIDINE DERIVATIVES	184.61	12/21/2013
599.71	Gross hematuria		12/21/2013
802.4	CLOSED FRACTURE OF MALAR AND MAXILLARY B	99.47	12/21/2013
V58.89	OTHER SPECIFIED AFTERCARE	88.76	08/08/2014

10/31/14 Allegiance Benefit Plan Management, Inc. PAGE: 150
LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 02 11/01/2013 to 10/31/2014 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

GROUP: 2001025 SSN: ********** SEQ: ** DIV: 0001 RELAT: Participant EFF: ********** DOB: ********** TERM: **********
LEVEL: P00 PLAN: WILCO-MED-EPO

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	00-*	250000.00	15.33	38318.70	.00	.00	.00	.00

==========Diagnosis Recap==========

Amount	Code	Description
$16,145.12	157.9	MALIGNANT NEOPLASM OF PANCREAS, PART UNSPECIFIED
$10,376.12	V58.11	ENCOUNTER FOR ANTINEOPLASTIC CHEMOTHERAPY
$2,343.76	577.9	UNSPECIFIED DISEASE OF PANCREAS
$2,160.01	789.00	OTHER SYMPTOMS INVOLVING ABDOMEN AND PELVIS
$1,999.78	535.50	GSTR/DDNTS NOS W/O HMRHG
$1,549.42	157.0	MALIGNANT NEOPLASM OF HEAD OF PANCREAS
$639.44	155.0	MALIGNANT NEOPLASM OF LIVER, PRIMARY
$535.60	DRUGS	PRESCRIPTION DRUGS
$440.52	787.91	OTHER SYMPTOMS INVOLVING DIGESTIVE SYSTEM; DIARRHEA
$329.20	999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEWHERE CLASSIFIED
$300.61	733.90	DISORDER OF BONE AND CARTILAGE, UNSPECIFIED
$295.48	V72.83	OTH SPCF PREOP EXAM
$295.39	157.1	MALIGNANT NEOPLASM OF BODY OF PANCREAS
$262.14	V76.12	OTHER SCREENING MAMMOGRAM
$182.54	789.06	OTHER SYMPTOMS INVOLVING ABDOMEN AND PELVIS
$157.88	553.3	DIAPHRAGMATIC HERNIA WITHOUT MENTION OF OBSTRUCTION OR GANGRENE
$92.49	793.11	Solitary pulmonary nodule
$88.76	490	BRONCHITIS, NOT SPECIFIED AS ACUTE OR CHRONIC
$44.60	537.9	UNSPECIFIED DISORDER OF STOMACH AND DUODENUM
$44.60	530.11	REFLUX ESOPHAGITIS
$35.24	244.9	UNSPECIFIED ACQUIRED HYPOTHYROIDISM

$38,318.70 Total Paid

	Diagnosis Summary for **********	Amount Paid	Last D.O.S.
DRUGS	PRESCRIPTION DRUGS	535.60	10/21/2014
V76.12	OTHER SCREENING MAMMOGRAM	262.14	11/05/2013
244.9	UNSPECIFIED ACQUIRED HYPOTHYROIDISM	35.24	01/04/2014
401.9	UNSPECIFIED ESSENTIAL HYPERTENSION		01/04/2014
490	BRONCHITIS, NOT SPECIFIED AS ACUTE OR CH	88.76	03/17/2014
786.2	COUGH		03/17/2014
733.90	DISORDER OF BONE AND CARTILAGE, UNSPECIF	300.61	04/30/2014
790.29	OTHER ABNORMAL GLUCOSE		05/28/2014
715.90	OSTEOARTHROSIS, UNSPECIFIED WHETHER GENE		07/30/2014
268.9	UNSPECIFIED VITAMIN D DEFICIENCY		05/28/2014
553.3	DIAPHRAGMATIC HERNIA WITHOUT MENTION OF	157.88	06/05/2014
789.00	OTHER SYMPTOMS INVOLVING ABDOMEN AND	2160.01	08/04/2014
789.06	OTHER SYMPTOMS INVOLVING ABDOMEN AND	182.54	05/30/2014
787.02	OTHER SYMPTOMS OF THE DIGESTIVE SYSTEM;		05/30/2014
272.4	OTHER AND UNSPECIFIED HYPERLIPIDEMIA		07/30/2014
530.81	ESOPHAGEAL REFLUX		06/02/2014
564.1	IRRITABLE COLON		06/02/2014
733.00	OSTEOPOROSIS, UNSPECIFIED		06/02/2014
530.11	REFLUX ESOPHAGITIS	44.60	06/05/2014
535.50	GSTR/DDNTS NOS W/O HMRHG	1999.78	06/05/2014
537.9	UNSPECIFIED DISORDER OF STOMACH AND DUOD	44.60	06/05/2014
305.1	TOBACCO USE DISORDER		06/02/2014
V58.69	LONG-TERM (CURRENT) USE OF OTHER		07/15/2014
790.21	IMPAIRED FASTING GLUCOSE		05/28/2014
577.9	UNSPECIFIED DISEASE OF PANCREAS	2343.76	06/27/2014
593.9	UNSPECIFIED DISORDER OF KIDNEY AND URETE		10/15/2014
573.9	DISORDER OF LIVER		06/19/2014
157.0	MALIGNANT NEOPLASM OF HEAD OF PANCREAS	1549.42	06/27/2014
157.9	MALIGNANT NEOPLASM OF PANCREAS, PART UNS	16145.12	10/20/2014
197.7	MALIGNANT NEOPLASM OF LIVER, SPECIFIED A		09/08/2014
783.21	LOSS OF WEIGHT		07/21/2014
199.1	OTHER MALIGNANT NEOPLASM OF UNSPECIFIED		09/08/2014
785.6	ENLARGEMENT OF LYMPH NODES		07/10/2014
562.10	DIVERTICULOSIS OF COLON		07/10/2014
787.91	OTHER SYMPTOMS INVOLVING DIGESTIVE	440.52	08/04/2014
787.03	SYMPTOMS INVOLVING DIGESTIVE SYSTEM		08/04/2014
999	COMPLICATIONS OF MEDICAL CARE, NOT ELSEW	329.20	07/21/2014
V72.83	OTH SPCF PREOP EXAM	295.48	10/20/2014
155.0	MALIGNANT NEOPLASM OF LIVER, PRIMARY	639.44	07/15/2014
V58.11	ENCOUNTER FOR ANTINEOPLASTIC	10376.12	09/22/2014

10/31/14 Allegiance Benefit Plan Management, Inc. PAGE: 151
LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 02 11/01/2013 to 10/31/2014 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
V58.64	LONG-TERM (CURRENT) USE OF NON-STEROIDAL		07/30/2014
287.49	Other secondary thrombocytopenia		10/20/2014
288.03	DRUG INDUCED NEUTROPENIA		09/22/2014
E933.1	ANTINEOPLASTIC AND IMMUNOSUPPRESSIVE DRU		10/20/2014
780.79	OTHER MALAISE AND FATIGUE		10/06/2014
157.1	MALIGNANT NEOPLASM OF BODY OF PANCREAS	295.39	09/22/2014
157.2	MALIGNANT NEOPLASM OF TAIL OF PANCREAS		09/22/2014
287.5	THROMBOCYTOPENIA, UNSPECIFIED		09/22/2014
357.6	POLYNEUROPATHY DUE TO DRUGS		10/06/2014
571.8	OTHER CHRONIC NONALCOHOLIC LIVER DISEASE		10/15/2014
793.11	Solitary pulmonary nodule	92.49	10/15/2014

GROUP: 2001025 SSN: ********** SEQ: ** DIV: 0001 RELAT: Spouse EFF: ********** DOB: ********** TERM: **********
LEVEL: F99 PLAN: WILCO-MED-EPO

PARTICIPANT ID & NAME	DEPENDENT	SPEC LMT	% OF SPEC	PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
(ID Suppressed)	01-*	250000.00	43.27	108186.25	.00	.00	.00	.00

==========Diagnosis Recap==========

Amount	Code	Description
$57,362.63	410.71	SUBENDOCARDIAL INFARCTION, INITIAL EPISODE OF CARE
$13,927.77	354.0	CARPAL TUNNEL SYNDROME
$8,447.94	745.5	OSTIUM SECUNDUM TYPE ATRIAL SEPTAL DEFECT
$7,819.55	410.70	SUBENDOCARDIAL INFARCTION, EPISODE OF CARE UNSPECIFIED
$7,463.99	786.50	UNSPECIFIED CHEST PAIN
$3,386.69	724.5	BACKACHE, UNSPECIFIED
$3,194.72	414.01	CORONARY ATHEROSCLEROSIS;OF NATIVE CORONARY ARTERY
$1,722.25	338.18	OTHER ACUTE POSTOPERATIVE PAIN
$954.95	410.90	ACUTE MYOCARDIAL INFARCTION OF UNSPECIFIED SITE, EPISODE OF CARE UNSPECIFIED
$848.57	DRUGS	PRESCRIPTION DRUGS
$649.22	782.0	DISTURBANCE OF SKIN SENSATION
$439.87	933.0	FOREIGN BODY IN PHARYNX
$436.58	250.10	DIABETES WITH KETOACIDOSIS,TYPE II OR UNSPECIFIED TYPE
$308.51	785.1	PALPITATIONS
$225.00	487.1	INFLUENZA WITH OTHER RESPIRATORY MANIFESTATIONS
$201.76	272.0	PURE HYPERCHOLESTEROLEMIA
$152.14	414.04	CORONARY ATHEROSCLEROSIS;OF ARTERY BYPASS GRAFT
$126.32	780.4	DIZZINESS AND GIDDINESS
$107.24	412	OLD MYOCARDIAL INFARCTION
$94.21	564.1	IRRITABLE COLON
$92.35	250.02	DIABETES MELLITUS WITHOUT MENTION OF COMPLICATION, TYPE II,UNCONTROLLED
$55.30	784.7	EPISTAXIS
$51.54	V67.00	FOLLOWING SURGERY, UNSPECIFIED
$31.00	784.99	OTHER SYMPTOMS INVOLVING HEAD AND NECK
$27.58	V58.82	FITTING AND ADJUSTMENT OF NONVASCULAR CATHETER, NEC
$17.12	V72.82	PREOP RESPIRATORY EXAM
$13.87	780.2	SYNCOPE AND COLLAPSE
$13.79	V45.81	POSTSURGICAL AORTOCORONARY BYPASS STATUS
$13.79	511.9	UNSPECIFIED PLEURAL EFFUSION

$108,186.25 Total Paid

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
933.0	FOREIGN BODY IN PHARYNX	439.87	11/12/2013
784.99	OTHER SYMPTOMS INVOLVING HEAD AND NECK	31.00	11/12/2013
V14.0	Hx, prsnl, penicillin allergy		11/12/2013
V14.2	Hx, prsnl, sulfonamides allergy		11/12/2013
V14.1	Hx, prsnl, antibiotic allergy NEC		11/12/2013
DRUGS	PRESCRIPTION DRUGS	848.57	10/01/2014
487.1	INFLUENZA WITH OTHER RESPIRATORY MANIFES	225.00	01/15/2014
780.60	Symptom, fever, unspecified		01/15/2014
564.1	IRRITABLE COLON	94.21	02/04/2014
847.1	THORACIC SPRAIN		02/04/2014
724.1	PAIN IN THORACIC SPINE		02/17/2014
784.7	EPISTAXIS	55.30	02/17/2014
410.90	ACUTE MYOCARDIAL INFARCTION OF UNSPECIFI	954.95	03/10/2014
401.9	UNSPECIFIED ESSENTIAL HYPERTENSION		05/14/2014
414.01	CORONARY ATHEROSCLEROSIS;OF NATIVE	3194.72	08/08/2014
276.7	HYPERPOTASSEMIA		03/10/2014
250.00	DIABETES MELLITUS WITHOUT MENTION OF		08/07/2014
V58.82	FITTING AND ADJUSTMENT OF NONVASCULAR	27.58	03/06/2014
410.70	SUBENDOCARDIAL INFARCTION, EPISODE OF CA	7819.55	03/03/2014
272.4	OTHER AND UNSPECIFIED HYPERLIPIDEMIA		03/03/2014
786.50	UNSPECIFIED CHEST PAIN	7463.99	08/07/2014
250.10	DIABETES WITH KETOACIDOSIS,TYPE II OR	436.58	04/09/2014
414.00	CORONARY ATHEROSCLEROSIS OF UNSPECIFIED		05/14/2014
278.00	OBESITY, UNSPECIFIED		03/11/2014
511.9	UNSPECIFIED PLEURAL EFFUSION	13.79	03/10/2014
V72.82	PREOP RESPIRATORY EXAM	17.12	03/04/2014

10/31/14 Allegiance Benefit Plan Management, Inc. PAGE: 152
LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

GROUP : 2001025 WILLIAMSON COUNTY
CARRIER : 00001-0109 COMPANION LIFE INS COMPANY

RENEWAL 02 11/01/2013 to 10/31/2014 INCLUDES ALL CLAIMANTS 10% OF SPECIFIC LIMIT

Diagnosis Summary for **********		Amount Paid	Last D.O.S.
338.18	OTHER ACUTE POSTOPERATIVE PAIN	1722.25	03/17/2014
V45.81	POSTSURGICAL AORTOCORONARY BYPASS STATUS	13.79	08/07/2014
250.62	DIABETES WITH NEUROLOGICAL MANIFESTATION		03/03/2014
300.00	ANXIETY STATE, UNSPECIFIED		04/03/2014
401.1	BENIGN ESSENTIAL HYPERTENSION		08/08/2014
272.2	Hyperlipidemia, mixed		08/08/2014
272.0	PURE HYPERCHOLESTEROLEMIA	201.76	05/15/2014
477.9	ALLERGIC RHINITIS, CAUSE UNSPECIFIED		04/03/2014
745.5	OSTIUM SECUNDUM TYPE ATRIAL SEPTAL DEFEC	8447.94	03/11/2014
410.71	SUBENDOCARDIAL INFARCTION, INITIAL EPISO	57362.63	03/11/2014
425.4	PRIMARY CARDIOMYOPATHIES		03/11/2014
785.1	PALPITATIONS	308.51	05/28/2014
412	OLD MYOCARDIAL INFARCTION	107.24	08/08/2014
V67.00	FOLLOWING SURGERY, UNSPECIFIED	51.54	05/05/2014
354.0	CARPAL TUNNEL SYNDROME	13927.77	05/21/2014
782.0	DISTURBANCE OF SKIN SENSATION	649.22	04/17/2014
728.87	MUSCLE WEAKNESS (GENERALIZED)		04/16/2014
250.02	DIABETES MELLITUS WITHOUT MENTION OF	92.35	05/15/2014
311	DEPRESSIVE DISORDER, NOT ELSEWHERE CLASS		05/15/2014
780.4	DIZZINESS AND GIDDINESS	126.32	05/20/2014
354.2	LESION OF ULNAR NERVE		05/21/2014
429.9	HEART DISEASE, UNSPECIFIED		05/14/2014
780.2	SYNCOPE AND COLLAPSE	13.87	05/14/2014
724.5	BACKACHE, UNSPECIFIED	3386.69	08/06/2014
511.0	PLEURISY WITHOUT MENTION OF EFFUSION OR		08/06/2014
414.04	CORONARY ATHEROSCLEROSIS;OF ARTERY	152.14	08/06/2014
V15.82	Hx, prsnl, tobacco use		08/07/2014
V58.66	LONG-TERM (CURRENT) USE OF ASPIRIN		08/07/2014

********** GROUP TOTALS **********

PAID YTD	OVER SPEC	REIMBURSED	PENDING	UNREPORTED
10123838.53	1346113.79	728391.56	549383.82	26769.40

TOTAL OF PRINTED CLAIM DETAIL: 10082269.52

10/31/14 Allegiance Benefit Plan Management, Inc. PAGE: 153
LXSLREGR STOP LOSS SPECIFIC DETAIL REGISTER

** TOTALS FOR ALL GROUPS **

********** TOTALS **********	10123838.53	1346113.79	728391.56	549383.82	26769.40

TOTAL OF PRINTED CLAIM DETAIL: 10082269.52

Division Break Down

0001	95	$8,481,511.35
0002	11	$755,896.04
RET2	5	$347,678.99
RETR	7	$497,183.14
Total	118	$10,082,269.52

WILLIAMSON COUNTY BENEFITS FUND
Profit & Loss
October 2013 through May 2014

Wilco Claims Expense - FY 2014 thru May

Source: Quick Books, Memorized Reports, "**Profit and Loss FY by Month**"

Active & COBRA are combined.

	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14	Apr 14	May 14	TOTAL
Expense									
004038 Retiree Vision Claims	2,364.98	2,774.55	983.00	1,545.70	2,219.00	2,958.61	2,179.50	565.00	15,590.34
004039 Retiree Dental									
004039 Retiree Dental High	3,992.25	4,590.72	3,421.62	4,065.60	3,316.95	6,100.32	6,574.55	7,933.09	39,995.10
004039 Retiree Dental Low	171.00	209.00	95.00	166.00	0.00	240.00	316.90	105.10	1,303.00
Total 004039 Retiree Dental	4,163.25	4,799.72	3,516.62	4,231.60	3,316.95	6,340.32	6,891.45	8,038.19	41,298.10
004040 - Retiree Claims									
004040 Retiree Claims- Core	420,952.69	168,946.40	72,583.82	34,026.72	57,829.20	39,454.57	38,656.78	18,626.55	851,076.73
004040 Retiree Claims- Ded	14,908.02	5,331.41	10,873.15	10,622.09	-1,410.10	25,869.89	11,220.65	42,903.69	120,318.80
004040 Retiree Claims- EPO	5,068.80	5,183.26	437.37	476.77	771.54	5,053.87	1,344.41	1,690.83	20,026.85
Total 004040 - Retiree Claims	440,929.51	179,461.07	83,894.34	45,125.58	57,190.64	70,378.33	51,221.84	63,221.07	991,422.38
004041 - Retiree Rx Claims Exp									
004041 Retiree Rx- Core	9,193.87	9,376.28	23,874.85	3,344.13	9,253.48	26,183.85	27,775.01	7,569.96	116,571.43
004041 Retiree Rx- Ded	6,307.82	9,002.81	12,106.80	6,979.53	8,226.29	17,168.66	14,462.13	11,451.87	85,705.91
004041 Retiree Rx- EPO	672.60	813.23	1,516.22	892.16	997.49	1,316.55	1,398.44	69.28	7,675.97
Total 004041 - Retiree Rx Claims Exp	16,174.29	19,192.32	37,497.87	11,215.82	18,477.26	44,669.06	43,635.58	19,091.11	209,953.31
004048 Vision Claim	23,913.33	44,785.13	28,019.27	25,175.96	16,561.63	29,391.62	17,968.08	19,793.34	205,608.36
004049 Dental Claims Paid									
004049 Dental Claims Paid - Hi	81,552.77	88,969.24	89,465.51	60,721.25	75,092.11	78,740.74	72,964.13	74,128.69	621,634.44
004049 Dental Claims Paid - Lo	9,557.90	10,151.42	6,095.16	9,059.67	8,614.69	10,451.02	7,825.97	9,712.43	71,468.26
Total 004049 Dental Claims Paid	91,110.67	99,120.66	95,560.67	69,780.92	83,706.80	89,191.76	80,790.10	83,841.12	693,102.70
004050 Med Claims Paid									
004050 Med Claims Paid- Core	1,328,275.31	284,370.26	128,803.85	417,496.29	391,322.13	508,337.80	298,959.34	275,498.39	3,633,063.37
004050 Med Claims Paid- Ded	347,551.48	233,856.51	390,718.58	358,770.59	466,504.82	935,981.65	686,685.67	551,708.67	3,971,777.97
004050 Med Claims Paid- EPO	77,589.88	56,103.83	47,077.82	77,839.00	126,753.47	162,561.41	62,354.32	132,904.95	743,184.68
Total 004050 Med Claims Paid	1,753,416.67	574,330.60	566,600.25	854,105.88	984,580.42	1,606,880.86	1,047,999.33	960,112.01	8,348,026.02
004051 Prescrip Drugs									
004051 Prescrip Drugs- Core	59,635.98	64,283.27	80,744.79	48,750.71	81,377.10	100,244.34	120,573.50	36,080.73	591,690.42
004051 Prescrip Drugs- Ded	105,285.37	100,783.32	160,393.51	71,687.05	107,962.59	182,334.09	188,858.49	71,029.66	988,334.08
004051 Prescrip Drugs- EPO	20,469.03	16,968.49	32,164.37	9,621.57	21,206.47	33,860.59	32,610.10	11,468.85	178,369.47
Total 004051 Prescrip Drugs	185,390.38	182,035.08	273,302.67	130,059.33	210,546.16	316,439.02	342,042.09	118,579.24	1,758,393.97

Arthur J. Gallagher & Co.
BUSINESS WITHOUT BARRIERS™

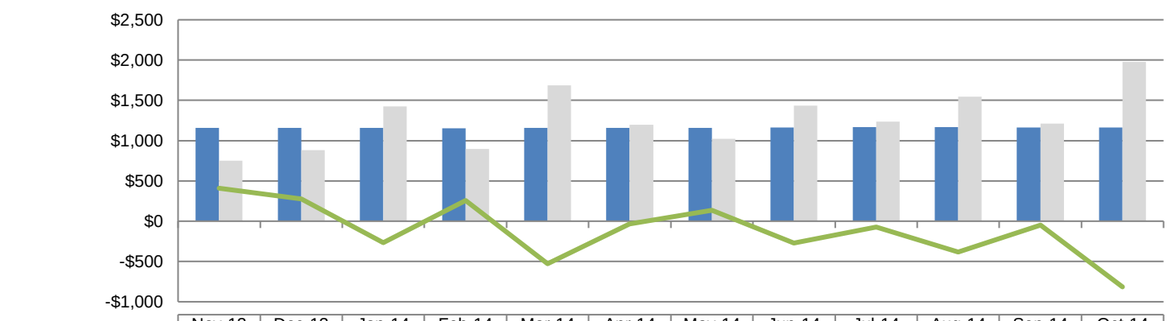
Medical Financial Monitoring Report - Williamson County

Reporting Month: October, 2014
Medical Plan Cost Comparison
All Plans

Carrier: Allegiance
Specific Deductible: $250,000
Plan Year: 11/1/2013 - 10/31/2014

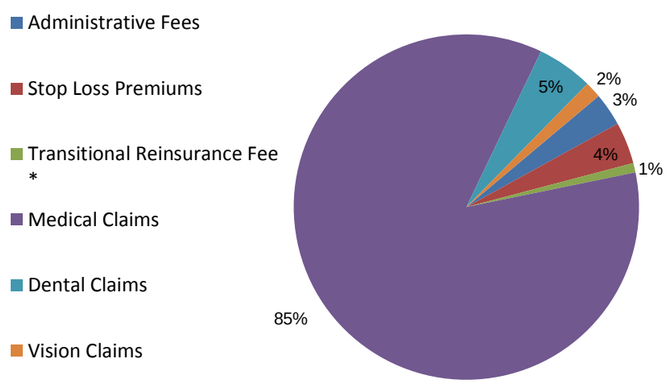
Paid Month	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Total	PEPM
Subscribers	**1,348**	**1,379**	**1,379**	**1,379**	**1,385**	**1,381**	**1,341**	**1,394**	**1,387**	**1,389**	**1,399**	**1,399**	**16,560**	
Claim Payments														
Medical Claims	$763,053	$961,198	$1,697,910	$1,024,477	$2,068,665	$1,421,765	$1,119,791	$1,739,767	$1,491,758	$1,873,944	$1,452,081	$2,488,859	$18,103,269	$1,093.19
Dental Claims	$82,112	$85,577	$108,702	$67,633	$98,197	$78,272	$95,664	$101,645	$78,604	$110,371	$75,409	$128,591	$1,110,778	$67.08
Vision Claims	$34,684	$28,744	$39,856	$14,039	$29,693	$23,116	$21,219	$23,951	$16,251	$27,262	$28,230	$38,589	$325,632	$19.66
Refunds	($3,631)	($1,817)	($19,307)	($8,041)	($4,682)	($11,259)	($3,823)	($3,949)	($9,925)	($3,205)	($3,602)	($30,122)	($103,363)	($6.24)
Total Claim Payments	**$876,219**	**$1,073,702**	**$1,827,161**	**$1,098,107**	**$2,191,874**	**$1,511,894**	**$1,232,850**	**$1,861,414**	**$1,576,687**	**$2,008,373**	**$1,552,119**	**$2,625,917**	**$19,436,316**	**$1,173.69**
Funding														
Administrative Fees	$53,489	$54,719	$54,719	$54,719	$54,957	$54,798	$53,211	$55,314	$55,036	$55,116	$55,512	$55,512	$657,101	$39.68
Stop Loss Premiums	$67,589	$69,143	$69,143	$69,143	$69,444	$69,243	$67,238	$69,895	$69,544	$69,644	$70,146	$70,146	$830,318	$50.14
Transitional Reinsurance Fee *	$15,180	$15,529	$15,529	$15,529	$15,597	$15,552	$15,101	$15,698	$15,619	$15,642	$15,754	$15,754	$186,486	$11.26
Total Fixed Costs	**$136,258**	**$139,391**	**$139,391**	**$139,391**	**$139,998**	**$139,593**	**$135,550**	**$140,907**	**$140,200**	**$140,402**	**$141,413**	**$141,413**	**$1,673,906**	**$101.08**
Total Plan Cost	**$1,012,476**	**$1,213,093**	**$1,966,552**	**$1,237,498**	**$2,331,871**	**$1,651,488**	**$1,368,400**	**$2,002,321**	**$1,716,887**	**$2,148,774**	**$1,693,532**	**$2,767,329**	**$21,110,222**	**$1,274.77**
Budget Comparison														
Budgeted Cost	$1,563,687	$1,595,351	$1,597,576	$1,593,203	$1,602,532	$1,602,097	$1,551,050	$1,622,261	$1,618,789	$1,620,188	$1,627,101	$1,626,714	$19,220,548	$1,160.66
Actual Cost	$1,012,476	$1,213,093	$1,966,552	$1,237,498	$2,331,871	$1,651,488	$1,368,400	$2,002,321	$1,716,887	$2,148,774	$1,693,532	$2,767,329	##########	$1,274.77
Variance from Actual	$551,211	$382,258	($368,976)	$355,704	($729,339)	($49,391)	$182,650	($380,059)	($98,098)	($528,586)	($66,431)	($1,140,616)	-$1,889,674	-$114.11

Budget Comparison PEPM



	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14
Budgeted Cost	$1,160	$1,157	$1,159	$1,155	$1,157	$1,160	$1,157	$1,164	$1,167	$1,166	$1,163	$1,163
Actual Cost	$751	$880	$1,426	$897	$1,684	$1,196	$1,020	$1,436	$1,238	$1,547	$1,211	$1,978
Surplus/Deficit	$409	$277	-$268	$258	-$527	-$36	$136	-$273	-$71	-$381	-$47	-$815

Combined Plan Expenses



* Estimated Transitional Reinsurance Fee is based on $5.25 PMPM (using 2.15 contract size) towards 2014 PPACA Fees. This does not represent actual amounts owed.

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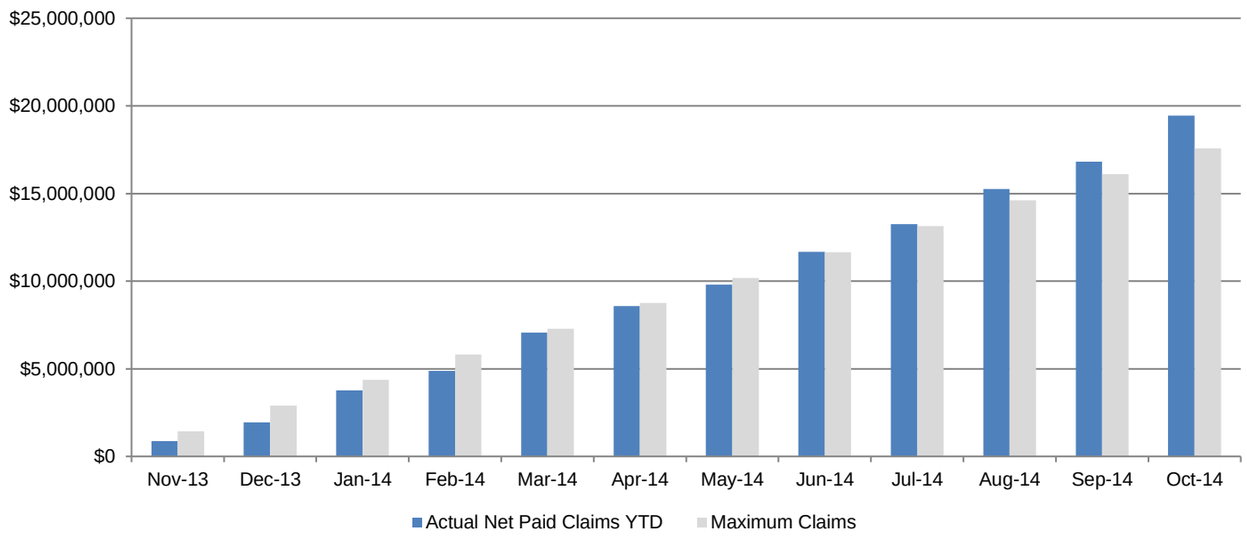
Medical Financial Monitoring Report - Williamson County

Reporting Month: October, 2014
Aggregate Stop Loss
All Plans

Carrier: Allegiance
Specific Deductible: $250,000
Plan Year: 11/1/2013 - 10/31/2014

Paid Month	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Total	PEPM
Subscribers	**1,348**	**1,379**	**1,379**	**1,379**	**1,385**	**1,381**	**1,341**	**1,394**	**1,387**	**1,389**	**1,399**	**1,399**	**16,560**	
Aggregate Stop Loss														
Actual Net Paid Claims	$876,219	$1,073,702	$1,827,161	$1,098,107	$2,191,874	$1,511,894	$1,232,850	$1,861,414	$1,576,687	$2,008,373	$1,552,119	$2,625,917	$19,436,316	$1,173.69
Maximum Claims	$1,430,767	$1,463,671	$1,463,671	$1,463,671	$1,470,039	$1,465,793	$1,423,337	$1,479,592	$1,472,162	$1,474,285	$1,484,899	$1,484,899	$17,576,784	$1,061
Actual vs. Maximum	61.2%	73.4%	124.8%	75.0%	149.1%	103.1%	86.6%	125.8%	107.1%	136.2%	104.5%	176.8%	110.6%	

Maximum vs. Aggregate Claims (YTD)





This analysis is for illustrative purposes only, and is not a guarantee of future expenses, claims costs, managed care savings, etc. There are many variables that can affect future health care costs including utilization patterns, catastrophic claims, changes in plan design, health care trend increases, etc. This analysis does not amend, extend, or alter the coverage provided by the actual insurance policies and contracts. Please see your policy or contact us for specific information or further details in this regard.

'illiamson County
laims through 7/31/15

Claimant #	Med	Rx	Total	Pooled Amt	
1	$121,146.93	$2,108.68	$123,255.61	$0.00	
2	$246,414.43	$402.24	$246,816.67	$0.00	
3	$159,884.78	$9,160.91	$169,045.69	$0.00	
4	$184,937.64	$0.00	$184,937.64	$0.00	
5	$140,490.36	$0.00	$140,490.36	$0.00	
6	$243,270.14	$6,729.86	$250,000.00	$78,198.78	
7	$123,147.92	$7,992.23	$131,140.15	$0.00	
8	$677,154.57	$2,555.42	$679,709.99	$0.00	Lasered

Question and Answers for Bid #1508-009 - Specific & Aggregate Stop Loss Insurance

Overall Bid Questions
There are no questions associated with this bid.

Commissioners Court - Regular Session **44.**

Meeting Date: 09/01/2015

New Rene Bates Auction Dates

Submitted By: Stacy Partridge, Purchasing

Department: Purchasing

Agenda Category: Regular Agenda Items

Information

Agenda Item

Discuss, consider, and take appropriate action on authorizing the Purchasing Department to have Rene Bates Auctioneers hold on-line auctions for the sale of surplus county property on the following dates: October 7th through October 21st in 2015, January 13th through January 27th, April 6th through April 20th, and July 13th through July 27th in 2016. All auctions closing by 5pm CST on these dates.

Background

Fiscal Impact

From/To	Acct No.	Description	Amount

Attachments

No file(s) attached.

Form Review

Inbox	Reviewed By	Date
Purchasing (Originator)	Kerstin Hancock	08/27/2015 09:58 AM
County Judge Exec Asst.	Wendy Coco	08/27/2015 10:05 AM
Purchasing (Originator)	Kerstin Hancock	08/27/2015 10:18 AM
Form Started By: Stacy Partridge		Started On: 08/27/2015 08:29 AM
Final Approval Date: 08/27/2015		

Commissioners Court - Regular Session **45.**

Meeting Date: 09/01/2015

bo.draft2

Submitted By: Rebecca Clemons, County Judge

Department: County Judge

Agenda Category: Regular Agenda Items

Information

Agenda Item

Discuss, consider and take appropriate action on the FY15/16 Budget Order.

Background

Fiscal Impact

From/To	Acct No.	Description	Amount

Attachments

budgetorderdraft

Form Review

Inbox	Reviewed By	Date
County Judge Exec Asst. (Originator)	Wendy Coco	08/26/2015 03:54 PM
Form Started By: Rebecca Clemons		Started On: 08/26/2015 03:28 PM
Final Approval Date: 08/26/2015		

STATE OF TEXAS
COUNTY OF WILLIAMSON
AN ORDER ADOPTING THE 2015/2016 COUNTY BUDGET

WHEREAS, the Williamson County Commissioners Court is authorized and required to adopt an annual budget for all Williamson County officials and their departments after due consideration;

WHEREAS, the Williamson County Commissioners Court did invite and encourage public participation from county officers, precinct officers, department heads, and the general public, as to the various needs of the citizens of Williamson County for the fiscal year 2015/2016;

WHEREAS, the Williamson County Commissioners Court, after a full discussion of the needs, did make changes in the proposed budget filed by the County Judge in accordance with law; NOW

THEREFORE, BE IT ORDERED BY THE WILLIAMSON COUNTY COMMISSIONERS COURT that the proposed budget filed by the County Judge and amended by the Commissioners Court be adopted with the following provisions:

POLICIES RELATED TO COMPENSATION AND BENEFITS

I. SALARIES

1. Salaries for County and Precinct Officials are set as follows:

a)	Judge of the County Court	115,485.10 per year
b)	Judge of the County Court at Law #1	157,000.00per year
c)	Judge of the County Court at Law #2	157,000.00 per year
d)	Judge of the County Court at Law #3	157,000.00 per year
e)	Judge of the County Court at Law #4	157,000.00 per year
f)	County Attorney	153,142.00 per year
g)	County Sheriff	116,669.13 per year
h)	County Clerk	95,660.82 per year
i)	County Tax Assessor/Collector	99,477.58 per year
j)	District Clerk	95,660.82 per year
k)	County Treasurer	92,038.86 per year
l)	Each County Commissioner	94,037.10 per year
m)	Each Justice of the Peace	83,714.09 per year
n)	Each Constable	79,187.92 per year

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2. The number of employee positions established and authorized for each official and/or department, and the maximum allowable salary for each position is reflected in the annual approved county budget filed with the County Clerk.

II. HOLIDAYS

The established holiday schedule for paid holidays for the 2015/2016 budget year is as follows:

Veterans Day	Wednesday	November 11, 2015
Thanksgiving Holiday	Thursday Friday	November 26, 2015 November 27, 2015
Christmas Holiday	Thursday Friday	December 24, 2015 December 25, 2015
New Year's Holiday	Thursday, Friday	December 31, 2015 January 1, 2016
Martin Luther King Day	Monday	January 18, 2016
President's Day	Monday	February 15, 2016
Good Friday	Friday	March 25, 2016
Memorial Day	Monday	May 30, 2016
Independence Holiday	Monday	July 4, 2016
Labor Day	Monday	September 5, 2016

See Addendum: The Williamson County Employee Policy Manual (as updated April 21,2015). Contains the policies for employee usage of paid holiday time as well as other policies affecting payroll related matters.

III. SUPPLEMENTAL PAY

1. A maximum of 18 approved positions within the Law Enforcement Bureau of the Williamson County Sheriff's office will be designated as Field Training Officers. To receive Field Training Officer incentive pay, a Deputy must be TCLEOSE certified as a Field Training Officer and be assigned by the Sheriff as one of the approved 18 officers. The Officers also must follow the Field Training Officer's Standard Operating Procedures in place with the Williamson County Sheriff's Office.

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2. A maximum of 12 approved positions within the Corrections Bureau of the Williamson County Sheriff's Office will be designated as Corrections Training Officers. The officers must have appropriate certification and follow established operating procedures.

3. A maximum of 11 approved law enforcement tenure positions within the Williamson County Sheriff's Office are eligible for Crisis Intervention Team Supplemental pay in the amount of $250 per month. In order to receive the CIT supplemental pay a law enforcement tenured deputy must hold the appropriate certifications and follow established policies and procedures.

43. A maximum of 8 positions in the 911 Communications division may receive up to $150.00 per month incentive pay as a designated Field Training Officer. This will be paid for a maximum of 8 months. To receive FTO pay the employee must be TCLEOSE certified as a Telecommunications Training Officer or must be certified as a Communications Training Officer by the Association of Public Safety Communications Officials. The FTO may only receive incentive pay when assigned new personnel during a training period. The trainer will be selected based on the position and duties of the newly hired personnel according to the type of training required such as Law Enforcement, Fire, Call Taker and EMS. The selection of the FTO will be on a rotation basis according to the training criteria required.

54. A maximum of 20 positions within the Emergency Medical Services Division of may be designated as Field Training Officers. A maximum of $150.00 per month may be paid as FTO incentive pay per employee. The employee must be certified or licensed by the Texas Department of State Health Services as a Paramedic (with no state sanctions or disciplinary restrictions) in order to receive the incentive pay. Also required: a) a completed course of instruction at the Paramedic level (National Registry preferred) b) a Williamson County EMS FTO training course c) valid Texas Driver License d) thorough knowledge of current principles and practices of emergency care at the basic and advanced levels e) responsible for the training and development of new Williamson County Emergency Medical Services personnel, First Responder Advanced Providers, senior paramedic students and instructor duties as assigned at EMS educational shift tracks.

65. A maximum of 4 positions within the MOT may be designated as Field Training Officers during the period of time that the position is participating in training. A maximum of $150.00 per month may be paid as FTO incentive pay per position so long as the $150.00 is continuing to be reimbursed by The Texas A&M University System Health Science Center on behalf of the College of Medicine in accordance with their agreement with Williamson County.

76. An Assistant District Attorney may receive supplemental pay for on call duties. The duties require the employee to carry a cell phone for a week at a time on a rotating basis. The week runs from Friday at 5:00 PM through the weekend until the following Friday at 5:00 PM. The assigned on call prosecutor will receive calls for charging advice and warrant assistance and may need to contact the assigned judge for review and approval of any warrant. The amount of the supplement will be $200.00 per week per employee. The funding for this supplemental pay will come from the District Attorney's Asset Forfeiture Fund

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87. An employee in the Facilities Maintenance department may receive up to $7550.00 per week for On Call duty work. The employee must be able to respond to an event within 1 hour of being notified while on call. A total of two employees may be requested to be on call each week. The week for on call duty will be from Wednesday to Wednesday. Only non-exempt staff will be selected for additional on call duty pay on a rotating basis. If the employee does not follow the departmental procedures provided in the Maintenance SOP then the employee will not receive additional pay.

98. "An employee in the Technology Services department may receive a supplement of up to $100 per week for On-Call duty work. The employee must be able to respond to an event within 30 minutes of being notified while on call. The duties require the employee to carry a cell phone while on call. The assigned on-call employee will receive calls from public safety personnel (i.e. Sheriff's Office, 911 Communications, EMS, city police, etc.) when they have critical technology issues that cannot wait until the next business day. The week for on-call duty will be from 5:00 pm Thursday to 5:00 pm Thursday. The on-call employee must follow the departmental procedures for On-Call duty in order to receive the supplemental pay."

IV. FINANCIAL POLICIES

1.
Fund Balance Policy: Williamson County recognizes the financial importance of maintaining an appropriate level of Unassigned Fund Balance. A formalized Fund Balance Policy demonstrates to the taxpayer fiscal prudence and the ability to meet its obligations in a timely manner. Independent financial analysts rate the county's financial stability. The county's credit strength and strong management control reported by these analysts is, in part, a result of this Fund Balance Policy.

> Williamson County will maintain reservations of Fund Balance, in accordance with Governmental Accounting and Financial Standards Board Statement No. 54, Fund Balance Reporting and Governmental Fund Type Definitions. This Policy shall only apply to the County's governmental funds. Fund Balance shall be composed of non-spendable, restricted, committed, assigned and unassigned amounts.

2.
General Fund: Unassigned Fund Balance represents the difference between assets and liabilities that is available for appropriation.

Commissioners Court has assigned $1.6 million dollars of fund balance for the purpose of funding Law Enforcement and Corrections salaries should the amount budgeted not be sufficient to fund the total amount of approved FTE's in these departments. A budget amendment will be placed on the consent agenda during the fiscal year should the departments exceed the budgeted total.

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Williamson County will maintain an appropriate level of Unassigned Fund Balance in the General Fund to protect against a reduction of services due to temporary revenue shortfalls or unexpected one-time expenditures. It also helps to ensure stable tax rates. The level of Unassigned Fund Balance for the General Fund shall not be less than 35% of total General Fund budgeted expenditures. The goal of each year's budget process will be to adopt a budget that maintains compliance with the General Fund Unassigned Fund Balance Policy. If it is determined there is a surplus (an amount exceeding the target limit), the funds may be designated or appropriated for the following, including but not limited to:

- Tax rate stabilization.
- Only one-time, non-recurring expenditures, such as capital improvement needs.
- Address any shortfall in related funds, i.e. Road and Bridge Fund.
- Reduction of debt; to include capital leases.

If it is determined there is a deficit (an amount below the lower limit), the County must develop a plan to rebuild the Unassigned Fund Balance to 35%.

3. **Tobacco Fund:** The initial distribution of Williamson County's share of the settlement established the fund in 1999. Revenues to the fund consist of interest income and the annual distribution by the state of the state trust earnings. To ensure continuation of the fund, the Williamson County Commissioner's Court has designated the portion of fund balance representing the amount of the original settlement ($2.5M). Designation means that this amount, or "principal" balance, cannot be expended. In addition to the original settlement amount, each year, 20% of the revenues from both interest income and the annual distribution from the state will be added to the designated fund balance in order to allow the fund to grow over time. Only 80% of revenues earned from interest and the earnings distributed annually by the state will be budgeted and expended. When determining the next year's budget, the amount available to expend will be calculated using actual revenue and interest revenue amounts from May 1st of the previous year to April 30th of the current year. Any unspent funds at the end of the fiscal year will be available to budget in the next year. If Tobacco Fund expenditures are budgeted to offset expenditures in other funds, the actual program cost to the other Funds will be determined prior to transferring in any dollars from the Tobacco Fund. This available balance will be tracked annually by the County Auditor's office.

Use and Distribution of Specific Special Revenue Funds

4. **Child Safety Fund:** Child Safety fees collected by justice, county and district courts in accordance with the Texas Education Code are accumulated in the Child Safety Fund. These funds are to be distributed to Williamson County school districts based on the number of students who reside in Williamson County for the purposes of providing school crossing guard services. This distribution will occur annually at the close of each fiscal year.

5. **School Fund:** Williamson County maintains a working interest ownership in two natural gas producing properties located on what was formerly county-owned property. The mineral rights that have been retained are designated to be distributed to school districts within the county based on the number of students who reside in the county. This distribution will occur annually at the close of each fiscal year and will coincide with the distribution of the Child Safety Fund proceeds.

~~**6. Uncompensated Care Fund:** The Uncompensated Care Fund was established as a result of the Williamson County Indigent Care Affiliation Agreements entered into between Williamson County, Seton Hospital Williamson County and St. David's Round Rock Medical Center. The County has now also entered Indigent Care Affiliation Agreements with Cedar Park Regional Medical Center and Scott & White Hospital – Round Rock. As part of the collaboration established between the hospitals and the County, the County has chosen to use a portion of its annual ad valorem tax revenues to fund Medicaid services provided to Williamson County residents by these hospitals. Revenues to this fund will be spent to pay for Medicaid services provided by St. David's Round Rock Medical Center, Seton Hospital Williamson County, Cedar Park Regional Medical Center and Scott & White Hospital – Round Rock, either through direct Medicaid payments to the hospitals or by funding Medicaid supplemental payments to the hospitals through intergovernmental transfers of funding to the State, for purposes of the private hospital Medicaid 1115 Waiver program authorized by Section 355.8201 of the Texas Administrative Code, Title 1.~~

6~~7~~. **Employee Fund**:

The Employee fund is proceeds collected from Williamson County's vending machine contract. Use of these funds must be **pre-approved** by the County Judge.

These funds may be used for the following purposes:

a) To offset the cost of the County Christmas Party
b) Flowers for the death of an employee only
c) An award or plaque upon retirement for employee recognition
d) Employee recognition expenditures as approved by the County Judge.
   (Purchasing guidelines must be adhered to)
   i. The employee must be vested
   ii. $40.00 allowed for employees with up to 15 years of service
   iii. $80.00 allowed for employees with over 15 years of service
e) Employee of the Year Awards

No reimbursement of sales tax will be allowed.
The amount allowed for use may never exceed the actual balance in the fund.

7~~8~~. **Self-Insured Health Plan Fund Policy**: Unassigned Fund Balance represents the difference between assets and liabilities that is available for appropriation. Williamson County will maintain an appropriate level of Unassigned Fund Balance in the Benefits Fund to protect against an inability to pay for claims and administration associated with the self-insured health plan due to temporary revenue shortfalls. It also helps to ensure stable employer and employee contribution rates.

The Self-Funded Health Plan Fund currently has a "goal of reaching and maintaining 25% of projected claims". The goal of each year's budget process will be to endeavor to adopt a budget that maintains compliance with the Benefits Fund Unassigned Fund Balance Policy.

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If it is determined there is a surplus (an amount exceeding the target limit), the funds may be designated or appropriated for contribution rate stabilization.

If it is determined there is a deficit (an amount below the lower limit), the County may develop a plan to rebuild the Unassigned Fund Balance to 25% of projected claims.

~~9. **Southwest Road District Fund**: This district was originally created to build roads in this area of the County. The district has paid off all debt and has been dissolved. The remaining funds including ongoing interest earnings are hereby committed for Road Construction, improvements and/or maintenance.~~

~~9~~10. **WM-City of Hutto and Hutto ISD Fun**d: The WM-City of Hutto and Hutto ISD Fund consists of proceeds paid by Waste Management annually. Per the agreement, these funds represent 2% of the Tip Fee and are to be expended for the benefit of the City of Hutto and Hutto ISD. The expenditures are at the County's sole option. The annual distribution will be allocated 50% to the City of Hutto and 50% to Hutto ISD. Each entity is required to request any disbursements from the fund.

10. Williamson County Community Recreational Facility Fund: This fund consists of fees collected through the Williamson County Landfill. Community organizations, groups, and individuals may submit a funding request to the Williamson County Commissioners Court for the construction, improvement, or remodel of community recreational facilities located in Williamson County that serve a public purpose.

V. PURCHASING – GENERAL PROCEDURES

~~1. Effective January 1, 2009, all P.O.'s must be submitted electronically. The following definitions apply to the Purchasing section of this order. The purpose of this section is to facilitate the judicious expenditure of county dollars. This policy will provide consistent procedures for the acquisition of materials, supplies, and services required by Williamson County. The responsibility to adhere to these guidelines rests with the employee, supervisor or department head who certifies conformance to them. Any questions related to conformance should be directed to the Purchasing Department prior to making a purchase.~~

~~2. The guidelines outlined in the Williamson County Purchasing Manual are expected to be followed for all purchases. The most current version of the purchasing manual is maintained on the county's website at www.wilco.org/procurement. Guidelines related to purchase orders can be found in the County's purchasing manual. All purchases for materials and supplies require a purchase order prior to placing the order. Approval for payment of invoices that do not have a purchase order must be obtained from the County Judge for his waiver of the requisition requirement. These requests for waiver must be accompanied by a written note from the Department Head, Appointed Official, or Elected Official stating the~~

~~reason for the break in policy. Requests for a purchase order after the order is placed will not be processed. Guidelines for emergency purchases and purchases that do not require a purchase order prior to placing an order may be found in the purchasing manual or you can contact the purchasing department if you have any questions.~~

~~3. **PROCUREMENT CARDS: Every procurement card issued is linked under one account by the P-Card vendor. A delay in getting the proper documentation from one cardholder could result in the suspension of card privileges for the entire County**.~~

~~a) The procurement card memo statement and all receipts must be submitted to Accounts Payable within 5 days of receipt of statement.~~
~~b) All receipts must be detailed to show items purchased.~~
~~c) Cardholders are responsible to resolve discrepancies with the P-Card vendor~~
~~d) Cardholder is responsible for reimbursing the County for sales tax charged~~
~~e) Cardholder is responsible to verify budget funds are available before purchase is made~~
~~f) Backup documentation is required for travel/training charges. Only airfare charges for county employees may be charged to a procurement card. Charges for non-employees are strictly prohibited.~~
~~g) If a receipt is lost then a signed affidavit attesting to the items purchased must be received in lieu of the receipt.~~
~~h) Day meals for day travel may not be charged on the procurement card. These items are taxable and must be reimbursed through payroll.~~

~~**Suspension of card privileges may be recommended for any cardholder who repeatedly does not follow proper procedures regarding documentation and timeliness for their P-card purchases.**~~

1. The purpose of this section is to facilitate the judicious expenditure of county dollars. This policy will provide consistent procedures for the acquisition of materials, supplies, and services required by Williamson County. The responsibility to adhere to all Purchasing policies rests with the employee, supervisor or department head who certifies conformance to them. Any questions related to conformance should be directed to the Purchasing Department prior to making a purchase. All P.O.'s must be submitted electronically.

2. Two documents exist in order to assist in the purchasing process within Williamson County.

1. ***How to Do Business with Williamson County*** is a guide for suppliers and the public and is located on the county website: http://www.wilco.org/CountyDepartments/Purchasing

2. The ***Williamson County Purchasing Manual*** is a guide for all Williamson County departments and employees. It is located on the Purchasing page of the internal Wilco 365 SharePoint site.

3. All County purchasing policies must be strictly adhered to for all purchases and can be located in the ***Williamson County Purchasing Manual***, including:

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- All county Purchase Requisitions and Purchase Orders must be submitted electronically.
- All purchases for materials and supplies require a purchase order, prior to placing the order.
- Requests for a Purchase Order after the order is placed will not be processed.
- Specific guidelines for emergency purchases.
- Any invoices that do not reference a valid Purchase Order must receive a waiver of the requisition requirement from the County Judge before the invoice can be approved and processed. All requests for waiver must be accompanied by a written statement from the Department Head, Appointed Official, or Elected Official describing the reason for the deviation from the policy.

3. **PROCUREMENT CARDS (P-cards):** Every procurement card issued is linked under one account by the P-Card vendor. **A delay in getting the proper documentation from one cardholder could result in the suspension of card privileges for the entire County**.

a) The procurement card monthly Expense Report and all receipts must be submitted to Accounts Payable within 5 days of receipt of statement.
b) All receipts must be detailed to show items purchased.
c) Cardholders are responsible to resolve discrepancies with the P-Card vendor.
d) Cardholder must not allow vendors to charge tax on P-Card transactions. Cardholder may be responsible for reimbursing the County for sales tax charged if tax is not credited back to the card by the next billing cycle.
e) Cardholder is responsible to verify budget funds are available before the purchase is made.
f) Backup documentation is required for travel/training charges. Charges for non-employees are strictly prohibited.
g) If a receipt is lost then a signed affidavit attesting to the items purchased must be received in lieu of the receipt.
h) Personal charges on the procurement card are strictly prohibited and may result in disciplinary action including suspension of card privileges and/or termination of employment.

Suspension of card privileges may be recommended for any cardholder who repeatedly does not follow proper procedures regarding documentation and timeliness for their P-card purchases.

VI. ACCOUNTS PAYABLE - GENERAL PROCEDURES

1. The following definitions apply to the Accounts Payable section of this order.

a) Authorized travel -any travel by a county official or employee for the purpose of official county business.
b) Day travel -travel **outside** the county that does not include an overnight stay.

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c) Overnight travel -travel **outside** the county that **exceeds** a 50-mile radius and does include an overnight stay.
d) Emergency -the occurrence of an unforeseen circumstance, which may result in harm to the public good.
e) Official county business -business that relates directly to a person's work function and directly benefits the county.
f) Training reimbursement -shall include all expenses relating to training including travel to the destination, meals, lodging and training aids. (workshops, seminars, conferences)
g) Travel reimbursement -shall include all expenses relating to travel including travel to the destination, meals and lodging. (Delivering documents, transporting a prisoner, attending county business meetings.)

2. The purpose of the Accounts Payable procedures is to promote the prudent exercise of judgment when spending county dollars. This policy will provide accountability and consistent Accounts Payable procedures in the issuance of checks for Williamson County obligations. The responsibility to observe these guidelines rests with the employee, supervisor or department head who certifies conformance to these guidelines by approving the expenditure.

a) Any bill or invoice must be submitted to the County Auditor for payment within fourteen (14) days of receipt by the Department all expense reimbursements must be submitted to the County Auditor for payment within sixty (60) days of the expenditure.
b) Checks for payment of county obligations will be issued not later than 30 days after the date the invoice is received in the Accounts Payable department, pursuant to Texas Govt. Code Sec. 2251.021.
c) Checks will be issued every Tuesday. When an issuance date falls on a holiday, checks will be issued on either the first working day before or after the holiday.

d) The cutoff day for receiving invoices for each check run will be Wednesday. The Accounts Payable department will endeavor to process invoices that are received from Thursday to the following Wednesday approximately 13-20 days after the invoice is received in our department.
e) Any invoice or expense reimbursement requiring additional review or signatures may cause delays in processing.
f) Manual checks will be issued in emergency situations only.
g) Purchase orders are required for ALL purchases of materials and supplies, pursuant with the Texas Local Government Code, Chapter 113, Section 901 and the County Purchasing Manual. The Auditor's office will not process payment for an invoice without the required purchase order. Any expense incurred without the required Purchase Order must be submitted to the County Judge for his waiver of the Requisition requirement prior to submitting the expense to Accounts Payable for payment.
h) Discrepancies between invoices & purchase orders should be brought to the attention of the Purchasing department before submitting to Accounts Payable.

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i) A copy of the PO should be submitted with the invoice to properly release encumbered funds.

j) Invoices shall be submitted as a signed original or electronically. Do not submit both ways to avoid duplication of payment. Please include all relevant back up documents and signatures with the electronic copy.

k) All authorizations and account coding should be made on the invoice.

l) Approval signatures and account coding should not be made on the remittance portion of the invoice. If necessary, attach an additional sheet with approval authorization.

m) Some suppliers require payment at the time an order is placed. Please complete a purchase requisition and send the relevant backup documentation to the Purchasing department, who will then forward the request to Accounts Payable.

n) If a PO is not required, (Consult Purchasing Guide) please submit a check requisition request with appropriate documentation directly to Accounts Payable. Please note, in either circumstance there is a 13-20 day processing time from the date Accounts Payable receives the request.

o) Any questions or extenuating circumstances should be directed to the Accounts Payable department.

p) A request for reimbursement for an on-line expense (e.g., e-tickets or hotel deposit) a printout of the on-line/e-mail receipt should be attached to your expense report.

q) Cell phone use will be reimbursed/paid according to the county cell phone policy attached hereto as Addendum A.

r) Any mailings sent by a county department or official using county funds must be in furtherance of legitimate county business and must comply with all state ethics rules and other laws and regulations.~~s~~) All county meetings should be held in county facilities whenever feasible and such facilities are available. If county meeting space is not available, other publicly owned facilities, such as those owned by cities and school districts, should be utilized as the rental of these facilities is often at little or no cost.

t) Transfer of funds out of the following line items will not be allowed:

i) Training
ii) Gasoline
iii) Cell Phones

u) Transfer of funds into any of the above line items may be allowed.

v) Transfer of funds out of, within, or to the following line items will not be allowed, with the exception of line item 1107/Temp-Seasonal:

i. Salaries- This pertains to salary line items that are budgeted based on position control. This includes object codes 1100, 1101, 1102, and 1105. Line item transfers between 8000 accounts and salary lines for

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the purpose of merit money allocation/ re-allocation are permissible and will be placed on the agenda quarterly for Commissioners Court approval/review.

ii. Fringe Benefits

w) The County Budget Officer has the authority to approve a Line Item Transfer from Merit Pay to Salaries in compliance with the Compensation Policy.

VII. COUNTY VEHICLES

1. The use of county equipment or vehicles for personal use is prohibited by law, but because of the need for specific officials and specific employees to respond to emergencies at night or on weekends, the following officials and employees (with the concurrence of their department head) are required to take a county vehicle to their home at night within Williamson County, even though this involves the use of a county vehicle for travel to and from their residence each day:

a) The Sheriff and paid law enforcement as follows: Sheriff's Patrol Deputies, Sheriff's Detectives, on call Crime Scene Technician, on call Animal Control Officers, Sergeants, Lieutenants, Captains and Chiefs
b) One Chief and three Captains in the Corrections Division of the Sheriff's Office
c) Each Constable and Deputy Constables
d) Investigators in the District Attorney and County Attorneys offices
e) Two on call maintenance employees designated by the Maintenance Director and approved by the Commissioners Court
f) The EMS Director, EMS Deputy Director, Division Commanders, and Operation Commander(s) approved by EMS Director~~Tenured Field Command, and Commander of Clinical Practices.~~
g) The Hazardous Materials Chief and Assistant Haz-Mat Chief
h) The Director of Road and Bridge, (7) Unified Road Foremen, Unified Road East & West Side Supervisor(s), (4) Unified Road County Inspectors
i) The Director of 911 Communications and Deputy Director who may take home the vehicle when on duty in absence of the Director of 911 Communications~~.~~
j) The MOT Director and all on call MOT counselors
k) The Manager of Emergency Management and the Assistant Manager of Emergency Management

The following list has been grandfathered in by the previous court, will not be expanded and shall show significant decreases in each budget year until phased out.

Sheriff's Office
S. Zion
S. Shanks
D. Garrett
J. Hicks

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Constable Office Pct. 2
S. Holt

County vehicles assigned to departments or individuals that are not take home vehicles, shall be returned and parked at the end of each work day at the facility where the primary office is located.
It is expressly forbidden under this order for any county vehicle to be used for personal use at any time.

2.
A County Fleet Committee will review fleet policies and purchases and make recommendations for budgeting purposes. This committee will consist of one Commissioner's Court member, the Fleet Director, Sr. Director of Human Resources, Sr. Director of Infrastructure, Purchasing Agent, and the Budget Officer.

3. All accidents involving County vehicles and equipment will be reported to the Director of Analytics and Administration in the Human Resources Department on a timely basis, but never more than three days after an accident. The Director of Analytics and Administration will provide a report to Commissioner's Court on a quarterly basis of the status of the entire county fleet. This report will consist of, but not be limited to, a listing of vehicles involved in accidents and vehicles that need to be taken out of service for any reason. It will include information in regards to the disposal of any county vehicles.

VIII. COMMISSIONER'S COURT

This order designates the Commissioner's Court will meet on Tuesdays each month.

WHEREUPON MOTION MADE AND SECONDED, the ORDER ADOPTING THE 2015/2016 WILLIAMSON COUNTY BUDGET ORDER was passed on a vote of 5 for, and 0 against on the day of September , 2015.

This ORDER being adopted, the County Judge is authorized to sign the ORDER and the County Clerk is instructed to record the ORDER and the Budget in the official minutes of the Commissioner's Court.

Attest:

_____ _____
Dan A. Gattis, County Judge Nancy E. Rister, County Clerk

The Following Addendums are included fully in the Budget Order as approved by the court:

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Cell Phone Policy

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Williamson County Cell Phone Policy

Policy
Williamson County will no longer purchase cell phones or provide cell phone service for individual use except for those required for security reasons. For the majority of County employees, a stipend policy has been implemented and is laid out below.

Procedures for the Stipend Policy

I. Each department head or elected official will identify who they require to maintain a cell phone account in order to conduct official county business. Only regular full time employees and department heads will be allowed a stipend. The funds for cell phone stipends must be submitted and approved as part of each department's annual budget process.

II. Seven levels of cell phone stipends will be established:

$20.00 Per Month – ($10.00 per pmt)
$30.00 Per Month - ($15.00 per pmt)
$40.00 Per Month – ($20.00 per pmt)
$50.00 Per Month – ($25.00 per pmt)
$60.00 Per Month – ($30.00 per pmt)
$70.00 Per Month – ($35.00 per pmt)
$80.00 Per Month – ($40.00 per pmt)

III. Stipends will be paid semi-monthly for each approved employee or department head (will not be included on the third paycheck that is received twice each year) The cell phone stipend shall be removed by the department whenever an employee is on Administrative Leave with pay.

IV. Employees who are currently assigned a County owned cell phone will be allowed to keep the phone if approved for a stipend and may use the phone to obtain individual phone service. Any current county owned cell phone must be returned to the Auditor's Office if the employee terminates, changes positions, elects to obtain a different phone or is denied a County stipend. Any employee allowed to keep a currently issued County owned cell phone will keep the phone in good working condition. Replacement cost and/or maintenance will be the employee's responsibility.

V. All current County maintained cell phone accounts will be terminated as soon as possible when the current contract ends. No additional termination fees will be approved for payment unless approved by the County Judge.

VI. The cell phone stipend is considered supplemental income subject to IRS taxes and reporting requirements and will be processed through Payroll and will be included in the employee's gross income. Retirement contributions will also be deducted and matched in accordance with TCDRS.

VII. Expenditures over the allowed stipend will not be reimbursed.

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VIII. An approved cell phone stipend will not follow an employee if the employee changes positions.

IX. Each department head or elected official is responsible for verifying and monitoring their employees receiving a cell phone stipend has obtained the required service. Disciplinary action up to and including termination may result in an employee who receives a stipend and does not provide their department head or elected official with the proper documentation of cell phone service. Each department will maintain a list of cell phone numbers for those individuals with stipends for audit purposes.

X. To minimize the risk of incurring unpaid time worked, Offices and Departments should carefully monitor phone and e-mail access outside of scheduled time worked for non-exempt employees. Failure to comply with this policy may result in termination.

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Commissioners Court - Regular Session **46.**

Meeting Date: 09/01/2015

Economic Development

Submitted For: Charlie Crossfield **Submitted By:** Charlie Crossfield, Road Bond

Department: Road Bond

Agenda Category: Executive Session

Information

Agenda Item

Discussion regarding economic development negotiations pursuant to Texas Government Code, Section 551.087:

a) Business prospect(s) that may locate or expand within Williamson County.
b) Discuss Pearson Road District.
c) Discuss North Woods Road District.
d) Discuss Kaufman Loop.

Background

Fiscal Impact

From/To	Acct No.	Description	Amount

Attachments

No file(s) attached.

Form Review

Inbox	Reviewed By	Date
County Judge Exec Asst.	Wendy Coco	08/27/2015 10:29 AM
Form Started By: Charlie Crossfield		Started On: 08/27/2015 10:27 AM
Final Approval Date: 08/27/2015		

Commissioners Court - Regular Session **47.**

Meeting Date: 09/01/2015

Executive Session

Submitted For: Charlie Crossfield **Submitted By:** Charlie Crossfield, Road Bond

Department: Road Bond

Agenda Category: Executive Session

Information

Agenda Item

Discuss real estate matters (EXECUTIVE SESSION as per VTCA Govt. Code sec. 551.072 Deliberation Regarding Real Estate Property if deliberation in an open meeting would have a detrimental effect on the position of the governmental body in negotiations with third person.)

A. Real Estate Owned by Third Parties

1. Preliminary discussions relating to proposed or potential purchase or lease of property owned by third parties
a) Discuss proposed acquisition of property for right-of-way for SH 195
b) Discuss proposed acquisition of property for proposed SH 29 project.
c) Discuss proposed acquisition of property for SW 183 and SH 29 Loop.
d) Discuss possible acquisition of property with endangered species for mitigation purposes.
e) Discuss the acquisition of real property: Sneed Loop
f) Discuss the acquisition of real property: Neenah Blvd.
g) Discuss the acquisition of real property: CR 119
h) Discuss the acquisition of real property: Tradesman Park.
i) Discuss the acquisition of real property for proposed CR 110 project. (All sections)
j) Discuss the acquisition of real property: CR 258
k) Discuss the acquisition of real property: Kruger property exchange (3901 CR 130 Hutto, TX)
l) Discuss the acquisition of real property: Arterial H.
m) Discuss the acquisition of real property for County Facilities.
n) Discuss the acquisition of real property for the Williamson County Expo Center.
o) Discuss the acquisition of Easement interests on CR 240.
p) Discuss the acquisition of Easement interests for the Brushy Creek Trail Project.

B. Property or Real Estate owned by Williamson County

1. Preliminary discussions relating to proposed or potential sale or lease of property owned by the County
a) Discuss County owned real estate containing underground water rights and interests.
b) Discuss proposed sale of real estate on Inner Loop
c) Discuss proposed trade of real estate adjacent to Chandler Rd. and CR 130
d) Discuss proposed exchange of property with Mr. Kruger
e) Discuss real estate at 355 Texas Ave.

Background

Fiscal Impact

From/To	Acct No.	Description	Amount

Attachments

No file(s) attached.

Form Review

Inbox	Reviewed By	Date
County Judge Exec Asst.	Wendy Coco	08/27/2015 10:29 AM
Form Started By: Charlie Crossfield		Started On: 08/27/2015 10:25 AM
Final Approval Date: 08/27/2015		