
**PLAN DOCUMENT AND
SUMMARY PLAN DESCRIPTION
FOR**

CITY OF STAFFORD HEALTH CARE BENEFITS PLAN

TABLE OF CONTENTS

INTRODUCTION.....	1
PPO CORE PLAN	3
PPO BUY-UP PLAN	10
ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS	17
OPEN ENROLLMENT	23
SCHEDULE OF BENEFITS	24
MEDICAL BENEFITS	27
COST MANAGEMENT SERVICES	35
DEFINED TERMS	39
HOW TO SUBMIT A CLAIM	52
COORDINATION OF BENEFITS.....	54
THIRD PARTY RECOVERY PROVISION.....	57
CONTINUATION COVERAGE RIGHTS UNDER COBRA	59
RESPONSIBILITIES FOR PLAN ADMINISTRATION	66
GENERAL PLAN INFORMATION.....	70

INTRODUCTION

This document is a description of City of Stafford Health Care Benefits Plan (the Plan). No oral interpretations can change this Plan. The Plan described is designed to protect Plan Participants against certain catastrophic health expenses.

Coverage under the Plan will take effect for an eligible Employee and designated Dependents when the Employee and such Dependents satisfy all the eligibility requirements of the Plan.

The Employer fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue or amend the Plan at any time and for any reason.

Changes in the Plan may occur in any or all parts of the Plan including benefit coverage, deductibles, maximums, copayments, exclusions, limitations, definitions, eligibility and the like.

Failure to follow the eligibility or enrollment requirements of this Plan may result in delay of coverage or no coverage at all. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, such as coordination of benefits, subrogation, exclusions, timeliness of COBRA elections, utilization review or other cost management requirements, lack of Medical Necessity, lack of timely filing of claims or lack of coverage. These provisions are explained in summary fashion in this document; additional information is available from the Plan Administrator at no extra cost.

The Plan will pay benefits only for the expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage terminated. An expense for a service or supply is incurred on the date the service or supply is furnished.

No action at law or in equity shall be brought to recover under any section of this Plan until the appeal rights provided have been exercised and the Plan benefits requested in such appeals have been denied in whole or in part.

If the Plan is terminated, amended, or benefits are eliminated, the rights of Covered Persons are limited to Covered Charges incurred before termination, amendment or elimination.

This document summarizes the Plan rights and benefits for covered Employees and their Dependents and is divided into the following parts:

Eligibility, Funding, Effective Date and Termination. Explains eligibility for coverage under the Plan, funding of the Plan and when the coverage takes effect and terminates.

Schedule of Benefits. Provides an outline of the Plan reimbursement formulas as well as payment limits on certain services.

Benefit Descriptions. Explains when the benefit applies and the types of charges covered.

Cost Management Services. Explains the methods used to curb unnecessary and excessive charges.

This part should be read carefully since each Participant is required to take action to assure that the maximum payment levels under the Plan are paid.

Defined Terms. Defines those Plan terms that have a specific meaning.

Plan Exclusions. Shows what charges are **not** covered.

Claim Provisions. Explains the rules for filing claims and the claim appeal process.

Coordination of Benefits. Shows the Plan payment order when a person is covered under more than one plan.

Third Party Recovery Provision. Explains the Plan's rights to recover payment of charges when a Covered Person has a claim against another person because of injuries sustained.

Continuation Coverage Rights Under COBRA. Explains when a person's coverage under the Plan ceases and the continuation options which are available.

ERISA Information. Explains the Plan's structure and the Participants' rights under the Plan.

BENEFIT COVERAGE – PPO Core Plan

MEDICAL BENEFITS		
Covered Services	PPO Provider	Non-PPO Providers
Calendar Year Deductible		
Per Person	\$500	\$1,000
Per Family	\$1,000	\$2,000
Participating Provider Network: Memorial Hermann Health Network Providers, Inc. (MHHNP) Website: www.mhhnp.org		
Note: For Covered Health Services rendered by a provider, the benefits of this Plan will be provided after the deductible has been met, at the percentage of Usual and Reasonable Charges specified below until out-of-pocket amounts have been reached each Calendar Year. Thereafter, this Plan will provide benefits at 100% of the Usual and Reasonable Charge for the remainder of the Calendar Year for all Covered Health Services, unless otherwise specified. Any balances of charges not covered by this Plan will be the Covered Person’s responsibility to pay. The Usual and Reasonable Charge for services provided by both PPO and Non-PPO providers will be limited to the PPO Provider Allowable Rate.		
Maximum eligible out-of-pocket Expense		
Per Person	\$2,000	\$4,000
Per Family	\$6,000	\$8,000
Note: The maximum out-of-pocket expense limits for all providers are combined.		
The following expenses will not apply toward the maximum out-of-pocket expense limit:		
(1) Deductibles.		
(2) Co-payments.		
(3) Reduced reimbursement for failure to follow Care Coordination Procedures.		
(4) Any charge excluded in the Plan Exclusions.		
(5) Inpatient and outpatient treatment of Mental Disorders and Substance Abuse Treatment. These services will not be paid at the 100% out-of-pocket level.		
Lifetime Maximum Amount	\$1,000,000	
Note: The Lifetime maximum for all providers is combined.		
Pre-Certification Penalty (for failure to Pre-Certify a procedure that requires authorization)	\$200	\$200
Covered charges will be reduced \$200 if timely notification is not received for services which require Pre-Certification. Please see the Cost Management section of the plan for details.		
Allergy Treatment		
Injections	70% after deductible	50% after deductible
Testing	100% after co-payment (deductible waived)	50% after deductible
Co-payment per visit	\$30	No co-payment
Serum	70% after deductible	50% after deductible
Ambulance Services	80% after deductible	50% after deductible
Chiropractic Services (limited to \$1,000 maximum payable per Calendar Year)	100% after co-payment (deductible waived)	50% after deductible
Co-payment per visit	\$20	No co-payment

Covered Services	PPO Provider	Non-PPO Provider
Diagnostic X-ray and Laboratory Services		
Inpatient	80% after deductible	50% after deductible
Outpatient	80% after deductible	50% after deductible
<i>May need to be pre-certified – See Cost Management Section</i>		
Durable Medical Equipment	80% after deductible	50% after deductible
<i>May need to be pre-certified – See Cost Management Section</i>		
Emergency Room Hospital and Physician Services		
Medical Emergency	100% after co-payment (deductible waived)	100% after co-payment (deductible waived)
Co-payment per visit (waived if admitted to Hospital)	\$100	\$100
Non-Medical Emergency	Not Covered	Not Covered
Note: Non-PPO Emergency Room Hospital and Physician services rendered for a Medical Emergency will be payable at the PPO level of benefits if choice of Hospital was beyond the control of the Covered Person.		
Home Health Care (limited to 100 visits per Calendar Year)	80% after deductible	50% after deductible
<i>Must be pre-certified – See Cost Management Section</i>		
Note: A home health care visit will be considered a periodic visit by either a nurse or therapist, as the case may be.		
Hospice Care / Bereavement Counseling (limited to 6 months per lifetime)	80% after deductible	50% after deductible
Hospital Services		
Inpatient	80% after deductible	50% after deductible
<i>Daily Room and Board limited to the average semi-private room rate.</i>		
<i>Intensive Care Unit limited to the Hospital's ICU charge.</i>		
Outpatient	80% after deductible	50% after deductible
<i>Must be pre-certified – See Cost Management Section</i>		
Note: Covered services provided by a Radiologist, Anesthesiologist, or Pathologist when rendered in a PPO Hospital will be payable at the PPO level of benefits.		

Covered Services	PPO Provider	Non-PPO Provider
Infertility - Diagnostic Testing	80% after deductible	50% after deductible
Infertility - In-Vitro Fertilization Procedures	Not Covered	Not Covered
Injury to or Care of Mouth, Teeth and Gums	80% after deductible	50% after deductible
Inpatient Rehabilitation Facility Services	80% after deductible	50% after deductible
<i>Must be pre-certified – See Cost Management Section</i>		
Maternity Care – (Employee and Spouse Only)		
Physician Charges		
Office Visits	100% after co-payment (deductible waived)	50% after deductible
Co-payment per Visit – co-pay for initial visit only	\$20	No co-payment
Delivery	80% after deductible	50% after deductible
Hospital Charges	80% after deductible	50% after deductible
Birthing Centers	80% after deductible	50% after deductible
<i>Notification of delivery required – See Cost Management Section</i>		
Medication Management		
For Outpatient Mental Disorders		
(Not applicable to Mental Disorders limits)	Same as any other illness	Same as any other illness
Organ and Tissue Transplants	80% after deductible	50% after deductible
<i>Must be pre-certified – See Cost Management Section</i>		
Orthotics	80% after deductible	50% after deductible
<i>May need to be pre-certified – See Cost Management Section</i>		
Outpatient Private Duty Nursing Care	80% after deductible	50% after deductible
Physical Therapy		
(limited to 60 visits per Calendar Year; limit applies to outpatient and office services)		
Inpatient Hospital	80% after deductible	50% after deductible
Outpatient Hospital	100% after co-payment (deductible waived)	50% after deductible
Co-payment per Visit	\$20	No co-payment
Office	100% after co-payment (deductible waived)	50% after deductible
Co-payment per Visit	\$20	No co-payment

Covered Services	PPO Provider	Non-PPO Provider
Physician Office Services	100% after co-payment (deductible waived)	50% after deductible
Co-payment per Office Visit	\$20	No co-payment
(Applies to office services including related outside lab/x-ray services and surgeries. For the purposes of this benefit, outside lab/x-ray services are defined as services which the specimen/film is sent to an outside facility for processing/interpretation or where the patient is sent to an independent lab facility for testing.)		
Note: Services provided in a Physician's office that are otherwise shown in the Schedule of Benefits are not covered under this Benefit. Related outpatient Non-PPO diagnostic x-ray and lab services that are incurred as a result of a PPO Physician office visit will be payable at the PPO level of benefits.		
Pre-Admission Testing	80% after deductible	50% after deductible
Prosthetics	80% after deductible	50% after deductible
Second Surgical Opinion	100% after co-payment (deductible waived)	50% after deductible
Co-payment per Office Visit	\$20	No co-payment
Skilled Nursing Facility - Inpatient Services (limited to 100 days per Calendar Year) <i>Covered daily charge limited to the facility's semi-private room rate.</i>	80% after deductible	50% after deductible
Must be pre-certified – See Cost Management Section		
Speech Therapy / Hearing Therapy (limited to 60 visits per Calendar Year; limit applies to outpatient and office services)		
Inpatient Hospital	80% after deductible	50% after deductible
Outpatient	80% after deductible	50% after deductible
Office	100% after co-payment (deductible waived)	50% after deductible
Co-payment per Visit	\$20	No co-payment
Sterilization/Family Planning Services	Same as any other Illness	Same as any other Illness
Must be pre-certified – See Cost Management Section		
Surgery Surgeon, assistant surgeon and anesthesiologist services		
Inpatient Services	80% after deductible	50% after deductible
Outpatient Services	80% after deductible	50% after deductible
Outpatient Surgery Facility	80% after deductible	50% after deductible
Must be precertified – See Cost Management Section		

Covered Services	PPO Provider	Non-PPO Provider
Surgery, continued		
Surgery Performed in a Physician's Office	100% after co-payment (deductible waived)	50% after deductible
Co-payment per visit	\$20	No co-payment
Temporomandibular Joint (TMJ) Syndrome	80% after deductible	50% after deductible
<i>Coverage includes diagnostic testing, surgical and non-surgical procedures.</i>		
Urgent Care Facility	100% after co-payment (deductible waived)	50% after deductible
Co-payment per visit	\$50	No co-payment
Well Care - Age 6 and Over	100% after co-payment (deductible waived)	Not Covered
Co-payment per visit subject to Maximum Annual Benefit	\$20	No co-payment
Maximum Annual Benefit	\$300 (after \$300 limit is reached coverage reverts to 80% after deductible)	Not Applicable
<i>Coverage includes routine physical exam (limited to one exam per Calendar Year), Pap smear, gynecological exam, mammogram (limited to one per Calendar Year), prostate exam, colon exam, x-rays, laboratory tests and immunizations. Hearing exams, hearing aids, vision exams (does not include refractions), speech exams, speech testing and speech assessment through 17 year of age by a family physician or pediatrician.</i>		
Well Child Care - Age 5 and Under	100% after co-payment (deductible waived)	Not Covered
Co-payment per visit subject to Maximum Annual Benefit	\$20	No co-payment
Maximum Annual Benefit	\$300 (after \$300 limit is reached coverage reverts to 80% after deductible)	Not Applicable
<i>Coverage includes routine physical exam, laboratory tests, x-rays, immunizations (based on AMA guidelines), hearing exams, vision exams (does not include refractions), speech exams, speech testing and speech assessment.</i>		

Covered Services	PPO Provider	Non-PPO Provider
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Wigs - after chemotherapy	80% after deductible	50% after deductible
Mental Disorders (Physician visits are limited to one treatment per day)		
Inpatient Care (limited to 45 days per Calendar Year)	80% after deductible	50% after deductible
<i>Must be pre-certified – See Cost Management Section</i>		
Partial Hospitalization (limited to 60 days per Calendar Year; combined with inpatient care limits; two days of Partial Hospitalization are equal to one day of inpatient care)	80% after deductible	50% after deductible
Outpatient Care (limited to 60 days per Calendar Year)	100% after co-payment (deductible waived)	50% after deductible (up to a \$70 maximum payable per visit)
Co-payment per visit	\$30	No co-payment
Note: After all 60 partial hospitalization days are utilized, then any unused inpatient care days can be used to extend the partial hospitalization benefit at a rate of 2 partial hospitalization days to 1 inpatient day. Example - If all 60 partial hospitalization days were used and only 15 inpatient care days had been used, the remaining 30 inpatient days can be exchanged for up to 60 additional partial hospitalization days.		
Substance Abuse Treatment (Physician visits are limited to one treatment per day)		
Inpatient Care (limited to 45 days per Calendar Year)	80% after deductible	50% after deductible
Partial Hospitalization (limited to 60 days per Calendar Year; combined with inpatient care limits; two days of Partial Hospitalization are equal to one day of inpatient care)	80% after deductible	50% after deductible
<i>Must be pre-certified – See Cost Management Section</i>		
Outpatient Care (limited to 60 days per Calendar Year)	100% after co-payment (deductible waived)	50% after deductible (up to a \$70 maximum payable per visit)
Co-payment per visit	\$30	No co-payment
Note: After all 60 partial hospitalization days are utilized, then any unused inpatient care days can be used to extend the partial hospitalization benefit at a rate of 2 partial hospitalization days to 1 inpatient day. Example - If all 60 partial hospitalization days were used and only 15 inpatient care days had been used, the remaining 30 inpatient days can be exchanged for up to 60 additional partial hospitalization days.		
Serious Mental Illness	Same as any other Illness	Same as any other Illness
<i>May need to be pre-certified – See Cost Management Section</i>		

Covered Services	PPO Provider	Non-PPO Provider
All Other Covered Expenses	80% after deductible	50% after deductible
Note: Treatment rendered while traveling or living (for purposes other than seeking medical care) "Out of Area" will be paid at the Non-PPO level of benefits, subject to the deductible and the maximum out-of-pocket expense. "Out of Area" is defined as 30 miles or more from the nearest PPO Hospital or Physician. Charges for services rendered by a Provider whose specific specialty is not available in the network area will be considered at the PPO level of benefits, subject to the deductible and the maximum out-of-pocket expense.		

PRESCRIPTION DRUG BENEFITS Participating Provider is Caremark	
Covered Services	Percentage and/or Dollar Amount
Pharmacy Option - Prescription Drug Deductible	
Per Person	\$50
Note: Co-payments apply after the deductible is satisfied, for retail drugs only	
Pharmacy Option - Caremark Co-payment per Prescription (30 day supply)	
Tier 3 – Name Brand Drugs	\$40 after deductible
Tier 2 – Name Brand Drugs	\$22 after deductible
Tier 1 – Generic Drugs	\$10 after deductible
Mail Order Prescription Drug Option - Caremark (no deductible) Co-payment per Prescription (90 day supply)	
Tier 3 – Name Brand Drugs	\$80
Tier 2 – Name Brand Drugs	\$44
Tier 1 – Generic Drugs	\$20

BENEFIT COVERAGE – PPO Buy-Up Plan

MEDICAL BENEFITS		
Covered Services	PPO Provider	Non-PPO Providers
Calendar Year Deductible		
Per Person	\$200	\$500
Per Family	\$600	\$1,500
Participating Provider Network: Private Healthcare Systems, Inc. (PHCS) Website: www.phcs.com		
Note: For Covered Health Services rendered by a provider, the benefits of this Plan will be provided after the deductible has been met, at the percentage of Usual and Reasonable Charges specified below until out-of-pocket amounts have been reached each Calendar Year. Thereafter, this Plan will provide benefits at 100% of the Usual and Reasonable Charge for the remainder of the Calendar Year for all Covered Health Services, unless otherwise specified. Any balances of charges not covered by this Plan will be the Covered Person's responsibility to pay. The Usual and Reasonable Charge for services provided by both PPO and Non-PPO providers will be limited to the PPO Provider Allowable Rate.		
Maximum eligible out-of-pocket Expense		
Per Person	\$1,000	\$3,000
Per Family	\$2,000	\$6,000
Note: The maximum out-of-pocket expense limits for all providers are combined.		
The following expenses will not apply toward the maximum out-of-pocket expense limit:		
(1) Deductibles. (2) Co-payments. (3) Reduced reimbursement for failure to follow Care Coordination Procedures. (4) Any charge excluded in the Plan Exclusions. (5) Inpatient and outpatient treatment of Mental Disorders and Substance Abuse Treatment. These services will not be paid at the 100% out-of-pocket level.		
Lifetime Maximum Amount	\$1,000,000	
Note: The Lifetime maximum for all providers is combined.		
Pre-Certification Penalty (for failure to Pre-Certify a procedure that requires authorization)	\$200	\$200
Covered charges will be reduced \$200 if timely notification is not received for services which require Pre-Certification. Please see the Cost Management section of the plan for details.		
Allergy Treatment		
Injections	70% after deductible	70% after deductible
Testing	100% after co-payment (deductible waived)	70% after deductible
Co-payment per visit	\$25	No co-payment
Serum	70% after deductible	70% after deductible
Ambulance Services	90% after deductible	70% after deductible
Chiropractic Services (limited to \$1,000 maximum payable per Calendar Year)	100% after co-payment (deductible waived)	70% after deductible
Co-payment per visit	\$15	No co-payment

Covered Services	PPO Provider	Non-PPO Provider
Diagnostic X-ray and Laboratory Services		
Inpatient	90% after deductible	70% after deductible
Outpatient	90% after deductible	70% after deductible
<i>May need to be pre-certified – See Cost Management Section</i>		
Durable Medical Equipment	90% after deductible	70% after deductible
<i>May need to be pre-certified – See Cost Management Section</i>		
Emergency Room Hospital and Physician Services		
Medical Emergency	100% after co-payment (deductible waived)	100% after co-payment (deductible waived)
Co-payment per visit (waived if admitted to Hospital)	\$100	\$100
Non-Medical Emergency	Not Covered	Not Covered
Note: Non-PPO Emergency Room Hospital and Physician services rendered for a Medical Emergency will be payable at the PPO level of benefits if choice of Hospital was beyond the control of the Covered Person.		
Home Health Care (limited to 100 visits per Calendar Year)	90% after deductible	70% after deductible
<i>Must be pre-certified – See Cost Management Section</i>		
Note: A home health care visit will be considered a periodic visit by either a nurse or therapist, as the case may be.		
Hospice Care / Bereavement Counseling (limited to 6 months per lifetime)	90% after deductible	70% after deductible
Hospital Services		
Inpatient	90% after deductible	70% after deductible
<i>Daily Room and Board limited to the average semi-private room rate.</i>		
<i>Intensive Care Unit limited to the Hospital's ICU charge.</i>		
Outpatient	90% after deductible	70% after deductible
<i>Must be pre-certified – See Cost Management Section</i>		
Note: Covered services provided by a Radiologist, Anesthesiologist, or Pathologist when rendered in a PPO Hospital will be payable at the PPO level of benefits.		

Covered Services	PPO Provider	Non-PPO Provider
Infertility - Diagnostic Testing	90% after deductible	70% after deductible
Infertility - In-Vitro Fertilization Procedures	Not Covered	Not Covered
Injury to or Care of Mouth, Teeth and Gums	90% after deductible	70% after deductible
Inpatient Rehabilitation Facility Services	90% after deductible	70% after deductible
<i>Must be pre-certified – See Cost Management Section</i>		
Maternity Care – (Employee and Spouse Only)		
Physician Charges		
Office Visits	100% after co-payment (deductible waived)	70% after deductible
Co-payment per Visit – co-pay for initial visit only	\$15	No co-payment
Delivery	90% after deductible	70% after deductible
Hospital Charges	90% after deductible	70% after deductible
Birthing Centers	90% after deductible	70% after deductible
<i>Notification of delivery required – See Cost Management Section</i>		
Medication Management		
For Outpatient Mental Disorders		
(Not applicable to Mental Disorders limits)	Same as any other illness	Same as any other illness
Organ and Tissue Transplants	90% after deductible	70% after deductible
<i>Must be pre-certified – See Cost Management Section</i>		
Orthotics	90% after deductible	70% after deductible
<i>May need to be pre-certified – See Cost Management Section</i>		
Outpatient Private Duty Nursing Care	90% after deductible	70% after deductible
Physical Therapy		
(limited to 60 visits per Calendar Year; limit applies to outpatient and office services)		
Inpatient Hospital	90% after deductible	70% after deductible
Outpatient Hospital	100% after co-payment (deductible waived)	70% after deductible
Co-payment per Visit	\$15	No co-payment
Office	100% after co-payment (deductible waived)	70% after deductible
Co-payment per Visit	\$15	No co-payment

Covered Services	PPO Provider	Non-PPO Provider
Physician Office Services	100% after co-payment (deductible waived)	70% after deductible
Co-payment per Office Visit	\$15	No co-payment
(Applies to office services including related outside lab/x-ray services and surgeries. For the purposes of this benefit, outside lab/x-ray services are defined as services which the specimen/film is sent to an outside facility for processing/interpretation or where the patient is sent to an independent lab facility for testing.)		
Note: Services provided in a Physician's office that are otherwise shown in the Schedule of Benefits are not covered under this Benefit. Related outpatient Non-PPO diagnostic x-ray and lab services that are incurred as a result of a PPO Physician office visit will be payable at the PPO level of benefits.		
Pre-Admission Testing	90% after deductible	70% after deductible
Prosthetics	90% after deductible	70% after deductible
Second Surgical Opinion	100% after co-payment (deductible waived)	70% after deductible
Co-payment per Office Visit	\$15	No co-payment
Skilled Nursing Facility - Inpatient Services (limited to 100 days per Calendar Year) <i>Covered daily charge limited to the facility's semi-private room rate.</i>	90% after deductible	70% after deductible
<i>Must be pre-certified – See Cost Management Section</i>		
Speech Therapy / Hearing Therapy (limited to 60 visits per Calendar Year; limit applies to outpatient and office services)		
Inpatient Hospital	90% after deductible	70% after deductible
Outpatient	90% after deductible	70% after deductible
Office	100% after co-payment (deductible waived)	70% after deductible
Co-payment per Visit	\$15	No co-payment
Sterilization/Family Planning Services	Same as any other Illness	Same as any other Illness
<i>Must be pre-certified – See Cost Management Section</i>		
Surgery Surgeon, assistant surgeon and anesthesiologist services		
Inpatient Services	90% after deductible	70% after deductible
Outpatient Services	90% after deductible	70% after deductible
Outpatient Surgery Facility	90% after deductible	70% after deductible
<i>Must be precertified – See Cost Management Section</i>		

Covered Services	PPO Provider	Non-PPO Provider
Surgery, continued		
Surgery Performed in a Physician's Office	100% after co-payment (deductible waived)	70% after deductible
Co-payment per visit	\$15	No co-payment
Temporomandibular Joint (TMJ) Syndrome	90% after deductible	70% after deductible
<i>Coverage includes diagnostic testing, surgical and non-surgical procedures.</i>		
Urgent Care Facility	100% after co-payment (deductible waived)	70% after deductible
Co-payment per visit	\$50	No co-payment
Well Care - Age 6 and Over	100% after co-payment (deductible waived)	Not Covered
Co-payment per visit subject to Maximum Annual Benefit	\$15	No co-payment
Maximum Annual Benefit	\$300 (after \$300 limit is reached coverage reverts to 90% after deductible)	Not Applicable
<i>Coverage includes routine physical exam (limited to one exam per Calendar Year), Pap smear, gynecological exam, mammogram (limited to one per Calendar Year), prostate exam, colon exam, x-rays, laboratory tests and immunizations. Hearing exams, hearing aids, vision exams (does not include refractions), speech exams, speech testing and speech assessment through 17 year of age by a family physician or pediatrician.</i>		
Well Child Care - Age 5 and Under	100% after co-payment (deductible waived)	Not Covered
Co-payment per visit subject to Maximum Annual Benefit	\$15	No co-payment
Maximum Annual Benefit	\$300 (after \$300 limit is reached coverage reverts to 90% after deductible)	Not Applicable
<i>Coverage includes routine physical exam, laboratory tests, x-rays, immunizations (based on AMA guidelines), hearing exams, vision exams (does not include refractions), speech exams, speech testing and speech assessment.</i>		

Covered Services	PPO Provider	Non-PPO Provider
Wigs - after chemotherapy	90% after deductible	70% after deductible
Mental Disorders (Physician visits are limited to one treatment per day)		
Inpatient Care (limited to 45 days per Calendar Year)	90% after deductible	70% after deductible
<i>Must be pre-certified – See Cost Management Section</i>		
Partial Hospitalization (limited to 60 days per Calendar Year; combined with inpatient care limits; two days of Partial Hospitalization are equal to one day of inpatient care)	90% after deductible	70% after deductible
Outpatient Care (limited to 60 days per Calendar Year)	100% after co-payment (deductible waived)	70% after deductible (up to a \$70 maximum payable per visit)
Co-payment per visit	\$25	No co-payment
Note: After all 60 partial hospitalization days are utilized, then any unused inpatient care days can be used to extend the partial hospitalization benefit at a rate of 2 partial hospitalization days to 1 inpatient day. Example - If all 60 partial hospitalization days were used and only 15 inpatient care days had been used, the remaining 30 inpatient days can be exchanged for up to 60 additional partial hospitalization days.		
Substance Abuse Treatment (Physician visits are limited to one treatment per day)		
Inpatient Care (limited to 45 days per Calendar Year)	90% after deductible	70% after deductible
Partial Hospitalization (limited to 60 days per Calendar Year; combined with inpatient care limits; two days of Partial Hospitalization are equal to one day of inpatient care)	90% after deductible	70% after deductible
<i>Must be pre-certified – See Cost Management Section</i>		
Outpatient Care (limited to 60 days per Calendar Year)	100% after co-payment (deductible waived)	70% after deductible (up to a \$70 maximum payable per visit)
Co-payment per visit	\$25	No co-payment
Note: After all 60 partial hospitalization days are utilized, then any unused inpatient care days can be used to extend the partial hospitalization benefit at a rate of 2 partial hospitalization days to 1 inpatient day. Example - If all 60 partial hospitalization days were used and only 15 inpatient care days had been used, the remaining 30 inpatient days can be exchanged for up to 60 additional partial hospitalization days.		
Serious Mental Illness	Same as any other Illness	Same as any other Illness
<i>May need to be pre-certified – See Cost Management Section</i>		

Covered Services	PPO Provider	Non-PPO Provider
All Other Covered Expenses	90% after deductible	70% after deductible
Note: Treatment rendered while traveling or living (for purposes other than seeking medical care) "Out of Area" will be paid at the Non-PPO level of benefits, subject to the deductible and the maximum out-of-pocket expense. "Out of Area" is defined as 30 miles or more from the nearest PPO Hospital or Physician. Charges for services rendered by a Provider whose specific specialty is not available in the network area will be considered at the PPO level of benefits, subject to the deductible and the maximum out-of-pocket expense.		

PRESCRIPTION DRUG BENEFITS Participating Provider is Caremark	
Covered Services	Percentage and/or Dollar Amount
Pharmacy Option - Prescription Drug Deductible Per Person	\$50
Note: Co-payments apply after the deductible is satisfied, for retail drugs only	
Pharmacy Option - Caremark Co-payment per Prescription (30 day supply)	
Tier 3 – Name Brand Drugs	\$40 after deductible
Tier 2 – Name Brand Drugs	\$22 after deductible
Tier 1 – Generic Drugs	\$10 after deductible
Mail Order Prescription Drug Option - Caremark (no deductible) Co-payment per Prescription (90 day supply)	
Tier 3 – Name Brand Drugs	\$80
Tier 2 – Name Brand Drugs	\$44
Tier 1 – Generic Drugs	\$20

ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS

A Plan Participant should contact the Plan Administrator to obtain additional information, free of charge, about Plan coverage of a specific benefit, particular drug, treatment, test or any other aspect of Plan benefits or requirements.

ELIGIBILITY

Eligible Classes of Employees. All Active Employees of the Employer.

Eligibility Requirements for Employee Coverage. A person is eligible for Employee coverage from the first day that he or she:

- (1) is a Full-Time, Active Employee of the Employer. An Employee is considered to be Full-Time if he or she normally works at least 40 hours per week and is on the regular payroll of the Employer for that work.
- (2) is in a class eligible for coverage.

Eligible Classes of Dependents. A Dependent is any one of the following persons:

- (1) A covered Employee's Spouse and unmarried children or grandchildren from birth to the limiting age of 19 years. The Dependent children and grandchildren must be primarily dependent upon the covered Employee for support and maintenance. When a child reaches the limiting age, coverage will end on the child's birthday.

The term "Spouse" shall mean the person recognized as the covered Employee's husband or wife under the laws of the state where the covered Employee lives. The Plan Administrator may require documentation proving a legal marital relationship.

The term "children" shall include natural children living in the same household as the Employee, adopted children or children placed with a covered Employee in anticipation of adoption or Foster Children. Step-children who reside in the Employee's household may also be included as long as a natural parent remains married to the Employee and also resides in the Employee's household.

The term "grandchildren" shall mean an unmarried grandchild of the Employee for whom the Employee is a legal guardian.

A Dependent does not include a grandchild of the Employee, unless the Employee is the Legal Guardian of the grandchild. A Legal Guardian is defined as an adult who has been given the legal right by a court to control and care for a minor child. Court documents to prove Legal Guardianship must be provided prior to enrollment in the Plan.

If a covered Employee is the Legal Guardian of an unmarried child or children, these children may be enrolled in this Plan as covered Dependents.

The phrase "child placed with a covered Employee in anticipation of adoption" refers to a child whom the Employee intends to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such placement for adoption. The term "placed" means the assumption and retention by such Employee of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

Any child of a Plan Participant who is an alternate recipient under a qualified medical child support order shall be considered as having a right to Dependent coverage under this Plan.

A participant of this Plan may obtain, without charge, a copy of the procedures governing qualified medical child support order (QMCSO) determinations from the Plan Administrator.

The phrase "primarily dependent upon" shall mean dependent upon the covered Employee for support and maintenance as defined by the Internal Revenue Code and the covered Employee must declare the child as an income tax deduction. The Plan Administrator may require documentation proving dependency, including birth certificates, tax records or initiation of legal proceedings severing parental rights.

- (2) A covered Dependent child who reaches the limiting age and is Totally Disabled, incapable of self-sustaining employment by reason of mental or physical handicap, primarily dependent upon the covered Employee for support and maintenance and unmarried. The Plan Administrator may require, at reasonable intervals during the two years following the Dependent's reaching the limiting age, subsequent proof of the child's Total Disability and dependency.

After such two-year period, the Plan Administrator may require subsequent proof not more than once each year. The Plan Administrator reserves the right to have such Dependent examined by a Physician of the Plan Administrator's choice, at the Plan's expense, to determine the existence of such incapacity.

These persons are excluded as Dependents: other individuals living in the covered Employee's home, but who are not eligible as defined; the legally separated or divorced former Spouse of the Employee; any person who is on active duty in any military service of any country; or any person who is covered under the Plan as an Employee.

If a person covered under this Plan changes status from Employee to Dependent or Dependent to Employee, and the person is covered continuously under this Plan before, during and after the change in status, credit will be given for deductibles and all amounts applied to maximums.

If both mother and father are Employees, their children will be covered as Dependents of the mother or father, but not of both.

Eligibility Requirements for Dependent Coverage. A family member of an Employee will become eligible for Dependent coverage on the first day that the Employee is eligible for Employee coverage and the family member satisfies the requirements for Dependent coverage.

At any time, the Plan may require proof that a Spouse or a child qualifies or continues to qualify as a Dependent as defined by this Plan.

- (3) A Dependent child will continue to be covered after age 19, provided the child is a full-time student at an accredited school, college, university, vocational school, or education institution, primarily dependent upon the covered Employee for support and maintenance, is unmarried and under the limiting age of 25. When the child reaches either limiting age, coverage will end on the child's birthday. If the child does not maintain full-time status or graduates, coverage ends last day the child is enrolled as a full-time student.

Full-time student coverage continues only between semester/quarters if the student is enrolled as a full-time student in the next regular semester/quarter. If the student is not enrolled as a full-time student, coverage will be terminated retroactively to the last day of the attended school term.

FUNDING

Cost of the Plan. City of Stafford shares the cost of Employee and Dependent coverage under this Plan with the covered Employees. The enrollment application for coverage will include a payroll deduction authorization. This authorization must be filled out, signed and returned with the enrollment application.

The level of any Employee contributions is set by the Plan Administrator. The Plan Administrator reserves the right to change the level of Employee contributions.

PRE-EXISTING CONDITIONS

Covered charges incurred under Medical Benefits for Pre-Existing Conditions are not payable unless incurred 12 consecutive months after the person's Enrollment Date. This time may be offset if the person has Credible Coverage.

NOTE: Please see the Defined Terms section for a complete definition of a Pre-Existing Condition.

Waiver of the Pre-Existing Condition Limit. This waiver applies to the benefits of person who were covered under a prior terminated plan on its day of termination and became covered under this Plan on the effective date of this Plan.

The prior plan means the plan of benefits that was provided through the Employer and is replaced by this Plan.

The amount of time these persons were covered under the previous plan will be credited toward the Pre-Existing Conditions time limit of this plan.

NOTE: The length of the Pre-Existing Conditions Limitation may be reduced or eliminated if an eligible person has Creditable Coverage from another health plan.

An eligible person may request a certificate of Creditable Coverage from his or her prior plan within 24 months after losing coverage and the Employer will assist any eligible person in obtaining a certificate of Creditable Coverage from a prior plan.

A Covered Person will be provided a certificate of Creditable Coverage if he or she requests one either before losing coverage or within 24 months of coverage ceasing.

If, after Creditable Coverage has been taken into account, there will still be a Pre-Existing Conditions Limitation imposed on an individual, that individual will be so notified.

ENROLLMENT

Enrollment Requirements. An Employee must enroll for coverage by filling out and signing an enrollment application. If the covered Employee already has Dependent coverage, a newborn child will be automatically enrolled for 31 days from birth; otherwise, separate enrollment for a newborn child is required.

Enrollment Requirements for Newborn Children.

A newborn child of a covered Employee who has Dependent coverage is automatically enrolled in this Plan for 31 days. Charges for covered nursery care will be applied toward the Plan of the newborn child. If the newborn child is not enrolled in this Plan on a timely basis, as defined in the section "Timely Enrollments" following this section, there will be no payment from the Plan and the covered parent will be responsible for all costs.

Charges for covered routine Physician care will be applied toward the Plan of the newborn child. If the newborn child is not enrolled in this Plan on a timely basis, there will be no payment from the Plan and the covered parent will be responsible for all costs.

If the child is not enrolled within 31 days of birth, the enrollment will be considered a Late Enrollment.

TIMELY OR LATE ENROLLMENT

- (1) **Timely Enrollment** - The enrollment will be "timely" if the completed form is received by the Plan Administrator no later than 31 days after the person becomes eligible for the coverage, either initially or under a Special Enrollment Period.

If two Employees (husband and wife) are covered under the Plan and the Employee who is covering the Dependent children terminates coverage, the Dependent coverage may be continued by the other covered Employee as long as coverage has been continuous.

- (2) **Late Enrollment** - An enrollment is "late" if it is not made on a "timely basis" or during a Special Enrollment Period. Late Enrollees and their Dependents who are not eligible to join the Plan during a Special Enrollment Period may join only during open enrollment.

If an individual loses eligibility for coverage as a result of terminating employment or a general suspension of coverage under the Plan, then upon becoming eligible again due to resumption of employment or due to resumption of Plan coverage, only the most recent period of eligibility will be considered for purposes of determining whether the individual is a Late Enrollee.

The time between the date a Late Enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period. Coverage begins on October 1.

SPECIAL ENROLLMENT PERIODS

The enrollment date for anyone who enrolls under a Special Enrollment Period is the first date of coverage. Thus, the time between the date a special enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period.

- (1) **Individuals losing other coverage.** An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if each of the following conditions is met:
 - (a) The Employee or Dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual.
 - (b) If required by the Plan Administrator, the Employee stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment.
 - (c) The coverage of the Employee or Dependent who had lost the coverage was under COBRA and the COBRA coverage was exhausted, or was not under COBRA and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment or reduction in the number of hours of employment) or employer contributions towards the coverage were terminated.
 - (d) The Employee or Dependent requests enrollment in this Plan not later than 31 days after the date of exhaustion of COBRA coverage or the termination of coverage or employer contributions, described above. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received.

If the Employee or Dependent lost the other coverage as a result of the individual's failure to pay premiums or required contributions or for cause (such as making a fraudulent claim), that individual does not have a Special Enrollment right.

- (2) **Dependent beneficiaries.** If:
 - (a) The Employee is a participant under this Plan (or is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period), and
 - (b) A person becomes a Dependent of the Employee through marriage, birth, adoption or placement for adoption,

then the Dependent (and if not otherwise enrolled, the Employee) may be enrolled under this Plan as a covered Dependent of the covered Employee. In the case of the birth or adoption of a child, the Spouse of the covered Employee may be enrolled as a Dependent of the covered Employee if the Spouse is otherwise eligible for coverage.

The Dependent Special Enrollment Period is a period of 31 days and begins on the date of the marriage, birth, adoption or placement for adoption.

The coverage of the Dependent enrolled in the Special Enrollment Period will be effective:

- (a) in the case of marriage, the first day of the first month beginning after the date of the completed request for enrollment is received;
- (b) in the case of a Dependent's birth, as of the date of birth; or
- (c) in the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

EFFECTIVE DATE

Effective Date of Employee Coverage. An Employee will be covered under this Plan as of the first day that the Employee satisfies all of the following:

- (1) The Eligibility Requirement.
- (2) The Active Employee Requirement.
- (3) The Enrollment Requirements of the Plan.

Active Employee Requirement.

An Employee must be an Active Employee (as defined by this Plan) for this coverage to take effect.

Effective Date of Dependent Coverage. A Dependent's coverage will take effect on the day that the Eligibility Requirements are met; the Employee is covered under the Plan; and all Enrollment Requirements are met.

TERMINATION OF COVERAGE

When coverage under this Plan stops, Plan Participants will receive a certificate that will show the period of coverage under this Plan. Please contact the Plan Administrator for further details.

When Employee Coverage Terminates. Employee coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Employee may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled Continuation Coverage Rights under COBRA):

- (1) The date the Plan is terminated.
- (2) The day the covered Employee ceases to be in one of the Eligible Classes. This includes death or termination of Active Employment of the covered Employee. (See the Continuation Coverage Rights under COBRA.)

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

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

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

Rehiring a Terminated Employee. A terminated Employee who is rehired will be treated as a new hire and be required to satisfy all Eligibility and Enrollment requirements. However, if the Employee is returning to work directly from COBRA coverage, this Employee does not have to satisfy Pre-Existing Conditions provision.

Employees on Military Leave. Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act under the following circumstances. These rights apply only to Employees and their Dependents covered under the Plan before leaving for military service.

- (1) The maximum period of coverage of a person under such an election shall be the lesser of:
 - (a) The 18 month period beginning on the date on which the person's absence begins; or
 - (b) The day after the date on which the person was required to apply for or return to a position of employment and fails to do so.
- (2) A person who elects to continue health plan coverage may be required to pay up to 102% of the full contribution under the Plan, except a person on active duty for 30 days or less cannot be required to pay more than the Employee's share, if any, for the coverage.
- (3) An exclusion or Waiting Period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or Waiting Period may be imposed for coverage of any Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

When Dependent Coverage Terminates. A Dependent's coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Dependent may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled Continuation Coverage Rights under COBRA):

- (1) The date the Plan or Dependent coverage under the Plan is terminated.
- (2) The date that the Employee's coverage under the Plan terminates for any reason including death. (See the Continuation Coverage Rights under COBRA.)
- (3) The date a covered Spouse loses coverage due to loss of dependency status. (See the Continuation Coverage Rights under COBRA.)
- (4) On the first date that a Dependent child ceases to be a Dependent as defined by the Plan. (See the Continuation Coverage Rights under COBRA.)

OPEN ENROLLMENT

OPEN ENROLLMENT

Every September, the annual open enrollment period, Employees and their Dependents who are Late Enrollees will be able to enroll in the Plan.

Benefit choices for Late Enrollees made during the open enrollment period will become effective October 1.

Plan Participants will receive detailed information regarding open enrollment from their Employer.

SCHEDULE OF BENEFITS

Verification of Eligibility (713) 448-6535

Call this number to verify eligibility for Plan benefits **before** the charge is incurred.

MEDICAL BENEFITS

All benefits described in this Schedule are subject to the exclusions and limitations described more fully herein including, but not limited to, the Plan Administrator's determination that: care and treatment is Medically Necessary; that charges are Usual and Reasonable; that services, supplies and care are not Experimental and/or Investigational. The meanings of these capitalized terms are in the Defined Terms section of this document.

Only a general description of health benefits covered by this Plan is included in this document. A more detailed schedule of coverage is available to any Plan Participant, at no cost, who requests one from the Plan Administrator.

Note: The following services must be Pre-Certified or reimbursement from the Plan may be reduced by \$200.

The attending Physician does not have to obtain Pre-Certification from the Plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery. The plan only requires notification of the delivery.

**Hospitalizations – all admissions – inpatient/outpatient at hospital, Rehab, Skilled Nursing, etc.
MRI/MRA/CAT scans
Skilled Nursing Facility stays
Home Health Care
Durable Medical Equipment >\$1,000
Outpatient surgical procedures – unless performed in a physician's office
All nuclear tests / imaging
Colonoscopy
HIDA Scan
Injection >\$1,000
Myelogram
Orthotics > \$1,000
Out-of-network services to be covered in network**

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

The Plan is a plan which contains two Network Provider Organizations.

Buy-Up Plan PPO:

PPO name: Private Healthcare Systems, Inc. (PHCS)
Address: 1100 Winter Street
Waltham, MA 02451
Telephone: (781) 895-3458
E-mail: www.phcs.com

Core Plan PPO:

PPO name: Freedom of Choice (MHHNP Network)
Provided by: Memorial Hermann Health Network Providers, Inc.
Address: 9301 Southwest Freeway, Suite 5000
Houston, TX 77074
Telephone: (713) 448-6535
Fax: (713) 448-6550
E-mail: www.mhhnp.org

** Freedom of Choice Network providers must be used by all residents of the 12-County Freedom of Choice Area (see map of the 12 counties below). This includes all employees who work within the 12-County Freedom of Choice Area. All plan members who reside outside the 12 counties must use providers in the Freedom of Choice Network when visiting the 12 counties except during emergency situations. To find a Freedom of Choice Network provider, select the link above.*

Note: PHCS Network providers in the 12-county area are considered out-of-network for all plan members.

Map of the 12-County Freedom of Choice Area



For Residents and Visitors Outside the Freedom of Choice 12-County Area

Private Healthcare Systems (PHCS) Network *

** PHCS Network providers are considered in-network only outside of the 12-County Freedom of Choice Area (see map of the 12 counties above). All plan members who reside outside the 12 counties must use providers in the Freedom of Choice Network when visiting the 12 counties except during emergency situations. Residents of the 12-County Freedom of Choice area must receive an authorization to see any provider—including a PHCS provider—when outside the 12 counties except during emergency situations. To find a PHCS Network provider, select the link above.*

Note: Employees who work within the 12-County Freedom of Choice Area are considered in the same category as residents of the 12-County area and subject to the same rules. Please see the Freedom of Choice section above for more information.

This Plan has entered into an agreement with certain Hospitals, Physicians and other health care providers, which are called Network Providers. Because these Network Providers have agreed to charge reduced fees to persons covered under the Plan, the Plan can afford to reimburse a higher percentage of their fees.

Therefore, when a Covered Person uses a Network Provider, that Covered Person will receive a higher payment from the Plan than when a Non-network Provider is used. It is the Covered Person's choice as to which Provider to use.

Under the following circumstances, the higher in-Network payment will be made for certain non-Network services:

If a Covered Person has no choice of Network Providers in the specialty that the Covered Person is seeking within the PPO service area.

If a Covered Person is out of the PPO service area and has a Medical Emergency requiring immediate care.

If a Covered Person receives Physician or anesthesia services by a non-Network Provider at an in-Network facility.

Additional information about this option, as well as a list of Network Providers, will be given to Plan Participants, at no cost, and updated as needed.

Deductibles/Copayments payable by Plan Participants

Deductibles/Copayments are dollar amounts that the Covered Person must pay before the Plan pays.

A deductible is an amount of money that is paid once a Calendar Year per Covered Person. Typically, there is one deductible amount per Plan and it must be paid before any money is paid by the Plan for any Covered Charges. Each January 1st, a new deductible amount is required. Deductibles do not accrue toward the 100% maximum out-of-pocket payment.

MEDICAL BENEFITS

Medical Benefits apply when Covered Charges are incurred by a Covered Person for care of an Injury or Sickness and while the person is covered for these benefits under the Plan.

DEDUCTIBLE

Deductible Amount. This is an amount of Covered Charges for which no benefits will be paid. Before benefits can be paid in a Calendar Year a Covered Person must meet the deductible shown in the Schedule of Benefits.

This amount will not accrue toward the 100% maximum out-of-pocket payment.

Family Unit Limit. When the maximum amount shown in the Schedule of Benefits has been incurred by members of a Family Unit toward their Calendar Year deductibles, the deductibles of all members of that Family Unit will be considered satisfied for that year.

BENEFIT PAYMENT

Each Calendar Year, benefits will be paid for the Covered Charges of a Covered Person that are in excess of the deductible and any copayments. Payment will be made at the rate shown under reimbursement rate in the Schedule of Benefits. No benefits will be paid in excess of the Maximum Benefit Amount or any listed limit of the Plan.

OUT-OF-POCKET LIMIT

Covered Charges are payable at the percentages shown each Calendar Year until the out-of-pocket limit shown in the Schedule of Benefits is reached. Then, Covered Charges incurred by a Covered Person will be payable at 100% (except for the charges excluded) for the rest of the Calendar Year.

When a Family Unit reaches the out-of-pocket limit, Covered Charges for that Family Unit will be payable at 100% (except for the charges excluded) for the rest of the Calendar Year.

LIFETIME MAXIMUM BENEFIT AMOUNT

The Maximum Benefit Amount is shown in the Schedule of Benefits. It is the total amount of benefits that will be paid under the Plan for all Covered Charges incurred by a Covered Person.

COVERED CHARGES

Covered charges are the Usual and Reasonable Charges that are incurred for the following items of service and supply. These charges are subject to the benefit limits, exclusions and other provisions of this Plan. A charge is incurred on the date that the service or supply is performed or furnished.

- (1) **Hospital Care.** The medical services and supplies furnished by a Hospital or Ambulatory Surgical Center or a Birthing Center. Covered charges for room and board will be payable as shown in the Schedule of Benefits. After 23 observation hours, a confinement will be considered an inpatient confinement.

Room charges made by a Hospital having only private rooms will be paid at 80% of the average private room rate.

Charges for an Intensive Care Unit stay are payable as described in the Schedule of Benefits.

- (2) **Coverage of Pregnancy.** The Usual and Reasonable Charges for the care and treatment of Pregnancy are covered the same as any other Sickness.

Group health plans generally may not, under Federal law, 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 cesarean section. However, Federal law generally does not

prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

The Usual and Reasonable Charges for the care and treatment of Pregnancy are covered the same as any other Sickness for a covered Employee or covered Spouse only. Only Usual and Reasonable Charges for a Complication of Pregnancy are payable for the Pregnancy of a Dependent child or Dependent grandchild.

(3) **Skilled Nursing Facility Care.** The room and board and nursing care furnished by a Skilled Nursing Facility will be payable if and when:

- (a) the patient is confined as a bed patient in the facility;
- (b) the attending Physician certifies that the confinement is needed for further care of the condition that caused the Hospital confinement; and
- (c) the attending Physician completes a treatment plan which includes a diagnosis, the proposed course of treatment and the projected date of discharge from the Skilled Nursing Facility.

Covered charges for a Covered Person's care in these facilities is limited to the covered daily maximum shown in the Schedule of Benefits.

(4) **Physician Care.** The professional services of a Physician for surgical or medical services.

- (a) Charges for **multiple surgical procedures** will be a Covered Charge subject to the following provisions:
 - (i) If bilateral or multiple surgical procedures are performed by one (1) surgeon, benefits will be determined based on the Usual and Reasonable Charge that is allowed for the primary procedures; 50% of the Usual and Reasonable Charge will be allowed for each additional procedure performed through the same incision. Any procedure that would not be an integral part of the primary procedure or is unrelated to the diagnosis will be considered "incidental" and no benefits will be provided for such procedures;
 - (ii) If multiple unrelated surgical procedures are performed by two (2) or more surgeons on separate operative fields, benefits will be based on the Usual and Reasonable Charge for each surgeon's primary procedure. If two (2) or more surgeons perform a procedure that is normally performed by one (1) surgeon, benefits for all surgeons will not exceed the Usual and Reasonable percentage allowed for that procedure; and
 - (iii) If an assistant surgeon is required, the assistant surgeon's covered charge will not exceed 20% of the surgeon's Usual and Reasonable allowance.

(5) **Private Duty Nursing Care.** The private duty nursing care by a licensed nurse (R.N., L.P.N. or L.V.N.). Covered charges for this service will be included to this extent:

- (a) **Inpatient Nursing Care.** Charges are covered only when care is Medically Necessary or not Custodial in nature and the Hospital's Intensive Care Unit is filled or the Hospital has no Intensive Care Unit.
- (b) **Outpatient Nursing Care.** Charges for outpatient private duty nursing care by a licensed nurse (R.N., L.P.N., or L.V.N.) when care is not Custodial in nature, as shown in the Schedule of Benefits.

(6) **Home Health Care Services and Supplies.** Charges for home health care services and supplies are covered only for care and treatment of an Injury or Sickness when Hospital or Skilled Nursing Facility

confinement would otherwise be required. The diagnosis, care and treatment must be certified by the attending Physician and be contained in a Home Health Care Plan.

Benefit payment for nursing, home health aide and therapy services is subject to the Home Health Care limit shown in the Schedule of Benefits.

A home health care visit will be considered a periodic visit by either a nurse or therapist, as the case may be, or four hours of home health aide services.

- (7) **Hospice Care Services and Supplies.** Charges for hospice care services and supplies are covered only when the attending Physician has diagnosed the Covered Person's condition as being terminal, determined that the person is not expected to live more than six months and placed the person under a Hospice Care Plan.

Covered charges for Hospice Care Services and Supplies are payable as described in the Schedule of Benefits.

Bereavement counseling services by a licensed social worker or a licensed pastoral counselor for the patient's immediate family (covered Spouse and/or covered Dependent Children). Bereavement services must be furnished within six months after the patient's death.

- (8) **Other Medical Services and Supplies.** These services and supplies not otherwise included in the items above are covered as follows:

- (a) **Abortion.** Elective, induced abortion.
- (b) **Allergy Treatment** – Allergy treatment to include injections, testing and serum, as shown in the Schedule of Benefits.
- (c) Local Medically Necessary professional land or air **Ambulance** service. A charge for this item will be a Covered Charge only if the service is to the nearest Hospital or Skilled Nursing Facility where necessary treatment can be provided unless the Plan Administrator finds a longer trip was Medically Necessary.
- (d) **Anesthetic;** oxygen; blood and blood derivatives that are not donated or replaced; intravenous injections and solutions. Administration of these items is included.
- (e) **Blood, Blood Derivatives and Other Fluids** – Blood and blood derivatives that are not donated or replaced; intravenous injections and solutions. Administration of these items is included.
- (f) **Cardiac Rehabilitation** as deemed Medically Necessary provided services are rendered (a) under the supervision of a Physician; (b) in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery; (c) initiated within 12 weeks after other treatment for the medical condition ends; and (d) in a Medical Care Facility as defined by this Plan.
- (g) Radiation or **Chemotherapy** and treatment with radioactive substances. The materials and services of technicians are included.
- (h) Initial **Contact lenses** or glasses required following cataract surgery.
- (i) **Cornea Transplants** – Cornea transplants and all related covered expenses when incurred by a Covered Person who is the recipient of such transplant.

This benefit includes organ and tissue procurement from a donor consisting of removal, surgical storage and transportation costs incurred which are directly related to the donation of an organ used in a covered transplant procedure.

- (j) **Diabetes Self-Management Training**, including initial training after a diagnosis of diabetes, and continuing education when prescribed by a Physician as warranted by the development of new techniques or treatments for diabetes.
- (k) **Diagnostic X-ray and Laboratory Services**, excluding dental x-rays, as shown in the Schedule of Benefits.
- (l) Rental of **durable medical or surgical equipment** if deemed Medically Necessary. These items may be bought rather than rented, with the cost not to exceed the fair market value of the equipment at the time of purchase, but only if agreed to in advance by the Plan Administrator.
- (m) **Emergency Room Services** for stabilization or initiation of treatment of a Medical Emergency condition provided on an outpatient basis at a Hospital, as shown in the Schedule of Benefits.
- (n) **Family Planning Services** Charges for tubal ligations ,IUD, vasectomy and diaphragms.
- (o) **Home Health Care** Part-time, intermittent Skilled Care Services provided by a Home Health Care Agency when a Hospital or Skilled Nursing Facility Confinement would otherwise be required. The diagnosis, care and treatment must be:
 - (i) certified by the attending Physician;
 - (ii) contained in a Home Health Care Plan;
 - (iii) provided where the Covered Person resides; and
 - (iv) provided by or under the supervision of a registered nurse.

Covered charges for Home Health Care are payable as shown in the Schedule of Benefits.

- (p) Care, supplies and services for the diagnosis of **infertility**. Diagnostic services as shown in the Schedule of Benefits, subject to the following:
 - (i) the patient and the patient's spouse have a history of infertility of at least five continuous years' duration, or the infertility is associated with one or more of the following conditions:
 - a. endometriosis;
 - b. exposure in utero to diethylstilbesterol (DES);
 - c. blockage of or surgical removal of one or both fallopian tubes; or
 - d. oligospermia;
- (q) **Inpatient Rehabilitation Facility Service**. Confinement in an Inpatient Rehabilitation Facility, including medical services and supplies provided during such Confinement as shown in the Schedule of Benefits. Benefits are available only for the care and treatment of an Illness or Injury when a Hospital Confinement would otherwise be required.
- (r) Medically Necessary services for care and treatment of **jaw joint conditions, including Temporomandibular Joint syndrome**.
- (s) **Laboratory studies**.
- (t) **Marital and Family Counseling/Training**. Charges for marital counseling, family counseling and other counseling or training.
- (u) **Maternity Care**. The Usual and Reasonable Charges for prenatal care, delivery, and postnatal care for treatment of Pregnancy are covered as shown in the Schedule of Benefits for a covered Employee or covered Spouse.

***Note:** Coverage for a Hospital stay following a normal vaginal delivery may not be limited to less than 48 hours for both the mother (if a Covered Person) and the newborn child unless a shorter stay is agreed to by both the mother and her attending Physician. Coverage for a Hospital stay in connection with childbirth following a Cesarean section may not be limited to*

less than 96 hours for both the mother (if a Covered Person) and the newborn child unless a shorter stay is agreed to by both the mother and her attending Physician.

There is no coverage of Pregnancy for a Dependent daughter or Dependent granddaughter. However, Complications of Pregnancy for a Dependent daughter or Dependent granddaughter are covered under this Plan.

- (v) Treatment of **Mental Disorders and Substance Abuse**. Covered charges for care, supplies and treatment of Mental Disorders and Substance Abuse will be limited as follows:

All treatment is subject to the benefit payment maximums shown in the Schedule of Benefits.

Physician's visits are limited to one treatment per day.

Psychiatrists (M.D.), psychologists (Ph.D.), counselors (Ph.D.) or Masters of Social Work (M.S.W.) may bill the Plan directly. Other licensed mental health practitioners must be under the direction of and must bill the Plan through these professionals.

- (w) Injury to or care of **mouth, teeth and gums**. Charges for Injury to or care of the mouth, teeth, gums and alveolar processes will be Covered Charges under Medical Benefits only if that care is for the following oral surgical procedures:

Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.

Emergency repair due to Injury to sound natural teeth.

Surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth.

Excision of benign bony growths of the jaw and hard palate.

External incision and drainage of cellulitis.

Incision of sensory sinuses, salivary glands or ducts.

Removal of impacted teeth.

Reduction of dislocations and excision of temporomandibular joints (TMJs).

No charge will be covered under Medical Benefits for dental and oral surgical procedures involving orthodontic care of the teeth, periodontal disease and preparing the mouth for the fitting of or continued use of dentures.

- (x) **Organ transplant** limits. Charges otherwise covered under the Plan that are incurred for the care and treatment due to an organ or tissue transplant are subject to these limits:

The transplant must be performed to replace an organ or tissue.

There is no coverage under the Plan for charges incurred in obtaining donor organs or tissues. This includes charges for:

evaluating the organ or tissue;

removing the organ or tissue from the donor; and

transportation of the organ or tissue from within the United States and Canada to the place where the transplant is to take place.

- (y) The initial purchase, fitting and repair of **orthotic appliances** such as braces, splints or other appliances which are required for support for an injured or deformed part of the body as a result of a disabling congenital condition or an Injury or Sickness.
 - (z) **Outpatient Private Duty Nursing** by a licensed nurse (R.N., L.P.N, or L.V.N.) when care is not Custodial in nature, as shown in the Schedule of Benefits.
 - (aa) **Physical therapy** by a licensed physical therapist. The therapy must be in accord with a Physician's exact orders as to type, frequency and duration and for conditions which are subject to significant improvement through short-term therapy.
 - (ab) Charges for special dietary formulas for **Phenylketonuria (PKU)** when recommended by a physician.
 - (ac) **Physical Therapy** by a licensed physical therapist, as shown in the Schedule of Benefits subject to the copayment shown in the Schedule of Benefits. The therapy must be in accord with a Physician's exact orders as to type, frequency and duration and to improve a body function. Massage therapy when performed by a licensed physical therapist in connection with covered physical therapy services is also included in this benefit.
 - (ad) **Physician Services** for an Illness or Injury, as shown in the Schedule of Benefits.
 - (ae) **Podiatry.** Treatment of any condition resulting from weak, unstable or flat feet, when an open cutting operation is performed or for treatment of corns, calluses or toenails, when at least part of the nail root is removed. Treatment of bunions when an open cutting operation or arthroscopy is performed.
 - (af) Diagnostic lab tests and x-ray exams for **Pre-Admission Testing** will be payable as shown in the Schedule of Benefits when:
 - (i) Related to the condition which causes the Confinement; and
 - (ii) Performed in place of tests while Hospital Confined.

Covered charges for this testing will be payable even if tests show the condition requires medical treatment prior to Hospital Confinement or the Hospital Confinement is not required.
 - (ag) **Prescription** Drugs as defined in the Prescription Drugs Benefits section of this booklet.
 - (ah) **Prosthetics.** The initial purchase, fitting, repair and replacement of fitted prosthetic devices, which replace body parts, as shown in the Schedule of Benefits.
 - (ai) **Reconstructive Surgery.** Correction of abnormal congenital conditions, repair of damage from an accident and reconstructive mammoplasties will be considered covered charges. Reconstructive surgery for craniofacial abnormalities in a child under 18 years of age, to improve the function of, or to attempt to create a normal appearance of an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infections, or disease.
- This mammoplasty coverage will include reimbursement for:
- (i) Reconstruction of the breast on which a mastectomy has been performed,
 - (ii) Surgery and reconstruction of the other breast to produce a symmetrical appearance, and
 - (iii) Coverage of prostheses and physical complications during all stages of mastectomy, including lymphedemas,
- in a manner determined in consultation with the attending Physician and the patient.
- (aj) **Routine Preventive Care.** Covered charges under Medical Benefits are payable for routine Preventive Care as described in the Schedule of Benefits.

Charges for Routine Well Adult Care. Routine well adult care is care by a Physician that is not for an Injury or Sickness.

Charges for Routine Well Child Care. Routine well child care is routine care by a Physician that is not for an Injury or Sickness.

Well Child Care includes appropriate immunizations including the following childhood immunizations:

Diphtheria
Haemophilus influenza type B
Hepatitis B
Measles
Mumps
Pertussis
Polio
Rubella
Tetanus
Varicella, and

Any other immunization that is required by law for the child

- (ak) Charges for the care and treatment of **Sleep Disorders**.
- (al) **Speech therapy** by a licensed speech therapist. Therapy must be ordered by a Physician and follow either: (i) surgery for correction of a congenital condition of the oral cavity, throat or nasal complex (other than a frenectomy) of a person; (ii) an Injury; or (iii) a Sickness that is other than a learning or Mental Disorder. Include wording for Hearing Therapy as well
- (am) **Spinal Manipulation/Chiropractic services** by a licensed M.D., D.O. or D.C.
- (an) **Sterilization** procedures.
- (ao) **Surgical dressings**, splints, casts and other devices used in the reduction of fractures and dislocations.
- (ap) Coverage of **Well Newborn Nursery/Physician Care**.

Charges for Routine Nursery Care. Routine well newborn nursery care is care while the newborn is Hospital-confined after birth and includes room, board and other normal care for which a Hospital makes a charge.

This coverage is only provided if a parent is a Covered Person who was covered under the Plan at the time of the birth and the newborn child is an eligible Dependent and is neither injured nor ill.

The benefit is limited to Usual and Reasonable Charges for nursery care for the newborn child while Hospital confined as a result of the child's birth.

Charges for covered routine nursery care will be applied toward the Plan of the newborn child.

Group health plans generally may not, under Federal law, 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 cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require

that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Charges for Routine Physician Care. The benefit is limited to the Usual and Reasonable Charges made by a Physician for the newborn child while Hospital confined as a result of the child's birth.

Charges for covered routine Physician care will be applied toward the Plan of the newborn child.

- (aq) Charges associated with the initial purchase of a **wig after chemotherapy**.
- (ar) Diagnostic **x-rays**.

COST MANAGEMENT SERVICES (Pre-Certification)

Cost Management Services Phone Number

Memorial Hermann Health Network Providers, Inc.
(713) 448-6588

Please refer to the Employee ID card for the Cost Management Services phone number.

The patient or family member must call this number to receive certification of certain Cost Management Services. This call must be made at least 15 days in advance of services being rendered or within 2 business days after an emergency.

Any reduced reimbursement due to failure to follow cost management procedures will not accrue toward the 100% maximum out-of-pocket payment.

UTILIZATION REVIEW

Utilization review is a program designed to help insure that all Covered Persons receive necessary and appropriate health care while avoiding unnecessary expenses.

The program consists of:

- (a) Precertification of the Medical Necessity for the following non-emergency services before Medical and/or Surgical services are provided:
 - Hospitalizations – all admissions – inpatient/outpatient at hospital, Rehab, Skilled Nursing, etc.
 - MRI/MRA/CAT scans
 - Skilled Nursing Facility stays
 - Home Health Care
 - Durable Medical Equipment >\$1,000
 - Outpatient surgical procedures – unless performed in a physician's office
 - All nuclear tests / imaging
 - Colonoscopy
 - HIDA Scan
 - Injection >\$1,000
 - Myelogram
 - Orthotics > \$1,000
 - Out-of-network services to be covered in network
- (b) Retrospective review of the Medical Necessity of the listed services provided on an emergency basis;
- (c) Concurrent review, based on the admitting diagnosis, of the listed services requested by the attending Physician; and
- (d) Certification of services and planning for discharge from a Medical Care Facility or cessation of medical treatment.

The purpose of the program is to determine what charges may be eligible for payment by the Plan. This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending Physician or other health care provider.

If a particular course of treatment or medical service is not certified, it means that either the Plan will not pay for the charges or the Plan will not consider that course of treatment as appropriate for the maximum reimbursement under the Plan. The patient is urged to find out why there is a discrepancy between what was requested and what was certified before incurring charges.

The attending Physician does not have to obtain precertification from the Plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.

In order to maximize Plan reimbursements, please read the following provisions carefully.

Here's how the program works.

Precertification. Before a Covered Person enters a Medical Care Facility on a non-emergency basis or receives other listed medical services, the utilization review administrator will, in conjunction with the attending Physician, certify the care as appropriate for Plan reimbursement. A non-emergency stay in a Medical Care Facility is one that can be scheduled in advance.

The utilization review program is set in motion by a telephone call from the Covered Person. Contact the utilization review administrator at the telephone number on your ID card **at least 15 days before** services are scheduled to be rendered with the following information:

- The name of the patient and relationship to the covered Employee
- The name, Social Security number and address of the covered Employee
- The name of the Employer
- The name and telephone number of the attending Physician
- The name of the Medical Care Facility, proposed date of admission, and proposed length of stay
- The diagnosis and/or type of surgery
- The proposed rendering of listed medical services

If there is an **emergency** admission to the Medical Care Facility, the patient, patient's family member, Medical Care Facility or attending Physician must contact the utilization review administrator **within 2 business days** of the first business day after the admission.

The utilization review administrator will determine the number of days of Medical Care Facility confinement or use of other listed medical services authorized for payment. **Failure to follow this procedure may reduce reimbursement received from the Plan.**

If the Covered Person does not receive authorization as explained in this section, the benefit payment will be reduced by \$200.

Concurrent review, discharge planning. Concurrent review of a course of treatment and discharge planning from a Medical Care Facility are parts of the utilization review program. The utilization review administrator will monitor the Covered Person's Medical Care Facility stay or use of other medical services and coordinate with the attending Physician, Medical Care Facilities and Covered Person either the scheduled release or an extension of the Medical Care Facility stay or extension or cessation of the use of other medical services.

If the attending Physician feels that it is Medically Necessary for a Covered Person to receive additional services or to stay in the Medical Care Facility for a greater length of time than has been precertified, the attending Physician must request the additional services or days.

SECOND AND/OR THIRD OPINION PROGRAM

Certain surgical procedures are performed either inappropriately or unnecessarily. In some cases, surgery is only one of several treatment options. In other cases, surgery will not help the condition.

In order to prevent unnecessary or potentially harmful surgical treatments, the second and/or third opinion program fulfills the dual purpose of protecting the health of the Plan's Covered Persons and protecting the financial integrity of the Plan.

Benefits will be provided for a second (and third, if necessary) opinion consultation to determine the Medical Necessity of an elective surgical procedure. An elective surgical procedure is one that can be scheduled in advance; that is, it is not an emergency or of a life-threatening nature. Benefits for the second (and third, if necessary) opinion will be paid as any other Sickness.

The patient may choose any board-certified specialist who is not an associate of the attending Physician and who is affiliated in the appropriate specialty.

While any surgical treatment is allowed a second opinion, the following procedures are ones for which surgery is often performed when other treatments are available.

Appendectomy	Hernia surgery	Spinal surgery
Cataract surgery	Hysterectomy	Surgery to knee, shoulder, elbow or toe
Cholecystectomy (gall bladder removal)	Mastectomy surgery	Tonsillectomy and adenoidectomy
Deviated septum (nose surgery)	Prostate surgery	Tympanotomy (inner ear)
Hemorrhoidectomy	Salpingo-oophorectomy (removal of tubes/ovaries)	Varicose vein ligation

PREADMISSION TESTING SERVICE

The Medical Benefits percentage payable will be for diagnostic lab tests and x-ray exams when:

- (1) performed on an outpatient basis within seven days before a Hospital confinement;
- (2) related to the condition which causes the confinement; and
- (3) performed in place of tests while Hospital confined.

Covered charges for this testing will be payable at 90% for In-Network services and 70% for Out-of-Network services even if tests show the condition requires medical treatment prior to Hospital confinement or the Hospital confinement is not required.

CASE MANAGEMENT

Case Management. The Plan may elect, in its sole discretion, when acting on a basis that precludes individual selection, to provide alternative benefits that are otherwise excluded under the Plan. The alternative benefits, called "Case Management," shall be determined on a case-by-case basis, and the Plan's determination to provide the benefits in one instance shall not obligate the Plan to provide the same or similar alternative benefits for the same or any other Covered Person, nor shall it be deemed to waive the right of the Plan to strictly enforce the provisions of the Plan.

A case manager consults with the patient, the family and the attending Physician in order to develop a plan of care for approval by the patient's attending Physician and the patient. This plan of care may include some or all of the following:

- personal support to the patient;
- contacting the family to offer assistance and support;
- monitoring Hospital or Skilled Nursing Facility;
- determining alternative care options; and
- assisting in obtaining any necessary equipment and services.

Case Management occurs when this alternate benefit will be beneficial to both the patient and the Plan.

The case manager will coordinate and implement the Case Management program by providing guidance and information on available resources and suggesting the most appropriate treatment plan. The Plan Administrator, attending Physician, patient and patient's family must all agree to the alternate treatment plan.

Once agreement has been reached, the Plan Administrator will direct the Plan to reimburse for Medically Necessary expenses as stated in the treatment plan, even if these expenses normally would not be paid by the Plan.

Note: Case Management is a voluntary service. There are no reductions of benefits or penalties if the patient and family choose not to participate.

Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.

DEFINED TERMS

The following terms have special meanings and when used in this Plan will be capitalized.

Active Employee is an Employee who is on the regular payroll of the Employer and who has begun to perform the duties of his or her job with the Employer on a full-time basis.

Ambulatory Surgical Center is a licensed facility that is used mainly for performing outpatient surgery, has a staff of Physicians, has continuous Physician and nursing care by registered nurses (R.N.s) and does not provide for overnight stays.

Birthing Center means any freestanding health facility, place, professional office or institution which is not a Hospital or in a Hospital, where births occur in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the facility is located.

The Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a Physician and either a registered nurse (R.N.) or a licensed nurse-midwife; and have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement.

Calendar Year means January 1st through December 31st of the same year.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Complications of Pregnancy are determined as follows:

These conditions are included before the Pregnancy ends: acute nephritis; ectopic Pregnancy; miscarriage; nephrosis; cardiac decompensation; missed abortion; hyperemesis gravidarum; and eclampsia of Pregnancy.

Other Pregnancy related conditions will be covered that are as medically severe as those listed.

These conditions are not included: false labor; occasional spotting; rest during Pregnancy even if prescribed by a Physician; morning sickness; or like conditions that are not medically termed as Complications of Pregnancy.

Confinement and Confined means an uninterrupted stay following formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility

Congenital Anomal is a physical developmental defect that is present at birth and identified within the first twelve months of birth

Cosmetic Dentistry means dentally unnecessary procedures

Cosmetic Procedures are procedures which improve physical appearance.

Covered Charge(s) means those Medically Necessary services or supplies that are covered under this Plan.

Covered Health Service means those health services provided for the purpose of preventing, diagnosing or treating an Illness, Injury, disease or symptoms. Covered Health Services must be provided:

- When the Plan is in effect; and
- Only when the recipient is a Covered Person and meets all eligibility requirements specified in this Plan.

A Covered Health Service must meet each of the following criteria:

- (1) It is supported by national medical standards of practice;
- (2) It is consistent with conclusions of prevailing medical research that:
 - (a) Demonstrates that the health service has a beneficial effect on health outcomes; and
 - (b) Is based on trials that meet the following designs:

- (i) Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
 - (ii) Well-conducted cohort studies. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)
- (3) It is the most cost-effective method and yields a similar outcome to other available alternatives.
- (4) All new technologies, procedures and treatments are decided based upon the language in (2)(b) above.

Covered Person is an Employee or Dependent who is covered under this Plan.

Creditable Coverage includes most health coverage, such as coverage under a group health plan (including COBRA continuation coverage), HMO membership, an individual health insurance policy, Medicaid or Medicare.

Creditable Coverage does not include coverage consisting solely of dental or vision benefits.

Custodial Care is care (including room and board needed to provide that care) that is given principally for personal hygiene or for assistance in daily activities and can, according to generally accepted medical standards, be performed by persons who have no medical training. Examples of Custodial Care are help in walking and getting out of bed; assistance in bathing, dressing, feeding; or supervision over medication which could normally be self-administered.

Dental Hygienist is a person who is currently licensed to practice dental hygiene by the governmental authority having jurisdiction over the licensing and practice of dental hygiene and who works under the supervision and direction of a Dentist.

Dentist is a person who is properly trained and licensed to practice Dentistry and who is practicing within the scope of such license.

Durable Medical Equipment means equipment which (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) generally is not useful to a person in the absence of an Illness or Injury and (d) is appropriate for use in the home.

Emergency Care means bona fide emergency services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to the patient's health, serious impairment of bodily functions, or serious dysfunction of any bodily organ or part.

Employee means a person who is an Active, regular Employee of the Employer, regularly scheduled to work for the Employer in an Employee/Employer relationship.

Employer is City of Stafford.

Enrollment Date is the first day of coverage or, if there is a Waiting Period, the first day of the Waiting Period.

ERISA is the Employee Retirement Income Security Act of 1974, as amended.

Experimental and/or Investigational, means services, supplies, care and treatment which does not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical community or government oversight agencies at the time services were rendered.

The Plan Administrator must make an independent evaluation of the experimental/nonexperimental standings of specific technologies. The Plan Administrator shall be guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The decision of the Plan Administrator will be final and binding on the Plan. The Plan Administrator will be guided by the following principles:

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

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

Drugs are considered Experimental if they are not commercially available for purchase and/or they are not approved by the Food and Drug Administration for general use.

Family Unit is the covered Employee and the family members who are covered as Dependents under the Plan.

Foster Child means an unmarried child under the limiting age shown in the Dependent Eligibility Section of this Plan for whom a covered Employee has assumed a legal obligation. All of the following conditions must be met: the child is being raised as the covered Employee's; the child depends on the covered Employee for primary support; the child lives in the home of the covered Employee; and the covered Employee may legally claim the child as a federal income tax deduction.

A covered Foster Child is not a child temporarily living in the covered Employee's home; one placed in the covered Employee's home by a social service agency which retains control of the child; or whose natural parent(s) may exercise or share parental responsibility and control.

Generic Drug means a Prescription Drug which has the equivalency of the brand name drug with the same use and metabolic disintegration. This Plan will consider as Generic Drug any Food and Drug Administration approved generic pharmaceutical dispensed accordingly to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

Genetic Information means information about genes, gene products and inherited characteristics that may derive from an individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories and direct analysis of genes or chromosomes.

Home Health Care Agency is an organization that meets all of these tests: its main function is to provide Home Health Care Services and Supplies; it is federally certified as a Home Health Care Agency; and it is licensed by the state in which it is located, if licensing is required.

Home Health Care Plan must meet these tests: it must be a formal written plan made by the patient's attending Physician which is reviewed at least every 30 days; it must state the diagnosis; it must certify that the Home Health Care is in place of Hospital confinement; and it must specify the type and extent of Home Health Care required for the treatment of the patient.

Home Health Care Services and Supplies include: part-time or intermittent nursing care by or under the supervision of a registered nurse (R.N.); part-time or intermittent home health aide services provided through a Home Health Care Agency (this does not include general housekeeping services); physical, occupational and speech therapy; medical supplies; and laboratory services by or on behalf of the Hospital.

Hospice Agency is an organization where its main function is to provide Hospice Care Services and Supplies and it is licensed by the state in which it is located, if licensing is required.

Hospice Care Plan is a plan of terminal patient care that is established and conducted by a Hospice Agency and supervised by a Physician.

Hospice Care Services and Supplies are those provided through a Hospice Agency and under a Hospice Care Plan and include inpatient care in a Hospice Unit or other licensed facility, home care, and family counseling during the bereavement period.

Hospice Unit is a facility or separate Hospital Unit, that provides treatment under a Hospice Care Plan and admits at least two unrelated persons who are expected to die within six months.

Hospital is an institution which is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and which fully meets these tests: it is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association Healthcare Facilities Accreditation Program; it is approved by Medicare as a Hospital; it maintains diagnostic and therapeutic facilities on the premises for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of Physicians; it continuously provides on the premises 24-hour-a-day nursing services by or under the supervision of registered nurses (R.N.s); and it is operated continuously with organized facilities for operative surgery on the premises.

The definition of "Hospital" shall be expanded to include the following:

- A facility operating legally as a psychiatric Hospital or residential treatment facility for mental health and licensed as such by the state in which the facility operates.
- A facility operating primarily for the treatment of Substance Abuse if it meets these tests: maintains permanent and full-time facilities for bed care and full-time confinement of at least 15 resident patients; has a Physician in regular attendance; continuously provides 24-hour a day nursing service by a registered nurse (R.N.); has a full-time psychiatrist or psychologist on the staff; and is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of Substance Abuse.

Illness means a bodily disorder, disease, physical sickness or Mental Disorder. Illness includes Pregnancy, childbirth, miscarriage or complications of Pregnancy.

Infertility means incapable of producing offspring.

Injury means an accidental physical Injury to the body caused by unexpected external means.

Inpatient Rehabilitation Facility is a Hospital (or a special unit of a Hospital that is designated as an Inpatient Rehabilitation Facility) that provides rehabilitation health services (physical therapy, Occupational Therapy, and/or speech therapy) on an inpatient basis authorized by law.

Intensive Care Unit is defined as a separate, clearly designated service area which is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a "coronary care unit" or an "acute care unit." It has: facilities for special nursing care not available in regular rooms and wards of the Hospital; special life saving equipment which is immediately available at all times; at least two beds for the accommodation of the critically ill; and at least one registered nurse (R.N.) in continuous and constant attendance 24 hours a day.

Late Enrollee means a Plan Participant who enrolls under the Plan other than during the first 31-day period in which the individual is eligible to enroll under the Plan or during a Special Enrollment Period.

Legal Guardian means a person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor child.

Lifetime is a word that appears in this Plan in reference to benefit maximums and limitations. Lifetime is understood to mean while covered under this Plan. Under no circumstances does Lifetime mean during the lifetime of the Covered Person.

Medical Care Facility means a Hospital, a facility that treats one or more specific ailments or any type of Skilled Nursing Facility.

Medical Emergency means a sudden onset of a condition with acute symptoms requiring immediate medical care and includes such conditions as heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions or other such acute medical conditions.

Medically Necessary care and treatment is recommended or approved by a Physician; is consistent with the patient's condition or accepted standards of good medical practice; is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of the patient or provider of medical services; is not conducted for research purposes; and is the most appropriate level of services which can be safely provided to the patient.

All of these criteria must be met; merely because a Physician recommends or approves certain care does not mean that it is Medically Necessary.

The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary.

Medicare is the Health Insurance For The Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

Mental Disorder means any disease or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

No-Fault Auto Insurance is the basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.

Outpatient Care and/or Services is treatment including services, supplies and medicines provided and used at a Hospital under the direction of a Physician to a person not admitted as a registered bed patient; or services rendered in a Physician's office, laboratory or X-ray facility, an Ambulatory Surgical Center, or the patient's home.

Partial Hospitalization is an outpatient program specifically designed for the diagnosis or active treatment of a Mental Disorder or Substance Abuse when there is reasonable expectation for improvement or when it is necessary to maintain a patient's functional level and prevent relapse; this program shall be administered in a psychiatric facility which is accredited by the Joint Commission on Accreditation of Health Care Organizations and shall be licensed to provide partial hospitalization services, if required, by the state in which the facility is providing these services. Treatment lasts less than 24 hours, but more than four hours, a day and no charge is made for room and board.

Pharmacy means a licensed establishment where covered Prescription Drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.

Physician means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Optometrist (O.D.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Audiologist, Certified Nurse Anesthetist, Licensed Professional Counselor, Licensed Professional Physical Therapist, , Midwife, Occupational Therapist, Doctor of Dental Surgery (D.D.S.), Physiotherapist, Psychiatrist, Psychologist (Ph.D.), Speech Language Pathologist and any other practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license.

Plan means City of Stafford Health Care Benefits Plan, which is a benefits plan for certain Employees of City of Stafford and is described in this document.

Plan Participant is any Employee or Dependent who is covered under this Plan.

Plan Year is the 12-month period beginning on either the effective date of the Plan or on the day following the end of the first Plan Year which is a short Plan Year.

A **Pre-Existing Condition** is a condition for which medical advice, diagnosis, care or treatment was recommended or received within six months prior to the person's Enrollment Date under this Plan. Genetic Information is not a condition. Treatment includes receiving services and supplies, consultations, diagnostic tests or prescribed medicines. In order to be taken into account, the medical advice, diagnosis, care or treatment must have been recommended by, or received from, a Physician.

The Pre-Existing Condition does not apply to Pregnancy, to a newborn child who is covered under this Plan within 31 days of birth, or to a child who is adopted or placed for adoption before attaining age 18 and who, as of the last day of the 31-day period beginning on the date of the adoption or placement for adoption, is covered under this Plan. A Pre-Existing Condition exclusion may apply to coverage before the date of the adoption or placement for adoption.

The prohibition on Pre-Existing Condition exclusion for newborn, adopted, or pre-adopted children does not apply to an individual after the end of the first 63-day period during all of which the individual was not covered under any Creditable Coverage.

Pregnancy is childbirth and conditions associated with Pregnancy, including complications.

Prescription Drug means any of the following: a Food and Drug Administration-approved drug or medicine which, under federal law, is required to bear the legend: "Caution: federal law prohibits dispensing without prescription"; injectable insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician. Such drug must be Medically Necessary in the treatment of a Sickness or Injury.

Reconstructive Surgery means surgery which is incidental to an Injury, Illness or Congenital Anomaly when the primary purpose is to improve physiological functioning of the involved part of the body. The fact that physical appearance may change or improve as a result of Reconstructive Surgery does not classify such surgery as cosmetic when a physical impairment exists, and the surgery restores or improves function. The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Illness or Congenital Anomaly does not classify surgery done to relieve such consequences or behavior as Reconstructive Surgery.

Serious Mental Illness means the following psychiatric Illnesses as defined by the American Psychiatric Association in the Diagnostic and Statistical Manual (DSM) IV-R.

- (1) Schizophrenia;
- (2) Paranoid and other psychotic disorders;
- (3) Bipolar disorders (mixed, manic and depressive);
- (4) Major depressive disorders (single episode or recurrent); or
- (5) Schizo-affective disorders (bipolar or depressive).

Sickness is:

For a covered Employee and covered Spouse: Illness, disease or Pregnancy.

For a covered Dependent other than Spouse: Illness, disease or Complications of Pregnancy.

Skilled Care Services are skilled nursing and skilled rehabilitation services, which meet all of the following criteria:

- (1) Must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient;
- (2) Are ordered by a Physician; and
- (3) Are necessary for the treatment of the Illness Injury or Pregnancy

Skilled Nursing Facility is a facility that fully meets all of these tests:

- (1) It is licensed to provide professional nursing services on an inpatient basis to persons convalescing from Injury or Sickness. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided.
- (2) Its services are provided for compensation and under the full-time supervision of a Physician.
- (3) It provides 24 hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse.
- (4) It maintains a complete medical record on each patient.
- (5) It has an effective utilization review plan.
- (6) It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mental retardates, Custodial or educational care or care of Mental Disorders.
- (7) It is approved and licensed by Medicare.

This term also applies to charges incurred in a facility referring to itself as an extended care facility, convalescent nursing home, rehabilitation hospital, long-term acute care facility or any other similar nomenclature.

Spinal Manipulation/Chiropractic Care means skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a Physician to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

Substance Abuse is regular excessive compulsive drinking of alcohol and/or physical habitual dependence on drugs. This does not include dependence on tobacco and ordinary caffeine-containing drinks.

Temporomandibular Joint (TMJ) syndrome is the treatment of jaw joint disorders including conditions of structures linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the temporomandibular joint. Care and treatment shall include, but are not limited to orthodontics, crowns, inlays, physical therapy and any appliance that is attached to or rests on the teeth.

Total Disability (Totally Disabled) means: In the case of an Employee, the complete inability to perform any and every duty of his or her occupation or of a similar occupation for which the person is reasonably capable due to education and training, as a result of Injury or Illness.

In the case of a Dependent child, the complete inability as a result of Injury or Sickness to perform the normal activities of a person of like age and sex in good health.

Urgent Care Center is a facility that provides Covered Health Services that are required to prevent serious deterioration of patients' health and that are required as a result of an unforeseen Illness, Injury or the onset of acute or severe symptoms.

Usual and Reasonable Charge is a charge which is not higher than the usual charge made by the provider of the care or supply and does not exceed the usual charge made by most providers of like service in the same area. This test will consider the nature and severity of the condition being treated. It will also consider medical complications or unusual circumstances that require more time, skill or experience.

The Plan will reimburse the actual charge billed if it is less than the Usual and Reasonable Charge.

The Plan Administrator has the discretionary authority to decide whether a charge is Usual and Reasonable.

PLAN EXCLUSIONS

For all Medical Benefits shown in the Schedule of Benefits, a charge for the following is not covered:

- (1) **Alcohol.** Services, supplies, care or treatment to a Covered Person for an Injury or Sickness which occurred as a result of that Covered Person's illegal use of alcohol. The arresting officer's determination of inebriation will be sufficient for this exclusion. Expenses will be covered for Injured Covered Persons other than the person illegally using alcohol and expenses will be covered for Substance Abuse treatment as specified in this Plan.
- (2) **Alternative treatment.** Acupressure, acupuncture, massage therapy (except in connection with Chiropractic Care), rolfing, aroma therapy, hypnotism, naturopathy, and other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health, except as otherwise specified as covered.
- (3) **Biofeedback therapy.**
- (4) **Circumcisions,** other than newborn male circumcisions.
- (5) **Complications of non-covered treatments.** Care, services or treatment required as a result of complications from a treatment not covered under the Plan are not covered. Complications from a non-covered abortion are covered.
- (6) **Cosmetic Procedures.** Care and treatment provided for cosmetic reasons, including but not limited to pharmacological regimens; nutritional procedures or treatments; plastic surgery; salabrasion, chemosurgery and other such skin abrasion procedures associated with the removal or revision of scars, tattoos, actinic changes, and/or which are performed as a treatment for acne. This exclusion will not apply if the care and treatment is for repair of damage from an accident or is for correction of abnormal congenital condition in a child.

Reconstructive mammoplasty will be covered as described in the Medical Benefits section under the Reconstructive Surgery Benefit.
- (7) **Custodial care.** Services or supplies provided mainly as a rest cure, maintenance or Custodial Care.
- (8) **Educational or vocational testing.** Services for educational or vocational testing or training.
- (9) **Excess charges.** The part of an expense for care and treatment of an Injury or Sickness that is in excess of the Usual and Reasonable Charge.
- (10) **Exercise programs.** Exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, occupational or physical therapy covered by this Plan.
- (11) **Experimental or not Medically Necessary.** Care and treatment that is either Experimental/Investigational or not Medically Necessary, as defined in Defined Terms on page 30.
- (12) **Eye care.** Radial keratotomy or other eye surgery to correct refractive disorders. Also, routine eye examinations, including refractions, lenses for the eyes and exams for their fitting. This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages or as may be covered under the well adult or well child sections of this Plan.
- (13) **Foot care.** Treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions (except open cutting operations), and treatment of corns, calluses or toenails (unless needed in treatment of a metabolic or peripheral-vascular disease).
- (14) **Foreign travel.** Care, treatment or supplies out of the U.S. if travel is for the sole purpose of obtaining medical services.
- (15) **Government coverage.** Care, treatment or supplies furnished by a program or agency funded by any government. This does not apply to Medicaid or when otherwise prohibited by law.

- (16) **Hair loss.** Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician, except for wigs after chemotherapy up to the limit shown in the Schedule of Benefits.
- (17) **Hospital employees.** Professional services billed by a Physician or nurse who is an employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service.
- (18) **Illegal acts.** Charges for services received as a result of Injury or Sickness occurring directly or indirectly, as a result of a Serious Illegal Act, or a riot or public disturbance. For purposes of this exclusion, the term "Serious Illegal Act" shall mean any act or series of acts that, if prosecuted as a criminal offense, a sentence to a term of imprisonment in excess of one year could be imposed. It is not necessary that criminal charges be filed, or, if filed, that a conviction result, or that a sentence of imprisonment for a term in excess of one year be imposed for this exclusion to apply. Proof beyond a reasonable doubt is not required. This exclusion does not apply if the Injury or Sickness resulted from an act of domestic violence or a medical (including both physical and mental health) condition.
- (19) **Illegal drugs or medications.** Services, supplies, care or treatment to a Covered Person for Injury or Sickness resulting from that Covered Person's voluntary taking of or being under the influence of any controlled substance, drug, hallucinogen or narcotic not administered on the advice of a Physician. Expenses will be covered for Injured Covered Persons other than the person using controlled substances and expenses will be covered for Substance Abuse treatment as specified in this Plan. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.
- (20) **Pre-marital counseling.** Care and treatment for pre-marital counseling.
- (21) **No charge.** Care and treatment for which there would not have been a charge if no coverage had been in force.
- (22) **Non-compliance.** All charges in connection with treatments or medications where the patient either is in non-compliance with or is discharged from a Hospital or Skilled Nursing Facility against medical advice.
- (23) **Non-emergency Hospital admissions.** Care and treatment billed by a Hospital for non-Medical Emergency admissions on a Friday or a Saturday. This does not apply if surgery is performed within 24 hours of admission.
- (24) **No obligation to pay.** Charges incurred for which the Plan has no legal obligation to pay.
- (25) **No Physician recommendation.** Care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the Covered Person is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the Injury or Sickness.
- (26) **Not specified as covered.** Non-traditional medical services, treatments and supplies which are not specified as covered under this Plan.
- (27) **Nutritionist services.** Services provided by a nutritionist.
- (28) **Obesity.** Care and treatment of obesity, weight loss or dietary control whether or not it is, in any case, a part of the treatment plan for another Sickness. Specifically excluded are charges for bariatric surgery, including but not limited to, gastric bypass, stapling and intestinal bypass, and lap band surgery, including reversals.
- (29) **Occupational.** Care and treatment of an Injury or Sickness that is occupational -- that is, arises from work for wage or profit including self-employment.
- (30) **Occupational Therapy.** Charges in connection with occupational therapy.

- (31) **Outpatient prescribed or non-prescribed medical supplies.** Outpatient prescribed or non-prescribed medical supplies including, but not limited to, over-the-counter drugs and treatments, elastic stockings, ace bandages, gauze, syringes, diabetic test strips, ostomy supplies and similar supplies. Tubings and masks are excluded except as integral use of Durable Medical Equipment.
- (32) **Personal comfort items.** Personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, nonprescription drugs and medicines, and first-aid supplies and nonhospital adjustable beds.
- (33) **Plan design excludes.** Charges excluded by the Plan design as mentioned in this document.
- (34) **Pregnancy of daughter or granddaughter.** Care and treatment of Pregnancy for a dependent daughter or a dependent granddaughter only. Complications of Pregnancy are covered.
- (35) **Private duty nursing.** Charges in connection with care, treatment or services of a private duty nurse.
- (36) **Relative giving services.** Professional services performed by a person who ordinarily resides in the Covered Person's home or is related to the Covered Person as a Spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.
- (37) **Replacement braces.** Replacement of braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the Covered Person's physical condition to make the original device no longer functional.
- (38) **Self-Inflicted.** Any loss due to an intentionally self-inflicted Injury, while sane or insane.
- (39) **Services before or after coverage.** Care, treatment or supplies for which a charge was incurred before a person was Covered under this Plan or after coverage ceased under this Plan.
- (40) **Sex changes.** Care, services or treatment for non-congenital transsexualism, gender dysphoria or sexual reassignment or change. This exclusion includes medications, implants, hormone therapy, surgery, medical or psychiatric treatment.
- (41) **Smoking cessation.** Care and treatment for smoking cessation programs, including smoking deterrent patches, unless Medically Necessary due to a severe active lung Illness such as emphysema or asthma.
- (42) **Sports-related safety/performance devices and programs.** Devices used specifically as safety items or to affect performance primarily in sports-related activities. All expenses related to physical conditioning programs, such as athletic training, body-building, exercise, fitness flexibility and diversion or general motivation.
- (43) **Surgical sterilization reversal.** Care and treatment for reversal of surgical sterilization.
- (44) **Travel or accommodations.** Charges for travel or accommodations, whether or not recommended by a Physician, except for ambulance charges as defined as a Covered Charge.
- (45) **War.** Any loss that is due to a declared or undeclared act of war.
- (46) **Wigs –** Charges for wigs after the diagnosis of alopecia areata

PRESCRIPTION DRUG BENEFITS

Pharmacy Drug Charge

Participating pharmacies have contracted with this Plan to charge Covered Persons reduced fees for covered Prescription Drugs. Caremark is the administrator of the Pharmacy drug plan.

Copayment. The copayment is applied to each covered Pharmacy drug charge and is shown in the Schedule of Benefits. The copayment amount is not a covered charge under the Medical Plan. Any one prescription is limited to a 30-day supply.

Note: *The quantity of drugs dispensed may be limited based on the dosing recommendations of the manufacturer.*

MAIL ORDER DRUG BENEFIT OPTION

The mail order drug benefit option is available for maintenance medications (those that are taken for long periods of time, such as drugs sometimes prescribed for heart disease, high blood pressure, asthma, etc.). Because of volume buying, Caremark, the mail order Pharmacy is able to offer Covered Persons significant savings on their prescriptions.

Copayment. The copayment is applied to each covered mail order prescription charge and is shown in the Schedule of Benefits. It is not a covered charge under the Medical Plan. Any one prescription is limited to a 90-day supply.

Note: *The quantity of drugs dispensed may be limited based on the dosing recommendations of the manufacturer.*

COVERED PRESCRIPTION DRUGS

- (1) All drugs prescribed by a Physician that require a prescription either by federal or state law, except the drugs listed under Prescription Drug Exclusions below.
- (2) All compounded prescriptions containing at least one prescription ingredient in a therapeutic quantity.
- (3) Insulin when prescribed by a Physician.

LIMITS TO THIS BENEFIT

This benefit applies only when a Covered Person incurs a covered Prescription Drug charge. The covered drug charge for any one prescription will be limited to:

- (1) Refills only up to the number of times specified by a Physician.
- (2) Refills up to one year from the date of order by a Physician.
- (3) Quantity restrictions based on dosage recommendations made by the manufacturer.
- (4) Prescription transdermal patches, Nicotrol NS, and Zyban are covered and limited to a 90-day supply per lifetime.

PRESCRIPTION DRUG EXCLUSIONS

This benefit will not cover a charge for any of the following:

- (1) **Administration.** Any charge for the administration of a covered Prescription Drug.
- (2) **Allergy Serums.** A charge for allergy serums. Allergy serums are covered under the medical benefit in the Plan.
- (3) **Anabolic Steroids.** A charge for anabolic steroids.

- (4) **Appetite Suppressants.** A charge for appetite suppressants.
- (5) **Biologicals/Vaccines/Immunization Agents.** A charge for biologicals, vaccines and immunization agents.
- (6) **Consumed on premises.** Any drug or medicine that is consumed or administered at the place where it is dispensed.
- (7) **Contraceptives.** A charge for the following contraceptives: topical (foams, condoms), implantable (Norplant), injectables (Depo-Provera).
- (8) **Devices.** Devices of any type, even though such devices may require a prescription. These include (but are not limited to) therapeutic devices, artificial appliances, braces, support garments, or any similar device.
- (9) **DESI Drugs.** Drugs released prior to FDA's existence.
- (10) **Diabetic Supplies.** Blood glucose testing monitors only.
- (11) **Erythroid Stimulants.** A charge for Erythroid stimulants (i.e., Epogan/Procrit).
- (12) **Experimental.** Experimental drugs and medicines, even though a charge is made to the Covered Person.
- (13) **FDA.** Any drug not approved by the Food and Drug Administration.
- (14) **Fertility.** A charge for oral and injectable fertility medication.
- (15) **Gamma Globulin.** A charge for gamma globulin.
- (16) **Growth Hormones.** A charge for growth hormones.
- (17) **Hair Growth Stimulants.** A charge for hair growth stimulants (i.e., Rogaine, Propecia).
- (18) **Imitrex Injections.** A charge for imitrex (sumatriptan) injections.
- (19) **Investigational.** A drug or medicine labeled: "Caution – limited by federal law to Investigational use".
- (20) **Interferon Alfa and Gamma.** A charge for Interferon Alfa and Gamma (i.e., Intro-A).
- (21) **Interferon Beta.** A charge for Interferon Beta (i.e. Betaseron, Avonex).
- (22) **Leuprolide.** A charge for Leuprolide (i.e., Lupron).
- (23) **Medical Exclusions.** A charge excluded under Medical Plan Exclusions.
- (24) **Myeloid Stimulants.** A charge for Myeloid stimulants.
- (25) **No Charge.** A charge for Prescription Drugs which may be properly received without charge under local, state or federal programs.
- (26) **Ostomy Supplies.** A charge for ostomy supplies.
- (27) **Over-the-counter.** A drug or medicine that can legally be bought without a written prescription. This does not apply to injectable insulin.
- (28) **Plasma/Blood Products.** A charge for plasma and blood products.

- (29) **Renova.** A charge for Renova.
- (30) **Retin-A.** A charge for Retin-A.
- (31) **Smoking Deterrents.** A charge for the following smoking deterrents: over-the-counter nicotine gum and over-the-counter transdermal patches. Prescription transdermal patches, Nicitrol NS, and Zyban are covered.
- (32) **Topical Fluoride Products.** A charge for legend and over-the-counter topical fluoride products.

HOW TO SUBMIT A CLAIM

Benefits under this Plan shall be paid only if the Plan Administrator decides in its discretion that a Covered Person is entitled to them.

When a Covered Person has a Claim to submit for payment that person must:

- (1) Obtain a Claim form from the Personnel Office or the Plan Administrator.
- (2) Complete the Employee portion of the form. ALL QUESTIONS MUST BE ANSWERED.
- (3) Have the Physician complete the provider's portion of the form.
- (4) For Plan reimbursements, attach bills for services rendered. ALL BILLS MUST SHOW:
 - Name of Plan
 - Group Number
 - Employee's name
 - Name of patient
 - Name, address, telephone number of the provider of care
 - Diagnosis
 - Type of services rendered, with diagnosis and/or procedure codes
 - Date of services
 - Charges
- (5) Send the above to the Claims Administrator at this address:

Memorial Hermann Health Network Providers
9301 Southwest Freeway, Suite 5000
Houston, Texas 77074
(713) 448-6535

WHEN CLAIMS SHOULD BE FILED

Claims should be filed with the Claims Administrator within 90 days of the date charges for the service were incurred. Benefits are based on the Plan's provisions at the time the charges were incurred. Claims filed later than that date may be declined or reduced unless:

- (a) it's not reasonably possible to submit the claim in that time; and
- (b) the claim is submitted within one year from the date incurred. This one year period will not apply when the person is not legally capable of submitting the claim.

The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested from the claimant. The Plan reserves the right to have a Plan Participant seek a second medical opinion.

A request for Plan benefits will be considered a claim for Plan benefits, and it will be subject to a full and fair review. If a claim is wholly or partially denied, the Claims Administrator will furnish the Plan Participant with a written notice of this denial. This written notice will be provided within 90 days after receipt of the claim. The written notice will contain the following information:

- (a) the specific reason or reasons for the denial;
- (b) specific reference to those Plan provisions on which the denial is based;
- (c) a description of any additional information or material necessary to correct the claim and an explanation of why such material or information is necessary; and
- (d) appropriate information as to the steps to be taken if a Plan Participant wishes to submit the claim for review.

A Plan Participant will be notified within 90 days of receipt of the claim as to the acceptance or denial of a claim and if not notified within 90 days, the claim shall be deemed denied.

If special circumstances require an extension of time for processing the claim, the Claims Administrator shall send written notice of the extension to the Plan Participant. The extension notice will indicate the special circumstances requiring the extension of time and the date by which the Plan expects to render the final decision on the claim. In no event will the extension exceed a period of 90 days from the end of the initial 90-day period.

CLAIMS REVIEW PROCEDURE

In cases where a claim for benefits payment is denied in whole or in part, the Plan Participant may appeal the denial. This appeal provision will allow the Plan Participant to:

- (a) Request from the Plan Administrator a review of any claim for benefits. Such request must include: the name of the Employee, his or her Social Security number, the name of the patient and the Group Identification Number, if any.
- (b) File the request for review in writing, stating in clear and concise terms the reason or reasons for this disagreement with the handling of the claim.

The request for review must be directed to the Plan Administrator or Claims Administrator within 60 days after the claim payment date or the date of the notification of denial of benefits.

A review of the denial will be made by the Plan Administrator and the Plan Administrator will provide the Plan Participant with a written response within 60 days of the date the Plan Administrator receives the Plan Participant's written request for review and if not notified, the Plan Participant may deem the claim denied. If, because of extenuating circumstances, the Plan Administrator is unable to complete the review process within 60 days, the Plan Administrator shall notify the Plan Participant of the delay within the 60 day period and shall provide a final written response to the request for review within 120 days of the date the Plan Administrator received the Plan Participant's written request for review.

The Plan Administrator's written response to the Plan Participant shall cite the specific Plan provision(s) upon which the denial is based.

A Plan Participant must exhaust the claims appeal procedure before filing a suit for benefits.

COORDINATION OF BENEFITS

Coordination of the benefit plans. Coordination of benefits sets out rules for the order of payment of Covered Charges when two or more plans -- including Medicare -- are paying. When a Covered Person is covered by this Plan and another plan, or the Covered Person's Spouse is covered by this Plan and by another plan or the couple's Covered children are covered under two or more plans, the plans will coordinate benefits when a claim is received.

The plan that pays first according to the rules will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance up to each one's plan formula minus whatever the primary plan paid. This is called non-duplication of benefits. The total reimbursement will never be more than the amount that would have been paid if the secondary plan had been the primary plan -- 50% or 80% or 100% -- whatever it may be. The balance due, if any, is the responsibility of the Covered Person.

Benefit plan. This provision will coordinate the medical benefits of a benefit plan. The term benefit plan means this Plan or any one of the following plans:

- (1) Group or group-type plans, including franchise or blanket benefit plans.
- (2) Blue Cross and Blue Shield group plans.
- (3) Group practice and other group prepayment plans.
- (4) Federal government plans or programs. This includes Medicare.
- (5) Other plans required or provided by law. This does not include Medicaid or any benefit plan like it that, by its terms, does not allow coordination.
- (6) No Fault Auto Insurance, by whatever name it is called, when not prohibited by law.

Allowable Charge. For a charge to be allowable it must be a Usual and Reasonable Charge and at least part of it must be covered under this Plan.

In the case of HMO (Health Maintenance Organization) or other in-network only plans: This Plan will not consider any charges in excess of what an HMO or network provider has agreed to accept as payment in full. Also, when an HMO or network plan is primary and the Covered Person does not use an HMO or network provider, this Plan will not consider as an Allowable Charge any charge that would have been covered by the HMO or network plan had the Covered Person used the services of an HMO or network provider.

In the case of service type plans where services are provided as benefits, the reasonable cash value of each service will be the Allowable Charge.

Automobile limitations. When medical payments are available under vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan deductibles. This Plan shall always be considered the secondary carrier regardless of the individual's election under PIP (personal injury protection) coverage with the auto carrier.

Benefit plan payment order. When two or more plans provide benefits for the same Allowable Charge, benefit payment will follow these rules:

- (1) Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.
- (2) Plans with a coordination provision will pay their benefits up to the Allowable Charge:
 - (a) The benefits of the plan which covers the person directly (that is, as an employee, member or subscriber) ("Plan A") are determined before those of the plan which covers the person as a dependent ("Plan B").

- (b) The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers that person as a laid-off or Retired Employee. The benefits of a benefit plan which covers a person as a Dependent of an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers a person as a Dependent of a laid off or Retired Employee. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.
- (c) The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired or a Dependent of an Employee who is neither laid off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary.
- (d) When a child is covered as a Dependent and the parents are not separated or divorced, these rules will apply:
 - (i) The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year;
 - (ii) If both parents have the same birthday, the benefits of the benefit plan which has covered the parent for the longer time are determined before those of the benefit plan which covers the other parent.
- (e) When a child's parents are divorced or legally separated, these rules will apply:
 - (i) This rule applies when the parent with custody of the child has not remarried. The benefit plan of the parent with custody will be considered before the benefit plan of the parent without custody.
 - (ii) This rule applies when the parent with custody of the child has remarried. The benefit plan of the parent with custody will be considered first. The benefit plan of the stepparent that covers the child as a Dependent will be considered next. The benefit plan of the parent without custody will be considered last.
 - (iii) This rule will be in place of items (i) and (ii) above when it applies. A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the benefit plan of that parent will be considered before other plans that cover the child as a Dependent.
 - (iv) If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a Dependent and the parents are not separated or divorced.
 - (v) For parents who were never married to each other, the rules apply as set out above as long as paternity has been established.
- (f) If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first. When there is a conflict in coordination of benefit rules, the Plan will never pay more than 50% of Allowable Charges when paying secondary.
- (3) Medicare will pay primary, secondary or last to the extent stated in federal law. When Medicare is to be the primary payer, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A, B and D, regardless of whether or not the person was enrolled under any of these parts.
- (4) If a Plan Participant is under a disability extension from a previous benefit plan, that benefit plan will pay first and this Plan will pay second.

Claims determination period. Benefits will be coordinated on a Calendar Year basis. This is called the claims determination period.

Right to receive or release necessary information. To make this provision work, this Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person. A Covered Person will give this Plan the information it asks for about other plans and their payment of Allowable Charges.

Facility of payment. This Plan may repay other plans for benefits paid that the Plan Administrator determines it should have paid. That repayment will count as a valid payment under this Plan.

Right of recovery. This Plan may pay benefits that should be paid by another benefit plan. In this case this Plan may recover the amount paid from the other benefit plan or the Covered Person. That repayment will count as a valid payment under the other benefit plan.

Further, this Plan may pay benefits that are later found to be greater than the Allowable Charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid.

THIRD PARTY RECOVERY PROVISION

RIGHT OF SUBROGATION AND REFUND

When this provision applies. The Covered Person may incur medical or dental charges due to Injuries which may be caused by the act or omission of a Third Party or a Third Party may be responsible for payment. In such circumstances, the Covered Person may have a claim against that Third Party, or insurer, for payment of the medical or dental charges. Accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan any rights the Covered Person may have to Recover payments from any Third Party or insurer. This Subrogation right allows the Plan to pursue any claim which the Covered Person has against any Third Party, or insurer, whether or not the Covered Person chooses to pursue that claim. The Plan may make a claim directly against the Third Party or insurer, but in any event, the Plan has a lien on any amount Recovered by the Covered Person whether or not designated as payment for medical expenses. This lien shall remain in effect until the Plan is repaid in full.

The payment for benefits received by a Covered Person under the Plan shall be made in accordance with the assignment of rights by or on behalf of the Covered Person as required by Medicaid.

In any case in which the Plan has a legal liability to make payments for benefits received by a Covered Person, to the extent that payment has been made through Medicaid, the payment for benefits under the Plan shall be made in accordance with any state law that has provided that the state has acquired the rights of the Covered Person to the payments of those benefits.

The Covered Person:

- (1) automatically assigns to the Plan his or her rights against any Third Party or insurer when this provision applies; and
- (2) must repay to the Plan the benefits paid on his or her behalf out of the Recovery made from the Third Party or insurer.

Amount subject to Subrogation or Refund. The Covered Person agrees to recognize the Plan's right to Subrogation and reimbursement. These rights provide the Plan with a 100%, first dollar priority over any and all Recoveries and funds paid by a Third Party to a Covered Person relative to the Injury or Sickness, including a priority over any claim for non-medical or dental charges, attorney fees, or other costs and expenses. Accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan any and all rights the Covered Person may have to recover payments from any responsible third party. Further, accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan the Covered Person's Third Party Claims.

Notwithstanding its priority to funds, the Plan's Subrogation and Refund rights, as well as the rights assigned to it, are limited to the extent to which the Plan has made, or will make, payments for medical or dental charges as well as any costs and fees associated with the enforcement of its rights under the Plan. The Plan reserves the right to be reimbursed for its court costs and attorneys' fees if the Plan needs to file suit in order to Recover payment for medical or dental expenses from the Covered Person. Also, the Plan's right to Subrogation still applies if the Recovery received by the Covered Person is less than the claimed damage, and, as a result, the claimant is not made whole.

When a right of Recovery exists, the Covered Person will execute and deliver all required instruments and papers as well as doing whatever else is needed to secure the Plan's right of Subrogation as a condition to having the Plan make payments. In addition, the Covered Person will do nothing to prejudice the right of the Plan to Subrogate.

Conditions Precedent to Coverage. The Plan shall have no obligation whatsoever to pay medical or dental benefits to a Covered Person if a Covered Person refuses to cooperate with the Plan's reimbursement and Subrogation rights or refuses to execute and deliver such papers as the Plan may require in furtherance of its reimbursement and Subrogation rights. Further, in the event the Covered Person is a minor, the Plan shall have no obligation to pay any medical or dental benefits incurred on account of Injury or Sickness caused by a responsible Third Party until after the Covered Person or his authorized legal representative obtains valid court recognition and approval of the Plan's 100%, first dollar reimbursement and Subrogation rights on all Recoveries, as well as approval for the execution of any papers necessary for the enforcement thereof, as described herein.

Defined terms: "Covered Person" means anyone covered under the Plan, including minor dependents.

"Recover," "Recovered," "Recovery" or "Recoveries" means all monies paid to the Covered Person by way of judgment, settlement, or otherwise to compensate for all losses caused by the Injury or Sickness, whether or not said losses reflect medical or dental charges covered by the Plan. "Recoveries" further includes, but is not limited to, recoveries for medical or dental expenses, attorneys' fees, costs and expenses, pain and suffering, loss of consortium, wrongful death, lost wages and any other recovery of any form of damages or compensation whatsoever.

"Refund" means repayment to the Plan for medical or dental benefits that it has paid toward care and treatment of the Injury or Sickness.

"Subrogation" means the Plan's right to pursue and place a lien upon the Covered Person's claims for medical or dental charges against the other person.

"Third Party" means any Third Party including another person or a business entity.

Recovery from another plan under which the Covered Person is covered. This right of Refund also applies when a Covered Person Recovers under an uninsured or underinsured motorist plan (which will be treated as Third Party coverage when reimbursement or Subrogation is in order), homeowner's plan, renter's plan, medical malpractice plan or any liability plan.

Rights of Plan Administrator. The Plan Administrator has a right to request reports on and approve of all settlements.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain Employees and their families covered under City of Stafford Health Care Benefits Plan (the Plan) will be entitled to the opportunity to elect a temporary extension of health coverage (called "COBRA continuation coverage") where coverage under the Plan would otherwise end. This notice is intended to inform Plan Participants and beneficiaries, in summary fashion, of their rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law.

The Plan Administrator is City of Stafford, 2610 South Main, Stafford, Texas, 77477, (281) 261-3900. COBRA continuation coverage for the Plan is administered by Memorial Hermann Health Network Providers, Inc., 9301 Southwest Freeway, Suite 5000, Houston, Texas 77074, (713) 448-6480. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator or its designee to Plan Participants who become Qualified Beneficiaries under COBRA.

What is COBRA continuation coverage? COBRA continuation coverage is the temporary extension of group health plan coverage that must be offered to certain Plan Participants and their eligible family members (called "Qualified Beneficiaries") at group rates. The right to COBRA continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the Plan (the "Qualifying Event"). The coverage must be identical to the Plan coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active employees who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries).

Who can become a Qualified Beneficiary? In general, a Qualified Beneficiary can be:

- (1) Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a covered Employee, the Spouse of a covered Employee, or a Dependent child of a covered Employee. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.
- (2) Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, and any individual who is covered by the Plan as an alternate recipient under a qualified medical support order. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

The term "covered Employee" includes not only common-law employees (whether part-time or full-time) but also any individual who is provided coverage under the Plan due to his or her performance of services for the employer sponsoring the Plan (e.g., self-employed individuals, independent contractor, or corporate director). However, this provision does not establish eligibility of these individuals. Eligibility for Plan Coverage shall be determined in accordance with Plan Eligibility provisions.

An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which the individual was a nonresident alien who received from the individual's Employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a Qualified Beneficiary, then a Spouse or Dependent child of the individual will also not be considered a Qualified Beneficiary by virtue of the relationship to the individual. A domestic partner is not a Qualified Beneficiary.

Each Qualified Beneficiary (including a child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

What is a Qualifying Event? A Qualifying Event is any of the following if the Plan provided that the Plan participant would lose coverage (i.e.: cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage:

- (1) The death of a covered Employee.
- (2) The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment.
- (3) The divorce or legal separation of a covered Employee from the Employee's Spouse. If the Employee reduces or eliminates the Employee's Spouse's Plan coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a Qualifying Event even though the Spouse's coverage was reduced or eliminated before the divorce or legal separation.
- (4) A covered Employee's enrollment in any part of the Medicare program.
- (5) A Dependent child's ceasing to satisfy the Plan's requirements for a Dependent child (for example, attainment of the maximum age for dependency under the Plan).

If the Qualifying Event causes the covered Employee, or the covered Spouse or a Dependent child of the covered Employee, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event, the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of COBRA are also met. For example, any increase in contribution that must be paid by a covered Employee, or the Spouse, or a Dependent child of the covered Employee, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

The taking of leave under the Family and Medical Leave Act of 1993 ("FMLA") does not constitute a Qualifying Event. A Qualifying Event will occur, however, if an Employee does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost.) Note that the covered Employee and family members will be entitled to COBRA continuation coverage even if they failed to pay the employee portion of premiums for coverage under the Plan during the FMLA leave.

What factors should be considered when determining to elect COBRA continuation coverage? You should take into account that a failure to continue your group health coverage will affect your rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied by other group health plans if there is more than a 63-day gap in health coverage and election of COBRA continuation coverage may help you avoid such a gap. Second, if you do not elect COBRA continuation coverage and pay the appropriate premiums for the maximum time available to you, you will lose the right to convert to an individual health insurance policy, which does not impose such pre-existing condition exclusions. Finally, you should take into account that you have special enrollment rights under federal law (HIPAA). You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your Spouse's employer) within 30 days after Plan coverage ends due to a Qualifying Event listed above. You will also have the same special right at the end of COBRA continuation coverage if you get COBRA continuation coverage for the maximum time available to you.

What is the procedure for obtaining COBRA continuation coverage? The Plan has conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period.

What is the election period and how long must it last? The election period is the time period within which the Qualified Beneficiary must elect COBRA continuation coverage under the Plan. The election period must begin not later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and ends 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage. If coverage is not elected within the 60 day period, all rights to elect COBRA continuation coverage are forfeited.

Note: If a covered employee who has been terminated or experienced a reduction of hours qualifies for a trade readjustment allowance or alternative trade adjustment assistance under a federal law called the Trade Act of 2002, and the employee and his or her covered dependents have not elected COBRA coverage within the normal election period, a second opportunity to elect COBRA coverage will be made available for themselves and certain family members, but only within a limited period of 60 days or less and only during the six months immediately after their group health plan coverage ended. Any person who qualifies or thinks that he and/or his family members may qualify for assistance under this special provision should contact the Plan Administrator for further information.

The Trade Act of 2002 also created a new tax credit for certain TAA-eligible individuals and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Consumer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact.

Is a covered Employee or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event? The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator or its designee has been timely notified that a Qualifying Event has occurred. The employer (if the employer is not the Plan Administrator) will notify the Plan Administrator of the Qualifying Event within 30 days following the date coverage ends when the Qualifying Event is:

- (1) the end of employment or reduction of hours of employment,
- (2) death of the employee,
- (3) commencement of a proceeding in bankruptcy with respect to the employer, or
- (4) enrollment of the employee in any part of Medicare.

IMPORTANT:

For the other Qualifying Events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you or someone on your behalf must notify the Plan Administrator or its designee in writing within 60 days after the Qualifying Event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator or its designee during the 60-day notice period, any spouse or dependent child who loses coverage will not be offered the option to elect continuation coverage. You must send this notice to the COBRA Administrator.

NOTICE PROCEDURES:

Any notice that you provide must be ***in writing***. Oral notice, including notice by telephone, is not acceptable. You must mail, fax or hand-deliver your notice to the person, department or firm listed below, at the following address:

**City of Stafford
2610 South Main
Stafford, Texas 77477
(281) 261-3900**

If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must state:

- the **name of the plan or plans** under which you lost or are losing coverage,
- the **name and address of the employee** covered under the plan,
- the **name(s) and address(es) of the Qualified Beneficiary(ies)**, and
- the **Qualifying Event** and the **date** it happened.

If the Qualifying Event is a **divorce or legal separation**, your notice must include **a copy of the divorce decree or the legal separation agreement**.

Be aware that there are other notice requirements in other contexts, for example, in order to qualify for a disability extension.

Once the Plan Administrator or its designee receives ***timely notice*** that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage for their spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that plan coverage would otherwise have been lost. If you or your spouse or dependent children do not elect continuation coverage within the 60-day election period described above, the right to elect continuation coverage will be lost.

Is a waiver before the end of the election period effective to end a Qualified Beneficiary's election rights? If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Plan Administrator or its designee, as applicable.

Is COBRA coverage available if a Qualified Beneficiary has other group health plan coverage or Medicare? Qualified beneficiaries who are entitled to elect COBRA continuation coverage may do so even if they are covered under another group health plan or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a Qualified Beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare or becomes covered under other group health plan coverage (but only after any applicable preexisting condition exclusions of that other plan have been exhausted or satisfied).

When may a Qualified Beneficiary's COBRA continuation coverage be terminated? During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

- (1) The last day of the applicable maximum coverage period.
- (2) The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.

- (3) The date upon which the Employer ceases to provide any group health plan (including a successor plan) to any employee.
- (4) The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other Plan that does not contain any exclusion or limitation with respect to any pre-existing condition, other than such an exclusion or limitation that does not apply to, or is satisfied by, the Qualified Beneficiary.
- (5) The date, after the date of the election, that the Qualified Beneficiary first enrolls in the Medicare program (either part A or part B, whichever occurs earlier).
- (6) In the case of a Qualified Beneficiary entitled to a disability extension, the later of:
 - (a) (i) 29 months after the date of the Qualifying Event, or (ii) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or
 - (b) the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

The Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of similarly situated non-COBRA beneficiaries, for example, for the submission of a fraudulent claim.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

What are the maximum coverage periods for COBRA continuation coverage? The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below:

- (1) In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event if there is not a disability extension and 29 months after the Qualifying Event if there is a disability extension.
- (2) In the case of a covered Employee's enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries other than the covered Employee ends on the later of:
 - (a) 36 months after the date the covered Employee becomes enrolled in the Medicare program; or
 - (b) 18 months (or 29 months, if there is a disability extension) after the date of the covered Employee's termination of employment or reduction of hours of employment.
- (3) In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.
- (4) In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the Qualifying Event.

Under what circumstances can the maximum coverage period be expanded? If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- or 29-month period, by a second

Qualifying Event that gives rise to a 36-months maximum coverage period, the original period is expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of and with respect to both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36 months after the date of the first Qualifying Event. The Plan Administrator must be notified of the second Qualifying Event within 60 days of the second Qualifying Event. This notice must be sent to the COBRA Administrator in accordance with the procedures above.

How does a Qualified Beneficiary become entitled to a disability extension? A disability extension will be granted if an individual (whether or not the covered Employee) who is a Qualified Beneficiary in connection with the Qualifying Event that is a termination or reduction of hours of a covered Employee's employment, is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Qualified Beneficiary must also provide the Plan Administrator with notice of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month maximum coverage. This notice should be sent to the COBRA Administrator in accordance with the procedures above.

Does the Plan require payment for COBRA continuation coverage? For any period of COBRA continuation coverage under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Qualified beneficiaries will pay up to 102% of the applicable premium and up to 150% of the applicable premium for any expanded period of COBRA continuation coverage covering a disabled Qualified Beneficiary due to a disability extension. The Plan will terminate a Qualified Beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made.

Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments? Yes. The Plan is also permitted to allow for payment at other intervals.

What is Timely Payment for payment for COBRA continuation coverage? Timely Payment means a payment made no later than 30 days after the first day of the coverage period. Payment that is made to the Plan by a later date is also considered Timely Payment if either under the terms of the Plan, covered employees or Qualified Beneficiaries are allowed until that later date to pay for their coverage for the period or under the terms of an arrangement between the Employer and the entity that provides Plan benefits on the Employer's behalf, the Employer is allowed until that later date to pay for coverage of similarly situated non-COBRA beneficiaries for the period.

Notwithstanding the above paragraph, the Plan does not require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is postmarked to the Plan.

If Timely Payment is made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the Plan's requirement for the amount to be paid, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" is 30 days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of \$50 or 10% of the required amount.

Must a qualified beneficiary be given the right to enroll in a conversion health plan at the end of the maximum coverage period for COBRA continuation coverage? If a Qualified Beneficiary's COBRA continuation coverage under a group health plan ends as a result of the expiration of the applicable maximum coverage period, the Plan will, during the 180-day period that ends on that expiration date, provide the Qualified Beneficiary with the option of enrolling under a conversion health plan if such an option is otherwise generally available to similarly situated non-COBRA beneficiaries under the Plan. If such a conversion option is not otherwise generally available, it need not be made available to Qualified Beneficiaries.

IF YOU HAVE QUESTIONS

If you have questions about your COBRA continuation coverage, you should contact the COBRA Administrator. For more information about your rights under COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

KEEP YOUR PLAN ADMINISTRATOR INFORMED OF ADDRESS CHANGES

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

RESPONSIBILITIES FOR PLAN ADMINISTRATION

PLAN ADMINISTRATOR. City of Stafford Health Care Benefits Plan is the benefit plan of City of Stafford, the Plan Administrator, also called the Plan Sponsor. An individual may be appointed by City of Stafford to be Plan Administrator and serve at the convenience of the Employer. If the Plan Administrator resigns, dies or is otherwise removed from the position, City of Stafford shall appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Plan Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties.

DUTIES OF THE PLAN ADMINISTRATOR.

- (1) To administer the Plan in accordance with its terms.
- (2) To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.
- (3) To decide disputes which may arise relative to a Plan Participant's rights.
- (4) To prescribe procedures for filing a claim for benefits and to review claim denials.
- (5) To keep and maintain the Plan documents and all other records pertaining to the Plan.
- (6) To appoint a Claims Administrator to pay claims.
- (7) To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

PLAN ADMINISTRATOR COMPENSATION. The Plan Administrator serves **without** compensation; however, all expenses for plan administration, including compensation for hired services, will be paid by the Plan.

CLAIMS ADMINISTRATOR IS NOT A FIDUCIARY. A Claims Administrator is **not** a fiduciary under the Plan by virtue of paying claims in accordance with the Plan's rules as established by the Plan Administrator.

COMPLIANCE WITH HIPAA PRIVACY STANDARDS. Certain members of the Employer's workforce perform services in connection with administration of the Plan. In order to perform these services, it is necessary for these employees from time to time to have access to Protected Health Information (as defined below).

Under the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the "Privacy Standards"), these employees are permitted to have such access subject to the following:

- (1) **General.** The Plan shall not disclose Protected Health Information to any member of the Employer's workforce unless each of the conditions set out in this HIPAA Privacy section is met. "Protected Health Information" shall have the same definition as set out in the Privacy Standards but generally shall mean individually identifiable health information about the past, present or future physical or mental health or condition of an individual, including information about treatment or payment for treatment.
- (2) **Permitted Uses and Disclosures.** Protected Health Information disclosed to members of the Employer's workforce shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative functions shall include all Plan payment and health care operations. The terms "payment" and "health care operations" shall have the same definitions as set out in the Privacy Standards, but the term "payment" generally shall mean activities taken with respect to payment of premiums or contributions, or to determine or fulfill Plan responsibilities with respect to coverage, provision of benefits, or reimbursement for health care. "Health care operations" generally shall mean activities on behalf of the Plan that are related to quality assessment; evaluation, training or accreditation of health care providers; underwriting, premium rating and other functions related to obtaining or

renewing an insurance contract, including stop-loss insurance; medical review; legal services or auditing functions; or business planning, management and general administrative activities.

- (3) **Authorized Employees.** The Plan shall disclose Protected Health Information only to members of the Employer's workforce who are designated and are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for these persons to perform duties with respect to the Plan. For purposes of this HIPAA Privacy section, "members of the Employer's workforce" shall refer to all employees and other persons under the control of the Employer.
- (a) **Updates Required.** The Employer shall amend the Plan promptly with respect to any changes in the members of its workforce who are authorized to receive Protected Health Information.
- (b) **Use and Disclosure Restricted.** An authorized member of the Employer's workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the Plan.
- (c) **Resolution of Issues of Noncompliance.** In the event that any member of the Employer's workforce uses or discloses Protected Health Information other than as permitted by the Privacy Standards, the incident shall be reported to the privacy official. The privacy official shall take appropriate action, including:
- (i) Investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;
 - (ii) Applying appropriate sanctions against the persons causing the breach, which, depending upon the nature of the breach, may include, oral or written reprimand, additional training, or termination of employment;
 - (iii) Mitigating any harm caused by the breach, to the extent practicable; and
 - (iv) Documentation of the incident and all actions taken to resolve the issue and mitigate any damages.
- (4) **Certification of Employer.** The Employer must provide certification to the Plan that it agrees to:
- (a) Not use or further disclose the Protected Health Information other than as permitted or required by the Plan documents or as required by law;
 - (b) Ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Employer with respect to such information;
 - (c) Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;
 - (d) Report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures hereunder or required by law;
 - (e) Make available Protected Health Information to individual Plan members in accordance with Section 164.524 of the Privacy Standards;
 - (f) Make available Protected Health Information for amendment by individual Plan members and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;
 - (g) Make available the Protected Health Information required to provide any accounting of disclosures to individual Plan members in accordance with Section 164.528 of the Privacy Standards;

- (h) Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;
- (i) If feasible, return or destroy all Protected Health Information received from the Plan that the Employer still maintains in any form, and retain no copies of such information when no longer needed for the purpose of which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information unfeasible; and
- (j) Ensure the adequate separation between the Plan and member of the Employer's workforce, as required by Section 164.504(f)(2)(iii) of the Privacy Standards.

The following members of City of Stafford's workforce are designated as authorized to receive Protected Health Information from City of Stafford Health Care Benefits Plan ("the Plan") in order to perform their duties with respect to the Plan: Director of Finance.

COMPLIANCE WITH HIPAA ELECTRONIC SECURITY STANDARDS. Under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the "Security Standards"), the Employer agrees to the following:

- (1) The Employer agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that the Employer creates, maintains or transmits on behalf of the Plan. "Electronic Protected Health Information" shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.
- (2) The Employer shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.
- (3) The Employer shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in Compliance With HIPAA Privacy Standards provisions (3) Authorized Employees and (4) Certification of Employers described above.

FUNDING THE PLAN AND PAYMENT OF BENEFITS

The cost of the Plan is funded as follows:

For Employee and Dependent Coverage: Funding is derived from the funds of the Employer and contributions made by the covered Employees.

The level of any Employee contributions will be set by the Plan Administrator. These Employee contributions will be used in funding the cost of the Plan as soon as practicable after they have been received from the Employee or withheld from the Employee's pay through payroll deduction.

Benefits are paid directly from the Plan through the Claims Administrator.

PLAN IS NOT AN EMPLOYMENT CONTRACT

The Plan is not to be construed as a contract for or of employment.

CLERICAL ERROR

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, due to a clerical error, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Plan Participant, if it is requested, the amount of overpayment will be deducted from future benefits payable.

GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION

The Plan is a self-funded group health Plan and the administration is provided through a Third Party Claims Administrator. The funding for the benefits is derived from the funds of the Employer and contributions made by covered Employees. The Plan is not insured.

Third Party Administration. Administrative services are provided as follows:

- Medical claim administration is provided by Memorial Hermann Health Network Providers
- The Prescription Drug program is administered by Caremark
- The Plan Administrator is responsible for the overall administration of the Plan.

PLAN NAME

City of Stafford Health Care Benefits Plan

PLAN NUMBER: STAFFPPO

TAX ID NUMBER: 74-6026239

PLAN EFFECTIVE DATE: October 1, 2004

PLAN YEAR ENDS: September 30

EMPLOYER INFORMATION

City of Stafford
2610 South Main
Stafford, Texas 77477
(281) 261-3900

PLAN ADMINISTRATOR

Director of Finance
City of Stafford
2610 South Main
Stafford, Texas 77477
(281) 261-3900

NAMED FIDUCIARY

Director of Finance
City of Stafford
2610 South Main
Stafford, Texas 77477

AGENT FOR SERVICE OF LEGAL PROCESS

City Attorney
City of Stafford
2610 South Main
Stafford, Texas 77477

CLAIMS ADMINISTRATOR

Memorial Hermann Health Network Providers
9301 Southwest Freeway, Suite 5000
Houston, Texas 77074
(713) 448-6535

BY THIS AGREEMENT, City of Stafford Health Care Benefits Plan is hereby adopted as shown.

IN WITNESS WHEREOF, this instrument is executed for City of Stafford on or as of the day and year first below written.

By _____
City of Stafford

Date _____

Witness _____

Date _____