TEXAS ANNUAL CONFERENCE OF THE UNITED METHODIST CHURCH

EMPLOYEE BENEFIT PLAN

STANDARD PPO PLAN DOCUMENT

REVISED EFFECTIVE: January 1, 2023

CONTRACT ADMINISTRATOR:

Boon-Chapman Benefit Administrators, Inc.

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SCHEDULE OF MEDICAL BENEFITS

Standard PPO Plan

Annual Medical Deductibles:
(Includes co-insurance; does not include co-payments)
*$1,000 Individual
$3,000 Family

Annual Benefit Maximum:
(Includes All Other Maximums)
Unlimited

Annual Medical Out-of-Pocket Maximums:
(Includes deductibles, co-payments, and co-insurance)
PPO: $4,500 Individual
PPO: $10,000 Family
Non-PPO: $50,000 Individual

Physician Office Visit Co-payment
(Applies to office visit charge only. Other services performed in the physician's office are subject to deductible and co-insurance.)
PPO: $30 – Primary Care Physician (PCP)
$40 – Specialist
Non-PPO: N/A

The Plan recognizes and approves of the practice that the Houston Methodist Hospital System and possibly other providers do not collect deductibles, co-pays and co-insurance from eligible participants. On occasion, Boon-Chapman (the Third-Party Administrator) and others will negotiate out-of-network provider fees on behalf of the plan.

Calendar Year Deductible
This is the amount of Covered Medical Expenses you pay each calendar year before benefits are paid. There is a Calendar Year Deductible that applies to each person.

Family Deductible Limit
If Covered Medical Expenses incurred in a calendar year by you and your dependents and applied against the separate Calendar Year Deductibles equals the Family Deductible Limit, you and your dependents will be considered to have met the separate Calendar Year Deductibles for the rest of that calendar year.

Common Accident Provision
Not more than one individual Annual Deductible will be applied to covered expenses incurred in relation to an accident involving two or more family members.

Multiple Birth
Not more than one Annual Deductible will be applied to covered expenses incurred in the same calendar year that two or more dependents are born in a multiple birth if such covered expenses are due to:

- premature birth;
- abnormal congenital condition; or
- injury or illness which begins not more than 30 days after birth.

Taxes
Any employee benefit plan taxes incurred under the Patient Protection and Affordable Care Act (PPACA) will be paid by The Texas Annual Conference of the United Methodist Church benefit plan.

Plan Co-Insurance

Plan co-insurance is the portion of covered expenses that the Plan will pay, excluding those covered expenses that a covered person must pay:

- as a deductible;

- as co-insurance;
- as co-payment; or
- because of a benefit maximum.

Exceptions to Plan Co-Insurance (Does not apply to transplants.)

Emergency Services

If a Covered Person has an emergency medical condition and receives emergency services from an out-of-network (non-PPO) provider or facility, services performed by non-PPO providers will be paid at the PPO provider benefit level and will not be subject to balance billing.

With regard to ambulance services, non-PPO emergency *air* ambulance services will be paid at the PPO provider benefit level and will not be subject to balance billing. Non-PPO *ground* ambulance services will be paid at the non-PPO provider benefit level (please see Schedule of Medical Benefits).

Services at an In-Network Hospital or Ambulatory Surgical Center

If a Covered Person receives services from an in-network (PPO) hospital or ambulatory surgical center, services provided by non-PPO providers (such as but not limited to pathology, anesthesia, radiology, laboratory, neonatology, or assistant surgeon services) will be paid at the PPO provider benefit level and will not be subject to balance billing.

The Co-insurance level for Covered Persons residing or traveling outside of a 50-mile radius from a network provider will be at the PPO benefit level. The PPO service area is defined as a 50-mile radius from the Covered Person's home address.

All other deductibles and benefit limitations apply and payment is based on the Maximum Allowable Charge as defined by the Contract Administrator.

Out-of-Pocket Maximums

Except as provided below, a covered person shall not be required to pay, in one calendar year, more than $4,500 or $10,000 for the family to PPO providers for his covered medical expenses. Once he/she has done so, the Plan will pay all his covered expenses for the remainder of the calendar year.

Except as provided below, a covered person shall not be required to pay, in one calendar year, more than $50,000 to all non-PPO providers for his covered medical expenses. Once he/she has done so, the Plan will pay all his covered expenses for the remainder of the calendar year.

These out-of-pocket maximums do not apply to any covered expenses a covered person must pay:

- as co-insurance because of failure to comply with the utilization review program; or
- because of a benefit maximum.

The Plan will pay benefits to covered persons for covered expenses as described herein in accordance with the schedule of benefits. The Plan provides maximum benefits to the covered persons when they:

- receive services or treatment from a provider who is a member of Aetna's Signature Administrator's PPO;
- follow the procedures of the utilization review program described herein, which is administered by, Capitol HealthCare Review, Inc. (CHR) dba Prime Dx, a utilization review organization.

If you have questions about participating providers or need help finding a participating provider, call Boon-Chapman's customer service number (800) 252-9653 or visit Aetna's website at www.asalookup.com. A current list of PPO providers for each of the PPO's is available, without charge, through the website. If you do not have access to a computer at your home, you may access this website at your place of employment or contact the Boon Chapman Eligibility Department.

If you have questions about the utilization review program, call Prime Dx at (512) 454-5112 in Austin or (800) 477-4625 outside Austin.

The Contract Administrator of the Plan is Boon-Chapman Benefit Administrators, Inc. If you have other questions about the Plan (including questions about claims, premiums, and eligibility), call (512) 454-2681 or (800) 252-9653.

Schedule of Medical Benefits

The following schedule summarizes co-payment amounts paid by you and the plan, benefit maximums and additional explanation needed for your benefits. Please refer to the text for additional plan provisions, which may affect your benefits.

Some benefits are subject to the annual deductible which must be met prior to any benefits being paid as indicated in the schedule below. Other benefits may have a fixed co-payment (co-pay) in lieu of having to meet the annual deductible.

Benefit Description	Annual Deductible or Co-pay	Plan Pays	Additional Limitations and Explanations
Alcohol/ Substance Abuse			
Inpatient Coverage			**All inpatient services must be pre-certified.** Inpatient Care includes both Acute Care and Residential Treatment, if medically necessary.
PPO	Deductible	80%	
Non-PPO	Deductible	60%	of Maximum Allowable Charge
Outpatient Coverage			
PPO	Deductible	80%	
Non-PPO	Deductible	60%	of Maximum Allowable Charge
Allergy Injections			
PPO	$30 co-pay	100%	Administration of Injection only; Serum/antigen falls under deductible/co-insurance
Non-PPO	Deductible	60%	of Maximum Allowable Charge
Air Ambulance Services			
PPO	Deductible	80%	
Non-PPO	Deductible	80%	
Ground Ambulance Services			
PPO	Deductible	80%	
Non-PPO	Deductible	80%	of Maximum Allowable Charge
Bariatric Surgery			See explanation of criteria that must be met for coverage in the Covered Expenses portion of this plan document.
PPO Only	Deductible	80%	
Chiropractic Therapy			Calendar year maximum of 35 visits.
PPO	$30 co-pay	100%	
Non-PPO	Deductible	60%	of Maximum Allowable Charge

Benefit Description	Annual Deductible or Co-pay	Plan Pays	Additional Limitations and Explanations
Diagnostic Lab and X-Ray			
PPO	Deductible	80%	
Non-PPO	Deductible	60%	of Maximum Allowable Charge
Preventive Diagnostic			
PPO	No	100%	
Non-PPO	Deductible	60%	of Maximum Allowable Charge
Dialysis Services			
Outpatient Dialysis			
All Providers	No	100%	

Important Note: The plan does not use a Preferred Provider Organization (PPO) Network for dialysis services. The definition of MAC is different for Outpatient Dialysis Services than other services. Please review the definition of "Maximum Allowable Charges" also referred to as "MAC", which is contained in the Section titled "Definitions" for details. The Maximum Allowable Charge for Outpatient Dialysis Services is 125% of what Medicare would allow.

A Covered Person Must: (1) notify Prime Dx when Dialysis treatment begins; (2) notify Prime Dx when diagnosed with End Stage Renal Disease ("ESRD"); and (3) enroll in Part A and B of Medicare when diagnosed with ESRD. While a Covered Person has ESRD and the Plan is primary, the Plan will pay or reimburse the Covered Person for Medicare Part B premiums.

Emergency Room (Medical Emergency)			
PPO	Deductible	80%	
Non-PPO	Deductible	80%	
Emergency Room (Non-Emergency Use)			
PPO	Deductible	80%	
Non-PPO	Deductible	60%	of Maximum Allowable Charge
Home Health Care			Maximum up to 60 visits per calendar year.
PPO	Deductible	80%	
Non-PPO	Deductible	60%	of Maximum Allowable Charge
Hospital Services			All Inpatient admissions must be pre-certified.
PPO	Deductible	80%	
Non-PPO	Deductible	60%	of Maximum Allowable Charge
Hospice Services			Bereavement Counseling Maximum Benefit per occurrence is 3 visits.
PPO	Deductible	80%	
Non-PPO	Deductible	60%	of Maximum Allowable Charge
Maternity			
Initial Pre-natal visit			
PPO	$30 co-pay	100%	Limited to initial visit to determine pregnancy.
Non-PPO	Deductible	60%	of Maximum Allowable Charge
All Other Services			
PPO	Deductible	80%	
Non-PPO	Deductible	60%	of Maximum Allowable Charge

Benefit Description	Annual Deductible or Co-pay	Plan Pays	Additional Limitations and Explanations
Mental and Nervous Care/Serious Mental Illness			**All inpatient services must be pre-certified.**
Inpatient Coverage			Inpatient Care includes both Acute Care and Residential Treatment, if medically necessary.
PPO	Deductible	80%	
Non-PPO	Deductible	60%	of Maximum Allowable Charge
Office Visits			
PPO-Primary Care	$30 co-pay	100%	
PPO-Specialist	$40 co-pay	100%	
Non-PPO	Deductible	60%	of Maximum Allowable Charge
Outpatient Coverage			
PPO	Deductible	80%	
Non-PPO	Deductible	60%	of Maximum Allowable Charge
Outpatient Rehabilitation			Includes charges for Physical Therapy, Speech Therapy, and Occupational Therapy. Maximum per diagnosis is 60 visits per calendar year.
PPO	$30 co-pay	100%	
Non-PPO	Deductible	60%	of Maximum Allowable Charge
Physician Office Visits			
PPO-Primary Care	$30 co-pay	100%	Primary Care Physician (PCP) includes General Practice, Family Practice, Pediatrician, Gynecologist, and Internal Medicine. Applies to office visit charge only.
PPO-Specialist	$40 co-pay		
Non-PPO	Deductible	60%	of Maximum Allowable Charge
Preventive Health Services			
PPO	No	100%	
Non-PPO	Deductible	60%	of Maximum Allowable Charge
Second Surgical Opinion			Primary Care Physician (PCP) includes General Practice, Family Practice, Pediatrician, Gynecologist, and Internal Medicine.
Physician's Office Visit			
PPO	PCP - $30 co-pay Specialist - $40 co-pay	100%	
Non-PPO	Deductible	60%	of Maximum Allowable Charge
Other Services			
PPO	Deductible	80%	
Non-PPO	Deductible	60%	of Maximum Allowable Charge
Skilled Nursing or Convalescent Facility			Maximum up to 60 days per calendar year.
PPO	Deductible	80%	
Non-PPO	Deductible	60%	of Maximum Allowable Charge
Teladoc®	No	100%	See page 6 for more information.

Benefit Description	Annual Deductible or Co-pay	Plan Pays	Additional Limitations and Explanations
Urgent Care Facility (Minor Emergency or Non-Emergency Use)			
PPO	Deductible	80%	
Non-PPO	Deductible	60%	of Maximum Allowable Charge
Wellness Benefit			
Physician's Office			
PPO	No	100%	
Non-PPO	Deductible	60%	of Maximum Allowable Charge
Wellness Benefit			
Associated Lab/X-ray			
PPO	No	100%	
Non-PPO	Deductible	60%	of Maximum Allowable Charge
All Other Covered Expenses			
PPO	Deductible	80%	
Non-PPO	Deductible	60%	of Maximum Allowable Charge

OUT OF PPO SERVICE AREA:
For those covered participants who have been designated as residing outside of the PPO area, benefits will be calculated at the PPO level, but would be subject to the Provider's Maximum Allowable Charge. Please see "Exceptions to Plan Co-Insurance" on page 2 of this plan document.

TELADOC®

Teladoc® is a telehealth medicine program that gives participants access to quality medical care via phone access 24 hours a day, seven days a week, 365 days a year. The doctors in this program are U.S. Board Certified in Internal Medicine, Family Practice, or Pediatrics. They average 15 years' practice experience, are licensed in your state, and incorporate Teladoc® into their day-to-day practice to provide members with convenient access to quality medical care. Teladoc® physicians can treat many medical conditions such as cold and flu symptoms, allergies, bronchitis, skin problems, respiratory infections and sinus problems, and can prescribe medications for short-term conditions.

Teladoc® is not meant to replace your primary care physician. Teladoc® should be used when you need immediate care for non-emergency medical issues. It is a free, convenient alternative to urgent care and ER visits. It is also helpful when you are on vacation, on a business trip, or away from home and cannot see your primary care physician for an urgent need.

To access this program, either visit www.teladoc.com or call 1-800-Teladoc (835-2362).

MENTAL HEALTH AND SUBSTANCE ABUSE BENEFITS

While being a member of the clergy provides many blessings, being in ministry is also highly stressful. Emotional and mental as well as physical wellbeing are essential for clergy, lay employees, and their families to optimally engage in ministering to and caring for others.

Mental Health Parity
Pursuant to the Mental Health Parity Act (MHPA) of 1996 and the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), collectively, the mental health parity provisions, this Plan applies its terms uniformly and enforces parity between covered health care benefits and covered mental health and substance disorder benefits relating to financial cost sharing restrictions and treatment duration limitations. For further details, please contact the Plan Administrator.

Mental Health and Substance Abuse
Benefits are available for Inpatient or Outpatient care for Mental Health and Substance Abuse conditions, including individual and group psychotherapy, psychiatric testing, and expenses related to the Diagnosis when rendered by a covered Provider. Benefits are available for Residential Treatment Facility, Partial Hospitalization, and Intensive Outpatient Services.

- Covered individuals can receive unlimited mental health visits per calendar year.
- Marriage and family counseling are ***not*** covered.
- There is a $30 co-pay (Primary Care) or a $40 co-pay (Specialist) per visit for PPO providers.
- For a non-PPO provider, your deductible and 40% co-insurance will apply.
- All *inpatient* mental health services including acute care and residential treatment must be pre-certified by calling Prime Dx at 1-800-477-4625.
- To find a Mental Health PPO provider, call Boon-Chapman customer service at 1-800-252-9653 or go to https://asalookup.aetnasignatureadministrators.com/.

Medical Care Coverages – Eligible Medical Expenses

The following are covered services as specified below:

Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD)
Treatment may include any of the following services:

- Initial diagnosis and assessment;
- Psychological, psychiatric and pharmaceutical (medication management) care; or
- Applied behavioral analysis (ABA) therapy.

Does not include services or treatment identified elsewhere as non-covered or excluded such as:

- Investigative/Experimental or unproven;
- Custodial; or
- Educational or services that should be provided through the school district.

Treatment must be considered medically necessary based on clinical information provided by the treating physician.

Autism Spectrum Disorder
Coverage for all generally recognized services prescribed in relation to autism spectrum disorder by the patient's physician in the treatment plan recommended by that physician. The prescribed treatment must be provided by an appropriately licensed, certified, or registered health care practitioner.

Generally recognized services may include:

- Evaluation and assessment services;
- Applied behavioral analysis;

- Behavior training and behavior management;
- Speech therapy;
- Occupational therapy;
- Physical therapy; or
- Medications or nutritional supplements used to address symptoms of autism spectrum disorder.

Benefits for non-rehabilitative treatment of autism are not covered under this plan.

Developmental Delays (Other Than Learning Disorders)
Treatment may include any of the following services:

- Initial diagnosis and assessment;
- Psychological, psychiatric and pharmaceutical (medication management) care;
- Speech therapy, occupational therapy; and physical therapy.

Does not include services or treatment identified elsewhere as non-covered or excluded such as:

- Investigative/Experimental or unproven;
- Custodial;
- Nutritional-diet supplements; or
- Educational or services that should be provided through the school district.

Treatment must be considered medically necessary based on clinical information provided by the treating physician.

Psychiatric, Psychological, or Neuropsychological Testing or Evaluation
Psychiatric, psychological or neuropsychological testing or evaluation specifically related to the treatment of a psychiatric condition, or as may be otherwise specifically provided herein.

Medical Limitations and Exclusions

The following are *not* covered benefits under the Plan:

Counseling, Evaluation or Therapy

- Psychiatric, psychological or neuropsychological testing or evaluation *not* specifically related to the treatment of a psychiatric condition except as may be specifically provided herein
- Vocational testing, evaluation, counseling, or therapy
- Hypnotherapy
- Marriage or family counseling
- Behavioral problems unrelated to the treatment of a psychiatric condition except as may be specifically provided herein
- Mental retardation
- Counseling for sexual dysfunctions or inadequacies.

Learning Disorders
Except as may be specifically provided herein, the plan does not cover:

- Psychiatric, psychological, or neuropsychological testing or evaluation of learning disorders; or
- Treatment of learning disorders (including behavioral problems). Treatment of learning disorders includes, but is not limited to, any physical, speech, and/or occupational therapy that may be prescribed for treatment.

RxBENEFITS~EXPRESS SCRIPTS PRESCRIPTION DRUG BENEFTS

Effective January 1, 2021, the Texas Annual Conference of the United Methodist Church has partnered with RxBenefits~Express Scripts to provide prescription drug benefits to Participants. RxBenefits administers the Prescription Drug Program, providing customer assistance and other services. Express Scripts provides prescription drugs to Participants as the Pharmacy Benefit Manager (PBM).

Participants can contact RxBenefits Member Services at 1.800.334.8134 for information regarding the Prescription Drug Program and for a complete list of covered drugs and supplies and applicable limitations and exclusions. Information is also available by registering at https://www.express-scripts.com/.

Participating pharmacies ("Participating Pharmacies") have contracted with the Plan to charge participants reduced fees for covered drugs. Participants will be issued an identification card to use at the pharmacy at the time of purchase. *No reimbursement will be made when a drug is purchased from a non-Participating Pharmacy or when the identification card is not used*. Participants will be held fully responsible for the consequences of any pharmacy identification card used after termination of coverage.

The Mail Order 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, Express Scripts' mail order pharmacy is able to offer Participants significant savings on their prescriptions.

Coinsurance amounts are applied to each charge and are shown on the Prescription Drug Schedule of Benefits below. Deductibles and coinsurance apply to prescriptions purchased through a participating pharmacy as designated by the Prescription Drug Card Program. Deductibles and coinsurance for the Prescription Drug Card Program will not apply to Medical Plan deductibles or out-of-pocket expenses.

The Annual Out-of-Pocket Maximum is the maximum amount Participants are responsible for paying for covered services during a Calendar Year, including Deductibles and Coinsurance.

When the individual and/or family out-of-pocket expenses reach the out-of-pocket maximum, the Plan will pay 100% of the Allowable Expenses for the individual and/or his or her Dependents for the remainder of the Calendar Year, as applicable. No family member will be charged more than the individual out-of-pocket maximum.

Prescription Drug Schedule of Benefits

	Individual	Family
Annual Deductible	$50	$100
Annual Out-of–Pocket Maximum	$2,000	$4,000
The Annual Prescription Drug Deductible and Annual Out-of-Pocket Maximum are effective every year beginning January 1.		

Covered Prescription Drug Expenses	Participating Pharmacy	Non-Participating Pharmacy	Limits
Retail Pharmacy			
Generic	20% coinsurance ($10 minimum)	Not Covered	Retail prescriptions limited to 90-day supply. Retail minimums noted here are for a 30-day supply.
Preferred Name Brand	20% coinsurance ($55 minimum)		
Non-Preferred Name Brands	20% coinsurance ($80 minimum)		
Mail Order			
Generic	20% coinsurance ($25 minimum)	Not Covered	Mail order limited to 90-day supply. Mail order minimums noted here are for a 31-90-day supply.
Preferred Name Brand	20% coinsurance ($137.50 minimum)		
Non-Preferred Name Brands	20% coinsurance ($200 minimum)		
Express Scripts Specialty Drug Program (Accredo)			
Specialty Generic	20% Coinsurance ($10 Minimum)	Not Covered	Specialty drugs limited to 30-day supply and must be obtained from Accredo Specialty Pharmacy.
Specialty Preferred Brand	20% Coinsurance ($55 Minimum)		
Specialty Non-Preferred Brand	20% Coinsurance ($80 Minimum)		
Generic Medications at No Charge Certain generic prescriptions for the treatment of asthma, high blood pressure, high cholesterol, diabetes and proton pump inhibitors are available at no charge. Contact RxBenefits Member Services at 1.800.334.8134 for more information.			

Express Scripts Specialty Drug Program (Accredo)
The Express Scripts Specialty Pharmacy Program focuses on the delivery and management of pharmaceutical products that are generally, but not exclusively, biotechnological in nature, and on coordinating care for members required to take these medications.

Specialty medications are high-cost drugs that are often injected or infused and require special storage and monitoring. These medications must be obtained through Accredo, Express Scripts' specialty pharmacy by calling Accredo at 1.800.803.2523. Some exceptions apply. These medications are limited to a 1-30 day supply.

Specialty medications largely fall into the formulary brand category but could also fall into the biosimilar or generic specialty drug category. These medications are subject to the appropriate coinsurance as listed above. Accredo Specialty Pharmacy also offers pharmaceutical care management services designed to provide you with assistance throughout your treatment.

Generic Dispense as Written Policy (DAW)
If a doctor writes a prescription stating that a Generic drug can be dispensed, the Plan will only pay for the Generic drug. If the Participant chooses to buy the Brand name drug in this situation, the Participant will pay both the Brand coinsurance amount plus the difference in cost between the Generic and the Brand name drug. This Generic DAW Policy will not apply if the doctor requires a Brand name medication.

Covered Drugs and Supplies
The following examples of Covered Drugs and supplies may be available with your prescription benefit coverage. FDA-approved pharmaceuticals requiring a written prescription, issued by a licensed physician, dentist, osteopath, podiatrist, optometrist (licensed professionals) or licensed advance practice certified nurse and dispensed by a licensed pharmacist. Please contact RxBenefits Member Services at 1.800.334.8134 if you have specific drug questions or register at express-scripts.com to check coverage.

- Federal Legend Drugs
- Insulin
- OTC Diabetic Supplies
- Insulin Pumps
- Self-Injectable Medications
- Specialty Medications
- Hemophilia Factors
- Impotency Drugs
- Addyi-HSDD Agents
- Nutritional Supplements Rx Only
- Prescription Vitamins
- Inhaler Assisting Devices
- Non-Insulin Syringes
- Oral, Extended Cycle, Transdermal, Intravaginal, Contraceptives ACA
- Emergency Contraceptives
- Injectable Contraceptives
- Diaphragms & Cervical Caps
- IUDs
- Implantable Contraceptives
- OTC Contraceptives
- Smoking Cessation (Rx)
- Smoking Cessation (OTC)
- HCR/ACA Vaccines

Covered Drug Limitations
Certain Prescription Drugs are covered up to preset limits. These limits are based upon standard FDA approved dosing for the medications. If you request that a prescription be filled for a drug that is subject to quantity limitations, the prescription will be filled up to the preset limits. In some cases, it may be medically necessary for you to exceed the preset limits. In those instances, Prior Authorization is required. In such cases your doctor may initiate Prior Authorization by calling RxBenefits toll-free at 1.800.334.8134. Several hundred drugs are subject to quantity limitations for patient safety based on FDA guidelines. Your plan has identified the following drug categories for Quantity Limits.

- Gastrointestinal-Antimetics
- Influenza
- Insomnia/Sedative Hypnotics
- Migraines

Compound Drugs
For compound drugs to be covered, they must satisfy certain requirements. In addition to being medically necessary and not experimental or investigative, compound drugs must not contain any ingredient on a list of excluded ingredients. Any denial of coverage of a compound drug may be appealed in the same manner as any other drug claim denial under this coverage. Compounded medications equal to or exceeding $300 per script will require prior authorization.

Limitations
The benefits set forth in this section will be limited to:

Dosages
1. With respect to the Pharmacy Option, any one prescription is limited to a 90-day supply.
2. With respect to the Mail Order Option, any one prescription is limited to a 90-day supply.
3. With respect to the Specialty Drug Option, any one prescription is limited to a 30-day supply.

Refills
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.

Exclusions
In addition to the General Limitations and Exclusions section, the following are not covered by the Plan:
- OTC Products
- Standard OTC Equivalents
- Anti-Obesity/Anorexiants
- Fertility(Oral)
- Fertility(Injectable)
- Fertility(Intra-Vaginal)
- Hair Growth Stimulants
- Medical Foods (Rx)
- Injectable/Implantable Medications
- Allergy Extracts

ELIGIBILITY AND EFFECTIVE DATES

Eligibility Requirements – Employees

The following eligibility rules are interpreted according to the policies published on the Texas Annual Conference (TAC) website. Please refer to these policies for additional clarification.

To be eligible to participate in the TAC Group Health Benefits plans, the employee must be in one of the following eligible categories and pay the appropriate rate for the relevant coverage.

Clergy Eligibility

Active Clergy
A clergy appointed by the Bishop of the Texas Annual Conference (TAC) of The United Methodist Church to a local church within the TAC or to an Extension Ministry as stipulated below, who works thirty (30) or more hours per week (*indicated by a 75% or 100% appointment),* and provides the required personal contribution, is eligible to participate in the Group Health Benefits Plan.

For student pastors, scheduled hours of academic classes count toward the thirty (30) hours requirement. Students not serving a local church are not eligible under this paragraph.

Extension Ministers
The following categories of clergy appointed to Extension Ministries within the TAC are eligible to participate in the Group Health Benefits Plan:

1. Clergy where the Texas Annual Conference (TAC) is the salary-paying unit, such as District Superintendents, Center Directors, and Associate Directors, as defined by ¶ 344.1.a.1 of the *2016 Book of Discipline*.
2. Clergy appointed to a TAC Wesley Foundation, as defined by ¶ 344.1.a.1 of the *2016 Book of Discipline*.

An Extension Minister who does not fall into one of the categories designated above is not eligible to participate in the TAC Group Health Benefits plan.

Effective Date – Clergy
Clergy become eligible for Group Health Benefits as of the date of their first appointment. Eligible clergy must complete an enrollment form and submit it to the TAC Benefits Office within 60 days of the date of their first appointment, whereupon coverage will be retroactive to the date of their first appointment. If an eligible clergy does not submit a completed enrollment form during this 60-day period, the employee and any eligible dependents must wait until the next annual open enrollment period to enroll unless gaining eligibility under provisions of a special enrollment period. Coverage for clergy and their dependents enrolling during the annual open enrollment period will be effective on January 1 of the following year.

Medical Leave (CPP Disability) (Group Health Benefits Policy 136)
Clergy appointed to Medical Leave (CPP Disability) by the Texas Annual Conference will be eligible to continue their TAC Group Health Benefits coverage as long as they are eligible for Medical Leave (CPP Disability) based on the eligibility rules of the Comprehensive Protection Plan (CPP). Clergy appointed to Medical Leave (CPP Disability) must submit evidence of applying for Medicare Disability benefits when appropriate. Once Medicare becomes the primary coverage, the participant then pays the appropriate Medicare Primary rate.

Medical Leave (Short-Term) (Group Health Benefits Policy 136)
Clergy approved for Medical Leave (Short-Term) will be eligible to continue their TAC Group Health Benefits coverage under their current appointment for up to a maximum of nine (9) months. If approved for CPP disability

benefits under the Comprehensive Protection Plan (CPP), the clergy will be appointed to Medical Leave (CPP Disability) as of the date of their eligibility for CPP disability benefits.

Medical Leave (non-CPP Disability) (Group Health Benefits Policy 136)
Clergy appointed to Medical Leave (non-CPP Disability) will be eligible for TAC Group Health Benefits coverage for up to a maximum of twelve (12) months. Clergy approved for Medical Leave (Short-Term) who do not qualify for CPP Disability and /or are unable to return to work at the end of their Short-Term Medical Leave may be appointed to Medical Leave (non-CPP Disability) not to exceed a total of twelve (12) months of combined Short-Term and non-CPP Disability Medical Leave.

Clergy Ineligibility

Clergy not eligible to participate in the Group Health Benefits plan includes, but is not limited to, the following categories:

Part-time
Part-time clergy working on average less than thirty (30) hours per week are not eligible to participate in the TAC Group Health Benefits plan.

Extension Ministers
Extension ministers who do not fall into one of the categories designated in the eligibility section above are not eligible to participate in the TAC Group Health Benefits plan.

Non-Payment of Personal Contribution
Clergy who fail to make payment of their personal contribution will lose eligibility for benefits after 90 days of non-payment if no payment arrangements have been made.

Unappointed Local Pastors
Licensed local pastors not under appointment are not eligible to participate in the TAC Group Health Benefits plan.

Termination
Clergy on Honorable Location, who surrender credentials or are otherwise terminated, are not eligible to participate in the TAC Group Health Benefits plan.

Leave of Absence
Clergy appointed to Personal Leave, Transitional Leave, Involuntary Leave, or Sabbatical Leave are not eligible to participate in the TAC Group Health Benefits Plan. Clergy appointed to Family Leave are not eligible to participate in the TAC Group Health Benefits Plan with the exception of a leave that qualifies under the provisions of the Family Medical Leave Act of 1993 (FMLA). For eligibility under the Family and Medical Leave Act of 1993 (FMLA), see the "Extension of Coverage" section in this document.

Intentional Interim Ministers (Group Health Benefits Policy 129)
Retired clergy serving a TAC local church as an Intentional Interim Minister are not eligible to participate in the TAC Group Health Benefits plan.

Early Retiree (Clergy) and Dependent Eligibility

A retired clergy under age 65 (early retiree) who meets the criteria for TAC Early Retiree Group Health Coverage can elect to remain on the TAC self-insured Group Health Plan along with any under age 65 eligible dependents until the clergy and/or enrolled dependents reach age 65 or otherwise lose eligibility under the plan.

To be eligible to enroll in TAC Early Retiree Group Health coverage, retired clergy must meet the following requirements:

1. Early retiree must be under age 65.
2. Early retiree must have participated in the TAC Group Health Benefits Plan for at least two years (24 consecutive months) immediately preceding retirement and must be enrolled at the time of retirement.
3. Early retiree must receive or be eligible to receive a pension from Wespath (former General Board of Pensions) (excluding UMPIP).
4. Early retirees under age 65 pay the appropriate direct billing rate as per the Rate Schedule.

To be eligible to enroll in TAC Early Retiree Dependent Group Health coverage, dependents of early retirees must meet the following requirements:

1. Dependents of early retirees must be under age 65.
2. Dependents of early retirees must have participated in the TAC Group Health Benefits Plan *for at least two years (24 consecutive months) immediately preceding the clergy's retirement and must be enrolled at the time of the clergy's retirement.*
3. ***Effective December 1, 2011, retired clergy will not be permitted to add any dependents to their group health coverage after they retire.*** Retiree group health coverage is a benefit provided based on the contributions of the clergy and spouse over the span of their active ministry. Thus, if a clergy remarries after retirement, the new spouse will not be eligible for retiree TAC Group Health coverage (unless the new spouse is a surviving spouse of a retired TAC clergy as described under Surviving Spouse coverage below).

Early Retiree (Clergy) and Dependent Loss of Eligibility

A retired clergy under age 65 (early retiree) who meets the criteria for TAC Early Retiree Group Health Coverage can elect to remain on the TAC self-insured Group Health Plan along with any under age 65 eligible dependents until the clergy and/or enrolled dependents reach age 65 or otherwise lose eligibility under the plan.

An early retiree or under 65 eligible dependent of an early retiree who chooses not to enroll in (or to terminate coverage in) the TAC self-insured Group Health Plan, will lose eligibility and *will not be allowed to re-enroll in the TAC self-insured Group Health Plan in the future.* An early retiree who transfers to a US Military Plan can return to the TAC plan only when the Military Plan ceases to exist.

Surviving Spouse Eligibility

Surviving spouses under age 65 and any eligible dependents of a TAC clergy enrolled in the plan at the time of the clergy's death can elect to remain on the TAC self-insured Group Health Plan along with their eligible dependents until the surviving spouse reaches age 65 or the surviving spouse or enrolled dependents otherwise lose eligibility under the plan. Under age 65 surviving spouses will pay the appropriate personal contribution amount as determined by the Rate Schedule.

Surviving Spouse Loss of Eligibility

In the event of remarriage, the surviving spouse's eligibility to participate in the plan will terminate at the end of the month in which the surviving spouse remarries unless the surviving spouse remarries a retired clergy of the TAC, in which case the surviving spouse will retain eligibility for benefits under the plan.

A surviving spouse under age 65 who chooses not to enroll in (or to terminate coverage in) the TAC self-insured Group Health Plan, will lose eligibility along with any enrolled dependents and *will not be allowed to re-enroll in the TAC self-insured Group Health in the future.*

Lay Employee Eligibility

Full-time Lay Employee
A lay employee whose salary-paying unit is the Texas Annual Conference Fiscal Office and who works an average of at least thirty (30) hours per week is eligible to participate in the Group Health Benefits Plan.

Effective Date – Lay Employees
Eligible lay employees may enroll in the Group Health Benefits Plan with an effective date of sixty (60) days from the eligible employee's start date by submitting an enrollment form to the TAC Benefits Office within sixty (60) days of their effective date. If an eligible lay employee does not submit a completed enrollment within sixty (60) days of their effective date, the employee and any eligible dependents must wait until the next annual open enrollment period to enroll unless gaining eligibility under provisions of a special enrollment period. Coverage for lay employees and their dependents enrolling during the annual open enrollment period will be effective on January 1 of the following year.

Lay Employee – Medical Leave (Long Term Disability Benefits) (Group Health Benefits Policy 136)
A lay employee of the Texas Annual Conference (TAC) Fiscal Office who qualifies for long term disability benefits under the TAC Fiscal Office Long Term Disability (LTD) Policy would be eligible to continue their TAC Group Health Benefits coverage for up to a maximum of three (3) years if the following conditions are met:

1. the individual has been a full-time employee of the TAC Fiscal Office for a minimum of five (5) consecutive years (including any FMLA Leave) at the time of eligibility for disability benefits;
2. following the initial waiting period, the individual has been continuously covered under the TAC Group Health Benefits Plan while a lay employee of the TAC Fiscal Office; and
3. the lay employee continues to qualify for LTD Benefits under the TAC Fiscal Office Long Term Disability Policy.

Lay Employee – Leave of Absence
A lay employee of the Texas Annual Conference approved for unpaid leave of absence may be eligible to participate in the TAC Group Health Benefits plan as indicated in the "Extension of Coverage" section in this document. For eligibility under the Family and Medical Leave Act of 1993 (FMLA), see the "Extension of Coverage" section in this document.

Lay Employee Ineligibility

Part-time
Part-time lay employees who work on average less than thirty (30) hours per week are not eligible to participate in the Group Health Benefits Plan.

Variable-Hour Lay Employees, Seasonal Lay Employees, and Lay Interns

Variable-hour lay employees, seasonal lay employees, and lay interns are not eligible to participate in the TAC Group Health Benefits Plan unless, following a six-month evaluation (the "measurement period," consisting of 28 weeks, measured consecutively from the employee's start date), the employee is determined to be a full-time employee.

If the TAC determines that the employee is a full-time employee at the end of the measurement period and the employee elects to enroll in the TAC Group Health Benefits Plan, coverage will begin on the first day of the first full calendar month following the expiration of the measurement period. (For example, under this scenario, if the employee's start date is January 15, 2014, coverage would begin on August 1, 2014.) If, based on the number of hours worked, the TAC determines that the employee is a full-time employee at the end of the measurement period, and the employee enrolls in the plan, coverage will continue for a minimum of six (6) months from the initial date of coverage (the "stability period"), regardless of the number of hours the employee works, so long as the employee remains employed by the TAC during the stability period. The measurement period will also apply to any employee

who is expected initially to be employed full-time but who is not expected to be employed full-time for more than six (6) consecutive months.

Eligibility Requirements — Dependents

If an employee is covered by the plan, the employee's eligible dependents can also be covered. An eligible dependent of an employee is:

1. A spouse. Such spouse must have met all requirements of a valid marriage contract in the state of marriage.
2. A child under the age of 26 who is the employee's:
    a. natural child;
    b. legally adopted child or child placed in the home (in accordance with applicable law) awaiting the employee's adoption; or
    c. stepchild.
3. A child under the age of 18 where the employee is the child's:
    a. foster parent;
    b. legal guardian; or
    c. permanent managing conservator or court-appointed permanent custodial parent.
4. A newborn child of the covered employee for the first 31 days after birth.
5. An otherwise eligible child who is age 26 or over and incapable of self-support because of developmental or physical handicap that began before his or her 26th birthday. You must submit written evidence of the child's incapacity within 31 days of the later of the child's 26th birthday or your effective date, and either:
    a. the child is a beneficiary immediately before his or her 26th birthday; or
    b. the child's 26th birthday preceded your effective date and the dependent has been continuously covered as your dependent on a group coverage since that birthday.

An eligible dependent does not include:

1. any person who is on active duty in a military service;
2. any person who is eligible as an employee under the plan; or
3. any person who is covered as a dependent of another employee under the plan.

As of December 1, 2011, no new dependents can be added to the benefit plan of any person in a Retiree or a Surviving Spouse status.

If a TAC retired employee age 65+ has a covered dependent or dependents under the age of 65, the under age 65 dependent(s) may remain on the TAC self-insured Group Health Plan until the earliest of the following:

- The dependent no longer qualifies as a dependent based on the provisions of this plan document; or
- The dependent becomes age 65.

Contributory Coverage
This plan may provide contributory coverage (the employee pays a part of the cost of the employee's and/or dependent coverage).

Effective Date — Dependents

An eligible dependent will be covered provided the employee submits the required enrollment or change form during the applicable enrollment period and the employee has agreed to pay any required contribution for such coverage. The effective date of dependent coverage will be determined by the applicable enrollment period:

- **Initial Enrollment Period** – Dependent coverage will be effective as of the date the employee's coverage begins, provided the employee enrolls the employee and any eligible dependents within 60 days of the employee's eligibility date; or
- **Annual Open Enrollment Period** – Dependent coverage will be effective January 1 of the year following receipt of an enrollment form during the annual open enrollment period; or

- **Special Enrollment Period** – Dependent coverage will be effective as of the applicable effective date as specified in the Special Enrollment Period provisions below.

Effective Date Provision
A dependent's coverage or change in coverage shall not become effective until the employee's coverage or change in coverage has also become effective. A dependent's coverage will not become effective prior to the employee's effective date.

Annual Open Enrollment Period
Eligible dependents not enrolled during the employee's initial 60-day enrollment period may be enrolled during the annual open enrollment period. A completed enrollment form must be submitted prior to December 1 of each year. Enrollment in the plan will be effective on the first day of January after the date on which the plan receives the completed enrollment form.

Special Enrollment Period – Marriage, Birth or Adoption of a Child
An enrolled employee may enroll all eligible dependents at any time provided that a spouse or child has become an eligible dependent of the employee through marriage, birth, adoption, or placement for adoption. In this case, the employee must submit a completed enrollment or change form within 31 days of the date of the marriage, birth, adoption or placement for adoption.

Enrollment in the plan will be effective on the date (1) of the employee's marriage; (2) of the new dependent's birth; or (3) of the new dependent's adoption or placement for adoption with the employee.

An employee participant who marries can add the spouse and the spouse's eligible child(ren) as dependents to the plan by submitting an enrollment or change form within 31 days of the date of marriage. Enrollment in the plan will be effective on the date of marriage. A new dependent not enrolled within 31 days of the date of marriage can only be enrolled during the annual open enrollment period unless gaining eligibility under provisions of a special enrollment period.

A newborn baby or adopted child will be covered for 31 days from birth or the date an adopted child is placed in the home (in accordance with applicable law) awaiting the employee's adoption if the employee has employee coverage in effect at the time of birth or placement for adoption. The dependent must be properly enrolled within 31 days to be eligible to continue participation in the Plan. A newborn baby or adopted child not enrolled within 31 days can only be enrolled during the annual open enrollment period unless gaining eligibility under provisions of a special enrollment period.

Special Enrollment Period – Loss of Prior Coverage
If an employee does not enroll the employee and/or the employee's dependents within sixty (60) days of becoming eligible for coverage and subsequently wishes to elect such coverage, in appropriate circumstances the employee may do so under the plan's special enrollment rules.

An employee may enroll the employee and all eligible dependents for coverage at any time provided that:

1. the employee is eligible for coverage under the plan but is not currently enrolled;
2. the employee declined coverage under the plan when it was offered previously due to being enrolled in alternative health coverage; and
3. the alternative coverage has terminated, because either:
    a. the alternative coverage was Six Months Continuation Coverage or COBRA Coverage that has been exhausted; or
    b. eligibility for the alternative coverage was lost (for reasons other than the individual's voluntary termination of coverage or failure to pay premiums or for cause); or
    c. eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage was lost; or
    d. employer contributions toward the cost of the coverage terminated; or

e. the employee or dependents became eligible for a premium assistance subsidy under Medicaid or CHIP and the employee requests coverage under the plan within 60 days after the date the employee or dependent is determined eligible for the premium assistance.

In this case, the employee must submit a completed enrollment form:

a. within 31 days of the date on which Six Months Continuation or COBRA coverage was exhausted; or

b. within 31 days of the date on which the alternative coverage terminated because of loss of eligibility for coverage; or

c. within 31 days of the date on which employer contributions toward the cost of the coverage terminated; or

d. within 60 days of the date the employee or dependents became eligible for a premium assistance subsidy under Medicaid or CHIP.

Provided the employee submits an enrollment form within the requisite special enrollment period, enrollment in the Plan will be effective the first day of the first calendar month following the date on which the Plan receives the completed enrollment form.

In addition, an enrolled employee may enroll all eligible dependents for coverage at any time provided that:

1. the dependent is eligible for coverage under the plan but is not currently enrolled;
2. the dependent declined coverage under the plan when it was offered previously due to being enrolled in alternative health coverage; and
3. the alternative coverage has terminated, because either:
   a. the alternative coverage was Six Months Continuation Coverage or COBRA Coverage that has been exhausted; or
   b. eligibility for the alternative coverage was lost (for reasons other than the individual's voluntary termination of coverage or failure to pay premiums or for cause); or
   c. eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage was lost; or
   d. employer contributions toward the cost of the coverage terminated; or
   e. the employee or dependents became eligible for a premium assistance subsidy under Medicaid or CHIP and the employee requests coverage under the plan within 60 days after the date the employee or dependent is determined eligible for the premium assistance.

In this case, the employee must submit a completed enrollment or change form:

a. within 31 days of the date on which Six Months Continuation or COBRA Coverage was exhausted; or

b. within 31 days of the date on which the alternative coverage terminated because of loss of eligibility for coverage; or

c. within 31 days of the date on which employer contributions toward the cost of the coverage terminated; or

d. within 60 days of the date the employee or dependents became eligible for a premium assistance subsidy under Medicaid or CHIP.

Provided the employee submits an enrollment or change form within the requisite special enrollment period, enrollment in the Plan will be effective the first day of the first calendar month following the date on which the Plan receives the completed enrollment or change form.

Qualified Medical Child Support Orders

The Plan Administrator shall enroll for immediate coverage under this Plan any Alternate Recipient who is the subject of a Medical Child Support Order that is a "Qualified Medical Child Support Order" (QMCSO) if such an individual is not already covered by the Plan as an Eligible Dependent, once the Plan Administrator has determined that such order meets the standards for qualification set forth below.

Alternate Recipient shall mean any Child of a Participant who is recognized under a Medical Child Support Order as having a right to enrollment under this Plan as the Participant's Eligible Dependent. For purposes of the

benefits provided under this Plan, an Alternate Recipient shall be treated as an Eligible Dependent, but for purposes of the reporting and disclosure requirements, an Alternate Recipient shall have the same status as a Participant.

Medical Child Support Order shall mean any judgment, decree or order (including approval of a domestic relations settlement agreement) issued by a court of competent jurisdiction that:

1. Provides for child support with respect to a Participant's Child or directs the Participant to provide coverage under a health benefits plan pursuant to a state domestic relations law (including a community property law); or
2. Enforces a law relating to medical child support described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822) with respect to a group health plan.

National Medical Support Notice (NMSN) shall mean a notice that contains the following information:

1. Name of an issuing state agency;
2. Name and mailing address (if any) of an employee who is a Participant under the Plan;
3. Name and mailing address of one or more Alternate Recipients (i.e., the child or children of the Participant or the name and address of a substituted official or agency that has been substituted for the mailing address of the Alternate Recipients(s)); and
4. Identity of an underlying child support order.

Qualified Medical Child Support Order is a Medical Child Support Order that creates or recognizes the existence of an Alternate Recipient's right to, or assigns to an Alternate Recipient the right to, receive benefits for which a Participant or Eligible Dependent is entitled under this Plan. In order for such order to be a QMCSO, it must clearly specify the following:

1. The name and last known mailing address (if any) of the Participant and the name and mailing address of each such Alternate Recipient covered by the order;
2. A reasonable description of the type of coverage to be provided by the Plan to each Alternate Recipient, or the manner in which such type of coverage is to be determined;
3. The period of coverage to which the order pertains; and
4. The name of this Plan.

In addition, a National Medical Support Notice shall be deemed a QMCSO if it:

1. Contains the information set forth above in the definition of "National Medical Support Notice";
2. Identifies either the specific type of coverage or all available group health coverage. If the Employer receives an NMSN that does not designate either specific type(s) of coverage or all available coverage, the Employer and the Plan Administrator will assume that all are designated; or
   Informs the Plan Administrator that, if a group health plan has multiple options and the participant is not enrolled, the issuing agency will make a selection after the NMSN is qualified, and, if the agency does not respond within 20 days, the child will be enrolled under the Plan's default option (if any); and
3. Specifies that the period of coverage may end for the Alternate Recipient(s) only when similarly situated dependents are no longer eligible for coverage under the terms of the Plan, or upon the occurrence of certain specified events.

However, such an order need not be recognized as "qualified" if it requires the Plan to provide any type or form of benefit, or any option, not otherwise provided to the Participants and Eligible Beneficiaries without regard to this provision, except to the extent necessary to meet the requirements of a state law relating to medical child support orders, as described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822).

Upon receiving a Medical Child Support Order, the Plan Administrator shall, as soon as administratively possible:

1. Notify the Participant and each Alternate Recipient covered by the Order (at the address included in the Order) in writing of the receipt of such Order and the Plan's procedures for determining whether the Order qualifies as a QMCSO; and

2. Make an administrative determination if the order is a QMCSO and notify the Participant and each affected Alternate Recipient of such determination.

Upon receiving a National Medical Support Notice, the Plan Administrator shall:

1. Notify the state agency issuing the notice with respect to the child whether coverage of the child is available under the terms of the Plan and, if so:
   (a) Whether the child is covered under the Plan; and
   (b) Either the effective date of the coverage or, if necessary, any steps to be taken by the custodial parent or by the official of a state or political subdivision to effectuate the coverage; and
2. Provide to the custodial parent (or any state official serving in a substitute capacity) a description of the coverage available and any forms or documents necessary to effectuate such coverage.

To give effect to this requirement, the Plan Administrator shall:

1. Establish reasonable, written procedures for determining the qualified status of a Medical Child Support Order or National Medical Support Notice; and
2. Permit any Alternate Recipient to designate a representative for receipt of copies of the notices that are sent to the Alternate Recipient with respect to the Order.

Transfer of Coverage

If a husband and wife are both employees and are covered as employees under this plan, and one of them terminates, the terminating spouse and any of his or her eligible and enrolled dependents will be permitted to immediately enroll under the remaining employee's coverage. Such new coverage shall be deemed a continuation of prior coverage and shall not operate to reduce or increase any coverage to which such person was entitled while enrolled as an employee or as a dependent of the terminated employee.

Clergy Change of Appointment

If an enrolled clergy has an appointment change, he/she and all eligible dependents will be given the opportunity to transfer from this PPO Plan to the High Deductible Plan, or alternately, from the High Deductible Plan to this PPO Plan, if he/she so chooses. This change must be made within 31 days of the change in appointment.

Adjustments for Prior Coverage

To the extent that coverages hereunder are a replacement of the prior plan offered by the Employer Group, any deductibles satisfied, with respect to such covered persons under the prior coverage, will be deemed to be deductibles satisfied under the Plan. Any contiguous periods a covered person was covered under prior coverage(s) of the Employer Group will be deemed to be time covered under the Plan. Documentation of satisfied deductibles is the responsibility of the covered person.

UTILIZATION MANAGEMENT PROGRAM

Call (800) 477-4625 or (512) 454-5112

The Plan's Utilization Management ("UM") Program is designed to provide covered individuals with quality medical care in a cost-effective manner. The Utilization Management company does not diagnose or treat medical conditions.

The Plan's Utilization Management company is Capitol HealthCare Review, Inc. ("CHR") **dba Prime Dx**.
Prime Dx, PO Box 9201, Austin, TX 78766
Phone: (800) 477-4625 or (512) 454-5112
Confidential Fax: (512) 454-1624 or (800) 213-5108

Covered employees receive an identification card that contains instructions concerning the UM Program on the back of the card. It should be carried by the employee at all times and shown to all health care providers.

The Utilization Management Program requires that a covered person call Prime Dx in certain instances as described below. It is the covered person's responsibility to ensure that the call is made in a timely manner; however, the covered person's family or health care provider can make the call.

Medical services requiring pre-certification can be pre-certified after the fact; however, when pre-certification is not obtained in advance, the participant runs the risk that the service may not be a covered benefit under the plan, or that the service may be determined not to be medically necessary or not to be appropriate standard of care, in which case the participant would receive no benefits under the plan and would be responsible for all charges. *(Please see definition of Medically Necessary below).*

Urgent or Emergency Hospital Admission Review

The covered person (or family member or health care provider) should call Prime Dx on the first business day after an urgent or emergency hospitalization. Prime Dx will review the medical necessity of the admission and length of stay and notify the individual or the provider whether the admission and the length of stay are authorized.

Non-Emergency Hospital Pre-Admission Review

The covered person (or family member or health care provider) must call Prime Dx at least five days before a scheduled non-emergency hospitalization. Prime Dx will review the medical necessity of the proposed admission and length of stay and notify the individual or the provider whether the admission and the length of stay are authorized.

Continued Hospital Stay Review

If a covered person needs to stay in the hospital longer than originally authorized, the covered person (or family member or health care provider) must contact Prime Dx as soon as possible. Prime Dx will review the medical necessity of the request and notify the individual or the provider whether the additional stay is authorized as medically necessary.

Review of Additional Services

Pregnancy
The covered person (or family member or health care provider) must call Prime Dx within thirty days of learning that the covered person is pregnant.

Transplant
The covered person (or family member or health care provider) must call Prime Dx within five days of the covered person becoming a possible candidate for an organ transplant.

Skilled Nursing Facility Admission
The covered person (or family member or health care provider) must notify Prime Dx as soon as possible prior to being admitted to a skilled nursing facility.

Review of Outpatient Services

The covered person (or family member or health care provider) should call Prime Dx <u>at least three business days before the following scheduled outpatient procedures or services</u>:

- Arthroscopy, Diagnostic & Surgical
- Blepharoplasty
- Cardiac Catheterization and/or Surgery
- Carpal Tunnel Surgery
- Chemotherapy – Initial treatment and/or changes to treatment plan
- Dialysis
- Durable Medical Equipment – Renting or purchasing if the cost exceeds $1,000
- High Tech Radiology (included but not limited to MRIs, CT Scans and PET Scans)
- Home Health Care
- Hospice Care
- Infusions or Injections for which billed charges are over $500
- Outpatient Services performed at a Skilled Nursing Facility
- Physical, Occupational, or Speech Therapy
- Radiation Therapy – Initial treatment and/or changes to treatment plan
- Septoplasty

Medically Necessary or Medical Necessity

Medically Necessary – When a service, treatment, device, drug, or supply is necessary and appropriate for the diagnosis or active treatment of an Illness or Injury based on generally accepted medical practice.

To be Medically Necessary, Covered Expenses must:

- *be rendered in connection with an Injury or Illness;*
- *be consistent with the diagnosis and treatment of your condition;*
- *be in accordance with the standards of good medical practice; and*
- *be provided at the most appropriate level of care or in the most appropriate type of health care facility*.

Only your medical condition (not the financial status or family situation, the distance from a facility or any other non-medical factor) is considered in determining which level of care or type of health care is appropriate.

Medically Necessary is the criteria by which the Plan Administrator determines the necessity of medical service and treatment under this Plan.
<u>The fact that any particular Physician may prescribe, order, recommend or approve a service, treatment, device, drug or supply does not, of itself, make it Medically Necessary.</u>

A service, treatment, device, drug, or supply <u>will not be considered Medically Necessary if</u>:

- it is provided only as a convenience to the Covered Person or provider;
- it is not appropriate treatment for the Covered Person's diagnosis or symptoms;

- it exceeds (in scope, duration or intensity) that level of care that is needed to provide safe, adequate and appropriate diagnosis or treatment;
- it is part of a plan of treatment that is considered to be Investigative, Experimental or for Research Purposes in the diagnosis or treatment of an Illness or Injury. "Investigative, Experimental or for Research Purposes" means services or supplies not recognized or proven to be effective treatment of an Illness or Injury in accordance with generally accepted medical practice, based on consultation with an appropriate source; or
- it involves the use of a drug or substance not formally approved by the United States Food & Drug Administration, even if approval is not required, or if it involves the use of a drug or substance that cannot be lawfully marketed without the approval of the Food and Drug Administration or other appropriate governmental agency, such approval not having been granted at the time of use or proposed use;
- is generally, commonly, and customarily regarded by experts who regularly practice in the area of treatment of the particular disease or condition in question as a drug, treatment, device, procedure, or other service whose usage should be substantially confined to research settings, as set forth in the published authoritative literature; or
- is being provided pursuant to a Food and Drug Administration Phase I or Phase II clinical trial or as the experimental or research arm of a Phase III clinical trial.

The sources of information to be relied upon are:
- the published authoritative medical or scientific literature regarding the drug, treatment, device, procedure, or other service at issue as it is applied to the particular Injury or Sickness at issue;
- a Covered Person's medical records;
- protocol pursuant to which the treatments is to be delivered; or
- any regulations and publications set forth by any governmental agency.

In the event the *Plan* Administrator determines that a service is not *medically necessary*, but the applicable *network* or *network provider* determines that a service is *medically necessary*, the *Plan* will consider the claim to be *medically necessary* if required by the applicable *network* agreement.

Case Management

Prime Dx will assign a case manager when it believes a patient's condition requires complex, specialty or long-term care. The case manager will attempt to coordinate health care services through direct interaction with the covered person, his family, or his physician in an effort to achieve quality care in a cost effective manner. Case management may occur in an inpatient or an outpatient setting.

Notice to Covered Persons about Medical Case Management ("MCM")
Medical Case Management allows the development of an appropriate and cost effective Treatment Plan for a patient suffering from a serious Illness or Injury, such as: premature birth, terminal Illness, stroke, heart attack, or brain Injury. MCM is provided without an additional charge by the Plan to Covered Persons and is administered by a national MCM firm.

The benefits of using MCM include:
- A medical professional is "assigned" to you by the case manager and is available to assist you, as well as to address your questions and concerns;
- A Treatment Plan is created which may allow flexibility with respect to the Plan's Coverage provisions;
- The Treatment Plan is coordinated between the patient, the primary Physician and other care givers; and
- MCM can often negotiate discounts on special equipment and required supplies.

Once the patient and the Plan agree to use MCM, a nurse coordinator will review the details of the case, evaluate the current Treatment Plan, and possibly recommend an alternative Treatment Plan that is both appropriate and cost effective.

If the Treatment Plan recommended by MCM is approved by the patient and the Physician, the MCM firm will request the Plan Administrator's cooperation. The Plan Administrator may or may not decide to Cover the alternative Treatment Plan. If the Plan does not agree to the alternative Treatment Plan, your regular Plan Benefits will apply.

Second Opinion

At any time during the UM process, Prime Dx may ask the covered person to obtain a second opinion about the medical necessity of a proposed surgery, procedure or health care treatment. The physician providing the second opinion will be chosen by Prime Dx. If the covered person does not obtain the second opinion no benefits will be paid by the Plan.

Plan Administrator Utilization Management Discretion

The Plan Administrator shall have the discretion to alter or waive the normal provisions of the Plan when it is reasonable to expect a cost-effective result without sacrificing the quality of care.

Effect of Obtaining an Authorization

The authorization of admission, care or services does not guarantee the payment of benefits. Eligibility and payment of benefits are subject to all of the terms and provisions of the Plan.

Disease Management

If you (or a covered dependent) are suffering from a chronic health condition, the Disease Management Program can help. Provided through Boon-Chapman, the program provides information and resources you can use to better manage chronic conditions. The program is free of charge to active participants of the PPO medical plans.

What is a chronic condition?
A chronic condition usually requires regular or periodic visits to a provider for treatment, continues over an extended time (usually three months or more), and may cause episodes of incapacity or continued incapacity. The common chronic conditions covered by the Disease Management Program are:

- Asthma
- Coronary artery disease
- Congestive heart failure
- Diabetes
- High blood pressure
- High cholesterol

About the Disease Management Program
The program integrates clinical physician care, assessment information, claims and pharmacy data to identify participants with certain medical conditions and provide some level of case management or intervention, along with incentives for participation and reaching certain milestones. With dual goals of improving your health and helping hold down costs, the program strives to:

- Achieve consistency in long-term management
- Improve participant's understanding of his or her condition
- Increase provider awareness and participation
- Initiate earlier collaboration between the medical plan and physician
- Promote improved compliance with treatment protocols
- Monitor participant condition, including consideration of other health conditions and lifestyle issues
- Reduce emergency room/inpatient admissions

The program is founded on clinical practice guidelines from nationally recognized sources such as the American Diabetes Association.

Disease Management Program Participation Incentives
If you qualify for the Disease Management Program (based on prior medical claims, prescription drug utilization and/or risk factors identified in the Wellness Program), you may be eligible for certain incentives. Incentives are based on the severity of the condition.

- **$50 incentive** when you participate in a baseline assessment (performed by a registered nurse)
- **$25 incentive** for each milestone completed (continues as long as you qualify to receive them)
- **Baseline assessment:** Comprehensive medical and psychosocial evaluation (30 minutes to one hour)

Milestone Assessments:

- High-intensity assessment (every three months)
- Moderate-intensity assessment (every six months)
- Low-intensity assessment (every 12 months)

Diabetic Advanced Glucose Monitoring Benefit
Diabetics enrolled in the Disease Management Program and participating in baseline and regular milestone assessments are eligible for a special blood glucose monitoring benefit provided through ActiveCare. This benefit provides the diabetic participant a free, state-of-the art cellular-enabled glucometer, as well as free test strips and lancets (some or all of the cost of replacement glucometers may be the responsibility of the participant). This glucometer would enable the diabetic to access their test results from a smart phone via a secure web portal and would also allow the participant to share test results with their physicians and the disease management nurse.

Comprehensive Diabetes Management Incentive (Standard of Care Treatment)
Diabetics enrolled in the Disease Management Program are eligible to participate in the Comprehensive Diabetes Management Incentive (Standard of Care Treatment). The incentive is payable if the participant meets the following qualifications and is in addition to any other incentives. This incentive, as with all other Disease Management incentives, is authorized by the Disease Management nurse. Requirements include:

- A1C test every 3 or 6 months
- Yearly lipid panel
- Yearly micro albumin urine test
- Yearly comprehensive foot exam
- Yearly dilated eye exam
- Monitor glucose at home

If you have any questions regarding the Disease Management Program, please contact Boon-Chapman (Prime Dx) at **1-800-477-4625**.

Wellness Program

The TAC Center for Connectional Resources Group Health Benefits (GHB) Wellness Program is designed to improve the health and well-being of participants in the TAC Group Health Benefits Plan.

Who is eligible to participate?
Following are the categories of participants in the TAC Group Health Benefits Plan who are eligible to participate in the TAC Group Health Benefits Wellness Program:

1. TAC clergy (active or early retiree) enrolled in the TAC Standard PPO or High Deductible PPO plans.
2. Active lay employees of the TAC Fiscal Office enrolled in the TAC Standard PPO or High Deductible PPO plans.
3. Spouses and surviving spouses enrolled in the TAC Standard PPO or High Deductible PPO plans.

Alternative Wellness Program
Your health plan is committed to helping you achieve your best health. Rewards for participating in the Wellness Program are available to all participants in the Group Health Plan. If you think you might be unable to meet a standard for a reward under this Wellness Program, you might qualify for an opportunity to earn the same reward by different means. Contact the TAC Benefits Office and we will work with you (and if you wish, your doctor) to

find a Wellness Program with the same reward that is right for you in light of your health status.

TAC Virtual Day of Wellness with Methodist Hospital

Entry into the TAC Group Health Benefits (GHB) Wellness Program begins with attending a virtual Day of Wellness event provided through Houston Methodist Hospital Wellness Services offered annually in the fall to newly eligible GHB participants. Invitations and registration information will be emailed approximately six weeks prior to the virtual Day of Wellness event. There is no charge to participate and successful completion of the TAC Virtual Day of Wellness, along with obtaining an annual physical and submission of the Physician Confirmation Form, enters eligible GHB participants into the TAC GHB Wellness Program and qualifies them to earn Wellness Program incentives.

You only need to attend the Day of Wellness once to be eligible to earn Wellness Program Incentives (i.e. you do not need to repeat the Day of Wellness each year).

Components of the Group Health Benefits Wellness Program
Following are the six components of the Group Health Benefits Wellness Program:

1. Participation in a Virtual Day of Wellness with Methodist Hospital
2. Measurable progress towards achieving the target Body Mass Index (BMI) of 25.0 or less.
3. Exercising at least three times per week for 20 minutes or more.
4. Eating a nutritious, balanced diet.
5. Participation in a small group spiritual experience.
   (Laity may substitute their weekly church attendance for this component).
6. Obtaining an annual physical exam.

Wellness Program Incentives
Wellness Program participants can receive up to $1,000 in cash incentives by losing 5% or 10% of their weight at the Day of Wellness and/or by losing the weight needed to reach a BMI (Body Mass Index) of 25.0 or less. In subsequent years, participants can receive a $1,000 Annual Maintenance Incentive for annually maintaining a BMI of 25.0 or less.

If you are already at a BMI of 25.0 or less at the Day of Wellness, you can receive the $1,000 Annual Maintenance Incentive after maintaining a BMI of 25.0 or less for six months following the Day of Wellness. There is an additional $1,000 Pregnancy Incentive for participants who return to their first trimester weight within a year of birth.

Weight Loss Incentives	Amount
5% of weight at the Day of Wellness	$200
10% of weight at the Day of Wellness	$200
100% of weight to reach a BMI of 25.0 or less	$600
Total Weight Loss Incentives	$1,000
Pregnancy Weight Loss Incentive	$1,000
Annual Maintenance Incentive	$1,000

Please note that the total Wellness Program weight loss and annual maintenance incentives that can be earned in a calendar year is limited to $2,000 per participant. All incentives are taxable and you will receive an IRS Form 1099-MISC for any wellness incentives received during that calendar year.

Body Mass Index (BMI)
A Body Mass Index (BMI) of 25.0 is the target BMI used for earning cash incentives as indicated above under the TAC GHB Wellness Program. BMI is used to assess weight relative to height and is calculated by dividing body weight in kilograms by height in meters squared. BMI correlates highly with body fat and is a good indicator of total body composition. A Body Mass Index value which exceeds the normal range is significantly related to negative health outcomes.

BMI Ranges:

Underweight:	less than 18.5
Normal:	18.5 - 24.9
Overweight:	25 - 29
Obese:	30 or greater

Determining your Body Mass Index (BMI)
The table below has already done the math and metric conversions. To use the table, find the appropriate height in the left-hand column. Move across the row to the given weight. The number at the top of the column is the BMI for that height and weight. *For the Wellness Program, the target is a BMI of 25.0 or lower.*

BMI (kg/m^2)	**19**	**20**	**21**	**22**	**23**	**24**	**25**	**26**	**27**	**28**	**29**	**30**	**35**	**40**
Height (in.)	**Weight (lb.)**													
58	91	96	100	105	110	115	119	124	129	134	138	143	167	191
59	94	99	104	109	114	119	124	128	133	138	143	148	173	198
60	97	102	107	112	118	123	128	133	138	143	148	153	179	204
61	100	106	111	116	122	127	132	137	143	148	153	158	185	211
62	104	109	115	120	126	131	136	142	147	153	158	164	191	218
63	107	113	118	124	130	135	141	146	152	158	163	169	197	225
64	110	116	122	128	134	140	145	151	157	163	169	174	204	232
65	114	120	126	132	138	144	150	156	162	168	174	180	210	240
66	118	124	130	136	142	148	155	161	167	173	179	186	216	247
67	121	127	134	140	146	153	159	166	172	178	185	191	223	255
68	125	131	138	144	151	158	164	171	177	184	190	197	230	262
69	128	135	142	149	155	162	169	176	182	189	196	203	236	270
70	132	139	146	153	160	167	174	181	188	195	202	207	243	278
71	136	143	150	157	165	172	179	186	193	200	208	215	250	286
72	140	147	154	162	169	177	184	191	199	206	213	221	258	294
73	144	151	159	166	174	182	189	197	204	212	219	227	265	302
74	148	155	163	171	179	186	194	202	210	218	225	233	272	311
75	152	160	168	176	184	192	200	208	216	224	232	240	279	319
76	156	164	172	180	189	197	205	213	221	230	238	246	287	328

Questions
For questions about the Wellness Program, visit Wellness Program - Texas Annual Conference of the United Methodist Church (txcumc.org) or contact Marianela Morales, TAC Wellness Program Coordinator, at wellness@txcumc.org.

The Group Health Benefits Committee reserves the right to modify or terminate this program at any time. Any disputes or misunderstandings will be resolved by the TAC Center for Connectional Resources Benefits Staff and their determination will be final.

Virgin Pulse Walking Program

The Virgin Pulse Walking Program is provided through Wespath (the General Board of Pensions). Clergy must be enrolled in the Pension Plan before enrolling in the Walking Program.

Who is eligible to participate?
Following are the categories of participants in the TAC Group Health Benefits Plan who are eligible to participate in the TAC Group Health Benefits Wellness Program:

1. TAC clergy (active or early retiree) enrolled in the TAC Standard PPO or High Deductible PPO plans.
2. Active lay employees of the TAC Fiscal Office enrolled in the TAC Standard PPO or High Deductible PPO plans.
3. Spouses and surviving spouses enrolled in the TAC Standard PPO or High Deductible PPO plans.

Group Health Plan participants do not have to attend a Day of Wellness in order to participate in the Walking Program.

Walking Program Incentives
Once you enroll you will earn points for the steps recorded on your pedometer and for other activities. As you reach various point levels during each quarter, you can earn up to a maximum of $75 per quarter (maximum of $300 per year) in incentives as described below which are distributed through your Virgin Pulse personal account.

Virgin Pulse Walking Program Incentives		
Points Reached	Incentive Earned	Total for Quarter
1,000	$5	$5
5,000	$15	$20
10,000	$25	$45
15,000	$30	$75

Visit the TAC website at Walking Program - Texas Annual Conference of the United Methodist Church (txcumc.org) for further information about the Virgin Pulse Walking Program or contact Patricia Goforth-Rakes, Walking Program Coordinator, at pgrakes@txcumc.org.

MEDICAL CARE COVERAGES

Eligible Medical Expenses

Except as otherwise noted below or in the medical schedule of benefits, eligible medical expenses are the maximum allowable charges for services listed below that are incurred by a covered person, subject to the "Definitions" and "Limitations and Exclusions" sections and all other provisions of the plan document. In general, services and supplies must be approved by a physician and must be medically necessary (see explanation below) for the care and treatment of a covered sickness, accidental injury, pregnancy, or other covered health care condition.

Medically Necessary or Medical Necessity

Medically Necessary – When a service, treatment, device, drug, or supply is necessary and appropriate for the diagnosis or active treatment of an Illness or Injury based on generally accepted medical practice.

To be Medically Necessary, Covered Expenses must:

- *be rendered in connection with an Injury or Illness;*
- *be consistent with the diagnosis and treatment of your condition;*
- *be in accordance with the standards of good medical practice; and*
- *be provided at the most appropriate level of care or in the most appropriate type of health care facility*.

Only your medical condition (not the financial status or family situation, the distance from a facility or any other non-medical factor) is considered in determining which level of care or type of health care is appropriate.

Medically Necessary is the criteria by which the Plan Administrator determines the necessity of medical service and treatment under this Plan.

The fact that any particular Physician may prescribe, order, recommend or approve a service, treatment, device, drug or supply does not, of itself, make it Medically Necessary.

A service, treatment, device, drug, or supply will not be considered Medically Necessary if:

- it is provided only as a convenience to the Covered Person or provider;
- it is not appropriate treatment for the Covered Person's diagnosis or symptoms;
- it exceeds (in scope, duration or intensity) that level of care that is needed to provide safe, adequate and appropriate diagnosis or treatment;
- it is part of a plan of treatment that is considered to be Investigative, Experimental or for Research Purposes in the diagnosis or treatment of an Illness or Injury. "Investigative, Experimental or for Research Purposes" means services or supplies not recognized or proven to be effective treatment of an Illness or Injury in accordance with generally accepted medical practice, based on consultation with an appropriate source; or
- it involves the use of a drug or substance not formally approved by the United States Food & Drug Administration, even if approval is not required, or if it involves the use of a drug or substance that cannot be lawfully marketed without the approval of the Food and Drug Administration or other appropriate governmental agency, such approval not having been granted at the time of use or proposed use;
- is generally, commonly, and customarily regarded by experts who regularly practice in the area of treatment of the particular disease or condition in question as a drug, treatment, device, procedure, or other service whose usage should be substantially confined to research settings, as set forth in the published authoritative literature; or
- is being provided pursuant to a Food and Drug Administration Phase I or Phase II clinical trial or as the experimental or research arm of a Phase III clinical trial.

The sources of information to be relied upon are:

- the published authoritative medical or scientific literature regarding the drug, treatment, device, procedure, or other service at issue as it is applied to the Injury or Sickness at issue;
- a Covered Person's medical records;
- protocol pursuant to which the treatments is to be delivered; or
- any regulations and publications set forth by any governmental agency.

For benefit purposes, medical expenses shall be deemed to be incurred on the latest of the following dates:
- the date a purchase is contracted;
- the date delivery is made; or
- the actual date a service is rendered.

Abortion
Covered expenses are limited to abortions that eliminate a substantial danger to the mother's life, but expenses incurred due to medical complications arising from an abortion are also covered.

Alcohol, Drug or Substance Abuse/Chemical Dependency
All inpatient care must be pre-certified. See Schedule of Benefits for additional information.

Allergy Testing
See Schedule of Benefits for possible limitations.

Ambulance
Professional local ambulance service by a state-licensed ambulance company to the nearest hospital in connection with care for a medical emergency or accidental injury.

Ambulatory Surgical Center/Licensed Surgical Facility

Anesthesia
The charges made for anesthetics and by a physician or nurse anesthetist for the administration of anesthesia. If both an anesthetist and a nurse anesthetist are utilized, covered charges are limited to maximum allowable charges of an anesthetist for the covered operative procedure.

Assistant Surgeon
The Plan will cover charges by an assistant surgeon when Medically Necessary due to the nature of the procedure being performed. The Plan will allow up to twenty-five percent (25%) of the primary surgeon's Covered Expenses.

Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD)
Treatment may include any of the following services:

- Initial diagnosis and assessment;
- Psychological, psychiatric and pharmaceutical (medication management) care; or
- Applied behavioral analysis (ABA) therapy.

Does not include services or treatment identified elsewhere as non-covered or excluded such as:
- Investigative/Experimental or unproven;
- Custodial; or
- Educational or services that should be provided through the school district.

Treatment must be considered medically necessary based on clinical information provided by the treating physician.

Autism Spectrum Disorder
Coverage for all generally recognized services prescribed in relation to autism spectrum disorder by the patient's physician in the treatment plan recommended by that physician. The prescribed treatment must be provided by an appropriately licensed, certified, or registered health care practitioner.

Generally recognized services may include:
- Evaluation and assessment services;
- Applied behavioral analysis;
- Behavior training and behavior management;
- Speech therapy;
- Occupational therapy;
- Physical therapy; or
- Medications or nutritional supplements used to address symptoms of autism spectrum disorder.

Benefits for non-rehabilitative treatment of autism are not covered under this plan.

Bariatric Surgery
Eligibility for coverage for Bariatric Surgery will be evaluated once the participant meets the following guidelines as specified below:
- Meet the Eligibility Criteria
- Meet the Qualification Criteria
- Accomplish Pre-Surgical Requirements as Outlined in the Bariatric Surgery Patient Pre-Surgical Checklist
- Sign a letter of Release and Commitment to Adhere to Aftercare Guidelines
- Submit all Required Documentation to Prime Dx/Boon-Chapman
- Choose an In-Network Provider and Facility after Coverage for Bariatric Surgery is Approved

<u>Eligibility Criteria for Bariatric Surgery</u>
- Patient must have been a TAC GHB plan participant for at least three (3) years AND
- Must be between ages 21 and 65.

<u>Qualification Criteria</u>
Patient MUST have the following:
- Documented five-year history of morbid obesity. This criterion must be substantiated in some way (through physician's notes, etc.)
- Body Mass Index (BMI) > 40or 100 lbs. overweight, or
- BMI > 35 with at least two high risk co-morbidities, such as:
    - Poorly controlled diabetes mellitus
    - Symptomatic sleep apnea not controlled by C-Pap
    - Severe cardio-pulmonary condition
    - Hypertension inadequately controlled with optimal conventional treatment
    - Uncontrolled Hyperlipidemia not amenable to optimal conventional treatment, or
    - Musculoskeletal dysfunction associated with obesity.

<u>Accomplish Pre-Surgical Requirements as Outlined in the Bariatric Surgery Patient Pre-Surgical Checklist</u>
- Attend the Day of Wellness at Methodist Hospital. You *must* take the Methodist Hospital Health Risk Assessment.
- If co-morbidities are identified, you must enroll in the TAC GHB sponsored disease management program and participate for a minimum of six months prior to surgery.
- Obtain written confirmation from two physicians that you:
    - can physically withstand the procedure, and
    - are psychologically motivated to change your lifestyle.

- Complete and pass a psychological evaluation by the Krist Samaritan Center (a $25 co-pay will apply, but the evaluation will not be charged against the EPO maximum of 50 visits per year.) A psychological evaluation must be performed to establish the emotional stability and ability to comply with post-surgical limitations as well as to determine that you are psychologically motivated to change your lifestyle.
- Evaluation of other treatable causes: you must undergo a comprehensive physical evaluation to rule out other treatable causes of morbid obesity. This evaluation will include a review of all prescription drugs.
- Previous Compliance with weight-loss programs:
  - You must demonstrate that you have failed to lose weight under a medically supervised program sponsored by a hospital or other weight loss program, and
  - Demonstrate compliance with physician-directed weight loss program including diet, exercise and behavioral modification for a minimum of one year.

Sign Letter of Release and Commitment to Adhere to Aftercare Guidelines

To be considered for Bariatric Surgery, you must sign a letter of commitment promising that you will follow the aftercare guidelines.

Through the commitment and release letter you commit that:

- you will follow post-surgical protocol to maintain a healthy lifestyle, and
- you will allow the TAC GHB committee and its agents access to Protected Health Information required to track your compliance with pre-surgery and post-surgical care requirements.

The aftercare requirement includes long-term behavioral modification support for at least one year after surgery as prescribed by the treating physician, including but not limited to:

- Compliance with all required follow-up visits as prescribed by your physician,
- Compliance with case management recommendations,
- Exercise counseling,
- Nutritional counseling,
- Psychological support through United Behavioral Health or support group meetings, and
- Enrollment in Prime Dx disease management program, as required.

Submit all Required Documentation to Prime Dx/Boon-Chapman

The following required documentation must be provided prior to evaluation for bariatric surgery:

- Copy of your Personal Wellness Profile from the Methodist Hospital Day of Wellness.
- Your signed TAC GHB Bariatric Surgery Benefit Commitment form. This form is located on the TAC website at bariatricsurgerycommitment.pdf (txcumc.org).
- All documents listed on the Bariatric Surgery Patient Pre-Surgical Checklist found on the last page of the Bariatric Surgery Requirements and Checklist Package located on the TAC website at https://www.txcumc.org/wp-content/uploads/2023/07/bariatricreqandchecklist-revised-7-20-2023.pdf
- Submit all required documentation to:

  Prime Dx/Boon-Chapman Nursing Department
  PO Box 9201
  Austin, TX 78766

Choose a Participating Network Provider and Facility after Coverage for Bariatric Surgery is Approved

- You must use a participating or in-network provider and facility for the procedure to be covered by TAC GHB. *Bariatric surgery is not covered if the surgery is performed by a non-participating or out-of-network provider or performed in a non-participating or out-of-network facility.*
- The Methodist Hospital write-off of deductibles and co-insurance applies for this surgery.
- Choose an appropriate Surgeon and Facility. As a general guideline, the facility should provide the following services in addition to the surgery itself:
  - Preoperative medical consultation and approval

- Preoperative psychiatric consultation and approval
- Nutritional counseling
- Exercise counseling
- Psychological counseling and
- Support group meetings.

- Inform the Disease Management nurse.

WHAT IS OR IS NOT COVERED BY TAC GHB?

Coverage under TAC GHB is as Follows:

- In network deductible and co-insurance applies the same as any other condition:
- Panniculectomy (a procedure to remove fatty tissue and excess skin from the lower to middle portions of the abdomen) may be covered at 50% up to $3,000. *This benefit is only available if the patient is compliant with aftercare guidelines.*
- The following Coverage Limits apply:
  - One Bariatric Surgery per lifetime.
  - Panniculectomy is excluded if the patient does not follow aftercare protocol.

Covered Procedures

- Adjustable Gastric Banding (Lap Banding)
- Vertical Banded Gastroplasty
- Roux-en-Y
- Biliopancreatic Diversion
- Duodenal Switch
- Sleeve Vertical Gastrectomy

Exclusions (the items below are non-covered expenses)

- Gastric Balloon, Intestinal Bypass alone, and Stapling procedures are specifically excluded from this Bariatric Surgery benefit.
- Bariatric Surgery performed by non-participating or out-of-network providers, even if you are in an out-of-area plan.
- Bariatric Surgery will not be covered if you have one or more of the following conditions:
  - Active substance abuse,
  - Defined non-compliance with previous medical care

Note: Once you have Bariatric Surgery, you are no longer eligible to receive incentives for weight loss under the TAC Wellness program.

Birthing Centers

Blood
The charges for blood and blood plasma (if not replaced by or for the patient), including blood processing charges.

Casts, Splints, Trusses, and Surgical Dressings

Chemical Dependency
See Alcohol, Drug or Substance Abuse/Chemical Dependency.

Chemotherapy

Chiropractic Care
Manipulation to correct such vertebral disorders as incomplete dislocation, off-centering, misalignment, fixation, or abnormal spacing. See Schedule of Benefits for possible limitations.

Clinical Trials (Routine Patient Costs)
The Plan will not terminate coverage, reduce benefits under the Plan, or otherwise discriminate against a Covered Person due to the Covered Person's participation in a Clinical Trial, if the Covered Person meets the following requirements:

- The Covered Person is eligible to participate in a Clinical Trial per the Clinical Trial protocol with respect to treatment of cancer or other life-threatening disease or condition; and
- The Covered Person's participation in such Clinical Trial would be appropriate based upon the Covered Person's eligibility to participate per the Clinical Trial protocol:
    - As concluded by the referring health care professional who is a participating health care provider in the Clinical Trial; or
    - As established by medical and scientific information provided by the Covered Person.

The Plan will not deny, or limit or impose additional conditions on, routine Covered Expenses for services and supplies that are furnished in connection with participation in the Clinical Trial, subject to the "Definitions" and "Limitations and Exclusions" sections and all other provisions of this Plan Document. In no event will the Plan cover services or supplies Out-of-Network unless Out-of-Network benefits are otherwise provided under the Plan.

The Plan may require a Covered Person who desires to participate in a Clinical Trial that is conducted in the State in which the Covered Person resides to participate through a Network Provider, if one or more Network Providers are participating in a Clinical Trial and the Network Provider will accept the Covered Person as a participant in the Clinical Trial.

For purposes of this section, "Clinical Trial" means an "approved clinical trial" as defined in Section 2709 of the Public Health Service Act. Contact the Contract Administrator for additional information.

Contraceptives
The charges for contraceptives both oral and surgical, such as but not limited to birth control pills, Norplant, Depo Provera, and IUD's, are covered expenses.

Developmental Delays (Other Than Learning Disorders)
Treatment may include any of the following services:

- Initial diagnosis and assessment;
- Psychological, psychiatric and pharmaceutical (medication management) care;
- Speech therapy, occupational therapy; and physical therapy.

Does not include services or treatment identified elsewhere as non-covered or excluded such as:

- Investigative/Experimental or unproven;
- Custodial;
- Nutritional-diet supplements; or
- Educational or services that should be provided through the school district.

Treatment must be considered medically necessary based on clinical information provided by the treating physician.

Diabetes
Care and treatment of diabetes for a covered person who has been diagnosed with insulin dependent or non-insulin dependent diabetes; elevated blood glucose levels induced by pregnancy; or another medical condition associated with elevated blood glucose levels for the following services and supplies:

- Diabetes equipment: blood glucose monitors, including monitors for use by the blind; insulin pumps and

associated appurtenances; insulin infusion devices; and podiatric appliances for the prevention of complications associated with diabetes.

- Diabetes supplies: test strips for blood glucose monitors; visual reading and urine test strip; lancets and lancet devices; insulin and insulin analogs; injection aids; syringes; prescriptive and nonprescriptive oral agents for controlling blood sugar levels; and glucagon emergency kits.
- Diabetes self-management training: training in the care and management of diabetes provided to a qualified insured after the initial diagnosis of diabetes, including nutritional counseling and proper use of equipment and supplies; and additional training authorized by the physician on a diagnosis of a significant change in the qualified insured's symptoms or conditions which requires a change in the program.

Diagnostic Services

Diagnostic Laboratory and X-ray Expenses, including charges for electrocardiograms, electroencephalograms, pneumoencephalograms, basal metabolism tests, or similar diagnostic tests generally approved by physicians throughout the United States. Diagnostic services (those imaging and laboratory capabilities) are used to determine the cause of an illness or disorder. Diagnostic services start when you already have signs of a health problem; therefore, your doctor may order tests to further diagnose your condition. Services considered as diagnostic in nature will apply towards your annual deductible and coinsurance. See "Pre-Admission Testing" for further information.

Preventive Diagnostic Services – While most imaging services and laboratory services are diagnostic in nature, some diagnostic services are used in preventive care (for example, a mammogram may be used as diagnostic or preventive). Preventive care refers to services that can help you stay healthy and identify problems early. These services are called preventive because they can help "prevent" serious health problems and are covered at 100% under your plan when obtained through a PPO (in-network) provider.

Disease Management Program

The plan provides a voluntary Disease Management Program (the "DM") for Covered Persons who are identified as having certain chronic illnesses that are designated for Coverage under the DM. The intended purpose of the DMP is to identify and contact such chronically ill Covered Persons and proactively assist them in managing their Illnesses for better health and lower healthcare costs.

Covered Persons are eligible to join the DM when they are identified by the Plan Administrator or its delegate as meeting the specific criteria for participation in the DM which is established by the Plan Administrator.

The DM provides coverage for certain health care services, which may include diagnosis, treatment, management, education and access to health care specialists, for the following chronic illnesses:

- Asthma
- Coronary artery disease
- Congestive heart failure
- Diabetes
- High-risk maternity, and
- Hypertension

Covered Persons participating in the DM will receive a $50 incentive for participating in a baseline assessment as well as a $25 incentive for each milestone completed.

Drug or Substance Abuse

See Alcohol, Drug or Substance Abuse/Chemical Dependency.

Durable Medical Equipment

Rental of durable medical equipment (but not to exceed the purchase price) or purchase of such equipment, where only purchase is permitted, prescribed by a physician and required for temporary (generally for a period not to exceed six months) therapeutic use in treatment of an active sickness or accidental injury.

Durable medical equipment includes such items as orthotics, braces, crutches, wheelchairs, hospital beds, iron lungs, dialysis equipment, Glucometers, Dextrometers, etc., that:

- can withstand repeated use;
- are primarily and customarily used to serve a medical purpose;
- generally are not useful to a person in the absence of sickness or accidental injury; and
- are appropriate for use in the home.

Purchase or rental of luxury medical equipment (e.g., motorized wheelchairs or other vehicles or bionic or computerized artificial limbs) is not covered when standard equipment is appropriate for the patient's condition.

Home Health Care

Covered expenses are limited to those for services listed herein that are furnished by a home health care agency to a covered person who is under the care of a physician. Home health care services must be furnished in accordance with a home health care plan that is established by the attending physician, and the orders must be renewed at least every 30 days. The attending physician must also certify that the proper treatment of the sickness or accidental injury would require confinement as a resident in-patient in a hospital or skilled nursing facility in the absence of the services and supplies provided as part of the home health care plan.

Covered expenses for home health care visits are limited to those made by:

- a registered graduate nurse (R.N.), a licensed practical nurse (L.P.N.), or a licensed vocational nurse (L.V.N.);
- home health aides under supervision of a R.N.;
- physical, occupational, and speech therapists; or
- a licensed midwife.

You must be homebound, and a doctor must certify that you're homebound. To be homebound means the following:

- Leaving your home isn't recommended because of your condition;
- Your condition keeps you from leaving home without help (such as needing special transportation, using a wheelchair or walker, or getting help from another person);
- Leaving home takes a considerable and taxing effort.

A person may leave home for medical treatment or short, infrequent absences for non-medical reasons, such as attending religious services. You can still get home health care if you attend adult day care, but you would get the home care services in your home.

Covered home health care expenses will also include medical supplies, drugs, and medicines prescribed by a physician, laboratory services, and special meals prescribed by a physician, nutritionist or dietitian, but only to the extent that such charges would have been covered if the covered person had remained in the hospital.

Home Infusion Therapy

Hospice

Covered expenses are limited to hospice care approved every thirty (30) days by the utilization review organization. In addition, eligible expenses are limited to charges for the following services provided by a hospice care program for the care of a covered person with a physician-diagnosed life expectancy of 6 months or less:

- nursing care by a registered graduate nurse, a licensed practical nurse, a licensed vocational nurse, or a public health nurse who is under the direct supervision of a registered nurse;
- physical therapy and speech therapy when rendered by a licensed therapist;
- medical services, supplies, and drugs; or
- physician's services.

In addition, bereavement counseling is a covered expense if provided by a hospice care program to a covered person's spouse, children, or parents within twelve (12) months of the death of a covered person who was in a hospice care program at the time of death. See schedule of benefits for possible limitations.

Hospital Services
For a medically necessary confinement, the plan covers:

- daily room and board charges based on the average semi-private room rate. If the hospital has only private rooms, the plan will cover the hospital's most standard rate for the private room;
- private room charges will be covered if medically necessary by the patient highly susceptible to contracting another illness by being in a semi-private room or patient is contagious; and
- all other medically necessary services and supplies furnished by the hospital, but not for private-duty nursing care.

See schedule of benefits for pre-certification requirements and preferred provider arrangements that may determine the level of benefits.

Hospital audits by an independent auditing firm will be considered covered charges under the plan.

Immunizations
Covered expenses include any required or recommended immunizations for a covered child from birth through the date the child is six years of age.

Mastectomy Reconstruction
Covered expenses include the following in connection with a covered mastectomy:

- reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and physical complications of all stages of mastectomy, including lymphedemas.

Medical Case Management
If medical case management is approved by the plan sponsor, such charges by the utilization review organization will be considered covered expenses under the plan.

Mental Health Care
Treatment for mental and nervous care, disorders, or conditions, as accepted by the general psychiatric community, including treatment for substance abuse. See Schedule of Benefits for possible limitations.

Midwife
Services of a registered nurse midwife.

Multiple Surgical Procedures
Multiple surgical procedure allowances are specified below:

- Primary procedure, bilateral primary procedure, or add-on to primary procedure: maximum allowable charge or negotiated fee;
- Secondary procedure in same operative area: limited to 50% of maximum allowable charge or negotiated fee;
- Bilateral secondary procedure in same operative area: limited to 50% of maximum allowable charge or negotiated fee;
- Add-on to secondary procedure in same operative area: limited to 50% of maximum allowable charge or negotiated fee;
- Separate (incidental) procedure in same operative area as any of the above: not covered;
- Separate operative area: maximum allowable charge or negotiated fee.

Newborn Care
Hospital and physician services rendered during the birth confinement to a covered newborn child (including such charges of a well newborn).

Nursing Services
The charges made by a registered graduate nurse (R.N.), licensed practical nurse (L.P.N.), or licensed vocational nurse (L.V.N.) for private-duty nursing services when medically necessary and prescribed in writing by the attending physician or surgeon specifically as to duration and type and when performed in the covered person's home. See schedule of benefits for possible limitations.

Observation Room Services:
For an observation stay (a period not to exceed 48 hours) to be considered medically necessary, the following conditions must be met:

- The patient is clinically unstable for discharge; **AND**
- Clinical monitoring, and/or laboratory, radiologic, or other testing is necessary in order to assess the patient's need for hospitalization; **OR**
- The treatment plan is not established or based upon the patient's conditions, is anticipated to be completed within a period not to exceed 48 hours; **OR**
- Change in status or condition are anticipated and immediate medical intervention may be required.

Observation room services are not covered when the above criteria are not met. Observation services that extend beyond a 48-hour period are not covered. Providers must contact Boon Chapman and obtain approval for inpatient status for services beyond the initial 48-hour period.

The following is a list of services that are not considered appropriate for observation room services (this list is not all inclusive):

- Services are not reasonable or necessary for the diagnosis and treatment of the patient
- Outpatient blood or chemotherapy administration
- Lack of/delay in patient transportation
- When used as a substitute for inpatient admission or services would normally require inpatient stay
- When it is provided only as a convenience for the physician, patient or patient's family
- While waiting for transfer to another facility
- When inpatient is discharged to observation status

Occupational Therapy
The charges for the professional services of a licensed occupational therapist, when specifically prescribed by and under the direct supervision of a physician or surgeon as to type and duration.

Out-Patient Surgery
Eligible expenses incurred in connection with any surgical procedure that is performed on an out-patient basis in a hospital, ambulatory surgical center, or physician's office. Charges must be incurred on the same day as the surgery, except that tests required by the hospital because of the surgery will be covered if they are incurred within seven days prior to the surgery.

Oxygen
Oxygen and services and supplies for the administration of oxygen.

Physical Therapy
The charges for the professional services of a licensed physical therapist, when specifically prescribed by and under the direct supervision of a physician or surgeon as to type and duration, but only to the extent that the therapy is for improvement of bodily function.

Physician Services
The charges made by a physician for medical and surgical treatment.

Pre-Admission Testing
The charges for diagnostic tests performed on an out-patient basis prior to a scheduled hospital admission when the tests are performed within seven days before admission to the hospital and the patient is subsequently admitted to the hospital.

Preferred Provider Organization
If a preferred provider organization (PPO) or specialty care referral program is shown in the schedule of benefits, maximum allowable charges for those programs will be considered covered expenses under the plan.

Pregnancy
Pregnancy expenses of a covered employee or covered dependent spouse or child are covered to the same extent as any sickness.

Group health plans and health insurance issuers offering group health insurance coverage 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 normal vaginal delivery, or less than 96 hours following a cesarean section, or require that a provider obtain authorization from the plan or insurance issuer from prescribing a length of stay not in excess of the above periods.

Preventive Health Services
Subject to the limitations below, Covered Expenses Incurred for periodic preventive health services recommended for a Covered Person's age and gender as indicated and required under 29 CFR § 2590.715-2713(a)(1) will be reimbursed at 100% for services provided by an in-network (PPO) provider (no cost-sharing, such as a Deductible, Co-insurance or Co-payment will apply) If an item or service required to be covered as a preventive health service under 29 CFR § 2590.715-2713(a)(1) is billed separately from an office visit, then a Co-payment, Co-insurance or Deductible may be applied to that office visit. If the item or service required to be covered under 29 CFR § 2590.715-2713(a)(1) is not billed separately from the office visit and the primary purpose of the office visit is to obtain the preventive care, then no Co-payment, Co-insurance or Deductible may apply to such office visit and preventive care service. If the item or service required to be covered under 29 CFR § 2590.715-2713(a)(1) is not billed separately and the primary purpose of the office visit is not to obtain the preventive service, then a Co-payment, Co-insurance or Deductible may be applied to the office visit.

Prosthetic Appliances
Covered expenses are limited to those for:

- an initial temporary and permanent prosthesis required to replace natural body parts lost or removed while a person is covered by the Plan;
- an initial prosthesis required to aid the function of body organs; and
- a replacement prosthesis necessitated by the growth of a child.

Psychiatric, Psychological, or Neuropsychological Testing or Evaluation
Psychiatric, psychological or neuropsychological testing or evaluation specifically related to the treatment of a psychiatric condition, or as may be otherwise specifically provided herein.

Radiation Therapy
Radium and radioactive isotope therapy.

Respiratory Therapy
The charges for the professional services of a licensed respiratory therapist, when specifically prescribed by a physician or surgeon as to type and duration, but only to the extent that the therapy is for improvement of bodily function.

Second Surgical Opinion
The maximum allowable charges of a physician for a second (or third) surgical opinion consultation and related diagnostic work, when recommended by the utilization review organization.

Skilled Nursing Facility
Covered expenses are limited to skilled nursing facility room and board and services when the confinement is approved and reviewed every thirty (30) days by the utilization review organization.

Sleep Disorders Treatment
Covered expenses are limited to treatment of apnea and narcolepsy.

Speech Therapy
Services by a qualified speech therapist when specifically prescribed by and under the direct supervision of a physician, to restore or rehabilitate any speech loss or impairment caused by injury, sickness, or congenital or developmental abnormalities as shown by age appropriate testing. In the case of a congenital defect that can be corrected or improved with surgery, expenses will be considered for speech therapy only if incurred after surgery for the defect. In case of developmental abnormalities, speech therapy services will be considered only after review of medical necessity. Speech therapy is not covered for mental, emotional, or nervous disorders.

Sterilization Procedures
Sterilization procedures for employees and spouses ONLY.

Telemedicine or Telehealth
Covered expenses include the use of interactive audio, video, or other electronic media for diagnosis, consultation, treatment, transfer of medical data, and medical education.

Temporomandibular Joint Dysfunction (TMJ)
Any services or supplies for the treatment of the temporomandibular joint or jaw-related neuromuscular conditions with oral appliances, oral splints, oral orthotics, devices, prosthetics, dental restorations, orthodontics, physical therapy, or alteration of the occlusal relationships of the teeth or jaws to eliminate pain or dysfunction of the temporomandibular joint and all adjacent or related muscles and nerves.

Transplants
Services and supplies in connection with transplant procedures, subject to the following conditions:

- Case management is required by the utilization review organization for all services.
- A second opinion must be obtained prior to undergoing any transplant procedure. This mandatory second opinion must concur with the attending physician's findings regarding the medical necessity of such procedure. The physician rendering this second opinion must be qualified to render such a service either through experience, specialty training or education, or similar criteria, and must not be affiliated in any way with the physician who will be performing the actual surgery.
- If the donor is covered under this plan, eligible medical expenses incurred by the donor will be considered for benefits.
- If the recipient is covered under this plan, eligible medical expenses incurred by the recipient will be considered for benefits. Expenses incurred by a donor who is not ordinarily covered under this plan per participant eligibility requirements will be considered eligible expenses to the extent that such expenses are not payable by the donor's plan. In no event will benefits be payable in excess of the maximum plan benefit still available to the recipient.

- If both the donor and the recipient are covered under this plan, eligible medical expenses incurred by each person will be treated separately for each person.
- The maximum allowable charges of securing an organ from a cadaver or tissue bank, including the surgeon's charge for removal of the organ and a hospital's charge for storage or transportation of the organ, will be considered a covered expense.

Urgent Care Facilities
A freestanding facility that is engaged primarily in providing minor emergency and episodic medical care and that has a board-certified physician, a registered graduate nurse (R.N.), and a registered x-ray technician in attendance at all times, and x-ray and laboratory equipment and a life support system. An urgent care facility does not include a clinic located at, operated in conjunction with, or in any way made a part of a regular hospital.

Vision Care
Covered expenses are limited to the initial purchase of glasses or contact lenses following cataract surgery covered by the plan.

Wellness Benefit
Preventive or routine medical services not necessary for the treatment of illness or injury. This benefit includes, but is not limited to routine physicals, well-baby exams, mammograms, or immunizations. See also, Preventive Health Services.

Medical Limitations and Exclusions

Except as specifically stated otherwise, no benefits shall be payable for expenses incurred for:

Abortion
Elective abortion unless the mother's life would be endangered if the pregnancy were allowed to continue to term. Complications arising out of an abortion, however, are covered as any other sickness.

Air Purification Units
Air conditioners, air-purification units, humidifiers, or electric heating units.

Bariatric Surgery
Except as specifically outlined under "Covered Expenses", the following are *always* excluded from this benefit:

- Gastric Balloon, Intestinal Bypass alone, and Stapling procedures are specifically excluded from the Bariatric Surgery benefit.
- Bariatric Surgery performed by non-participating or out-of-network providers, even if you are in an out-of-area plan.
- Bariatric Surgery will not be covered if you have one or more of the following conditions:
    - Active substance abuse
    - Defined non-compliance with previous medical care

Biofeedback

Blood
Whole blood or plasma when donated or otherwise replaced by or on behalf of the patient.

Breast Implants
Breast implants placed for cosmetic reasons, removal, reconstruction or re-implantation due to complications are not covered. There will be coverage if there is documentation of leakage of a silicone implant and/or a positive silicone antibody study for removal of implants only.

Cosmetic Surgery
Any surgery, service, drug, or supply designed to improve the appearance of an individual by alteration of a physical characteristic that is within the broad range of normal but that may be considered unpleasing or unsightly, except when:

- necessitated by a non-occupational accidental injury;
- necessary for correction of post-surgical deformity; or
- necessary to correct a congenital abnormality in a child.

Counseling, Evaluation or Therapy

- Psychiatric, psychological or neuropsychological testing or evaluation *not* specifically related to the treatment of a psychiatric condition except as may be specifically provided herein;
- Vocational testing, evaluation, counseling, or therapy;
- Hypnotherapy;
- Marriage or family counseling;
- Behavioral problems unrelated to the treatment of a psychiatric condition except as may be specifically provided herein;
- Mental retardation; or
- Counseling for sexual dysfunctions or inadequacies.

Custodial Care
Care or confinement primarily for meeting personal needs that could be rendered at home or by persons without professional skills or training.

Dental Care Under the Medical Plan
Care or treatment of or to the teeth, alveolar processes, or gingival tissue or for malocclusion will not be covered medical expenses except for:

- treatment of fracture of facial bones;
- excision of lesions of the mandibular joints, mouth, lips, or tongue;
- incision of accessory sinuses or mouth salivary glands or ducts;
- treatment of dislocation of the jaw;
- plastic reconstruction or repair of the mouth or lips necessary to correct or repair traumatic injury or congenital defect arising after the effective date of coverage; or
- treatment required because of accidental bodily injury to natural teeth. Such expenses must be incurred within six months of the date of the accident.

Replacement of teeth that were broken due to a chewing injury is not covered.

Diagnostic Hospital Admissions
Hospital confinement for diagnostic purposes only, when such diagnostic services could be performed in an out-patient setting.

Educational, Recreational, or Vocational Testing, Training, or Therapy

Exercise Equipment
Exercising equipment, vibratory equipment, or swimming or therapy pools.

Foot Care (routine)

- Expenses incurred for the non-surgical treatment of the feet, treatment of corns, calluses, or toenails, or other routine foot care unless the charges are for the removal of nail roots or for the treatment of a metabolic or peripheral-vascular disease.
- Expenses incurred for orthopedic shoes (except when permanently attached to braces) and other supportive appliances for the feet.

Hair Transplants

Hearing Aids or Related Examinations *(covered under a separate Hearing Aid Out-of-Pocket Reimbursement Benefit – please see information on the TAC website at* Hearing Aid Benefits - Texas Annual Conference of the United Methodist Church (txcumc.org)*)*

Impregnation
Artificial insemination, in-vitro fertilization, or any other type of artificial impregnation procedure.

Infertility
Charges related to or in connection with fertility studies, sterility studies, or procedures to restore or enhance fertility.

Learning Disorders
Except as may be specifically provided herein, the plan does not cover:

- Psychiatric, psychological, or neuropsychological testing or evaluation of learning disorders; or
- Treatment of learning disorders (including behavioral problems). Treatment of learning disorders includes, but is not limited to, any physical, speech, and/or occupational therapy that may be prescribed for treatment.

Massage Therapy

Nicotine Addiction

Not Medically Necessary
Any services or supplies that are not medically necessary, except as expressly included herein.

Obesity
See "Weight Control."

Personal Comfort or Convenience Items
Services or supplies provided for personal comfort and not necessary for treatment of covered sickness, accidental injury, or pregnancy including, but not limited to, the purchase or rental of telephones, televisions, orthopedic mattresses, allergy-free pillows, blankets, mattress covers, wigs, non-prescription drugs and medicines, non-hospital adjustable beds, waterbeds, motorized transportation equipment, elevators, escalators, professional medical equipment (such as blood pressure kits), or supplies or attachments for such equipment.

Pregnancy
Charges related to a surrogate mother are not covered.

Prescription Drugs - Outpatient
Outpatient prescription drug coverage is provided only under the terms of the section titled "Script Care Prescription Drug Card Program."

Self-Procured Services
Charges for services rendered to a covered person who is not under the regular care of a physician or charges for services, supplies, or treatment, including any period of hospital confinement, not recommended, approved, and certified as medically necessary and reasonable by a physician.

Sex-Change Procedures
Sex-change counseling or treatment, services incident to sex-change surgery, or any resulting complications.

Sterilization Reversal Surgery
Expenses incurred for the reconstruction (reversal) of a previous sterilization procedure.

Vision Care
Eye examinations for prescribing corrective lenses, eye glasses, or contact lenses or the fitting thereof.

The plan does not cover vision procedures whose purpose is the correction of refractive error, such as radial keratotomy.

Weight Control
Services or supplies for obesity, weight reduction, or dietary control, except for those services covered under Bariatric Surgery benefits.

Wigs and Wig Maintenance

GENERAL HEALTH CARE COVERAGE EXCLUSIONS

The following exclusions apply to all health benefits, and no benefits shall be payable under these health care coverages for:

Court-Ordered Confinement
Any confinement of a covered person in a public or private institution as the result of a court order.

Criminal Activities
Any injury or any complication thereof resulting from or occurring during the covered person's commission of a felony offense or in the immediate flight therefrom.

Excess Charges
Charges in excess of maximum allowable charges for services or supplies provided.

Forms Completion
Charges for the completion of claim forms or for providing supplemental information.

Government-Operated Facilities
The plan does not cover loss caused by or resulting from confinement or treatment for which the covered person is not legally obligated to pay, such as in any government hospital. However, the U.S. government has a right to recover or collect benefits for any care or services incurred by a covered person as a result of a non-service-connected injury or illness. The U.S. government may recover or collect to the extent that the covered person would be eligible to receive benefits under this plan if such care or services had not been furnished by a department or agency of the United States.

Incorrect and/or inappropriate coding and/or billing practices
Any portion of a claim that the administrator determines to be incorrectly or inappropriately billed by a physician, health professional, facility or hospital. This includes, but is not limited to: unbundling of procedural services, office visits that take place within a global period or take place on the same day, duplicate services, and inappropriate modifier use. The determination that a service was incorrectly or inappropriately billed is based on documentation from the Centers for Medicare and Medicaid Services, The National Correct coding Initiative and/or other coding vendors or industry regulatory agencies.

Late-Filed Claims
Claims that are not filed with the contract administrator for handling within 12 months after the date the expenses are incurred.

Military Service
Charges for treatment of any injury sustained or illness contracted while in the military service of any country.

Missed Appointments
Expenses incurred for failure to keep a scheduled appointment.

No Charge/No Legal Requirement to Pay
Services for which no charge is made or for which a covered person is not required to pay, is not billed, or would not have been billed in the absence of coverage under this plan.

Other Coverage
Health care services or supplies for which a covered person is entitled (or could have been entitled if proper application had been made) to be reimbursed by or services or supplies furnished by any plan, authority, or law of any government or governmental agency (federal, state, dominion, or province or any political subdivision thereof).

Outside United States
Charges incurred outside of the United States if the covered person traveled to such location for the sole purpose of obtaining such health care services, drugs, or supplies.

Prior Coverage
Services or supplies for which the covered person is eligible for benefits under the plan that this plan replaces.

Relative or Resident Care
Any service rendered to a covered person by a relative or anyone who customarily lives in the covered person's household.

Travel Expenses for Medical Treatment
Unless approved by the utilization review organization.

Veteran's Hospital
See "Government-Operated Facilities."

War
Health conditions resulting from insurrection, war (declared or undeclared), or any act of war and any complications therefrom, or service in the armed forces of any country.

Work-Related Injury or Sickness
Any injury or sickness that is caused by, or connected in any way to, employment of the covered person. (This includes self-employment or employment by others. It applies whether or not workers' compensation or similar law covers the expenses incurred.)

COORDINATION OF BENEFITS

All benefits provided under the health care coverages of this plan are subject to the following provisions and limitations, unless specifically stated otherwise.

Definitions

As used in this provision, the following terms shall have the meanings indicated:

Other Plan
Other plans include benefits, services, or treatment provided by:

- Group, blanket, or franchise insurance coverage;
- Group hospital or medical service pre-payment plans (HMOs, PPOs, EPOs);
- Group Blue Cross and Blue Shield coverage;
- Group automobile insurance;
- Individual auto insurance based upon the principles of no-fault coverage;
- Any coverage under labor-management trusteed plans, union welfare plans, employer or professional organization plans, or employee benefit organization plans;
- Any coverage under government programs including Medicare (Titles XVIII and XIX of the Social Security Act as enacted or thereafter amended), CHAMPUS, or any coverage required or provided by a statute. For purposes of implementing this provision, eligibility alone will constitute coverage; or
- Any group coverage sponsored by or provided through a school or other educational institution.

This Plan
The health care coverages of this plan.

Allowable Expense
Any maximum allowable charges incurred while the person for whom claim is made is covered under this plan, at least a part of which is covered under any other plan. When a plan provides benefits in the form of service rather than cash payments, the reasonable cash value of each service rendered shall be deemed to be both an allowable expense and a benefit paid.

Claim Determination Period
A period that commences each January 1 and ends at 12 o'clock midnight on the next December 31, or that portion of such period during which the claimant has been covered under this plan.

Effect on Benefits Under This Plan

When Other Plan Does Not Contain a Coordination of Benefits Provision
As to any claim determination period to which this provision is applicable, the benefits that would be payable under this plan in the absence of this provision shall be reduced to the extent necessary so that the sum of all the benefits payable for such allowable expenses under this plan and all other plans shall not exceed the total of such allowable expenses. Benefits payable under the other plans include benefits that would have been payable had claim been duly made for them.

When Other Plan Contains a Coordination of Benefits Provision
If the other plan insuring the person covered by this plan contains a similar non-duplication of benefits provision that coordinates its benefits with those of this plan and would, according to its rules and the order of benefit rules below, determine its benefits after the benefits of this plan have been determined, then the benefits of such other plan will not be considered for the purpose of determining the benefits due under this plan.

If, per the other plan's rules and the order of benefit rules below, this plan is to determine its benefits after the other plan's benefits are determined, then the sum of all the benefits payable for allowable expenses under this plan and all other plans shall not exceed the total of such allowable expenses incurred during the claim determination period.

If the primary plan (i.e., plan that is to pay its benefits first) has a limitation for non-compliance with a utilization review-type of program, this plan will base its coordination only on the amounts that would have been paid if the participant had met the provisions of the primary plan.

If the primary plan has a PPO arrangement or a health maintenance organization (HMO) and the participant is penalized for failure to use these providers, this plan will base its coordination on the amounts that would have been paid if PPO or HMO providers had been used.

When This Plan's PPO negotiates a specific COB provision with a particular participating provider
The Plan's normal COB provision will be superseded by the PPO's COB provision.

Order of Benefit Determination
The rules establishing the order of benefit determination are:

- the benefits of a plan that covers the patient as an active employee shall be determined before the benefits of a plan that covers such patient as a retired employee or as a dependent;
- the benefits of a plan for individuals with COBRA continuation coverage will be secondary to the plan covering the individual as an employee or a dependent of such employee;
- the benefits of a plan that covers a person as an employee who is neither laid-off nor retired, or as that employee's dependent, are determined before those of a plan that covers a person as a laid-off or retired employee or as that employee's dependent. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefit determination, the rule of the other plan will prevail;
- when claimant is a dependent child and such child's parents are not separated or divorced, the benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in the year, but:
  (i) if both parents have the same birthday, the benefits of the plan that covered the parent longer are determined before those of the plan that covered the other parent for a shorter period of time; or
  (ii) if the other plan does not have the rule described above under (i), and if, as a result, the plans do not agree on the order of benefits, the rule of the other plan will determine the order of benefits;

When claimant is a dependent child whose father and mother are legally separated or divorced:

- the benefits of a plan that covers the patient as a dependent child of the parent with custody shall be determined first;
- the plan of the spouse of the parent with custody will be determined second; and
- the plan of the parent not having custody of the child will be determined third; or
- if a court decree assigns financial responsibility for the health care expenses of a dependent child to one of the parents, the benefits of the assigned parent's plan will be determined first.

Notwithstanding the foregoing, this plan is always secondary to no-fault auto insurance coverages.

If none of the above rules establishes an order of benefit determination, the benefits of the plan that has covered the claimant for the longer period of time are determined before those of the plan that has covered that person for the shorter period of time.

When this provision operates to reduce the total amount of benefits otherwise payable to a person covered under this plan during any claim determination period, each benefit that would be payable in the absence of this provision shall be reduced, and such reduced amount shall be charged against any applicable benefit limit of the plan.

Right to Receive and Release Necessary Information
For the purpose of enforcing or determining the applicability of the terms of this provision of this plan or any similar provision of any other plan, the contract administrator may, without the consent of any person, release to or obtain from any insurance company, organization, or person any information with respect to any person it deems to be necessary for such purposes. Any person claiming benefits under this plan shall furnish to the contract administrator such information as may be necessary to enforce this provision.

Special Provisions with Respect to Medicare

In accordance with the Tax Equity Fiscal Responsibility Act of 1983 (TEFRA), an active employee or spouse over age 65 who is eligible for Medicare may elect or reject coverage under this plan. If such person elects coverage under this plan, the benefits of this plan shall generally be determined before any benefits provided by Medicare. However, whenever this plan may lawfully assume a secondary position it will do so and benefits will be determined in accordance with the coordination of benefits provision above.

When this plan may lawfully assume a secondary position and an employee or dependent becomes eligible for the program of benefits provided under Medicare, he/she is deemed to be covered by both Medicare parts A and B for all purposes under this plan. An employee or dependent is considered to be covered by Medicare on the earliest date any coverage of him under Medicare could have been effective had he/she applied for Medicare in a timely manner.

All health expenses covered under this Plan will be reduced by any Medicare benefits available for those expenses. This will be done before the health benefits of this Plan are calculated. Any rules for coordinating other plan benefits with those under this Plan will be applied after this Plan's benefits have been determined under the above rules. Allowable Expenses will be reduced by any Medicare benefits available for those expenses.

SUBROGATION AND REIMBURSEMENTS

Benefits Subject to This Provision
This provision shall apply to all benefits provided under any section of this Plan.

When This Provision Applies
A Covered Person may incur medical or other charges related to Injuries or Sickness caused by the act or omission of another person; or Another Party may be liable or legally responsible for payment of charges incurred in connection with the Injuries or Sickness. If so, the Covered Person may have a claim against that other person or Another Party for payment of the medical or other charges. In that event, the Plan will be secondary, not primary, and the Plan will be Subrogated to all rights the Covered Person may have against that other person or Another Party and will be entitled to Reimbursement. In addition, the Plan shall have the first lien against any Recovery to the extent of benefits paid or to be paid and expenses incurred by the Plan in enforcing this provision. The Plan's first lien supersedes any right that the Covered Person may have to be "made whole." In other words, the Plan is entitled to the right of first Reimbursement out of any Recovery the Covered Person procures or may be entitled to procure regardless of whether the Covered Person has received compensation for any of his damages or expenses, including any of his attorneys' fees or costs. Additionally, the Plan's right of first Reimbursement will not be reduced for any reason, including attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise. As a condition to receiving benefits under the Plan, the Covered Person agrees that acceptance of benefits is constructive notice of this provision.

The Covered Person must:
Execute and deliver a Subrogation and Reimbursement Agreement;

Authorize the Plan to sue, compromise and settle in the Covered Person's name to the extent of the amount of medical or other benefits paid for the Injuries or Sickness under the Plan and the expenses incurred by the Plan in collecting this amount, and assign to the Plan the Covered Person's rights to Recovery when this provision applies;

Immediately Reimburse the Plan, out of any Recovery made from Another Party, 100% of the amount of medical or other benefits paid for the Injuries or Sickness under the Plan and expenses (including attorneys' fees and costs of suit, regardless of an action's outcome) incurred by the Plan in collecting this amount (without reduction for attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise);

Notify the Plan in writing of any proposed settlement and obtain the Plan's written consent before signing any release or agreeing to any settlement; and

Cooperate fully with the Plan in its exercise of its rights under this provision, do nothing that would interfere with or diminish those rights and furnish any information required by the Plan.

When a right of recovery exists, and as a condition to any payment by the Plan (including payment of future benefits for other Sicknesses or Injuries), the Covered Person will execute and deliver all required instruments and papers, including a Subrogation and Reimbursement Agreement provided by the Plan, as well as doing and providing whatever else is needed, to secure the Plan's rights of Subrogation and Reimbursement, before any medical or other benefits will be paid by the Plan for the Injuries or Sickness. If the Plan pays any medical or other benefits for the Injuries or Sickness before these papers are signed and things are done, the Plan still will be entitled to Subrogation and Reimbursement. In addition, the Covered Person will do nothing to prejudice the Plan's right to Subrogation and Reimbursement and acknowledges that the Plan precludes operation of the made-whole and common-fund doctrines.

The Plan Administrator has maximum discretion to interpret the terms of this provision and to make changes as it deems necessary. The Plan Administrator also has maximum discretion to reduce, settle or otherwise compromise the amount of the Plan's Subrogation interest or the amount to which it is entitled to Reimbursement, and to agree

to payment of attorneys' fees and costs, where, in its sole discretion, it determines that circumstances warrant such reduction.

Amount Subject to Subrogation or Reimbursement
Any amounts recovered will be subject to Subrogation or Reimbursement. In no case will the amount subject to Subrogation or Reimbursement exceed the amount of medical or other benefits paid for the Injuries or Sickness under the Plan and the expenses incurred by the Plan in collecting this amount. The Plan has a right to recover in full, without reduction for attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise, even if the Covered Person does not receive full compensation for all his charges and expenses.

Another Party
Another Party shall mean any individual or organization, other than the Plan, who is liable or legally responsible to pay expenses, compensation or damages in connection with a Covered Person's Injuries or Sickness.

Another Party shall include the party or parties who caused the Injuries or Sickness; the insurer, guarantor or other indemnifier of the party or parties who caused the Injuries or Sickness; a Covered Person's own insurer, such as uninsured, underinsured, medical payments, no-fault, homeowner's, renter's or any other liability insurer; a workers' compensation insurer; and any other individual or organization that is liable or legally responsible for payment in connection with the Injuries or Sickness.

Recovery
Recovery shall mean any and all monies paid to the Covered Person by way of judgment, settlement or otherwise (no matter how those monies may be characterized, designated or allocated) to compensate for any losses caused by, or in connection with, the Injuries or Sickness. Any Recovery shall be deemed to apply, first, for Reimbursement.

Subrogation
Subrogation shall mean the Plan's right to pursue the Covered Person's claims for medical or other charges paid by the Plan against Another Party.

Reimbursement
Reimbursement shall mean repayment to the Plan for medical or other benefits that it has paid toward care and treatment of the Injury or Sickness and for the expenses incurred by the Plan in collecting this benefit amount.

When a Covered Person Retains an Attorney
If the Covered Person retains an attorney, that attorney must sign the Subrogation and Reimbursement Agreement as a condition to any payment of benefits and as a condition to any payment of future benefits for other Sicknesses or Injuries. Additionally, the Covered Person's attorney must recognize and consent to the fact that the Plan precludes the operation of the "made-whole" and "common fund" doctrines, and the attorney must agree not to assert either doctrine in his pursuit of Recovery. The Plan will neither pay the Covered Person's attorneys' fees and costs associated with the recovery of funds, nor reduce its reimbursement pro rata for the payment of the Covered Person's attorneys' fees and costs. Attorneys' fees will be payable from the Recovery only after the Plan has received full Reimbursement.

A Covered Person or his attorney who receives any Recovery (whether by judgment, settlement, compromise, or otherwise) has an absolute obligation to immediately tender the Recovery to the Plan under the terms of this provision. A Covered Person or his attorney who receives any such Recovery and does not immediately tender the Recovery to the Plan will be deemed to hold the Recovery in constructive trust for the Plan, because the Covered Person or his attorney is not the rightful owner of the Recovery and should not be in possession of the Recovery until the Plan has been fully reimbursed.

When the Covered Person is a Minor or is Deceased
These provisions apply to the parents, trustee, guardian or other representative of a minor Covered Person and to the heir or personal representative of the estate of a deceased Covered Person, regardless of applicable law and whether or not the minor's representative has access or control of the Recovery.

When a Covered Person Does Not Comply
When a Covered Person does not comply with the provisions of this section, the Plan Administrator shall have the authority, in its sole discretion, to deny payment of any claims for benefits by the Covered Person and to deny or reduce future benefits payable (including payment of future benefits for other Injuries or Sicknesses) under the Plan by the amount due as Reimbursement to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for other Injuries or Sicknesses) under any other group benefits plan maintained by the Plan Sponsor. The reductions will equal the amount of the required Reimbursement. If the Plan must bring an action against a Covered Person to enforce this provision, then that Covered Person agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

TERMINATION OF COVERAGE

Employee Coverage Termination
An employee's coverage under the health coverage of the plan shall terminate upon the earliest of the following:

- termination of the plan;
- the last day of the month in which the employee prospectively terminates participation in the plan;
- the last day of the month in which the covered employee leaves or is dismissed from the employment of the employer;
- the last day of the month in which the employee ceases to be eligible;
- the date of expiration of the period for which employee last made the required contribution, if the coverage is provided on a contributory basis (the employee shares in the cost); or
- the date prior to the date of the employee's entry into the armed forces of any country.

If an eligible clergy elects not to enroll or to disenroll from the plan, the church is still responsible for the church's contribution based on the clergy's eligible appointment.

Dependent Coverage Termination
A dependent's coverage under the health care coverages of the plan shall terminate upon any of the following:

- termination of the plan;
- the last day of the month in which the coverage of the employee terminates;
- the last day of the month in which the Plan receives actual notice that the covered person no longer satisfies the plan's definition of a dependent;
- the date of expiration of the period for which the employee last made the required contribution for such coverage, if dependent's coverage is provided on a contributory basis (the employee shares in the cost); or
- the date prior to the date of the dependent's entry into the armed forces of any country.

Employee participants can voluntarily terminate an eligible dependent's coverage at any time by submitting an enrollment or change form to the plan. Termination will take effect on the first of the month following receipt of the enrollment or change form. Clergy who participate in a Section 125 Plan should consult their Section 125 Plan Administrator regarding any potential tax consequences of terminating dependent coverage prior to the end of the plan year.

Certificates of Coverage
The plan will provide a certificate of coverage upon request to any employee or dependent after the individual loses coverage in the plan if requested within 24 months after the loss of coverage. In that case, the certificate will be provided at the earliest time that the plan, acting in a reasonable and prompt fashion, can furnish it.

The plan will make reasonable efforts to collect information applicable to any dependents of the employee and to include that information on the certificate.

CONTINUATION OF COVERAGE

The Texas Annual Conference Group Health Benefits (TAC GHB) Plan is exempt from the Consolidated Omnibus Budget Reconciliation Act (COBRA) as a church plan.

Continuation of Coverage Option terminated effective July 1, 2019

The previous TAC GHB Continuation of Coverage Option allowed active participants who lost eligibility for TAC GHB coverage to continue their group health coverage for up to a maximum of six (6) months on a self-pay basis.

Since self-funded group health plans are not required to offer continuation of coverage, the Group Health Benefits Committee determined the Continuation of Coverage Option was no longer needed for the following reasons:

1. The high monthly cost of the Continuation of Coverage Option and the availability of less expensive coverage elsewhere
2. Low enrollment in the Continuation of Coverage Option by participants
3. Elimination of the tax penalty under the Affordable Care Act for not enrolling in health insurance coverage.

Effective July 1, 2019, The TAC GHB Plan does not offer any Continuation of Coverage Option for terminated participants.

EXTENSION OF COVERAGE

Extension of Coverage for Handicapped Dependent Children

If an already covered dependent child attains the age that would otherwise terminate his status as a dependent, and:

- if on the day immediately prior to the attainment of such age the child was a covered dependent under the plan;
- at the time of attainment of such age the child is incapable of self-sustaining employment by reason of mental retardation, physical handicap, or disability that commenced prior to the attainment of such age; and
- such child is primarily dependent upon the employee for support and maintenance,

then such child's status as a dependent shall not terminate solely by reason of his having attained the specified age, and he/she shall continue to be considered a covered dependent under the plan so long as he/she remains in such condition and otherwise conforms to the definition of a dependent.

The employee must submit to the contract administrator proof of the child's incapacity within thirty-one days of the child's attainment of such age and thereafter as may be required, but not more frequently than once a year after the two-year period following the child's attainment of such age.

Extension of Coverage during Periods of Employer-Certified Disability or Leave of Absence

A person may remain eligible for a limited time if active, full-time work ceases due to Disability, Medical Leave, Maternity or Paternity Leave, or Short-term Sabbatical Leave.

While continued, coverage will be that which was in force on the last day worked as an *active employee*. However, if benefits reduce for others in the class, they will also reduce for the continued person.

Subject to the provisions of this Section, the terms and conditions for such continued coverage (*e.g.*, duration of coverage, required contributions, etc.) will be administered in accordance with Group Health Benefits Policy 136, which may be amended from time to time.

Extension of Coverage under Provisions of the Affordable Care Act (ACA)

A clergy employed less than thirty (30) hours per week and under less than a 75% appointment will still be considered a “full-time clergy” for Plan eligibility purposes under the following circumstances:

1. The clergy’s salary-paying unit is an applicable large employer (“ALE”) under Section 4980H of the Internal Revenue Code;
2. The ALE uses the “look-back measurement method” (under which employers may determine the status of an employee as a full-time employee during a future “stability” period as described in Section 4980H of the Internal Revenue Code and regulations adopted pursuant thereto);
3. The clergy is currently in the “stability period” following full-time employment during the appropriate “measurement period”; and
4. The ALE notifies the Plan (TAC Benefits Office) in writing of the stability period during which the clergy should be characterized as employed full-time.

A lay employee of the TAC Fiscal Office employed less than thirty (30) hours per week will still be considered a “full-time lay employee” for Plan eligibility purposes under the following circumstances:

1. The TAC Fiscal Office uses the "look-back measurement method" (under which employers may determine the status of an employee as a full-time employee during a future "stability" period as described in Section 4980H of the Internal Revenue Code and regulations adopted pursuant thereto);
2. The lay employee is currently in the "stability period" following full-time employment during the appropriate "measurement period"; and
3. The TAC Fiscal Office notifies the Plan (TAC Benefits Office) in writing of the stability period during which the lay employee should be characterized as employed full-time.

Extension of Coverage under Provisions of the Family and Medical Leave Act of 1993 (FMLA)
Administered by the Salary-Paying Unit

A. Coverage

If you are covered under the Plan and are eligible for an unpaid family or medical leave of absence as provided under the Family and Medical Leave Act of 1993 (FMLA), your coverage may continue during such leave for up to twelve (12) weeks. The FMLA requires any employer (salary-paying unit) with fifty (50) or more employees within 75 miles, as defined by the Act, to maintain health coverage for an employee during a period of eligible leave at the same level and under the same conditions coverage would have been provided if the employee had remained a member of the eligible group and covered under the Plan. You are considered eligible for FMLA leave if you have been employed by the *employer* for at least twelve (12) months, and have performed at least 1,250 hours of service with the *employer* in the twelve (12) months immediately preceding the start of the leave.

The FMLA entitles eligible employees of covered employers to take unpaid, job-protected leave for specified family and medical reasons with continuation of group health insurance coverage under the same terms and conditions as if the employee had not taken leave.

B. Reasons for FMLA Leave

Eligible employees are entitled to:

Up to twelve (12) workweeks of unpaid FMLA leave in a 12-month period for any of the following reasons:

1. The birth of a child and to care for the newborn child within one year of birth;
2. The placement with the employee of a child for adoption or foster care and to care for the newly placed child within one year of placement;
3. To care for the employee's spouse, child, or parent who has a serious health condition;
4. A serious health condition that makes the employee unable to perform the essential functions of his or her job;
5. Any "qualifying exigency" arising out of the foreign deployment of the employee's spouse, son, daughter, or parent who is a member of the Armed Forces (including the National Guard and Reserves) and who is on covered active duty or has been notified of an impending call or order to covered active duty.

Up to twenty-six (26) workweeks of unpaid FMLA Military Caregiver Leave during a single 12-month period to care for a covered servicemember with a serious injury or illness if the eligible employee is the servicemember's spouse, son, daughter, parent or next of kin and qualifies for FMLA Military Caregiver Leave based on the criteria set forth under FMLA provisions.

Up to twenty-six (26) workweeks of unpaid FMLA Military Caregiver Leave during a single 12-month period to care for a covered veteran with a serious injury or illness if the eligible employee is the covered veteran's spouse, son, daughter, parent or next of kin and qualifies for FMLA Military Caregiver Leave based on the criteria set forth under FMLA provisions.

Disabled clergy (clergy appointed to Medical Leave) may continue coverage as defined in the "Eligibility and Effective Dates" section of this document.

CLAIMS PROCEDURES FOR HEALTH CARE COVERAGE

The procedures outlined below must be followed by Claimants to obtain payment of health benefits under this Plan.

Health Claims
All claims and questions regarding health claims should be directed to the Contract Administrator. The Plan Administrator shall be ultimately and finally responsible for adjudicating such claims and for providing full and fair review of the decision on such claims. Benefits under the Plan will be paid only if the Plan Administrator decides in its discretion that the Claimant is entitled to them. The responsibility to process claims in accordance with the Plan Document may be delegated to the Contract Administrator; provided, however, that the Contract Administrator is not a fiduciary of the Plan and does not have the authority to make decisions involving the use of discretion.

The Plan will ensure that all claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) will not be made based upon the likelihood that the individual will support the denial of benefits.

Each Claimant claiming benefits under the Plan shall be responsible for supplying, at such times and in such manner as the Plan Administrator in its sole discretion may require, written proof that the expenses were Incurred or that the benefit is covered under the Plan. If the Plan Administrator in its sole discretion shall determine that the Claimant has not Incurred a Covered Expense or that the benefit is not covered under the Plan, or if the Claimant shall fail to furnish such proof as is requested, no benefits shall be payable under the Plan.

Important Definitions
The following defined terms are used in this Claims Procedures section:

"Adverse Benefit Determination" means any of the following: (1) a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit under the Plan, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Covered Person's eligibility to participate in the Plan; (2) a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit under the Plan, resulting from the application of precertification procedures or other utilization review procedures; (3) a failure to cover an item or service for which benefits under the Plan are otherwise provided because it is determined to be experimental and/or investigational or not medically necessary or because another exclusion applies under the Plan; or (4) a rescission of coverage, which is a cancellation or discontinuance of coverage that has a retroactive effect, whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time.

"Adverse Benefit Determination on Review" means the upholding or affirmation of an appealed Adverse Benefit Determination.

"Benefit Determination" means a determination by the Plan Administrator on a claim for benefits under the Plan, whether or not an Adverse Benefit Determination.

"Benefit Determination on Review" means a determination by the Plan Administrator on an appeal of an Adverse Benefit Determination, whether or not an Adverse Benefit Determination on Review.

"Claimant" means a Covered Person under the Plan, or his authorized representative or health care provider, who is designated by the Covered Person to act on his behalf.

“External Review” means a review of an Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination) conducted pursuant to the Federal External Review process described in this Claims Procedures section.

“Final Internal Adverse Benefit Determination” means an Adverse Benefit Determination on Review that has been upheld by the Plan at the completion of the internal appeals process (or an Adverse Benefit Determination with respect to which the internal appeals process has been exhausted under the deemed exhaustion rules).

“Independent Review Organization” or “IRO” means an entity that conducts independent External Reviews of Adverse Benefit Determinations and Final Internal Adverse Benefit Determinations.

Under the Plan, there are three types of claims: Pre-service Non-urgent, Concurrent Care and Post-service.

Pre-Service Claims
A "Pre-service Claim" is a claim for a benefit under the Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

A "Pre-service Urgent Care Claim" is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the Claimant or the Claimant’s ability to regain maximum function, or, in the opinion of a Physician with knowledge of the Claimant’s medical condition, would subject the Claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

It is important to remember that, if a Claimant needs medical care for a condition, which could seriously jeopardize his life, there is no need to contact the Plan for prior approval. The Claimant should obtain such care without delay.

Further, since the Plan does not require the Claimant to obtain approval of a medical service in an urgent care situation prior to getting treatment, there is no "Pre-service Urgent Care Claim." The Claimant simply follows the Plan's procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a Post-service Claim.

Concurrent Claims
A "Concurrent Claim" arises when the Plan has approved an on-going course of treatment to be provided over a period of time or number of treatments, and either (a) the Plan determines that the course of treatment should be reduced or terminated, or (b) the Claimant requests extension of the course of treatment beyond that which the Plan has approved.

It is important to remember that, in the event of an urgent care situation, the Covered Person need only notify CHR on the first business day after the additional stay begins. Since the Plan does not require the Claimant to obtain approval of a medical service in an urgent care situation prior to getting treatment, there is no need to contact the Plan Administrator to request an extension of a course of treatment. The Claimant simply follows the Plan's procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a Post-service Claim.

Post-service Claims
A "Post-service Claim" is a claim for a benefit under the Plan after the services have been rendered.

When Health Claims Must Be Filed
Health claims must be filed with the Contract Administrator within 12 months from the date on which Covered Expenses were Incurred. Claims filed later than that date shall be denied. Benefits are based upon the Plan's provisions at the time the charges were Incurred.

A Pre-service Claim (including a Concurrent Claim that also is a Pre-service Claim) is considered to be filed when the request for approval of treatment or services is made and received by the Contract Administrator in accordance with the Plan's procedures. However, a Post-service Claim is considered to be filed when the following information is received by the Contract Administrator, together with a Form HCFA or Form UB92:

1. The date of service;
2. The name, address, telephone number and tax identification number of the provider of the services or supplies;
3. The place where the services were rendered;
4. The diagnosis and procedure codes;
5. The amount of charges;
6. The name of the Plan;
7. The name of the covered Employee; and
8. The name of the patient.

Upon receipt of this information, the claim will be deemed to be filed with the Plan. The Contract Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested as provided herein. This additional information must be received by the Contract Administrator within 45 days from receipt by the Claimant of the request for additional information. Failure to do so may result in claims being declined or reduced.

Timing of Claim Decisions
The Plan Administrator shall notify the Claimant, in accordance with the provisions set forth below, of any Adverse Benefit Determination (and, in the case of Pre-service Claims and Concurrent Claims, of decisions that a claim is payable in full) within the timeframes described under each type of claim listed below.

Pre-service Non-urgent Care Claims
If the Claimant has provided all of the information needed to process the claim, the Claimant will be notified in a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.

If the Claimant has not provided all of the information needed to process the claim, then the Claimant will be notified as to what specific information is needed as soon as possible, but not later than 5 days after receipt of the claim. The Claimant will be notified of a determination of benefits in a reasonable period of time appropriate to the medical circumstances, either prior to the end of the extension period (if additional information was requested during the initial processing period), or by the date agreed to by the Plan Administrator and the Claimant (if additional information was requested during the extension period).

Concurrent Claims

Plan Notice of Reduction or Termination.
If the Plan Administrator is notifying the Claimant of a reduction or termination of a course of treatment (other than by Plan amendment or termination), before the end of such period of time or number of treatments, then the Claimant will be notified sufficiently in advance of the reduction or termination to allow the Claimant to appeal and obtain a determination on review of that Adverse Benefit Determination before the benefit is reduced or terminated.

Request by Claimant Involving Non-urgent Care
If the Plan Administrator receives a request from the Claimant to extend the course of treatment beyond the period of time or number of treatments that is a claim not involving Urgent Care, the request will be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim (either as a Pre-service Non-urgent Claim or a Post-service Claim).

Post-service Claims
If the Claimant has provided all of the information needed to process the claim, the Claimant will be notified in a reasonable period of time, but not later than 30 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.

If the Claimant has not provided all of the information needed to process the claim and additional information is requested during the initial processing period, then the Claimant will be notified of a determination of benefits prior to the end of the extension period, unless additional information is requested during the extension period, then the Claimant will be notified of the determination by a date agreed to by the Plan Administrator and the Claimant.

Extensions – Pre-service Non-Urgent Care Claims
This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial 15-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

Extensions – Post-service Claims
This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial 30-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

Calculating Time Periods
The period of time within which a Benefit Determination is required to be made shall begin at the time a claim is deemed to be filed in accordance with the procedures of the Plan.

Notification of an Adverse Benefit Determination
The Plan Administrator shall provide a Claimant with a notice, either in writing or electronically containing the following information:

1. The specific reason or reasons for the Adverse Benefit Determination;
2. Reference to the specific Plan provisions upon which the determination is based;
3. A description of additional material or information necessary for the Claimant to perfect the claim and an explanation of why such material or information is necessary;
4. A description of the Plan's appeal procedures and time limits applicable to such procedures following an Adverse Benefit Determination on Review;
5. If the Adverse Benefit Determination is based upon:
    a. An internal rule, guideline, protocol, or other similar criterion, either the specific rule, guideline, protocol, or other similar criterion, or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the Claimant upon request; or
    b. A medical necessity or experimental and/or investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;
6. Information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);
7. The reason or reasons for the Adverse Benefit Determination, including the denial code and its corresponding meaning, as well as a description of the Plan's standard, if any, that was used in denying the claim;
8. A description of available internal appeals and External Review processes, including information regarding how to initiate an appeal; and

9. The availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established to assist individuals with the internal claims and appeals and External Review processes.

Appeal of Adverse Benefit Determinations

Full and Fair Review of All Claims
In cases where a claim for benefits is denied, in whole or in part, and the Claimant believes the claim has been denied wrongly, the Claimant may appeal the denial and review pertinent documents. The claims procedures of this Plan provide a Claimant with a reasonable opportunity for a full and fair review of a claim and Adverse Benefit Determination. A Claimant is allowed to review the claim file and to present evidence and testimony as part of the internal claims and appeals process. More specifically, the Plan provides:

1. Claimants at least 180 days following receipt of a notification of an initial Adverse Benefit Determination within which to appeal the determination;
2. Claimants the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;
3. For a review that does not afford deference to the previous Adverse Benefit Determination and that is conducted by an appropriate named fiduciary of the Plan, who shall be neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual;
4. For a review that takes into account all comments, documents, records, and other information submitted by the Claimant relating to the claim, without regard to whether such information was submitted or considered in the prior Benefit Determination;
5. Each Claimant will be provided, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of Final Internal Adverse Benefit Determination is required to be provided to give the Claimant a reasonable opportunity to respond prior to that date;
6. Before the Plan can issue a Final Internal Adverse Benefit Determination based on a new or additional rationale, the Claimant will be provided, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of Final Internal Adverse Benefit Determination is required to be provided to give the Claimant a reasonable opportunity to respond prior to that date;
7. That, in deciding an appeal of any Adverse Benefit Determination that is based in whole or in part upon a medical judgment, the Plan fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, who is neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of any such individual;
8. For the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claim, even if the Plan did not rely upon their advice; and
9. That a Claimant will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim for benefits in possession of the Plan Administrator or the Contract Administrator.

Requirements for Appeal
The Claimant must file the appeal in writing within 180 days following receipt of the notice of an Adverse Benefit Determination. To file an appeal, the Claimant's appeal must be addressed as follows and either mailed or faxed as follows: Pre-service Non-urgent Claims – Prime Dx, P.O. Box 9201, Austin, Texas 78766, Fax Number (512) 454-1624or Post-service Claims – Boon-Chapman Benefit Administrators, Inc., Attention: Appeals, P.O. Box 9201, Austin, Texas 78766 Fax Number: 512-459-1552.

It shall be the responsibility of the Claimant to submit proof that the claim for benefits is covered and payable under the provisions of the Plan. Any appeal must include:

1. The name of the Employee/Claimant;
2. The Employee/Claimant's social security number;
3. The group name or identification number;
4. All facts and theories supporting the claim for benefits. Failure to include any theories or facts in the appeal will result in their being deemed waived. In other words, the Claimant will lose the right to raise factual arguments and theories which support this claim if the Claimant fails to include them in the appeal;
5. A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim; and
6. Any material or information that the Claimant has which indicates that the Claimant is entitled to benefits under the Plan.

If the Claimant provides all of the required information, it may be that the expenses will be eligible for payment under the Plan.

Timing of Notification of Benefit Determination on Review
The Plan Administrator shall notify the Claimant of the Plan's Benefit Determination on Review within the following timeframes:

Pre-service Non-Urgent Care Claims
Within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of the appeal.

Concurrent Claims
The response will be made in the appropriate time period based upon the type of claim – Pre-service Non-urgent or Post-service.

Post-service Claims
Within a reasonable period of time, but not later than 60 days after receipt of the appeal.

Calculating Time Periods
The period of time within which the Plan's determination is required to be made shall begin at the time an appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

Manner and Content of Notification of Adverse Benefit Determination on Review.
The Plan Administrator shall provide a Claimant with notification, in writing or electronically, of a Plan's Adverse Benefit Determination on Review, setting forth:

1. The specific reason or reasons for the denial;
2. Reference to the specific portion(s) of the Plan Document on which the denial is based;
3. A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim for benefits;
4. A statement describing any voluntary appeal procedures offered by the Plan and the Claimant's right to obtain the information about such procedures;
5. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the Claimant upon request;
6. If the Adverse Benefit Determination is based upon a medical judgment, a statement that an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, will be provided free of charge upon request;

7. The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency";
8. Information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);
9. The reason or reasons for the Final Internal Adverse Benefit Determination including the denial code and its corresponding meaning, as well as a description of the Plan's standard, if any, that was used in denying the claim. In the case of a notice of Final Internal Adverse Benefit Determination, this description must include a discussion of the decision;
10. A description of available internal appeals and External Review processes, including information regarding how to initiate an appeal; and
11. The availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established to assist individuals with the internal claims and appeals and External Review processes.

External Review

In accordance with the U.S. Department of Labor Technical Release 2010-01, the Plan will comply with the safe harbor for non-grandfathered self-funded group health plans not subject to a State External Review process, and therefore subject to the Federal External Review process, until superseded by future guidance. External Review will be available with respect to claims for medical benefits. However, a claim for dental benefits or a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a Claimant fails to meet eligibility requirements under the Plan is not eligible for External Review.

1. Request for Standard External Review. A Claimant shall have four (4) months from the receipt of the notice of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination to submit a written request an External Review to the Plan Administrator.

2. Preliminary Determination. Within five (5) business days of receipt of a request for an External Review, the Plan Administrator shall complete a preliminary review of the request to determine whether:

    a. The Claimant is or was covered by the Plan at the time the health care item or service in question was requested or provided, or that the health care item or service was covered under the Plan at the time the health care item or service was provided;
    b. The Final Internal Adverse Benefit Determination does not relate to whether the Claimant satisfied the eligibility requirements of the Plan;
    c. The Claimant has exhausted the Plan's internal appeal process, unless the Claimant is not required to exhaust the internal appeal process under 29 C.F.R. § 2590.715-2719; and
    d. The Claimant has provided all the information and forms required to process an External Review.

3. Preliminary Notice. If a request is not eligible for External Review, the Plan Administrator must issue a written notice to the Claimant within one (1) business day after the Plan Administrator completes the preliminary review, which must include the reasons the requested appeal is not eligible for External Review and contact information for the Employee Benefit Security Administration. If a request is not eligible for External Review because it is incomplete, the notice must include a description of the information necessary to complete the request and permit the Claimant to submit such information by the later of 48 hours after the Claimant receives the notice or by the end of the four (4) month period during which the External Review must be requested.

4. Standard External Review. If a claim is eligible for External Review, the Plan will assign the claim to an IRO that is one of at least three IROs retained by the Plan to conduct External Reviews and which is due to receive the claim on the Plan's rotational basis established to ensure independence. The external IRO will conduct a full review of the file, applicable Plan provisions and any material submitted as required by

applicable guidance and in compliance with the IRO's contract with the Plan. The IRO will conduct this review on a de novo basis without deference to the Plan's decision.

Within five business (5) days after the Plan has assigned an IRO to review the claim, the Plan shall provide the documents and information considered by the Plan in making its Final Internal Adverse Benefit Determination. If the IRO receives any new evidence or information, it shall provide such information to the Plan and the Plan may reconsider its decision. If the Plan changes its decision upon reconsideration, it must notify the Claimant and the IRO of its new decision within one (1) business day of making such decision. The IRO must then terminate its review.

The IRO shall provide the Claimant and the Plan with a written notice of its decision within 45 days of the date on which the IRO received the request for External Review. Such notice shall include all information required by applicable guidance.

Upon receipt of the IRO's final determination reversing the Plan's determination, the Plan shall immediately provide coverage or payment for the claim.

5. Expedited External Review. An expedited External Review shall be provided:

   a. If the Claimant received a Final Internal Adverse Benefit Determination and the Claimant has a medical condition where the timeframe for completion of a standard External Review would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function; or

   b. If the Final Internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the Claimant received emergency services, but has not been discharged since receiving such emergency services.

   Upon receipt of a request for an expedited External Review, the Plan shall determine if the request satisfies the requirements to be eligible for a standard External Review. The Plan must immediately send the Claimant a notice of such preliminary determination of eligibility.

   If a claim is eligible for expedited External Review, the Plan shall assign the claim to an IRO. The IRO shall provide the Claimant and the Plan with a written notice of its decision as soon as possible, but in no event more than 72 hours after the IRO received the request for an expedited External Review. If the notice is not in writing, within 48 hours of the date the notice is provided, the IRO must provide a written confirmation of its decision to the Claimant and the Plan.

Exhaustion of Administrative Remedies
No action at law or in equity may be brought to recover under the Plan until all administrative remedies have been exhausted. If a Claimant fails to file a timely claim, or if the Claimant fails to request a review in accordance with the Plan's claim procedures outlined herein, such Claimant will have no right of review under the Plan. The denial of the claim will become final and binding on all persons for all purposes.

If the Plan fails to strictly adhere to all the requirements of the Claims Procedures with respect to a claim, the Claimant is deemed to have exhausted the internal claims and appeals process. In such case, the Claimant may initiate an External Review and is also entitled to pursue any available remedies under State law, as applicable, on the basis that the Plan has failed to provide a reasonable internal claims and appeals process that would yield a decision on the merits of the claim

Decision on Review to be Final
If, for any reason, the Claimant does not receive a written response to the appeal within the appropriate time period set forth above, the Claimant may assume that the appeal has been denied. The decision by the Plan Administrator or other appropriate named fiduciary of the Plan on review will be final, binding and conclusive

and will be afforded the maximum deference permitted by law. All claim review procedures provided for in the Plan must be exhausted before any legal action is brought. Any legal action for the recovery of any benefits must be commenced within one year after the Plan's claim review procedures have been exhausted.

Appointment of Authorized Representative
A Claimant is permitted to appoint an authorized representative to act on his behalf with respect to a benefit claim or appeal of a denial. An assignment of benefits by a Claimant to a provider will not constitute appointment of that provider as an authorized representative. To appoint such a representative, the Claimant must complete a form, which can be obtained from the Plan Administrator or the Contract Administrator. In the event a Claimant designates an authorized representative, all future communications from the Plan will be with the representative, rather than the Claimant, unless the Claimant directs the Plan Administrator, in writing, to the contrary.

Unclaimed Benefits
If, within twelve (12) months after any amount becomes payable hereunder to a Covered Person or Beneficiary, and the same will not have been claimed or any check issued under the Plan remains uncashed, provided reasonable care will have been exercised in attempting to make such payments, the amount thereof will be forfeited and will cease to be a liability of the Plan.

DEFINITIONS

When used within, the following items shall have the meanings shown below:

Accidental Dental Injury
An injury to the mouth or structures within the oral cavity that is caused by an external traumatic force. It does not include damage to the teeth that is the result of biting into food or other substances.

Accidental Injury
Any accidental bodily injury that occurs while an individual is covered under the Plan and that is caused by external forces under unexpected circumstances and that does not arise out of or in the course of the employment of the covered person. Sprains and strains resulting from over-exertion, excessive use, or over-stretching are not considered accidental injuries.

Affiliation Period
A period of time that must expire before health insurance coverage provided by an HMO becomes effective, and during which the HMO is not required to provide coverage.

Affordable Care Act
The Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010, and subsequent guidance issued thereunder.

Alternate Procedure
The most cost-effective treatment of a dental condition which will provide a professionally acceptable result as determined by national standards of dental practice. Consideration is given to the current clinical oral condition based upon the diagnostic material submitted by the dentist.

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

Birthing Center
A special room in a hospital that exists to provide delivery, prenatal, and postnatal care with a minimum of medical intervention, or a free-standing out-patient facility that:

- is in compliance with licensing and other legal requirements in the jurisdiction where it is located;
- is engaged mainly in providing a comprehensive birth service program to persons who are considered normal low-risk patients;
- has organized facilities for birth services on its premises; and
- provides birth services by physicians, registered nurses, or midwife nurse practitioners when a patient is in the center.

Body Mass Index (BMI)
A measurement that takes into account height and weight in calculating overall body fat. This normalized measure is used to determine levels of obesity for an average adult.

BMI Categorization
0 < 25 Normal
25<27 Overweight
27<30 Mild Obesity
30<35 Moderate Obesity

35>40 Severe Obesity
40<50 Morbid Obesity
50<60 Super Obesity

Business Associate
Shall generally have the same meaning as the term "business associate" at 45 CFR 160.103, and in reference to the party to this plan, shall mean Texas Annual Conference of the United Methodist Church.

Calendar Year
The period of time commencing at 12:01 a. m. on January 1 of each year and ending at 12:01 a.m. on the next January 1. Each succeeding like period will be considered a new calendar year.

Calendar Year Maximum Benefit
The most benefits the Plan will pay for covered expenses of a covered person incurred during a calendar year.

Certificate of Coverage
A written certification provided by any source that offers medical care coverage, including this plan, for the purpose of confirming the duration and type of an individual's previous coverage.

Claimant
Any covered person on whose behalf a claim is submitted for benefits under the Plan.

Class of Coverage
The benefits for which a group of employees is eligible, according to criteria specified by the employer in the participation agreement or subsequent amendments thereto.

Close Relative
The spouse, parent, brother, sister, child or spouse's parent of a Covered Person.

COBRA
The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended. COBRA does not apply to the TAC group because it is a church plan.

Co-Insurance
The part of covered expenses that the Plan or covered person pays, excluding amounts that are payable by a covered person as a deductible or co-payment or because of a benefit maximum.

Contract Administrator
The company that provides claims adjudication and other services to the Plan in accordance with an administrative services agreement between the Contract Administrator and the Plan.

Covered Entity
Shall generally have the same meaning as the term "covered entity" at 45 CFR 160.103, and in reference to the party to this plan, shall mean Texas Annual Conference of the United Methodist Church.

Covered Expense
An expense incurred by a covered person that is payable by the Plan as co-insurance or is payable by the covered person as a deductible, as co-insurance, as a co-payment, or because of a benefit.

Covered Person
A covered employee, a covered dependent, or a qualified COBRA beneficiary.

Creditable Coverage
Prior medical coverage that an individual had from any of the following sources: a group health plan, health insurance coverage, Medicare, Medicaid, medical and dental care for members and former members of the uniformed services and their dependents, a medical care program of the Indian Health Service or tribal organization, a state health benefits risk pool, certain other state-sponsored arrangements established primarily to provide medical benefits to persons who have difficulty in obtaining affordable coverage because of a medical condition, a health plan offered under the Federal Employees Health Benefits Program, a public health plan, or a health benefit plan under the Peace Corps Act, provided the coverage did not consist solely of excepted benefits under federal law.

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

Deductible
See schedule of benefits for information.

Dependent
See "Eligibility and Effective Dates."

Durable Medical Equipment
Durable medical equipment includes such items as orthotics, braces, crutches, wheelchairs, hospital beds, iron lungs, dialysis equipment, Glucometers, Dextrometers, etc., that:

- can withstand repeated use;
- are primarily and customarily used to serve a medical purpose;
- generally are not useful to a person in the absence of sickness or accidental injury; and
- are appropriate for use in the home.

Eligible Expense
An expense that is covered by a specific benefit provision of the plan document and incurred while the person is covered by the plan document.

Employee
See "Eligibility and Effective Dates."

Employer
The employer or employers participating in the plan as stated in "General Plan Information."

Essential Health Benefits
Includes (1) ambulatory services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services, including behavioral treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care, as determined by the Plan Administrator in accordance with the Affordable Care Act.

Exclusive Provider Organization (EPO)
A group of providers such as physicians, hospital facilities, outpatient facilities and or other providers who have contracted with the health plan to supply services to covered individuals under special fee arrangements.

Health Breach Notification Rule
Shall mean 16 CFR Part 318

HIPAA Rules
The Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Part 160 and Part 164.

Home Health Care Agency
An agency or organization that:

- is certified under Title 18 of the United States Social Security Act of 1965, as amended from time to time; or
- is certified to participate as a home health care agency in the area in which the services are rendered.

Hospice Care Program
An entity:

- providing a coordinated set of services rendered at home, in an out-patient setting, or in an institutional setting for covered persons suffering from a condition that has a terminal prognosis;
- that has an interdisciplinary group of personnel including at least one physician and one registered graduate nurse;
- that maintains central clinical records on all patients; and
- meets the standards of the National Hospice Organization and applicable state licensing requirements.

Hospital
An institution that:

- complies with all licensing and other legal requirements and is operating lawfully in the jurisdiction where it is located;
- is primarily engaged in providing medical treatment to sick and injured persons as registered bed-patients;
- has a staff of one or more licensed doctors of medicine or doctors of osteopathy available at all times;
- continuously provides a 24-hour-a-day nursing service by registered graduate nurses;
- maintains facilities for diagnosis of injury and disease;
- maintains permanent facilities for major surgical operations on its premises; and
- is not, other than incidentally, a place of rest, for custodial care, for the aged, for drug addicts or alcoholics, for the care of senile persons, a nursing home, a hotel, a school, or a similar institution.

A hospital will also include:

- an institution that is legally constituted as a hospital and for which the laws of the state specify requirements other than those listed above and that is operated primarily for the care and treatment of sick and injured person as in-patients;
- an institution or facility that provides treatment for mental illness, provided that such institution or facility:
    - is licensed by the state licensing body or is approved by the state department responsible for such institutions or facilities; and
    - renders recognized treatment for the condition for which it is licensed or approved to operate; or
- an alcohol dependency treatment center that provides a program for the treatment of alcohol dependency pursuant to a written treatment plan approved and monitored by a physician and which facility is also:
    - affiliated with a hospital under a contractual agreement with an established system for patient referral;
    - accredited as such a facility by the Joint Commission on Accreditation of Hospitals; or
    - licensed, certified, or approved as an alcohol dependency treatment program or center by any other state agency having legal authority to so license, certify, or approve.

Illness
A bodily disorder, disease, physical sickness, mental infirmity, Functional Nervous disorder or Pregnancy of a Covered Person. A recurrent illness will be considered one illness. Concurrent illnesses will be considered one illness unless the concurrent illnesses are totally unrelated. All such disorders existing simultaneously which are due to the same or related causes shall be considered one illness.

Immediate Family
You, your spouse, and the children, brothers, sisters, and parents of you and your spouse.

Incurred
Expenses shall be deemed to be incurred on the latest of the following dates:

- the date a purchase is contracted;
- the date delivery is made; or
- the actual date a service is rendered.

Injury
A condition caused by accidental means which results in damage to the Covered Person's body from an external force.

In-Patient
A person physically occupying a room and being charged for room and board in a facility (hospital, skilled nursing facility, etc.) that is covered by the Plan and to which the person has been assigned on a 24-hour-a-day basis without being issued passes to leave the premises.

Late Enrollee
An individual who is allowed to enroll in the plan, other than during the period of initial eligibility.

Local Community Network (LCN)
See Exclusive Provider Organization and other local community provider arrangements.

Maximum Allowable Charge
An amount determined at the discretion of Plan Administrator or its delegate considering:

- For in-network claims the negotiated preferred provider allowable.
- For out-of-network claims the amount agreed to by the non-network provider and Plan Administrator or its delegate. If the amount has not been negotiated, then one of the following amounts will apply:
  - For out-of-network hospital claims the lesser of billed charges or 150% of the published rates allowed by Medicare for the same or similar service or supply.
  - For out-of-network professional claims and other providers the lesser of billed charges or 150% of the published rates allowed by Medicare for the same or similar service or supply.
  - For out-of-network claims submitted by providers that don't participate in Medicare, for care provided in non-standard settings and for services and supplies not covered by Medicare the Payer Compass equivalency tables, Payer Compass approximation tool, Payer Compass cross walks or the Optum360 Essential RBRVS Schedule will be considered at corresponding percentile listed above.
  - In determining the Maximum Allowable Charge for any out-of-network claim, the Plan Administrator or its delegate may consider any other relevant factor, including but not limited to the Average Wholesale Price, the invoice price, Medicare cost data, Medicare cost-to-charge ratios, the amount Medicaid would allow for the same or similar service and the Fair Health Data Base.
- The Maximum Allowable Charge for Outpatient Dialysis Services for non-PPO (out-of-network) providers is the *lesser* of:
  - The provider's normal charge for the same or similar service or supply; or
  - 125% of what Medicare would allow.

Maximum Plan Benefit
The total of all benefits the Plan will pay for covered expenses of a covered person incurred during all periods a person is covered under the Plan.

Medically Necessary or Medical Necessity
When a service, treatment, device, drug, or supply is necessary and appropriate for the diagnosis or active treatment of an Illness or Injury based on generally accepted medical practice.

To be Medically Necessary, Covered Expenses must:

- *be rendered in connection with an Injury or Illness;*
- *be consistent with the diagnosis and treatment of your condition;*
- *be in accordance with the standards of good medical practice; and*
- *be provided at the most appropriate level of care or in the most appropriate type of health care facility*.

Only your medical condition (not the financial status or family situation, the distance from a facility or any other non-medical factor) is considered in determining which level of care or type of health care is appropriate.

Medically Necessary is the criteria by which the Plan Administrator determines the necessity of medical service and treatment under this Plan.

The fact that any particular Physician may prescribe, order, recommend or approve a service, treatment, device, drug or supply does not, of itself, make it Medically Necessary.

A service, treatment, device, drug, or supply will not be considered Medically Necessary if:

- it is provided only as a convenience to the Covered Person or provider;
- it is not appropriate treatment for the Covered Person's diagnosis or symptoms;
- it exceeds (in scope, duration or intensity) that level of care that is needed to provide safe, adequate and appropriate diagnosis or treatment;
- it is part of a plan of treatment that is considered to be Investigative, Experimental or for Research Purposes in the diagnosis or treatment of an Illness or Injury. "Investigative, Experimental or for Research Purposes" means services or supplies not recognized or proven to be effective treatment of an Illness or Injury in accordance with generally accepted medical practice, based on consultation with an appropriate source; or
- it involves the use of a drug or substance not formally approved by the United States Food & Drug Administration, even if approval is not required, or if it involves the use of a drug or substance that cannot be lawfully marketed without the approval of the Food and Drug Administration or other appropriate governmental agency, such approval not having been granted at the time of use or proposed use;
- is generally, commonly, and customarily regarded by experts who regularly practice in the area of treatment of the particular disease or condition in question as a drug, treatment, device, procedure, or other service whose usage should be substantially confined to research settings, as set forth in the published authoritative literature; or
- is being provided pursuant to a Food and Drug Administration Phase I or Phase II clinical trial or as the experimental or research arm of a Phase III clinical trial.

The sources of information to be relied upon are:

- the published authoritative medical or scientific literature regarding the drug, treatment, device, procedure, or other service at issue as it is applied to the particular Injury or Sickness at issue;
- a Covered Person's medical records;
- protocol pursuant to which the treatments is to be delivered; or
- any regulations and publications set forth by any governmental agency.

In the event the *Plan* Administrator determines that a service is not *medically necessary*, but the applicable *network* or *network provider* determines that a service is *medically necessary*, the *Plan* will consider the claim to be *medically necessary* if required by the applicable *network* agreement.

Medicare
Health insurance for the aged as established by Title I of Public Law 89-98 including parts A & B and Title XVIII of the Social Security Act, as amended from time to time.

Mental and Nervous Care/Substance Abuse
Such terms include treatment for mental and nervous care, disorders, or conditions, as accepted by the general psychiatric community, including treatment for substance abuse.

Nurse
A person who is a licensed registered graduate nurse (R.N.), licensed practical nurse (L.P.N.), or a licensed vocational nurse (L.V.N.).

Nurse Anesthetist
A Certified Registered Nurse Anesthetist (CRNA) is a trained nurse who has specialized in anesthesia and possesses documented capability for giving anesthetics.

Occupational Injury or Sickness
Any injury or sickness that the covered person has or had a right to compensation under any workers' compensation law, occupational disease law, or other law of similar purpose; or, resulted from employment or occupation for compensation.

Oral Surgery
Necessary procedures for surgery in the oral cavity, including pre- and post-operative care.

Orthodontic Treatment
The movement of teeth through bone, by means of active appliances, to correct the position of maloccluded or malpositioned teeth.

Out-Patient
Services rendered on other than an in-patient basis.

PHI
Protected Health Information, as enacted pursuant to HIPAA.

Physician
A doctor of medicine, (M.D.), or doctor of osteopathy (D.O.), who is licensed to practice medicine or osteopathy where the care is provided.

"Physician" also includes the following providers, but only when the provider is licensed to practice where the care is rendered and is rendering a service within the scope of that license:

- Dentist (D.D.S. or D.M.D.);
- Optometrist (O.D.);
- Podiatrist or Chiropodist (D.P.M., D.S.P., or D.S.C.);
- Psychologist (Ph.D.); and
- Chiropractor (D.C.).

"Physician" will also include the following providers, but only when the provider is licensed to practice where the care is rendered, is rendering a service within the scope of that license, and is rendering a service to an individual who was referred to him by an M.D. or D.O.:

- Physical therapist (P.T. or R.P.T.);

- Speech pathologist;
- Audiologist;
- Certified Registered Nurse Anesthetist (C.R.N.A.);
- Medical Social Worker (M.S.W.);
- Licensed Professional Counselor (L.P.C.);
- Physician's Assistant (P.A.);
- Certified Nurse Practitioner;
- Certified Midwife; and
- Occupational therapist (O.T.R.).

For purposes of certifying total disability, "physician" will include only doctors of medicine (M.D.) and doctors of osteopathy (D.O.).

Plan Administrator
See "Plan Sponsor."

Plan Sponsor
The entity sponsoring this Plan.

Plan Year
The period of time commencing at 12:01 a.m. on the effective date of each employer's plan and ending at 12:01 a.m. on the same day twelve consecutive months later.

PPO
Preferred provider organization.

Preferred Provider Organization (PPO)
An organization that has contracted with the plan sponsor or the contract administrator to provide certain dental care services to covered persons at specific rates. See the schedule of medical benefits for the special benefit level that applies to services obtained from contracted providers.

Pregnancy
Childbirth or miscarriage or complications arising therefrom.

Primary Care Network (PCN)
A group of primary care physicians who have joined together to provide health care services to covered individuals under special fee arrangements and contracted with the health plan.

Primary Care Physician
A physician in family practice, general practice, internal medicine, pediatrician or OB/GYN.

Prosthesis
An artificial device to replace a missing part of the body or to aid the function of a bodily organ.

Relative
A spouse or a parent, brother, sister, or child of the employee or the employee's spouse.

Semi-Private Room Charge
The standard charge by a facility for semi-private room and board accommodations, or the average of such charges where the facility has more than one established level of such charges, or the lowest charge by the facility for single room and board accommodations if the facility does not provide any semi-private accommodations.

Sickness
Physician-diagnosed bodily illness or disease, or congenital abnormalities of a covered newborn child. Mental health conditions are not included.

Significant Break in Coverage
A period of 63 consecutive days during all of which an individual did not have any creditable coverage, but does not include a waiting period or an affiliation period.

Skilled Nursing Facility
An institution that:

- is duly licensed as a convalescent hospital, extended care facility, skilled nursing facility, or intermediate care facility and is operated in accordance with the governing laws and regulations;
- is primarily engaged in providing accommodations and skilled nursing care 24 hours a day for convalescing persons and has facilities for the full-time care of at least five (5) patients;
- is under the full-time supervision of a physician or a registered graduate nurse;
- admits patients only upon the recommendation of a physician;
- maintains complete medical records;
- has the services of a physician available at all times; and
- is not, other than incidentally, a nursing home, a hotel, a school, or a similar institution, a place of rest, for custodial care, for the aged, for drug addicts, for alcoholics, for the care of mentally ill or persons with nervous disorders, or for the care of senile persons.

Specialists
Specialists are other covered physicians who are not listed under Primary Care Physician.

Surgery
Any operative or diagnostic procedure performed in the treatment of an injury or illness by instrument or cutting procedure through any natural body opening or incision.

Temporomandibular Joint Dysfunction
Any services or supplies for the treatment of the temporomandibular joint or jaw-related neuromuscular conditions with oral appliances, oral splints, oral orthotics, devices, prosthetics, dental restorations, orthodontics, physical therapy, or alteration of the occlusal relationships of the teeth or jaws to eliminate pain or dysfunction of the temporomandibular joint and all adjacent or related muscles and nerves.

Total Disability or Totally Disabled
Regarding an employee, disability resulting solely from a sickness or accidental injury that prevents the employee from engaging in any employment or occupation for which he/she is or becomes qualified because of education, training, or experience.

For a dependent, disability that prevents the dependent from engaging in substantially all the normal activities of a person in good health of like age and gender.

A covered person must also be under the care of a physician (M.D. or D.O.) to be considered totally disabled for benefit purposes.

Waiting Period
The period that must pass before an employee or dependent is eligible to enroll under the terms of a group health plan. If an employee or dependent enrolls as a late enrollee, any period before such late enrollment is not a waiting period. If an individual seeks and obtains coverage in the individual market, any period after the date the individual files a substantially complete application for coverage and before the first day of coverage is a waiting period.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice is required to be included prior to September 23, 2013.

This Plan complies with the requirements of § 164.504(f) of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations, 45 C.F.R. parts 160 through 164 (the regulations are referred to herein as the "HIPAA Privacy Rule" and § 164.504(f) is referred to as "the "504" provisions") which establish the extent to which the Plan sponsor will receive, use and/or disclose Protected Health Information.

The Plan's Designation of Person/Entity to Act on its Behalf

The Plan has determined that it is a group health plan within the meaning of the HIPAA Privacy Rule, and the Plan designates Barbara Kilby, Privacy Officer, to take all actions required to be taken by the Plan in connection with the HIPAA Privacy Rule (*e.g.,* entering into business associate contracts; accepting certification from the Plan sponsor).

The Plan's disclosure of Protected Health Information to the Plan sponsor – Required Certification of Compliance by Plan sponsor

Except as provided below with respect to the Plan's disclosure of summary health information, the Plan will (a) disclose Protected Health Information to the Plan sponsor or (b) provide for or permit the disclosure of Protected Health Information to the Plan sponsor by a health insurance issuer or HMO with respect to the Plan, only if the Plan has received a certification (signed on behalf of the Plan sponsor) that:

1. the Plan Documents have been amended to establish the permitted and required uses and disclosures of such information by the Plan sponsor, consistent with the "504" provisions;
2. the Plan Documents have been amended to incorporate the Plan provisions set forth in this section; and
3. the Plan sponsor agrees to comply with the Plan provisions as described by this section

Permitted disclosure of members' Protected Health Information to the Plan sponsor

The Plan (and any health insurance issuer or HMO servicing the Plan) will disclose members' Protected Health Information to the Plan sponsor only to permit the Plan sponsor to carry out plan administration functions. Such disclosure will be consistent with the provisions of this section.

All disclosures of the Protected Health Information of the Plan's members by a health insurance issuer or HMO to the Plan sponsor will comply with the restrictions and requirements set forth in this section and in the "504" provisions.

The Plan may not, and may not permit a health insurance issuer or HMO, to disclose members' Protected Health Information to the Plan sponsor for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan sponsor.

The Plan sponsor will not use or further disclose members' Protected Health Information other than as described in the Plan Documents and permitted by the "504" provisions.

The Plan sponsor will ensure that any agent(s), including a subcontractor, to whom it provides members' Protected Health Information received from the Plan (or from the Plan's health insurance issuer or HMO), agrees

to the same restrictions and conditions that apply to the Plan sponsor with respect to such Protected Health Information.

The Plan sponsor will not use or disclose members' Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan sponsor.
The Plan sponsor will report to the Plan any use or disclosure of Protected Health Information that is inconsistent with the uses or disclosures provided for in the Plan Documents (as amended) and in the "504" provisions, of which the Plan sponsor becomes aware.

Disclosure of members' Protected Health Information – Disclosure by the Plan sponsor

The following types of uses and disclosures of a member's Protected Health Information may not be disclosed by the Plan sponsor without the member's written authorization:

1. Uses and disclosures for marketing purposes.
2. Uses and disclosures that constitute the sale of Protected Health Information.
3. Other uses and disclosures not described in this notice.

If a member authorizes any of the above uses or disclosures, the member may revoke such authorization in accordance with 45 C.F.R. § 164.508(b)(5).

Individual Rights
Under the HIPAA Privacy Rule, individuals have the following rights with respect to Protected Health Information:

A member may request restrictions on certain uses and disclosures of Protected Health Information as provided by 45 C.F.R. § 164.522(a). The Plan sponsor is not required to agree to a requested restriction, except in the case of a disclosure restricted under C.F.R. § 164.522(a)(1)(vi).

A member has the right to receive confidential communications of Protected Health Information as provided by 45 C.F.R. § 164.522(b), as applicable.

The Plan sponsor will make the Protected Health Information of the member who is the subject of the Protected Health Information available to such member in accordance with 45 C.F.R. § 164.524.

The Plan sponsor will make members' Protected Health Information available for amendment and incorporate any amendments to members' Protected Health Information in accordance with 45 C.F.R. § 164.526.

The Plan sponsor will make and maintain an accounting so that it can make available those disclosures of members' Protected Health Information that it must account for in accordance with 45 C.F.R. § 164.528.

The Plan sponsor will provide a paper copy of this notice to any member upon request, including any member who has agreed to receive the notice electronically.

The Plan sponsor will make its internal practices, books and records relating to the use and disclosure of members' Protected Health Information received from the Plan available to the U.S. Department of Health and Human Services for purposes of determining compliance by the Plan with the HIPAA Privacy Rule.

The Plan sponsor will, if feasible, return or destroy all members' Protected Health Information received from the Plan (or a health insurance issuer or HMO with respect to the Plan) that the Plan sponsor still maintains in any form after such information is no longer needed for the purpose for which the use or disclosure was made. Additionally, the Plan sponsor will not retain copies of such Protected Health Information after such information is no longer needed for the purpose for which the use or disclosure was made. If, however, such return or

destruction is not feasible, the Plan sponsor will limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

The Plan sponsor will ensure that the required adequate separation, described below, is established and maintained.

Disclosures of Summary Health Information and Enrollment and Disenrollment Information to the Plan sponsor

The Plan, or a health insurance issuer or HMO with respect to the Plan, may disclose summary health information to the Plan sponsor, if the Plan sponsor requests the summary health information for the purpose of:

1. Obtaining premium bids from health plans for providing health insurance coverage under the Plan; or
2. Modifying, amending, or terminating the Plan.

The Plan sponsor is prohibited from using or disclosing Protected Health Information that is genetic information of an individual for underwriting purposes.

The Plan, or a health insurance issuer or HMO with respect to the Plan, may disclose enrollment and disenrollment information to the Plan sponsor without the need to amend the Plan Documents as provided for in the "504" provisions.

Required separation between the Plan and the Plan sponsor

In accordance with the "504" provisions, this section describes the employees or classes of employees or workforce members under the control of the Plan sponsor who may be given access to members' Protected Health Information received from the Plan or from a health insurance issuer or HMO servicing the Plan. (Classes may include, for example: Analyst/Administrators; Service Personnel; Information Technology Personnel; Clerical Personnel; Supervisors/Managers; Quality Assurance Unit)

1. Service Personnel
2. Clerical Personnel
3. Broker / Consultant
4. Group Health Benefits Committee

This list reflects the employees, classes of employees, or other workforce members of the Plan sponsor who receive members' Protected Health Information relating to payment under, health care operations of, or other matters pertaining to plan administration functions that the Plan sponsor provides for the Plan. These individuals will have access to members' Protected Health Information solely to perform these identified functions, and they will be subject to disciplinary action and/or sanctions (including termination of employment or affiliation with the Plan sponsor) for any use or disclosure of members' Protected Health Information in violation of, or noncompliance with, the provisions of this section.

The Plan sponsor will promptly report any such breach, violation, or noncompliance to the Plan and will cooperate with the Plan to correct the violation or noncompliance; to impose appropriate disciplinary action and/or sanctions, and to mitigate any deleterious effect of the violation or noncompliance.

The Plan sponsor is required to abide by the terms of this notice as long as this notice remains in effect.

The Plan sponsor reserves the right to change the terms of this notice and to make the new notice provisions effective for all Protected Health Information that the Plan sponsor maintains. Any changes to the terms of this notice will be published on the Plan Sponsor's website [and a notice of such changes will be mailed to each member].

If a member believes their privacy rights have been violated, the member may complain to the Plan sponsor and to the Secretary of the Department of Health and Human Services. Any complaint filed with the Plan sponsor must be in writing and directed to Privacy Officer Barbara Kilby using the contact information listed below. The member will not be retaliated against in any way for filing a complaint.

Barbara Kilby
Benefits Manager
HIPAA Privacy Officer
Center for Connectional Resources
Texas Annual Conference of The United Methodist Church
5215 Main St., Houston, TX 77002
Ph: 713-533-3703
Fax: 713-521-7516
bkilby@txcumc.org

ADOPTION OF THE PLAN DOCUMENT
STANDARD PPO PLAN

Adoption
Plan sponsor hereby adopts this plan document as the written description of its employee welfare benefit plan (the "plan"). This plan document is a restatement of the plan, with benefit changes, and is effective on January 1, 2023.

Purpose of the Plan
The purpose of the plan is to provide certain benefits for eligible employees of the employer and their eligible dependents. The benefits provided by the plan include:

HEALTH CARE COVERAGES
Medical Coverage (Hospital, Physician Services, etc.)
Prescription Drug Card

About the Plan
While the Texas Annual Conference intends to continue this plan indefinitely, it reserves the right to change or end the plan in its entirety or with respect to any covered class or classes. In addition, the Group Health Benefits Committee reserves the right to determine who is eligible for benefits, the amount of benefits to be paid, and to determine all plan provisions.

The Plan is sponsored by the Texas Annual Conference of The United Methodist Church. Administration of the plan is the responsibility of the Group Health Benefits Office under the direction of Conference Group Health Benefits Committee. The plan is a self-funded plan and payments are derived from apportionments, church contributions, personal contributions, and investment returns. It is intended that the plan will serve to describe the nature, funding, and benefits of the plan.

Acceptance of the Plan Document
IN WITNESS WHEREOF, the plan sponsor has caused this instrument to be executed, effective as of January 1, 2023.

TEXAS ANNUAL CONFERENCE OF
THE UNITED METHODIST CHURCH

By: 

Title: Director, Center for Connectional Resources

Date: January 1, 2023

ADMINISTRATIVE INFORMATION

Name of Plan:	Texas Annual Conference of The United Methodist Church Employee Benefit Plan
Plan Sponsor:	Texas Annual Conference of The United Methodist Church
Address:	5215 Main Street Houston, Texas 77002-9792
Business Phone Number:	(713) 521-9383, (800) 606-0350
Plan Sponsor ID Number (EIN):	74-1491628
Plan Number/Identifier:	002928
Plan Year:	January 1
Plan Benefits:	Medical Prescription Drug Card
Fiduciaries:	Barbara Kilby Texas Annual Conference of The United Methodist Church
Address:	5215 Main Street Houston, Texas 77002-9792
Designated Legal Agent:	Barbara Kilby Texas Annual Conference of The United Methodist Church
Address:	5215 Main Street Houston, Texas 77002-9792
Privacy Officer	Barbara Kilby Texas Annual Conference of The United Methodist Church
Address:	5215 Main Street Houston, Texas 77002-9792
Contract Administrator:	Boon-Chapman Benefit Administrators, Inc.
Street Address:	9401 Amberglen Blvd., Building I, Suite 100 Austin, Texas 78729
Mailing Address:	P.O. Box 9201 Austin, Texas 78766
Phone:	(512) 454-2681 / (800) 252-9653
FAX:	(512) 459-1552