2013

BENEFITS HANDBOOK

for Texas Health Employees

Texas Health Resources®

Healing Hands. Caring Hearts.℠

About This Employee Benefits Handbook

Texas Health Resources is committed to providing employees with a choice of comprehensive, affordable, and competitive benefits. Your benefits are an important part of your compensation from Texas Health. And, as part of your total compensation, Texas Health pays a substantial portion of the benefit costs for eligible employees and their families.

Texas Health is pleased to provide you with this Employee Benefits Handbook. It is important for you to read this Handbook and keep it for reference throughout the year. It describes the main features of the benefit plans, explains how to use these benefits, and identifies resources for help when you need it. You should understand your Texas Health benefits and how they work—so you can select the benefits that best protect the needs of you and your family.

Throughout this Handbook, the term "Texas Health" refers to Texas Health Resources and the other employers that have adopted the benefits being described. A list of the employers that have adopted each plan is available from the Benefits Department at Texas Health.

The following is important information about this Handbook:

- This Employee Benefits Handbook is the Summary Plan Description (SPD) for the Texas Health Flexible Benefits Plan, the Texas Health Retirement Program, and other benefits offered to employees of Texas Health. The provisions of this Handbook apply to eligible employees of Texas Health and their eligible family members.
- Nothing in this Handbook says or implies that coverage under or participation in any plan is a guarantee of continued employment with Texas Health or other employers who have adopted the Texas Health benefits program. Neither this Handbook nor updated materials are contracts or assurances of compensation, continued employment, or benefits of any kind.
- There are no guarantees that the right to participate in benefits under the plans for employees or other covered persons will exist or remain unchanged.
- Texas Health intends to continue the plans indefinitely but reserves the right to change them at any time. This includes the right to change any amounts contributed by Texas Health or employees toward the cost of benefits, the level of benefits provided, and the types of employees eligible for benefits.
- Texas Health reserves the sole right to alter, amend, modify, or terminate the plans, any program described in this Handbook, or any part thereof at its discretion at any time, either in their entirety or with respect to any covered types of employees. From time to time, you may receive updated information concerning benefit changes.
- In the event of a conflict between the provisions of this Handbook and the provisions contained in the legal plan documents, the legal plan documents will govern.
- No employee of Texas Health is responsible for advising you on the tax effect of your participation in any plan described in this Handbook. Because tax laws are complicated and constantly changing, it is recommended that you consult a tax advisor if you have any questions about how participation in any of these plans will affect your personal tax situation.
- The plan administrator and in some cases the claims administrator has the authority to interpret each plan. Any interpretation made by the plan administrator or the claims administrator will be conclusive.

A glossary of terms begins on page 161. It defines many important terms for understanding your benefits under the plans.

This Handbook is also available on the Texas Health employee portal **www.MyTHR.org** and on **MyTexasHealth**.

If you have questions concerning your benefits that are not answered in this Employee Benefits Handbook, please contact Human Resources.

Texas Health Promise

The Texas Health Promise is "Individuals Caring for Individuals, Together.℠" It is a recurring theme throughout this 2013 Benefits Handbook. Whether you are a direct caregiver or support those who provide patient care, living the Promise enables everyone at Texas Health to better serve those who entrust their medical care to us.

Texas Health's Promise is valued throughout our organization—and that includes providing you and your family great benefits. Texas Health covers over 80% of the costs of medical coverage for all employees.

Mission

To improve the health of the people in the communities we serve.

Vision

Texas Health Resources, a faith-based organization joining with physicians, will be the health care system of choice.

Values

Respect, Integrity, Compassion, Excellence (RICE)

Texas Health Policies and Procedures

For more information on Texas Health's policies, go to **MyTexasHealth**.

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Where to Get More Information

Online

- **www.MyTHR.org:** MyTHR is not only where you enroll in benefits each year, but also the location where you can view your paychecks, PTO balance and much more.
- **MyTexasHealth:** This is the Texas Health intranet located on your Internet Explorer home page at work.

By Phone

- **1-877-MyTHRLink (1-877-698-4754):** Calling this number gives you direct access to all of our benefits providers, including United Healthcare, Caremark (prescription), Aetna (dental), MHN (EAP), Weight Watchers, Tuition Reimbursement, and more.
- **Health Advocate:** If you are not sure who you need to talk to, call 1-877-MyTHRLink (1-877-698-4754) and select prompt 2 to reach a Health Advocate. The Health Advocate will help you find the resource to meet your needs.

In Person

- **Human Resources:** Each location has a Human Resources office available to assist with your benefit questions. The last page of your 2013 Employee Benefits Guide lists the phone number for each Human Resources office.

Welcome to Total Health, Where Wellness is a Way of Life!

Texas Health's employee benefit philosophy focuses on helping our employees and their families optimize their health and well-being. We have named our benefits program Total Health because of our focus on the total person. Total Health provides one source for all your benefit needs—including information about medical, dental, vision, life insurance, disability, Paid Time Off (PTO), and 401(k) benefits. Optimizing your health and well-being by taking advantage of all the programs and resources offered through Total Health supports Texas Health's mission to improve the health of our employees and our community.

In addition to medical, prescription drug, dental, and vision coverage, your Texas Health Benefit Program includes generous coverage for preventive care, a robust wellness program which includes a maternity support program, and other programs that help our employees and their families manage illnesses.

In return for low medical premiums and quality coverage, Texas Health asks that you actively work at being healthy. This means participating in *Be Healthy*, using your benefit resources, and making wellness a way of life.

FOR ANSWERS to your benefit questions or to access Total Health program information: Call 1-877-MyTHRLink (1-877-698-4754) or go online to www.MyTHR.org or **MyTexasHealth**

Get Rewarded for Getting Healthy

Your 2013 Employee Benefits Guide describes the *Be Healthy* wellness incentives and tells you about the rewards you can earn. *Be Healthy* is a wellness program designed to inspire and motivate you to take the best possible care of yourself. *Be Healthy* gives you important tools to help you better understand your health and make wellness a way of life.

As a benefits-eligible employee, you receive a reward each time you complete an incented *Be Healthy* element. After you have completed the requirements for a reward, you will receive an email notifying you that the amount is available in your rewards account. Your reward is redeemable for gift cards from more than 100 national retailers, restaurants, entertainment, and travel providers, or you can receive it in the form of a Visa gift card.

Why does Texas Health offer these generous rewards? Because we want you to participate in *Be Healthy*!

As your employer, Texas Health spends millions of health care dollars each year on illnesses that could have been prevented or managed better if each of us had taken a more active role in managing our health. Our choice is clear—we can improve our health or end up paying more for medical insurance and medical care.

For more information about *Be Healthy* wellness programs, check your Benefits Guide or online at **www.MyTHR.org** or see page 52 of this handbook.

Your Coach Wants You to Win

Research has shown that people who have support in managing their health are more successful than people who try to manage their health alone. To help you succeed, Total Health provides you support through personal Health Coaches.

Texas Health has carefully selected companies that have professionals specializing in helping you manage different health issues. These professionals—called Health Coaches—are nurses, counselors, dietitians, and fitness experts who will call you to offer support and resources.

Based on your Health Assessment results or claims data, you may be eligible to participate in the personalized Health Coaching program. The companies Texas Health has selected to provide these services include Optum Health, MHN EAP, Caremark Pharmacy, Alere® Tobacco Cessation, and UnitedHealthcare. Your personal Health Coach will provide one-on-one coaching and many other resources to help you lead a healthier life.

Participation is voluntary and your individual participation is completely confidential.

Overview

Texas Health provides eligible employees with a comprehensive Flexible Benefits Plan that includes Medical, Dental, Vision, Life, Disability, Long Term Care Insurance, and Flexible Spending Accounts. These benefits help protect you and your family from the financial hardships of illness, injury, disability, and death. Read "Eligibility for Flexible Benefits" on page 5 to determine whether you meet requirements for participating in each plan.

Summary of Your Benefits

As an eligible employee, you can choose the combination of benefits that best meets your needs. You also can enroll eligible family members in certain benefits, as described below.

FLEXIBLE BENEFITS

Plan	Who Can Be Covered	Choices
Medical	You and your eligible family members (as defined on pages 5 – 6)	• UHC Choice 500 High Rx • UHC Choice 500 Low Rx • UHC Choice 1000 High Rx • UHC Choice 1000 Low Rx • UHC Choice 1500 Plus High Rx • UHC Choice 1500 Plus Low Rx
Dental	You and your eligible family members (as defined on pages 5 – 6)	• Aetna® Managed Dental Plan Dental Maintenance Organization (DMO®) • Participating Dental Network (PPO; low option) administered by Aetna® • Participating Dental Network (PDN; high option) administered by Aetna®
Vision	You and your eligible family members (as defined on pages 5 – 6)	• Superior Vision® Plan
Short Term Disability	You	• Coverage of 60% of your weekly base pay, up to $1,700 per week • Choose either a 14-day or a 30-day waiting period
Basic Long Term Disability[1]	You	• Employer-paid coverage of 50% of your monthly base pay, up to a maximum benefit of $15,000 per month after 180 days of disability
Additional Long Term Disability[1]	You	• Coverage equal to 10% (for a total of 60%) of your monthly base pay, up to $15,000 per month (including Basic LTD) after 180 days of disability
Basic Life Insurance	You	• Employer-paid coverage of one times your annual base pay, up to $50,000
Additional Life Insurance	You	• Coverage of one to six times your annual base pay, up to a maximum of $2,000,000[2] including Basic Life
Dependent Life Insurance	Your eligible family members (as defined on pages 5 – 6)	• Coverage for your spouse in $10,000 increments up to the total of your Basic and Additional Life coverage, but not more than $50,000 • Coverage for your eligible children of $10,000 per child up to age 25
Basic Accidental Death & Dismemberment (AD&D) Insurance	You	• Employer-paid coverage of one times your annual base pay, up to $50,000

[1] Physicians employed by THPG are covered through separate policies and are not eligible for the Texas Health Long Term Disability Plan.

[2] Medical underwriting or evidence of insurability is required for coverage over $1,000,000 (including Basic Life).

FLEXIBLE BENEFITS (CONTINUED)

Plan	Who Can Be Covered	Choices
Additional AD&D Insurance	You and your eligible family members (as defined on pages 5 – 6)	• You may elect either employee-only coverage or employee and family coverage. • Employee coverage of one to 10 times your annual base pay, up to $750,000 Depending on the makeup of your family, family coverage provides: • Spouse-only coverage of 50% of your Additional AD&D coverage • Spouse coverage of 40% of your Additional AD&D coverage, and 10% for each child • Child-only coverage of 15% of your Additional AD&D coverage for each of your eligible children up to age 25
Health Care Spending Account	You and your eligible family members (as defined on pages 5 – 6)	• You may contribute up to $2,500 per year before-tax.
Day Care Spending Account	Your eligible family members (as defined on pages 5 – 6)	• You may contribute up to $5,000 per year before-tax.

OTHER BENEFITS

In addition to the Flexible Benefits listed above, you may also be eligible for the following benefits.

Plan	Description
Long Term Care Insurance	• Daily benefit amount $100, $200, or $300 with lifetime maximum for two, three or five years. • You may cover yourself, your spouse, parents, grandparents, and in-laws.
Retirement Program	• After one year of service, Texas Health matches up to the first 6% of pay you save (based on length of service) if you contribute at least 2% of your pay to the plan each pay period. You may join the plan as soon as you are hired by Texas Health. • For 2013, the Texas Health 401(k) Retirement Plan allows you to save up to $17,500 per year ($23,000 if you are age 50 or older) of your pay.
Paid Time Off (PTO) [1, 2]	• Full-time and part-time benefits-eligible employees accrue PTO per pay period, depending on years of service and your classification in Texas Health's HR/Payroll system. • You may sell some of your PTO two times a year for a cash payment (up to 80 hours per year). • You may donate PTO for contribution to an approved charity anytime during the year (up to 80 hours per year). • You may donate PTO to the Helping Hands Fund.
Conversion of Paid Time Off (PTO)[1, 2]	• You may convert up to 80 hours of PTO earned in 2013 (in eight-hour increments) to pay for benefits; available only during open enrollment and only if you elect at least one Flexible Benefit.
Be Healthy	• Full-time and part-time benefits-eligible employees may earn rewards in the 2013 program year.
Additional Benefits	• Business Travel Accident Insurance • Tuition reimbursement • Adoption assistance • Credit union • MHN EAP • Tobacco cessation program • On-site child care (in certain locations) • Employee Discount Program

[1] The combined amount of PTO you sell, donate, and convert cannot be more than 100 hours per year. Donations of PTO to the Helping Hands Fund do not count toward the 100 hour annual maximum.

[2] Physicians and physician extenders of THPG are not eligible for PTO. Time away from work is based on their contract.

Participation

Eligibility for Flexible Benefits

Your eligibility for Flexible Benefits is determined by your job status (full-time or part-time benefits-eligible) and, in some cases, by your length of service.

Employees of Texas Health wholly owned or controlled affiliates are eligible for benefits. Physicians employed by Texas Health Physician Group (THPG) are not eligible to participate in the following Texas Health plans:

- Long Term Disability
- Paid Time Off
- Separation Pay.

Physician extenders employed by THPG are not eligible to participate in the Texas Health PTO Plan or the Separation Pay Plan.

Employees

ELIGIBILITY REQUIREMENTS

Unless otherwise noted in this Handbook, eligibility for benefits is determined by your classification in Texas Health's HR/Payroll system, according to these categories:

- Full-time employee—an employee of Texas Health who is classified to work at least 64 hours per pay period
- Part-time benefits-eligible employee—an employee of Texas Health who is classified to work 48-63 hours per pay period.

Your eligibility for benefits is based on your classification in the HR/Payroll system—not the number of hours you actually work. For those with more than one job, benefit eligibility is determined by the total combined hours from all active jobs.

Part-time benefits-ineligible employees (as defined in the glossary) and PRN employees are eligible to participate in the Texas Health 401(k) Retirement Plan, MHN EAP, and Alere Quit for Life Tobacco Cessation program. They are not eligible to participate in the Flexible Benefits Plan or any other plan or program.

EMPLOYMENT STATUS CHANGE

If your job classification changes so you are classified as full-time or part-time benefits-eligible, you can begin participating in Flexible Benefits on the first day of the pay period on the later of:

- The date your job classification changes or
- The date you have completed one month of service.

Family Members

If you are an eligible employee and you elect coverage under Flexible Benefits, you also can elect the following coverage for your eligible family members:

- Medical
- Dental
- Vision
- Dependent Life
- Additional Accidental Death and Dismemberment (AD&D).

You may enroll your eligible family members for Dependent Life insurance coverage even if you do not elect any Additional Life insurance coverage for yourself. For all other Flexible Benefits, you must have coverage for yourself to enroll your eligible family members.

Your eligible family members include (eligibility is determined according to these categories unless otherwise noted in this Handbook):

- Your legal spouse (as defined on this page)
- Your dependent children—including biological children, children who have been adopted or placed for adoption, foster children, stepchildren, grandchildren [1], and other qualified children (as defined on pages 6 – 7).

You will be required to reimburse Texas Health for all benefits the plan pays for a spouse or child who did not meet the definition of eligible family member at the time the benefits were paid. You may also be subject to corrective action up to and including termination.

SPOUSE

Your eligible spouse is the person of the opposite sex who is legally married to you and who legally resides in the United States. In the case of a common law marriage, you must have filed a declaration of informal (common law) marriage with the county clerk on a form provided by the Bureau of Vital Statistics and provide a copy to Human Resources. If your spouse is a common law spouse, certification of common law marriage is required. Tax returns will not be accepted as documentation of your spouse's eligibility.

If Family Members Work for Texas Health

No person can be covered as both an employee and a dependent under the same benefit plan. If you are eligible for Texas Health's benefit plans and your spouse, parent, or child also works for Texas Health and is eligible for benefits, you will need to determine whether it is better for you to each elect coverage as an employee or whether it is more cost-effective for one of you to cover the other as a dependent (if eligible).

- If both spouses work for Texas Health, only one of you may cover your eligible children and grandchildren.[1]
- If a parent and child work for Texas Health:
  - The child may be covered as the parent's dependent only if the child meets the eligibility requirements
  - Only one of you may cover the grandchildren[1] (the child's children).
  - The parent cannot elect Dependent Life Insurance coverage for that child.

[1] Footnotes are on the next page.

CHILD

To be eligible for coverage under the Total Health Medical Plan, a child must meet all the following criteria:

- Be under 26 (or any age if unmarried and physically or mentally incapable of self-support)
- Live in the United States

To be eligible for dental, vision, or life insurance coverage, a child must meet all the following criteria:

- Be under 25[2] (or any age if physically or mentally incapable of self-support)
- Be unmarried
- Live in the United States[3]
- Have the same primary residence as you and be a member of your household[3]

You may also cover a child who meets the above criteria if you can provide a copy of the court order signed by the judge showing one of the following:

- You have adopted the child
- The child has been placed in your home for foster care
- You have been appointed by the court as the child's legal guardian or non-parent managing conservator.

A child serving in the military or armed forces of any country is ineligible for coverage.

The employee's child may be covered under a Qualified Medical Child Support Order (explained on the next page) even if you do not claim the child as a dependent on your federal income tax return.

Newborn Children

If you elect coverage under the Medical Plan, your newborn child will automatically receive medical coverage for 31 days following birth. *If you wish to extend coverage beyond the 31-day period, you must enroll the newborn online within 31 days of the child's birth.*

Stepchildren

Your stepchildren are eligible for coverage under the Total Health Medical Plan only if they meet all the requirements above and your spouse (the child's parent) is covered under the plan as your dependent or as a Texas Health employee. This provision does not apply to dental, vision or life insurance coverage.

Child Placed for Adoption

A child under age 18 will be considered placed with you for adoption if you have assumed a legal obligation for total or partial support of the child in anticipation of the adoption. In this situation, you should provide Human Resources with documentation (such as a signed court order) that the adoption agency or other entity had legal custody of the child on the date the child was placed with you for adoption.

Incapacitated Child

Coverage for an unmarried, incapacitated child does not end just because the child has reached a certain age. You may extend the coverage for that child beyond the limiting age if both of the following are true. The child:

- Is not able to be self-supporting because of mental retardation or physical handicap and
- Depends mainly on you for support

Coverage will continue as long as the enrolled dependent is incapacitated and meets the definition of dependent, unless coverage is otherwise terminated under the terms of the plan.

You must furnish UnitedHealthcare (UHC) with proof of the child's incapacity and dependency within 31 days of the date coverage would otherwise have ended because the child reached a certain age. Before UHC agrees to this extension of coverage, they may require that a physician chosen by UHC examine the child. UHC will pay for that examination.

UHC may continue to ask you for proof that the child continues to meet these conditions of incapacity and dependency. Such proof might include medical examinations at UHC's expense. However, you will not generally be asked for this information more than once a year.

You may add coverage for an incapacitated child only if the child meets the definition of eligible child (described on this page) and the definition of incapacitated child (described above) and either:

- Your adult child who was not covered by the plan becomes incapacitated or
- You have an adult child who is incapacitated and are enrolling in the Texas Health Medical Plan as a new employee.

[1] To cover your grandchildren, you must provide documentation of court appointed legal guardianship or managing conservatorship to Human Resources before the enrollment deadline.

[2] The dental and life insurance plans allow you to cover eligible children up to age 25, regardless of student or employment status. The vision plan allows you to cover unmarried dependent children up to age 25 who are not regularly employed on a full-time basis.

[3] Under the life insurance plan, you may cover an eligible child who does not have the same primary residence as you or live in the U.S.

Qualified Medical Child Support Order (QMCSO)

Dependent coverage will be offered to the extent it is required by a QMCSO, provided you continue to meet the eligibility requirements of the medical plan and you are enrolled in the plan. If you are not enrolled in a Total Health Medical Plan at the time the plan administrator receives the QMCSO, you and your child will be enrolled in the UHC Choice 500 High Rx Plan to comply with the court order and the applicable premium will be deducted from your paycheck. The plan administrator will determine whether an order or notice is a QMCSO.

A QMCSO ordering your spouse to provide coverage for your stepchildren is not binding on Texas Health. If your spouse is ordered to provide medical coverage for his or her children (your stepchildren) under a QMCSO, you may cover them under a Total Health Medical Plan only if your spouse (the child's parent) is also currently covered under the plan and the child meets the definition of eligible child on the previous page.

A QMCSO is any judgment, decree, or order (including a settlement agreement) issued by a court of competent jurisdiction that:

- Provides for child support with respect to a child of a participant under a group health plan
- Provides health benefit coverage to a child pursuant to a state domestic relations law (including a community property law), and relates to benefits under the plan, or
- Enforces a law (including a community property law) and relates to benefits under the plan, or law relating to medical child support described in the Social Security Act with respect to a group health plan.

The following information must be included in the QMCSO:

- The name and the last known mailing address of the participant and the name and mailing address of each child covered by the order
- A reasonable description of the type of coverage to be provided by the plan to each child, or the manner in which the type of coverage will be determined
- The time period during which the order applies, and
- Each plan to which the order applies.

A medical child support order is not qualified by the plan administrator if it requires a plan to provide any benefit not otherwise provided under the plan.

The plan administrator has the responsibility for determining whether a QMCSO exists. When a QMCSO is received, the plan administrator will notify you and each child that the order has been received. The notification describes the procedures that will be used to determine its qualification.

After the review process is completed, the plan administrator will notify you and your child(ren) of the Administrator's determination and, if applicable, the appeal process that may be requested.

You may request a free copy of the procedures governing Qualified Medical Child Support Order determinations from the plan administrator. Any health benefits paid under a QMCSO as reimbursement for expenses paid by the child or the child's custodial parent or legal guardian will be paid to the child or the child's custodial parent or legal guardian.

DOCUMENTATION FOR DEPENDENTS

You must provide the social security number for all covered dependents who are at least six months old. You will enter those online when enrolling.

To ensure only eligible dependents are covered under our plans, Texas Health requires you to provide documentation when adding a dependent to medical, dental or vision coverage (for a new hire, rehire, status change or during open enrollment). If you are an employee who left Texas Health and you were rehired more than one year later, you are required to resubmit documentation of your dependents' eligibility.

Following are acceptable forms of documentation:

- Spouse: **Both** of the following need to be provided for your spouse:
  - Photocopy of marriage license, marriage certificate provided by your religious organization, most recent tax return or certification of common law marriage (your tax return is not acceptable documentation of common law marriage) ***and***
  - Photocopy of driver's license, most recent tax return, bill or some other documentation that shows both you and your spouse currently have the same address
- Children: One of the following needs to be provided for each child:
  - Photocopy of birth certificate that shows you and/or your spouse as parents or
  - Photocopy of birth record from hospital that shows you and/or your spouse as parents or
  - Photocopy of legal guardianship or adoption papers or
  - Photocopy of Qualified Medical Child Support Order (QMCSO)

You must send documentation to your Human Resources office or fax documentation to the Benefits Department at 682-236-6997 within 31 days of your event (new hire, family status change, etc.). If you do not provide complete and timely documentation, your dependents will not be added to your coverage. If your dependent is dropped because of lack of documentation, premiums you have paid will not be refunded.

Appealing Eligibility Determination

If you believe you or your dependent is eligible for coverage, within 60 days of your eligibility date you may submit this claim by emailing the plan administrator at **THRBenefits@texashealth.org** or sending a written request to the plan administrator at the address on pages 153 – 154 of this handbook. You must list the names of the people you believe are eligible to participate and explain the reasons you believe they are eligible. You should include any documents you would like to have considered.

If your claim for eligibility is denied in whole or in part, the plan administrator will notify you in writing within 15 days after the date the plan administrator receives your claim. (This time period may be extended for an additional 15 days for matters beyond the plan administrator's control including cases in which a claim is incomplete. The plan administrator will provide written notice of any extension, including the reasons for the extension and the date by which the plan administrator expects to make a decision. If a claim is incomplete, the extension notice will also describe the required information and will allow you 45 days from receipt of the notice to provide the specified information. The extension suspends the time for a decision on your claim until the specified information is provided.)

Notification of a denied claim will include:

- A specific reason or reasons for the denial
- The specific plan provision on which the denial is based
- A description of any additional material or information necessary for you to validate the claim and an explanation of why this information is necessary
- Information on the steps you must take to appeal the plan administrator's decision, including your right to submit written comments and have them considered, your right to review (upon request and at no charge) relevant information, and your right to file suit under ERISA (where applicable) with respect to any adverse determination after appeal of your claim.

APPEALS

If your claim is denied in whole or part, you (or your authorized representative) may request review by writing to the People and Culture Committee (the committee) who acts on behalf of the plan administrator with respect to appeals. Your appeal must be made in writing within 180 days after you receive the notice that the claim was denied. If you do not appeal on time, you will lose the right to appeal the denial and the right to file suit in court. Your written appeal should state the reasons you believe your claim should not have been denied. It should include any additional facts and/or documents you believe support your claim. You will have the opportunity to ask additional questions and make written comments, and you may review (upon request and at no charge) the information relevant to your appeal.

DECISION ON REVIEW

Your appeal will be reviewed and decided by the committee or other entity designated by the plan in a reasonable time not later than 60 days after the committee receives your request for review. The committee may, in its discretion, hold a hearing on the denied claim. If the decision on review affirms the initial denial of your claim, you will be furnished with a notice that explains:

- The specific reasons for the decision on review
- The specific plan provisions on which the decision is based
- A statement of your right to review (upon request and at no charge) relevant documents and other information
- If an internal rule, guideline, protocol, or other similar criterion is relied on in making the decision on review, a description of that rule, guideline, protocol, or other similar criterion or a statement that it was relied on and that a copy will be provided free of charge to you upon request, and
- A statement of your right to bring suit under ERISA §502(a) (where applicable).

Discrimination Prohibited

Eligibility under the Medical, Dental, and Vision Plans will not be based on a health-related factor, such as genetic information or evidence of insurability. Federal law prohibits any discrimination in eligibility or cost of coverage because of a health status-related factor.

Misstatements of Facts

Texas Health benefits are provided for the exclusive benefit of Texas Health employees and their families, so coverage is limited to eligible employees and their eligible family members. If you elect to cover an ineligible person or do not accurately provide the correct information about that person—such as giving a false age, gender, marital status or any other condition, you will be subject to corrective action, up to and including termination and may result in loss of coverage as explained on page 140 under "When Coverage Ends." Texas Health also reserves the right to recover any overpayments made on behalf of a person who is ineligible.

Documentation

Texas Health has the right to request complete documentation of dependent status, eligibility for coverage or change in coverage, or of a claim for benefits. Texas Health reserves the right to refuse coverage or benefits if it does not believe the facts are accurate.

Enrolling In Flexible Benefits

You have the opportunity to enroll in Flexible Benefits as a new hire and during the open enrollment period each year. You also may enroll or change your benefit elections during the year if you experience a status change or have special enrollment rights, as explained on pages 10 – 13.

The benefit choices you make during open enrollment remain in effect for the entire plan year unless you have a status change or special enrollment rights as described on pages 10 – 13.

New Employee Enrollment

- New hires must enroll within 14 calendar days of hire date. *If you do not enroll within 14 calendar days, your next opportunity to enroll will be the next open enrollment period. In this case, you will not have any Flexible Benefits (only Basic Benefits) unless you later enroll because you have a status change or qualify for special enrollment rights as explained on pages 10 – 13.*
- You may change your elections online as many times as you would like within your 14 day enrollment period. Your benefits that take effect will be the last elections you save.
- Your participation in Flexible Benefits begins the first pay period after you complete one month of service.
- You will be required to provide documentation of all dependents you cover under medical, dental or vision as described on page 7.

YOU MUST provide documentation for your dependents.

If you miss the deadline for enrollment or dependent verification and you still want medical coverage, you must contact Human Resources within 60 days of your missed deadline. Only one medical plan option is available during this 60-day period—UHC Choice 500 High Rx plan paid on an after-tax basis. You may not enroll in any other benefits until the next open enrollment period unless you have a qualified status change. Contact Human Resources for information on how to make this election. Your after-tax plan will be effective the first day of the following pay period after complete forms and documentation are received.

BASIC BENEFITS

Eligible employees are automatically enrolled in the following employer-paid Basic Benefits on the first day of the pay period after one month of service:

- Basic Long Term Disability (LTD)
- Basic Life Insurance
- Basic AD&D Insurance
- Business Travel Accident Insurance
- Paid Time Off (PTO).[1]

FLEXIBLE BENEFITS

Benefits-eligible employees must enroll within the required time frames to receive the following Flexible Benefits:

- Medical
- Dental
- Vision
- Short Term Disability
- Additional Long Term Disability
- Additional Life Insurance
- Dependent Life Insurance
- Additional AD&D Insurance
- Flexible Spending Accounts.

Open Enrollment

Current employees will receive enrollment materials prior to the open enrollment period.

- Carefully review these materials and determine which benefits you will choose for yourself and your eligible dependents.
- Enroll in Flexible Benefits during the open enrollment period typically held in November. Your elections become effective January 1.

MISSED ENROLLMENT DEADLINE

If you are not enrolled in medical coverage and you miss the deadline for enrollment but you still want medical coverage, you must contact Human Resources within 60 days of your missed deadline. However, within the 60 day period, you may choose only one medical plan option — UHC Choice 500 High Rx plan paid on an after-tax basis. You may not enroll in any other benefits until the next open enrollment period unless you have a qualified status change. Contact Human Resources for information on how to make this election.

MISSED DEPENDENT VERIFICATION DEADLINE

If you miss the deadline for dependent verification and you still want medical coverage for your dependents, you must contact Human Resources prior to January 1. However, you may choose only one medical plan option — UHC Choice 500 High Rx plan paid on an after-tax basis. You may not enroll in any other benefits until the next open enrollment period unless you have a qualified status change. Contact Human Resources for information on how to make this election.

[1] You begin to accrue PTO on your date of hire.

Bridging of Service

REHIRED EMPLOYEE ENROLLMENT

If you are rehired by Texas Health within 180 days of your termination, you qualify for "bridging of service." Bridging service means the time gap is closed and your PTO accrual picks up at the rate when you terminated. Because your service is bridged, you must continue the same coverage in effect before you left. However, your reinstated benefits are based on your new ABBR. The rule to continue the same coverage in effect before you left does not apply to employees who go from full-time to term and then benefits-eligible part-time or from benefits-eligible part-time to term then to full-time within 180 days. Coverage is immediate if you previously satisfied the waiting period, unless you were rehired in a different calendar year than the year in which you terminated. In that case, you have 14 days to make new benefit elections. Those newly elected benefits will take effect the first of the pay period following the date you submit new elections.

If you are rehired more than 180 days after your termination, you will be subject to a new waiting period and you may make new benefit elections that are effective for the remainder of the year. Those newly elected benefits will take effect the first of the pay period following the date you submit new elections.

STATUS CHANGE ELIGIBILITY

If you regain eligibility for benefits within 180 days of your loss of benefits due to a status change, you qualify for "bridging of service." Bridging service means the time gap is closed and your PTO accrual picks up at the rate when you lost benefits. Because your service is bridged, you must continue the same coverage in effect before you lost benefit eligibility. However, your reinstated benefits are based on your new ABBR. The rule to continue the same coverage in effect before you left does not apply to employees who go from full-time to non-benefits-eligible and then to benefits-eligible part-time or from benefits-eligible part-time to non-benefits-eligible then to full-time within 180 days. Coverage is immediate if you previously satisfied the waiting period, unless your status change occurs in a different calendar year than the year in which you lost benefit eligibility. In that case, you have 14 days to make new benefit elections.

If you regain eligibility for benefits more than 180 days after your loss of benefits due to status change, you will be subject to a new waiting period and you may make new benefit elections that are effective for the remainder of the year. Those newly elected benefits will take effect the first of the pay period following the date you submit new elections.

SEE PAGE 14 for a table that summarizes the changes you may make based on your life event.

Changing Your Coverage

You may add or drop certain coverages when you experience a status change or if you have special enrollment rights as described later in this section.

STATUS CHANGES

The Texas Health Flexible Benefits Plan is regulated by federal laws and regulations that restrict when you may change your elections. According to these regulations, you may request changes to certain benefits during the year only if you have a qualified status change that affects eligibility or coverage.

Qualified status changes include:

- You or your eligible family member becomes covered by one of the Total Health Medical Plans because of special enrollment rights as explained beginning on page 12 (you may make changes only to medical coverage levels, such as adding or dropping family members, but you may not change plans).
- Your marital status changes due to marriage, death of your spouse, divorce, or annulment.
- The number of your dependents for federal income tax purposes changes due to birth, adoption, placement for adoption, or death. (If you gain a new dependent and already have family coverage, you must go online within 31 days of your change to add the new dependent to your coverages. *A new dependent is not automatically enrolled, even if you already have coverage for your family.)*
- You or your eligible family member begins or ends employment that affects eligibility for benefits
- You or your eligible family member experiences a change in employment status that affects eligibility for benefits—for example, you switch between part-time and full-time, PRN and full-time, or part-time and PRN.
- You or your eligible family member takes or returns from an unpaid leave of absence that affects coverage.

- Your family member becomes eligible or loses eligibility for medical, dental or vision coverage due to age (see page 6).
- You or your eligible family member moves to a new home or work location (this applies only to dental DMO).
- You or your family member becomes entitled to coverage or loses coverage under Medicare, Medicaid, or state-sponsored child health plan.
- A QMCSO (explained on page 7) requires you or your former spouse to provide coverage for a dependent under a Texas Health welfare plan and that coverage is, in fact, provided.
- Your spouse's employer offers benefit plans with a different plan year that affects your coverage.

If your status change allows you to add one family member, you may enroll all other eligible family members at this time, as well.

Your new election must be consistent with your status change. Under the medical, dental, vision, STD, LTD, life, and AD&D plans and the flexible spending accounts, "consistent" means the change must result in the gain or loss of coverage by you, your spouse, or any of your dependent children, and the new election must reflect that gain or loss. You may add or drop family members, which may change your coverage level, but you may not change medical or dental plans (for example, you cannot change from 500 High Rx to 1000 High Rx, but you can change from employee only coverage to employee + children) when you experience a family status change. However, if you change job status (for example, from benefits-eligible part-time to full-time or full-time to benefits-eligible part-time), you may change medical or dental plans.

SEE PAGE 14 for a table that summarizes the changes you may make based on your life event.

You may change or revoke your previous election for the Day Care Spending Account during the year and make a new election (you must notify Human Resources, make your election, and provide documentation within 31 days—if documentation is not provided the election will be reversed) under these circumstances:

- The cost of dependent care significantly increases or decreases (you can change or revoke your previous election only if the provider is not your relative, as defined in the plan).
- You remove your child from a facility
- You or your spouse quit working
- You experience a qualified status change, as defined on pages 10 – 12.

The plan administrator or its authorized agent will determine whether your requested change is consistent with your status change.

If you miss the deadline for your status change or dependent verification and you still want medical coverage (cannot be previously enrolled), you must contact Human Resources within 60 days of your missed deadline. However, within the 60 day period, you may choose only one medical plan option—UHC Choice 500 High Rx plan paid on an after-tax basis. You may not enroll in any other benefits until the next open enrollment period unless you have a qualified status change. Contact Human Resources for information on how to make this election.

If your cost for benefits coverage significantly increases or decreases during the year, you will be allowed to make a change in your elections. However, you may not change your election for the Health Care Spending Account.

If you, your spouse, or dependent child has a significant reduction in coverage during the year, you may be allowed to change your election. If the curtailment results in the loss of coverage, you would be permitted to either elect new coverage under another option or drop future coverage if no similar coverage is offered.

A loss of coverage means:

- Your current option is being eliminated.
- Your network is no longer being offered where you live.

In addition, the plan administrator may consider the following a loss of coverage:

- A substantial decrease in the number of medical care providers available under an option
- A reduction in benefits for a specific type of medical condition or treatment for which you, your spouse, or dependent child is currently in a course of treatment

You may also make a new election if the change is because of and corresponds with a change in another employer-sponsored plan (including your spouse's plan), if the period of coverage is different.

Requesting a Change in Coverage and Your Responsibility for Notification

To change your coverage, you must contact Human Resources within 31 days of your status change. When you initially notify Human Resources of your event, they will explain how to enroll or discontinue coverage. After you enroll, you must provide documentation within 31 days of the event. Your documentation must show your name, the date of the change and, if applicable, your new dependent's name.

You will be required to provide documentation for dependents you cover, as described on page 7.

When you go online and make changes based on spouse eligibility, you also need to provide documentation to Human Resources.

You are also responsible for notifying Human Resources when your divorce is final so coverage can be stopped. If you notify Human Resources and provide documentation after 31 days, your dependent will be dropped from coverage. However, because of IRS regulations and plan rules, you will continue to pay the premium for the rest of the plan year. You will not receive a refund.

Effective Date of Changes

When you request a change in status, you have 31 days from the date of the event that resulted in the status change to notify Human Resources, provide documentation and enter new benefit elections. The online enrollment system will show an effective date of coverage as the first of the pay period following the date you enter your benefit elections online. This is your effective date provided you:

- Notify Human Resources of your status change via the online enrollment system
- Provide appropriate documentation
- Have been employed by Texas Health for at least one month
- Enter your elections online with an accurate event date.

Your online elections will not become effective until you have sent documentation supporting the event (such as your divorce decree in the event of a divorce) to the Benefits Department and your documentation has been approved. Your effective date provided by the enrollment system and/or elections will be changed if:

- You submit the documentation after the pay period in which you make your online elections
- You entered an event date that does not correspond with the date shown in your documentation
- The benefit changes you requested online are not consistent with your status change.

The Benefits Department will review your elections and your documentation to ensure the status change and elections entered meet the qualified status change requirements. In the event your effective date is changed because of one of the above reasons, your effective date will follow these rules:

- If you do not submit your paperwork within the same pay period that you made the online elections, your effective date will be the first of the pay period following the date you sent the paperwork to the Benefits Department.
- If your documentation shows a different date than what you entered online, your effective date is the first of the pay period following the date of your status change, provided you made the change request within 31 days of the event date.

If you do not make the request and complete all the steps listed above within 31 days, you must wait until the next open enrollment period. If you have not completed one month of service at the time your job classification changes, your benefits will be effective on the first payroll period after you make your new election and complete a month of service.

When adding coverage because of the birth or adoption of a dependent, your new coverage is effective as of the date of the birth or adoption.

SPECIAL ENROLLMENT RIGHTS

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you and your dependents may be entitled to enroll in a Total Health Medical Plan at times other than the open enrollment period. Special enrollment rights are available when you lose coverage under another plan or gain a new dependent.

If you lose coverage, special enrollment rights are available for you and/or your dependents if:

- You or your dependents were eligible but not enrolled under a Total Health Medical Plan, and you or your dependents were covered under another health plan or had health insurance coverage at the time coverage was previously offered to you and
- You or your dependents who had lost coverage under the other health plan because it was COBRA coverage that was exhausted, or the coverage was not under COBRA and either:
  - The coverage was terminated as a result of loss of eligibility for the coverage (including divorce, death, termination of employment or reduction in number of hours of employment) or
  - Employer contributions toward the coverage were terminated.

The term "loss of eligibility" does not include loss of coverage because of failure to pay premiums on a timely basis or any termination of coverage for cause.

If you gain a new dependent, you and your dependents are eligible for special enrollment rights if:

- You are eligible for a Total Health Medical Plan but are not currently enrolled, and
- You acquire a new dependent through marriage, birth, adoption, or placement for adoption.

You may enroll yourself and all your eligible dependents on account of your marriage or a child's birth, adoption, or placement for adoption with you.

You may add or drop coverage if your dependent becomes eligible for premium assistance under Medicaid or a state health plan (CHIP) or loses coverage under one of those plans as a result of loss of eligibility.

Requesting Special Enrollment

You must notify Human Resources and provide documentation within 31 days of the event that caused your special enrollment rights or you will lose your special enrollment rights for that event. The plan administrator may require documentation of the event.

When you initially notify Human Resources of your event, they will explain how to enroll. After you enroll, you must provide documentation within 31 days of the event.

Your documentation must show your name, the date of the change and, if applicable, your new dependent's name, Social Security number, gender, and birth date.

You will also be required to provide documentation for the dependents you cover as described on page 7.

Effective Date of Changes

The effective date for special enrollment rights is the earlier of the first day of the month or the first day of the pay period after you notify Human Resources, provide the appropriate documentation, and complete the enrollment (all of this must be done within 31 days of the event). If you are adding coverage because of the birth or adoption of a dependent, your new coverage is effective as of the date of the birth or adoption. See pages 167 – 168 for the 2013 cost of coverage.

If you do not request your change and provide documentation within 31 days of the qualifying event, you may elect to change your benefits only during the next open enrollment period or if you have special enrollment rights, as explained beginning on page 12. If you do not provide the required documentation after you have made your elections, the election will be reversed or cancelled and premiums will not be refunded.

SEE PAGE 14 for a table that summarizes the changes you may make based on your life event.

Summary of Allowable Changes in Coverage

The following table lists the changes you may be allowed to make for qualified status changes or special enrollment rights you may have. Boxes marked with a √ indicate when changes are allowed. The term "Dep" in the table means "Dependent." **The benefits you select must be consistent with your family status change.**

Event	Medical, Dental & Vision					Add'l Life		STD/LTD		Spouse & Child Life		Add'l AD&D		Health & Day Care FSA	
	Add Plan	Drop Plan	Add Dep	Drop Dep	Change Plan	Add Plan	Drop Plan	Add Plan	Drop Plan	Add Plan	Drop Plan	Add Plan	Drop Plan	Increase Amount	Decrease Amount
Newly hired employee is eligible for benefits[1]	√		√			√		√		√		√		√	
Spouse gets job with other coverage or becomes eligible for Medicare		√		√			√				√		√	√	√
Spouse has a different enrollment period and change in coverage	√	√	√	√		√	√			√	√	√	√	√	√
Employee is rehired 180 or more days following termination[1]	√		√			√		√ [2]		√		√		√	
Employee changes from part-time to full-time	√		√		√	√		√ [2]		√		√		√	√
Employee changes from full-time to part-time		√		√	√		√		√		√		√	√ [3]	√
Employee changes from PRN or part-time (working less than 24 hours/week) to full-time or part-time (working more than 24 hours/week)[4]	√		√			√		√ [2]		√		√		√	
Employee goes on unpaid LOA		√		√			√				√		√		√
Employee returns from unpaid LOA[12]	√		√			√				√		√		√	
Employee marries	√ [5]	√	√	√		√		√ [2]		√		√	√	√	√
Employee divorces	√		√	√		√		√ [2]			√ [6]	√	√	√	√
Spouse dies	√		√	√		√				√ [7]	√	√	√	√	√
Employee gains a child due to birth, adoption, marriage, etc.	√ [5]		√			√		√ [2]		√ [8]		√		√	√
Child is no longer eligible due to other coverage, (CHIP, Medicaid or other insurance) divorce, death, reaching the age limit				√							√ [9]		√ [9]	√	√
Spouse or child terminates employment, or coverage offered by spouse's or child's employer changes significantly, resulting in loss of eligibility for the plans in which they were enrolled or resulting in a significant change in benefit cost or coverage	√		√			√[6]		√ [2]		√[6]		√[6]		√	√ [10]
Employee moves to location outside the plan's service area	√ [11]	√ [11]			√ [11]										
Cost of day care changes (and care is not provided by relative)														√ [10]	√ [10]

[1] An employee who is rehired less than 180 days following termination will have the same coverage as before termination, unless rehired in a new plan year or unless the employee has changed to a different status.
[2] Pre-existing condition limitations apply.
[3] If medical, dental or vision is dropped
[4] An employee who loses eligibility for benefits and again becomes eligible for benefits within 180 days will have the same coverage as before the loss of eligibility.
[5] Employee can only add plan if adding dependents.
[6] Spouse event only
[7] Child life only
[8] If this is your first child, you may add Spouse Life, as well.
[9] You may not drop spouse life or AD&D and can only drop child life coverage for the affected child.
[10] Day Care FSA only
[11] Medical and Dental only
[12] You are re-enrolled in your previous coverage if you request re-enrollment.

YOU ARE required to provide documentation for your dependents.

Paying for Your Flexible Benefits

You and Texas Health both pay the cost of your Flexible Benefits. Texas Health pays the total cost for some benefits, you pay the total cost for some benefits, and you and Texas Health share some costs, as shown below. Your cost for benefits is deducted from 26 paychecks of each calendar year. Any missed premiums will be deducted from the next paycheck.

Benefits Paid in Full by Texas Health

- Paid Time Off
- Basic Life Insurance
- Basic AD&D Insurance
- Basic Long Term Disability
- Business Travel Accident Insurance
- Tuition Reimbursement
- *Be Healthy* wellness program
- Adoption Assistance

Benefits Paid by You and Texas Health

- Medical/Prescription

Benefits Paid in Full by You

- Dental
- Vision
- Additional AD&D Insurance
- Flexible Spending Accounts
- Additional Life Insurance
- Dependent Life Insurance
- Short Term Disability
- Additional Long Term Disability
- Long Term Care Insurance

If you take an approved leave of absence, you must pay your portion of the cost for benefits bi-weekly to continue coverage during the leave. If you do not pay your premiums while on leave, your benefits will be canceled.

Before-tax Benefits

You pay your portion of the cost for most benefits with before-tax dollars. This means your contributions for benefits are deducted from your paycheck before federal income and Social Security taxes are taken out.

You pay for the following benefits on a before-tax basis:

- Medical
- Dental
- Vision
- Additional AD&D Insurance
- Flexible Spending Accounts

Because you do not pay taxes on the earnings you use to pay for these benefits, your total tax bill may be reduced.

After-tax Benefits

Your contributions for after-tax benefits are subject to federal income taxes and Social Security taxes. Contributions are deducted from your paycheck after taxes have been taken out. Your after-tax benefits include:

- Additional Life Insurance
- Dependent Life Insurance
- Short Term Disability
- Additional Long Term Disability
- Long Term Care Insurance

Benefits Base Rate

Some of your premiums for benefits are based on your benefits base rate (as defined in the glossary), which is your base pay on the latest of:

- Your hire date
- Your rehire date
- October 1 of the previous year
- The date of your last change in job status (full-time to part-time, part-time to full-time, benefits-eligible to non-benefits-eligible).

Premiums that are based on your benefits base rate include:

- Medical
- Basic Life Insurance
- Additional Life Insurance
- Basic AD&D Insurance
- Additional AD&D Insurance
- Short Term Disability
- Basic Long Term Disability
- Additional Long Term Disability

Payroll Deductions

You will pay for the benefits you elect through payroll deduction. These deductions are taken from 26 paychecks during the year.

Payroll deductions for medical, dental, and vision benefits are based on the plan you elected and the family members you elect to cover. Your cost for medical coverage also varies by which prescription drug coverage you choose and by your benefits base rate, depending on whether you earn:

- Less than $25,000
- $25,000 – $49,999
- $50,000 – $74,999
- $75,000 – $99,999
- $100,000 or more

Separate medical rates also apply to part-time employees.

Payroll deductions for other optional benefits are based on the level of coverage you select and, in some cases, your age and earnings.

Your 2013 costs are listed on pages 167 – 168.

Medical Subsidy

Because retirement can have a significant financial effect on you and your family, Texas Health will provide a medical subsidy if you are age 55 or older and work part-time. This subsidy (which is taxable), will make your net cost for medical coverage the same as for full-time employees earning between $50,000 and $74,999 per year—regardless of how much you actually earn.

For example, if you elect medical coverage under the Choice 500 Low Rx plan for Employee + Spouse, the part-time premium listed on page 167 is $216.16. This is the amount that will be shown on your paycheck as a deduction for medical coverage. The premium for full-time employees earning $50,000 – $74,999 is $90.60. The difference of $125.56 will be shown on your paycheck as a medical subsidy from Texas Health.

$216.16	Part-time premium
– $90.60	Premium for full-time employees earning $50,000 – $74,999
$125.56	Subsidy for part-time employees over age 55

Converting Paid Time Off*

During open enrollment, you can elect to convert up to 80 hours of Paid Time Off (PTO) in eight-hour increments that you will earn the following year to pay for your Flexible Benefits. To be eligible to convert PTO, you must elect at least one Flexible Benefit option (other than the 401(k) Retirement Plan).

You are limited to a combined total of 100 hours per year for conversion, selling and donating PTO. For example, if you elect to convert 40 hours of PTO to pay for 2013 benefits, you will have 60 hours of PTO available to sell or donate during 2013. See page 126 for details on converting PTO.

* Physicians and physician extenders are not eligible for PTO conversion.

Medical & Wellness

Total Health Medical Plan

Overview

Texas Health offers eligible employees a medical plan that allows you to choose the network, medical coverage level, and prescription drug coverage that's best for you and your family.

You have one source for all employee benefits needs—Total Health.

Treating illness is only part of the way you protect your health. To truly protect yourself, you need good medical coverage and good resources so you can take an active role in your health.

Here is what the Total Health Medical Plans include:

- *Medical Coverage*—gives you access to UnitedHealthcare's Choice and Choice Plus network and your choice of three different deductible and coinsurance levels. You save money on your health care costs when you use Texas Health Preferred Hospitals.
- *Prescription Drug Coverage*—you have two options that differ in the percentage they pay for covered prescription drugs.
- *Complex and Chronic Patient Management (CCPM)*—Working on behalf of Texas Health Resources, Total Health Nurses, who are skilled case managers, identify patients with complex and chronic conditions and build on in-office care to fill potential care gaps with:
  - Coordination of multiple physicians
  - Access to community resources
  - Longer-term condition support
  - Complex access
  - Care plan coordination
  - Psychosocial and knowledge needs.
- *Transition Support Program*—provides support to help improve your health care experience by providing support from the time you learn you need to go to the hospital until after you return home.
- *Health Advocacy*—Whenever you have questions about your health, you can ask Health Advocacy. Texas Health gives you free access to Health Advocacy for information by phone at 1-877-MyTHRLink (1-877-698-4754), option 2 or online at **www.myuhc.com**. Health Advocacy offers a team of specially trained individuals who help you navigate the health care system and gives you a trusted source for health care information and support 24 hours a day.
- *Be Healthy*—supports you in optimizing and maintaining your health and well-being.
- *Preventive Care*—is covered for you and each covered member of your family. The Total Health Medical Plans cover an extensive array of preventive exams including, but not limited to, physicals, mammograms, pap smears, prostate exams, and colonoscopies. You are encouraged to have these yearly check ups. Prevention is one of the best ways to make wellness a way of life.
- *Maternity Support Program*—offers you personal support through all stages of pregnancy and delivery and rewards you for participating.
- *MHN Employee Assistance Program (EAP)*—gives you free phone and Internet access to counselors and information to help you cope with life challenges like stress, relationship issues, and financial concerns. It includes up to six free face-to-face counseling sessions per issue per year. The EAP is available 24 hours a day, seven days a week.
- *Benefits for Mental Health and Substance Abuse*—Mental health and substance abuse treatment must be coordinated through United Behavioral Health (UBH) if you are covered by the Total Health Medical Plans.

Choose Your Network

The Total Health Medical Plans offer UnitedHealthcare's (UHC's) Choice and Choice Plus networks of doctors, hospitals, and other health care providers. Both networks include the same in-network providers. The difference is that you are covered for out-of-network care only if you select the UHC Choice Plus network.

Regardless of which network you choose, you have the opportunity to save even more. To keep your out-of-pocket costs as low as possible, Texas Health encourages you to use Texas Health Preferred Hospitals. Texas Health Preferred Hospitals are not a separate network. They are a select group of hospitals within the UHC network. When you use Texas Health Preferred Hospitals, you will receive the highest level of benefit coverage and pay the lowest out-of-pocket costs. It is your responsibility to verify whether a hospital is a Texas Health Preferred Hospital before you receive care.

When you need medical care, first check to be sure your doctor, hospital or health care provider is part of the UHC Choice or Choice Plus network. By using network providers, you can save money on the cost of your care. These networks are large and include most medical specialties you will need.

You are not required to choose a primary care physician (PCP), but the network copays are lower when you use a physician who specializes in general practice, family practice, internal medicine, or pediatrics. You may use a network specialist without a referral from a primary physician, but you pay the higher specialist copay.

For a complete list of Texas Health Preferred Hospitals, log on to **www.MyTHR.org.** You can also get the list of Texas Health Preferred Hospitals on **www.myuhc.com** by entering "THR" as your user name and password.

Choose Your Medical Coverage

Regardless of which network or medical plan you choose, all the plans cover the same medical services. The differences are in the premiums and the amount you pay out of your own pocket for medical care.

If you select the UHC Choice network, you have the option of:

- Choice Plan 500
- Choice Plan 1000.

If you select the UHC Choice Plus network, you have:

- Choice Plan 1500 Plus.

For a comparison of these plans, see pages 20 – 22.

Once you have chosen your medical plan network and coverage, it is time to select a prescription drug coverage that works best for you and your family. Two options are available:

- High Rx
- Low Rx.

Both options cover the same medicines and have the same copay for generic drugs. The difference is in the percentage of coinsurance you will pay for preferred and non-preferred drugs. For a comparison of the plans, see page 23.

Before making an election, you should review all the plan options carefully to determine which one is most appropriate for you. Refer to the Medical Plan Comparison table on pages 20 – 22.

Important terms that appear in this section are defined in the Glossary of Terms beginning on page 161.

Who Can Be Covered

As a full-time or part-time benefits-eligible employee or as a COBRA participant (as defined on page 5), you may elect one of the following levels of coverage under one of the medical plans:

- You only
- You and your spouse
- You and your children
- You and your family.

Your dependents must be covered under the same option as you are covered under. See page 6 for information on eligibility.

You will be required to provide documentation that confirms the eligibility of dependents you cover, as explained on page 7.

OUT-OF-AREA FAMILY MEMBERS

If you want to cover a family member who does not live in an area that has UHC network providers, you may want to select the UHC Choice Plus network because it covers out-of-network care.

To find out whether there are any UHC network providers who practice in the location where your dependent lives, logon to **www.myUHC.com** and enter THR as your user name and password. After you have logged in, you'll see the option to "Find Physicians and Facilities."

If you elect the UHC Choice Plus Plan, your dependents may use any provider, either in- or out-of-network. You must submit claims for services received out-of-network.

Pre-existing Conditions

Texas Health is proud that we do not have any pre-existing condition limitations under any of the medical plan options. This means if you are newly enrolling in our plans, you do not need to be concerned that our medical plans will not cover a condition that you or your dependent has at the time you enroll—so long as it is a condition that is otherwise covered by our medical plan.

Texas Health Preferred Hospitals

EVEN WHEN you use a doctor who is in the UHC Choice or Choice Plus network, you still need to be sure your doctor refers you to Texas Health Preferred Hospitals. You will pay more if you use a network hospital that is not a Texas Health Preferred Hospital. *It is your responsibility to verify whether a hospital is a Texas Health Preferred Hospital before you receive care.*

2013 Medical Plan Comparison

The following table compares the key features of the different medical options and the copays or coinsurance you must pay. All the plan provisions are subject to each plan's copays, coinsurance and/or deductible amounts, as applicable. Some services require prior notification. Excluded medical expenses are described on pages 35 – 38.

DEDUCTIBLES AND OUT-OF-POCKET MAXIMUMS

Plan Name	Preferred Hospitals		UHC Choice Network		Out-of-Network [1]	
	Individual	Family	Individual	Family	Individual	Family
Choice Plan 500						
Annual Deductible	$500	$1,500	$3,000	$9,000	Not covered	Not covered
Annual Out-of-Pocket Maximum [2]	$3,000	$6,000	$12,000	$24,000	Not covered	Not covered
Choice Plan 1000						
Annual Deductible	$1,000	$3,000	$4,000	$12,000	Not covered	Not covered
Annual Out-of-Pocket Maximum [2]	$5,000	$10,000	$15,000	$30,000	Not covered	Not covered
Choice Plan 1500 Plus						
Annual Deductible	$1,500	$4,500	$4,000	$12,000	$5,000	$15,000
Annual Out-of-Pocket Maximum [2]	$5,500	$11,000	$15,000	$30,000	$18,000	$36,000

YOUR COST FOR COVERED SERVICES

The deductibles and out-of-pocket maximums are different under each of the three plan options. However, after you pay the annual deductible for your chosen plan, the coverage is the same under all plans. Only the Choice Plan 1500 Plus covers out-of-network care.

Plan Feature	Preferred Hospitals	UHC Choice Network	Out-of-Network [1] (Covered only Under Choice Plan 1500 Plus)
Outpatient Care			
Office Visits for Illness or Injury	$30 copay for primary physician $50 copay for specialist		50% after deductible
Outpatient Diagnostic Lab & X-ray [3] (excluding MRI, CT, PET scans)	No additional charge if processed in doctor's office; 10% after deductible if not in doctor's office	No additional charge if processed in doctor's office; 10% or 50% after deductible if not in doctor's office*	50% after deductible
Chemotherapy Treatment	$50 copay for specialist		50% after deductible
Radiation	10% after deductible	10% or 50% after deductible*	50% after deductible
MRI, CT & PET Scans [3]	10% after deductible	10% or 50% after deductible*	50% after deductible
Outpatient Surgery	Office visit copay applies; 10% after deductible if not in doctor's office	Office visit copay applies; 10% or 50% after deductible if not in doctor's office*	50% after deductible with notification [4]
Emergency Room	10% after deductible		
Urgent Care Clinic	$50 copay		50% after deductible
* Coinsurance is 10% at a freestanding network facility and 50% at a hospital that is not a Texas Health Preferred Hospital.			

OUT-OF-NETWORK CARE is **not** covered under Choice Plans 500 or 1000, unless it is for an emergency.

Footnotes are on page 22.

Plan Feature	Preferred Hospitals	UHC Choice Network	Out-of-Network[1] (Covered only Under Choice Plan 1500 Plus)
Preventive Care			
Routine Physicals [6]	$0		Not covered
Well-woman/man exams [6] (including pap test and PSA test)	$0		Not covered
Well-child exams (including immunizations) [6]	$0		Not covered
Mammography [5]	$0		Not covered
Colonoscopy [6]	$0		Not covered
Maternity Care			
Office Visits for Pre- and Post-natal Care	$30 for initial office visit; no cost for additional visits		50% after deductible
In-hospital Delivery and Newborn Nursery Care including all physician charges	10% after deductible and only one deductible applies to the mother and newborn child	50% after deductible[4]	
Inpatient Hospital Care			
Hospital Admission [7]	10% after deductible	50% after deductible	50% after deductible with notification[4]
Family Planning			
Infertility Services—diagnostic testing [8]	10% after deductible	50% after deductible	
Sterilization (tubal ligation or vasectomy)	Office visit copay applies; 10% after deductible if not in doctor's office	Office visit copay applies; 50% after deductible if not in doctor's office	50% after deductible
Mental Health Care and Substance Abuse Treatment			
Outpatient Mental Health Care and Substance Abuse Treatment	$50 per visit		50% after deductible
Inpatient Mental Health Care and Substance Abuse Treatment	10% after deductible		50% after deductible[4]
Hearing Care			
Hearing Evaluation	Office visit copay applies; 10% after deductible if not in doctor's office	Office visit copay applies; 50% after deductible if not in doctor's office	50% after deductible
Hearing Aids (one new pair every 36 months)	10% after deductible		50% after deductible
Outpatient Therapy			
Acupuncture (up to four treatments per year)	$50 per visit		50% after deductible
Cardiac Rehabilitation (up to 36 visits per year)	$30 per visit	$50 per visit	50% after deductible
Chiropractic and Spinal Manipulation (20 visits)	$50 per visit		50% after deductible
Pulmonary and Cardiac Therapy (20 visits)	$30 per visit	$50 per visit	50% after deductible
Speech, Occupational, and Physical Therapy (combined 60 visits)	$30 per visit	$50 per visit	50% after deductible
Care at Alternate Sites			
Home Health Care (up to 100 visits per year; one visit is up to four hours)	10% after deductible		50% after deductible[4]
Skilled Nursing Care (up to 60 days per year)	10% after deductible		50% after deductible[4]
Hospice Care	10% after deductible		50% after deductible[4]

Footnotes are on page 22.

Plan Feature	Preferred Hospitals	UHC Choice Network	Out-of-Network[1] (Covered only Under Choice Plan 1500 Plus)
Other Services			
Ambulance	Covered in full with no deductible for a medical emergency. Transportation to nearest facility that can provide appropriate medical care and treatment.		
Allergy Tests and Treatment	$30 primary physician $50 specialist (or cost of serum if less)		50% after deductible
Cosmetic Surgery[9]	10% after deductible	50% after deductible	50% after deductible[4]
Durable Medical Equipment (diabetic supplies are unlimited)[10]	10% after deductible		50% after deductible[4]
Glasses or Contacts[11]	10% after deductible		50% after deductible
Organ and Tissue Transplants[12]	10% after deductible		Not covered
Orthognathic and TMJ[13]	10% after deductible	50% after deductible	
Ostomy Supplies	10% after deductible		50% after deductible
Bariatric Surgery[14] (must meet specific guidelines described on page 32 under "obesity" and be at least 18 years old)	10% after deductible plus $4,000 hospital copay	50% after deductible plus $4,000 hospital copay	Not covered
Medical Nutrition Therapy (one initial assessment and up to three 30-minute sessions per year)[15]	$0 copay per session (only at Texas Health facilities)	Not covered	
Diabetes Education[16]	$10 copay		Not covered

OUT-OF-NETWORK CARE is **not** covered under Choice Plans 500 or 1000, unless it is for an emergency.

[1] Whenever you use an out-of-network provider, you must pay for services at the time you receive them and file a claim for reimbursement of eligible expenses.

[2] The annual out-of-pocket maximum does not include the annual deductible, medical copays, prescription copays, non-compliance penalties, or expenses that are not covered by the plan.

[3] Whenever you have an X-ray or lab service, you incur two separate charges. One is for the service itself, and the other is for the radiologist or pathologist who interprets the results. The radiologist or pathologist must be in-network for charges to be covered under Choice 500 and Choice 1000.

[4] $1,000 penalty for failure to provide notification.

[5] One per year is covered in full; additional screenings are covered, however you pay the coinsurance after your deductible.

[6] One well exam per year is covered in full if the claims administrator determines the physical is for preventive care. Additional screenings or services will be considered diagnostic services and will be covered after you pay the applicable copay or deductible and coinsurance. At the time of your preventive care visit, if other services are performed that are not preventive services, as determined by the claims administrator, they will **not** be paid at 100% even if they are submitted as part of a claim for preventive care. Some items require you to pay the appropriate copay or coinsurance, including electrocardiograms (EKGs), focused office visits, thyroid scans, breast MRI, vitamin D assays, and transvaginal ultrasounds.

[7] Includes network providers for all of the following: inpatient doctor's visits and consultations, surgeon, anesthesiologist, pathologist, and radiologist.

[8] Infertility drugs, procedures to correct infertility, artificial insemination, GIFT, ZIFT, and other infertility treatments are not covered.

[9] Coverage limited to accidental bodily injury, correction of a congenital anomaly, reconstructive breast surgery, or removal of breast implants (if deemed necessary by the claims administrator).

[10] You must pre-notify UHC for durable medical equipment that costs more than $1,000.

[11] Only covered when prescribed within 12 months following cataract surgery.

[12] Coverage is limited to non-experimental transplants at approved hospitals, as explained on page 34.

[13] No coverage for appliances and orthodontic treatment. Must meet specific guidelines.

[14] Bariatric surgery can only be performed at Texas Health hospitals that are designated as a UHC Center of Excellence.

[15] You must have a physician's referral.

[16] You must have a physician's referral. If you visit a THR diabetes educator, you may receive free test strips.

Prescription Drug Comparison

Type of Prescription	High Rx		Low Rx	
	Retail [17]	**Mail Order** [18]	**Retail** [17]	**Mail Order** [18]
Generic	$10 copay	$20 copay	$10 copay	$20 copay
Preferred	25% of cost of 31-day supply ($20 minimum and $100 maximum copay per prescription)	25% of cost of 90-day supply ($40 minimum and $200 maximum copay per prescription)	40% of cost of 31-day supply ($20 minimum and $150 maximum copay per prescription)	40% of cost of 90-day supply ($40 minimum and $300 maximum copay per prescription)
Non-Preferred	40% of cost of 31-day supply ($40 minimum with no maximum copay per prescription)	40% of cost of 90-day supply ($80 minimum with no maximum copay per prescription)	50% of cost of 31-day supply ($40 minimum with no maximum copay per prescription)	50% of cost of 90-day supply ($80 minimum with no maximum copay per prescription)
Annual Out-of-Pocket Maximum [19]	$2,000 per person if you earn $25,000 or more. $1,000 if you earn less than $25,000. [20]		$2,000 per person if you earn $25,000 or more. $1,000 if you earn less than $25,000. [20]	

[17] Up to a 31-day supply

[18] Up to a 90-day supply. Mail order is required for maintenance medications on the third time you fill it. Or you may purchase a 90-day supply at the retail pharmacy at Texas Health Dallas and Texas Health Plano, or any CVS pharmacy. Otherwise you pay double the retail charge.

[19] Maximum combined for retail and mail-order prescriptions. Prescription drug annual out-of-pocket maximum is separate from medical annual out-of-pocket maximum. Copays for generic drugs, as well as coinsurance for drugs, apply toward the out-of-pocket maximum. The out-of-pocket maximum does not include the dispense as written (DAW) penalty explained on page 39.

[20] Based on your base benefits rate. All COBRA participants will have a $2,000 annual out-of-pocket maximum.

UHC Choice Plan

The UHC Choice Plan pays benefits only when you use providers who are part of the UHC Choice network. You pay a copay for doctor office visits and urgent care. For most other services, you must meet an annual deductible and pay your coinsurance before the plan pays benefits. You do not file any claims. This plan generally pays no benefits if you use out-of-network providers, except in the event of an emergency (as defined on page 163).

Advantages of this plan include:

- Lower deductible
- Lower out-of-pocket expenses
- Covered preventive care (such as routine physical exams and well-child care) received from network providers
- No claims to file
- Lower premiums.

UHC Choice Plus Plan

The UHC Choice Plus Plan offers you the savings of the UHC Choice Plus network—while giving you the flexibility to use non-network providers when you want. You can receive care through a UHC Choice Plus network provider or through another provider of your choice.

If you receive care through an out-of-network provider, you pay higher out-of-pocket costs. You must file claims for out-of-network services. The plan controls your expenses with an annual out-of-pocket maximum, which limits the amount you must pay for covered services in one calendar year.

Advantages of the UHC Choice Plus Plan include:

- The choice of using a network or out-of-network provider each time you need medical care
- Higher benefit levels when you use network providers
- Covered preventive care (such as routine physical exams and well-child care) received from network providers
- No claims to file when you use network providers.

How the Plans Work

UHC Choice and Choice Plus Plan network providers agree to charge contracted rates for their services. You must meet an annual deductible before the plan pays benefits for services requiring you to pay coinsurance. You are not required to satisfy a deductible when a copay amount applies. All medical treatment must be considered a covered health service (as explained on page 162) to be eligible for coverage by the plan. The plan will not pay more than the eligible expenses.

See pages 28 – 35 for a list of covered medical expenses under the UHC Choice and Choice Plus Plans.

You may use any UHC Choice or Choice Plus network provider or facility you wish. However, if your UHC Choice network doctor refers you to a network hospital that is *not* a Texas Health Preferred Hospital, you will pay more (50% of the cost of covered services) than if you use a Texas Health Preferred Hospital (10% of the cost of covered services). *If you choose a Texas Health Preferred Hospital, the plan pays a higher benefit, which reduces your out-of-pocket costs.* Because network providers may change, you should always verify that the hospital is in the network before receiving services.

MyTexasHealth and **www.MyTHR.org** provide a list of Texas Health Preferred Hospitals. You can also use the Texas Health WellCall Center 1-877-THR-WELL (1-877-847-9355) to find a physician.

If you have a medical condition that the claims administrator believes needs special services, they may direct you to a designated facility or other provider chosen by them. If you require certain complex covered health services for which network expertise is limited, the claims administrator may direct you to an out-of-network facility or provider. Benefits will be paid as though you had used a Preferred Hospital only if the covered services or supplies for that condition are provided by or arranged by the designated facility or other provider chosen by the claims administrator.

YOUR COSTS

Individual Deductible

A deductible is the amount you must pay each year from your pocket before the plan begins to pay benefits for covered health services. Copays do not count towards the deductible. After you satisfy the deductible, the plan pays a percentage of eligible expenses. Your prescription copays are not subject to deductibles.

Family Deductible

After two covered family members meet their individual annual deductibles, or more than two family members combined meet the family deductible, other covered family members are not required to satisfy individual deductibles for the year. The plan administrator reserves the right to allocate the deductible and benefits to any covered persons.

How Deductibles Cross-apply

If you participate in Choice Plan 500 or 1000, the Preferred Hospital and UHC Choice Network deductibles count towards each other.

If you participate in the Choice Plan 1500 Plus, the Preferred Hospital and UHC Choice Network deductibles count towards each other. However, Texas Health Preferred and UHC Choice Network annual deductibles do not cross-apply to the out-of-network annual deductible and the out-of-network annual deductible does not cross-apply to either the Texas Health Preferred or UHC Choice Network annual deductibles.

Coinsurance

Coinsurance is the percentage of medical expenses you are responsible for paying after you meet the annual deductible. All services require coinsurance except generic prescriptions, office visits, routine physicals, urgent care, and ambulance service. You pay your coinsurance and the plan pays the remaining percentage. You must file claims for benefits that require coinsurance when you use out-of-network providers under the UHC Choice Plus Plan.

Out-of-Pocket Maximum

Under the UHC Choice and Choice Plus Plans, you will not pay more than the annual out-of-pocket maximum in one year for covered services when you use network providers. In-network services have a separate out-of-pocket maximum from out-of-network services in the Choice Plus Plan.

After your coinsurance costs reach the applicable out-of-pocket maximum, the plan pays the full cost of covered expenses for the rest of the year.

If you are in Choice Plan 500 or 1000, deductible and coinsurance amounts you pay for services provided by Texas Health Preferred and UHC Choice Network will cross-apply to the annual deductibles and out-of-pocket maximums for both the Texas Health Preferred and UHC Choice Networks.

If you are in Choice Plan 1500 Plus, deductible and coinsurance amounts you pay for services provided by Texas Health Preferred and UHC Choice Network will cross-apply to the annual deductibles and out-of-pocket maximums to both the Texas Health Preferred and UHC Choice Networks. However, Texas Health Preferred and UHC Choice Network expenses do not cross-apply to the out-of-network annual deductible or out-of-pocket maximum and out-of-network expenses do not cross-apply to either the Texas Health Preferred or UHC Choice Network annual deductible or out-of-pocket maximum.

Annual deductibles, medical copays, non-notification penalties, prescription drugs, and non-covered medical expenses do not count toward the out-of-pocket maximum. Prescriptions have a separate out-of-pocket maximum listed on page 23.

Fee Limits

The UHC Choice and Choice Plus Plans pay in-network benefits based on contracted rates. Out-of-network claims for the UHC Choice Plus Plan will be paid at 140% of the Medicare allowable amount. This is the maximum amount the plans will consider as an eligible expense for a medical service or supply. By using the UHC Choice or Choice Plus network, you can keep your costs lower. Network doctors and hospitals agree to keep their fees within the plan's eligible expenses or allowable amount for your area.

If you are covered under the UHC Choice Plus and use an out-of-network provider whose fees are more than the plan's eligible expenses or allowable amount, you must pay any amount that exceeds the limit, in addition to your deductible and coinsurance amounts.

Choice Network

Eligible expenses are charges for covered health services that are provided while the plan is in effect and are determined as follows:

For:	Eligible Expenses are Based On:
Network Providers	Contracted rates with that provider
Non-network Providers	If you receive covered health services from a non-network provider in an emergency, eligible expenses are the amounts billed by the provider, unless the claims administrator negotiates lower rates.

For certain covered health services, you are required to pay a percentage of eligible expenses in the form of coinsurance.

Choice Plus Network

Network Benefits. Contracted rates with the provider.

Non-network Benefits.

- Negotiated rates agreed to by the non-network provider and either the claims administrator or one of its vendors, affiliates or subcontractors, at the discretion of the claims administrator.
- If rates have not been negotiated, then one of the following amounts:
  - 140% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for Medicare for the same or similar service within the geographic market, or
  - When a rate is not published by CMS for the service, the claims administrator uses an available gap methodology to determine a rate for the service as follows
  - For services other than physician-administered pharmaceutical products, the claims administrator uses a gap methodology that uses a relative value scale, which is usually based on the difficulty, time, work, risk and resources of the service. The relative value scale currently used is created by Ingenix. If the Ingenix relative value scale becomes no longer available, a comparable scale will be used. The claims administrator and Ingenix are related companies through common ownership by UnitedHealth Group.
  - For physician-administered pharmaceutical products, the claims administrator uses gap methodologies that are similar to the pricing methodology used by CMS, and produces fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by RJ Health Systems, Thomson Reuters (published in its Red Book), or the claims administrator based on an internally developed pharmaceutical pricing resource.

When a rate is not published by CMS for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under CMS published rates or a gap methodology, the eligible expense is based on 50% of the provider's billed charge, except that certain eligible expenses for mental health and substance abuse services are based on 80% of the billed charge.

The claims administrator updates the CMS published rate data on a regular basis when updated data from CMS becomes available. Theses updates are typically implemented within 30 to 90 days after CMS updates its data.

For certain covered health services, you are required to pay a percentage of eligible expenses in the form of coinsurance. Eligible expenses are subject to the claims administrator's reimbursement policy guidelines. You may request a copy of the guidelines related to your claim from the claims administrator.

RECEIVING CARE

Preventive Care

The UHC Choice and Choice Plus Plans cover routine physicals when you use network providers at 100%.* Routine physicals include well-woman, well-man and well-child exams. Routine physicals and well-child care are not covered out-of-network. See page 33 for more information about preventive care.

Urgent Care

If you need urgent care for symptoms such as high fevers, flu, cuts that may require stitches, or sprains, call your primary physician or family doctor. He or she will direct you to the appropriate place for treatment. Urgent care clinics or centers (as defined on page 166) are listed in the UHC directory or on **www.MyUHC.com**.

SITUATIONS REQUIRING Notification

YOU MUST prenotify UHC in the following situations:

- Elective admissions—five business days before admission
- Maternity (inpatient stays greater than 48 hours for regular delivery and 96 hours for Cesarean delivery)
- Skilled nursing/inpatient rehabilitation facilities
- Reconstructive procedures
- Nonelective admissions—within one business day or the same day of admission
- Emergency admissions—within two business days
- Durable medical equipment costing $1,000 or more
- Home health care
- Hospice care
- Inpatient services for mental health or substance abuse conditions
- Dental/oral surgery (for an accident)
- Transplants
- Congenital heart disease—as soon as it is suspected or diagnosed (in utero detection, at birth, or as determined and before the time an evaluation for CHD is performed)

IF YOU do not follow the plan's requirement for notification, as explained below under "Your Responsibility for Notification" you may be subject to a penalty.

NOTIFICATION IS not a guarantee or a determination of benefits.

Emergency Care

The plans cover emergency care worldwide. When you have a medical emergency (as defined on page 163), your visit to a hospital emergency room is covered as shown in the table on page 20.

In the event of an emergency, you may receive benefits at the Preferred Hospital level when using an out-of-network provider if you call the toll-free number on the back of your ID card within two business days after the emergency.

Care While Traveling

If you have an emergency, acute illness, or injury while traveling, get medical attention immediately. Then, call your doctor or the number on your plan ID card within 48 hours of receiving care to be eligible for network benefits.

YOUR RESPONSIBILITY FOR NOTIFICATION

Prior notification is required before you receive certain covered services or supplies. In general, network providers are responsible for notifying Personal Health Support℠ before they provide these services to you. However, you are responsible for notifying Personal Health Support℠ for certain network benefits.

For mental health/substance abuse services, you are responsible for notifying United Behavioral Health.

If you elected Plan 1500 Plus and you receive certain covered services or supplies from non-network providers, you are responsible for notifying Personal Health Support℠ before you receive these covered health services. You will be subject to a $1,000 penalty if you do not pre-notify.

* One well exam per year is covered in full if the claims administrator determines the physical is for preventive care. Additional screenings or services will be considered diagnostic services and will be covered after you pay the applicable copay or deductible and coinsurance. At the time of your preventive care visit, if other services are performed that are not preventive services, as determined by the claims administrator, they will **not** be paid at 100% even if they are submitted as part of a claim for preventive care. Some items require you to pay the appropriate copay or coinsurance, including electrocardiograms (EKGs), focused office visits, thyroid scans, breast MRI, vitamin D assays, and transvaginal ultrasounds.

You are required to provide prior notification for the services listed in the box on the previous page.

To notify Personal Health Support℠ or United Behavioral Health, call the telephone number on your ID card.

When you receive services from non-network providers, you should confirm with Personal Health Support℠ that the services you plan to receive are covered.

You must notify the claims administrator of hospital admissions as follows:

- Elective admissions—five business days before admission
- Nonelective admissions—within one business day
- Emergency admissions—within two business days.

UHC PERSONAL HEALTH SUPPORT℠ & CCPM

UHC Personal Health Support provides you with support to help you improve your health care experience. It can help you when you need to be admitted to a hospital or have an outpatient procedure. The program:

- Keeps decision-making between you and your doctors
- Helps you navigate the complexity of the health care system to get the services you need.

Personal Health Support includes:

- *Notification:* If you have a situation that requires notification (listed in the box on the previous page), UHC makes your experience easier by verifying eligibility, confirming benefits, helping you understand your benefits, and offering recommendations for network doctors, hospitals, and other health care providers.
- *Admission Counseling℠:* Before a scheduled hospital admission, you may receive a call to answer your questions or to explain what help you might need after you are discharged from the hospital.
- *Transition Support:* Your Transition Support nurse will talk with you or your caregiver, usually within 24 - 48 hours of your admission to the hospital or care facility.

  After you're home, your nurse will work with you face-to-face or by phone to help you do all you can to prevent a return to the hospital.

  Your Transition Support nurse will help you:
  - Understand your condition and follow your discharge plan
  - Avoid infection or other illness during your recovery
  - Make follow-up appointments with your doctor and other providers
  - Learn about medications, including what they're supposed to do, side effects and tips for making them more affordable
  - Discover the best options for future health care needs.
- *Complex and Chronic Patient Management (CCPM):* Employees with complex and chronic conditions have access to Total Health Nurses who help ensure they understand their diagnosis and treatment recommendations. Total Health Nurses will collaborate with you and your physician/care team telephonically, by visiting your home, or by attending doctor visits with you. They can help you:
  - Understand your condition and treatment plan options
  - Make lifestyle changes that will improve your health
  - Select the appropriate health care resources
  - Discover the best options for future health care needs
  - Learn about medications, including what they're supposed to do, side effects and tips for making them more affordable
  - Make follow-up appointments with your doctor and other providers.
- *Reminder Programs:* You'll receive reminder letters about recommended screening exams like mammograms, adolescent immunizations, cervical cancer screening, diabetes screening, and if you are over age 65, flu and pneumonia shots.
- *Dedicated Team of Nurses:* A dedicated team of nurses is available to help you manage your pregnancy, as well as chronic and complex conditions.

HEALTH ADVOCACY

Coping with health concerns can be time-consuming and complex. And, with so many choices, it can be hard to know where to look for trusted information and support. That's why Health Advocacy services were developed—to give you peace of mind with:

- Immediate answers to your health and wellness questions any time, from any where—24 hours a day
- Access to caring registered nurses who have an average of 15 years' clinical experience
- Trusted, physician-approved information to guide your health care decisions

When you call 1-877-MyTHRLink (1-877-698-4754) prompt 2, a caring nurse can help you:

- Choose appropriate medical care
  - Understand a wide range of symptoms
  - Determine if the emergency room, a doctor visit or self-care is right for your needs
- Find a doctor or hospital
  - Find doctors or hospitals that meet your needs and preferences
  - Locate an urgent care center and other health resources
- Understand treatment options
  - Learn more about a diagnosis
  - Explore the risks, benefits and possible outcomes of your treatment options
- Achieve a healthful lifestyle
  - Get tips on how nutrition and exercise can help you maintain a healthful weight
  - Learn about important health screenings and immunizations
- Ask medication questions
  - Explore how to save money on prescriptions
  - Learn how to take medication safely and avoid interactions.

While Health Advocacy is an excellent information resource, it cannot diagnose problems or recommend specific treatment. This service is not a substitute for your doctor's care.

TEXAS HEALTH WELLCALL CENTER AND CONSUMER WEB SERVICES

Texas Health offers you two resources to make it easier for you to use Texas Health hospitals for your own health care—the WellCall Center and Consumer Web Services.

Consumer Web Services

Log on to **www.TexasHealth.org** for access to a wealth of online resources, including:

- Pre-registration for elective surgery, maternity stay, or outpatient surgery at Texas Health hospitals
- Information on family and community education classes
- Hospital bill payment
- Electronic get-well cards
- Medical encyclopedias in English and Spanish
- Information about prescription drugs in English and Spanish

WellCall Center

You can access free Texas Health System information by calling 1-877-THR-WELL (1-877-847-9355). The call center provides:

- Directory listing of physicians on the medical staff at Texas Health hospitals (Be sure the physician you select is in your UHC network.)
- Physician referrals with information matched to your specific needs such as specialty, clinical interest, insurance accepted, and hospital privileges (Be sure the physician you select is in your UHC network.)
- Family and community class information and registration
- Information on Texas Health hospital departments and services.

You can call and speak to an operator between 8 a.m. and 5:30 p.m. Monday through Friday.

HEALTH CARE LAWS

Mental Health Parity Act

According to the Mental Health Parity Act of 1996, mental health benefits under the Texas Health Medical Plan are equal to medical and surgical benefits under this plan.

Women's Health Act

The Women's Health and Cancer Rights Act of 1998 requires that all health insurance plans that cover mastectomy also cover the following medical care:

- Reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

Newborn's and Mother's Health Protection Act

Federal law (Newborn's and Mother's Health Protection Act of 1996) prohibits the plan from limiting a mother's or newborn's length of hospital stay to less than 48 hours for a normal delivery or 96 hours for a Cesarean delivery or from requiring the provider to obtain preauthorization for a stay of 48 or 96 hours, as appropriate.

However, federal law generally does not prohibit the attending provider, after consultation with the mother, from discharging the mother or her newborn earlier than 48 hours for normal delivery or 96 hours for Cesarean delivery.

Covered Medical Expenses

Covered medical expenses are services and supplies that are eligible under the plan and that you or a covered dependent receives to diagnose or treat an illness or injury. The claims administrator has the discretion and authority to initially determine whether a treatment or supply is covered and how the eligible expense will be handled by the plan. See the plan comparison table on pages 20 – 22 for a summary of copays and coinsurance required for certain services.

The following items are considered covered expenses if the claims administrator determines that they are an eligible expense for diagnosis or treatment of the patient's condition. All services are subject to the excluded expenses listed on pages 35 – 38.

- Acupuncture—up to four visits per year
- Allergy treatment, testing and serum injections
- Ambulance—for medical emergencies to the nearest hospital where emergency health services can be performed. Non-emergency coverage is available for non-emergency ambulance transport when it is medically necessary.
- Anesthesia
- Anorexia and bulimia
- Attention Deficit Disorder (ADD) and Attention Deficit Hyperactivity Disorder (ADHD)—diagnosis and treatment are covered. Other limitations described on page 31 under "Mental health and substance abuse" also apply.
- Audiologists—includes charges by a licensed or certified audiologist for physician-prescribed hearing evaluations to determine the location of a disease within the auditory system; for validation or tests to confirm an organic hearing problem
- Autism—plan will cover occupational, physical, and speech therapy for children up to age 18 with Autistic Spectrum Disorder (ASD). Subject to maximum limits per plan year of 60 visits combined.
- Bereavement counseling—for the immediate family if the patient was receiving hospice care covered under the medical plan
- Birthing center
- Blood pressure cuffs—covered at 100% with a doctor's order. Contact Personal Health Support® at 1-877-MyTHRLink (1-877-698-4754), prompt 2 for more information.
- Blood processing and administration
- Breast implant removal—if due to a medical condition

- Breast prostheses and reconstruction—internal or external prostheses needed due to a mastectomy
- Breast Pump—Preventive care benefits defined under the Health Resources and Services Administration (HRSA) requirement include the cost of renting one breast pump per Pregnancy in conjunction with childbirth. Benefits for breast pumps also include the cost of purchasing one breast pump per Pregnancy in conjunction with childbirth. Benefits are only available if breast pumps are obtained from a DME provider, Hospital or Physician.
- Breast reduction—for certain functional impairments but not to solely improve appearance or to improve athletic performance
- Cardiac rehabilitation services—up to 36 visits per calendar year combined across all benefit levels for services that are expected to result in significant physical improvement in the patient's condition within two months of the start of treatment. Services must be performed by a licensed therapy provider under the direction of a physician.
- Chemotherapy—including wigs for alopecia following chemotherapy
- Chiropractic care/spinal manipulation—up to 20 visits per calendar year combined across all benefit levels. Benefits are paid only for rehabilitation services that are expected to result in a significant physical improvement in your condition. In addition, the claims administrator has the right to deny benefits for any type of therapy, service, or supply for the treatment of a condition that ceases to be therapeutic treatment and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or reoccurring.

  Each visit may include one spinal manipulation, one extra-spinal manipulation and up to three modalities. Massage therapy is not covered.

  Children under 12 are covered for manipulative therapy only for acute or repetitive musculoskeletal injuries, excluding birth trauma and scoliosis.
- Cochlear implant—for a person who has been diagnosed with a severe to profound sensorineural hearing loss and severely difficult speech discrimination or post-lingual sensorineural deafness in an adult
- Colonoscopy—one per year covered if preventive*
- Congenital heart disease services—health services for congenital heart disease (CHD) are covered when ordered by a physician. CHD services may be received at a Congenital Heart Disease Resource Services program. Benefits are available for the CHD services when they meet the definition of a covered health service and are not an experimental or investigational service or an unproven service.

  Personal health support notification is required for all CHD services, including outpatient diagnostic testing, in-utero services and evaluation. Covered services include:
  - Congenital heart disease surgical interventions
  - Interventional cardiac catheterizations
  - Fetal echocardiograms
  - Approved fetal interventions

  You do not pay the copayment or annual deductible when the CHD service is received at a Congenital Heart Disease Resource Services program.

  CHD services other than those listed above are excluded from coverage unless Personal Health Support determines the service is a proven procedure for the involved diagnoses. Contact Personal Health Support at 1-877-MyTHRLink (1-877-698-4754) prompt 2, for information about CHD services.

  Notify Personal Health Support: As soon as CHD is suspected or diagnosed (in-utero detection, at birth, or as determined and before the time an evaluation for CHD is performed). If you don't notify Personal Health Support, benefits will be reduced to 50% of eligible expenses.
- Contact lenses—initial pair prescribed and purchased within 12 months after cataract surgery
- Cornea transplant
- Dental care/oral surgery—Prior notification is required. Failure to prenotify will result in a $1,000 penalty. Services must be performed by a doctor of dental surgery (DDS) or a Doctor of Medical Dentistry (DMD).

* One well exam per year is covered in full if the claims administrator determines the physical is for preventive care. Additional screenings or services will be considered diagnostic services and will be covered after you pay the applicable copay or deductible and coinsurance. At the time of your preventive care visit, if other services are performed that are not preventive services, as determined by the claims administrator, they will **not** be paid at 100% even if they are submitted as part of a claim for preventive care. Some items that were previously covered as preventive care are no longer covered as preventive care and now require you to pay the appropriate copay or coinsurance, including electrocardiograms (EKGs), focused office visits, thyroid scans, breast MRI, vitamin D assays, and transvaginal ultrasounds.

Covered expenses are limited to:

- Surgical treatment of fractures and dislocations of the jaw or for treatment of accidental injury to sound, natural teeth, including replacement of such teeth. The service must be started within three months and completed within 12 months after the date of an accident.
- Surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor, and roof of the mouth. Accidental injury must be severe enough that the initial contact with the physician or dentist occurred within 72 hours of the accident.
- Treatment of a sound, natural tooth. The physician or dentist must certify that the injury to the tooth was a virgin or unrestored tooth, has no decay, no filling on more than two surfaces, no gum disease associated with bone loss, no root canal therapy, is not a dental implant, and functions normally in chewing and speech.
- Removal of non-odontogenic lesions, tumors or cysts by a Doctor of Dental Surgery (DDS) or Doctor of Medical Dentistry (DMD)
- Incision and drainage of non-odontogenic cellulitis
- Surgical treatment of accessory sinuses, salivary glands, ducts, and tongue
- Treatment to correct a non-odontogenic congenital defect that results in a functional defect of a covered dependent child.

- Diabetes education—After a $10 copay, the individual and group education sessions for both adult and pediatric diabetes patients are covered 100% at Texas Health Preferred Hospitals and UHC network providers but only with a physician's referral. You are eligible to earn free test strips for self-monitoring of your blood glucose when you visit with Texas Health diabetes educators at least quarterly.
- Diabetes supplies—the Caremark prescription drug plan covers oral medications, insulin, syringes, blood glucose monitors, test strips, lancets, and chem strips. The medical plan covers durable medical equipment, including external insulin pumps, supplies for your pump (infusion sets, cartridges, batteries, and medical tape), and glucagon emergency kits when ordered by the physician. External pumps that deliver insulin into the intraperitoneal cavity are not covered. You can receive a glucose monitor free through Caremark.
- Diagnostic X-ray and lab
- Dialysis—when done on an outpatient basis, notification is not required by UHC
- Disposable or consumable medical supplies—covered only when a doctor's prescription is required. Elastic stockings are limited to two pairs per calendar year. Supplies that can be purchased without a prescription are not covered, such as bandages, gauze, and dressings.
- Durable medical equipment—for equipment that costs $1,000 or more, prior notification is required. Benefits are available for the replacement of durable medical equipment once every three calendar years.
- Emergency care—for medical emergencies (see page 163 for a definition). The plan administrator must be notified within 48 hours.
- Enteral nutrition—the sole source of nutrition or when a nutritional formula treats inborn error of metabolism
- Eyeglasses—initial pair of lenses and frames prescribed and purchased within 12 months following cataract surgery
- Family planning—covered services include Norplant, IUD, diaphragms, Depo Provera and home birth; marriage counseling is excluded (see page 60 for services offered by the MHN EAP).
- Foot care—includes foot surgery or diabetic care; excludes services for corns, calluses, and ingrown toenails unless considered an eligible expense as determined by UHC
- Hearing care—hearing screening as part of a routine preventive office visit; purchase of aid and hearing tests associated with the purchase of an aid, every 36 months. Bone anchored hearing aids are covered only for covered persons:
  - Who have craniofacial anomalies
  - Whose abnormal or absent ear canals preclude the use of wearable hearing aids or
  - Whose hearing loss is of sufficient severity that it would not be adequately remedied by wearable hearing aids.
- Home health care—up to 100 visits per calendar year; prior notification is required; each visit lasting for four hours or less is considered one visit; each visit must be ordered by a physician; part-time or intermittent nursing care by a registered nurse, licensed practical nurse or licensed vocational nurse; services of a certified social worker; medical supplies, drugs and medicines prescribed by a physician, and laboratory services provided by or on behalf of a hospital, but only to the extent that they would have been covered under the plan if you had remained in the hospital; services of a licensed physical therapist; the care cannot be for the purpose of assisting with daily living activities
- Hospice care—for people with terminal illness (diagnosed with six months or less to live). Prenotification is required. Covered expenses are limited to:
  - Room and board for confinement in a hospice
  - Ancillary charges furnished by the hospice while you are confined, including rental of durable medical equipment that is used solely for treating an injury or illness
  - Medical supplies, drugs and medicines prescribed by the attending physician, but only to the extent such items are necessary for pain control and management of a terminal condition

  - Physician services and nursing care by a registered nurse, a licensed practical nurse, or a licensed vocational nurse
  - Home health aide services
  - Home care charges by a hospital or home health care agency, under the supervision of a registered nurse, a licensed practical nurse, a licensed vocational nurse, or a home health aide
  - Medical social services by licensed or trained social workers, psychologists, or counselors
  - Nutrition services by a licensed dietitian.
- Hospital confinement—prior notification is required; private room at Texas Health hospitals or semi-private room at other facilities, board, and other necessary medical services and supplies, up to the usual and customary limit (or, for a hospital without semi-private rooms, 90% of the most common private room rate.)

  Benefits are not payable for hospital admissions on a Friday, Saturday, or Sunday unless surgery is performed within 24 hours of admission, or the admission is an emergency; you must prenotify UHC before hospitalization except in emergencies.
- Infertility treatment—coverage for diagnosis of underlying cause of infertility in a physician's office or medical facility; excludes fertility drugs, artificial insemination, in-vitro fertilization, gamete intra fallopian transfer (GIFT), zygote intra fallopian transfer (ZIFT).
- Injections—the lesser of the copay or the cost of the injection
- Intensive care
- Intensive outpatient program (IOP)
  - Designed for plan participants who are recovering from severe and/or chronic behavioral health conditions including mental health conditions and substance abuse disorders that occur at the same time
  - May include psychotherapy, pharmacotherapy, and supportive/rehabilitative interventions
  - Provided in a freestanding or hospital-based program
  - Half-day partial-hospital programs provide services at least three hours per day, two or more days per week
  - Covered as an inpatient benefit with 5 days IOP = 1 day inpatient care
  - May be used as a point of entry into care, a step up from routine outpatient services, or a transition after acute inpatient, residential care or a partial hospital program
- Laboratory charges—includes tests and X-rays
- Mastectomy—includes reconstruction of the breast on which the mastectomy was performed or surgery and reconstruction of the other breast to produce a symmetrical appearance and prosthesis and physical complications in all stages of the mastectomy, including lymphedemas
- Maternity care—includes prenatal care, labor, delivery, hospitalization or a birthing center, and newborn care; maternity charges for dependent children are covered, but the newborn child of a dependent (grandchild of the employee) may be covered beyond 31 days after birth only if the employee's grandchild meets eligibility requirements described on page 6; notification is required if the stay is longer than 48 hours for vaginal delivery and 96 hours for Cesarean delivery. In the event the newborn stays longer than the mother, the newborn will be treated as discharged from maternity and re-admitted as a sick infant. There is no newborn coverage after 31 days.
- Medical nutrition therapy—coverage for participants with body mass index (BMI) of 28 or more; requires physician referral; therapy covered only if provided by a Texas Health clinical dietitian. You may receive one initial 90-minute assessment and up to three 30-minute sessions each year.
- Mental health and substance abuse—treatment for inpatient care or for outpatient care. Prior notification is required for inpatient services. Residential treatment for mental health and substance abuse will be permitted if it is a covered health service, as defined on page 162.

  This also applies to diagnosis and treatment of Attention Deficit Disorder (ADD) and Attention Deficit Hyperactivity Disorder (ADHD) and Autism.

Treatment Site	Ratio
Residential treatment	1.5 days = 1 inpatient day
Day treatment/ partial hospitalization	2 days = 1 inpatient day
Structured outpatient	5 days = 1 inpatient day
Intensive Outpatient Program (IOP)	5 days = 1 inpatient day
Sober living/ transitional living	10 days = 1 inpatient day
Outpatient psychotherapy visit	6 days = 1 inpatient day

  Any inpatient admission for mental health or substance abuse treatment that occurs more than 48 hours following discharge for such a treatment is considered an additional admission. This applies regardless of whether the covered person's discharge is against medical advice. Residential treatment for mental health care and substance abuse will be covered if it meets the definition of a covered health service, subject to the same coverage and limitations as inpatient care.
- Midwife—services of a licensed state-certified midwife who is a registered nurse
- Multiple surgical procedures—when performed at the same time as the primary surgical procedure, secondary procedures (excluding incidental procedures or separate operative areas) are covered at 50% of the in-network negotiated rate or 50% of the allowable expense for each additional procedure.
- Narcolepsy—diagnosis and treatment of sleep apnea and narcolepsy
- Nutritional Counseling—for covered persons with a body mass index of 28, to be provided by a registered dietitian at a Texas Health preferred hospital. Nutritional counseling is limited to an initial assessment of 90 minutes and up to three 30 minute sessions.

- Newborn care—coverage includes routine nursery and pediatric care following birth, including room and board, professional services for well newborn, and circumcision; newborn must be enrolled for coverage within 31 days of birth to receive coverage after 31 days
- Obesity— nonsurgical or surgical treatment of morbid obesity (as defined by the claims administrator). Nonsurgical treatment is covered only when provided in a physician's office.

  To be eligible for surgical treatment (bariatric surgery), your medical records must document a body mass index (BMI) of 40 or higher for at least two years with documented sleep apnea, diabetes, hypertension, or immobility secondary to joint pain that is not responsive to medical intervention for at least six months. You must have participated in the Healthy Weight Management Program for six months. Counseling is required before and after surgery.

  The surgery is covered only at Texas Health hospitals that are designated as a UHC Center of Excellence, and only for participants who are at least age 18.

  You pay a $4,000 copay for the surgery in addition to your plan's deductible and coinsurance. This copay does not apply toward your annual out-of-pocket maximum.

  Bariatric surgery may be repeated if you experience a significant complication or technical failure requiring surgical revision of original procedure, provided you have been compliant with the prescribed nutrition and exercise program.

  Gastric bypass sleeve procedure and vertical banded gastrolasty (VBG) are covered, however adjustable gastric band (AGB or lap band) is not covered.

  Panniculectomy may also be covered. (See Panniculectomy for more information.)
- Occupational therapy—up to 60 outpatient visits per calendar year (combined with speech therapy and physical therapy); benefits are paid only for rehabilitation services that are expected to result in a significant improvement in your condition within two months of the start of treatment. In addition, the claims administrator has the right to deny benefits for any type of therapy, service, or supply for the treatment of a condition that ceases to be therapeutic treatment and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or reoccurring. Therapy must be performed by a licensed therapist under a physician's order.
- Office visit—for medical diagnosis or treatment
- Orthognathic surgery—covered only for the following conditions:
  - A jaw deformity resulting from a facial trauma or cancer
  - A skeletal anomaly of the jaw that demonstrates a functional medical impairment, such as:
    - Being unable to chew solid food
    - Choking on solid food that has not been completely chewed
    - Damaging soft tissue while chewing
    - Having a speech impediment caused by a jaw deformity
    - Suffering from malnutrition or weight loss because of inadequate intake as a result of a jaw deformity
- Orthoptic therapy—orthoptic (vision) therapy for the treatment of convergence insufficiency in the absence of accommodative disorder. Orthoptic therapy is not a covered expense for treatment of reading or learning disabilities, or for vision-related diagnoses other than those listed as covered, because there is not enough clinical evidence that these are safe or effective in published, peer-reviewed medical literature.
- Orthotic Devices—covered when linked with a medical diagnosis such as wrist/hand, elbow, and lower extremity orthotics (excluding foot)
- Ostomy supplies—pouches, faceplates, belts, irrigation sleeves/bags, catheters, and skin barriers
- Outpatient hospital charges
- Outpatient surgery—contact Personal Health Support when using an out-of-network provider or facility
- Panniculectomy—Removal of excess skin will be covered if deemed medically necessary by UHC if you maintain a weight loss of at least 20% for at least two years by any means of weight loss.
- Physical therapy—up to 60 outpatient visits per calendar year (combined with speech therapy and occupational therapy); benefits are paid only for rehabilitation services that are expected to result in a significant physical improvement in your condition within two months of the start of treatment (except autism). In addition, the claims administrator has the right to deny benefits for any type of therapy, service, or supply for the treatment of a condition that ceases to be therapeutic treatment and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or reoccurring.
- Physician services—including care in the office and hospital visits by primary physicians and specialists
- Pre-admission testing
- Prenatal care/postnatal care
- Prescription drugs—covered through Caremark (see page 39)

THIS LIST is not all-inclusive and should not be used to determine whether you may receive treatment.

- Preventive care— The plan pays benefits for preventive care services provided on an outpatient basis at a physician's office, an alternate facility or a hospital. Preventive care encompasses medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and include the following as required under applicable law:
  - Evidence-based items or services that have a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force
  - Immunizations that have a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention
  - With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration
  - With respect to women, additional preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration.
  - Generic birth control prescriptions covered at 100% including pills, implants and patches
- Preventive care—one well exam per year is covered in full if the claims administrator determines the physical is for preventive care. Additional screenings or services will be considered diagnostic services and will be covered after you pay the applicable copay or deductible and coinsurance. At the time of your preventive care visit, if other services are performed that are not preventive services, as determined by the claims administrator, they will not be paid at 100% even if they are submitted as part of a claim for preventive care.
- Private rooms—covered only at Texas Health hospitals
- Prosthetic devices—
  - Initial purchase and fitting of external prosthetic which is necessary to alleviate or correct sickness, injury, or congenital defect, to replace or substitute for a missing body part, limited to artificial arms and legs and terminal devices such as a hand or hook;
  - Devices may be evaluated for replacement after five years due to normal wear and tear;
  - Devices may be replaced before five years for adults and children if it is determined by medical review as appropriate (for example defective or damaged) or if needed due to normal body growth in children
- Psychological counseling—subject to mental health treatment plan
- Pulmonary therapy—up to 20 outpatient visits per calendar year combined across all benefit levels; benefits are paid only for rehabilitation services that are expected to result in a significant improvement in your condition within two months of the start of treatment. Services must be provided by a licensed therapy provider under the direction of a physician. In addition, the claims administrator has the right to deny benefits for any type of therapy, service, or supply for the treatment of a condition that ceases to be therapeutic treatment and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or reoccurring.
- Radiation therapy
- Reconstructive procedures—services are considered reconstructive procedures when a physical impairment exists and the primary purpose of the procedure is to improve or restore physiologic function for an organ or body part to make it work better. An example of reconstructive procedure is surgery on the inside of the nose so that a person's breathing can be improved or restored.

  Cosmetic surgery is covered only for the following situations:
  - Repair of injuries caused by an accident
  - Surgical correction of a congenital birth defect in a child
  - Reconstructive breast surgery following mastectomy
  - Removal of breast implants if the claims administrator deems it necessary

  Services are considered cosmetic procedures when they improve appearance without making an organ or body part work better.

  The fact that a person may suffer psychological consequences from the impairment does not classify a procedure as a reconstructive procedure. (Reshaping a nose with a prominent "bump" is an example of a cosmetic procedure because it improves appearance without affecting a function like breathing.) This plan does not provide benefits for cosmetic procedures.

  Some services are considered cosmetic in some circumstances and reconstructive in others. (An example is upper eyelid surgery. At times, this procedure will improve vision, while at other times, it only improves appearance.)
- Respiratory therapy—see Pulmonary therapy
- Second surgical opinions
- Short-term rehabilitation therapy—Benefits can be denied or shortened for covered persons who are not progressing in goal-directed rehabilitation or if rehabilitation goals have been previously met.
- Skilled nursing and rehabilitation—at an in-network skilled nursing facility or long-term rehabilitation facility up to 60 days per year. Services are covered only for care related to the injury or illness for which you are confined.
- Sleep disorders—therapy to treat sleep apnea or narcolepsy
- Specialist office visit

- Speech therapy—up to 60 (combined with physical therapy and occupational therapy) outpatient visits per calendar year; covered only when the speech impediment or speech dysfunction results from injury, sickness, cancer, autism spectrum disorder, stroke or congenital anomaly, or is required following the placement of a cochlear implant. Learning disabilities and developmental delays are excluded.

  Services must be performed by a licensed therapy provider under the direction of a physician. Benefits are available only for rehabilitation services that are expected to result in significant physical improvement in the patient's condition within two months of the start of treatment (except autism). In addition, the claims administrator has the right to deny benefits for any type of therapy, service, or supply for the treatment of a condition that ceases to be therapeutic treatment and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or reoccurring.
- Sterilization—voluntary vasectomy or tubal ligation; does not cover sterilization reversal
- Substance abuse treatment—inpatient treatment will be permitted if it meets the definition of a covered health service, but is subject to the same coverage and limitations as inpatient care.

  Any inpatient admission for mental health or substance abuse treatment that occurs more that 48 hours following discharge for treatment is considered an additional admission. This applies regardless of whether the covered person's discharge is against medical advice. Residential treatment for mental health care and substance abuse will be covered if medically necessary, subject to the same coverage and limitations as inpatient care.
- Support garments—covered if the claims administrator determines them to be necessary, subject to limitations (see page 30 for disposable or consumable medical supplies)
- Surgeon's services—includes assistant surgeon charges
- Temporomandibular joint syndrome (TMJ) treatment—covered for diagnostic and surgical treatment of conditions affecting the temporomandibular joint when provided by or under the direction of physician. Coverage includes necessary diagnostic or surgical treatment required as a result of accident, trauma, congenital defect, developmental defect, or pathology. Dental services, including appliances and orthodontic treatment, are not covered in any situation. The following charges are covered:
  - Arthrocentesis for the treatment of documented, symptomatic degenerative joint disease, osteoarthritis or documented, intracapsular soft tissue abnormalities (such as disc displacement or adhesions).
  - Arthroplasty for the treatment of documented symptomatic osteophytes affecting the temporomandibular joint or documented symptomatic intracapsular soft tissue abnormality (such as disc displacement or adhesions)
  - Arthrotomy for the treatment of intracapsular soft tissue abnormality (such as disc replacement or adhesions).

  However, arthroscopy is not covered for treatment of TMJ because of inadequate clinical evidence of its safety and/or efficacy in published, peer-reviewed medical literature.
- Termination of pregnancy—only if it meets the definition of a covered health service
- Transplants—non-experimental human organ and tissue transplants covered only at facilities approved in advance by UHC; prior notification is required; includes donor's expenses to the extent they are not covered by donor's own medical benefits

  Covered organ transplant services include the recipient's medical, surgical, and hospital services; inpatient immunosuppressive medications; and costs for organ procurement:
  - Blood/marrow/stem cell
  - Cornea
  - Heart
  - Heart/lung
  - Intestine
  - Kidney
  - Kidney/pancreas
  - Kidney/liver
  - Liver
  - Liver/intestine
  - Lung
  - Pancreas.

  Coverage for organ procurement costs will be limited to costs directly related to procurement of an organ from a cadaver or a live donor and will consist of surgery necessary for organ removal, organ transportation, and the transportation, hospitalization, and surgery of a live donor.

  Compatibility testing undertaken before procurement is covered if UHC considers it to be an eligible expense; the amount payable for donor's medical costs will be reduced by the amount payable for those costs from any other plan; certain transplants are not covered, see Excluded Medical Expenses.

  If you are the recipient, your covered health services will include:
  - The expenses (based on URN contracted rates) incurred to secure the organ or tissue directly from a cadaver or through an organ bank, and
  - The medical expenses incurred by a living donor, but only if they are not covered by the donor's own plan of benefits

  If you are the donor, your covered health services will include the medical expenses that you incur to donate the organ or tissue.
- Urgent care clinic or center

- Vision care—examinations by a licensed ophthalmologist or optometrist and glasses, including frames and one set of lenses (including contacts) within 12 months of cataract surgery; limited to one diabetic retinal exam annually; does not include routine examinations required by an employer in connection with your employment
- Well-baby care and immunizations —covered at 100%; no coverage for out-of-network providers
- Wigs—for hair loss following chemotherapy
- X-rays—the use of X-ray, radium, or radioactive isotopes and laboratory services to diagnose or treat an injury or illness

Excluded Medical Expenses

To provide adequate medical coverage and control costs, the medical plan sets reasonable limits on the benefits for certain types of services and supplies. Benefits are not payable for services that the claims administrator determines do not meet the definition of a covered health service (see page 162). In making a determination, the claims administrator considers the condition and overall health of the patient. The following services are excluded under the medical plan:

- Alternative medicine treatments—herbal, holistic and homeopathic medicine, aromatherapy, rolfing, acupressure and other forms, as defined by the office of Alternative Medicine of the National Institute of Health
- Behavior training
- Biofeedback therapy
- Breast implant replacement—if the earlier breast implant was performed as a cosmetic procedure
- Charges incurred before you were covered
- Chelation therapy—covered only to treat heavy metal poisoning
- Claim forms—the plans will not pay the cost for anyone to complete your claim form.
- Cosmetic treatment or drugs—treatments or drugs solely for cosmetic purposes (hair loss, acne scars, liposuction, and sclerotherapy) including pharmacological regimens, nutritional procedures and treatments, scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery or other skin abrasion procedures) skin abrasion procedures performed as a treatment for acne
- Custodial care and convenience items—such as incontinence briefs, liners, diapers when used for custodial purposes, beauty/barber shop
- Dental care/oral surgery—except as specifically described as a covered expense on pages 29 – 30. Treatment of congenitally missing, malpositioned, or supernumerary teeth is not covered, even if part of a congenital anomaly. Also excluded are extraction, restoration, replacement, medical or surgical treatment of dental conditions and services to improve dental outcomes, dental implants, dental braces, dental x-rays, supplies and appliances, and all associated expenses, including hospitalization and anesthesia (except for transplant preparation, initiation of immunosuppressives, the direct treatment of acute traumatic injury, cancer or cleft palate), and fluoride preparations.
- Developmental therapy for children
- Disposable or consumable supplies—including orthotic devices for feet
- Duplicate coverage—dependent's expenses if he or she is receiving benefits for the same expenses as a covered employee
- Educational testing or training—testing or training that does not diagnose or treat a medical condition includes learning disabilities and treatment for hyperkinetic syndrome, except ADD or ADHD
- Ecological and environmental medicine
- Emergency room visits for non-emergencies
- Experimental, unproven, or investigational treatment—any medical treatment, service, device, drug, or supply that is regarded by the claims administrator as experimental or any research studies or any service or supply not considered legal in the U.S.
- Eye care—surgical procedure for the correction of a visual refractive problem, including radial keratotomy or LASIK; the purchase or fitting of eyeglasses or contact lenses, except the first pair prescribed and purchased within 12 months following cataract surgery
- Fetal reduction surgery
- Fluoride preparations

- Foot care—manipulative procedures for weak or fallen arches, flat or pronated foot, foot strain, orthopedic shoes, support devices and orthotics; callus or corn paring or excision, toenail trimming, hygienic and preventive maintenance, including cleaning and soaking feet, applying creams to maintain skin tone, or any other service not performed to treat a localized illness, injury or symptom involving the foot, treatment of subluxation of the foot
- Foreign care—health services provided in a foreign country, unless required in an emergency
- Free care or treatment—care, treatment, services, or supplies for which payment is not legally required or which the provider offers to waive
- Government-paid care—care, treatment, services, or supplies provided or paid for by any governmental plan or law when the coverage is not restricted to the government's civilian employees and their dependents (this exclusion does not apply to Medicare or Medicaid)
- Grandchildren—medical expenses of an employee's grandchild (the child of an employee's unmarried dependent child) after 31 days following birth, unless the employee's grandchild meets the eligibility requirements described on page 6
- Gynecomastia—treatment of benign gynecomastia (abnormal breast enlargement in males)
- Home health care—services and supplies not included in the home health care plan recommended by the attending physician; services of your close relative or a person who ordinarily resides in your home; services of any social worker unless designated C.S.W.A.C.P; transportation, custodial care, housekeeping
- Hospice—services or supplies not included in the hospice care program; services of a close relative or a person who ordinarily resides in your home; curative or life-prolonging procedures; for any period not under the care of a physician
- Hospitalization primarily for X-rays, laboratory, diagnostic study, physiotherapy, hydrotherapy, medical observation, convalescent or rest care, or any medical examination or test not connected with an illness or injury; admissions on a Friday, Saturday, or Sunday unless surgery is performed within 24 hours
- Hypnotherapy
- Immunization agents—prescriptions for immunization agents, biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions and medications used for travel prophylaxis
- Infertility treatment—includes in-vitro fertilization, artificial insemination, gamete intra-fallopian transfer (GIFT), zygote intra-fallopian transfer (ZIFT), or any other procedure or drug intended to increase fertility
- IQ testing
- Jawbone surgery—upper or lower jawbone surgery except as required for direct treatment of acute traumatic injury or cancer
- Liposuction
- Maintenance care
- Marriage counseling
- Massage therapy—massage and soft-tissue therapy, regardless of who performs the service
- Medical records—charges for requests of medical records
- Mental Health or Substance Abuse:
  - Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association
  - Services for mental health or substance abuse that extend beyond the period necessary for short-term evaluation, diagnosis, treatment or crisis intervention
  - Treatment for insomnia, dementia, neurological disorders, and other disorders with a known physical basis
  - Treatment for conduct and impulse control disorders, personality disorders, paraphilias and other mental illnesses that will not substantially improve beyond the current level of functioning or that are not subject to favorable modification or management according to prevailing national standards of clinical practice, as reasonably determined by United Behavioral Health, the company that administers mental health/substance abuse benefits under the Total Health Medical Plan
  - Services utilizing methadone treatment as maintenance, L.A.A.M. (L-Alpha-Acctyl-Methadol), Cyclazocine, or their equivalent
  - Treatment provided in connection with or to comply with involuntary commitments, police detentions, or other similar arrangements, unless authorized by United Behavioral Health
  - Residential treatment services
- Military service—illness or injury received while serving in the armed forces of any country
- Missed or broken appointments—charges for missing an appointment with a health care provider
- Naturopath
- Nonmedical facility—charges for education, training, or bed and board while confined in an institution that is mainly a school or other institution for training or a place of rest, a place for the aged, or a nursing home
- Nursing care, as it relates to:
  - Care, treatment, services, or supplies that do not require the skills and training of a nurse
  - A nurse who is a close relative (spouse, child, parent, brother, sister, in-law) or lives in the same household

- Nutritional therapy and supplements—megavitamin and nutrition-based therapy, nutritional counseling for individuals or groups, including weight loss programs, health clubs, and spa programs, enteral feeding and other nutritional and electrolyte supplements, including infant formula, donor breast milk, dietary supplements, electrolyte supplements, diets for weight control or treatment of obesity (including liquid diets and food), food of any kind (diabetic, low fat, low cholesterol), oral vitamins and/or minerals, except when the sole source of nutrition or when certain nutritional formula is used to treat a specific inborn error of metabolism
- Organ donation—expenses incurred as an organ donor by a non-Texas Health member
- Organ transplants—experimental transplants; artificial organ transplants; cross-species organ transplants; organ donor costs not directly related to organ procurement; transplants performed at a facility not approved by UHC
- Orthognathic surgery—not covered for the following conditions:
  - Myofascial, neck, head, and shoulder pain
  - Irritation of the head or neck muscles
  - Popping or clicking of the temporomandibular joints
  - Potential for development or exacerbation of TMJ
  - Teeth grinding

  Treatment of malocclusion is dental and, therefore, not a covered medical service.
- Over-the-counter medications or supplies—see page 165
- Penile prostheses
- Personal comfort items, such as charges for hospital television or telephone use
- Pharmacological regimens, nutritional procedures or treatments
- Physical conditioning—programs such as athletic training, bodybuilding, exercise, fitness, flexibility, diversion, general motivation, or any therapy to improve general physical condition
- Physical examinations not required for health reasons—including employment, insurance, government license, court-ordered, forensic, or custodial evaluations
- Physician fees for any treatment not rendered by or provided under the supervision of a physician
- Prescription drugs—covered through a separate prescription drug plan as explained on page 39
- Private-duty nursing
- Prostheses—replacement for theft or loss, wear and tear, destruction, or any biomechanical external prosthetic device
- Providers—services provided at free-standing or hospital-based diagnostic facility without a written order by a physician or other provider; services that are self-directed to a free-standing or hospital-based diagnostic facility, services ordered by a physician or other provider who was not actively involved in your medical care before ordering the service, or is not actively involved in your medical care after the service is received. This exclusion does not apply to mammography.
- Relatives—treatment by a medical practitioner (including but not limited to: a nurse, physician, physiotherapist or speech therapist) who is a close relative (spouse, child, brother, sister, parent, or grandparent of you or your spouse, including in-law and step relatives) or by a person who lives in the same household as the covered person
- Reproduction—surrogate parenting, fees or direct payments to a donor or doctor for sperm or ovum donations, fees for maintenance or storage of frozen embryos (sperm or egg), health services and associated expenses for elective abortion, contraceptive supplies and services
- Reversal of sterilization or any form of contraception not specifically covered
- Safety items—devices used specifically as safety items or to affect performance in sports-related activities
- Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other skin abrasion procedures)
- Sex changes or transsexual and related operations and hormone therapies
- Sex-determination testing—amniocentesis, ultrasound, or any other procedures requested solely for sex determination of a fetus, unless it meets medical criteria to determine the existence of a sex-linked genetic disorder
- Sexual dysfunctions, deviations or disorders—all drugs and treatment are excluded (except limited drugs for erectile dysfunction)
- Skin abrasion procedures performed as a treatment for acne
- Sleep therapy—medical and surgical treatment for snoring is not covered, except when provided as part of treatment for documented obstructive sleep apnea; appliances for snoring are not covered
- Smoking cessation aids—except for those covered by the wellness program as described on page 57
- Speech therapy—except as required for treatment of a speech impediment or speech dysfunction that results from injury, stroke, or congenital anomaly. Not covered if:
  - Considered custodial and educational
  - Therapy to improve speech skills not fully developed (non-restorative)
  - To maintain speech communication or
  - To treat stuttering, stammering, or other articulation disorders
- Termination of pregnancy—if elective abortion
- Therapeutic devices
- Travel or transportation expenses—even if prescribed by a physician. Some travel expenses related to covered services may be reimbursed at the discretion of Texas Health.

- War-related—services or supplies received as a result of a declared or undeclared war or caused during service in armed forces of any country
- Weight reduction—except for the diagnosis of morbid obesity, which is specifically covered by the plan
- Wellness items—items that promote well-being and are not medical in nature, such as massage therapy, dehumidifiers, air filtering systems, air conditioners, bicycles, exercise equipment, whirlpool spas, and health club memberships
- Work-related—treatment or drug for any illness or injury that occurs during or as a result of work for pay or profit, or for which the covered person is entitled to benefits under any worker's compensation or occupational disease law or any such similar law

In addition to the items above, the plan will not cover the following:

- Charges incurred before the effective date of coverage or after coverage is terminated
- Charges for services or supplies that the claims administrator does not consider a covered health service
- Charges for routine exams and immunizations, except those listed as covered expenses
- Charges that others are responsible for paying
- Expenses covered by a mandatory auto insurance policy written to comply with a "no-fault" or uninsured-motorist insurance law
- Expenses for treatment provided or paid for by the government, unless the Total Health Medical Plan is required to pay first
- Charges resulting from or occurring during the commission of a crime or while engaged in an illegal act, illegal occupation or aggravated assault unless injuries result from a medical condition or domestic violence
- Charges in connection with any cosmetic surgery or treatment, unless specifically listed under covered expenses

Coordination of Benefits

Your medical plan is designed to integrate benefits with other group or individual plans or policies or government programs, including Medicare. If you are eligible, either as the insured or a dependent, to receive medical benefits from another plan (including automobile insurance) or government program, the total benefits you are eligible to receive from all plans will not be more than the benefits that would be payable from the Total Health Medical Plan if you had no other coverage. This applies whether or not you file a claim under the other plan. If needed, you must authorize the claims administrator to get information from the other plans.

If you are covered by two medical plans, one of the plans will be primary and the other will be secondary. The primary plan pays benefits first. The following criteria determine which plan is primary:

- A plan without a coordinating provision is always the primary plan.
- If all plans have a coordinating provision, the plan covering you directly (rather than as a spouse or dependent) is primary.
- If a child is covered by both parents' plans, the plan of the parent whose birth date falls first in the calendar year is primary. If the birth dates are the same, the plan of the parent who has been covered under the plan the longest is primary. If the other plan does not have these requirements, the other plan will be primary.

If your child is covered and you are divorced, then the plan of the parent with custody pays first, unless a court order or decree specifies the other parent's plan pays first. The plan of a step-parent with whom the child lives pays second (if applicable).

If payments should have been made under this plan but have been made under any other plan, the claims administrator has the right, in its sole discretion, to pay to any insurance company or other organization or person making such other payments any amounts it determines and to the extent of such payments, Texas Health and the plan will be fully discharged from liability. The benefits that are payable will be charged against any applicable maximum payment or benefit of this plan rather than the amount payable in the absence of this provision.

If you are enrolled in both the medical and dental plans and need treatment that both plans will cover, the medical plan pays first. The dental plan pays second, but only if it covers the same service.

If you or a dependent has active medical coverage through Texas Health and is covered under Medicare, your Texas Health coverage is primary and your Medicare is secondary.

Prescription Drug Benefits

The Total Health Medical Plan offers two prescription drug options—a High Rx and a Low Rx program (see page 23 for details). Both are administered by Caremark and include a list of cost-effective generic and preferred drugs.

Your cost for prescription drugs depends on which option you choose and whether the medication is generic, preferred, or non-preferred. When possible, you may substitute a less expensive generic drug for a preferred or non-preferred drug and pay a lower copay. If the prescribing physician specifies "dispense as written," you may not make a substitution and will have to pay the applicable copay.

The plan's minimum and maximum copays for preferred prescriptions and the out-of-pocket maximum keep your costs down by limiting the amount you must pay from your own pocket each time you fill a prescription. Generic copays apply toward the out-of-pocket prescription maximum. DAW penalties do not apply towards the out-of-pocket prescription maximum. This maximum is separate from the medical plan's out-of-pocket maximum.

Your annual out-of-pocket maximum is:

ABBR*	Out-of-pocket Maximum
Under $25,000	$1,000
Over $25,000	$2,000
*Annual Benefits Base Rate	

After the second time you fill a maintenance medication, you are required to have your maintenance medications filled with a 90-day prescription or you will be penalized by paying double the retail charge. You can get a 90-day supply at retail pharmacies located at Texas Health Dallas and Texas Health Plano, Caremark mail order, or any CVS pharmacy.

IF YOU have diabetes, you are eligible for free test strips when you receive regular follow-up with a diabetes educator at a Texas Health facility.

Maintenance medications are those medications that your physician prescribes for chronic or long-term conditions (such as diabetes, high blood pressure, heart conditions, allergies, thyroid conditions, etc.). If you are not sure if the prescription is for a chronic condition, please check with your pharmacist.

PREVENTIVE DRUGS

The Total Health Medical Plan Benefits covers preventive care medications at no cost to you. Preventive care medications are medications for which a prescription from a physician is required under any of the following:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; or
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

To find out whether a medication is considered to be a preventive care medication, sign in or register at **www.caremark.com** and use the Check Drug Coverage and Cost tool or call 1-877-797-9847.

NON-USE OF GENERICS

If a generic drug is available and you elect or your doctor prescribes a preferred or non-preferred drug, you will pay a higher copay plus a "dispense as written (DAW) penalty"—which is the difference in cost between the preferred or non-preferred and generic drug. Certain prescriptions may require preauthorization.

In order to have coverage for prescriptions drugs in certain drug classes, you must try a generic drug first. If you try (or have tried) a generic drug and it does not work for you, then you may receive coverage for a brand-name drug. However, if you choose to use a brand-name drug without trying a generic first or without getting prior approval, coverage may be denied.

The following drug classes require use of the generic step therapy program: ulcer, cholesterol, hypertension, urinary, asthma, osteoarthritis, sleep aids, anti-inflammatory, migraines, and allergy. Contact Caremark at 1-877-MyTHRLink (1-877-698-4754), prompt 3 for more information.

CAREMARK RESOURCES

It is important to understand your pharmacy benefit options so you can make informed and cost-effective decisions about your care. To give you access to the most up-to-date information Caremark provides a tool called "Check Drug Costs" on **www.caremark.com**. "Check Drug Costs" is a tool that you can use to learn about your options for prescription medications.

Before you fill a prescription, check to be sure the medication is on the formulary list. Caremark updates the formulary list each quarter. You can view the formulary list online at **www.caremark.com**.

COVERED DRUGS

Drugs that are covered include:

- Birth control, oral contraceptives, and contraceptive devices (IUD or diaphragm) and implants (Norplant)
- Compounded medication of which at least one ingredient is a prescription legend drug
- Disposable insulin needles/syringes by prescription
- Drugs that may only be dispensed upon the written prescription of a physician or other lawful qualified prescriber under the applicable state law
- Glucose test strips and lancets
- Growth hormones and releasing agents, subject to Caremark's guidelines
- Insulin by prescription
- Prenatal vitamins prescribed by a physician
- Prescription drugs and generic drugs, except those drugs listed in the exclusions
- Smoking cessation drugs covered by the wellness program
- Tretinoin, all dosage forms (for example, Retin-A), for individuals age 29 and under

DRUGS NOT COVERED

Drugs that are not covered are:

- Charges for the administration or injection of any drug are not paid as part of the drug benefits
- Charges incurred before a person was covered
- Dental drugs
- DESI drugs (drugs determined by the FDA as lacking substantial efficacy)
- Drugs labeled "Caution-limited by federal law to investigational use," or experimental drugs, even though a charge is made to the covered person
- Drugs newly approved by the FDA, prior to review by the applicable Pharmacy and Therapeutics Committee
- Hair replacement drugs for treatment of alopecia (hair loss) including Minoxidil (Rogaine) and Propecia are not covered unless the hair loss is a result of chemotherapy.
- Hematinics, except Epogen or Procrit
- Immunization agents, biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions and medications used for travel prophylaxis
- Infertility drugs
- Medication to be taken or administered, in whole or in part, while a patient is in a licensed hospital, rest home, sanitarium, extended care facility, convalescent hospital, skilled nursing facility, or similar institution that operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals
- Medications to enhance athletic performance
- Mineral supplements, except folic acid
- Obesity drugs
- Over-the-counter medicines and supplies—that do not require a physician's prescription and may be obtained over-the-counter, regardless of whether a physician has written a prescription for the item are not covered except for diabetic supplies and prenatal vitamins
- Prescription and nonprescription supplies, devices, and appliances other than syringes used in conjunction with injectable medications
- Prescription drugs or medications used for treatment of sexual dysfunction, including but not limited to erectile dysfunction, delayed ejaculation, anorgasmia and decreased libido; however, up to six pills a month are covered for drugs to treat erectile dysfunction
- Prescription drugs provided free of charge from local, state, or federal programs
- Prescription drugs used for cosmetic purposes such as: drugs used to reduce wrinkles, drugs to promote hair growth, drugs used to control perspiration and fade cream products
- Prescriptions provided without charge under a worker's compensation program
- Prescription vitamins (other than prenatal vitamins), dietary supplements and fluoride products
- Replacement of lost or stolen prescriptions
- Smoking-deterrent medications containing nicotine or any other smoking-cessation aids, all dosage forms (such as Nicorette, Nicoderm, etc.) except as covered under the Tobacco Cessation program described beginning on page 57
- Therapeutic devices or appliances, including needles, syringes, support garments (unless they are a covered health service, as defined on page 162), and other nonmedical substances, regardless of intended use, are not covered unless specifically listed as covered items.

SPECIALTY MEDICATIONS

If you take a specialty medication for a chronic condition such as rheumatoid arthritis or hemophilia, you may be directed to a designated pharmacy to obtain those medications. If you choose not to obtain your specialty medications from a designated pharmacy, no benefits will be paid and you will be responsible for paying the full cost of your specialty medication.

MAIL ORDER

Caremark has its own mail order service. Please refer to your Caremark packet for your mail order prescription form, mailing address and phone number. You may also get information and forms online at **www.caremark.com**. Mail order prescriptions are normally filled and mailed within two weeks following receipt of the prescription.

NEW PRESCRIPTIONS

If your physician gives you a new prescription for a maintenance medication, you should ask him or her for a 30-day prescription that you can fill immediately and a 90-day prescription that you can fill for ongoing use.

Take the 30-day prescription to your local pharmacy to be filled. Then order a 90-day supply of your prescription at the retail pharmacy at Texas Health Presbyterian Hospitals at Dallas and Plano, through Caremark mail order or at any CVS pharmacy.

If you are currently taking maintenance medications, contact your physician and ask for a 90-day prescription.

Filing and Appealing Claims

Benefits under the medical plan are self-funded, which means all claims are paid from employee payroll deductions and Texas Health's general assets. UHC and Caremark provide claims services, but do not insure the plan.

CLAIMS

UHC is the claims processor for the medical plan options. The following summarizes how to file claims under UHC Choice and Choice Plus Plans.

Whenever you file a claim, be sure to keep a copy of the claim and any other information (such as itemized bills) that you include with the claim.

Network Providers

When you use network providers, you do not need to file claims. The provider will file the claim with UHC. For network benefits, if there is any difference between the eligible expenses and the amount the provider bills, you are not responsible for paying the difference unless you agreed to reimburse the provider for such services.

Out-of-network Providers

Out-of-network care is generally not covered under the UHC Choice Plan. When you use out-of-network providers under the Choice Plus Plan, you must file a claim for reimbursement as follows:

- Complete a medical claim form (available on the Internet at **www.myuhc.com**) each time you receive medical services. Be sure to follow the instructions on the form.
- Submit all itemized receipts from your physician or other health care provider. A canceled check is not acceptable documentation.
- Mail the completed claim form with the original itemized bills and receipts to UHC at the address on the claim form.

You must submit the original itemized bill or receipt provided by your physician, hospital, or other medical service provider, so you should make copies for your own records. Photocopies of receipts are not accepted for claims. In addition, each bill or receipt must include the following:

- Name of patient
- Date the treatment or service was provided
- Diagnosis of the injury or illness for which treatment or service was given
- Itemized charges for the treatment or service
- Provider's name, address, and tax ID number

Most medical claims payments are sent to you along with an explanation of benefits (EOB) explaining the amount paid. In some cases, payments may be sent directly to your physician, hospital, or other medical provider if your provider accepts assignment of benefits (as defined on page 161). In this case, the EOB will be mailed to you and the payment mailed to your provider. For out-of-network benefits, you are responsible for directly paying to the out-of-network provider any difference between the amount the provider bills you and the amount UHC considers as the eligible expense.

Prescription Drugs

You do not need to file claims for prescriptions purchased through network providers. You pay a copay or coinsurance when you present your Caremark member ID card at a network pharmacy or when you use the mail-order prescription program. You may also use your Caremark member ID card at out-of-network pharmacies.

NOTICE AND PROOF OF CLAIM

You or your primary physician should file notice and proof of a claim on the proper claim form with the claims administrator as soon as possible after the claim is incurred and within the time frames described in this section. The claim must be filed as soon as possible and in no event (except in the case of your legal incapacity) later than December 31 following the plan year in which the claim was incurred. For example, if a claim is incurred July 2013 you have until December 31, 2014 to submit the claim.

If there is a change in claims administrator, all claims incurred before the change in vendor must be received by the old claims administrator by December 31 following the end of the year.

If the plan is terminated, all claims incurred before the plan termination must be received within 30 days after the plan's termination or the claims will not be paid. Any claims incurred after termination of plan coverage for any reason are not covered under the plan.

Each claim will be adjudicated (processed) in a way that ensures that the people involved in making the decisions act independently and impartially. For this reason, decisions regarding hiring, compensation, termination, promotion, or other similar matters related to the individual who is designated as the fiduciary for an internal appeal, or any health care professional or other medical or vocational expert involved in the claim or internal appeal, will not be based on the likelihood that the individual will support a denial of benefits.

TYPES OF CLAIMS

There are four different types of claims. The claim type is determined initially when the claim is filed. If the nature of the claim changes as it proceeds through claims processing, the claim may be re-characterized. For example, a claim may initially be an urgent care claim. If the urgency subsides, it may be re-characterized as a pre-service claim.

Pre-service Claims

On receipt of a pre-service claim, the claims administrator will determine whether or not it involves urgent care. If a physician with knowledge of your medical condition determines that a claim involves urgent care, the claim will be treated as an urgent care claim.

A claim is a pre-service claim if all or part of your right to the benefit is conditioned on receiving approval before obtaining the medical care (such as preauthorization). This does not apply to a claim involving urgent care, as defined below.

Urgent Care Claims

An urgent care claim is any pre-service claim for medical care or treatment when time periods that otherwise apply to pre-service claims could seriously jeopardize your life, health, or ability to regain maximum function or would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Post-service Claims

A post-service claim is any claim for a benefit that is not a pre-service claim or an urgent care claim.

Concurrent Care Claims

A concurrent care claim is one in which the claims administrator approves a course of treatment over a period of time or for a specified number of treatments. However, a concurrent care claim may be reconsidered by the claims administrator and the initially approved period of time or number of treatments may be either reduced, terminated, or extended.

If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an urgent care claim as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. The claims administrator will make a determination on your request for the extended treatment within 24 hours from receipt of your request.

If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new request and decided according to post-service or pre-service time frames, whichever applies.

If your request for extended treatment is not made at least 24 hours before the end of the approved treatment, the request will be treated as an urgent care claim and decided according to the time frames described on this page and the next. If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new claim and decided according to post-service or pre-service time frames, whichever applies.

CLAIM AND APPEAL TIME FRAME

Urgent Care Claims [1]

Action	Timing
If your claim is incomplete	
UHC must notify you within:	24 hours
You must then provide completed claim information to UHC within:	48 hours after receiving notice
Notification of Determination	
UHC must notify you of the benefit determination: • If the initial claim is complete, within: • After receiving the completed claim (if the initial claim is incomplete), within:	 72 hours 48 hours
You must appeal a claim denial no later than:	180 days after receiving the denial
UHC must notify you of the appeal decision within:	72 hours after receiving the appeal

[1] You do not need to submit urgent care claims in writing. You should call UHC as soon as possible to appeal an urgent care claim.

Pre-Service Claims

Action	Timing
If your claim is filed improperly	
UHC must notify you within:	5 days
If your claim is incomplete	
UHC must notify you within:	15 days
You must then provide completed claim information to UHC within:	45 days after receiving an extension notice [1]
If UHC denies your initial claim	
UHC must notify you of the denial: • If the initial claim is complete, within: • After receiving the completed claim (if the initial claim is incomplete), within:	 15 days 15 days
You must appeal the claim denial no later than:	180 days after receiving the denial
UHC must notify you of the first level appeal decision within:	15 days after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	60 days after receiving the first level appeal decision
UHC must notify you of the second level appeal decision within:	15 days after receiving the second level appeal [2]

[2] UHC may require a one-time extension of no more than 15 days only if more time is needed due to circumstances beyond their control.

Post-Service Claims

Action	Timing
If your claim is incomplete	
UHC must notify you within:	30 days
You must then provide completed claim information to UHC within:	45 days after receiving an extension notice [2]
If UHC denies your initial claim	
UHC must notify you of the denial: • If the initial claim is complete, within: • After receiving the completed claim (if the initial claim is incomplete), within:	 30 days 30 days
You must appeal the claim denial no later than:	180 days after receiving the denial
UHC must notify you of the first level appeal decision within:	30 days after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	60 days after receiving the first level appeal decision
UHC must notify you of the second level appeal decision within:	30 days after receiving the second level appeal [3]

[3] UHC may require a one-time extension of no more than 15 days only if more time is needed due to circumstances beyond their control.

HOW TO FILE A CLAIM FOR BENEFITS

Except for urgent care claims, a claim for benefits is made when you (or your authorized representative) submit a written claim form as follows.

Medical claims administrator:
UnitedHealthcare
P.O. Box 30555
Salt Lake City, UT 84130-0555
www.uhc.com

Prescription claims administrator:
Caremark Claims Department
P.O. Box 686005
San Antonio, TX 78268-6005
www.caremark.com

You can request a claim form from the claims administrator for your plan. A claim form is considered to be received by the plan on the date it is delivered to the applicable address shown above or the date that it is deposited in the U.S. Mail for first-class delivery in a properly stamped envelope containing the above name and address. The postmark will be proof of the date of mailing.

Because of the expedited time frames for a decision regarding urgent care claims, an urgent care claim may be submitted to the claims administrator at the telephone number on your ID card. The claim should include at least the following information:

- Your name
- A specific medical condition or symptom
- A specific treatment, service, or product for which approval or payment is requested.

These claims procedures do not apply to any request for benefits that is not made according to these claims procedures, except that:

- In the case of an incorrectly filed pre-service claim, you should be notified as soon as possible but no later than five days after the claims administrator receives the incorrectly filed claim and
- In the case of an incorrectly filed urgent care claim, you should be notified as soon as possible, but no later than 24 hours after the claims administrator receives the incorrectly filed claim. The notice will explain that the request is not a claim and describe the proper procedures for filing a claim. The notice may be oral unless you specifically request written notice.

TIME FRAME FOR DECIDING INITIAL BENEFIT CLAIMS

The claims administrator will decide an initial pre-service claim and notify you within a reasonable time appropriate to the medical circumstances, but no later than 15 days after receipt of the claim.

The plan will decide an initial urgent care claim as soon as possible, taking into account the medical urgency and notify you of the determination, whether or not adverse, but no later than 72 hours after the claim is received.

If a claim is a request to extend a concurrent care decision involving urgent care and it is made at least 24 hours before the end of the initially approved time period or number of treatments, the claim will be decided within no more than 24 hours after the claim is received. Any other request to extend a concurrent care decision will be decided within the applicable time frames for pre-service, urgent care, or post-service claims.

If the claims administrator notifies you that an initially approved course of treatment will be reduced or terminated, the notice will be provided sufficiently in advance of the reduction or termination to allow you to appeal the adverse decision and receive a decision on review under these procedures before the reduction or termination. In the meantime, to the extent required by applicable law, the plan will continue to provide coverage to you with respect to ongoing course of treatment pending the outcome of the internal appeal.

The claims administrator will decide and notify you of an initial post-service claim within a reasonable time but no later than 30 days after receiving the claim.

You may agree to voluntarily extend the above time frames. If the claims administrator is not able to decide a pre-service or post-service claim within the above time frames for reasons beyond its control, one 15-day extension of the applicable time frame is permitted, provided that you are notified in writing before the end of the initial time frame for the claim. The extension notice will include a description of the reasons beyond the plan's control that justify the extension and the date by which a decision is expected. No extension is permitted for urgent care claims.

If any information needed to process a claim is missing, the claim will be treated as incomplete.

If an urgent care claim is incomplete, the claims administrator will notify you as soon as possible, but no later than 24 hours following receipt of the incomplete claim. The notification may be made orally to you, unless you request written notice. It will describe the information necessary to complete the claim and will specify a reasonable time, no less than 48 hours, within which the claim must be completed.

The claims administrator will decide the claim as soon as possible, but not later than 48 hours after the earlier of:

- Receipt of the specified information or
- The end of the period of time provided to submit the specified information.

If a pre-service or post-service claim is incomplete, the claims administrator may deny the claim or may take an extension of time, as described above.

If the claims administrator takes an extension of time, the extension notice will include a description of the missing information and specify a time frame, no less than 45 days, in which the necessary information must be provided.

The time frame for deciding the claim will be suspended from the date you receive the extension notice until the date the missing information is provided to the claims administrator. If the requested information is provided, the plan will decide the claim within the period specified in the extension notice. If the requested information is not provided within the time specified, the claim may be decided without that information.

NOTIFICATION OF INITIAL BENEFIT DECISION BY THE PLAN

Written or electronic notification of the claims administrator's decision on a pre-service or urgent care claim will be provided to you, whether or not the decision is adverse. A decision is adverse if it is a denial, reduction, or termination of a benefit, a failure to provide or make payment in whole or in part, or a rescission of coverage. A rescission of coverage is any retroactive termination of your coverage, except where you perform an act of fraud or make or make an intentional misrepresentation of a material fact. Retroactive termination of your coverage for failure to make timely payment of your premiums or contributions toward the cost of coverage is not a rescission.

Any new or additional evidence that was considered, relied upon, or generated in connection with the claim will be provided to you at no cost and in advance of the date of the notice of adverse benefit determination.

You will receive written or electronic notification of the adverse decision. The notice will be written so you can understand it, will be made in a culturally and linguistically appropriate manner, and will include the following:

- Information sufficient to identify the claim involved, including the date of service, the health care provider, the claim amount (if applicable) and either the diagnosis code and its corresponding meaning and the treatment code and its corresponding meaning or a statement describing your opportunity to receive as soon as practical upon request the diagnosis and treatment codes (and their meanings)
- The specific reasons for the decision, 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
- References to the specific plan provisions on which the decision is based
- A description of any additional material or information necessary to perfect the claim and why such information is necessary
- A description of the plan procedures and time limits for appeal of the decision, the right to obtain information about those procedures, the right to sue in federal court and a description of the procedures to obtain an external review of the claim
- A statement disclosing any internal rule, guidelines, protocol or similar criterion that was used in making the adverse decision (or a statement that such information will be provided free of charge upon request) and
- If the decision involves scientific or clinical judgment, it will disclose either an explanation of the scientific or clinical judgment applying the terms of the plan to the covered person's medical circumstances or a statement that such explanation will be provided at no charge upon request.
- In the case of an adverse decision concerning an urgent care claim, a description of the expedited review process. Notification of the plan's adverse decision on an urgent care claim may be provided orally, but written or electronic notification will be furnished not later than three days after the oral notice.
- The availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Service Act to assist individuals with the claims and the plan's internal appeal processes and external review processes.

THE RIGHT TO INTERNAL APPEAL

You have the right to appeal an adverse decision under these claims procedures. Except for urgent care claims, discussed below, an appeal of an adverse benefit decision is filed when you (or your authorized representative) submit a written request (go to **www.myuhc.com** to print the member service request form for medical appeal) for review to your claims administrator:

UHC Appeals
P.O. Box 30432
Salt Lake City, UT 84130-0432

Caremark Appeals
Caremark, Inc.
Appeals Department
MC 109
P.O. Box 52084
Phoenix, AZ 85072-2084
Fax: (866) 689-3092

You should request a review in writing. A request for review will be treated as received by the plan on the date it is delivered to the applicable address listed above or on the date that it is deposited in the U.S. Mail for first-class delivery in a properly stamped envelope containing the above name and address. The postmark on any such envelope will be proof of the date of mailing.

You have the right to submit documents, written comments, or other information in support of an appeal. The claims administrator must provide you with any new or additional evidence considered, relied upon, or generated by the plan (or at the direction of the claims administrator or plan administrator) in connection with the claim and, if applicable, the rationale for the final internal adverse benefit determination based on such new or additional evidence.

The claims administrator or its delegate must provide this information as soon as possible and sufficiently in advance of the date on which the notice of final adverse benefit determination is required so you will have an opportunity to respond by, for example, presenting evidence and testimony, prior to that date.

The appeal of a denied pre-service request for benefits, post-service claim or a rescission of coverage must be filed with the claims administrator within 180 days after you receive the notification of adverse benefit decision.

This communication should include:

- The patient's name and ID number as shown on the ID Card;
- The provider's name;
- The date of medical service;
- The reason you disagree with the denial; and
- Any documentation or other written information to support your request.

However, an appeal of the plan's decision to reduce or terminate an initially approved course of treatment (see definition of concurrent care decision) must be filed within 30 days of your receipt of the notification of the plan's decision to reduce or terminate. Failure to comply with this important deadline may cause you to forfeit any right to any further review of an adverse decision under these procedures or in a court of law.

To initiate a pre-service urgent care appeal, call 1-877-MyTHRLink (1-877-698-4754) select prompt 2 and ask for Care Coordination. The claim should include at least the following information:

- Your name
- A specific medical condition or symptom
- A specific treatment, service, or product for which approval or payment is requested and
- Any reasons why the appeal should be processed on a more expedited basis.

HOW THE APPEAL WILL BE DECIDED

The appeal of an adverse benefit decision will be reviewed and decided by the claims administrator because they are the named fiduciary under the plan. The person who reviews and decides an appeal will be a different individual than the person who made the initial benefit decision and will not be a subordinate of the person who made the initial benefit decision. The claims administrator will follow these procedures when deciding any appeal.

The review by the claims administrator will take into account all information you submitted, whether or not it was presented or available at the initial benefit decision. The claims administrator will give no deference to the initial benefit decision.

In the case of a claim that was denied on the grounds of a medical judgment, the claims administrator will consult with a health professional with appropriate training and experience. The health care professional who is consulted on appeal will not be the same individual, if any, who was consulted regarding the initial benefit decision or a subordinate of that individual.

Upon your request and free of charge, you will have reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits. If the advice of a medical or vocational expert was obtained in connection with the initial benefit decision, the names of each expert will be provided on your request, regardless of whether the advice was relied on by the plan.

All necessary information in connection with an urgent care appeal will be transmitted between the plan and you by telephone, fax, or email.

TIME FRAMES FOR DECIDING BENEFITS APPEALS

The claims administrator will decide the appeal of a pre-service claim within a reasonable time appropriate to the medical circumstances, but no later than 30 days after receiving the request for review.

The claims administrator will decide the appeal of an urgent care claim as soon as possible, taking into account the urgent medical situation, but no later than 72 hours after the plan receives the request for review.

The claims administrator will decide the appeal of a post-service claim within a reasonable period, but no later than 60 days after receipt of the request for review.

The claims administrator will decide the appeal of a decision to reduce or terminate an initially approved course of treatment (under a concurrent care claim) before the proposed reduction or termination takes place.

The claims administrator will decide the appeal of a denied request to extend a concurrent care claim in the appeal time frame for pre-service, urgent care, or post-service claims described above, as appropriate to the request.

NOTIFICATION OF DECISION ON APPEAL

Written notification of the decision regarding an appeal will be provided to you whether or not the decision is adverse. A decision regarding an appeal is adverse if it is either:

- A denial, reduction, or termination of benefits or
- A failure to provide or make all or part of a payment for a benefit.

You will receive written notification of an adverse decision regarding an appeal. It will include the following information, written in a manner that you can understand, and in a culturally and linguistically appropriate manner according to applicable law:

- 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

- The specific reasons for the appeal decision, 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 and a discussion of the decision
- A reference to the specific plan provisions on which the decision is based
- A statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse decision (or a statement that such information will be provided free of charge on request)
- A statement of the right to sue in federal court and a description of the procedures to obtain an external review of the claim
- A statement indicating you are entitled to receive reasonable access to or copies of all documents, records or other information relevant to the determination (on request and without change) and
- If the decision involves scientific or clinical judgment, either an explanation of the scientific or clinical judgment applying the terms of the plan to your medical circumstance or a statement that such explanation will be provided at no charge on request.
- The availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Service Act to assist individuals with the claims and plan's external review process.

Notification of an adverse decision regarding an appeal of an urgent care claim may be provided verbally, but written notification will be furnished not later than three days after the oral notice.

You must exhaust the internal claims appeals process before you pursue any other legal or equitable remedy. A decision of your entitlement to benefits upon exhaustion of this process will constitute a final internal adverse benefit determination.

You will be deemed to have exhausted the internal claims appeals process if the plan or claims administrator fails to adhere to the requirements described above and under applicable law.

VOLUNTARY APPEAL

Within 180 days after the date you receive written notice of the decision by the claims administrator regarding an appeal, you (or your authorized representative) may file a written request for a review of your denied claim. You (or your authorized representative) may submit written issues and comments to the Voluntary Review Process (VRP) Board.

The VRP Board will notify you of its decision in writing. Such notification will be written in a manner that you can understand and will contain specific reasons for the decision, as well as specific references to pertinent plan provisions. The decision on review will be made within 60 days after the VRP Board receives your request for review.

If you do not request a voluntary appeal, the plan cannot say that you failed to exhaust your administrative remedies. The time you spend pursuing your voluntary appeal does not shorten the period within which you must file a lawsuit.

You may submit a voluntary appeal only after exhausting the appeal to the claims administrator.

Upon your request, the claims administrator will provide you sufficient information relating to the voluntary appeal to enable you to make an informed judgment about whether to submit a benefit dispute to the voluntary appeal. This information will include a statement that your decision to submit a benefit dispute to the voluntary appeal will have no effect on your rights to any other benefits under the plan.

It will also include information about the applicable rules, your right to representation, the process for selecting the decision maker, and the circumstances, if any, that may affect the impartiality of the decision maker, such as any financial or personal interests in the result or any past or present relationship with any party to the review process. No fees or costs are imposed on you as part of the voluntary appeal.

You may file a lawsuit for benefits only after you have exercised all appeals described in this section (except the voluntary appeal) and all or part of the benefits you request on appeal have been denied.

EXTERNAL REVIEW PROGRAM

If you are not satisfied with the final determination after exhausting your internal appeals, you may choose to participate in the external review program.

This program applies only if the adverse benefit determination is based on issues of medical judgment, including but not limited to those based on the requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or the determination that a treatment is experimental or investigational.

This external review offers an independent process to review the denial of a requested service or procedure or payment for a service or procedure. Within four months after receipt of a notice of an adverse benefit determination, you must request an external review of the claim for benefits. If the last filing date would fall on a Saturday, Sunday, or federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or federal holiday. You or your authorized representative may request an external review by contacting the toll-free number on your ID card or by sending a written request to the address on your ID card.

Within five business days following receipt of your request, the claims administrator will complete a preliminary review of the request for external review to determine the following:

- Whether you are or were covered under the Plan at the time the health care item or service was requested or provided;
- Whether the adverse benefit determination relates to the fact that you do not meet the eligibility requirements to participate under the terms of the Plan;
- Whether you have exhausted the Plan's internal claims procedures; and
- Whether you have provided all the information and forms required to process the request for an external review of the claim for benefits.

If your request for external review is complete, but the claim is not eligible for an external review, the claims administrator will, within one business day following completion of its preliminary review, provide you with written notice of the reasons for the claim's ineligibility for external review and the contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)).

If your request for external review is incomplete, the claims administrator or its delegate, within one business day following completion of its preliminary review, will provide you with written notice describing the information or materials needed to complete the request for external review. You must provide the information necessary by the later of the applicable four-month filing period or the 48-hour period following the receipt of the notification, whichever is later.

Upon receipt of a completed and eligible request for external review, the plan must, in accordance with applicable law, assign an IRO to conduct the external review. Within five business days following the date of assignment of the IRO, the plan will provide to the IRO the documents and any information considered in making the adverse benefit determination. If the plan fails to timely provide the documents and information, the IRO may terminate the external review and make a decision to reverse the adverse benefit determination.

Within one business day after making the decision to terminate the external review and reverse the prior adverse benefit determination, the IRO must notify you of its determination. The IRO will notify you, in writing, of the eligibility and acceptance of the claim for external review, and you may, within ten business days following the date of receipt of such notice, submit, in writing, to the IRO additional information for the IRO to consider when conducting the external review of the claim for benefits.

Upon receipt of any information forwarded by the IRO, the plan may reconsider its adverse benefit determination that is the subject of the external review. Reconsideration by the plan will not delay the external review of the claim for benefits. If the plan decides, upon completion of its reconsideration, to reverse its adverse benefit determination and provide coverage or payment, the external review of the claim for benefits may be terminated.

In conducting its review, the IRO will consider the information provided the plan and any additional information and documents you timely submit. In reaching its decision, the IRO will review the claim de novo and is to be bound by any decisions or conclusions reached during the plan's internal claims process. The IRO may also consider:

- Your medical records;
- The attending health care professional's recommendation;
- Reports from appropriate health care professionals and other documents submitted by the plan, you, or your treating provider;
- The terms of the plan, to ensure that the IRO's decision is not contrary to the terms of the plan, unless the terms are inconsistent with applicable law;
- Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards, and associations;
- Any applicable clinical review criteria developed and used by the plan, unless the criteria are inconsistent with the terms of the plan or with applicable law; and
- The opinion of the IRO's clinical reviewer or reviewers after considering the information to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

Within forty-five days after the IRO receives the request for the external review, the IRO must provide you written notice of the final external review decision. If you requested an expedited external review, the IRO will provide notice of the final external review decision to you as expeditiously as your medical condition or circumstances require, but in no event more than seventy-two hours after the IRO receives your request for an expedited external review. Notice of the final external review decision may be given orally, but only if the IRO furnishes you written notification of the final external review decision within forty-eight hours after the date of providing the oral notice.

The notice of the final external review decision by the IRO should include the following:

- A general description of the reason you requested an external review of the claim for benefits, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial);
- The date the IRO received the assignment to conduct the external review of the claim for benefits and the date on which the final external review decision was made;
- References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching the final external review decision;
- A discussion of the principal reason or reasons for the final external review decision, including the rationale for the final external review decision and any evidence-based standards that were relied on in making the final external review decision;
- A statement that the determination is binding except to the extent that other remedies may be available under state or federal law;
- A statement that judicial review may be available; and
- Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Service Act.

Upon receipt of a notice of a final external review decision reversing the adverse benefit determination, the Plan immediately must provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

You may request an expedited external review at the time you receive:

- An adverse benefit determination that involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and with respect to which you have filed a request for an expedited internal appeal; or
- An adverse benefit determination, if you have a medical condition where the time frame for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but have not been discharged from a facility.

You may contact the claims administrator at the toll-free number on your ID card for more information regarding your external appeal rights and the independent review process.

PAYMENT OF CLAIMS

Plan benefits are payable to you unless you give written direction, at the time you file your claim, to directly pay the health care provider or unless a Qualified Medical Child Support Order directs the payment to someone else. If any benefit remains unpaid at your death, if the covered person is a minor or legally incapable (in the opinion of the claims administrator) of giving a valid receipt and discharge for payment, the claims administrator may, at its option, pay benefits to the spouse, parent or child of the covered person.

Payment to the covered person's relative constitutes a complete discharge of the claims administrator's obligation to the extent of the payment. The claims administrator is not required to see the application of the money.

Subrogation

The plan may be entitled to recover, through either or both of its rights to reimbursement or subrogation, the cost of certain benefits previously provided to you as a result of an illness, injury or condition for which a Responsible Third Party is or may be held legally responsible. The following explains the circumstances under which the plan will have these rights to recovery and your obligations under such circumstances. Please note that your failure to comply with the requirements of this section may result in a loss of coverage under the plan.

IMPORTANT DEFINITIONS

There are important terms used throughout this section, the definitions of which are provided below:

- "Reimbursement" refers to the repayment by you of expenses previously paid by the plan for an illness, injury or condition for which a responsible third party is or may be held legally responsible.
- "Subrogation" refers to the substitution of you by the plan with respect to your claim related to an illness, injury or condition for which a Responsible Third Party is or may be held legally responsible.
- "Responsible third party" means any person other than the plan, including, but not limited to, any of the following:
  - The party or parties who caused the illness, injury, or condition,
  - The insurer, guarantor, or other indemnifier of the party or parties who caused the illness, injury, or condition,
  - Your own insurer (for example, uninsured, underinsured, and no fault coverage),
  - A worker's compensation insurer, and/or
  - Any other person, entity, policy, healthcare plan or insurer that is liable or legally responsible for the illness, injury, or condition.

GENERAL

If you receive payment or reimbursement of expenses from the plan, or you submit a claim to the plan for payment or reimbursement of expenses, which relate to the treatment of an illness, injury, or condition for which a responsible third party is or may be held liable or legally responsible (for example, when the plan pays claims for the treatment of an illness, injury or condition caused by an automobile accident or another person's negligence), the payment, reimbursement, or claim, as applicable, will be subject to the plan's rights of reimbursement and subrogation as further described in this section.

NOTICE TO PLAN

You are required to notify the plan of any payment, reimbursement or claim for expenses under the plan that relates to the treatment of an illness, injury or condition for which a responsible third party is or may be held liable or legally responsible.

Notice can be provided directly to the claims administrator by calling United Healthcare between 8:00 a.m. and 5:00 p.m. Central time, or by logging on to **www.myuhc.com.**

CONDITIONAL BENEFIT PAYMENTS

The payment by or on behalf of the plan of any claim for benefits for which a responsible third party is or may be held liable or legally responsible is conditioned and contingent upon actual repayment to the plan in the event of a recovery from a responsible third party.

LIEN

The plan will have a first priority lien against, and will be entitled to recovery of, the first dollars paid or payable to you or on your behalf by a Responsible Third Party.

It is important to note that the plan's lien applies regardless of how the claims, awards, recoveries or amounts paid or payable by or on behalf of a responsible third party are classified or characterized by the parties, the courts or any other person or entity, including, for example, amounts paid to or for your benefit for general damages, and regardless of whether you are made whole for your losses and claims for benefits following the plan's recovery, and regardless of whether the Responsible Third Party is at fault or has had made an admission of fault.

REIMBURSEMENT OF PAID EXPENSES

Upon recovery of any amounts from a responsible third party, you are required to reimburse the plan first from such recovery for the amount of benefits paid by the plan, if any, for the illness, injury, or condition to which the recovery relates, plus the costs and expenses incurred by the plan in collecting such recovery from you or the responsible third party. If you fail to the reimburse the plan within thirty days of receipt of such recovery, the plan may charge you interest on the amount you are required to reimburse the plan in accordance with this provision. All interest charged pursuant to this section will be added to the amount of the plan's lien, as described above.

PAYMENT OF FUTURE EXPENSES

Upon recovery of any amounts from a Responsible Third Party, future expenses incurred by you that relate to the same illness, injury or condition with respect to which you received such recovery will not thereafter be reimbursable from, or paid directly by, the plan, unless otherwise provided in a separate written agreement signed by you and the plan administrator.

Any funds paid or payable by a Responsible Third Party to or on behalf of you for future medical claims relating to the same illness, injury or condition for which the Responsible Third Party is, or may be, held liable or legally responsible are required to be set aside in an escrow account for your benefit.

All benefits paid by the plan with respect to such illness, injury or condition will be added to the amount of the plan's lien, as described above. As a result, the plan will have the right to recover such amounts from the escrow account or directly from you.

NO OFFSET OF COSTS

The plan will not pay, offset any recovery, or in any way be responsible for any fees or costs associated with enforcing its reimbursement or subrogation rights under the plan unless the plan administrator, in its sole and absolute discretion, agrees to do so in writing. All costs and fees incurred by the plan to enforce its reimbursement and subrogation rights will be added to the amount of the plan's lien, as described above.

SUBROGATION OF RIGHTS AGAINST THIRD PARTIES

The plan will be subrogated to and will succeed to all claims, demands, actions and rights of recovery (under all possible legal theories) that you may have against any responsible third party with respect to any illness, injury, or condition for which such responsible third party may be held liable or legally responsible.

This means the plan may, at its option, take over your right to pursue or receive payments from a responsible third party, provided the plan's recovery will not exceed the amount of the plan's lien described above.

Upon such request, and prior to the plan's receipt of an executed agreement, any claim related to the illness, injury or condition that is the subject of the reimbursement or subrogation rights of the plan will be pended and will not be processed or paid.

PRESERVATION OF RIGHTS

The plan administrator may, in its sole and absolute discretion, take any action as it, in its sole and absolute discretion, determines necessary or appropriate to preserve the plan's rights to reimbursement and/or subrogation.

COOPERATION AND ASSISTANCE

You are required to cooperate in protecting the plan's rights to reimbursement and subrogation, and may not act (or fail to act) at any time or in any manner that prejudices the plan's rights to reimbursement and/or subrogation (including but not limited to settling a claim with a responsible third party, without advance notice to and approval of the plan administrator). You are required to provide all information and sign and return all documents necessary for the plan to exercise its rights to reimbursement and subrogation within five business days of a request by the plan administrator.

WRITTEN AGREEMENTS

As a condition to your continued participation under the plan, you may be required to execute a written agreement acknowledging the plan's rights of reimbursement and subrogation. Upon such request, and prior to the plan's receipt of an executed agreement, any claim related to the illness, injury or condition that is the subject of the reimbursement or subrogation rights of the plan will be pended and will not be processed or paid.

FAILURE TO COMPLY

Your benefits under the plan are conditioned on your compliance with the requirements related to the plan's rights to reimbursement and subrogation. If you do not reimburse the plan such amounts, the plan may take any action the plan administrator deems appropriate, including but not limited to the following:

- Reducing future benefits that would otherwise be payable for any illness or injury,
- Terminating coverage under the plan for you and your dependents.

When Coverage Ends

Generally, coverage for you and your covered dependents under the Total Health Medical Plan ends on the last day of the pay period in which you terminate employment.

However, there are certain situations when it would end on a different date. For example, it would end on the date:

- The employee dies
- You divorce
- Your dependent reaches the plan's maximum age.

See page 140 for more information.

CONTINUATION OF MEDICAL COVERAGE

In some cases, you and your covered dependents may be eligible for COBRA continued health coverage, as explained in "Coverage After Termination" on page 141.

CERTIFICATE OF CREDITABLE COVERAGE

Federal laws require Texas Health to provide a Certificate of Creditable Coverage outlining your medical coverage and showing the dates you were covered.

UHC will provide you with a Certificate of Creditable Coverage if your coverage terminates under the plan:

- At the time of the qualifying event or other termination of coverage
- At the time your COBRA coverage ends.

You can also make a written request for a Certificate of Creditable Coverage to the claims administrator, provided that your request is made within 24 months after your coverage ends.

Retiree Medical Coverage

Employees who retire from Texas Health at age 55 or older with a combined age and years of continuous service equal to or greater than 75 may continue medical coverage until age 65.

Eligible retirees must elect this coverage within 60 days of their retirement date by completing the Retiree Medical form. You are required to continue the same medical coverage you had as an active employee. (Coverage for retirees may change when coverage for active employees changes.)

Retirees can change medical options during open enrollment, with coverage normally effective on the following January 1. Individuals who drop medical coverage after retirement will not be eligible to re-enroll at a later date. Retirees are required to pay the entire premium, including both the employee's and Texas Health's portion of the cost for medical coverage, plus an additional cost for administration.

If a retiree reaches age 65 before his or her spouse (or dies before reaching age 65), the spouse may continue medical coverage until he/she turns age 65, as long as the spouse was covered under the plan at the employee's date of retirement or death. Otherwise, the spouse's coverage ends when the retiree's coverage ends. If the retiree dies, an eligible surviving spouse who remarries may not add his or her new spouse to the plan. If the covered spouse is older than the retiree, the spouse's coverage ends when the spouse turns age 65. For more information see the booklet entitled "What To Do When You Retire Before Age 65" which is available on **MyTexasHealth**.

Texas Health reserves the right to amend or terminate retiree medical coverage at any time at its discretion. Contact Human Resources for more information or to obtain a Retiree Medical form to enroll before your planned retirement date.

You will also receive a packet explaining your right to elect COBRA continuation coverage. If you chose to elect COBRA continuation coverage, you will not be eligible to elect retiree medical coverage at a later date.

Be Healthy Wellness Program

Texas Health offers the *Be Healthy* wellness program that gives you the tools to focus on getting healthy and staying healthy. This section describes those tools.

Research has shown that people who have support in managing their health are more successful than people who try to manage their health alone. To provide the support you need, Texas Health has carefully selected companies that have professionals focusing on different health issues.

These professionals—called Health Coaches—are nurses, counselors, dietitians and fitness experts who will call you to offer support and direct you to resources that can help you achieve your wellness objectives.

Benefits-eligible employees are all full-time and part-time employees who are classified to work 48 hours or more each pay period. Your status as full-time or part-time is based on your status in Texas Health's HR/payroll system and not based on the number of hours you work.

Dependents can access the *Be Healthy* website, but are not eligible to earn most rewards. COBRA participants are not eligible for *Be Healthy* rewards.

Be Healthy provides many opportunities to improve your health—and your life. Several of the program elements also allow you to earn rewards for completing them. The table below describes your eligibility for each program.

Eligibility for *Be Healthy* Wellness Programs

Program Name	Benefits-eligible employees enrolled in the Total Health Medical Plan			Benefits-eligible employees *not* enrolled in the Total Health Medical Plan			PRN		
	Employees	Spouses	Children	Employees	Spouses	Children	Employees	Spouses	Children
Online Health Assessment	√	√	√[2]	√					
***Be Healthy* Basics**	√	√[2]	√[2]	√[4]					
Preventive/Wellness Exam	√	√	√[2]						
Age Appropriate Cancer Screenings									
• Colorectal Cancer (Colonoscopy)	√	√[2]	√[2]						
• Mammogram	√	√[2]	√[2]						
• Prostate Exam	√	√[2]	√[2]						
Maternity Support Program	√	√	√						
Health Coaches	√	√	√	√					
Diabetes Management Program	√	√	√						
Cancer Support Nurse	√	√	√						
Tobacco Cessation Program	√	√	√	√	√	√	√	√	√
Employee Assistance Program	√	√	√	√	√	√	√	√	√
Health Advocacy	√	√	√	√	√	√	√	√	√
Medical Nutrition Therapy (available to participants with a BMI over 28)	√	√	√						
Weight Watchers[1]	√			√			Not subsidized		
Fitness Memberships[1]	√	√	√	√	√	√	√[3]		

[1] Weight Watchers and fitness memberships are not included in the Total Health Medical Plan.

[2] Dependents can participate in the program but do not receive an incentive.

[3] PRN's are eligible for discounts at fitness centers through Globalfit but not at Texas Health fitness centers.

[4] Employees getting their labs completed at their physician's office must use the "Health Provider Screening Form" found at https://register.wellness-inc.com/thr in order to receive an incentive.

Be Healthy Incentives

To earn a reward, most of the 2013 *Be Healthy* program elements can be completed anytime during the year. To be eligible for the reward for the Health Assessment, you must complete it during the open benefits enrollment period or within 14 calendar days of your hire date if you are a new employee, or within 31 calendar days of becoming benefits-eligible. It may take 6 – 8 weeks for your reward notification to arrive.

Be Healthy is administered by UnitedHealthcare®. UnitedHealthcare also administers our wellness website.

The first time you access the wellness website, you will be required to register and provide your email address so you can be notified whenever you have earned a reward. Your privacy is protected in all parts of the *Be Healthy* program.

After you have completed the requirements for a reward, you will receive an email notifying you that the amount is available in your rewards account. Your reward is redeemable for gift cards from more than 100 national retailers, restaurants, entertainment, and travel providers or you can receive it in the form of a Visa gift card.

The reward notification will be sent to the address you provide in your profile on the *Be Healthy* wellness website.

The IRS considers incentive rewards a part of your pay. That means you will have to pay taxes on the rewards you receive and your 401(k) contributions will be deducted. The tax for your reward will be shown on your paycheck as additional pay. On average, the tax on a $25 reward will be around $5.

HOW TO PARTICIPATE IN THE *BE HEALTHY* INCENTIVE PROGRAM

Program Element[1]	When and How to Complete It	Reward	How to Get the Reward
Health Assessment [2]	Log on to www.MyTHR.org to enroll. After you enroll, you'll have the option to complete the Health Assessment. • Active employees: during open enrollment • New employees: within 14 calendar days of your hire date • Newly eligible employees: within 31 calendar days of becoming benefits-eligible	$75	Your completion of the Health Assessment is reported automatically.
	Spouses enrolled in the Total Health Medical Plan: Log on to www.BeHealthyTHR.org and complete a profile, then complete the Health Assessment. • Spouses enrolled in our medical plan in 2012: during open enrollment in November 2012 • Spouses not enrolled in our medical plan in 2012: during open enrollment in November 2013	$25	Your spouse's completion of the Health Assessment is reported automatically.
***Be Healthy* Basics**	All benefits-eligible employees: get your *Be Healthy* Basics at your entity's health fair or take the "Health Provider Screening Form" to your appointment with your doctor anytime during 2013. You must meet certain requirements to earn this reward. See page 54 for details.	$50	If you participate through the health fair, UHC will report your participation. If you get your *Be Healthy* Basics at your doctor's office, your doctor will complete the form for you to fax back.
Preventive/ Wellness Exam	You must be enrolled in the Total Health Medical Plan to receive credit. You can complete this element anytime during 2013.	$100	When your network doctor files your claim, UHC will automatically report your participation.
	Spouses enrolled in the Total Health Medical Plan may complete this element anytime during 2013.	$25	
Cancer Screenings	You must be enrolled in the Total Health Medical Plan to receive credit. If you have a mammogram, prostate exam or colonoscopy anytime during 2013, you are eligible.	$25	When your network doctor files your claim, UHC will automatically report your participation.
Maternity Support Program	You must be enrolled in the Maternity Support Program by your 16th week and actively participate through the 12th week after your baby is born. To enroll, call 1-877-MyTHRLink (1-877-698-4754), select prompt 2 between 8 a.m. and 5 p.m. Monday through Friday, or log on to www.myuhc.com.	$100	It's automatic if you're a Total Health participant.

[1] One reward per element per year.

[2] If you are a new hire or experience a status change between October 1 and the end of Open Enrollment each year, you will only complete the Open Enrollment Health Assessment.

Online Health Assessment

When you log on to **www.MyTHR.org** to enroll for your 2013 benefits, you also can complete an online Health Assessment after you've finished your benefits enrollment. Most of the questions on the Health Assessment are about things you know right away—like how much you weigh and how many times a week you exercise. It will also ask you to enter recent lab results such as your cholesterol, blood sugar (glucose) and blood pressure. Even if you don't have lab results, you can still complete the Health Assessment.

The Health Assessment asks questions and then gives you results in a confidential, personal report that helps you understand more about your health and your health risks. The more complete and accurate information you provide, the more valuable the results will be to you. Your personal report will explain how to improve your health and maintain a healthy lifestyle.

Based on your Health Assessment results, you may be eligible to participate in a personalized Wellness Coaching program. You can register immediately after you complete your Health Assessment or a coach will contact you by letter or a phone call to invite you to participate. Your personal Health Coach will provide one-on-one coaching and many other resources to help you reach your health goals.

If you completed the Health Assessment during the 2013 open enrollment period (November 1 – November 15) or within 14 days of your hire date if you are a new employee, or within 31 days of becoming benefits-eligible, a $75 reward will be mailed to your home after you select your reward online. To complete the Health Assessment go to **www.MyTHR.org** and select the *Be Healthy* link in the upper left corner.

SPOUSE HEALTH ASSESSMENT

Spouses enrolled in the Total Health Medical Plan are eligible to earn a $25 reward. They can complete the health assessment during open enrollment by logging on to **http://BeHealthyTHR.org.**

Spouses covered by the Total Health medical plan in 2012 were eligible for the Health Assessment during open enrollment in November 2012. Spouses added to coverage under the Total Health medical plan in 2013 may take the health assessment during open enrollment in November 2013.

Eligible child dependents are not able to earn a reward but can complete the health assessment. Spouses and eligible dependents must use their social security number when they register. The first time spouses take the Health Assessment, they should:

- Click "Register."
- Complete the required fields, then click "Continue." Please note that a Social Security Number should be used for the "Unique ID."
- After completing the registration, click on "I AM" then "Take the health assessment."

Be Healthy Basics

Be Healthy Basics are measures of your physical condition that provides clues about your health. They tell you and your doctor about your current health, identify health risks, and provide important information about managing your health. Based on your results, you will be offered wellness opportunities to optimize your health and well-being.

There are two ways to earn this $50 reward:

- If at least two of the following *Be Healthy* Basics are within the healthy range, you earn the $50 reward:
  - Your total cholesterol is less than 200 mg/dl
  - Your blood pressure is 130/80 or lower
  - Your body mass index (BMI) is 25 or lower.
- If you do not have at least two *Be Healthy Basics* that fall within these ranges, you can still qualify for the $50 reward by completing one of the following prior to December 31, 2013:
  - Weight Watchers
  - Health Coaching by phone.

You may get your *Be Healthy* Basics at your entity's health fair or your physician may order your lab panel between January 1 and December 31, 2013.

If you attend your entity's onsite health fair, you can get a blood test and screen to find out your blood pressure, blood glucose, lipids, body mass index (BMI), and body fat percentage. Dependents cannot get a blood screen at the health fair.

GETTING YOUR BASICS FROM YOUR DOCTOR

To receive credit for getting your *Be Healthy* Basics at your doctor's office, here's what you need to do:

- Go to https://register.wellness-inc.com/thr. Select Health Provider Screening Form and then follow the prompts. Step-by-step instructions are available on MyTexasHealth.
- Take your form to your appointment with your doctor. After your doctor completes the form, fax it to 877-457-2612. The forms are processed daily.

If you are covered by a Total Health Medical Plan, remember to use a UHC Choice or Choice Plus network lab.

ONE REWARD PER YEAR

You may earn only one $50 reward per year for this element. It may take 6 – 8 weeks for your reward notification to arrive. If you had lab tests done at the same time as your preventive/wellness exam, they are billed separately and your rewards may arrive at separate times.

Preventive/Wellness Exam

Getting regular check-ups is important for everyone—even if you are in good health. By getting a preventive/wellness exam, your doctor may be able to identify your risk for future medical problems, screen for diseases, encourage a healthy lifestyle, and update your vaccinations. Plus, it is important to have a relationship with a doctor in the event of an illness in the future.

To get the most from your exam, write down important information to tell your doctor—like your personal and family medical history, symptoms you have now and medicines you take. Even non-prescription and herbal remedies are important for your doctor to know about. Bring a pen and paper to make notes while you talk to your doctor.

It is important that your doctor's office codes your visit as a wellness exam and not a routine office visit so you will be able to receive this reward.

This exam may be performed by your primary care physician or women can get a well-woman exam with their gynecologist. Be sure to take your *Be Healthy* Basics with you and tell your doctor about the *Be Healthy* wellness programs available to you.

Based on the results of your preventive/wellness exam, your doctor may recommend that you participate in one of them.

If you are enrolled in a Total Health Medical Plan, you will receive a $100 reward for getting a preventive/wellness exam anytime during 2013. Spouses enrolled in the Total Health Medical Plan are eligible to earn a $25 reward. Your completion of the wellness exam will be automatically reported so you receive the reward.

Because of administrative limitations, only those enrolled in the Total Health Medical Plan are eligible to earn a reward for a preventive/wellness exam. At this time, the administrator of the *Be Healthy* incentive program is not able to receive information about physical exams from any other medical plan.

After your doctor files a claim for your exam and it is processed, a reward notification will be mailed to your home. It may take 6 – 8 weeks for it to arrive. If you had lab tests done at the same time as your preventive/wellness exam, they are billed separately and your reward notifications may arrive at separate times. You may earn only one $100 reward per year for the preventive/wellness exam.

Be sure you select a doctor who is part of the UHC Choice or Choice Plus network and that they use one of the codes listed in the table.

Health Advocacy

With so many health care choices and so much information from many sources, it can be hard to know where to look for trusted information and support. Health Advocacy services were developed to give you peace of mind. Texas Health employees have access to a team of specially trained individuals who help you navigate the health care system and give you a trusted source for health care information and support 24 hours a day.

ELIGIBILITY

All employees and their eligible family members are eligible to use the Health Advocacy Services.

HOW TO PARTICIPATE

To speak to a Health Advocate, call 1-877-MyTHRLink (1-877-698-4754) and select prompt 2.

HOW A HEALTH ADVOCATE CAN HELP

Coping with health concerns can be time-consuming and complex. When you call, a Health Advocate can help you:

- Choose appropriate medical care
  - Understand a wide range of symptoms
  - Determine if the emergency room, a doctor visit or self-care is right for your needs
- Find a doctor or hospital
  - Find doctors or hospitals that meet your needs and preferences
  - Locate an urgent care center and other health resources
- Understand treatment options
  - Learn more about a diagnosis
  - Explore the risks, benefits and possible outcomes of your treatment options
- Achieve a healthy lifestyle
  - Get tips on how nutrition and exercise can help you maintain a healthy weight
  - Learn about important health screenings and immunizations
- Ask medication questions
  - Explore how to save money on prescriptions
  - Learn how to take medication safely and avoid interactions.

Maternity Support Program

If you are pregnant or thinking about becoming pregnant and you are enrolled in the Total Health Medical Plan, you can get valuable educational information, advice, and comprehensive case management by enrolling in the Maternity Support Program.

The program is designed to enhance your pregnancy experience by assigning a dedicated OB nurse to help you better understand your pregnancy. Your OB nurse will provide clinical and practical advice and answer your questions throughout your pregnancy.

To take full advantage of the program, you are encouraged to enroll within the first trimester of pregnancy. If you enroll in the Maternity Support Program by your 16th week and actively participate through the 12th week after your baby is born, you will receive a $100 reward.

There is no cost to enroll in the program. Some of the services include:

- Pre-conception health coaching
- Toll-free information lines staffed by experienced OB nurses
- Your choice of a book: *What to Expect When You're Expecting*, *What to Expect the First Year*, or *Baby Play and Learn*
- Printed and online educational resources covering a wide range of topics
- First and second trimester risk screenings
- Identification and management of at-risk or high-risk conditions that may affect pregnancy
- Pre-delivery consultation
- Coordination with and referrals to other benefits and programs available under the medical plan
- Support after your baby is born, including a phone call from a nurse approximately two weeks after your baby is born to answer your questions and give you information about newborn care, feeding, immunizations and more
- Screening for postpartum depression.

For more information or to enroll, call 1-877-MyTHRLink (1-877-698-4754), select prompt 2 between 8 a.m. and 5 p.m. Monday through Friday, or log on to **www.myuhc.com** for more details.

Cancer Support Nurse

If you have been diagnosed with cancer and you are enrolled in the Total Health medical plan, you can be assisted by an experienced cancer nurse who is dedicated to Texas Health employees. The nurse is available to help you and/or your dependents during active treatment for ***all*** forms of cancer.

The cancer nurse focuses on patients at high risk of complications and side effects. The nurse will collaborate with your treating physicians to fill gaps in your knowledge of the cancer you have. He or she works to prevent avoidable complications and side effects to keep you out of the hospital and emergency room. The nurse will also educate and empower you to actively participate in your own treatment and recovery. And in the case of terminal cancer, the nurse increases your awareness and choice of palliative care and hospice services, when appropriate. To reach the cancer nurse, call 1-877-MyTHRLink (1-877-698-4754) and select prompt 2.

Health Coaches

Start making wellness part of your everyday life. Start by taking a good look at what you're doing today, decide whether to make any changes, set goals and decide how to meet your goals.

A Health Coach helps you develop a personal wellness strategy. After you've completed the 2013 Health Assessment, you will get a Personal Results report.

This is an online personalized health profile that reviews your lifestyle practices and identifies health issues that could be affected by your personal choices. Because it's an individualized report, your strategy won't be exactly like anyone else's.

With your Health Coach, you evaluate your lifestyle, identify opportunities for improvement, and get support in making any changes you choose.

The Health Coach Program includes powerful online tools, educational materials, and activities to help you change behavior. You may speak with a Health Coach by phone or participate online. The Health Coach can help you create a plan to change your behavior, support you along the way, and help you revise your strategy as your individual needs change.

The Health Coach program by phone consists of at least three calls with a Health Coach. To enroll, call 1-877-MyTHRLink (1-877-698-4754), prompt 2.

For some health conditions, you can also complete the program online. Each online module contains five levels and each level takes a minimum of one week to complete.

Examples of a Health Coach:

- An online module that can help with nutrition and fitness, meal planning, and exercise planning
- A personal Health Coach who can provide support by phone during weight loss and after you meet your goals
- Referrals to specialists when being overweight may be a risk factor for other health problems.

This program is administered by UnitedHealthcare and is available to all benefits-eligible employees and their eligible dependents.

To enroll, go to **www.MyTHR.org** and click on the *Be Healthy* link in the upper left corner, then click on the appropriate program under "I Do."

ALTERNATIVE TO BE HEALTHY BASICS

You may complete a Health Coaching program by phone as an alternative to the *Be Healthy* Basics. Your participation will be automatically reported to satisfy this *Be Healthy* Basics alternative.

Diabetes Management Program

Texas Health offers a program that includes diabetes education and support. Diabetes education for adults or children (not available at all locations) is covered under the Medical Plan after a $10 copay at a Preferred Hospital or UHC provider. Coverage includes either individual or group education sessions with a certified diabetes educator. A physician's referral is required.

Benefits-eligible employees and eligible dependents enrolled in the medical plan are eligible to earn free test strips for self-monitoring of your blood glucose when you visit with a Texas Health diabetes educator at least quarterly. The prescription drug plan covers oral medications, insulin, syringes, blood glucose monitors, test strips, lancets, and chemical strips. You can receive a free glucose monitor. The Medical Plan covers durable medical equipment including insulin pumps, supplies for your pump (infusion sets, cartridges, batteries, and medical tape), and glucagon emergency kits, when ordered by your physician.

Medical Nutrition Therapy

Members in the Total Health medical plan with a BMI greater than 28 are eligible for the Medical Nutrition Therapy program which provides one initial assessment and up to three 30-minute therapy sessions per year at no cost to you. To be covered, you need a physician referral and the therapy must be provided by a Texas Health clinical dietitian.

A registered dietitian will customize a healthy eating plan that meets your specific health and wellness needs. You can make an appointment for:

- A personal lifestyle assessment
- Personalized meal planning
- Behavior modification counseling to work on your personal challenges such as emotional eating, skipping meals, portion management, and listening to hunger/fullness cues.

Tobacco Cessation

Texas Health has retained Alere, a company specializing in tobacco cessation for over 20 years, to provide you with resources to help you stop using tobacco. This program is available at no charge to help all employees (including PRNs) and their eligible family members.

The Quit for Life™ program provides:

- An in-depth assessment with a personal Quit Coach™ including five outbound calls. Coaches can be called for extra support as many times as needed, any day of the week. Your Quit Coach helps you create a personal quitting plan that may include treatments to help you with withdrawal.
- Personalized Quit Guides with helpful tips and information
- Nicotine Replacement Therapy (NRT)
- Participants can access one eight-week shipment of one type of NRT (patch, gum or lozenges) through enrollment in Quit for Life.
- Prescription medication bupropion is available at any Caremark pharmacy (for those enrolled in the Total Health medical plan) or through Texas Health Dallas Apothecary, Texas Health Dallas Prescription Shop and Texas Health Plano Medicine Chest (regardless of whether you are enrolled in the Total Health medical plan). Copays are waived for this medication if the participant is enrolled in Quit for Life.
- Prescription medication Chantix™ is covered for participants enrolled in Alere Tobacco Cessation program if recommended by the Quit Coach. Chantix is a prescription medicine used to help adults quit smoking. Chantix contains no nicotine and helps reduce the urge to smoke.
  - Pharmacy co-pays apply to purchasing Chantix if you are enrolled in the Total Health medical plan – for those not in the medical plan, there is a 40 percent copay. Chantix is available with a prescription at any Caremark pharmacy (for those enrolled in the Total Health medical plan) or through Texas Health Dallas Apothecary, Texas Health Dallas Prescription Shop and Texas Health Plano Medicine Chest (for those not enrolled in the Total Health Medical Plan).

Now is the best time to take the first step toward quitting. This free program is available to all employees and their eligible family members. Your chances of quitting are six times better with the Quit For Life Program than trying to quit on your own.

To participate in the Quit for Life Program, call 1-877-MyTHRLink (1-877-698-4754) and choose option 4, then press 2 or go online to **www.MyTHR.org** and click on the Alere link.

TO ENROLL or find out about any of these programs, go to **www.MyTHR.org** or **MyTexasHealth.**

Weight Watchers®

Texas Health offers the following Weight Watchers programs to all employees:

- **Weight Watchers at Work meetings:** A Weight Watchers leader comes to your workplace to provide experienced guidance at weekly meetings that fit your busy work schedule. You benefit from the proven advantage of group support from your coworkers. A meeting must have at least 15 Texas Health employees enrolled.
- **Weight Watchers community meeting monthly pass:** If you are not able to attend a meeting at work, you may receive a monthly pass, which offers the flexibility of attending Weight Watchers meetings in your community.
- **Weight Watchers online subscription:** Weight Watchers online is available for employees who are not able to participate in Weight Watchers at-Work or Weight Watchers community meetings. Follow Weight Watchers online with interactive tools and resources like the WeightTracker, progress charts, restaurant guides, and hundreds of recipes, tips and meal ideas.

ELIGIBILITY

All benefits-eligible employees are eligible for Weight Watchers at-Work, the community meeting program, or Weight Watchers online. Your membership is non-transferable. PRN employees may participate in these Weight Watchers options, but must pay for the entire program.

PARTICIPATION REQUIREMENTS AND COST

Texas Health will pay for your participation in Weight Watchers, as follows:

- **Weight Watchers at Work:** Texas Health pays 100% of the membership fees if you attend at least 10 meetings in a 3-month period. If you do not attend at least 10 meetings in a 3-month period, you will be required to pay the entire membership fee through payroll deduction. If you miss an at-work meeting, you can make it up by going to a community meeting or another entity's at-work meeting within the same week.
- **Weight Watchers community meeting monthly pass:** Texas Health will pay 50% of the fees if you attend at least 10 meetings in a 3-month period. You pay your half directly by credit card.
- **Weight Watchers online:** Texas Health will contribute 50% for a Weight Watchers 3-month online membership. You pay your half by credit card.

HOW TO PARTICIPATE

Find out how to enroll for Weight Watchers by searching for "Weight Watchers" on MyTexasHealth.

ALTERNATIVE TO BE HEALTHY BASICS

You may attend Weight Watchers as an alternative to *Be Healthy* Basics. To receive credit, you must enroll and attend at least 10 meetings in a 3-month period before December 31, 2013. To satisfy this *Be Healthy* Basics alternative, your participation will be automatically reported.

WEIGHT WATCHERS ONLINE SUBSCRIPTION

With an online subscription you can follow the Weight Watchers plan step-by-step online. It provides interactive tools and resources like a weight tracker, progress charts, restaurant guides and much more. It is available in versions specifically designed for men and women with tailored content that speaks directly to each audience. To sign up, call 1-877-MyTHRLink (1-877-698-4754), press prompt 4, then option 1.

Fitness Memberships

Discounted fitness memberships are available for benefits-eligible employees and their dependents.

- Texas Health Fort Worth, Texas Health Dallas, Texas Health Arlington Memorial, Texas Health Burleson, Texas Health Denton and Texas Health Hurst-Euless-Bedford have convenient on-site fitness centers.
- Global Fit, a fitness center provider, will help you find a fitness center near you at rates lower than retail. Visit **www.globalfit.com/thrtotalhealth** or call 1-(800) 294-1500.
- As a benefits-eligible employee, you can join the Cooper Aerobics Center at Craig Ranch for $50 per month (a $20 discount). You pay an additional cost for family members.

Cancer Screenings

It is important to have regular screening exams that can detect cancer or conditions that could lead to cancer. Screening exams can help doctors find and treat some types of cancer early—when they are often more easily treated. For people who do not have any specific symptoms and who are not in any high-risk group for a certain type of cancer, the table on this page lists the recommended cancer screenings.

You may want to ask your doctor:

- Do you recommend that I have any cancer screenings?
- What will the screening exam feel like?
- What are the risks of this exam?
- How and when will I know the results?
- What would be the next step?

People who are at increased risk for certain types of cancer may need to be screened earlier or more often.

If you believe you have symptoms related to cancer or you have an unexplained change in the way you feel, you should see your doctor right away.

While other cancer screenings are covered health services under the Total Health Medical Plan, only the screenings in the table below are eligible for a reward. You can earn a $25 reward for each one you complete, limited to one reward per screening per year.

AGE APPROPRIATE CANCER SCREENINGS

Type of cancer and screening exam	Description	Recommended first exam	Recommended follow-up exams	You pay under the Total Health Medical Plan
Colorectal cancer—colonoscopy	This type of cancer can be successfully treated when detected early. It involves cancer cells that grow in the colon, rectum, or both. According to the American Cancer Society, 90% of cases are in people over age 50.	Men and women starting at age 50	Every 10 years	Covered at 100% one time per year[2]
Breast cancer—mammogram	This type of cancer is the second leading cause of death among American women. But most women who are diagnosed at an early stage survive and continue to live normal lives.	Women starting at age 40[1]	Every year	Covered at 100% one time per year[2]
Prostate cancer—prostate exam or PSA test	One out of every six men get this type of cancer. It usually begins as a tumor in the prostate gland, but it can spread. It is the second most common type of cancer among American men.	Men starting at age 50	Every year	Covered at 100% one time per year[2]

[1] While some health organizations are recommending other time frames for getting mammograms, the National Cancer Institute, American Cancer Society, and BreastCancer.org still recommend getting regular mammograms beginning at age 40 or based on the individual woman's breast cancer risk profile.

[2] One well exam per year is covered in full if the claims administrator determines the physical is for preventive care. Additional screenings or services will be considered diagnostic services and will be covered after you pay the applicable copay or deductible and coinsurance. At the time of your preventive care visit, if other services are performed that are not preventive services, as determined by the claims administrator, they will **not** be paid at 100% even if they are submitted as part of a claim for preventive care. Some items now require you to pay the appropriate copay or coinsurance, including electrocardiograms (EKGs), focused office visits, thyroid scans, breast MRI, vitamin D assays, and transvaginal ultrasounds.

YOUR PRIVACY Is Protected

IT IS important for you to know that an independent company manages *Be Healthy* and provides summary reports to Texas Health. Texas Health uses this data to make decisions about what benefit programs we will offer to employees.

TEXAS HEALTH uses independent companies to operate *Be Healthy* and provide Health Coaching. These companies include OptumHealth, MHN EAP, Caremark Pharmacy, Alere Quit for Life™ tobacco cessation program, and UnitedHealthcare. They must take the necessary steps to protect your information and give you appropriate information and education.

Employee Assistance Program (EAP)

OVERVIEW

To help you manage life's challenges, Texas Health offers the Employee Assistance Program (EAP), administered by MHN. It includes free, unlimited phone and Internet access to counselors and information to help you resolve personal issues. You can also receive up to six face-to-face counseling sessions per issue per year.

This program is available to all employees (including non-benefits-eligible) and their eligible dependents. Availability lasts during an employee's tenure with Texas Health and for 12 weeks after employment with Texas Health ends.

CLINICAL SUPPORT

Call the EAP to get help with emotional issues. An intake specialist will listen to your needs and refer you to a licensed professional who can help. The EAP is available around the clock to help with:

- Marriage, relationship and family issues
- Problems in the workplace
- Domestic violence
- Alcohol and drug dependency
- Stress, anxiety and sadness
- Changes in mood
- Grief and loss
- Response to traumatic events.

Clinical support comes in three ways:

- Face-to-face counseling
- Telephonic consultations
- Web-video consultations

Face-to-face counseling is provided by a professional (a marriage and family therapist or psychologist, for example) from MHN's network. You can get a referral when you call or search for a provider at www.members.mhn.com. (enter company code "thr").

Convenient and confidential solutions and support are available at no charge, 24 hours a day, seven days a week. Contact the EAP by dialing 1-877-MyTHRLink (1-877-698-4754) prompt 4, then 4 again.

WORK AND LIFE SERVICES

Your EAP also features services to help you make the best of life's chores and challenges. Online and telephonic guidance or referrals are available to help with childcare and eldercare, financial services, legal services, identity theft, daily living services and more. See a more complete list in the box below.

EAP WEBSITE

MHN's website has tools to help you take charge of your wellbeing. You can ask our expert an emotional health question, make a change with self-help programs, take advantage of interactive e-learning programs, access childcare and eldercare directories, and find articles and videos on emotional health, physical health and making healthy choices. Visit www.members.mhn.com and enter the company code "thr" to access the site.

EXAMPLES OF WORK AND LIFE SERVICES YOUR EAP CAN HELP WITH

- **Legal services** – Talk to a professional over the phone or face-to-face about:
  - Civil, consumer and criminal law (medical malpractice cases and disputes or actions between members and their employers or between members and MHN are excluded)
  - Personal and family law, including adoption, divorce and custody issues
  - Financial matters
  - Business law
  - Real estate
  - Estate planning
- **Identity theft recovery services** – Get information on ID theft prevention, plus an ID theft emergency response kit. If your identity is stolen, a fraud resolution specialist can help.
- **Childcare and eldercare assistance** – A representative will give you names and numbers of providers who can help you care for children or elders in your life.
- **Financial services** – Talk to an advisor over the phone about:
  - Budgeting
  - Credit and financial questions (investment advice, loans and bill payments not included)
  - Retirement planning
  - Tax issues
- **Daily living services** – Need help with household repairs? Planning an event or a vacation? MHN will track down businesses and consultants for you. (MHN does not cover the cost nor guarantee delivery of vendors' services.)

Dental & Vision

Dental Plan

Overview

Texas Health offers you a choice in dental coverage so you may select the option that best meets your needs. You have three dental options: one is a managed dental plan that pays benefits only when you use network providers, and the other two are preferred dental networks that pay benefits both in-network and out-of-network. All dental options cover preventive care, basic care, major care, and orthodontia.

Your dental plan choices are:

- Aetna Dental Maintenance Organization (DMO®)
- Aetna Preferred Provider Organization Max (PPO) Low Option
- Participating Dental Network (PDN) High Option.

The managed dental plan, Aetna DMO® is a fully insured plan underwritten by Aetna Dental, Inc. It offers a network of dentists and providers to help you save on the cost of your dental care.

The Aetna PPO (PPO) and the Participating Dental Network (PDN) plans use the Aetna network and are fully insured plans underwritten by Aetna Life Insurance Company. These plans allow you to decide whether to use network or out-of-network providers whenever you need dental care. They are described in more detail in this section.

Aetna is the brand name used for products and services provided by one or more of the Aetna group of companies. In case of a discrepancy between this summary plan description and the group insurance contracts issued by Aetna Dental Inc., or in case of any legal action, the terms of the group insurance contracts will prevail.

For more detailed information on the Aetna plans, refer to the schedule of benefits available on **MyTexasHealth**.

Who Can Be Covered

As a full-time or part-time benefits-eligible employee or as a COBRA participant, you may elect the following levels of coverage under the Texas Health Dental Plan:

- You only
- You and your spouse
- You and your unmarried dependent children up to age 25, regardless of student status
- You and your family.

See pages 5 – 7 for more information on eligibility.

Aetna DMO®

The Aetna DMO® provides dental services through a network of dentists very similar to a medical HMO. To receive benefits, you must use a network dentist.

Under this plan, you pay no deductibles and most expenses for diagnostic and preventive care are fully paid by the plan. For other dental expenses, you pay copays according to the plan's schedule. The copays vary depending on the services. For a detailed listing of covered services and copays, go to **MyTexasHealth**. COBRA participants can call 682-236-7236.

When you enroll in the managed dental plan, you (and each enrolled family member) select a network dentist located in the state of Texas from the provider directory. Except for emergency treatment outside the service area, you must use the dentist you have selected to receive dental benefits.

Advantages of the managed dental plan include:

- No claims to file
- No annual deductible to meet
- Orthodontia coverage for children and adults
- Ability to change dentists during the year
- No annual maximum benefit limits for most services.

For more information on the managed dental plan, consult the schedule of benefits available on **MyTexasHealth**.

Aetna PPO/PDN Max (Low Option)

Aetna Preferred Provider Organization offers a network similar to a medical PPO that allows you to use either network or out-of-network providers. However, you receive greater benefits when you use network providers.

If you choose the PPO (Low Option), which uses the Aetna network, you don't have to satisfy a deductible for preventive care, but you must satisfy the deductible before the plan pays for other kinds of care. Dental network providers agree to charge discounted rates for their services.

Although coverage is the same for network and out-of-network care, out-of-network providers may charge higher fees than network providers, resulting in higher out-of-pocket expenses for you. You must file claims when using an out-of-network provider to receive benefits under the PPO. Members may be responsible for the difference between Aetna's negotiated fees and the out-of-network dentist's actual charge.

Advantages of the PPO include:

- Choice of using network or out-of-network providers
- Discounted services when you use network providers
- 80% coverage for preventive services whether you use network or out-of-network providers.

PPO PLAN FEATURES

Dental coverage under the PPO is subject to the following features:

- *Alternative treatment*—If you undergo a more expensive treatment or procedure when a less expensive alternative was available, the plan may pay benefits based on the less expensive procedure that is consistent with good dental care.
- *Annual benefit maximum*—The plan pays a maximum benefit of $1,000 per covered person per year.
- *Coordination of benefits*—If you or a covered dependent has coverage under any other group dental plan, this plan will coordinate benefits with the other plan.
- *Deductible*—You must meet the individual or family deductible before the plan pays benefits for non-preventive care. The annual deductible for Basic and Major Care is $50 per person or $150 per family. Only covered expenses for which no benefits are payable can be counted toward the deductible.
- *Fee limit*—The amount of benefits paid for eligible expenses is based on the contracted fee limit for a service or item provided by participating providers in the zip code area where the service is provided.
- *In-network*—A group of dental providers in the PPO has agreed to charge negotiated rates for services and items.
- *Necessary services and supplies*—Only dental services that are necessary are covered by the plan. Cosmetic services are not covered, except to repair accidental injuries not covered by the Total Health Medical Plan. The service must be:
  - For the diagnosis or direct treatment of a dental injury or illness
  - Appropriate and consistent with the symptoms and findings or diagnosis and the treatment of the covered person's injury or illness
  - Provided in accordance with generally accepted dental practice on a national basis
  - The most appropriate supply or level of service that can be provided on a cost-effective basis.

  The fact that your network dentist prescribes services or supplies does not automatically mean they are necessary and covered by the plan.
- Out-of-network—You receive the lower level of benefits if you use a provider who is not a member of the PPO.
- Predetermination of benefits—You should request a predetermination of benefits if your dentist recommends a treatment expected to cost $350 or more to find out how the plan may cover the procedure before receiving treatment. Your dentist completes a form listing the recommended dental services and showing the charge for each service. The claims administrator reviews the form and informs the dentist of your estimated benefits. The dentist may be asked to provide supporting X-rays or other diagnostic records before predetermination is made.
- Reimbursement—The plan will deduct your coinsurance amount from the total amount of your reimbursement.

SUMMARY OF BENEFITS

The table below briefly summarizes how the PPO (Low Option) covers dental expenses and shows what the plan pays for your care.

Plan Feature	PPO (Low Option) Network or Out-of-network*
Deductible	$50 per person $150 per family
Preventive care (Two visits per year) • Routine checkups • X-rays • Cleaning and polishing • Space maintainers	80% after deductible
Basic care • Fillings • Extractions • Anterior/bicuspid root canal therapy • Oral surgery	60% after deductible
Major care • Bridges • Dentures • Crowns • Molar root canal therapy • Inlays and onlays	40% after deductible
Maximum annual benefit	$1,000 per person
Orthodontic care (For eligible adults and dependent children)	50% with no deductible $1,000 lifetime maximum

* You will have higher out-of-pocket expenses when you use out-of-network providers.

What the PPO (Low Option) Covers

To be covered by a dental plan, a dental expense must be necessary and provided by a duly qualified and licensed dentist. Charges for covered items must be within the usual and customary fee limits.

PREVENTIVE SERVICES

Preventive services are covered at 80% and include the following:

- Office visits during regular office hours, for oral examination (limited to two visits per year)
- Prophylaxis (cleaning) limited to two treatments per year
- Topical application of fluoride (limited to one course of treatment per year for children under age 16)
- Bitewing X-rays (limited to once per year)
- Complete X-ray series or panoramic film including bitewings, if necessary (limited to once every three years)
- Vertical bitewing X-rays (limited to one set every three years)

Space Maintainers

- No age limit (covered only for premature loss of primary teeth)
- Includes all adjustments within six months after installation
- Fixed space maintainer (band type)
- Removable acrylic with round wire rest only
- Removable inhibiting appliance to correct thumb sucking
- Fixed or cemented inhibiting appliance to correct thumb sucking

BASIC SERVICES

Basic services are covered at 60% after you meet the deductible and include the following:

Visits and Exams

- Professional visit after hours (payment will be made on the basis of services rendered or visit, whichever is greater)
- Emergency palliative treatment

X-ray and Pathology

- Single films (up to 13)
- Intra-oral, occlusal view, maxillary or mandibular
- Upper or lower jaw, extra-oral
- Biopsy and histopathologic examination of oral tissue

Oral Surgery

- Local anesthetics and routine postoperative care
- Uncomplicated extractions
- Uncomplicated surgical removal of an erupted tooth
- Postoperative visit (sutures and complications) after multiple extractions and impaction
- Surgical removal of impacted tooth (soft tissue)
- Alveolectomy (edentulous)
- Alveolectomy (in addition to removal of teeth)
- Alveoplasty with ridge extension
- Removal of exostosis
- Excision of hyperplastic tissue
- Excision of pericoronal gingiva
- Incision and drainage of abscess
- Removal of odontogenic cyst or tumor
- Sialolithotomy (removal of salivary calculus)
- Closure of salivary fistula
- Dilation of salivary duct
- Transplantation of tooth or tooth bud
- Removal of foreign body from bone (independent procedure)
- Maxillary sinusotomy for removal of tooth fragment or foreign body
- Closure of oral fistula of maxillary sinus
- Sequestrectomy for osteomyelitis or bone abscess, superficial
- Condylectomy of temporomandibular joint
- Meniscectomy of temporomandibular joint
- Radical resection of mandible with bone graft
- Crown exposure to aid eruption
- Removal of foreign body from soft tissue
- Frenectomy
- Suture of soft tissue injury
- Injection of sclerosing agent into temporomandibular joint
- Treatment of trigeminal neuralgia by injection into second and third divisions

Periodontics

- Emergency treatment (periodontal abscess, acute periodontitis, etc.)
- Root planing and scaling, per quadrant (not prophylaxis), limited to four separate quadrants every two years
- Correction of occlusion related to periodontal surgery—occlusal guards, one every three years
- Gingivectomy (including post-surgical visits) one per quadrant per site every three years
- Gingivectomy, treatment per tooth (less than four teeth per quad)
- Post-surgical visits

Endodontics

- Pulp capping
- Therapeutic pulpotomy (in addition to restoration)
- Vital pulpotomy
- Remineralization (calcium hydroxide, temporary restoration) as a separate procedure only
- Root canals (devitalized teeth only, other than molar root canal therapy), including necessary X-rays and cultures but excluding final restoration
- Canal therapy (traditional or sargenti method), includes single rooted or bi-rooted
- Local anesthetics when necessary

Restorative Dentistry

- Excludes inlays, crowns (other than stainless steel) and bridges
- Multiple restorations in one surface will be considered as a single restoration
- Restorations (involving one, two or three or more surfaces), includes amalgam, silicate cement, plastic, and composite fillings
- Pins (retention) when part of the restoration used instead of gold or crown restoration
- Stainless steel crowns (when tooth cannot be restored with a filling material)
- Recementation of inlay, crown, or bridge
- Full and partial denture repairs
  - Broken dentures, no teeth involved
  - Partial denture repairs (metal)
  - Replacing missing or broken teeth.

MAJOR SERVICES

Major services are covered at 40% after you meet the deductible and include the following:

Restorative

- Gold restorations and crowns—covered only as treatment for decay or traumatic injury and only when teeth cannot be restored with a filling material or when the tooth is an abutment to a fixed bridge
- Inlays and onlays (one or more surfaces)
- Crowns
  - Acrylic
  - Acrylic with gold
  - Acrylic with non-precious metal
  - Porcelain
  - Porcelain with gold
  - Porcelain with non-precious metal
  - Non-precious metal (full cast)
  - Gold (full cast)
  - Gold (3/4 cast)
  - Gold dowel pin
- Adding teeth to partial denture to replace extracted natural teeth—teeth and clasps
- Repairs to crowns and bridges

Prosthodontics

- Bridge Abutments (See Inlays and Crowns above)
- Pontics
  - Cast Gold (sanitary)
  - Cast non-precious metal
  - Slotted facing
  - Slotted pontic
  - Porcelain fused to gold
  - Porcelain fused to non-precious metal
  - Plastic processed to gold
  - Plastic processed to non-precious metal
- Removable Bridge (unilateral)—one piece casting, chrome cobalt alloy clasp attachment (all types) including pontics
- Dentures and partials—fees for dentures, partial dentures and relining include adjustments within six months after installation; specialized techniques and characterizations are not eligible
  - Complete upper denture
  - Complete lower denture
  - Partial acrylic upper or lower with chrome cobalt alloy clasps, base, all teeth and two clasps
  - Additional clasps
  - Partial lower or upper with chrome cobalt alloy lingual or palatal bar and acrylic saddles, base, all teeth and two clasps plus additional clasps
  - Simple stress breakers, extra
  - Stayplate, base and additional clasps
  - Office reline, cold cure, acrylic
  - Laboratory reline
  - Special tissue conditioning, per denture
  - Denture duplication (jump case), per denture
  - Adjustment to denture more than six months after installation

Oral Surgery

- General anesthesia, only when provided in conjunction with a surgical procedure

Periodontics

- Osseous surgery (including flap entry and closure)—modifies the bony support of teeth by reshaping the alveolar process to achieve a more physiologic form. May include removal of supporting bone or non-supporting bone and limited to one per quadrant every three years.

Endodontics

- Molar root canal therapy.

ORTHODONTIA EXPENSES

The PPO (Low Option) covers 50% of eligible orthodontia expenses for eligible adults and dependent children. The plan covers only the orthodontic services and treatments described below. The lifetime maximum orthodontia benefit is $1,000.

The PPO (Low Option) will not cover expenses for orthodontia treatment begun or appliances installed before you or your eligible dependent became covered by the Total Health Dental Plan.

Orthodontic Treatment Plan

The plan defines orthodontic treatment as the use of active appliances to move teeth to correct faulty position of teeth (malposition) or abnormal bite (malocclusion).

Before beginning treatment, the dentist must submit a treatment plan to the claims administrator that:

- States the class of malocclusion or malposition
- Recommends and describes the required orthodontic treatment
- Estimates the duration of the treatment
- Estimates the total cost for the treatment
- Includes cephalometric X-rays, study models, and any other supporting evidence that the claims administrator may reasonably require.

The plan will return an estimate of your orthodontic benefits to the dentist. After your treatment plan is approved, you begin paying your portion of orthodontia expenses in equal installments over the duration of treatment. The PPO (Low Option) pays expenses in equal quarterly installments, beginning with the end of the three-month period following the date the appliances are first inserted.

Covered Orthodontia Expenses

The PPO (Low Option) will cover expenses for orthodontia treatment, up to the lifetime maximum, for the following charges:

- Services or supplies furnished in connection with an orthodontic procedure and before the end of the estimated duration shown in the orthodontic treatment plan
- Active appliances inserted while you or your dependent is covered by the PPO (Low Option)
- Orthodontic procedures needed to correct one of these conditions:
  - Vertical or horizontal overlap of upper teeth over lower teeth (overbite or overjet)
  - Faulty alignment (either frontwards or backwards) of the upper and lower arches with each other
  - Cross-bite
- Services or supplies as part of an orthodontic treatment plan that, before the procedure is performed, have been:
  - Sent to the claims administrator for review
  - Returned by the claims administrator to the dentist showing estimated benefits.

Participating Dental Network (PDN) (High Option)

A PDN is similar to a medical PPO in that you may use either network or out-of-network providers. However, you receive greater benefits when you use network providers.

If you choose the PDN (High Option) (which uses the Aetna network) you don't have to satisfy a deductible for preventive care, but you must satisfy the deductible before the plan pays for other kinds of care. Dental network providers agree to charge discounted rates for their services.

Although coverage is the same for network and out-of-network care, out-of-network providers may charge higher fees than network providers, resulting in higher out-of-pocket expenses for you. When you use an out-of-network provider, you must file claims to receive benefits under the PDN.

Out-of-network payments are based on Reasonable & Customary charges using the 80th percentile of the FAIR Health Benchmark database profile. The database consists of provider charge data collected from more than 150 major contributors, including commercial insurance companies and third-party administrators. Members may be responsible for the difference between the R&C amount and the out-of-network dentist's actual charge.

Advantages of the PDN include:

- Choice of using network or out-of-network providers
- Discounted services when you use network providers
- 100% coverage for preventive services whether you use network or out-of-network providers.

PDN PLAN FEATURES

Dental coverage under the PDN is subject to the following features:

- *Alternative treatment*—If you undergo a more expensive treatment or procedure when a less expensive alternative was available, the plan may pay benefits based on the less expensive procedure that is consistent with good dental care.
- *Annual benefit maximum*—The plan pays a maximum benefit of $1,500 per covered person per year.
- *Bitewing X-rays* (limited to once per year)
- *Coordination of benefits*—If you or a covered dependent has coverage under any other group dental plan, this plan will coordinate benefits with the other plan.
- *Deductible*—You must meet the individual or family deductible before the plan pays benefits for non-preventive care. The annual deductible for Basic and Major Care is $50 per person or $150 per family. Only covered expenses for which no benefits are payable can be counted toward the deductible.
- *In-network*—A group of dental providers in the PDN has agreed to charge negotiated rates for services and items.
- *Necessary services and supplies*—Only dental services that are necessary are covered by the plan. Cosmetic services are not covered, except to repair accidental injuries not covered by the Total Health Medical Plan. The service must be:
  - For the diagnosis or direct treatment of a dental injury or illness
  - Appropriate and consistent with the symptoms and findings or diagnosis and the treatment of the covered person's injury or illness
  - Provided in accordance with generally accepted dental practice on a national basis
  - The most appropriate supply or level of service which can be provided on a cost-effective basis

  The fact that your network dentist prescribes services or supplies does not automatically mean they are necessary and covered by the plan.
- *Out-of-network*—You receive the lower level of benefits if you use a provider who is not a member of the PDN.
- *Predetermination of benefits*—You should request a predetermination of benefits if your dentist recommends a treatment expected to cost $350 or more to find out how the plan may cover the procedure before receiving treatment. Your dentist completes a form listing the recommended dental services and showing the charge for each service. The claims administrator reviews the form and informs the dentist of your estimated benefits. The dentist may be asked to provide supporting X-rays or other diagnostic records before predetermination is made.
- *Reimbursement*—The plan will deduct your coinsurance amount from the total amount of your reimbursement.
- *Usual and customary fee limit*—The amount of benefits paid for eligible expenses is based on the usual and customary fee limit for a service or item in the geographic area where you reside. The usual fee is the fee most frequently charged or accepted for covered expenses for dental care or supplies by a physician or hospital. The customary fee is the fee charged or accepted for covered dental care or supplies by those of a similar professional standing in the same geographic area, as determined by Aetna.

SUMMARY OF BENEFITS

The table below briefly summarizes how the PDN (High Option) covers dental expenses and shows what the plan pays for your care.

Plan Feature	PDN (High Option) Network or Out-of-network*
Deductible	$50 per person $150 per family
Preventive care (Two visits per year) • Routine checkups • X-rays • Cleaning and polishing • Space maintainers	No cost to the employee. Plan pays 100% with no deductible.
Basic care • Fillings • Extractions • Anterior/ bicuspid root canal therapy • Oral surgery	80% after deductible
Major care • Bridges • Dentures • Crowns • Molar root canal therapy • Inlays and onlays	50% after deductible
Maximum annual benefit	$1,500 per person
Orthodontic care (For eligible adults and dependent children)	50% with no deductible $1,250 lifetime maximum

* You will have higher out-of-pocket expenses when you use out-of-network providers.

What the PDN (High Option) Covers

To be covered by a dental plan, a dental expense must be necessary and provided by a duly qualified and licensed dentist. Charges for covered items must be within the usual and customary fee limits.

PREVENTIVE SERVICES

Preventive Services are covered at 100% and include the following:

- Office visits during regular office hours, for oral examination (limited to two visits per year)
- Prophylaxis (cleaning) limited to two treatments per year
- Topical application of fluoride, including prophylaxis (limited to one course of treatment per year for children under age 16)
- Bitewing X-rays (limited to once per year)
- Complete X-ray series or panoramic film including bitewings, if necessary (limited to once every three years)
- Vertical bitewing X-rays (limited to one set every three years)

Space Maintainers

- Includes all adjustments within six months after installation
- Fixed space maintainer (band type)
- Removable acrylic with round wire rest only
- Removable inhibiting appliance to correct thumb sucking
- Fixed or cemented inhibiting appliance to correct thumb sucking

BASIC SERVICES

Basic services are covered at 80% after you meet the deductible and include the following:

Visits and Exams

- Professional visit after hours (payment will be made on the basis of services rendered or visit, whichever is greater)
- Emergency palliative treatment

X-ray and Pathology

- Single films (up to 13)
- Intra-oral, occlusal view, maxillary or mandibular
- Upper or lower jaw, extra-oral
- Biopsy and examination of oral tissue

Oral Surgery

- Local anesthetics and routine postoperative care
- Uncomplicated extractions
- Uncomplicated surgical removal of an erupted tooth
- Postoperative visit (sutures and complications) after multiple extractions and impaction
- Surgical removal of impacted tooth (soft tissue)
- Alveolectomy (edentulous)
- Alveolectomy (in addition to removal of teeth)
- Alveoplasty with ridge extension
- Removal of exostosis
- Excision of hyperplastic tissue
- Excision of pericoronal gingiva
- Incision and drainage of abscess
- Removal of odontogenic cyst or tumor
- Sialolithotomy (removal of salivary calculus)
- Closure of salivary fistula
- Dilation of salivary duct
- Transplantation of tooth or tooth bud
- Removal of foreign body from bone (independent procedure)
- Maxillary sinusotomy for removal of tooth fragment or foreign body
- Closure of oral fistula of maxillary sinus
- Sequestrectomy for osteomyelitis or bone abscess, superficial
- Condylectomy of temporomandibular joint
- Meniscectomy of temporomandibular joint
- Radical resection of mandible with bone graft
- Crown exposure to aid eruption
- Removal of foreign body from soft tissue
- Frenectomy
- Suture of soft tissue injury
- Injection of sclerosing agent into temporomandibular joint
- Treatment of trigeminal neuralgia by injection into second and third divisions

Periodontics

- Emergency treatment (periodontal abscess, acute periodontitis, etc.)
- Root planing and scaling, per quadrant (not prophylaxis), limited to four separate quadrants every two years
- Correction of occlusion related to periodontal surgery—occlusal guards, one every three years
- Gingivectomy (including post-surgical visits)
- Gingivectomy, treatment per tooth (less than four teeth per quad)
- Post-surgical visits

Endodontics

- Pulp capping
- Therapeutic pulpotomy (in addition to restoration)
- Vital pulpotomy
- Remineralization (calcium hydroxide, temporary restoration) as a separate procedure only
- Root canals (devitalized teeth only, other than molar root canal therapy), including necessary X-rays and cultures but excluding final restoration
- Canal therapy (traditional or sargenti method), includes single rooted or bi-rooted
- Local anesthetics where necessary

Restorative Dentistry

- Excludes inlays, crowns (other than stainless steel) and bridges
- Multiple restorations in one surface will be considered as a single restoration
- Restorations (involving one, two or three or more surfaces), includes amalgam, silicate cement, plastic, and composite fillings
- Pins (retention) when part of the restoration used instead of gold or crown restoration
- Stainless steel crowns (when tooth cannot be restored with a filling material)
- Recementation of inlay, crown, or bridge
- Full and partial denture repairs
  - Broken dentures, no teeth involved
  - Partial denture repairs (metal)
  - Replacing missing or broken teeth.

MAJOR SERVICES

Major services are covered at 50% after you meet the deductible and include the following:

Restorative

- Gold restorations and crowns—covered only as treatment for decay or traumatic injury and only when teeth cannot be restored with a filling material or when the tooth is an abutment to a fixed bridge
- Inlays and onlays (one or more surfaces)
- Crowns
  - Acrylic
  - Acrylic with gold
  - Acrylic with non-precious metal
  - Porcelain
  - Porcelain with gold
  - Porcelain with non-precious metal
  - Non-precious metal (full cast)
  - Gold (full cast)
  - Gold (¾ cast)
  - Gold dowel pin
- Adding teeth to partial denture to replace extracted natural teeth—teeth and clasps
- Repairs to crowns and bridges

Prosthodontics

- Bridge Abutments (see Inlays and Crowns above)
- Pontics
  - Cast Gold (sanitary)
  - Cast non-precious metal
  - Slotted facing
  - Slotted pontic
  - Porcelain fused to gold
  - Porcelain fused to non-precious metal
  - Plastic processed to gold
  - Plastic processed to non-precious metal
- Removable Bridge (unilateral)—one piece casting, chrome cobalt alloy clasp attachment (all types) including pontics
- Dentures and partials—fees for dentures, partial dentures and relining include adjustments within six months after installation; specialized techniques and characterizations are not eligible
  - Complete upper denture
  - Complete lower denture
  - Partial acrylic upper or lower with chrome cobalt alloy clasps, base, all teeth and two clasps
  - Additional clasps
  - Partial lower or upper with chrome cobalt alloy lingual or palatal bar and acrylic saddles, base, all teeth and two clasps plus additional clasps
  - Simple stress breakers, extra
  - Stayplate, base and additional clasps
  - Office reline, cold cure, acrylic
  - Laboratory reline
  - Special tissue conditioning, per denture
  - Denture duplication (jump case), per denture
  - Adjustment to denture more than six months after installation

Oral Surgery

- General anesthesia, only when provided in conjunction with a surgical procedure

Periodontics

- Osseous surgery (including flap entry and closure)—modifies the bony support of teeth by reshaping the alveolar process to achieve a more physiologic form. May include removal of supporting bone or non-supporting bone and limited to one per quadrant every three years.

Endodontics

- Molar root canal therapy.

ORTHODONTIA EXPENSES

The PDN (High Option) covers 50% of eligible orthodontia expenses for eligible adults and dependent children. The plan covers only the orthodontic services and treatments described below. The lifetime maximum orthodontia benefit is $1,250.

The PDN (High Option) will not cover expenses for orthodontia treatment begun or appliances installed before you or your eligible dependent became covered by the Texas Health Dental Plan.

Orthodontic Treatment Plan

The plan defines orthodontic treatment as the use of active appliances to move teeth to correct faulty position of teeth (malposition) or abnormal bite (malocclusion).

Before beginning treatment, the dentist must submit a treatment plan to the claims administrator that:

- States the class of malocclusion or malposition
- Recommends and describes the required orthodontic treatment
- Estimates the duration of the treatment
- Estimates the total cost for the treatment
- Includes cephalometric X-rays, study models, and any other supporting evidence that the claims administrator may reasonably require.

The plan will return an estimate of your orthodontic benefits to the dentist. After your treatment plan is approved, you begin paying your portion of orthodontia expenses in equal installments over the duration of treatment. The PDN (High Option) pays expenses in equal quarterly installments, beginning with the end of the three-month period following the date the appliances are first inserted.

Covered Orthodontia Expenses

The PDN (High Option) will cover expenses for orthodontia treatment, up to the lifetime maximum, for the following charges:

- Services or supplies furnished in connection with an orthodontic procedure and before the end of the estimated duration shown in the orthodontic treatment plan
- Active appliances inserted while you or your dependent is covered by the PDN (High Option)
- Orthodontic procedures needed to correct one of these conditions:
  - Vertical or horizontal overlap of upper teeth over lower teeth (overbite or overjet)
  - Faulty alignment (either frontwards or backwards) of the upper and lower arches with each other
  - Cross-bite
- Services or supplies as part of an orthodontic treatment plan that, before the procedure is performed, have been:
  - Sent to the claims administrator for review
  - Returned by the claims administrator to the dentist showing estimated benefits.

Excluded Expenses

The following expenses are not eligible for benefits under the PPO (Low Option) or PDN (High Option).

- Services not necessary or not customarily performed for the dental care of a specific condition as determined by Aetna
- Services not furnished by a dentist. This does not apply if the service is performed by a licensed dental hygienist under the direction of a dentist or is an X-ray ordered by a dentist.
- Charges for a service:
  - Furnished by or for the United States government or any other government, unless payment of the charge is required by law
  - To the extent that the service, or any benefit for the charge, is provided by any law or governmental plan under which the patient is or could be covered. This does not apply to a state plan under Medicaid or to any law or plan when, by law, its benefits are in addition to those of any private insurance program or other non-governmental program.
- Implants
- Replacement or modification of a partial or full removable denture, removable bridge or fixed bridgework, or for adding teeth to any of these within five years after that denture, bridge, or bridgework was installed
- Replacement or modification of a crown or gold restoration within five years after that crown or gold restoration was installed
- Charges for any of the following services:
  - An appliance, or modification of one, if an impression for it was made before you were covered under the plan
  - A crown, bridge or gold restoration, if a tooth was prepared for it before you were covered under the plan
  - Root canal therapy, if the pulp chamber for it was opened before you were covered under the plan
- Cosmetic treatment—Facings on crowns or pontics behind the second bicuspid will always be considered cosmetic. This does not apply if the treatment is needed as a result of accidental injuries sustained while you are covered under the plan.
- Charges in connection with:
  - Replacement of lost or stolen appliances
  - Appliances, restorations or procedures needed to alter vertical dimensions or restore occlusion, or for the purpose of splinting or correcting attrition or abrasion
- Charges in connection with injury arising out of, or in the course of, any work for wage or profit (whether or not with Texas Health)
- Charges in connection with a disease covered by any workers' compensation law, occupational disease law or similar law
- Charges for a service to the extent it is more than the usual charge made by the provider for the service when there is no coverage
- Charges above the prevailing rate in the area for dental care of a comparable nature. The area and the range are determined by the claims administrator
- Charges for a service or supply furnished by a network provider in excess of the provider's negotiated charge for that service or supply. A negotiated charge is the maximum a network provider has agreed to charge for a service or supply under the PDN.

Filing and Appealing Dental Claims

Benefits under all dental plans are fully insured by Aetna. Aetna processes all claims under these plans. Whenever you file a claim, be sure to keep a copy of the claim and any other information (such as itemized bills) that you include with the claim.

AETNA DMO

The Aetna DMO pays benefits only when you use network providers, so you do not need to file claims for benefits. You pay a copay for services, your provider files claims for you, and the plan pays the rest of the cost.

However, in an emergency, you may use a non-network provider and you or the provider would need to file a claim. Consult the plan materials for more information on claims for benefits.

DENTAL PPO AND PDN

Under the PPO and PDN plans, you may use network or out-of-network providers. However, you receive greater benefits when you use network providers.

Network Providers

When you use a PPO or PDN provider, you must first satisfy a deductible and pay a coinsurance for basic care, major care, and orthodontia. Network providers will normally file your claims for benefits with Aetna PPO or PDN.

If plan benefits differ depending on whether care is given by, or accessed through, a network provider, you may obtain, without charge, a listing of network providers from your claims administrator, or by calling the toll-free Member Services number on your ID Card. A current list of providers in the Aetna network is available through DocFind®, at **www.aetna.com**.

Out-of-network Providers

When you use an out-of-network provider, you must file a claim (the form is available online) for dental expense benefits as follows:

- Complete the top portion of the dental expense claim form by following the instructions that accompany the form. Then, present the form to your dentist, who completes the remaining portion.
- Submit all itemized receipts from your dentist. A canceled check is not acceptable documentation.
- Mail the completed claim form with the original itemized bills and receipts to Aetna at the address on the claim form.

You must submit the original itemized bill or receipt provided by your dentist, so you should make copies for your own records. Photocopies of receipts are not accepted for claims. In addition, each bill or receipt must include the following:

- Name of patient
- Date the treatment or service was provided
- Diagnosis
- Itemized charges for the treatment or service
- Provider's name, address, and tax ID number.

All dental claims payments are sent to you along with an explanation of benefits (EOB) explaining the amount paid. Payments may, however, be sent directly to your dentist or other dental provider if your provider accepts assignment of benefits. In this case, the EOB will be mailed to you and the payment mailed to your provider.

TYPES OF CLAIMS

There are four different types of claims. The claim type is determined initially when the claim is filed. If the nature of the claim changes as it proceeds through claims processing, the claim may be re-characterized. For example, a claim may initially be an urgent care claim. If the urgency subsides, it may be re-characterized as a pre-service claim.

Pre-service claims

On receipt of a pre-service claim, the claims administrator will determine whether or not it involves urgent care. If a dentist with knowledge of your medical condition determines that a claim involves urgent care, the claim will be treated as an urgent care claim.

If the plan requires you to obtain advance approval for a service, supply, or procedure, your request for advance approval is considered a pre-service claim. The claims administrator will notify you of its decision no later than 15 days after receiving your claim.

This does not apply to a claim involving urgent care, as defined below.

Urgent Care Claims

If the plan requires advance approval for a service, supply, or procedure before a benefit is payable, and the plan or your dentist determines that your claim is an urgent care claim, the claims administrator will notify you of its decision no later than 72 hours after receiving your claim.

Urgent care means services received for sudden illness, injury, or condition that is not an emergency condition but requires immediate outpatient medical care that cannot be postponed. An urgent situation is one that is severe enough to require prompt medical attention to avoid serious deterioration of your health. This includes a condition that would subject you to severe pain that could not be adequately managed without prompt treatment.

If the claims administrator does not have enough information to decide the claim, they will notify you of the information needed to complete the claim as soon as possible after receiving your claim but no more than 24 hours later. The claims administrator will give you a reasonable time to provide the information but not less than 48 hours. They will notify you of their decision no later than 48 hours after the end of the additional time period, or after they receive the information, if earlier.

Post-service Claims

A post-service claim is any claim for a benefit that is not a pre-service claim or an urgent care claim. For post-service claims, the claims administrator will notify you no later than 30 days after receiving your claim.

Ongoing Care

A claim for ongoing care is one in which the claims administrator approves a course of treatment over a period of time or for a specified number of treatments. However, a claim for ongoing care may be reconsidered by the claims administrator and the initially approved period of time or number of treatments may be either reduced, terminated, or extended.

The claims administrator will notify you in advance if the plan intends to terminate or reduce benefits for a course of ongoing care so you will have an opportunity to appeal the decision before the termination or reduction takes effect. If the ongoing care involves urgent care, and you request an extension of the ongoing care at least 24 hours before it expires, the claims administrator will notify you of its decision within 24 hours after receiving your request.

EXTENSION OF TIME PERIODS

For pre-service and post-service claims, the claims administrator may extend the time periods for up to an additional 15 days for circumstances outside the plan's control. If an extension is required, you will be notified of the extension before the end of the initial 15- or 30-day period. For example, if you have not submitted sufficient information for the claims administrator to decide the claim, they will notify you of the specific information needed and provide an additional period of at least 45 days to furnish the information. The claims administrator will notify you of their decision no later than 15 days after the end of the extended period, or after receipt of the information, if earlier.

If you file a pre-service claim and include the name of the patient, dental condition, and service or supply for which approval is being requested but you do not follow the plan's procedures for filing pre-service claims, the claims administrator will notify you of the proper procedures within five days (or within 24 hours for an urgent care claim). The notification may be oral unless you request written notification.

HOW TO FILE A CLAIM FOR BENEFITS

Except for urgent care claims, a claim for benefits is made when you (or your authorized representative) submit a written claim form to:

Aetna
P.O. Box 14066
Lexington, KY 40512-4066
www.aetna.com.

COORDINATION OF BENEFITS

If you have dental coverage through any other plan, the PDN Plans are coordinated with the other plan so that you do not receive greater benefits than the cost of covered services.

CLAIM FILING DEADLINE

You must submit all dental claims within 90 days after the date the expenses were incurred.

PAYMENT OF CLAIMS

Plan benefits are payable to you, unless you give written direction at the time you file your claim, to directly pay the dentist or unless a Qualified Medical Child Support Order directs the payment to someone else.

You may request that the claims processor pay your dentist directly by assigning your benefits. You may assign benefits for eligible expenses incurred for dental care only to the person or institution that provides the services or supplies for which these benefits are payable.

If any benefit remains unpaid at your death, if the covered person is a minor or legally incapable (in the opinion of the claims administrator) of giving a valid receipt and discharge for payment, the claims administrator may, at its option, pay benefits to the spouse, parent or child of the covered person. Payment to the covered person's relative constitutes a complete discharge of the claims administrator's obligation to the extent of the payment. The claims administrator is not required to see the application of the money.

FILING AN APPEAL

With the exception of urgent care claims, you have 180 days to file an appeal after you receive an adverse decision. After the claims administrator receives your appeal, they will notify you of their decision no more than:

- 15 days later for a pre-service claim
- 30 days later for a post-service claim.

You may submit written comments, documents, records, or other information relating to your claim, even if you did not submit them with the initial claim. You may also request that the plan provide copies of all documents, records, and other information relevant to the claim. Those copies will be provided free of charge.

If your claim involves urgent care, you may make an expedited appeal by calling Aetna's Member Services at the telephone number on your ID card. You or your authorized representative may appeal an urgent care claim denial either orally or in writing. All necessary communication will be made by telephone, facsimile, or other similar method, including the appeal decision. You will be notified of the decision within 36 hours after your appeal is received.

If you are dissatisfied with the appeal decision on a claim involving urgent care, you may file a second-level appeal with Aetna. You will be notified of the decision no later than 36 hours after the appeal is received.

If you are dissatisfied with a pre-service or post-service appeal decision, you may file a second level appeal with Aetna within 60 days of receipt of the first appeal decision. Aetna will notify you of the decision no later than 15 days (for pre-service claims) or 30 days (for post-service claims) after the appeal is received.

If you do not agree with the final determination on review, you have the right to bring civil action under Section 502(a) of ERISA, if applicable.

If you have the DMO plan and wish to obtain information or make a complaint:

- You may call Aetna Dental Inc.'s toll-free telephone number at 1-(877) 238-6200.
- You may write to Aetna Dental Inc. at:
  Aetna Dental Inc.
  One Prudential Circle
  Sugar Land, TX 77478
- You may call the Texas Department of Insurance at 1-(800) 252-3439.
- You may write the Texas Department of Insurance at:
  P.O. Box 149104
  Austin, TX 78714-9104
  Fax: (512) 475-1771
  Web: **http://www.tdi.state.tx.us**
  Email: ConsumerProtection@tdi.state.tx.us.

Should you have a dispute concerning your premium or about a claim you should contact Aetna first. If the dispute is not resolved you may contact the Texas Department of Insurance. This notice is for information only and does not become a part or condition of the DMO plan as described in the Handbook.

When Coverage Ends

Generally, coverage for you and your covered dependents under the Total Health Dental Plan ends on the last day of the pay period in which you terminate employment. See page 140 for more information.

In some cases, you and your covered dependents may be eligible for COBRA continuation coverage, as explained on page 141.

Vision Plan

Overview

You may elect coverage for vision care through the Superior Vision Plan. The plan pays benefits for annual eye exams and corrective lenses. You pay a copay for exams and materials (materials copayment applies to lenses and frames, not contact lenses) the plan pays benefits for frames and lenses up to certain limits. Under this plan you may use network or out-of-network vision care providers, but you receive greater benefits when you use network providers.

The Superior Vision Plan allows you to choose your eye care provider. You can choose a network provider or an out-of-network provider. Network providers file all claim forms. When you use an out-of-network provider, you pay the full cost of vision care expenses to the provider and submit a claim for reimbursement. Your reimbursement will be paid under the out-of-network schedule of allowances, less any applicable copay amounts.

Who Can Be Covered

You may elect the following levels of coverage under the Vision Plan:

- You only
- You and your spouse
- You and your unmarried dependent children up to age 25 who are not regularly employed on a full-time basis
- You and your family

See pages 5 – 7 for more information on eligibility.

Summary of Benefits

The following table summarizes how the plan pays benefits and your cost for certain services and supplies.

Feature	Network	Out-of-network
Comprehensive eye exam once every 12 consecutive months	Covered in full after $10 copay	Up to $42 for ophthalmologist (M.D.) or $37 for optometrist (O.D.)
Standard lenses once every 12 consecutive months[1]	Covered in full after $10 copay	Single vision–up to $32 Bifocal–up to $46 Trifocal–up to $61 Lenticular–up to $84
Contact lens fitting (standard)	Covered in full after $35 copay	Not covered
Contact lens fitting (specialty)	Up to $50 retail allowance after a $35 copay	Not covered
Contact lenses (per pair, in lieu of eyeglasses) once every 12 consecutive months[1]	Cosmetic elective–up to $140 allowance ($35 copay for contact lens fitting exam) Medically necessary–covered in full[2]	Cosmetic elective–up to $100 retail allowance Medically necessary–up to $210[2]
Standard frames once every 12 consecutive months	Up to $140 retail allowance	Up to $53 retail allowance
Refractive surgery (LASIK, radial keratotomy, or photo-refractive keratotomy)	5%–50% discount	No benefit
Add-ons to covered lenses (covered in-network only) You receive 20% off retail, up to the dollar amount listed: • Factory scratch coat – $13[3] • Ultraviolet coat – $15[3] • Standard anti-reflective coat – $50[3] • High index 1.6 – $55[4] • Polycarbonate – $40[4] • Standard transitions and other photochromic – $80[4] • Glass coloring – $35[5] • Plastic tints solid or gradient – $25[5] You receive 20% discount off retail for these add-ons to any type of lenses: • Power over 4.00D sphere, 2.00D cylinder and 5.00D prism • Cosmetic finishing, beveling, edging, and mounting • All other lens options or upgrades		

[1] The plan will pay for either contact lenses or eyeglass frames and lenses once every 12 consecutive months. You may not receive benefits for eyeglasses in the same consecutive 12 month period in which you receive benefits for contact lenses.

[2] Must have prior approval and only certain medical eye conditions will be approved

[3] Single-vision and standard lined multifocal lenses

[4] Single-vision lenses only

[5] Any type of lenses

Network Providers

To find a list of network providers, visit **www.superiorvision.com** or call Superior Vision at 1-877-MyTHRLink (1-877-698-4754), prompt 6, press 4. When you choose a Superior Vision Services network provider, you should identify yourself as a member of the plan when making your appointment. Superior Vision Services will give the provider an authorization number to verify your benefits before you receive your services. Although it is not required, it is recommended that you present your ID card to the provider at the time you receive services. This makes the identification process easier. You can print additional cards by logging on to **www.superiorvision.com**.

When you receive care, pay only your copay and any charges not covered by the plan. The network provider will handle claims for you.

To receive the discount for refractive surgery, simply present your ID card to a participating refractive surgeon listed in the Superior Vision provider directory with the notation "RF" under services provided.

Covered In-Network Expenses

You may receive benefits for a comprehensive vision examination by an ophthalmologist or optometrist once every 12 consecutive months, which must include:

- Case history
- Visual health evaluation, to include:
  - Internal and external examinations with direct and indirect ophthalmoscopy
  - Pupillary reflexes and motility evaluation
  - Biomicroscopy
  - Visual fields testing
  - Tonometry
- Refractive state evaluation, to include:
  - Visual acuity uncorrected and best corrected acuity
  - Subjective refraction with accommodative function
  - Objective refraction by retinoscopy or autorefractor
- Binocular function.

Your vision benefits also include:

- Standard lenses (plastic or glass) that are clear—once every 12 consecutive months
  - Single vision
  - Bifocal
  - Trifocal
  - Lenticular
- Frames—once every 12 consecutive months
- Contact lenses—once every 12 consecutive months in lieu of eyeglass lenses and frames
  - Contact lens exam/fitting fee—Most providers charge a fee for fitting contact lenses. This $35 copay is separate from the comprehensive eye examination. Contact lens exam and fitting charges are not covered out-of-network.
  - Medically necessary—covered in full in-network, up to $210 allowance out-of-network
  - Elective—up to $140 allowance
  - You may order contact lenses online at **www.svcontacts.com**.

OPTIONS AT AN ADDITIONAL COST

The Superior Vision Plan is designed to provide your basic eyewear needs. Many lens upgrades and add-ons are not covered or have limitations. If you choose any of the options listed below, you will pay for the options in addition to the covered benefit. You will pay these additional charges directly to your provider at the time of service; however discounts may apply.

- Progressive power lenses—The provider's charge for a standard **trifocal** is credited toward the charge for the style of progressive lens selected. You pay the provider the difference between the two.
- Blended (no-line) bifocal lenses
- Faceted lenses
- Polished bevel lenses
- Polycarbonate lenses
- Hi-index lenses
- Polaroid lenses
- Photochromic lenses
- Laminated lenses
- Slab-off lenses
- Prism lenses
- Coating on lenses (anti-scratch, anti-reflective, sunglass colors, etc.)
- Tints (except rose tint #1 and #2)
- Oversized charge for lenses larger than 61 mm
- Ultra-violet tint or coating
- Retail charges for frames in excess of the retail frame allowance
- Additional cost for elective contact lenses over the allowance.

You may also take advantage of many discounts through Superior Vision Plan—more information is available at **www.superiorvision.com**.

Exclusions

There is no benefit coverage for the following products and services:

- Replacement frames and/or lenses except at normal intervals when services are otherwise available
- Nonprescription glasses/sunglasses or oversized lenses
- Orthoptics or vision training and any associated supplemental testing
- Frame cases
- Low (subnormal) vision aids
- Eye exams required by your employer as a condition for employment
- Services and materials covered by another vision plan
- Conditions covered by workers' compensation
- Benefits provided under your medical insurance
- Medical or surgical treatment of the eyes

- Professional services and/or materials in connection with:
  - Blended bifocals, no line
  - Compensated or special multi-focal lenses
  - Plain (non-prescription) lenses
  - Anti-reflective, scratch, UV400, or any coating or lamination applied to lenses
  - Subnormal visual aids
  - Tints other than solid
  - Orthoptics, vision training and developmental vision procedures
  - Polycarbonate lenses
- Services rendered or materials purchased outside the U.S. or Canada
- Charges in excess of the usual, customary and reasonable charge for the professional service or materials
- Experimental or non-conventional treatment or device
- Safety eyewear
- Services or materials rendered by a provider other than an Ophthalmologist, Optometrist, or Optician acting within the scope of his or her license
- Any additional service required other than basic vision analyses for contact lenses, except fitting fees
- Services rendered after the date a participant ceases to be covered, except when vision materials ordered before coverage ended are delivered and the services rendered to the participant within 31 days from the date of such order
- Services rendered or materials ordered before the date coverage began.

Coordination of Benefits

The Vision Plan is designed to integrate benefits with other group or individual plans or policies. If you are eligible either as the insured or a dependent to receive vision benefits from another plan (including automobile insurance) or government program, the total benefits you are eligible to receive from all plans will not be more than the benefits that would be payable from the Total Health Vision Plan if you had no other coverage. This applies whether or not you file a claim under the other plan. If needed, you must authorize the claims administrator to get information from the other plans.

If you are covered by two vision plans, one of the plans will be primary and the other will be secondary. The primary plan pays benefits first. The following criteria determine which plan is primary:

- If only the other plan is not with Superior Vision, then the Total Health Vision Plan is the primary plan.
- If both plans are with Superior Vision, then the plan under which the insured is the member rather than a dependent, is primary.
- If both plans are with Superior Vision and the insured is a dependent child, the father's plan is primary.

If payments should have been made under this plan but have been made under any other plan, the claims administrator has the right, in its sole discretion, to pay to any insurance company or other organization or person making such other payments any amounts it determines and to the extent of such payments, Texas Health and the plan will be fully discharged from liability. The benefits that are payable will be charged against any applicable maximum payment or benefit of this plan rather than the amount payable in the absence of this provision.

Filing Claims

Written notice of your claim must be given to Superior Vision within twenty (20) days of the date such loss begins. Notice must be given to Superior Vision with enough information to identify you or your dependents. Failure to file such notice within the time required will not invalidate nor reduce any claim that was not reasonably possible to file notice within such time. However, the notice must be given as soon as reasonably possible. Superior Vision will provide claim forms when you request or when Superior Vision receives notice of claim. If the forms are not given within fifteen (15) days, you can submit written proof covering the occurrence, character and extent of loss for which claim is made.

You or your network provider must provide written proof of your claim to Superior Vision not later than ninety (90) days after the date of such loss. Failure to give such proof within such time will not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time. However, such proof must be furnished as soon as reasonably possible, but in no event, except in the absence of legal capacity of the claimant, later than one (1) year from the date of the claim.

Superior Vision, at its expense, has the right to examine you regarding any claim when and as often as may be reasonably required while the claim is pending.

If you file a claim, be sure to keep a copy of the claim and any other information (such as itemized bills) that you include with the claim.

If you cover your dependent under the Vision Plan and do not have legal custody of that dependent, Superior Vision may make benefit payments directly to the care provider at the request of the custodial parent. Superior Vision will be released from all further liability to the extent of the payments made.

Superior Vision has the right to contest the validity of your or your dependent's coverage under the plan because of inaccurate or false information about eligibility for coverage. Superior Vision has two years from the effective date of your coverage to contest eligibility. Only statements that are in writing and signed by you or your covered dependent can be used to contest coverage.

If you, your covered dependent, or your vision care provider receives an overpayment of benefits under the Vision Plan, you are required to repay any excess benefits to the plan.

OUT-OF-NETWORK PROVIDERS

When you use an out-of-network provider, you must file a claim for vision reimbursement.

Before you receive services, you should call Superior Vision Member Services at 1-877-MyTHRLink (1-877-698-4754), prompt 6, press 4 to verify your eligibility and receive an authorization number. After receiving services, obtain an itemized invoice or receipt and mail it to the Superior Vision Claims Unit for reimbursement. Your claim will be paid under the out-of-network schedule of allowances, less any applicable copay amounts.

The mailing address is:

Superior Vision Services
P.O. Box 967
Rancho Cordova, CA 95741

Reimbursements will be mailed to your home address along with an explanation of benefits (EOB) describing the amounts you have been paid. You must submit all vision claims within 12 months after the date the expenses were incurred.

GRIEVANCE PROCEDURE

If a claim for benefits is wholly or partially denied, you will be notified in writing of such denial and of your right to file a grievance and the procedure to follow. The notice of denial will state the specific reason for the denial of benefits.

Within 60 days of receipt of such written notice a member may file a grievance and make a written request for review to:

National Guardian Life Insurance Company
c/o Superior Vision Services, Inc.
P.O. Box 967
Rancho Cordova, CA 95741

Superior Vision will resolve the grievance within 30 calendar days of receiving it. If Superior Vision is unable to resolve the grievance within that period, the time period may be extended another 30 calendar days if Superior Vision notifies in writing the person who filed the grievance. The notice will include advice as to when resolution of the grievance can be expected and the reason why additional time is needed. You or someone on his/her behalf also has the right to appear in person before the Superior Vision grievance committee to present written or oral information and to question those people responsible for making the determination that resulted in the grievance. You will be informed in writing of the time and place of the meeting at least seven calendar days before the meeting.

For purposes of this grievance procedure, a grievance is a written complaint submitted in accordance with the above grievance procedure by or on behalf of you or a dependent regarding dissatisfaction with the administration of claims practices or provision of services of this panel provider plan relative to you. In situations requiring urgent care, grievances will be resolved within four business days of receiving the grievance.

Superior Vision Services has final discretionary authority to determine all questions of eligibility and status and to interpret and construe the terms of the insurance policy.

When Coverage Ends

Generally, coverage for you and your covered dependents under the vision plan ends on the last day of the pay period in which you terminate employment. See page 140 for more information.

In some situations you may continue vision coverage after you leave Texas Health. See page 141 for information on electing COBRA continuation coverage.

Spending Accounts

Flexible Spending Accounts

Overview

Most people have medical expenses that are not covered by any benefit plan—things like deductibles, copays, coinsurance, or dental and vision expenses. And, if you have young children at home or are caring for a parent, you may have to pay someone to care for them while you work.

As a full-time or part-time benefits-eligible employee, you may be able to use the Flexible Spending Accounts under the Total Health Flexible Benefits Plan to pay these expenses with tax-free dollars. You pay no federal income or Social Security taxes on the earnings you deposit in the accounts, meaning you pay lower overall taxes on your income.

The Health Care Spending Account (HCSA) allows you to set aside tax-free money through payroll deductions to pay eligible health care expenses. Eligible expenses are amounts not reimbursed by any health coverage, including a spouse's plan, for the care of you, your spouse, your children, and other qualified dependents.

The Day Care Spending Account allows you to set aside tax-free money through payroll deductions to pay eligible day care expenses. Eligible expenses include day care for your children under age 13 or a disabled dependent of any age when the care enables you (and your spouse, if you are married) to work.

HOW MUCH YOU MAY CONTRIBUTE

You may participate in either or both accounts. During enrollment, you decide how much to deposit on a before-tax basis for the year, up to:

- $2,500 per year into your Health Care Spending Account (a minimum of $130 per year)
- $5,000 per year into your Day Care Spending Account. If you are married and your spouse's employer offers a Dependent Care Spending Account, your combined total annual contribution cannot exceed $5,000. If you are married and you file a separate income tax return, contributions cannot exceed $2,500 for each of you, with a $5,000 total maximum (a minimum of $130 per year).

The annual amount you contribute is divided into equal amounts and deducted from each paycheck.

For example, if you elected to contribute $1,430 during open enrollment, that amount is divided by 26 pay periods to figure your per-pay-period deduction of $55. If you enroll during the calendar year, the annual contribution you elect is divided by the number of pay periods remaining in the calendar year.

"Use It or Lose It"

The IRS restricts how you may use the funds in your Flexible Spending Accounts. If you decide to contribute to either or both accounts, you should carefully estimate your expenses for the coming year. The law requires that the accounts operate on a "use it or lose it" basis. This means you forfeit any money remaining in your spending accounts after all eligible expenses have been reimbursed according to plan guidelines. All Flexible Spending Account forfeitures are used to pay for the plan's administrative expenses.

Your expenses claimed for reimbursement must be for health care or day care services incurred between January 1, 2013, and March 15, 2014, and only during the months that you are eligible to participate. If you participate in the Health Care and Day Care Spending Accounts, keep in mind that the accounts are maintained separately. You may not transfer money between the accounts. All claims must be submitted by March 31 of the following year to be eligible for reimbursement.

Health Care Spending Account

The Health Care Spending Account can be used to pay for certain health care expenses that are not covered by insurance. Eligible expenses include medical, dental, and vision expenses not paid by your medical coverage, such as deductibles, copays, coinsurance, and amounts above the usual and customary fee limits.

WHO CAN BE COVERED

The Health Care Spending Account allows you to receive tax-free reimbursement of health care expenses for you and your eligible dependents, even if you don't cover them under the Total Health Medical Plan. You may file claims for reimbursement of expenses incurred by:

- You
- Your spouse
- Your dependent children
- Anyone else you can claim as a dependent on your federal income tax return.

CHANGING YOUR ELECTIONS

If, as a result of a status change, you stop your deposits during the year, you may file claims and be reimbursed for eligible health care expenses incurred before the change. These expenses will be reimbursed up to the original amount you elected to deposit. You will not be reimbursed for expenses incurred after you stop your elections. Any unused amount will be forfeited. If you reduce your deposits as a result of a status change, you may be reimbursed for eligible health care expenses up to the amount of your revised deposit amount. However, you are not allowed to reduce your deposit to less than the amount you have been reimbursed. For example, if your original contribution was $1,000 and you have been reimbursed $500, you could only lower your new contribution to $500.

REHIRES

If you terminate your employment or lose eligibility and then you are rehired within 180 days of your termination, you will be reinstated in the plan at the same contribution rate.

HCSA DEBIT CARD

You will receive a Benefits Card which is a MasterCard that provides you immediate access to your FSA funds upon initial enrollment. You will not receive a new card each year. Your new annual election will be loaded on the card each year. Until March 15, 2013, when you use your debit card, funds will be drawn from your 2012 account balance. After you use all the money in your 2012 account, when you use your card it will withdraw from your 2013 account. When you use your card after March 15, 2013, it will withdraw from your 2013 account and you will no longer be able to access your 2012 account. Your Benefits Card can be used for medical, dental and vision expenses at eligible merchants with a valid merchant code.

When you use your debit card, you may be required to provide documentation such as an Explanation of Benefits from your medical/dental insurance carrier or itemized receipts showing the charges for the service and the amount of insurance payment (if any). In addition, we may request additional information such as a statement of medical purpose from your doctor. Your debit card will be deactivated if you provide documentation that shows your transaction is not an eligible FSA expense, or your documentation is not received within 60 days of the date of the letter.

If you do not provide the required documentation showing that the transaction amount is eligible under the IRS tax code governing FSA plans, you will need to repay the amount to your account.

The debit card can only be used for expenses you actually incur. For example, you may be asked to pay your provider's portion of your newborn services by a certain month of your pregnancy. However, this amount cannot be paid using the debit card. When using your debit card, please remember that your FSA funds should be used as the final payer. The card cannot be used for pre-treatment or estimated charges.

If you go to a retail pharmacy, your Benefits Card can be used for your prescription medication at any network pharmacy that is set up to take the card. (Please note that not all participating pharmacies will be able to accept the card.) Mail order prescriptions can be processed without authorization from Caremark and you should be able to use your Benefits Card. You may also purchase a 90-day supply at the retail pharmacy at Texas Health Presbyterian Hospitals of Dallas and Plano.

If your provider does not accept MasterCard, or you use a pharmacy that is not set up to process your FSA payment, you will be required to pay at the time of service and file a paper claim for reimbursement.

If you have trouble using your card at a physician's office, pharmacy, dental or vision provider, you may still submit paper reimbursement forms to PayFlex and your eligible claims will be reimbursed to you.

Go to **www.healthhub.com** to track your Health Care Spending Account expenses, balances, and statement of claims or to see a listing of your account activity.

If you have other questions about your FSA, call PayFlex at 1-877-MyTHRLink (1-877-698-4754), select prompt 6, then press 6.

COBRA PARTICIPANTS HCSA DEBIT CARD

Upon termination, you will no longer be able to use your HCSA debit card. As a COBRA participant, to receive reimbursement for eligible expenses, you will need to file claims as explained on page 141.

ELIGIBLE HEALTH CARE EXPENSES

In general, your Health Care Spending Account can be used to pay any unreimbursed health care expenses that the Internal Revenue Service (IRS) would normally allow you to deduct when you calculate your taxes. The list below gives examples of the expenses that qualify for reimbursement. For a more comprehensive listing of eligible expenses, refer to IRS Publication 502 at **http://www.irs.gov/pub/irs-pdf/p502.pdf**. Excluded expenses are listed on the next page.

- Most medical and dental plan copays (such as for office visits), deductibles, and out-of-pocket expenses (but not medical or dental insurance premiums)
- Hearing expenses including hearing aids, special instructions or training for the deaf (such as lip reading), and the cost of acquiring and training a dog for the deaf
- Vision expenses including eyeglasses, contact lenses, ophthalmologist fees, the cost of a guide dog for the blind, and special education devices for the blind, such as an interpreter

Examples of medical expenses that may be reimbursed if not covered by a Total Health Medical Plan or other medical coverage you may have include, but are not limited to, the following:

- Acupuncture that is not paid by the medical plan
- Artificial insemination, including in-vitro fertilization
- Bandages, support hose, or other pressure garments (when recommended by a physician to cure a specific ailment)
- Blood, blood plasma, or blood substitutes
- Braces, appliances, or equipment, including procurement or use
- Car controls for the handicapped
- Charges in excess of usual and customary fee limits
- Chromosome or fertility studies
- Confinement to a facility primarily for screening tests and physical therapy

- Copays for covered medical expenses
- Experimental treatment
- Foot disorders and treatments for corns, bunions, calluses, and structural disorders
- Home health care, hospice care, nursing care, or home health care aides
- Hypnosis for treatment of illness
- Immunizations
- Learning disability tutoring or therapy
- Nursing home care
- Physical exams
- Physical therapy
- Prescription drug copays
- Prescription eyeglasses and contact lenses
- Prescription vitamins
- Psychiatric or psychological counseling
- Radial keratotomies and LASIK procedures to correct nearsightedness
- Sexual dysfunctions or inadequacy treatments
- Smoking cessation program costs, if prescribed, and prescription nicotine withdrawal medications if prescribed by a physician
- Speech therapy
- Syringes, needles, injections
- Transportation expenses to receive medical care, including fares for public transportation and private auto expenses (consult your tax advisor for the current IRS mileage allowance)
- Weight loss programs—program fees only with a letter of medical necessity and diagnosis of obesity or hypertension
- Work-related sickness or injury (not covered by Workers' Compensation).

Examples of dental expenses that may be reimbursed if not covered by the Total Health Dental Plan or other dental coverage include, but are not limited to:

- Anesthesia
- Charges in excess of usual and customary fee limits
- Drugs and their administration
- Experimental treatment
- Extra sets of dentures or other dental appliances
- Medically necessary orthodontia expenses for adults or dependents
- Myofunctional therapy
- Orthodontia expenses
- Replacement of dentures or bridgework less than five years old
- Replacement of lost, stolen, or missing dentures or orthodontic devices
- Tooth cleaning more than twice per year.

Please note that effective January 1, 2011, over-the-counter medications sold without a prescription are no longer a reimbursable expense under the flexible spending account.

EXCLUDED EXPENSES

Some health care expenses you may incur are not eligible for reimbursement. These expenses should not be included in your budgeting to determine the amount you contribute to either spending account. Excluded expenses include:

- Medical expenses that have been reimbursed through any other policy, plan, or program including Medicare or any other federal or state program
- Capital expenses
  - Air conditioning units
  - Structural additions or changes
  - Swimming pools
  - Whirlpools
  - Wheelchair ramps
- Cosmetic medical treatments or surgery, other than those that are medically necessary due to accident, trauma, disease or birth defect
- Cosmetic prescriptions and cosmetic dental procedures such as cosmetic tooth bonding or whitening
- Electrolysis (unless prescribed by a physician to treat a medical condition)
- Expenses claimed as a deduction or credit on your federal income tax return
- Expenses incurred before you enrolled or after you terminated from the plan
- Expenses incurred before or after the end of the calendar year for which the account was established
- Expenses for which you do not submit the appropriate documentation
- Health club fees and exercise classes
- Marriage and family counseling
- Massage therapy (unless prescribed by a physician to treat a medical condition)
- Medical, dental, or vision insurance premiums
- Over the counter medications without prescription
- Personal care items such as cosmetics and toiletries
- Transportation expenses for the handicapped to and from work
- Vacation travel for health purposes
- Vitamins and nutritional supplements
- Weight loss programs—program fees are not eligible unless you have a letter of medical necessity and diagnosis of obesity or hypertension. Food and other costs are not reimbursable.

HEALTH CARE SPENDING ACCOUNT VS. TAX DEDUCTION

If you pay eligible health care expenses through your Health Care Spending Account, you may not also take a deduction for these expenses on your tax return. However, if you choose to take the tax deduction instead of using the account, you may deduct only expenses that are greater than 10% of your adjusted gross income, provided that you itemize deductions in your income tax return.

Example

For example, if your adjusted gross income is $20,000, only medical expenses of more than $2,000 can be deducted on your income tax return:

10% of $20,000 = $2,000

If you are in a combined 22.65% tax bracket (15% income tax + 7.65% FICA tax), that means you pay $453 more in taxes by not reimbursing these expenses through the Health Care Spending Account: 22.65% of $2,5000 = $453.

Day Care Spending Account

The Day Care Spending Account can be used to pay eligible child or dependent care expenses using before-tax dollars while you (and your spouse, if you are married) are at work.

If you are married, your spouse must be either:

- Employed
- A full-time student at an educational institution, or
- Unable to care for himself or herself because of a mental or physical condition.

WHO CAN BE COVERED

You may claim day care expenses for your eligible dependents, including:

- Children under age 13 claimed as dependents on your federal income tax return who spend at least eight hours a day in your home, and
- A person over age 13 (including your child, spouse or parent) if the person meets all of the following criteria:
  - Lives with you and depends on you for more than half of his or her financial support
  - Is physically or mentally incapable of self-care
  - Spends at least eight hours a day in your home, and
  - Is claimed as a dependent on your federal income tax return.

CHANGING YOUR ELECTIONS

You may change or revoke your previous election for Day Care Spending Account during the year and make new election if you experience one of the following situations:

- The cost of dependent care significantly increases or decreases (you can change or revoke your previous election only if the provider is not your relative, as defined in the plan).
- You remove your child from a facility
- You or your spouse quit working
- You experience a qualified status change, as defined on pages 10 – 12.

You must notify Human Resources, make your election, and provide documentation of the reason for the change within 31 days. If you do not provide the documentation, your new election will be reversed.

HOW MUCH YOU MAY CONTRIBUTE

In general, you may contribute up to $5,000 a year (a minimum of $130 per year) to your Day Care Spending Account. If you are married and you and your spouse are both contributing to a Day Care Spending Account (regardless of whether your spouse works for Texas Health or another employer), you and your spouse have a combined contribution limit of $5,000. (The limit is per married couple, not per individual.) The annual amount you contribute is divided equally amount your paychecks. Unlike your Healthcare Spending Account, which is credited at the beginning of the year with the amount you have elected to contribute for the full year, your day care account is credited with each payroll deduction.

For example, if you elected to contribute $2,600 during open enrollment, that amount is divided by 26 pay periods to figure your per-pay-period deduction of $100. If you enroll during the calendar year, the annual contribution you elect is divided by the number of pay periods remaining in the calendar year.

You cannot contribute more than your earned income or your spouse's earned income, whichever is less. For example, if your spouse works part-time and earns $2,000 a year, you can deposit no more than $2,000 a year into this account. Please consult with a tax advisor to determine the limitations that apply in this situation.

Because the IRS specifies that any unused money in your Day Care Flexible Spending Account is forfeited at the end of the year, consider the following guidelines when enrolling in this program:

- Carefully determine the number of weeks of dependent day care you will purchase. Estimate and deduct weeks that might include vacation, illness, or occasions where your dependents might have free care.
- Don't anticipate expenses you are not sure about, such as day care for a child not yet born. Birth of a child is considered an eligible life event, so you may start participating in a Day Care Flexible Spending Account at that time.
- You must be actively at work to contribute.

ELIGIBLE DAY CARE EXPENSES

To qualify for reimbursement, care must be provided by a licensed day care facility or by an individual who is not your dependent.

Expenses paid to the following providers may be reimbursed through your account if you can provide their Social Security or taxpayer identification number:

- A licensed child care center or adult day care center, including a church or non-profit center
- A babysitter inside or outside your home if the sitter does not care for more than six children at a time (not including the sitter's own dependents)
- A housekeeper whose duties include dependent day care
- A relative who cares for your dependents but is neither your spouse, your child, nor your dependent
- Someone who cares for an elderly or disabled dependent inside or outside your home
- Au pairs (foreign visitors to the U.S. who perform day care and domestic services in exchange for living expenses), provided the au pair agency is a non-profit organization or the au pair obtains a U.S. Social Security number for tax identification purposes
- Facilities away from home, provided your dependent spends at least eight hours per day at home.

EXCLUDED EXPENSES

Some day care expenses you may incur are not eligible for reimbursement. Therefore, these expenses should not be included in your budgeting to determine the amount you contribute to either spending account. Excluded expenses include:

- Care provided by anyone you or your spouse claim as a dependent on your income tax return
- Care by occasional baby sitters
- A facility or individual for whom you cannot provide a taxpayer identification or Social Security number
- Expenses claimed as a deduction or credit on your federal income tax return
- Expenses incurred before you enrolled or after you terminated from the plan
- Expenses incurred before or after the end of the calendar year for which the account was established
- Day care expenses that in any calendar year are more than your income or your spouse's income (whichever is less), unless you are married and your spouse is a full-time student or mentally or physically disabled
- Expenses for which you do not submit the appropriate documentation
- Expenses for child care when your spouse is not employed (unless your spouse is a full-time student or is mentally or physically disabled).

DAY CARE SPENDING ACCOUNT VS. FEDERAL TAX CREDIT

Federal tax laws allow you to take a tax credit for eligible dependent care expenses. The tax credit is a percentage of your dependent day care expenses, up to $3,000 for one dependent or $6,000 for two or more dependents. You may use both the dependent day care tax credit and the Day Care Spending Account, but not for the same expenses. Amounts reimbursed from your account are to be deducted from your tax credit.

In some cases, using the Day Care Spending Account saves you more. In other cases, you may save more by taking the credit on your tax return. Because tax laws are complex and change from time to time, you should consult a tax advisor or contact the IRS to obtain Publication 503 at: **http://www.irs.gov/pub/irs-pdf/p503.pdf**.

Filing Claims

The Health Care and Day Care Flexible Spending Accounts are administered separately. You must submit claims to PayFlex to receive reimbursement for eligible health care and dependent day care expenses.

You may file claims for eligible expenses at any time during the plan year. Reimbursements are processed twice each week. After your claim is approved, either a check will be mailed to your home address or your reimbursement will be direct deposited to your account.

HEALTH CARE SPENDING ACCOUNT

After you have made your first deposit through payroll deduction, the entire amount you have agreed to deposit for the calendar year is available for reimbursement. Ongoing deposits will repay your account for earlier reimbursements you received. If you enroll in the plan during the year, you are eligible for reimbursement only of expenses you incur after becoming a plan participant.

Before filing a claim for reimbursement from your account:

- Pay your health care expense and submit a claim to the appropriate Medical, Dental, or Vision Plan. If you are not required to submit a claim for benefits (for example, when you pay a doctor's office copay), keep your receipt from the service provider.
- If you have other coverage, such as through your spouse's employer, you must first submit your claim to that coverage and receive the other plan's explanation of benefits (EOB) before filing for reimbursement from your Health Care Spending Account.
- If you incur an eligible expense for which you have no coverage, you may submit the expense directly for reimbursement.

To submit a claim for eligible health care expenses:

- Complete a Flexible Spending Account Claim Form (available from Human Resources and online at **www.healthhub.com**).
- Attach documentation of your expenses, such as an original receipt from the medical service provider or your explanation of benefits (EOB) from your plan. A canceled check is not acceptable documentation. Each bill or receipt must include:
  - Name of patient
  - Date the treatment or service was provided
  - Description of the treatment or service given
  - Itemized charges for the treatment or service
  - Provider's name.
- Mail, email or fax the completed claim form with the original itemized bills, Explanation of Benefits (EOB) and receipts to PayFlex at the address or fax number on the claim form.
- The claims processor will determine whether the expense is eligible for reimbursement.

DAY CARE SPENDING ACCOUNT

Unlike the Health Care Flexible Spending Account, you may be reimbursed from the Day Care Account only up to the amount you have actually deposited at the time you submit the claim (less any claims that have already been paid). If your account balance is less than the amount you request, your reimbursement will equal only the amount in your account. However, unpaid amounts are automatically paid as additional deposits are made to cover them. If you enroll in the plan during the year, you are eligible for reimbursement only for expenses you incur after becoming a plan participant.

Pay your day care expenses to your provider and ask for a receipt. You will only be reimbursed for dependent day care expenses after the actual care has been received.

To file a claim:

- Complete a Flexible Spending Account Claim Form and attach original documentation of your expenses, such as a receipt from your day care provider. Documentation must include the dependent care provider's name and the dependent's age. A canceled check is not acceptable documentation.
- Mail, email or fax the completed claim form and documentation to PayFlex at the address or fax number on the claim form.

CLAIM FILING DEADLINE

You have until March 31, 2014 to submit claims for health care or day care expenses incurred:

- Between January 1, 2013 and March 15, 2014
- Before you stopped making contributions because you experienced a status change during the year.

Filing and Appealing Health Care and Dependent Care Spending Account Claims

Whenever you file a claim, be sure to keep a copy of the claim and any other information (such as itemized bills) that you include with the claim. A canceled check is not acceptable documentation. You should file your spending account claims using the claim form found on **MyTexasHealth** and **www.healthhub.com** and send claims to:

PayFlex Systems USA, Inc.
Flex Dept.
P.O. Box 3039
Omaha, NE 68103-3039
Fax: (402) 231-4310
www.healthhub.com

You appeal spending account claims in the same way you appeal medical claims (described beginning on page 41) except you send a spending account appeal to PayFlex at the above address.

For information on how to appeal a denied claim, see pages 44 – 49.

When Coverage Ends

Coverage ends under the Flexible Spending Accounts at the end of the pay period in which you terminate employment with Texas Health or stop your contributions. You have until March 31 of the following year to submit claims for dependent care and health care expenses incurred before your termination or before you stopped your contributions.

You may continue to participate in the Health Care Spending Account by electing COBRA continuation coverage (see page 142). By making this election, you may extend your participation in the Health Care FSA. Although you would now make contributions on an after-tax basis, by electing continuation of coverage for this account you would still have the opportunity to file claims for reimbursement based on your account balance for the year.

Income Protection

Disability Coverage

Overview

Disability insurance coverage helps you meet your financial obligations if you are unable to work due to your own injury or sickness. This coverage is an important element in your financial planning because it provides a continuing source of income if you are unable to work because of a disability. Before choosing disability coverage, think about how you and your family would manage without your salary. Disability coverage is provided by CIGNA. See pages 5 – 7 for information on eligibility.

To protect yourself and your family, full-time and part-time benefits-eligible employees (as defined on page 5) are eligible for the following:

- Short Term Disability (STD) with a choice of a 14-day or 30-day elimination period
- Basic Long Term Disability (LTD)
- Additional Long Term Disability.

If you are a PRN, part-time benefits-ineligible employee (as defined on page 165), or medical resident/intern, you are not eligible for STD, Basic LTD, or Additional LTD. Physicians employed by THPG are covered by the STD policy described in this section, but are covered through a separate LTD policy and are not eligible for the Texas Health Long Term Disability Plan.

Summary of Disability Benefits

The table on the next page summarizes the disability benefits available to eligible Texas Health employees.

To make your disability benefits go further, you pay for disability coverage on an after-tax basis so that any disability benefits you receive are not taxable income.

Base pay is your hourly rate times the number of hours you are classified in the HR/Payroll system to work and that you were receiving on your last day as an active employee before the date of disability. Base pay does not include shift differentials, bonuses, overtime earnings, commissions, or other compensation.

You must have active disability coverage on the date you become disabled to receive benefits. If you are absent from work due to sickness or injury on the date your STD or LTD coverage would otherwise become effective, coverage becomes effective only after you are actively at work for one full day.

PRE-EXISTING CONDITIONS

The Texas Health disability plan does not require evidence of insurability. However, it does have certain limitations and exclusions for pre-existing conditions when you enroll for the plan during open enrollment or add the benefit after a status change. (New hire enrollment isn't subject to pre-existing condition limitations).

A pre-existing condition is any injury or sickness for which you incurred expenses, received medical treatment, care or services including diagnostic measures, or took prescribed drugs or medicines within 12 months before your most recent effective date of coverage.

Examples of pre-existing conditions include, but are not limited to, the following;

- Illness
- Chronic medical conditions
- Pregnancy
- Mental health conditions.

This limitation does not apply to a period of disability that begins after you have been covered for at least 12 months (counted from your most recent effective date of coverage or the effective date of any added or increased benefits).

If you have a disability that is caused by, contributed to, or the result of a pre-existing condition within the first 12 months after your coverage becomes effective under the disability plan, your benefits will be limited to 4 weeks (if you were not covered by STD within 12 months before your disability began).

LTD plan benefits will be paid for any period of disability caused by, contributed to, or resulting from a pre-existing condition.

Definition of Disability

STD

The STD plan considers you to be disabled if you are not able to perform the material duties of your own occupation only because of disease or injury. You could still meet this definition if you are performing some of those duties, provided you are earning less than 80% of your pre-disability base pay only because of your disease or injury.

You must be under the appropriate, regular care for your condition from a licensed physician who is not you or a member of your family.

If your occupation requires a professional or occupational license or certification of any kind, the STD plan does not consider you to be disabled solely because you lose your license or certification.

LTD

From the date that you first become disabled and until monthly benefits are payable for 24 months, the LTD plan considers you to be disabled on any day if:

- You are not able to perform the material duties of your own occupation solely because of disease or injury and
- Your work earnings are 80% or less of your adjusted pre-disability base pay.

After the first 24 months that any monthly disability benefit is payable, the LTD plan considers you to be disabled if you are not able to perform the material duties of any occupation for which you are reasonably qualified by training, education, or experience and you are unable to earn 80% or more of your earnings solely because of disease or injury.

You must be under the appropriate, regular care for your condition from a licensed physician who is not you or a member of your family.

If your occupation requires a professional or occupational license or certification of any kind, the LTD plan does not consider you to be disabled solely because you lose your license or certification.

The insurance carrier has the right to ask you to undergo an examination by the physician of its choice to confirm your disability. You are responsible for providing documentation of your disability to the insurance carrier.

You may be considered disabled during and after the elimination period during any week in which you are employed if an injury or sickness is causing physical or mental impairment that is severe enough that you are unable to earn at least 80% of your base pay in any occupation for which you are qualified by education, training, or experience.

You are not considered disabled if you are able to earn more than 80% of your base pay. Base pay is your hourly rate times the number of hours you are classified to work in the HR/Payroll system. Base pay does not include shift differentials, bonuses, overtime earning, commissions, or any other compensation. It does not include PTO pay. If you receive a lump sum payment, it will be prorated over the time it accrued or the period for which it was paid.

COMPARISON OF DISABILITY PLANS

Coverage	When Benefits Begin	When Benefits End	Amount of Benefit
Short Term Disability 14-day elimination period	After 14 continuous calendar days of disability	See page 88 for a complete explanation	60% of your base pay, up to $1,700 per week and reduced for certain earnings
Short Term Disability 30-day elimination period	After 30 continuous calendar days of disability	See page 88 for a complete explanation	60% of your base pay, up to $1,700 per week and reduced for certain earnings
Basic Long Term Disability	After 180 continuous days of disability or after STD benefits end	See page 91 for a complete explanation	50% of your base pay, up to $15,000 per month
Additional Long Term Disability	The same date Basic LTD benefits begin	The same date Basic LTD benefits end	10% of your base pay, combined with Basic LTD for a total of 60% of your base pay, up to $15,000 per month

Coordination of Benefits

Your disability benefits are reduced by other income you may receive. Examples of other income include:

- Any amounts you or your dependents receive (or are assumed to receive) under any governmental program or coverage provided by statute, because of your disability
- Any Social Security disability or retirement benefits you or your dependents receive (or are assumed to receive) for which you are eligible. This does not include any Social Security benefits you were receiving before the date of your disability.
- Any proceeds payable under another group disability plan or similar plan. If other insurance is payable, disability benefits under this plan will be paid on a prorated basis.
- Any benefit payable (or assumed to be payable) under workers compensation or similar law
- Any amounts paid because of loss of earnings or earning capacity through settlement, judgment, arbitration, or otherwise where a third party may be liable, regardless of whether liability is determined.

A dependent is anyone who receives or is assumed to receive benefits under any applicable law because of your entitlement to benefits.

You and your dependents, if applicable, will be assumed to be receiving benefits for which you are eligible from other income benefits. Your disability benefits will be reduced by the amount it is estimated you are receiving from other income benefits. You must provide proof that you have applied for other income benefits and that all appeals have been exhausted. You must also provide documentation that you have been denied other income benefits.

You may be required to apply for Social Security benefits. If benefits you receive from other sources, including Social Security, result in an overpayment of your Texas Health disability benefits, you must repay CIGNA.

Short Term Disability (STD)

Short Term Disability coverage is an insurance benefit that replaces 60% of your base pay, up to $1,700 per week if you elect coverage under this plan and you become disabled while covered. You may choose:

Waiting Period	14 days	30 days
Maximum number of weeks that benefits will be paid	24 weeks	22 weeks
Premium Costs	More than the 30-day option	Less than the 14-day option

You pay for STD coverage with after-tax payroll deductions. Your cost is based on your benefits base rate as of October of the preceding year.

WHEN BENEFITS BEGIN

You must meet all of the following requirements to receive STD benefits:

- You have STD coverage in force on the date you become disabled and on the date the elimination period begins.
- You are receiving appropriate and regular care for your condition from a doctor who is someone other than you or your immediate family and whose specialty or expertise is the most appropriate for your disabling condition(s) according to generally accepted medical practice.

The elimination period is the length of time you must be continuously disabled or partially disabled before you qualify to receive benefits (either 14 or 30 days). The elimination period begins on the first day you are determined to be either totally or partially disabled. Your disability must continue through the entire elimination period.

BENEFITS

Your STD benefits begin after the elimination period and continue for up to 24 weeks following the 14 calendar day elimination period or for up to 22 weeks following the 30 calendar day elimination period, provided you remain disabled for that period. You will be required to provide proof of your disability from time to time.

STD benefits are based on your base pay for which you paid premiums, as reported to the insurance company. If you are disabled, you may receive a weekly benefit. STD benefits are paid by the insurance company, not Texas Health. The weekly benefit is equal to 60% of your current base pay for one week, up to a maximum benefit of $1,700 per week, less other income benefits you receive (as explained on page 88 under "Coordination of Benefits"). Base pay is determined on your last day as an active employee before the date of disability. Base pay does not include shift differentials, bonuses, overtime earnings, commissions, or other compensation paid to you. Benefits are paid for each week for which you are qualified.

Your STD benefits will begin only after you have completed the 14 or 30 calendar day elimination period *and* your healthcare provider has submitted necessary proof of medical care to support the claim.

CIGNA has a rigid time line for receipt of documentation from the provider. If you miss the deadline, the claim is denied and you must go through the appeals process—adding even more time until benefits are paid if the late claim is eventually approved.

Weekly income benefits are paid for the period for which you qualified. Your weekly benefit is reduced by any disability retirement, unemployment benefit paid by law or Social Security disability or retirement benefits you or your dependents receive on your own behalf or for your dependents because of your disability. The weekly benefit will also be reduced by any disability or unemployment benefits paid as a result of employment with Texas Health or as a result of membership with any group or organization or any retirement benefits paid after age 65.

CIGNA may help you apply for Social Security Disability Income (SSDI) benefits and may require you to file an appeal if your request is denied. If you refuse to cooperate with or participate in the Social Security Assistance Program, your disability benefits will be reduced by the amount CIGNA estimates you will receive. You may receive Paid Time Off (PTO) or benefits from the Sick Leave Bank/EIB while receiving STD benefits, up to a combined total of 100% of your base pay.

During your 30-day or 14-day elimination period, you may use Paid Time Off (PTO) benefits. If you choose to use PTO benefits while receiving an STD benefit, it will not be offset with the STD benefit. You may only receive a PTO amount that, when combined with STD benefit, does not exceed 100% of your pre-disability earnings.

CIGNA has the right to recover any overpaid benefits. To collect an overpayment, CIGNA may request a lump sum payment, reduce any amounts payable under this plan, and/or take appropriate collection activity.

If you are disabled for part of a week, your STD benefit will be prorated.

RETURN TO WORK INCENTIVE

You may receive STD benefits if you are disabled after the STD plan's elimination period and continue working, or return to work on a limited basis. The weekly benefit is reduced only if the total of your pay from working plus your STD benefit payable exceeds 100% of your pre-disability base pay. Periodically, the insurance company will review your status and will require satisfactory proof of earnings and continued disability.

No disability benefit will be paid and benefits will end if CIGNA determines you are able to work under a modified work arrangement and you refuse to do so without good cause.

Rehabilitation During Disability

If CIGNA determines that you are a suitable candidate for rehabilitation, CIGNA may require you to participate in a rehabilitation plan. CIGNA has the sole discretion to approve your participation in a rehabilitation plan and to approve a program as a rehabilitation plan. CIGNA will work with you, your provider and others, as well as with Texas Health to perform the assessment, develop the rehabilitation plan, and discuss return to work opportunities.

At CIGNA's discretion, the rehabilitation plan may allow for payment of your expenses for medical care, education, moving, living accommodations or family care while you participate in the program.

If you do not fully cooperate in all required phases of the rehabilitation plan and assessment without good cause, no disability benefits will be paid, and all coverage will end.

SUCCESSIVE DISABILITIES

A successive disability is a second disability due to the same cause as the first disability, that occurs less than 30 days after you have returned to your regular job from the first disability, and/or if during that 30-day period you earn less than 80% of your pre-disability pay during at least one week. A successive disability has:

- No additional elimination period
- The same maximum benefit period as the previous disability.

For any separate period of disability that is not considered continuous, you will be required to complete a new elimination period.

WHEN STD BENEFITS END

Your disability benefits will end on the earliest of the following events:

- You earn more than 80% of your pre-disability base pay from any occupation
- CIGNA determines you are not disabled
- You reach the end of the maximum benefit period
- Your death
- You refuse, without good cause, to fully cooperate in all required phases of the rehabilitation plan and assessment
- You are no longer receiving appropriate care
- You fail to cooperate with CIGNA in the administration of the disability claim, including, but not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.

Benefits may be resumed if you begin to fully cooperate in the rehabilitation plan within 30 days of the date benefits terminated.

If your STD coverage terminates during a period of disability that began while you were eligible for coverage, STD benefits will continue as long as you remain disabled up to the 180-day maximum.

Long Term Disability (LTD)

Texas Health automatically provides you with Basic LTD coverage on your first day of eligibility. Basic LTD begins paying benefits if you remain disabled after you have completed the 180-day elimination period. LTD replaces 50% of your base pay, up to $15,000 per month.

You can increase your LTD coverage to a total of 60% of your base pay by purchasing Additional LTD. This plan pays an additional 10% of your base pay in addition to Basic LTD, up to a combined total of $15,000 per month.

LTD does not cover pre-existing conditions. A condition is considered pre-existing if you incurred expenses, received medical treatment, care or services including diagnostic measures, or took prescribed drugs or medicines within 12 months before the effective date of your LTD coverage. A condition is not considered pre-existing if it causes a disability that begins after the LTD coverage has been in force for at least 12 months or at least 12 months after the effective date of any added or increased benefits.

Texas Health pays the full cost of Basic LTD coverage. You pay for Additional LTD with after-tax payroll deductions. Your cost is based on your benefits base rate as of October 1 of the preceding year.

Physicians employed by THPG are covered by the STD policy described in this section, but are covered through a separate LTD policy and are not eligible for the Texas Health Long Term Disability Plan.

WHEN BENEFITS BEGIN

LTD benefits begin after you have been continuously disabled for 180 consecutive days or reached the end of your STD benefits (whichever is later). This is called your elimination period.

You must meet all of the following requirements:

- Your disability starts while you are covered under the LTD plan.
- Your disability continues during and past the elimination period.
- You meet the LTD plan's eligibility requirements described on page 86.
- You are under the appropriate care of a physician.

You must provide satisfactory proof of disability before benefits will be paid.

BENEFITS

The basic monthly LTD benefit is equal to 50% of your current base pay, up to a maximum benefit of $15,000 per month, less other income benefits you are eligible to receive as described earlier in this section. If you purchase Additional LTD coverage, your benefit will be equal to 60% of your base pay, up to a combined maximum benefit of $15,000 per month. Base pay does not include shift differentials, bonuses, overtime earnings, commissions, or other compensation paid to you. Base pay is determined on your last day as an active employee before the date of disability.

The minimum monthly benefit payable is the greater of $100 or 10% of your gross monthly benefit. Benefits are paid at the end of each month for the period for which you qualified.

As described previously, your LTD benefit is reduced by other income benefits such as disability, retirement, or unemployment benefits for which you may be eligible due to your disability. This does not include any Social Security benefits you were receiving before your date of disability.

The LTD benefit will be prorated for any period less than one month.

After 12 monthly LTD benefits payments, your monthly benefit is increased on each anniversary of the month you first received an LTD benefit payment. The amount of each increase will be the lesser of:

- 10% of your indexed earnings (base pay plus any annual increase) from the preceding year or
- The rate of increase in the Consumer Price Index (CPI-W) during the preceding year.

RETURN TO WORK INCENTIVE

If you are disabled after the LTD plan's elimination period, you may continue working or return to work on a limited basis and also receive LTD benefits.

During the first 24 months in which disability benefits are payable, the disability benefit is reduced only if the total of your pay from working plus your LTD benefit payable exceeds 100% of your pre-disability base pay.

After disability benefits are payable for 24 months, the monthly benefit payable is the monthly LTD benefit reduced by other earnings and 50% of your pay from working.

Periodically, CIGNA will review your status and will require satisfactory proof of earnings and continued disability.

If CIGNA determines you are able to work under a modified work arrangement and you refuse to do so without good cause, no disability benefit will be paid and coverage will end.

Rehabilitation During Disability

If CIGNA determines that you are a suitable candidate for rehabilitation, you may be required to participate in a rehabilitation plan and assessment at CIGNA's expense. CIGNA has the sole discretion to approve your participation in rehabilitation and to approve a program as a rehabilitation plan. CIGNA will work with you, your provider and others, as well as with THR to perform the assessment, develop the rehabilitation plan, and discuss return to work opportunities.

At CIGNA's discretion, the rehabilitation plan may allow for payment of your expenses for medical care, education, moving, living accommodations or family care while you participate in the program.

If you fail to fully cooperate in all required phases of the rehabilitation plan and assessment without good cause, no disability payments will be paid and coverage will end.

DURATION OF BENEFITS

If your disability starts before age 62, it will end on the later of your 65th birthday or the date the 42nd monthly benefit is payable. If your disability starts on or after the date you reach age 62, it will continue for a certain number of months of disability counted from the date you complete the elimination period, as shown in this table:

Age at Disability	Maximum Duration of LTD Benefits
63 but less than 64	36 months
64 but less than 65	30 months
65 but less than 66	24 months
66 but less than 67	21 months
67 but less than 68	18 months
68 but less than 69	15 months
69 and over	12 months

Your LTD benefits will end sooner for the reasons listed on the next page.

To continue receiving benefits, you may be required to undergo a medical examination by a physician or a functional capacities evaluation and continue to prove your disability. If you refuse, your disability benefits will be temporarily discontinued until the required physical examination or evaluation has been completed.

SUCCESSIVE DISABILITIES

A successive disability is a second disability due to the same cause as the first disability that occurs less than six consecutive months after you have returned to your regular job from the first disability, and/or during that six month period you earn less than 80% of your pre-disability pay during at least one month. A successive disability has:

- No additional elimination period
- The same maximum benefit period as the previous disability.

For any separate period of disability that is not considered continuous, you will be required to complete a new elimination period.

LIMITED BENEFITS

- **Mental or Nervous Disorders:** Disability benefits will be provided on a limited basis for disabilities caused by or contributed to by certain conditions. After 24 monthly LTD benefits have been paid, no further benefits will be payable for any of the following conditions:
  - Anxiety disorders
  - Delusional (paranoid) disorders
  - Depressive disorders
  - Eating disorders
  - Mental illness
  - Somatoform disorders (psychosomatic illness)

  If you are confined to a hospital for more than 14 consecutive days before reaching your lifetime maximum benefit, the period of confinement will not count against your lifetime limit. The confinement must be for the appropriate care of any of the above conditions.

  The 24-month limitation does not apply to a disability caused by schizophrenia or bi-polar disorder.
- **Alcoholism and Drug Addiction or Abuse**: After 24 monthly disability payments have been paid, no further benefits will be payable for any of the following conditions:
  - Alcoholism
  - Drug addition or abuse.

  If you are confined to a hospital for more than 14 consecutive days before reaching your lifetime maximum benefit, the period of confinement will not count against your lifetime limit. The confinement must be for the appropriate care of any of the above conditions.

SURVIVOR INCOME BENEFIT

If you die while disabled, a single, lump sum benefit will be paid under this provision if you have an eligible survivor (as defined below) and at least three monthly benefits have been payable to you for a continuous period of disability. The survivor income benefit will equal 100% of the sum of the last full disability benefit payable to you plus the amount of any earnings from work by which the benefit had been reduced for that month. A single lump sum payment equal to three monthly survivor income benefits will be payable.

The survivor income benefit will be paid to your spouse. If you do not have a spouse, the benefit will be paid to your surviving children (including step-children) who are unmarried, under age 21 and chiefly dependent on you for support and maintenance. If you do not have a spouse or eligible children, the benefit will be paid to your estate.

The benefit will be paid as soon as CIGNA receives the necessary written proof of your death and disability status.

If your monthly benefit payments is more than you are entitled to receive, the plan has the right to apply the overpayment towards the survivor benefit.

WHEN LTD BENEFITS END

Your LTD benefits automatically end on the earliest of the following dates:

- You earn more than 80% of your pre-disability base pay from any occupation
- The insurance company determines you are not disabled
- The end of the maximum benefit period
- You die
- You refuse, without good cause, to fully cooperate in all required phases of the rehabilitation plan and assessment
- You are no longer receiving appropriate care
- You fail to cooperate with CIGNA in the administration of the disability claim, including, but not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.

Benefits may be resumed if you begin to cooperate fully in the rehabilitation plan within 30 days of the date benefits are terminated.

Exclusions and Limitations

Disability benefits will not be paid for a disability resulting directly or indirectly from:

- Suicide, attempted suicide, or self-inflicted injury while sane or insane
- War or any act of war, whether or not declared
- Active participation in a riot
- Commission of a felony
- The revocation, restriction, or non-renewal of your license, permit, or certification necessary to perform the duties of your occupation unless due solely to injury or sickness covered by the disability insurance plan

The following exclusions apply only to STD:

- Any cosmetic surgery or surgical procedure that is not a covered health service. Benefits may be paid if disability is caused by an organ donation in a non-experimental transplant procedure.
- Work-related injury or sickness and/or one in which you are entitled to benefits from workers compensation.

In addition, STD or LTD benefits will not be paid for any period of disability during which you are incarcerated in a penal or corrections institution.

The following exclusions and limitations apply only to the LTD plan:

- Disability beyond 24 months (after the elimination period) if it is because of certain mental disorders listed on the previous page. Confinement in a hospital or institution licensed to provide care and treatment for mental illness will not be counted as part of the 24-month limit.
- Substance abuse related disability (drug or alcohol) unless you are participating in a substance abuse treatment program approved by the state. The cost of the treatment must be paid by you or another Texas Health plan (if one is available and covers this type of treatment). In no event will LTD monthly benefits be paid for substance abuse beyond the earliest of the date you:
  - Have received 24 LTD monthly benefit payments
  - Have reached the maximum period payable
  - Refuse to participate in an appropriate, available treatment program or you leave the treatment program before completing it
  - Are no longer following the requirements of your treatment plan under the program
  - Complete the initial treatment plan, not including any aftercare or follow-up services.

Filing STD and LTD Claims

To initiate your claim for STD or LTD benefits, you are responsible for contacting the insurance carrier within 31 days of the start of your leave of absence. Contact CIGNA at 1-(800) 36-CIGNA or 1-(800) 362-4462.

You, your medical provider, and Texas Health will need to provide the insurance carrier or its authorized agent with required information on your claim as soon as possible. If you are not able to meet the filing deadline, through no fault of your own, your claim will be accepted if you file as soon as possible.

Unless you are legally incapacitated, late claims will not be covered if they are filed more than one year after the filing deadline. Contact the Texas Health Integrated Disability Management department for additional information on filing a disability claim.

The STD, Basic LTD, and Additional LTD plans are fully insured plans and benefits are paid by CIGNA.

You may be asked for additional information about your disability. You will be notified of the decision regarding your claim. Notification and/or payment are made directly to you.

CLAIM FILING DEADLINE

You must call CIGNA at 1-(800) 36-CIGNA or 1-(800) 362-4462 within 30 days of the date of disability for STD and within 30 days after you become disabled for LTD.

PROOF OF DISABILITY

For STD, you must provide written proof of your disability before payment of benefits can be approved. Your claim will be denied if you do not provide written proof in a timely manner. CIGNA may request that you must provide the information listed below, at your expense, as part of your proof of disability. Failure to provide all of this information may delay, suspend, or terminate your benefits.

For LTD, you must provide the claims administrator with written proof of your disability within 90 days after the end of your elimination period. If it is not possible to provide proof within 90 days, the claim is not affected if you give proof as soon as possible. However, unless you are legally incapacitated, you must provide proof no later than one year after it is due. Otherwise late claims will not be covered.

See page 149 for information on what to do if your claim is denied.

Your written description may include:

- The date your disability began
- The cause of your disability
- The prognosis of your disability
- Proof that you are receiving regular and appropriate care for your condition from a doctor whose specialty is most appropriate for your disabling condition according to generally accepted medical practice (The doctor may not be a member of your immediate family.)
- Objective medical findings that support your disability, such as tests, procedures, or clinical examinations that are accepted as standard medical practice for your disabling condition
- A description of the extent of your disability, including restrictions and limitations that are preventing you from performing your regular occupation
- Appropriate documentation of your base pay and, if applicable, regular monthly documentation of your disability earnings
- The name and address of any hospital or health care facility where you have been treated for your disability.

AUTHORIZATION AND DOCUMENTATION

You may be required to supply the following:

- Signed authorization for the claims administrator to obtain and release all reasonably necessary medical, financial, or other non-medical information that supports your disability claim. Failure to submit this information may deny, suspend, or terminate your benefits.
- Proof that you have applied for all other applicable deductible income benefits such as Workers' Compensation or Social Security disability benefits
- Objective medical findings that support your disability, such as tests, procedures, or clinical examinations that are accepted as standard medical practice for your disabling condition
- A description of the extent of your disability, including restrictions and limitations that are preventing you from performing your regular occupation
- Appropriate documentation of your base pay and, if applicable, regular monthly documentation of your disability earnings
- The name and address of any hospital or health care facility where you have been treated for your disability
- Notification to the claims administrator when you are awarded other income benefits, including the nature of that benefit, the amount, the period for which the benefit applies, and the duration of the benefit if it is being paid in installments.

TIMING OF CLAIM PAYMENTS

The claims administrator will begin paying benefits after your elimination period after receiving and approving your claim. Benefits will continue as long as you continue to qualify up to the maximum period.

Your benefits are not assignable, which means you may not transfer your benefits to anyone else.

SUBROGATION

The plan has the right to pursue all rights of recovery you have against any third party for any benefits provided with respect to your disability. The term "third party" includes any party possibly responsible for your injuries or illnesses or your no-fault automobile insurance coverage. You must fully cooperate with the plan's efforts to recover benefits paid. You are required to notify CIGNA within 45 days of the date any notice is given to any other party (including an attorney) of any intention to pursue or investigate a claim to recover damages due to injuries or illnesses that you sustained. The plan's subrogation rights are a first priority claim against all potential liable parties and are to be paid before any other claim for your damages. This applies even if the remainder of the payments from the third party is insufficient to make you whole or compensate you in part or in whole for the damages you sustained.

The claims administrator reserves any and all rights to subrogation and/or reimbursement to the fullest extent allowed by statute and customary practice. Neither you nor anyone else may do anything to prejudice the claims administrator's right to receive subrogation or reimbursement without the claims administrator's prior agreement.

When Coverage Ends

Generally, coverage for you under the STD Plan and the LTD Plan ends when you are no longer eligible for coverage, you do not elect coverage, you do not pay your premiums, or you terminate employment with Texas Health.

Converting Coverages

SHORT TERM DISABILITY COVERAGE

You may not convert STD coverage to an individual policy when your coverage under the Texas Health STD Plan ends.

LONG TERM DISABILITY COVERAGE

If your coverage under the plan ends because your employment ends or you have been laid off, you may be eligible to convert your Additional LTD coverage without any evidence of insurability.

To be eligible to convert, you must:

- Have been covered by the LTD plan and actively at work for at least 12 consecutive months
- Make application for conversion insurance within 31 days after coverage under the Texas Health group LTD plan ends.

Conversion coverage will be effective as of the date coverage ends under this plan.

If you apply more than 31 days after coverage ends under this plan, you will be required to submit satisfactory evidence of good health at your own expense. Conversion coverage will be effective on the date CIGNA agrees in writing to insure you.

The coverage under the conversion plan will be those benefits offered at the time you apply. Premiums will be based on the rates in effect for conversion plans at that time.

You may not convert your Additional LTD coverage if:

- You are retired or age 70 or older;
- You are not in active service with Texas Health because of disability
- The policy is cancelled for any reason
- You are no longer in an eligible class of employees, even though you work for Texas Health.

Life and Accident Coverage

Overview

You rely on your paycheck to meet daily living expenses. A severe accidental injury or your death could jeopardize your family's financial security. If death or injury occurs, your family needs protection.

Texas Health pays the full cost of the following benefits for full-time and part-time benefits-eligible employees:

- Basic Life Insurance
- Basic Accidental Death and Dismemberment (AD&D) Insurance
- Business Travel Accident Insurance.

Coverage is effective on your first day of eligibility (see page 5).

Full-time and part-time benefits-eligible employees may purchase the following benefits:

- Additional Life Insurance
- Dependent Life Insurance
- Additional AD&D Insurance.

If you and your spouse both work for Texas Health and are eligible for Flexible Benefits, you cannot be covered both as an employee and a dependent on the same plan. Also, only one of you may cover your children.

If you and your benefits-eligible child work for Texas Health, your child cannot be covered as an employee and a dependent on the same plan. Therefore, you cannot cover this child for child life insurance or family AD&D.

If your spouse is a former Texas Health employee approved for premium waiver life insurance through Texas Health, you can not cover your spouse as a dependent.

Summary of Benefits

When you make your benefit decisions, you should consider those who might be affected by your disability or death.

If you:	This policy:	Pays this benefit:	To:
Die	Life Insurance	Full benefit amount	Your beneficiary
Die in an accident	Life Insurance and AD&D Insurance	Full benefit amount	Your beneficiary
Suffer a covered dismemberment	AD&D	Percentage of total benefit amount	You

If you are absent from work because of sickness or injury on the date your Life and/or AD&D coverage or increase in coverage would otherwise become effective, your effective date will be deferred until you return to active service.

All Life and AD&D claims are calculated using your annual base pay at the time of your loss. Annual base pay is your hourly rate of pay times the number of hours you are classified in the HR/Payroll system to work. Base pay does not include shift differentials, bonuses, overtime earnings, commissions, or other compensation paid to you. Benefit amounts are rounded to the next highest $1,000.

Life Insurance

Your financial plan should include tools to help your family deal not only with your own death, but also with the death of a spouse or child. Texas Health provides Basic Life coverage for you, and you can purchase coverage for your spouse and children. You may also increase your own coverage by purchasing Additional Life Insurance.

Life Insurance cost each year is based on your age as of January 1 and your benefits base rate as of October 1 of the previous year. If you receive an increase in your base pay during the year, your Life Insurance coverage will increase at the same time. However, your cost for coverage will not increase until the next open enrollment period. Your new rate for coverage will become effective the following January 1.

BASIC LIFE INSURANCE

Texas Health pays the full cost of Basic Life Insurance coverage for full-time and part-time benefits-eligible employees. If you die, your beneficiary will receive a benefit equal to one times your annual base pay, up to $50,000. If you have been diagnosed as terminally ill, you may also qualify for Terminal Illness Benefit, as explained later in this section.

ADDITIONAL LIFE INSURANCE

If you are a full-time or part-time benefits-eligible employee, you may elect Additional Life Insurance for yourself in addition to the Basic Life Insurance provided by Texas Health. Your cost for Additional Life Insurance is based on your benefits base rate, your age, and the amount of coverage you select. You pay for Additional Life coverage on an after-tax basis.

When you first become eligible, you may choose coverage of one, two, three, four, five or six times your annual base pay, up to a combined maximum of $2,000,000[1] for Basic and Additional Life coverage. Each open enrollment period after your initial enrollment, you may increase your coverage by only one level, but you may decrease your coverage to any level.

Employees are guaranteed issue of coverage up to $1,000,000. Coverage amounts over the $1,000,000 guaranteed issue amount require employees complete an Evidence of Insurability insurance application, which contains health related questions. The forms must all be returned to Cigna (at the address listed on the form) within 60 days of the enrollment. Sending the forms to Cigna ensures your privacy because Texas Health will never see the completed form with employee responses. When an employee elects a coverage amount over $1,000,000, the amount over is placed in a pending status. Employees only pay premiums on the $950,000 ($1,000,000 - $50,000 Basic) guaranteed amount until the additional pended amount is approved by Cigna. Once approved, coverage for the total amount goes into effect as of the approval date and employees will start paying the new premium the following pay period.

If you have been diagnosed as terminally ill, you may also qualify for a Terminal Illness Benefit, as explained later in this section.

DEPENDENT LIFE INSURANCE

If you are a full-time or part-time benefits-eligible employee, you may elect Dependent Life Insurance coverage for your eligible dependents, as defined on pages 5 – 7. To be eligible for Dependent Life Insurance coverage, your dependents do not have to reside with you, be a U.S. citizen, or live in the U.S. Dependent Life coverage pays a benefit to you if your covered dependent dies.

You may cover your unmarried dependent children from live birth or older but under age 25, regardless of student status.

[1] Coverage over $1,000,000 (including basic) is subject to evidence of insurability.

Child life coverage for your fully handicapped dependent child may be continued past maximum age for a dependent child. Your child is fully handicapped if he or she is:

- Incapable of self-sustaining employment because of a mental or physical handicap
- Primarily supported by you.

You must submit proof of the child's condition and dependence to CIGNA within 31 days after your child reaches the maximum age. During the next two years, CIGNA may, from time to time, require proof of the continued condition and dependence. After that, CIGNA may require proof no more than once a year.

You may cover your dependents for the following amounts:

- *Spouse*—You may elect coverage for your spouse in $10,000 increments, up to the total amount of your Basic and Additional Life coverage, but no more than $50,000. Each open enrollment period after your initial enrollment you may increase your spouse's coverage by one level, up to $50,000. The cost of spouse coverage is based on the employee's age as of January 1.
- *Each child*—You may elect coverage of $10,000 for your eligible children. Newborns may be covered from the date of live birth. You pay the same premium amount for Child Life regardless of the number of children covered.

Your cost for Dependent Life is based on which family members you choose to cover. The options for dependent coverage are spouse only, children only, or spouse and children. You purchase Dependent Life through payroll deductions on an after-tax basis.

Dependent life coverage will be delayed if, on the date the insurance would otherwise be effective, the dependent is confined to his or her home under the care of a physician or is an inpatient in a hospital, hospice, rehabilitation or convalescence center, or custodial care facility. Coverage will be effective on the date he or she is no longer an inpatient in these facilities or confined at home.

Your request to change the amount of coverage may be delayed if the dependent was in the hospital or disabled due to illness or injury on the effective date of the initial enrollment or increase.

If your covered spouse has been diagnosed as terminally ill, he or she may also qualify for a Terminal Illness Benefit, as explained later in this section.

EXCLUSIONS

There are no exclusions for Basic Life coverage.

If an insured commits suicide, while sane or insane, within two years from the date his or her insurance under the policy becomes effective, additional life and dependent life insurance will be limited to a refund of the premiums paid on the insured's behalf. If a dependent child commits suicide and is survived by other dependent children covered under the same certificate, no refund of premiums will be paid. The suicide exclusion applies from the effective date of any additional benefits or increases in life insurance benefits.

WAIVER OF PREMIUM FOR DISABILITY

If you submit satisfactory proof that you have been continuously disabled for nine months from the date you were no longer working as a result of the disability, coverage will be extended up to age 65. Dependent coverage is not eligible for waiver of premium.

You must submit this proof to CIGNA no later than three months after the date the nine month waiting period ends. Premiums will be waived from the date CIGNA agrees in writing to waive your premiums. After premiums have been waived for 12 months, they will be waived for future 12-month periods if you remain disabled and submit satisfactory proof that disability continues. Satisfactory proof must be submitted to CIGNA three months before the end of the 12-month period.

Amount of Insurance

If you die while disabled and while coverage is continued under this provision, CIGNA will pay a death benefit equal to the amount of coverage in effect on the date you became disabled. However, the life insurance benefit will be subject to a reduction of coverage amount because of age, retirement, or payment of an accelerated benefit. Automatic increases in life insurance benefits will not apply while premiums are waived. CIGNA will pay benefits only if proof of your continuous disability is received within one year of the date of the loss.

Termination of Waiver

If premiums are waived, your insurance will end on the earliest of the following dates:

- The date you are no longer disabled.
- The date you refuse to submit to any physical examination required by CIGNA.
- The last day of the 12-month period of disability during which you fail to submit satisfactory proof of continued disability.
- The date following your 70th birthday.

"Disability" or "disabled" means because of injury or sickness, you are unable to perform all the material duties of any occupation which you may reasonably become qualified based on education, training or experience.

TERMINAL ILLNESS BENEFIT

If you or a covered spouse has a terminal illness, you may be eligible to receive up to 75% of your Basic Life and Additional Life or Dependent Life Insurance benefit (to a maximum of $500,000) during your lifetime under the Terminal Illness Benefit.

You must be terminally ill (for example, have a prognosis of 12 months or less to live), as diagnosed by a physician. This money can be used to defray medical expenses or replace lost income during the last months of an illness.

For the purpose of determining the existence of a terminal illness, CIGNA will require you to submit the following proof:

- A written diagnosis and prognosis by two physicians licensed to practice in the United States
- Supportive evidence satisfactory to CIGNA, including but not limited to radiological, historical, or laboratory reports documenting the terminal illness.

CIGNA may require, at its expense, an examination of you or your dependent and a review of the documented evidence by a physician of its choice.

Any Terminal Illness Benefit paid will be deducted from the amount of life insurance payable upon your death or your dependent's death.

Accidental Death & Dismemberment (AD&D) Insurance

In addition to Life coverage, you can protect yourself and your family members from the financial hardship of certain accidental injuries or death with AD&D coverage. AD&D provides broad 24-hour protection year round, including coverage during travel. The plan pays benefits to you if you have a serious accidental injury, and it pays your beneficiary if you die as the result of an accident. Death or dismemberment must occur as result of, and within 365 days following, the accident.

If you or a covered dependent becomes totally disabled as a result of an accident and that disability is continuous from the date of the accident until your death, your beneficiary will receive the amount of your Principal Sum. Total disability means you:

- Are not currently employed to do any type of work for which you are or may become qualified by reason of education, training or experience or
- Are not currently able to perform all of the activities of daily living including eating, transferring, dressing, toileting, bathing, and continence, without human supervision or assistance.

If a death benefit is payable, it will be reduced by any other paid or unpaid accidental dismemberment loss. To pay the death benefit, the insurance company must receive written notice of your death within 12 months of your death.

You may be required to undergo a physical examination to provide proof of your loss before AD&D benefits will be paid.

If you experience more than one loss as a result of the same accident, the plan pays benefits for the largest loss amount, up to 100% of the total coverage amount.

Loss	Benefit[1]
Life	100%
Two hands, two feet, or one hand and one foot	100%
Sight of both eyes	100%
One hand or foot and sight in one eye	100%
Hearing in both ears and speech	100%
Quadriplegia	100%
One burn covering 75% or more of person's body	100%
Paraplegia	75%
One burn covering 50 – 74% of person's body	75%
Hemiplegia	50%
One hand or one foot	50%
Sight in one eye	50%
Speech	50%
Hearing in both ears	50%
Third degree burn covering 25 – 49% of person's body	50%
Thumb and index finger of the same hand	25%
All four fingers of the same hand	25%
Uniplegia	25%
All the toes of the same foot	20%

[1] Benefit as a percentage of annual base pay.

BASIC AD&D INSURANCE

Texas Health pays the full cost of Basic AD&D Insurance coverage for full-time and part-time benefits-eligible employees.

If you are injured or killed as a result of an accident, you or your beneficiary will receive a benefit based on the extent of the injury as shown in the table on page 97. The maximum benefit is one times your annual base pay, up to $50,000. Benefit amounts are rounded to the next highest $1,000.

Base pay is your hourly rate times the number of hours you are classified in the HR/Payroll system to work. Base pay does not include shift differentials, bonuses, overtime earnings, commissions, or other compensation.

Basic AD&D Insurance pays benefits in addition to any other benefits you may receive under your Life Insurance coverage if you die as a result of an accident. Benefits are paid in a single lump sum payment.

ADDITIONAL AD&D INSURANCE

If you are a full-time or part-time benefits-eligible employee, you may purchase Additional AD&D Insurance. If you elect Additional AD&D for yourself, you can also elect AD&D coverage for your family. Additional AD&D coverage pays benefits in addition to any other benefits you may receive under your Life or Dependent Life coverage if death occurs as a result of an accident.

You may elect Additional AD&D coverage for yourself of one to 10 times your annual base pay, up to $750,000. If you elect coverage for your family, all eligible members of your family are covered.

If your covered spouse or child is injured or dies as a result of an accident, you will receive a benefit based on the extent of the injury as shown in the table for Basic AD&D on page 97 and then applying the percentages in the table in the next column.

If you have these family members:	Family coverage will be:
Spouse only	50% of your Additional AD&D coverage
Spouse and children	• Your spouse's coverage is 40% of your Additional AD&D coverage. • Each child's coverage is 10% of your Additional AD&D coverage.
Children only	Each child's coverage is 15% of your Additional AD&D.

Here is an example:

Your base pay = $30,000.

You elect coverage of 2 times base pay for family = $60,000.

Your family includes you and children.

Your child loses sight of one eye.

Benefit payable on basic table on page 97 = 50% of $60,000 = $30,000.

The percentage of child coverage in the above table = 15% of $30,000. $4,500 is the amount payable in this example.

You purchase Additional AD&D through payroll deduction on a before-tax basis, so the premium reduces your taxable income. Your cost for Additional AD&D is based on the amount of coverage and coverage level you select.

AD&D SPECIAL FEATURES

Seat Belt Benefit

Basic AD&D coverage provides a seat belt benefit for you and your covered family members.

If you or your covered family member dies in an accident as the driver or passenger of a private automobile, and the covered person was properly wearing a seat belt at the time of the accident (as verified in a police accident report), a benefit will be payable. If an airbag is activated as a result of the same accident, an additional benefit will be payable. The plans pay an additional $10,000 for use of seat belt and an additional $5,000 if an airbag is activated under the Plan.

If the police report is not available or it is unclear whether the covered person was wearing a seatbelt or positioned in a seat protected by an airbag, CIGNA will pay a default benefit of $1,000.

No benefit will be paid if the covered person was under the influence of drugs or any intoxicant while operating the automobile.

Other Special Features

Basic and Additional AD&D coverage also provides the following special benefits for you and your covered dependents:

- *Coma Benefit*—If you or a covered dependent becomes comatose as the result of an accident, you receive 1% per month of the principal sum less any benefits already paid out or payable for up to 11 months. After 12 months of continuous coma, the full principal sum is payable less any benefit amount paid or payable because of the same accident.

  Monthly benefit payments will cease on the earliest of the date all monthly payments have been made; the full principal sum is paid; the coma ceases; failure to have any required exam or to give proof of continuous coma; or the policy terminates.

- *Day Care Benefit*—If you or your spouse dies as the result of an accident and your child age 13 or under is covered by AD&D and was enrolled or does enroll in a child care center within 90 days from the date of the accident, the plan pays an annual benefit of 3% of your total coverage amount (up to $2,000 per child, per year) for the cost of the surviving child's care in a licensed child care center. This benefit is payable for up to four years from the date of death or until the child turns 13.
- *Dependent Education Benefit*—If you die as the result of an accident, the plan pays 5% of your total coverage amount (up to $5,000 per year) to each dependent child for education. This benefit is payable to your surviving spouse for up to four consecutive years, as long as the child:
  - Enrolls as a full-time student at an accredited school of higher learning before reaching age 25;
  - Continues his or her education as a full-time student; and
  - Incurs expenses for tuition, fees, books, room and board, transportation and any other costs payable directly to or approved and certified by the school.

  This benefit is payable for your surviving spouse for up to four consecutive years, as long as your spouse:
  - Enrolls in any accredited school to retrain or refresh skills needed for employment within one year of the date of the employee's accident;
  - Remains enrolled in an accredited school; and
  - Incurs expenses payable directly to, or approved by the school.

  If the dependent child(ren) or surviving spouse does not qualify for the special education benefits within 365 days of the employee's death, CIGNA will pay the default benefit of $1,000 to your beneficiary.

Additional AD&D Features

- *Bereavement and Trauma Counseling Benefit*—CIGNA will pay up to $50 per session for up to five counseling sessions, up to $250 and subject to conditions and exclusions, when the covered person or immediate family member requires bereavement and trauma counseling because the covered person suffered a loss that resulted from an accident.
- *HIV Occupational Accident Benefit*—CIGNA will pay the benefit of 10% of the principal sum to a maximum of $25,000, subject to the conditions and exclusions, when the employee suffers an injury resulting from an accident. The accident must occur during the performance of occupational duties and result in the covered employee acquiring and testing positive for Human Immunodeficiency Virus (HIV) antibodies within one year of the covered injury.
- *Hepatitis C Occupational Duties Accident Benefit*—CIGNA will pay the benefit of 10% of the principal sum, to a maximum of $25,000, subject to conditions and exclusions, when the covered person suffers an injury resulting from an accident. The accident must have occurred during the performance of occupational duties and resulted in the covered person acquiring and testing positive for Hepatitis C within one year of the injury.
- *Home Alteration and Vehicle Modification Benefit*—CIGNA will pay the Home Alteration and Vehicle Modification Benefit of 10% of the principal sum, to a maximum of $25,000, subject to conditions and exclusions, when as a direct result of the loss, the covered person requires adaptive devices or adaptation of residence and/or vehicle to maintain an independent lifestyle.
- *Rehabilitation Benefit*—CIGNA will pay a Rehabilitation Benefit of 5% of the principal sum (up to $10,000), subject to conditions and exclusions, when the covered person requires rehabilitation after sustaining a loss resulting from an accident. The covered person must require rehabilitation within two years after the date of the loss.

Contact Human Resources for more information on these special AD&D features.

COVERED LOSSES

The AD&D plan pays a benefit if you or a covered dependent has a loss within 365 days of an accidental injury. The following table explains when an injury is covered as a loss.

If injury is to:	It must be:
Hand or foot	Severed through or above the wrist or ankle joint
Thumb and index finger or four fingers of same hand	Severed through or above the metacarpophalangeal joint
Sight, speech or hearing	Entire and irrecoverable loss
Movement of limbs	Complete and irreversible paralysis of limbs
Toes	Severed through the metacarpophalangeal joint
Paralysis	Total loss of use of limbs with physician determination that the loss is complete and irreversible

EXCLUSIONS FOR AD&D COVERAGE

AD&D benefits do not cover injury or death caused or contributed to by the following:

- Intentionally self-inflicted injury, suicide or attempted suicide or self-injury while sane or insane;
- Commission or attempt to commit a felony or an assault;
- Commission of or active participation in a riot, insurrection or terrorist act;
- Bungee jumping, parachuting, skydiving, parasailing, hang-gliding;
- Declared or undeclared war or act of war;
- Flying in, boarding or alighting from an aircraft or any craft designed to fly above the Earth's surface, except as a passenger on a regularly scheduled commercial airline. This includes an aircraft:
  - Being flown by the covered person or in which the covered person is a member of the crew;
  - Being used for:
    - Crop dusting, spraying or seeding, giving and receiving flying instruction, fire fighting, sky writing, sky diving or hang-gliding, pipeline or power line inspection, aerial photography or exploration, racing, endurance tests, stunt or acrobatic flying; or
    - Any operation that requires a special permit from the FAA, even if it is granted (this does not apply if the permit is required only because of the territory flown over or landed on);
  - Designed for flight above or beyond the Earth's atmosphere;
  - An ultra-light or glider;
  - Being used for the purpose of parachuting or skydiving;
  - Being used by any military authority, except an aircraft used by the Air Mobility Command or its foreign equivalent;
- Sickness, disease, bodily or mental infirmity, bacterial or viral infection or medical or surgical treatment, except for any bacterial infection resulting from an accidental external cut or wound or accidental ingestion of contaminated food;
- Travel in any aircraft owned, leased or controlled by Texas Health, or any of its subsidiaries or affiliates. An aircraft will be deemed to be "controlled" by Texas Health if the aircraft may be used as Texas Health wishes for more than 10 consecutive days, or more than 15 days in any year;
- An accident that occurs while engaged in the activities of active duty service in the military, navy or air force of any country or international organization. Accidents that occur while engaged in Reserve or National Guard training are not excluded until training extends beyond 31 days;
- Operating any type of vehicle while under the influence of alcohol or any drug, narcotic or other intoxicant including any prescribed drug for which the covered person has been provided a written warning against operating a vehicle while taking it. Under the influence of alcohol, for purposes of this exclusion, means intoxicated, as defined by the law of the state in which the accident occurred;
- Voluntary ingestion of any narcotic, drug, poison, gas or fumes, unless prescribed or taken under the direction of a physician and taken in accordance with the prescribed dosage;
- In addition, benefits will not be paid for services or treatment rendered by a physician, nurse or any other person who is:
  - Providing homeopathic, aroma-therapeutic, or herbal therapeutic services;
  - Living in the covered person's household;
  - A parent, sibling, spouse or child of the covered person.

Business Travel Accident Insurance

Texas Health pays the full cost of Business Travel Accident (BTA) Insurance coverage for all eligible employees (as defined on page 5). BTA provides coverage if you die or lose a body part as the result of an accident while traveling on Texas Health business.

BTA pays a benefit if you lose part of your body as the result of an accident while traveling on business for Texas Health according to the following table:

Loss	Benefit[1]
Life	100%
Two hands, two feet, or one hand and one foot	100%
Sight of both eyes	100%
One hand or foot and sight in one eye	100%
Hearing in both ears and speech	100%
Quadriplegia	100%
Paraplegia	75%
Hemiplegia	50%
One hand or one foot	50%
Sight in one eye	50%
Speech	50%
Hearing in both ears	50%
Thumb and index finger of the same hand	25%
All four fingers of the same hand	25%
Uniplegia	25%
All the toes of the same foot	20%

[1] Benefit as a percentage of annual base pay

Base pay is your hourly rate times the number of hours you are classified in the HR/Payroll system to work. Base pay does not include shift differentials, bonuses, overtime earnings, commissions, or other compensation. If your base pay changes, the amount of your coverage will change on the date your pay changes.

To be eligible for benefits, the loss must meet the plan's definition according to the table at the top of the next column.

If injury is to:	It must be:
Hand or foot	Severed through or above the wrist or ankle joint
Thumb and index finger	Severed through or above the metacarpophalangeal joint
Sight, speech or hearing	Entire and irrecoverable loss
Movement of limbs	Complete and irreversible paralysis of limbs

If you die as the result of an accident while traveling on business for Texas Health, your beneficiary will receive a benefit of one times your base pay, up to $800,000.

You may be eligible for a benefit if you become comatose within 30 days of a covered accident while traveling on business for Texas Health and remain in a coma for 60 consecutive days. The monthly coma benefit is 1% of annual base pay, payable for 11 months at the end of each month that you are in a coma. A lump sum benefit of 100% of your annual base pay will be paid at the beginning of the 12th month. You must be diagnosed and regularly treated by a physician. A benefit is not payable for any state of unconsciousness intentionally induced during the course of treatment, unless the state of unconsciousness results from the administration of anesthesia in preparation for surgical treatment of injuries sustained in a covered accident.

Benefits are reduced if you are over 70 when the accident occurs, as shown in this table.

If your age is:	Benefits will be reduced to:
70 but less than 75	65%
75 but less than 80	45%
80 but less than 85	30%
85 or over	15%

If you experience more than one loss as a result of the same accident, the plan pays benefits for the largest loss amount, up to 100% of the total coverage amount.

Coverage is effective when you leave your home or regular work location (whichever occurs later) to begin a business trip. It ends when you return home or to your regular work location (whichever occurs first). Everyday travel to and from work is not covered. Death or dismemberment must occur as result of, and within 365 days following, the accident.

BTA coverage has aggregate maximums. The maximum total benefit payable for the same accident, regardless of the number of employees injured or killed, is $3,250,000 per accident (except accidents on company owned or leased aircraft). BTA coverage pays benefits in addition to any other benefits you may receive under your Life and/or AD&D coverage. Benefit amounts are rounded to the next highest $10,000.

Benefits are paid in a single lump-sum payment, with the exception of the coma benefit.

If you have a covered injury resulting from an accident while on a business trip that is approved in advance, you will be entitled to an additional benefit if either:

- The loss is the result of unavoidable exposure to the elements because of a forced landing, stranding, sinking, or wrecking of the form of transportation in which you were traveling at the time of the accident or
- Your body has not been found within one year of the date that the form of transportation in which you were traveling disappeared, made a forced landing, sank, or was wrecked.

BTA SPECIAL FEATURES

BTA pays additional benefits if the loss occurs in an automobile while properly using a seat belt. Seat belt use must be verified in the police accident report or, if not mentioned in the police accident report, by a signed statement from a doctor, paramedic, police officer, coroner, or other person of competent authority who was at the scene of the accident.

The seat belt benefit equals 10% of your annual base pay up to a maximum of $10,000. If you were in a seat that has a working airbag that inflates upon impact, a benefit of 5% of annual base pay will be paid, to a maximum of $5,000.

EXCLUSIONS FOR BTA COVERAGE

BTA benefits do not cover injury or death resulting from the following:

- Commuting to and from work
- Suicide or intentionally self-inflicted injury, whether sane or insane
- Commission of or attempt to commit an assault or felony
- Commission of or active participation in a riot or insurrection
- Sickness, disease, bodily or mental infirmity, bacterial or viral infection or medical or surgical treatment of these; exposure (whether or not accidental) to viral, bacterial or chemical agents; unless the bacterial infection results from an accidental external cut or wound or accidental ingestion of contaminated food
- Voluntary ingestion of a narcotic, drug, poison, gas or fumes, unless prescribed or taken under the direction of a physician and in the prescribed dosage
- Injury sustained while in the armed forces of any country or international authority
- Any act of war, declared or undeclared
- Travel or flight as a pilot or crew member in any kind of aircraft
- Flight in, boarding or alighting from an aircraft or any craft designed to fly above the Earth's surface, except as a fare-paying passenger on a regularly scheduled commercial or charter airline
- Operating any type of vehicle while under the influence of alcohol or any drug, narcotic or other intoxicant including any prescribed drug for which you have been provided a written warning against operating a vehicle while taking it
- Travel to a location where you are expected to be assigned for more than 60 days

- Any activity not authorized or organized, or not reimbursable, by Texas Health
- Any activity not related to the purpose of the business trip that you do while traveling for business
- Driving any vehicle or automobile for pay or hire.

BTA does not provide any benefits while you are performing job duties during work hours in a residence work area, as specified in the Texas Health written telecommuting policy.

In addition, benefits will not be paid for services or treatment rendered by you or any person who is either:

- Employed by Texas Health
- Living your household or
- The parent, sibling, spouse, or child of you or your spouse.

Beneficiary Designation

In the event of your death, benefits for Basic and Additional Life, Basic and Additional AD&D, and Business Travel Accident coverage are paid to your named beneficiaries. To ensure that benefits are paid according to your wishes in the event of your death, you should go online to designate a beneficiary which can be done at any time.

You may name a different beneficiary for each plan or combination of plans if you wish. You may name more than one beneficiary for each plan, such as your spouse and adult children. Beneficiary information cannot be given or changed over the phone.

To name a beneficiary, logon to **www.MyTHR.org** and click on My Benefits. A new Benefits website will open, click View/Edit Benefits. Next click My Benefits to see a list of your current benefits. Scroll down the page to #6 Life and click View/Edit Information. Under the sections titled Life and Voluntary Life is a Beneficiaries section. Click the word Edit and you are ready to add/edit/remove your beneficiaries. After adding your life insurance beneficiaries, scroll down to #7 Accident and follow the same steps as before. Be sure to enter a beneficiary for the Basic plans and the additional plans if you elected coverage.

The beneficiary you name for Basic Life Insurance will also be your beneficiary for the Business Travel Accident plan. If you do not name a beneficiary designation for each benefit, the beneficiary designation you entered for Basic Life will apply to the other benefits. For example, if you designate a beneficiary in Basic Life but not Additional Life, then the Basic Life beneficiary will be applied to Additional Life. If both Basic AD&D and Additional AD&D are missing beneficiary designations, the Basic Life Beneficiary will apply to those benefits as well.

You may name anyone as your beneficiary. However, Life, AD&D, and BTA insurance proceeds cannot be paid to a minor child until the earlier of the date:

- The child reaches the age of majority (age 18 in Texas) or
- A court has appointed a legal guardian of the minors' estate. This appointment process can be costly, and state law may limit who may be named a guardian of an estate.

As an alternative to naming a minor child as your beneficiary, you can establish a trust for your child and designate the trust as your beneficiary. The trust would receive and manage your life insurance proceeds on your child's behalf. You should obtain legal advice to determine the best way to set up the trust under Texas laws.

Unless prohibited by law, your life insurance benefits are distributed as indicated by your beneficiary designation. For this reason, you should periodically review your beneficiary designation, especially if you get married or divorced or have or adopt a child. If there is no living designated beneficiary at the time of your death, benefits will be paid in accordance with the applicable policy provision.

If you elect life insurance coverage for your spouse or children, you are automatically the beneficiary for their insurance benefits.

If more than one person is named as beneficiary, the interests of each will be equal unless you specify otherwise. The share of any beneficiary who does not survive you will pass equally to any surviving beneficiaries unless otherwise specified. If there is no named beneficiary or surviving beneficiary, or if you die while benefits are payable to you, the remaining benefits will be paid to the first surviving class:

- Spouse
- Child or children
- Parents
- Siblings
- Your estate.

In the event of a covered accidental injury, AD&D coverage pays benefits to:

- You in the case of certain accidental injuries
- Your named beneficiary in the event of your death.

Filing Claims

Texas Health's Life Insurance program is fully insured by CIGNA Group Insurance. Business Travel Accident is fully insured by Life Insurance Company of North America. They also process all claims. The following summarizes the procedure for filing a claim for life insurance benefits.

For information on what to do if your claim is denied, refer to page 149. Send your life insurance or AD&D appeal to:

CIGNA Group Insurance
P.O. Box 22328
Pittsburgh, PA 15222-0328
1-(800) 238-2125

Send your BTA appeal to:

CIGNA Group Insurance
Life Insurance Company of North America
Claims Administration
P.O. Box 22328
Pittsburgh, PA 15222-0328

EMPLOYEE LIFE INSURANCE

If you die, your beneficiary should contact Texas Health as soon as possible for information about the benefits payable and the form of payment. Your beneficiary will receive help with the documents needed for processing the claim. Contact:

Benefits Specialist
Texas Health Benefits Department
682-236-7237

The Benefits Specialist will send the claim form to your beneficiary, which must be returned to the Benefits Specialist with an original death certificate before the claim can be paid.

If the payment to one individual is less than $5,000, benefits are paid in a single lump sum payment. If the payment is $5,000 or more, your beneficiary will receive a checkbook that can be used to withdraw the proceeds.

In either case, payment will be made as soon as possible after all information is received.

Claim Filing Deadline

In addition to filing a life insurance claim, your family should notify the Texas Health Benefits Specialist of your death. They must submit all life insurance claims within one year of your death and provide a certified copy of your death certificate before benefits can be paid. Claims submitted more than one year after death will not be considered for payment.

DEPENDENT LIFE INSURANCE

If your covered dependent dies, contact the Texas Health Benefits Specialist listed above as soon as possible for assistance with the documents needed for processing the claim. You are the sole beneficiary for your spouse's or child's life insurance. When the Texas Health benefits department receives notification of a death, they will make appropriate changes in coverage and send you confirmation of the changes.

You must submit an original death certificate before benefits can be paid. Benefits will be paid in a single lump sum payment if less than $5,000. If the payment is $5,000 or more, a checkbook is issued as soon as possible after all information is received. You should consult a tax advisor to be sure you understand the tax consequences of life insurance proceeds.

Terminal Illness Benefit

To file a claim for a Terminal Illness Benefit, you or your covered dependent must be totally disabled and terminally ill (not expected to live more than 12 months). Two physicians must certify the terminal status of the covered person. Contact the Benefits Specialist at Texas Health to file a claim for a Terminal Illness Benefit.

Claim Filing Deadline

In addition to filing a life insurance claim, you or your family should notify the Texas Health Benefits Specialist of the death. Before benefits can be paid, the claims administrator must receive a certified copy of death certificate along with all life insurance claims within one year of the death. Claims submitted more than one year after death will not be considered for payment.

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

If you or your covered dependent is injured as the result of an accident, you must contact the Benefits Specialist at Texas Health, who will help you file an AD&D claim. If you or your covered dependent dies, you must submit an original death certificate before benefits can be paid. Benefits will be paid in a single lump sum payment as soon as possible after all information is received. You should consult a tax advisor to be sure you understand the tax consequences of the life insurance proceeds.

Claim Filing Deadline

For a covered dismemberment, you must file the claim and provide proof of the loss within 20 days of the loss or death. If it is not reasonably possible to provide proof within 20 days, you must provide it as soon as possible, but no later than one year after the loss. For a covered accidental death, you (or your beneficiary) must submit all life insurance claims within one year of the death and provide a certified copy of the death certificate before benefits can be paid. Claims submitted more than one year after death will not be considered for payment.

BUSINESS TRAVEL ACCIDENT INSURANCE

If you die or are injured in an accident while traveling on Texas Health business, you or your dependents should contact Texas Health as soon as possible. Human Resources will help your beneficiary with the forms and documents needed for processing the claim. If you die, your beneficiary must provide a certified copy of your death certificate before benefits can be paid. Benefits are usually paid in a single lump sum payment as soon as possible after all information is received.

Claim Filing Deadline

For a covered injury, you must file the claim and provide proof of your loss within 30 days of the first loss. If it is not reasonably possible to provide proof within 30 days, you must provide it as soon as possible, but no later than one year after the loss. Before benefits can be paid for a covered accidental death, your beneficiary must provide a certified copy of your death certificate and submit all life insurance claims within one year of your death. Claims submitted more than one year after death will not be considered for payment.

When Coverage Ends

Your Life, AD&D, and Business Travel Accident coverage, including dependent coverage, will end on the earlier of the date:

- Your employment ends
- You are no longer an eligible employee
- You fail to make any required premium payments
- The plan terminates
- Your dependents are no longer eligible
- Coverage becomes effective after an open enrollment period in which you fail to enroll.

See page 140 for additional information.

Continuing Coverage

PORTABILITY OPTIONS

You or your covered dependents can choose to continue the elected additional life insurance amount after your benefit ends with Texas Health due to termination of employment or loss of benefit eligibility. You and/or your dependent may choose to continue life insurance coverage with no proof of insurability by submitting your application and payment to CIGNA within 31 days of the date coverage ends with Texas Health. The portability application may be requested from the Texas Health Benefits Department by calling 682-236-7237 or emailing BenefitsTHR@texashealth.org. The coverage will be at the same level as when coverage ended. Coverage continues to age 70 or until the end of period for which premiums are paid.

Benefits for You

If your coverage ends prior to age 70 due to termination of employment or loss of benefit eligibility, you may choose to continue the same level of coverage you had as an active employee at a rate similar to the group rate you paid at the time your Texas Health coverage ended.

If you choose to continue coverage, you may also elect to continue spouse and child coverage. Employee and Spouse coverage ends when you (the employee) reach age 70. Coverage for a dependent child ends when the child no longer qualifies as a dependent child.

Benefits for Your Former Spouse

A spouse who is legally separated, divorced, or widowed from an insured employee may choose to continue their life insurance. If your spouse continues coverage, coverage may also be continued coverage for dependent children. Dependent child coverage ends when he or she no longer qualifies as a dependent child.

Benefits for Children Who Are No Longer Eligible Dependents

A dependent child who is insured and is at least 19 years of age may choose to continue life insurance. The dependent child must apply with CIGNA and pay the required premium within 31 days after the date he or she reaches ages 19 or no longer qualifies as a dependent child.

CONVERSION OPTIONS

You or a covered dependent may convert all or any portion of your life insurance that would end due to termination of employment or loss of eligibility. You may apply for any type of life insurance CIGNA offers to persons of the same age in the amount applied for, except you may not:

- Choose term insurance;
- Apply for an amount of insurance greater than the coverage amount at the time of termination. (Also, the conversion policy will not provide accident, disability, or other benefits.)

To apply for conversion, you or your covered dependent must, within 31 days after coverage ends, submit an application to CIGNA and pay the required premium. The conversion application may be requested from the Texas Health Benefits Department by calling 682-236-7237 or emailing BenefitsTHR@texashealth.org. Evidence of insurability is not required.

Contact Human Resources for more information or to request a form.

Long Term Care Insurance Plan

Overview

You may apply for long term care insurance coverage through Genworth Life Insurance Company (Genworth Life). Long Term Care (LTC) is not one service, but many different services that can help people who have physical or cognitive impairments and are unable to care for themselves for an extended period of time. Services might include assistance in the home for day-to-day activities or care services in a nursing home.

If you apply for LTC insurance, Genworth Life will provide you with an outline of coverage. This information from Genworth Life will describe the eligibility, benefits, and terms and conditions applicable to LTC insurance benefits. Genworth Life's outline governs your benefits and takes precedence over any materials that Texas Health provides, including this Handbook. The following information provides a brief overview of the types of benefits available under the LTC insurance plan.

You select coverage for a daily benefit amount, lifetime maximum benefit and increase option. Key features of the LTC insurance plan are:

- You can choose a feature that will increase your daily benefit amount and lifetime maximum benefit to help keep pace with the rising cost of long term care without requiring you to provide evidence of insurability.
- As an employee, if you apply when first eligible, you may use the short enrollment form and answer only a few medical questions when applying. You must be approved for coverage.
- There is a 90-day waiting period before benefits begin.
- Coverage is guaranteed to be renewable.

Who Can Be Covered

You may elect coverage for yourself and any of the following family members who are ages 18 - 79:

- Your spouse
- Your parents
- Your in-laws
- Your grandparents/grandparents in-law.

If you enroll in LTC insurance when first eligible (as a new hire, or newly benefit eligible employee), you must complete a short application. If you apply during another time, you must provide additional evidence of insurability before coverage becomes effective.

Family members must complete a long application with medical information and be approved before coverage begins. Your spouse may use the short form if he or she is under age 66.

Summary of Benefits

You select coverage for a daily benefit amount and lifetime maximum benefit as shown in this table:

Daily Benefit Amount	Lifetime Maximum Benefit		
	Up to 2 years	Up to 3 years	Up to 5 years
$100	$73,000	$109,500	$182,500
$200	$146,000	$219,000	$365,000
$300	$219,000	$328,500	$547,500

PREMIUMS

Your contributions for the cost of LTC insurance coverage for you and your spouse may be deducted from your paycheck on an after-tax basis. However, premiums for coverage of all other covered family members must be paid directly to Genworth Life. Payments must be made in advance.

PORTABILITY

You may continue coverage after you end your employment with Texas Health by paying premiums directly to Genworth Life.

HOW TO ENROLL

Although Texas Health makes this program available to employees at attractive group rates, Texas Health does not administer the LTC plan. Genworth Life provides complete administrative services for the LTC program, so you must contact Genworth Life directly to request more information or to enroll.

Call 1-800-416-3624 to speak to a Long Term Care Specialist or go to **https://www.genworth.com/groupltc**. Enter "THR" as the group name and enter "groupltc" as the password. The website provides complete details of the program, including costs, benefits, exclusions and limitations and how to enroll.

Retirement

Texas Health 401(k) Retirement Plan

Overview

The Texas Health 401(k) Retirement Plan is designed to help you save for your future. Through contributions to your account, you build income for retirement. You can choose from a variety of investment options offered by the plan to help meet your goals and personal investment style.

When it was formed in 1997, Texas Health assumed responsibility for the retirement plans that had previously been sponsored by Harris Methodist Health System (HMHS) and Presbyterian Healthcare System (PHS) and established the Texas Health 401(k) Retirement Plan effective January 1, 1998. The plans previously sponsored by HMHS and PHS are now frozen, meaning that you can no longer make contributions to them, but they do continue to have investment gains or losses with the market. However, if you had funds in one or more of these plans, you may be able to take loans or withdrawals under certain circumstances.

Together, the Texas Health 401(k) Retirement Plan and the frozen plans make up the Texas Health Retirement Program. Refer to the section "Other Texas Health Retirement Plans" beginning on page 121 for more information on the frozen plans. The following sections describe the current Texas Health 401(k) Retirement Plan.

Texas Health is the plan administrator for the Texas Health Retirement Plan. The People and Culture Committee acts on behalf of Texas Health in its capacity as plan administrator. The People and Culture Committee can be contacted at:

People and Culture Committee
Attn: Executive Vice President, People & Culture
Texas Health
612 E. Lamar Blvd., Suite 900
Arlington, Texas 76011
682-236-7900

The members of the People and Culture Committee are listed on page 153.

The People and Culture Committee has contracted with JPMorgan to provide many of the day-to-day administrative functions for the Texas Health Retirement Program, including recordkeeping.

Texas Health 401(k) Retirement Plan

WHO IS ELIGIBLE

All employees of Texas Health are eligible to participate in the plan. A person who is treated by Texas Health as an independent contractor but who is later determined to be an employee, will not be an eligible employee for any part of any plan year in which the person was treated as an independent contractor despite any retroactive recharacterization.

Contract medical directors are not eligible to participate in the plan.

WHEN PARTICIPATION BEGINS

You are eligible to participate in the plan as a new hire. There is no waiting period.

If you have a Texas Health email address, J.P. Morgan Retirement Plan Services will send you an email with a link to a Welcome Guide within two weeks of your hire date. It will contain detailed information about the plan and instructions on how to enroll, along with information on rolling accounts over from other qualified plans.

If you do not have a Texas Health email address, your Welcome Guide will be mailed to your home address within two weeks of your hire date. After you have received your kit, you can enroll in the plan by calling JPMorgan at 1-800-345-2345 or online at **www.retireonline.com**.

HOW MUCH YOU MAY CONTRIBUTE

You may contribute from 1% to 100% of your pay, in whole percentages, to your Texas Health 401(k) account, subject to limits explained later in this section. For example, if you earn $50,000 during 2013, you can contribute the full $17,500 (see "Legal Limits" on the next page) to the plan by electing a 35% contribution rate. Your contributions are automatically taken out of each paycheck and added to your account in the Texas Health 401(k) Retirement Trust.

If you work for more than one employer that has adopted the Texas Health 401(k) Retirement Plan, your contribution election will apply to your pay from all employers. Certain limits may apply to your contributions, as described under "Legal Limits."

CATCH-UP CONTRIBUTIONS

If you are age 50 or older during the plan year, you may contribute an additional "catch-up" contribution to the plan. The "catch-up contribution" for 2013 is $5,500, giving you a contribution maximum of $23,000 for 2013 (annual maximum contribution of $17,500 plus catch-up contribution of $5,500).

THE 401(K) Retirement Plan can help provide the financial security you will need when you retire.

DEFINING YOUR PAY

For purposes of making contributions to the Texas Health 401(k) Retirement Plan, your pay is your W-2 Social Security earnings plus your before-tax contributions under the Flexible Benefits Plan and the Texas Health 401(k) Retirement Plan and certain executive tax-deferred plans. W-2 Social Security earnings include, but are not limited to, your base pay, overtime, shift differentials, Paid Time Off (PTO), and PTO cash-out. Federal law limits eligible wages for 401(k) contributions and the employer match to $250,000 for 2013. This limit may be adjusted annually.

All bonuses, incentive payments, prizes and similar compensation are excluded from the definition of pay in determining eligible before-tax contributions and matching contributions. Payments from the Separation Pay Plan are not part of eligible pay under this plan.

LEGAL LIMITS

Federal law limits the amount you may contribute to the Texas Health 401(k) Retirement Plan each year. For 2013, your total annual contributions (both before-tax and Roth) are limited to $17,500 of your W-2 pay. The $17,500 limit also includes contributions you may have made to a similar plan through another employer during the same year.

Rollover contributions from a previous employer's qualified plan do not count toward these limits.

The 2013 catch up amount for employees age 50 or older is $5,500. In addition to these limits on your contributions, all contributions, including your total annual contributions (both before-tax and Roth) and the employer matching contributions made on your behalf, are limited to 100% of your annual gross pay or $49,000, whichever is less. You may designate your catch-up contributions as before-tax, Roth 401(k) contributions, or a combination of both.

If you exceed these limits, the plan will return the excess (plus any earnings and minus any losses) to you during the following year. In addition, to comply with IRS rules, Texas Health may change the amount of your contributions and may be required to return some of your contributions to you. You may forfeit employer matching contributions, if any, on your refunded contributions. You will be notified if the plan administrator makes any adjustments to your account.

In addition to the limits noted previously, federal law imposes certain discrimination tests that can limit the amount that highly compensated employees (as defined by the IRS) can contribute and receive. Generally, employees earning more than $115,000 in 2013 are considered highly compensated employees. The amount of pay that determines whether you are considered highly compensated is indexed for inflation.

If you are affected by these limits, the plan will return the excess (plus any earnings and minus any losses) to you during the following year. If you are likely to be affected, you will be notified by the plan administrator.

Contributions

You may contribute to the plan in before-tax dollars and/or make Roth 401(k) after-tax contributions to the plan.

Before-tax contributions help you reduce your federal income tax liability immediately. At retirement your contributions, the matching contributions and any earnings are taxable.

Roth 401(k) contributions are made after tax. If they meet certain criteria when you withdraw them, your contributions and their earnings could be tax free (company match is taxable).

You can make one or both types of contributions. However, your combined before-tax and Roth 401(k) contributions cannot exceed the IRS contribution limit for the year. (The limit for 2013 is $17,500 or $23,000 if you're age 50 or older.)

Because you save a percentage of your pay, your contributions automatically adjust when your pay changes. For example, if you receive a pay raise, the amount you save will automatically increase while the percentage of pay saved remains the same. Or, if you work fewer hours than anticipated and earn less than expected, you will save a smaller amount while the percentage of pay saved remains the same.

Your individual circumstances will help you decide whether before-tax or Roth 401(k) or a combination of the two are best for you.

BEFORE-TAX CONTRIBUTIONS

Your 401(k) contributions are not subject to federal income tax at the time they are made, but they are subject to Social Security and Medicare taxes. You generally pay income taxes when you receive money from the plan if you are not rolling over your account to another qualified plan or IRA. However, before making any withdrawal or taking a payment from the plan, you should seek the advice of a professional tax advisor.

ROTH 401(K) CONTRIBUTIONS

The Roth 401(k) allows you to save on an after-tax basis, accumulate tax-free investment returns, and receive tax-free qualified distributions.

You must meet two conditions to have a "qualified distribution" that allows you to receive your Roth 401(k) investment returns tax-free. (Your Roth 401(k) contributions are always distributed tax-free.):

- You must have had your Roth 401(k) account for five years.
- Your distribution must be made due to termination, death, disability, hardship, or termination of the plan.

Roth 401(k) contributions are added to the before-tax contributions, and the IRS limit applies ($17,500 for 2013, or $23,000 if you are age 50 or older).

YOUR CONTRIBUTION OPTIONS

As you consider Roth 401(k) contributions in addition to or instead of your before-tax contributions, it's important to understand how they differ.

One factor is your current tax rate compared to your expected tax rate at retirement.

- If you expect that your tax rate will remain the same, there may be no significant difference between making Roth and before-tax contributions.
- If your tax rate in retirement will be lower than in your working years, you may come out ahead with before-tax contributions.
- If your tax rate in retirement will be higher than in your working years, Roth contributions may provide more income in retirement.

However, no one can predict future tax rates due to changes in tax policy and your individual circumstances. Another factor is whether you'll keep your contribution rate the same if you begin making Roth 401(k) contributions. Because Roth 401(k) contributions are taken from your paycheck after taxes are deducted, if you elect the same contribution percentage, your take-home pay will be lower with Roth 401(k) contributions than before-tax contributions.

So you may need to reduce your Roth 401(k) contribution rate, which can affect your final outcome. However, qualified distributions from your Roth account will be tax-free (compared to fully taxable distributions from your before-tax account), and this may more than make up for the impact on your paycheck.

	Before-tax	Roth 401(k)
Contributions taxed when made	No	Yes
Contributions taxed when distributed	Yes	No
Investment returns taxed when distributed	Yes	No, if you take a qualified distribution
Eligible for company match*	Yes	Yes
10% early distribution penalty	Yes	Yes (on taxable investment returns if the distribution is not a qualified distribution)
Distribution options if you leave the company	• Keep your money in the plan** • Roll over your money to new employer's plan • Roll over your money to an Individual Retirement Account (IRA) • Take your money as cash	• Keep your money in the plan** • Roll over your money to new employer's Roth 401(k), if available • Roll over your money to a Roth IRA • Take your money as cash (if money does not remain in Roth 401(k) for at least 5 years, your returns will not be tax-free)

* Company match is before-tax.
** If your balance is over $5,000.

ROLLOVERS FROM OTHER PLANS

You may be eligible to roll over before-tax balances from a previous employer's 401(k) plan, 403(b) plan, or other qualified defined contribution plan or conduit IRA into the Texas Health 401(k) Retirement Plan. The rollover must be a lump-sum distribution of your before-tax balances from a previous employer's plan or conduit IRA. To avoid tax consequences, you must make a rollover contribution within 60 days of the time you receive the distribution from your previous employer's plan.

You may also roll over Roth 401(k) balances into the Texas Health 401(k) Retirement Plan.

To make a rollover from your prior employer's qualified plan into the Texas Health 401(k) Retirement Plan, you must complete a Rollover Application and your prior employer must sign off on the Eligible Rollover Distribution Certification. These forms are available by calling JPMorgan and requesting a Rollover Kit or going online to **www.retireonline.com**.

After you log on, click "Texas Health 401(k) Retirement Plan," click "Forms and Publications" on the left side in the gray box under Account Detail.

Matching Contributions

Texas Health will match a portion of each dollar you save, up to the first 6% of pay. The match is made each pay period and depends on your length of service. *To receive the match, you must contribute at least 2% of your pay* ***each pay period****. To receive the maximum match, you must contribute at least 6% of your pay* ***each pay period****.*

You are eligible to immediately begin receiving the employer match if you were hired before January 1, 2010, or if you were hired on or after January 1, 2010, and you have completed one year of service. Texas Health does not match rollover distributions from a previous employer's plan.

The following table shows the amount of employer matching contributions you receive based on your years of service with Texas Health. The table assumes that you contribute at least 2% of your pay each payroll period.

If your years of service with Texas Health equal[1]:	For each $1 you contribute, Texas Health adds[2]:
1 but less than 5	$0.75
5 but less than 10	$1.00
10 or more	$1.25

[1] You are eligible for company matching contributions if have completed one year of service.

[2] Up to 6% of your eligible pay.

Federal law limits eligible wages for the 401(k) employer match which may be adjusted annually. For 2013 it is $250,000. The table at the top of the next column shows the maximum employer match that may be received in 2013.

If you reach the employee IRS contribution limit before the end of the year, you may not receive the highest possible match from Texas Health because you receive the match ***only*** when you make a contribution.

2013 Employer Match Limits*	
Less than 5 Years of Service	$11,250.00
5 Years of Service, but less than 10 Years of Service	$ 15,000.00
10 or more 10 Years of Service	$ 18,750.00

*The employer match limit is calculated using the current IRS maximum eligible compensation limit of $250,000, then applying the match formula based on years of service. The maximum eligible compensation limit is subject to change due to IRS regulations.

VESTING

Vesting refers to your ownership of the money in your account. You are always 100% vested in your own contributions (both before-tax and Roth), rollovers from other employer plans or conduit IRA, and investment returns on these amounts.

You become vested in Texas Health's matching contributions, any forfeitures allocated to your account, and the investment returns on those contributions based on your years of service as follows:

If your years of service with Texas Health equal:	Your vesting in the Texas Health match is:
Less than 2	None
2 but less than 3	25%
3 but less than 4	50%
4 but less than 5	75%
5 or more	100%

A year of service is explained below under "Length of Service." You become fully vested in your account (regardless of your years of service) in the event of your normal retirement (at age 65), disability, or death.

How Termination Affects Vesting

If you terminate employment when you are 0% vested in the Texas Health match, you will forfeit the entire employer match. Forfeited amounts are generally used to reduce Texas Health matching contributions and to pay expenses of the plan.

If you terminate employment when you are partially vested in your matching contributions, you will forfeit the non-vested portion of your employer match on the earlier of the date you:

- Have a five-year break in service, or
- Receive your vested amounts.

A five-year break in service occurs if you are not employed by Texas Health for 60 consecutive months.

If you return to work for Texas Health before you incur five consecutive one-year breaks in service, you may have your forfeited amounts restored. Restoration will occur only if you repay the matching contributions that were distributed to you by the plan before the earlier of:

- Your fifth anniversary of re-employment, or
- The date you incur five consecutive one-year breaks in service.

LENGTH OF SERVICE

Your length of service with Texas Health determines:

- Your eligibility to receive the match made by your employer
- The amount of the matching contribution
- Your vesting.

You generally will receive credit for one year of service for each 365-day period (whether or not consecutive) that you are employed by Texas Health or another employer that participates in the Texas Health 401(k) Retirement Plan. This period is measured from either your first day of employment or your anniversary date of employment during 1997, whichever is later.

Service Credit From Other Plans

Your service that was credited to you under the HMHS Plans and the PHS Plans may also be counted under the Texas Health 401(k) Retirement Plan for purposes of determining the rate of matching contribution and vesting service. You will be credited with your years of service under the HMHS Plans and the PHS Plans unless as of the later of January 1, 1998, or your most recent date of employment, your breaks in service equal or exceed the greater of five years or your years of service under these plans.

Years of service under the HMHS and PHS Plans will be based on the definitions of years of service contained in those plans.

Your service credited to you under the pension plan sponsored by Arlington Memorial Hospital may also be counted under the Texas Health 401(k) Retirement Plan for purposes of determining the rate of matching contributions and vesting service.

If you were employed by Presbyterian Hospital of Denton on May 30, 2009, you will receive credit for your years of service with them under the Texas Health 401(k) Retirement Plan. If you were employed by Texas Health Partners on January 1, 2009, or by Medical Edge/ PhyServe on December 31, 2010, you will receive credit for all your years of service. Certain acquisitions of the Texas Health Physician Group also receive credit for all years of service. Contact the plan administrator for more information.

A break in service is generally a period of greater than 12 months in which you were not employed by an employer who has adopted the Texas Health 401(k) Retirement Plan.

REHIRED EMPLOYEES

If you terminate employment with Texas Health and are later rehired, you are immediately eligible to begin making contributions to the Texas Health 401(k) Retirement Plan. If your break in service is less than one year, you retain the vesting date you had. If you are not vested in the matching contribution when you terminate and are rehired after you have five consecutive breaks in service, you will not be credited with your prior vesting service. If you were employed by Harris Methodist Health System or Presbyterian Healthcare Resources before August 1, 1997, but were not credited with any years of service under any of the HMHS or PHS Plans, your service for purposes of the Texas Health 401(k) Retirement Plan will begin on your 1997 anniversary date. You will not be credited with any service before your 1997 anniversary date.

Changing Your Contributions

You may change or stop your contributions to the Texas Health 401(k) Retirement Plan at any time and as often as you would like during the plan year. To change or stop your contributions, simply contact JPMorgan at 1-800-345-2345 or online at **www.retireonline.com**.

Your election to change or stop contributions will be effective as soon as administratively practical after JPMorgan receives your change.

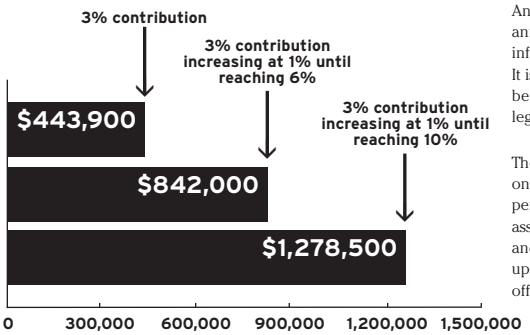
AUTO-INCREASE FEATURE

A smart way to make investing for your retirement easier and more efficient is to take advantage of the Texas Health 401(k) Retirement Plan's automatic contribution increase feature. This online tool allows you to automatically increase your contribution percentage each year. You decide what percentage and which month you wish the increase to happen on an annual basis. Your automatic increase will occur each year until you choose to stop the increase or you reach the annual plan or IRS limit (whichever is lower). You can stop the automatic increases at any time.

You might consider having your automatic increase occur when you receive pay increases. It's a great way to contribute an extra percentage automatically, and you won't notice the difference in your paycheck. Take a look at the graph below to see how a 1% increase each year can make a huge difference down the road.

To sign up for this service or make any changes to your account, log on to **www.retireonline.com**. Click on your plan name, then click on "Contribution Amount" under Account Management. Select the "Auto-Increase" tab to make your selections. You also may call JPMorgan at 1-800-345-2345.

Take a look at what a difference 1 percentage point could make:



Assumes starting salary of $30,000 with a 3% annual wage inflation. Contributions are made at the end of each month starting at age 22 and continuing until age 65. Annual rate of return is 8% compounded annually. This material has been prepared for informational and educational purposes only. It is not intended to provide, and should not be relied upon for, investment, accounting, legal or tax advice.

The assumptions are for illustrative purposes only and are not representative of the performance of any security. There is no assurance similar results can be achieved, and this information should not be relied upon as a specific recommendation or an offer to buy or sell securities.

Investing Your Retirement Accounts

The Texas Health 401(k) Retirement Plan offers a variety of funds which you may select for the investment of your account under the Texas Health 401(k) Retirement Plan. Each fund invests in specific types of securities and, therefore, has different degrees of risk and potential reward.

The plan trustees may change the investment funds available to you at any time. The plan trustees may also direct that any amounts currently invested in a fund that is no longer offered under the Texas Health 401(k) Retirement Plan be reinvested in a new fund. You will be notified if the available funds change and of any mandatory reinvestment of amounts held in your retirement account. Make your investment choices by contacting JPMorgan.

If you do not direct the investment of your account, the plan trustees will invest your contributions on your behalf in the JPMorgan Smart Retirement Target Date Fund dated closest to the year you turn 65.

CHOOSING YOUR INVESTMENT OPTIONS

Before deciding how to invest your contributions you should take into account your age, earnings from all sources, tax bracket, existing savings, and future spending needs. Your investment decisions are your own. No employee or officer of Texas Health or your employer is authorized to give investment advice.

Consider all of your options carefully before making an investment choice. Also keep in mind that any investment carries a degree of risk. Investments can go down as well as up in value. If that happens, as it probably will from time to time, the dollar value of the funds invested in stocks or bonds will decrease/increase with the market.

To help you in the investment process, the Retirement Plan Welcome Guide you receive includes an investment description of each fund. If you would like more detailed information about the individual funds, you can contact JPMorgan and request a prospectus for any of the funds.

These prospectuses have been prepared by JPMorgan and other investment firms whose funds are offered and have neither been reviewed nor endorsed by Texas Health. Texas Health does not guarantee the performance of any of the investments offered under the plan.

Additional information about the mutual funds currently offered under the plan is available through **www.retireonline.com**.

If you do not choose any investment elections, your contributions will automatically be invested in the JPMorgan Smart Retirement Target Date Fund dated closest to the year you turn 65.

JPMorgan Smart Retirement Target Date Funds

You may select from among the mutual funds described below in "Mutual Fund Choices" to create your own investment mix. Or you may choose from the target date funds, or a combination of both. Target date retirement funds are made up of multiple asset classes. They are professionally managed and offer a diversified investment in a single fund.

These funds are meant to align with an expected retirement date. The investment allocation will change over time. The funds will become increasingly more conservative as the target retirement date approaches. Participants may choose to invest in any of the other target retirement funds or any other investments in the lineup. As with all investments, the principal value of the fund(s) is not guaranteed at any time, including at the target date.

Mutual Fund Choices

You may select any combination of the mutual funds offered under the plan. A variety of funds are offered to allow you to diversify your investment selections to create an investment portfolio consistent with your personal savings objectives. Mutual funds typically exhibit a specific style of investing which falls into the categories listed below:

- *Money Market Funds*—Managed to maintain a stable share price, these funds pay a variable rate of monthly income based upon the interest returns of the fund's investments. These are the most conservative type of mutual funds.
- *Income or Bond Funds*—These seek to offer a high rate of current income. Both the yield and share price of these funds will fluctuate up or down with changing market conditions.
- *Equity or Stock Funds*—These funds seek to capture the investment returns of the various segments of the economy. Typically, individual funds are characterized by investments in companies of a particular capitalization range (for example, size of the company) and the following investment styles. The share price of all of these funds will fluctuate up or down with changing market conditions.
  - *Growth Funds*—Attempt to invest in companies with above average growth prospects. Typically, investments are made in companies that have exhibited consistent above average growth, and/or companies which are expected to exhibit above average growth in the near future.
  - *Value Funds*—Attempt to invest in companies with a stock price that is considered undervalued relative to the market.

  - *Index Funds*—Seek to match, as closely as possible, the investment results of the S&P 500 Composite Stock Price Index, which emphasizes stocks of large U.S. companies by using a passive investment approach. Typically, investments replicate the companies and weightings of a style specific index.
  - *Global Funds*—Invest in common stocks and other types of securities of U.S. and/or foreign based companies, typically with a higher degree of risk and price fluctuation than domestic, U.S. equity funds.
  - *International Funds*—Invest exclusively in common stocks and other securities of foreign-based companies, typically with a higher degree of risk and price fluctuation than domestic, U.S. equity funds.
- *Brokerage Account*—Allows you to invest a portion of your account in an unlimited number of mutual funds, stocks, and bonds. All fees associated with brokerage accounts will be paid by participating employees. For more information, you can speak with a Retirement Consultant by calling 1-800-776-6061.

Personal Online Advisor[1]

If you prefer to take an active approach to managing your account and are looking for more direction or investment advice, Personal Online Advisor might be the right solution for you. Personal Online Advisor, offered by J.P. Morgan Institutional Investments Inc. (JPMII) and powered by Financial Engines®, is a web-based service offering a step-by-step action plan for selecting investments, deciding how much to save, when to consider retirement and more. You still control all investment decisions, and you can check back regularly for any updated recommendations. This service is available at no cost to you. You can access Personal Online Advisor on www.retireonline.com. Simply logon, click the plan name, and then click the green "Get advice" button.

J.P. Morgan Personal Asset Manager[1]

If you don't have the time or interest to invest and manage your account, consider enrolling in the J.P. Morgan Personal Asset Manager program, also offered by JPMII and powered by Financial Engines. In this program, investment professionals choose your investments and manage your account for you. Fees are based on your managed account balance. The program uses financial models and research to create and monitor an investment strategy for you. You can access J.P. Morgan Personal Asset Manager and relevant information regarding fees on **www.retireonline.com**. Simply logon, click the plan name, and then click the green "Get advice" button.

If you choose the JPMorgan Personal Asset Manager, you pay a fee of 0.6% of your account balance per year. For example, if you have $10,000 in your account, you receive professional management for about $5 a month.[2] The fee is deducted directly from your retirement plan account, so there is no bill to pay and no reduction in your take-home pay. For more information about JPMorgan Personal Asset Manager or to enroll in the program, contact JPMorgan.

CHANGING YOUR INVESTMENT OPTIONS

You may change your investment fund elections for existing balances and future contributions (both employee and employer) at any time by contacting JPMorgan at the phone number or website listed on the inside back cover. Changes made by 3:00 p.m. take effect the same day. Changes made after 3:00 p.m. will take effect the next business day.

A confirmation letter will be sent to you after JPMorgan processes the change. You do not need to complete any paperwork. Before making any change, you should review the prospectus of the funds that you wish to select. Contact JPMorgan to request the prospectus.

If you were employed before 1997 or were part of an acquisition, you may have other accounts in addition to the Texas Health 401(k) Retirement Plan. When making investment changes, you are able to designate changes for each individual plan.

In adherence with securities laws that are applicable to mutual funds, Texas Health began complying with Rule 22c-2 as of October 1, 2006. This rule is intended to identify and control abusive short-term trading activity in retirement plans with mutual funds.

1 J.P. Morgan Institutional Investments Inc. (JPMII) has hired Financial Engines Advisors L.L.C. ("FEA") to provide sub-advisory services. JPMII is a federally registered investment advisor. FEA, a federally registered investment advisor and wholly owned subsidiary of Financial Engines Inc., is an independent company that is not affiliated with J.P. Morgan Retirement Plan Services LLC or JPMII. Neither JPMII, FEA, nor their affiliates guarantee future results. Financial Engines® is a registered trademark of Financial Engines, Inc. All other marks are the exclusive property of their respective owners. ©2005-2012. Financial Engines, Inc. All rights reserved. Used with permission. J. P. Morgan Retirement Plan Services provides plan recordkeeping and administrative services.

2 Discounts may apply for accounts over $100,000. Call 1-800-345-2345 for details.

JPMorgan monitors potential short-term abusive trading activity for our funds. You will be notified if your account is identified as having short-term abusive trading activity. Contact JPMorgan for specific trading activity rules allowed for each fund.

QUARTERLY REBALANCING ELECTION

The quarterly rebalancing election allows you to keep the same investment allocation percentages over time that you initially selected. If you elect the rebalancing feature, each quarter JPMorgan will automatically buy or sell shares of mutual funds in your account so your investment mix is rearranged to produce an investment mix that reflects the percentages you originally selected.

For example, you initially invest 40% of your account in a bond fund and 60% of your account in a growth fund. At the end of a quarter, changes in the relative value of your investments result in an investment mix that is 45% bond fund and 55% growth fund. If you select the rebalancing feature, JPMorgan will automatically sell interests in the bond fund and buy interests in the growth fund to reestablish your initial 40/60 investment mix.

If you were employed before 1997 or were part of an acquisition, you may have other accounts in addition to the Texas Health 401(k) Retirement Plan. When making investment changes, you are able to designate changes for each individual plan.

For more detailed information on rebalancing, contact JPMorgan.

ACCOUNT STATEMENTS

Your first-, second-, and third-quarter statements are available only online. Your fourth-quarter statement will be mailed to your home. Statements should be available online 10 to 15 days after the end of the quarter. (To view your statement online, log on to **www.retireonline.com**, select the account from which you want to print a statement, then click "Account Statements" in the left column. If you prefer to continue receiving quarterly paper statements, you can opt out of electronic statement delivery anytime by contacting JPMorgan.

If you were employed before 1997 or were part of an acquisition, you may have other accounts in addition to the Texas Health 401(k) Retirement Plan. When making investment changes, you are able to designate changes for each individual plan.

Your quarterly statement will show your activity for the previous three months with account balances in the retirement plan based on the last business day of the quarter. Your account balance is the sum of contributions (employee and employer match) if any, allocated to your account, plus your investment gains or losses on those contributions. Your accounts will reflect gains and losses as of the end of the previous business day.

If you want more detailed information about your account statement or the balances of your accounts between quarterly statements, contact JPMorgan or view your information online at **www.retireonline.com**.

Plan Loans

The Texas Health 401(k) Retirement Plan allows you to borrow money from your participant contributions and rollovers in your account. The amount you may borrow includes 50% of your contributions and the investment returns on those contributions, plus any rollovers from other plans. You are charged interest for your 401(k) loan and must repay your own account.

The amount you may borrow is subject to certain limits. You must borrow a minimum of $1,000. The maximum you can borrow is the lesser of:

- 50% of your contributions and rollovers (including investment returns) or
- $50,000—less your outstanding loan balance during the previous 12-month period.

You may take only one loan per plan per calendar year, and may have only one loan per plan outstanding at a time. The interest you pay on your loan is fixed for the period of the loan at a rate established by the plan administrator. Currently, the loan interest rate is the prime interest rate plus 1% as of the first of the month when your request is received. The loan is secured by the remaining 50% of your account balance.

Most employees repay loans through after-tax payroll deductions. When you take a loan, you choose the repayment period. Your choice will affect the amount of your loan payment. The repayment period available for your loan depends on your reason for taking the loan:

- For a general purpose loan, you can elect a repayment period of up to five years
- For a loan to purchase your primary home, you can elect a repayment of up to 20 years. You must provide documentation of your home purchase.

Choosing Pre-tax or Roth 401(k) Contributions

VISIT WWW.RETIREONLINE.COM for help in making the decision between pre-tax and Roth 401(k) contributions using the Roth 401(k) Planner located under the Financial Tools tab.

Generally, you do not pay taxes on a loan unless you do not repay the loan in a timely manner. In these cases, the loan may be treated as a taxable distribution, and if you are under age 59½, a 10% premature distribution penalty may apply. If you terminate employment while the loan is outstanding, your loan will be due in full on the earlier of the date you take a distribution or 30 days after you terminate. If you do not repay your loan in full by this date, your loan is in default.

A loan is considered in default if the full amount of any payment is not paid by the end of the quarter immediately following the quarter in which it was due. In case of default, your account balance will be reduced by the amount of the outstanding loan balance that was defaulted. Please consult your tax advisor on the consequences of taking a loan from your account.

Other limitations or rules may restrict your ability to borrow from the Texas Health 401(k) Retirement Plan. For additional information or to apply for a loan, call JPMorgan at 1-800-345-2345. A $50 loan processing fee will be deducted from your account for each new loan you take.

LOANS WHILE ON LOA

Employees on a leave of absence (LOA) may make loan payments directly to JPMorgan while on leave. If employees on a leave of absence do not send their missed payments directly to JPMorgan, their loan will automatically be re-amortized when they return to work to bring the loan current.

If your loan reaches maturity while on leave, the entire balance will be due in full based on the default period, which is the end of the quarter following the quarter the last payment was made. If this occurs, you will need to contact JPMorgan to get the exact balance due and send a manual payment to JPMorgan to pay off the loan in full before the default period is reached.

If the loan is not paid off in full by the end of default period, it will be defaulted and the balance left on the loan will be considered income for the current year. JPMorgan will issue a 1099-R form that you will use when filing your taxes.

Plan Withdrawals

Under certain circumstances, federal law allows you to make a withdrawal of your vested contributions from the Texas Health 401(k) Retirement Plan while you are an active Texas Health employee. You may make withdrawals when you reach age 59½ or later, or during a time of serious financial hardship. Each option is explained below.

IN-SERVICE WITHDRAWALS AFTER AGE 59 1/2

You may withdraw all or a part of your vested account from the Texas Health 401(k) Retirement Plan without penalty while you are an active employee after you reach age 59½. If you do not roll the account over, the distributions will be subject to federal income tax, but no tax penalties. You may continue contributing to the plan after you take a withdrawal.

To request an in-service withdrawal, go online to **www.retireonline.com** or contact JPMorgan by phone.

HARDSHIP WITHDRAWALS

While you are an active Texas Health employee (regardless of your age), you may withdraw some or all of your contributions, but not the investment returns on them if you have an immediate and heavy financial need as defined by the IRS.

The distribution cannot be more than the amount of your immediate financial need (including applicable taxes) and you must already have received all distributions and all non-taxable loans from this plan and other plans of your employer.

The following reasons are defined as hardships:

- Cost related to the purchase of a primary residence (not including mortgage payments)
- Payment of medical expenses incurred by you, your spouse, or your dependents that would be deductible on your federal income tax return
- Payment of tuition and board for the next 12 months of post-secondary education for you, your spouse, or your dependents
- Prevention of your eviction from or foreclosure on your primary residence
- Funeral expenses for your parent, spouse, children or other dependents
- Expenses for the repair of damage to your principal residence that would qualify for a casualty loss deduction.

You will be required to submit proof of your hardship.

The amount of hardship withdrawal you receive will be subject to federal income tax. In addition, if you are younger than 59½, you must also pay a 10% tax penalty on the amount of the hardship withdrawal. You do not have to pay the penalty if the hardship withdrawal is being made to pay deductible medical expenses or if you meet the IRS definition of disability.

By federal law, you cannot make contributions to the plan and cannot receive employer matching contributions for six months after you make a hardship withdrawal.

If you want to take a hardship withdrawal, contact JPMorgan at 1-800-345-2345.

Plan Distributions

The Texas Health 401(k) Retirement Plan generally distributes your full vested account balance to you when your participation in the plan ends because you experience one of the following events. Either you:

- Retire at age 65 or later
- Terminate employment with Texas Health
- Become disabled (as determined by the plan administrator)
- Die.

You can request a distribution by calling JPMorgan at 1-800-345-2345 or by going online to **www.retireonline.com.** The table on this page indicates the ways you can request a distribution, depending on the reason for the distribution.

If you request a distribution, your account will be valued on the day your distribution is processed by JPMorgan. If you are concerned that your account balance will fluctuate during the distribution processing period, you may want to consider changing your investment choices to a more conservative investment option.

You will be required to take a minimum distribution beginning the year you reach age 70½ if you are no longer actively at work. If you roll your Roth money into a Roth IRA, you can avoid minimum distribution requirements, have the ability to take out as much or as little as you like, and leave it to your beneficiaries.

You must meet two conditions to have a "qualified distribution" that allows you to receive your Roth 401(k) investment returns tax-free. (Your Roth 401(k) contributions are always distributed tax-free.):

- You must have had your Roth 401(k) account for five years.
- Your distribution must be made due to termination, death, disability, hardship, or termination of the plan.

A Roth account is separate from the employer match and employee before-tax contribution accounts.

When you take a distribution from a Roth account, you will receive two checks. One check will be for your Roth contributions and the other will be for the earnings on your Roth account, your employer match, and employee before-tax contributions, if applicable.

RETIREMENT

Your normal retirement date under the Texas Health 401(k) Retirement Plan is your 65th birthday. You may continue to participate in the plan after age 65 if you are still employed by Texas Health. If you continue to work for Texas Health after age 65, a distribution of your total account balance (less any outstanding loan balance) will automatically be made by April 1st following the plan year in which you actually retire from Texas Health.

DISTRIBUTION OPTIONS

Type of distribution	Online at www.retireonline.com	By phone with JPMorgan (800) 345-2345	Request paper form from JPMorgan and return to JPMorgan
Distribution due to termination	X	X	
PHS 401(a) distribution			X
Hardships			X
In-service - active employee over age 59 1/2	X	X	
QDROs	X*	X*	
Beneficiary distribution (upon employee's death)			X*

*You must also complete an IRS Form W-9, available online at www.irs.gov.

TERMINATION

Generally, within two weeks of your termination from Texas Health, JPMorgan will be notified of the event. At that time, you may request a distribution from your account by logging on to **www.retireonline.com** or by contacting JPMorgan.

Following are restrictions on how your account can be distributed.

If Your Balance is Greater than $5,000

You may leave your money in the Texas Health 401(k) Retirement Plan until you reach age 65 while your vested balance remains $5,000 or more. When you turn age 65, JPMorgan will send notification that you are now required to take a distribution.

If you request a distribution of your account after you terminate employment, you immediately forfeit the non-vested portion of your account. If you do not elect a direct rollover of your vested account balance, the law requires the plan to withhold 20% of your distribution for income taxes. If you are younger than 59½, a 10% penalty for early withdrawal may apply. You should consult with your tax advisor regarding the tax consequences.

If Your Balance is More Than $1,000, but not More Than $5,000

If you do not initiate a distribution of your account after termination and your vested account balance is more than $1,000, but not more than $5,000, your vested account balance (and any rollover account balances) will be directly rolled over to an individual retirement account (IRA) designated by the plan administrator. You will forfeit the non-vested portion of your account. You will be informed of the automatic rollover by JPMorgan in March, June or September depending on your date of termination. You will be notified of the financial institution that holds your IRA after the rollover is complete.

If you elect to have your vested account balance paid in the form of a lump sum, the law requires the plan to withhold 20% of your distribution for income taxes. If you are younger than 59½, a 10% penalty for early withdrawal may apply. After you return your distribution form and elect to roll over your account, you will have 60 days from the time you receive the check to roll over your distribution to another employer's plan or individual retirement account. You should consult with your tax advisor regarding the tax consequences of any distributions.

If Your Balance is $1,000 or Less

If you do not initiate a distribution of your account by the end of the quarter following the quarter in which you terminated, and your vested account balance is $1,000 or less (including any rollover account balances), your vested account will be automatically distributed to you and you will forfeit the non-vested portion of your account.

The law requires the plan to withhold 20% of your distribution for income taxes. If you are younger than 59½, a 10% penalty for early withdrawal may apply.

If you terminate employment and take a distribution in or after the year in which you reach age 55, the 10% penalty does not apply. It also does not apply for distributions that are paid due to disability, beneficiary claims or Qualified Domestic Relations Orders.

If you have an account balance of $1,000 or less, you have not elected a direct rollover, and you have not settled payment within 180 days of distribution or cannot be located within 180 days after your account becomes payable, the plan administrator will treat your account as a forfeiture. Your account will be restored if you make a claim after the account is forfeited.

You should consult with your tax advisor regarding the tax consequences of any distributions.

If you worked for the company before 1998, the above information also applies to the Frozen PHS and HMHS 401(k), the Frozen PHS and HMHS 403(b), and the Frozen PHS 401(a). However, you may leave money in those plans until April 1 following the year in which you reach age 70½. The above information also applies to the Frozen Prior Employer 401(k) Plan.

Direct Rollovers

You may elect to take all or part of your vested account balance as a direct rollover. A direct rollover is the payment by the Trustee of your vested account balance to another employer's qualified retirement plan or an IRA. You can make a direct rollover of part of your balance and receive the rest of it as a direct lump-sum distribution. By making a direct rollover to an Individual Retirement Account (IRA) or to an employer's qualified plan, you avoid tax withholding and penalties that you would pay if you received a distribution payable to you.

You can also rollover your Roth 401(k) contributions as long as your new employer's plan accepts rollovers of Roth amounts. If not, you may roll your Roth 401(k) into a Roth IRA or leave the money in the Texas Health Retirement Program if it meets the minimum balance requirements.

REHIRED EMPLOYEES

If you receive your vested account balance when you terminate and then are rehired by Texas Health before you have a five-year break in service (as described under "Rehired Employees" on page 111), the amount of your account that was forfeited will be reinstated if you repay the amount of your distribution before either your fifth anniversary of reemployment or the date you incur a five-year break in service, whichever occurs first. If you do not repay the amount of the distribution, your forfeited account balance will not be reinstated.

DISABILITY

If the plan administrator determines that you meet the plan's definition of disability, you can receive a distribution of your full account balance (less any outstanding loan balance) as soon as administratively practical. The distribution will be made according to the procedure described above for termination of employment.

If the plan administrator receives satisfactory evidence that you are physically unable or mentally incompetent to receive the distribution, the plan administrator may make payments on your behalf to your spouse, a relative, or your custodian.

DEATH

In the event of your death, your full account balance (less any outstanding loan balance) will be paid as a lump sum to your spouse if you are married, or to any beneficiary you have designated on a properly completed Designation of Beneficiary Form. Payment will be made as soon as possible following your death, but no later than the end of the plan year following the plan year of your death.

Naming a Beneficiary

As part of the enrollment process, you should complete a Designation of Beneficiary Form. Your beneficiary is the person who will receive the value of your Texas Health 401(k) Retirement Plan account(s) upon your death. You may change your beneficiary at any time by completing a new beneficiary form.

Designation of Beneficiary Forms are available online at **MyTexasHealth**, **www.retireonline.com** and at your Human Resources office. The completed form should be sent to:

Texas Health
Attn: Retirement Administrator
612 E. Lamar Blvd.
Suite 400
Arlington, TX 76011

According to federal law, if you are married you must have your spouse's written consent to designate a beneficiary other than your spouse. Your spouse's signature on the Designation of Beneficiary Form must be witnessed by a notary public. If you name a beneficiary other than your spouse but the waiver form has not been signed by your spouse and notarized, your designation is invalid.

If you list more than one beneficiary, the people you name will share your account equally unless you specify different percentages. You may name both primary and contingent beneficiaries. A contingent beneficiary will receive proceeds only if all of the primary beneficiaries die before payment is made.

If you have named your spouse as your beneficiary and later you divorce, the designation of your spouse will be deemed to be revoked if written notice of the divorce is received by the plan administrator before payment has been made.

Unless otherwise designated in writing on a form provided by the plan administrator, the beneficiary you name to receive your accounts under the Texas Health 401(k) Retirement Plan will also be the beneficiary designated for any other retirement plan included in the Texas Health Retirement Program.

If you completed a beneficiary designation under the Harris Methodist Health System Retirement Plan or the Presbyterian Healthcare System Employees' Retirement Plan before 1998 and did not complete a new form after January 1, 1998, the people named in the designation will be the beneficiaries only for those plans and not for the Texas Health 401(k) Retirement Plan.

Other Provisions

QUALIFIED DOMESTIC RELATIONS ORDERS

Generally, you cannot pledge or assign your account balance in the Texas Health 401(k) Retirement Plan or any other plan that is part of the Texas Health Retirement Program. The plan may be required by law to recognize obligations you incur as a result of court ordered child support, agreed alimony, or as a result of the division of your community property interest in your account balance in connection with your divorce. To bind the plan administrator, the court order must be a Qualified Domestic Relations Order (QDRO). If you are in the process of a divorce, the plan administrator can provide you with acceptable language for your court order.

By law the plan must recognize a QDRO, which is a decree or order issued by a court that obligates you to pay child support or agreed alimony, or otherwise allocates a portion of your account balance to an alternate payee, who may be your spouse, former spouse, child, or other dependent. If such an order is received by the plan, all or a portion of your account will be used to satisfy the obligation.

The plan administrator is responsible for determining whether a QDRO exists. When a QDRO is received, the plan administrator will notify the participant and each alternate payee and explain the procedures that will be used to determine its qualification. After the review process is completed, the plan administrator will notify the participant and each alternate payee of the plan administrator's determination and, if applicable, the appeal process that may be requested.

You may request a free copy of the QDRO determination procedure from the plan administrator.

CLAIMS PROCEDURES

For information on how to file a claim or appeal a claim that has been denied, see "Claims Information" beginning on page 149.

UNCLAIMED BENEFITS

When you or your beneficiary become entitled to payment of a benefit, the plan administrator will send you or your beneficiary a notice of the right to receive the benefit. The notice will be sent to the last known address of the person as shown on the plan's records.

If the benefit is not claimed within six months after the date the notice is mailed (or if the plan is being terminated before the effective date of the plan's termination), the benefit may be segregated in an interest-bearing account in your name while the plan administrator attempts to locate you or your beneficiary.

The segregated account will not receive allocations of investment returns. It will, however, be entitled to all investment returns it earns as a separate account and will separately bear all expenses or losses related to its operation.

If the benefit is not claimed within five years, it will be forfeited. Your benefit will be restored after you or your beneficiary is located. You should make sure Texas Health always has your current address and the current address of your beneficiary.

If you terminate when your vested account balance is $1,000 or less (including any rollover account balances), you must take a distribution of your account. See page 117 for more information.

NO PBGC COVERAGE

While a government agency known as the Pension Benefit Guaranty Corporation (PBGC) insures benefits payable under certain types of retirement plans, it does not insure any of the benefits provided under the Texas Health Retirement Program because each participant's benefits depend upon his or her account balance under the particular plan at the time of payment. The PBGC insures only benefits payable under those plans that provide for fixed and determinable (defined benefit) retirement plans.

NO FIXED BENEFIT AMOUNT

ERISA classifies the Texas Health 401(k) Retirement Plan as a "defined contribution plan." This means the plan does not provide a fixed dollar amount of benefit. Your actual benefit will depend on the fair market value of your account balances under a particular plan at the time of distribution. Your account balances will reflect contributions and investment earnings on those contributions.

LIMITATIONS ON EMPLOYMENT

The plan does not give you the right to continue to be employed by any of the participating employers or diminish your employer's right to terminate you at any time.

AMENDMENT OF THE PLAN

Texas Health has the right to amend the Texas Health 401(k) Retirement Plan at any time and for any reason. However, no amendment to the plan may:

- Authorize or permit any part of the plan's assets to be used for purposes other than the payment of benefits and the payment of reasonable plan expenses
- Reduce the amount of your account balance or the vested portion thereof
- Cause any plan assets to revert to any employer.

PLAN TERMINATION

Texas Health has the right to terminate the Texas Health 401(k) Retirement Plan at any time and for any reason. Upon termination of the plan, you will become 100% vested in all amounts credited to your account under the plan. Texas Health has certain options upon termination of the plan concerning when your benefits will be distributed, and the fact that the plan has been terminated does not necessarily entitle you to immediate payment of your benefits. Termination procedures adopted by Texas Health will be explained to you upon termination of a plan.

WITHDRAWAL BY PARTICIPATING EMPLOYER

A participating employer may withdraw from the Texas Health 401(k) Retirement Plan at any time. Texas Health, as the sponsor, may also terminate the employer's participation in the plan at any time. Either way, the participating employer may continue the plan on its own.

TEXAS HEALTH CONTRIBUTIONS CONDITIONED

Contributions to the Texas Health 401(k) Retirement Plan by Texas Health or your employer are conditioned upon the initial qualification of the plan for federal income tax purposes and the deductibility of the contribution for federal income tax purposes (for for-profit companies). Such conditional contributions can be returned to Texas Health or your employer if these conditions are not satisfied.

YOUR RIGHTS UNDER THE PLAN

Except for Texas Health's contributions being conditioned upon the initial qualification of the plan, there are no specific plan provisions that provide for a disqualification of your status as a participant under the plan or for denial or loss of vested plan benefits.

YOUR ERISA RIGHTS

See "Your ERISA Rights" on page 152 for more information.

Other Texas Health Retirement Plans

When Harris Methodist Health System (HMHS) and Presbyterian Healthcare System (PHS) formed Texas Health in 1997, Texas Health assumed responsibility for the HMHS and PHS Retirement Programs. The former HMHS and PHS retirement plans were frozen on December 31, 1997, which means that no one is eligible to become a participant, no additional contributions may be made, and all participants are 100% vested. Many of the provisions previously described under the Texas Health 401(k) Retirement Plan also apply to the frozen PHS and HMHS retirement plans. These provisions are:

- Investing Your Retirement Accounts—see page 112
- Choosing Your Investment Options—see page 112
- Changing Your Investment Options—see page 113
- Quarterly Rebalancing Election—see page 114
- Account Statements—see page 114
- Plan Loans—see page 114 (not applicable to the Frozen PHS 401(a) Plan
- Plan Withdrawals—see page 115 (not applicable to the Frozen PHS 401(a) Plan)
- Naming a Beneficiary—see page 118
- Qualified Domestic Relations Orders—see page 119
- Claims Procedures—page 119
- Unclaimed Benefits—see page 119
- No PBGC Coverage—see page 119
- Limitations on Employment—see page 119
- Amendment of the Plan—see page 119
- Plan Termination—see page 120
- Your Rights Under the Plan—see page 120
- Your ERISA Rights—see page 152.

Frozen PHS and HMHS 403(b) Annuity Plan

On October 1, 2001, the following plans were merged to form the Frozen PHS/HMHS 403(b) Plan:

- Harris Methodist Health Retirement Plan—HMHS 403(b) Plan
- Presbyterian Healthcare System Section 403(b) Annuity Plan—PHS 403(b) Plan.

VESTING

You are 100% vested in all contributions made on your behalf.

INSURANCE INVESTMENTS

You may have part of your contributions invested in an insurance company contract or an annuity contract. You may direct the plan administrator to transfer all or a portion of these contributions to one or more of the investment funds available in the Texas Health Retirement Program. If you would like to transfer your contributions, please contact Human Resources. You are 100% vested in all contributions made on your behalf.

Pre-1989 Contributions

If you were a participant in the HMHS 403(b) Plan before January 1, 1989, you may withdraw any of the savings and earnings credited to your account before January 1, 1989. You may make a withdrawal for any reason regardless of your age or financial need if the savings were always held in an annuity contract maintained by an insurance carrier. You cannot withdraw matching funds, however. Amounts held by JPMorgan are not eligible for withdrawal. You must withdraw eligible contributions (those made before January 1, 1989) and earnings before making any financial hardship withdrawal.

You may receive a distribution of your full account from the Frozen PHS and HMHS 403(b) for the same reasons (retirement, termination, disability, and death) at the same time, and in the same way as described for the Texas Health 401(k) Retirement Plan on pages 116 – 117 except that you may delay the distribution of your account until April 1 following the year in which you reach age 70½ if your account balance is $5,000 or greater. At that time, your account will be distributed in the form of a lump sum to you.

Frozen PHS and HMHS 401(k) Plan

On October 1, 2001, the following plans were merged to form the Frozen PHS/HMHS 401(k) Plan:

- Harris Methodist Health System 401(k) Retirement Plan—HMHS 401(k) Plan
- Harris Methodist Health System Productivity Sharing Plan and Trust—HMHS 401(a) Plan
- Harris Methodist Health System Thrift Savings Plan—HMHS 401(m) Plan
- Presbyterian Healthcare System Section 401(k) Retirement Plan—PHS 401(k) Plan.

VESTING

You are 100% vested in all contributions made on your behalf.

You may receive a distribution of your full account from the Frozen PHS and HMHS 401(k) for the same reasons (retirement, termination, disability, and death) at the same time, and in the same way as described for the Texas Health 401(k) Retirement Plan on pages 116 – 117, except that you may delay the distribution of your account until April 1 following the year in which you reach age 70½ if your account balance is $5,000 or greater. At that time your account will be distributed in the form of a lump sum to you.

Frozen PHS 401(a) Plan

On October 1, 2001, the PHS 401(a) Plan was renamed the Frozen PHS 401(a) Plan.

VESTING

You are 100% vested in all contributions made on your behalf.

PLAN WITHDRAWALS WHILE EMPLOYED BY TEXAS HEALTH

You may not make any withdrawals from the 401(a) Plan, including hardship withdrawals, while you are working for Texas Health.

PLAN LOANS

The PHS 401(a) Plan does not permit loans.

PLAN DISTRIBUTIONS

You may receive a distribution of your full account from the Frozen PHS 401(a) Plan for the same reasons (retirement, termination, disability, and death), at the same time as described for the Texas Health 401(k) Retirement Plan on pages 116 – 117 by contacting JPMorgan to request a distribution form, except as described below. You may delay your distribution until April 1 following the year you turn 70½.

Distributions Other Than On Death

If you are married on the date your benefits are to begin, you will automatically receive a joint and survivor annuity unless you elect to waive this form of distribution. Under a joint and survivor annuity when you die, your spouse will receive a monthly benefit for the remainder of his or her life equal to 50% or 75% of the benefit you were receiving while both of you were alive. If your spouse dies before you do, your benefit will not be reduced and you will continue to receive the same monthly benefit you were receiving while both you and your spouse were alive. Although the total value is equivalent to other forms of payment, a joint and survivor annuity may provide a lower monthly benefit amount than other forms of payment.

If you are not married on the date your benefits are to begin, you will receive a life annuity unless you elect to waive this form of distribution. Under a life annuity, you will receive equal monthly payments for as long as you live.

You may elect not to receive the automatic form of distribution and to receive a lump sum distribution by contacting JPMorgan to request a distribution form. If you are married, your spouse must consent in writing on a notarized waiver if the value of your account is more than $5,000. You may revoke your waiver election, but your spouse may revoke his or her waiver only if you revoke yours.

Disability

If the plan administrator determines that you meet the plan's definition of disability, you can receive a distribution of your full account balance (less any outstanding loan balance) as soon as administratively practicable. The distribution will be made according to the procedure described above for termination of employment. To request a disability distribution, contact JPMorgan.

If the plan administrator receives satisfactory evidence that you are physically unable or mentally incompetent to receive the distribution, the plan administrator may make payments on your behalf to your spouse, a relative, or your custodian.

Death

If you die and your account balance is $5,000 or less, it will be automatically distributed to your spouse (if you are married) in a lump sum balance as soon as administratively practicable, unless you have elected otherwise with your spouse's consent in writing on a form furnished to you by the plan administrator.

If your spouse has validly waived the right to the death benefit or you are not married at the time of your death and have not begun receiving benefits under the plan, then your death benefit will be paid to the beneficiary of your choice in a single lump sum. You may designate a beneficiary using a form available from Human Resources (see page 118 for more information).

If you die with an account balance greater than $5,000, your account balance will be distributed to your spouse if you are married, unless you have elected otherwise with your spouse's consent in writing on a form furnished to you by the plan administrator. Your account balance will be paid to your spouse in the form of a survivor annuity—that is, periodic payments for the life of your spouse. The size of the monthly payments will depend upon the value of your account balance at the time of your death. The plan administrator may, however, distribute the benefit in a single lump sum, provided your spouse consents in writing on a notarized form.

If your spouse consents, you may waive the survivor annuity at any time after the first day of the plan year in which you reach age 35. If your spouse has validly waived the right to the death benefit, or you are not married at the time of your death and have not begun receiving your plan benefits, then your death benefit will be paid to the beneficiary of your choice in a single lump sum.

If you are not married, your account will be paid to the beneficiary you designate in one of the forms described above. You may designate a beneficiary on a form available from Human Resources (see page 118 for more information).

Termination

When you leave Texas Health before age 65, you will receive a description of the annuity distribution and the lump sum option available to you. This information is included with the distribution paperwork. You will indicate your choice of the method of distribution on the form. The tax consequences of the distribution option may vary, and you should consult with a tax advisor before making any elections.

Frozen Prior Employer 401(k) Plan

The plans sponsored by the companies listed below were transferred to the Frozen Prior Employer 401(k) Plan on the date indicated. If you were working for one of these companies on the date indicated, your retirement account may have been transferred to the Frozen Prior Employer 401(k) Plan:

- Texas Health Partners, transferred on October 19, 2009
- Presbyterian Plan Center for Radiation Services, PPCRS, transferred February 1, 2010
- AMH Cath Lab, transferred on April 1, 2010
- Health First, transferred on May 1, 2010.

Many of the provisions described under the Texas Health 401(k) Retirement Plan also apply to the Frozen Prior Employer 401(k) Plan. These provisions are:

- Investing Your Retirement Accounts—see page 112
- Choosing Your Investment Options—see page 112
- Changing Your Investment Options—see page 113
- Quarterly Rebalancing Election—see page 114
- Account Statements—see page 114
- Plan Loans—see page 114
- Plan Withdrawals—see page 115
- Naming a Beneficiary—see page 118
- Qualified Domestic Relations Orders—see page 119
- Claims Procedures—see page 119
- Unclaimed Benefits—see page 119
- No PBGC Coverage—see page 119
- Limitations on Employment—see page 119
- Amendment of the Plan—see page 119
- Plan Termination—see page 120
- Your Rights Under the Plan—see page 120
- Your ERISA Rights—see page 152.

Vesting

You are 100% vested in all contributions made on your behalf.

Plan Withdrawals While Employed by Texas Health

You may receive a distribution of your full account from the Frozen Prior Employer 401(k) Plan for the same reasons (retirement, termination, disability, or death) at the same time, and in the same way as described for the Texas Health 401(k) Retirement Plan on pages 116 – 117. You may also withdraw all or any portion of your rollover contributions and any earnings allocated on them at any time, regardless of whether you have reached age 59½.

Time Off

Time Away From Work

Paid Time Off (PTO)

Texas Health recognizes that time away from work is important and necessary for you to balance work with the rest of your life. Texas Health offers a Paid Time Off program to help you continue receiving pay when you take time off. The primary purpose of the PTO program is to provide you pay while you are away from work due to:

- Vacation
- Holidays
- Illness or injury
- Leave of absence
- Family and Medical Leave.

Paid time off (PTO) is a combination of vacation, holiday, and sick time. You receive PTO based on your employment status, position, and length of service, as described below. If you miss work for more than three consecutive calendar days due to a medical condition (your own or an immediate family member's), you must contact Integrated Disability Management at 1-877-MyTHRLink (1-877-698-4754), prompt 6, press 1 to discuss eligibility for leave of absence. Although PTO provides pay for a brief illness, to be sure you have protected your income in case of a longer illness or injury, it is important to consider Short Term Disability coverage as explained on pages 88 – 89.

It is important to manage your PTO bank like a savings account. You want to make sure there is enough PTO for vacations and holidays; but also have some set aside in case you have to miss work due to illness or disability.

Who Is Eligible

Both full-time and part-time benefits-eligible employees (as defined on page 5) are eligible to receive PTO.

PRNs and part-time benefits-ineligible employees (as defined on page 165), medical residents/interns/fellows are not eligible for PTO. Time away from work for contract medical directors, physicians and physician extenders employed by THPG is based on their contract.

Accruing PTO

You accrue PTO each pay period beginning on your date of hire.

FULL-TIME EMPLOYEES

The table below shows the annual PTO accrual schedule for a full-time employee. If you are a full-time employee (as defined on page 5), you accrue PTO as a percentage of the following schedule.

Years of Service	Annual PTO Accrual	
	Positions Below Director	Director & Above
Less than 2	192 hours	232 hours
2 but less than 4	208 hours	248 hours
4 but less than 9	232 hours	272 hours
9 but less than 14	256 hours	296 hours
14 but less than 20	280 hours	312 hours
20 or more	296 hours	328 hours

If you are a full-time employee classified in the HR/Payroll system to work 64 - 79 hours per pay period, you will accrue a percentage of the 80-hour PTO schedule. For example, if you are classified in the HR/Payroll system to work 64 hours per pay period, you will accrue 80% of the 80-hour PTO schedule (64 hours is 80% of 80 hours).

PART-TIME EMPLOYEES

If you are a part-time benefits-eligible employee (as defined on page 5), you will accrue a percentage of the 80-hour PTO schedule. For example, if you are classified in the HR/Payroll system to work 48 hours per pay period, you will accrue 60% of the 80-hour PTO schedule.

NEWLY HIRED EMPLOYEES

New hires who are eligible for PTO will begin accruing PTO on their date of hire. New hires may use PTO as it is accrued and available, subject to supervisor approval.

EMPLOYEES ON LEAVE OF ABSENCE

You do not accrue PTO while on paid or unpaid leave of absence.

MAXIMUM PTO

You may accrue up to 600 hours of PTO. You will forfeit hours in excess of the maximum accrual. You may carry over up to 600 PTO hours to the next calendar year. Your year-to-date PTO accrual is shown on each paycheck.

Using PTO

PTO provides you with pay while you take time off from work for vacation, holiday, illness, or disability. Your annual PTO accrual is based on your standard hours in the HR/Payroll System and your years of service. Subject to your supervisor's approval, you can use your PTO as soon as it is accrued, up to the amount that matches your scheduled hours in the HR/ Payroll system. If you are a full-time employee, you are encouraged to take at least 10 days (80 hours) of PTO each year.

You may use PTO when you are away from work on a regularly scheduled day, unless it would cause you to exceed the number of hours you are classified in the HR/Payroll system to work. However, there are some exceptions.

You cannot use PTO if:

- Your absence is due to jury duty.
- You are receiving bereavement pay.

You may use PTO, but are not required to use it if:

- You have not worked the hours you are regularly scheduled to work according to your status in the HR/ Payroll system
- You are on military reserve training or duty.
- You are not at work or are sent home because of low census or other business reason.
- You are on a leave of absence.

Exempt employees must use PTO in full-day increments unless on intermittent FMLA.

If you are receiving STD or *workers' compensation temporary income* benefits, you have the option of receiving PTO to make up the difference between your regular weekly base pay and your STD *or workers' compensation benefits*. However, the combined amounts cannot be more than 100% of your normal base pay.

EXEMPT EMPLOYEES

If you are an exempt employee, you must use PTO in full-day increments based on your schedule for the day, unless you are on an intermittent FMLA leave. If you are on an approved intermittent FMLA leave and you choose to use your PTO for the portion of the day not worked, you must use PTO in hourly increments. If you are an exempt employee who is not on intermittent FMLA and you miss a portion of a scheduled day, you are paid for the full day without the addition of PTO.

NON-EXEMPT EMPLOYEES

If you are a non-exempt employee and do not work your regularly scheduled hours, you can decide whether to use PTO to bring you up to the hours for the week according to your Full-time Equivalent (FTE) defined in the HR/ Payroll system.

For example, if your FTE is 100% (40 hours per week) and you work 36 hours during the week, you may use four hours of PTO or choose to be paid for 36 hours. You may not use PTO during any pay week if using it would cause you to exceed the number of hours you are classified in the HR/Payroll system to work. If you do not notify your supervisor of your choice, no PTO hours will be added.

Converting PTO

By converting PTO, you can use some of the PTO pay you earn in the current year to instead pay for Flexible Benefits during this year. During annual benefit enrollment, most employees can elect to convert up to 80 hours of PTO (in eight-hour increments) that you will earn next year to pay for next years Flexible Benefits. The value of PTO hours you elect to convert will be deducted from your paycheck over 26 pay periods based on your hourly rate of pay at the time the PTO is converted. To be eligible to convert PTO, you must elect at least one Flexible Benefit option (Medical, Dental, Vision, Additional Life, Additional AD&D, Short Term Disability, Additional Long Term Disability, Dependent Life Insurance, or a Flexible Spending Account) during the open enrollment period. The hours you convert are included in the 100-hour annual maximum for the selling, converting, and donating of PTO. You may convert a maximum of 80 hours per year. PTO conversion is suspended while you are on a leave of absence.

Selling PTO

The primary purpose of the PTO program is to provide you with pay while you are away from work for vacation, illness, or disability. However, there may be times when you need additional income for an unexpected expense.

You may sell PTO two times a year, up to an annual total of 80 hours anytime during each calendar year, based on pay-period ending dates. You must maintain at least 80 hours of PTO after the sale. Each hour of PTO is valued at your regular hourly pay rate. You may sell a maximum of 80 hours per year.

The hours you sell are included in the 100-hour annual maximum for selling, converting, and donating PTO. For example, if you converted 40 hours during open enrollment and have not sold any PTO this year, you have 60 hours that can be sold or donated during 2013. However, if you have donated 40 hours and converted 40 hours this year, you only have 20 hours available to sell during 2013.

When you sell PTO, you will receive 80% of the value of your sold PTO hours as a cash payment, less the applicable payroll taxes. The 20% penalty is imposed for tax-related reasons. If you participate in the Texas Health 401(k) Retirement Plan, your contribution to the 401(k) Plan will also be deducted from the PTO payment.

Contact Human Resources if you are interested in selling PTO. You cannot be suspended at the time you choose to sell PTO or when the payment is made.

Due to IRS regulations, the combined amount of PTO you convert, sell, and donate must be less than 100 hours per year. Each plan has an individual maximum, as well. This maximum does not apply to Helping Hands donations.

TERMINATING EMPLOYMENT

If you leave Texas Health, you will be paid for 100% of your accrued and unused PTO hours (up to 600 hours), provided you continue to work for at least two weeks (four weeks for management employees and supervisors) after giving written notice of your intent to resign. If you do not give proper written notice, your PTO will be reduced to offset the amount of notice not given. PTO hours may generally be used only during the notice period for PTO scheduled and approved by your supervisor before you give notice. You may not use PTO to extend pay or benefits after your last day of work.

If you switch to a status that is not eligible for benefits (such as full-time to PRN), you will be paid for 100% of your accrued and unused PTO, up to 600 hours, within two or three pay periods after your change. Your PTO cash-out will be subject to applicable payroll taxes and 401(k) deductions if you are enrolled in the 401(k) Plan.

CHANGING EMPLOYERS

If you work in a department, division, or operating unit or an affiliate or subsidiary that Texas Health sells or otherwise transfers to a third party and you are employed by the new owner, your PTO will be transferred to your new employer if Texas Health and the new owner agree to the transfer before the date you are employed by the new owner. If the new owner does not agree to the transfer, you will be paid your PTO as if you had terminated employment, as explained above.

BENEFICIARY

In the event of your death, your PTO balance will be paid to the beneficiary you named for Basic Life Insurance.

Donating PTO to Charity

You may sell your PTO hours to Texas Health and direct that the net after-tax proceeds from the sale be donated to one or a combination of the following charities:

- Community Giving
  - United Way
  - American Cancer Society
  - American Heart Association
  - March of Dimes
  - Susan G. Komen for the Cure Foundation
- Texas Health Associates
  - Arlington Memorial Hospital, Inc.
  - Harris Methodist Health Foundation
  - Presbyterian Healthcare Foundation.

You may sell up to 80 hours of PTO for charity any time during the year, as long as you maintain at least 80 hours of PTO after the sale. The hours you donate are included in the 100-hour annual maximum for the selling, converting, and donating of PTO.

When you sell your PTO for donation to a charity, the proceeds are reported as taxable income to you. Your PTO donation will be subject to applicable payroll taxes and 401(k) deductions (if you are enrolled in the 401(k) Plan).

You may be able to claim the net after-tax proceeds of the sale as a tax-deductible charitable contribution if you itemize tax deductions when you file your income tax return.

Donating PTO to the Helping Hands Fund

The Helping Hands Fund is a program that gives Texas Health employees a way to help other employees.

You may donate PTO to the Helping Hands Fund.[1] Then, an employee who must miss work due to a personal/family illness or a catastrophic event and has used all of his or her PTO can apply and, if approved, receive PTO hours from the fund.

A central system-wide Helping Hands Committee administers distributions from the fund. They will consider the nature of the catastrophic event, employee's economic circumstances, the estimated length of absence from work, and the amount of PTO requested.

To be an employee donor, you:

- Must be an active, benefits-eligible employee with at least one year of service
- May make a single donation of PTO (in one hour increments), or you can sign up to make regular donations of PTO each pay period.
- Have enough PTO in your bank that you will have at least 80 hours left after making the donation.[2]

Because the PTO that you donate to the Helping Hands Fund is actually used by other employees to take time off, there is no maximum donation and it does not count toward the 100 hour annual maximum that includes PTO you sell, donate, or convert. Because no taxes have been withheld from the PTO you donate, the donation itself is not tax deductible. To donate PTO, complete the PTO donation form on **MyTexasHealth** or go to Human Resources.

Receiving PTO from the Helping Hands Fund

To be eligible to receive PTO benefits from the Helping Hands Fund, you must:

- Be missing time from work
- Be an active, benefits-eligible employee with at least 90 days of service
- Have already applied for short-term disability benefits (if applicable)
- Have exhausted all other means of help, including using all of your PTO
- Not currently be receiving income benefits from another source such as short-term disability or workers' compensation
- Have not given away work shifts, etc.
- Demonstrate that an unpaid leave will create a financial hardship
- Not have received more than 80 hours of PTO from the Texas Health Helping Hands Fund in the same calendar year
- Be in good standing at your entity and are not under any type of disciplinary action program.

The PTO you receive is considered taxable income and will have other deductions taken from it, such as your 401(k) contribution. You can receive a maximum of 80 hours of donated PTO in a calendar year.

The Helping Hands Fund is not intended to act as an income replacement fund or to help people who don't have catastrophic situations.

When you apply for the Helping Hands Fund, you will also be referred to the MHN EAP (see page 60) to identify other community resources and services that may be of additional help to you. Contact Human Resources to request a donation from the Helping Hands Fund.

Receiving PTO as an Incentive

You cannot receive extra PTO as an incentive to participate in philanthropic events or activities. PTO can only be earned through the normal accrual process.

Extended Illness Bank/ Sick Bank

Before the formation of Texas Health, some employers had an Extended Illness Bank (EIB) or Sick Bank program to provide paid time off for illness or injury. These programs are now frozen and no longer accrue hours, but employees may use their previously accrued hours under certain circumstances until their accounts are depleted.

Employees with hours credited to the former Presbyterian EIB or the Harris Methodist Sick Bank before January 1, 1998, or the Arlington Memorial Hospital Sick Bank before January 1, 2000, or Presbyterian Hospital of Denton EIB before May 1, 2009, can access them after three consecutive days of absence due to illness or injury. If your schedule is 12 hours a day, you will have to take 36 hours of PTO before you are eligible to use EIB. You may use PTO time, if available, during the three-day waiting period. You cannot substitute EIB or Sick Bank to replace the three days of PTO.

You may use EIB/Sick Bank hours for an approved FMLA leave of absence. You cannot transfer EIB or Sick Bank time between accounts or exchange them for PTO. Unused time will not be paid out upon your termination of employment or change in status to benefits-ineligible regardless of your years of service.

If you terminate or have a change in status to benefits-ineligible (such as PRN or part-time benefits-ineligible as defined on page 165) you will forfeit your EIB or Sick Bank time even if you are later rehired or move back into a benefits-eligible status.

[1] You cannot donate PTO from frozen accounts.

[2] The 80-hour minimum does not apply to chaplain residents.

Bereavement Pay

If you are a full-time or part-time benefits-eligible employee (based on the employee's eligibility requirements as defined on page 5) in an active status, when a family member dies you can take days off with pay to grieve, attend the funeral, make funeral arrangements, or settle the estate. The time off does not need to be consecutive.

You are paid at your base pay for each hour you are away from work for bereavement, to the amount based on the number of hours you are classified to work in the HR/Payroll system. You may be eligible for bereavement pay for the following:

Amount of Days	Relationship to Employee*
Up to three days	• Spouse • Child or step-child • Grandchild • Sibling, step-sibling, or spouse's sibling • Parent, step-parent, or spouse's parent • Grandparent • Great-grandparent • Son- or daughter-in-law • Brother or sister-in-law • Niece or nephew
Up to one day	• Aunt or uncle of employee • Spouse of grandchild • Brother- or sister-in-law of employee's spouse • Niece or nephew of employee's spouse • Great-grandchild

* Applies to current step relationships only.

You may not receive bereavement pay during any pay week if using it would cause you to exceed the number of hours you are classified to work in the HR/Payroll system.

An employee on any approved leave of absence (paid or unpaid) may receive bereavement pay.

To receive bereavement pay while on any of the eligible leave types you must do the following:

- Integrated Disability Management (IDM) must be notified by the employee, the manager, or Human Resources of the death of the eligible family member and the expected amount of days off as listed in the table on this page.
- The IDM department will inform the employee of the required documentation (a copy of the death certificate, obituary or funeral program). Upon the receipt of the documentation, the IDM department will send a request to the applicable Payroll Department for payment of bereavement.
- The applicable Payroll Department will process the request via a pay sheet.

You will be paid only for the number of hours you were classified to work in the HR/Payroll system.

Community Time Off

Each full-time and benefits-eligible part-time employee is eligible for up to one regularly scheduled workday of paid time off per year to volunteer at a hospital/entity/system sponsored community benefit event and/or for a non-profit organization in the community. Hours may be taken incrementally, as approved by your manager. CTO hours are non-productive paid time that counts toward hours worked, however is not meant to place an employee into overtime.

Guidelines for the program are:

- Full-time and benefits-eligible part-time employees receive one full, scheduled workday per year for CTO
- The activity must be within the Texas Health service area.
- It must benefit a charitable 501(c)3 or 170c-1 (school) organization.
- The activity utilizes Texas Health paid time.
- Your manager's approval is required prior to using CTO and is contingent on business and operational needs.
- Hours may be taken incrementally as approved by a manager.
- CTO hours are categorized as productive paid time so the CTO hours worked count toward the calculation of overtime.
- Both exempt and non-exempt employees should report CTO time to their department time keeper for tracking on THR's annual Community Benefit report. THR does many activities in and for the community and we want to make sure that the hours you work in this capacity are tracked in this report each year.
- Exempt employees do not receive additional compensation for participating in CTO projects.
- Non-exempt employees must be paid for all CTO hours worked.
- Managers may flex a non-exempt employee's hours to compensate for CTO to avoid placing the employee in overtime.
- CTO cannot be donated.
- CTO cannot be used to solicit funds or donations from employees and is to be used strictly for community volunteerism.

Your responsibilities:

- Log on to Employee Volunteer Tool located at **www.TexasHealth.org/TexasHealthGives**.
- Complete your employee profile.
- Read the CTO policy.
- Join an existing project or propose a new project and submit your CTO request two weeks prior to the volunteer project.
- Your supervisor will receive an email requesting approval of your CTO project.
- If your project is approved by your supervisor, report CTO hours to department personnel responsible for payroll entry (CTO payroll code) before payroll Monday.

Qualifying charitable organization is one that is tax-exempt under section 501(c)3 or 170c1:

- Healthcare organization/ social services—all health care organizations qualify, including community health activities that Texas Health may organize that benefit the community at large. CTO is not for personal benefit such as visiting a sick relative or friend.
- Faith organizations—all faith organizations qualify for CTO as long as it is used to promote the health and well being of the faith organization members or the community at large. An example includes participating in faith community activities that feed the homeless.
- Schools—all public and private schools are qualifying organizations as long as CTO is used to further education through the support of academic programs. Examples would include mentoring, tutoring and science fairs. Examples of ineligible activities would be watching a school performance, parent-teacher conferences, field trip, or driving a child to a school event.

Non-qualifying organizations include political organizations and organizations that may compete with Texas Health.

For more information contact Texas Health Community Affairs Department at 682-236-7619 or email thrcommunityaffairs@texashealth.org.

Jury Duty

If you are a full-time or part-time benefits-eligible employee, you will be paid for each hour you are away from work to perform jury duty or serve as a subpoenaed witness on behalf of Texas Health. Jury Duty pay is equal to your hourly base pay rate. The maximum pay per day is based on the number of hours you are classified to work in the HR/ Payroll system.

You may not use jury duty leave during any pay week if using it would cause you to exceed the number of hours you are classified to work in the HR/Payroll system.

Leaves of Absence

Full-time and part-time benefits-eligible employees (as defined on page 5) may take the following types of leave:

- Family and Medical Leave
- Military Leave
- Medical Leave (non-FMLA)
- Personal/Educational Leave.

Depending on the reason for the leave and the amount of PTO you have accumulated, you may be paid during your leave of absence.

You do not accrue PTO while on a paid or unpaid leave of absence.

During your leave, you may keep your coverage effective under the Texas Health benefits plans by paying your share of the premiums. Your cost will be the same as active employees pay. If you are receiving PTO and/or EIB, your premiums will be deducted from your check. If you are not receiving PTO and/ or EIB for all of your leave, you must pay your share of the premiums by check or credit card each pay period. If you do not pay your premiums, your benefits will be canceled.

If you have LTC coverage, Genworth Life will bill you directly for LTC premiums. If you have a 401(k) loan, during an approved leave of absence, you may request that loan payments be suspended during your leave. If you suspend payments during a leave of absence, the loan will be reamortized upon returning to work.

You may continue the following Texas Health benefits during an unpaid leave of absence:

- Medical
- Dental
- Vision
- Short Term Disability (STD)
- Long Term Disability (LTD)
- Life Insurance
- Voluntary AD&D
- Long Term Care (LTC)
- Health Care Flexible Spending Account.

You may not participate in the Day Care Flexible Spending Account during a leave of absence.

If you continue coverage during your leave, you will pay the same cost of coverage as active employees pay. If you do not pay your premiums, your benefits will be canceled.

For more information, contact the Integrated Disability Management Department at 1-877-MyTHRLink (1-877-698-4754), prompt 6, press 1. You may view the Texas Health Leave of Absence policy on **MyTexasHealth** or email at THRIDM@TexasHealth.org.

Benefits During Family and Medical Leave

BASIC FAMILY AND MEDICAL LEAVE

FMLA is a federal law that gives you the opportunity to take up to 12 work weeks of unpaid leave during any 12-month period for the following reasons:

- The birth and care of your newborn child
- The placement of a child with you for adoption or foster care
- The care of your spouse, child (under age 18 or incapable of caring for him- or herself because of physical or mental disability) or parent who has a serious health condition
- Your own serious health condition that makes you unable to perform the essential functions of your job.

MILITARY FAMILY LEAVE

If you have a spouse, son, daughter, or parent who is an active duty member of the military who is deployed to a foreign country or on active duty or called to active duty status in the National Guard or Reserves in support of a contingency operation, you may use your 12 weeks of FMLA to address certain qualifying exigencies. Examples of qualifying exigencies include attending certain military events, arranging for alternative childcare, participating in certain counseling sessions, and attending post-deployment reintegration briefings.

Another special FMLA leave permits eligible employees to take up to 26 weeks of leave to care for a covered service member who has been injured in the line of duty and is unfit to perform his or her duties or who is a veteran undergoing medical treatment, recuperation, or therapy for a serious illness or injury and who was a member of the Armed Forces (including the National Guard or Reserves) at any time during the five years preceding the date the veteran undergoes treatment.

If you are the spouse, son, daughter, parent, or next of kin of a service member, you may be eligible to take up to 26 weeks of FMLA leave in a single 12-month period to care for the service member.

QUALIFYING FOR FMLA

To qualify for FMLA you must have been employed by Texas Health for 12 months and worked at least 1,250 hours in the 12-month period before the leave.

During your leave, you are entitled to keep in effect your coverage under the Texas Health benefit plans. You must pay your share of the premiums. If you are receiving PTO, your premiums will be deducted from your check. If you are not receiving PTO for all of your leave, you must pay by check your share of the premiums. If you do not pay your premiums, your benefits will be canceled.

You may also revoke your election of coverage under any of the above plans before your leave or during your leave, as long as it's within 31 days of beginning of unpaid leave. You also have the right to revoke or change elections under the same terms and conditions as are available to employees participating in the plan who are not on leave (see "Status Changes" on pages 10 – 12).

If your coverage under one of the plans has been terminated, you may choose to be reinstated on your return to work after your leave on the same terms as before the leave (including family and dependent coverage).

If your coverage under a plan terminates while you are on FMLA leave, you are not entitled to receive reimbursements for claims incurred during the period when the coverage was terminated. If you later elect to be reinstated in a plan upon return from FMLA leave for the reminder of the plan year, you may not retroactively elect coverage for claims incurred during the period when the coverage was terminated.

If you have a qualifying change in family status (such as the birth of a child, marriage, etc.) during your leave, you must contact Human Resources and make the change within 31 days of your status change (see "Status Changes" on pages 10 – 12).

You should refer to the Texas Health Leave of Absence Policy to get more information about your rights under FMLA. You may also contact the Integrated Disability Management department at 1-877-MyTHRLink (1-877-698-4754), prompt 6, press 1.

Other Benefits

Other Benefits

Tuition Reimbursement

Attending school can open many doors for your career, but paying for it can be a big challenge. Texas Health offers the Tuition Reimbursement Program to help you further your education. Through the Tuition Reimbursement Program, Texas Health will reimburse tuition and some recurring fees for approved degree plans that benefit Texas Health or your position at Texas Health (certificate programs are not eligible for tuition reimbursement). Courses must be taken at universities, colleges and vocational tech schools in the U.S. that have been accredited by specific nationally recognized accrediting agencies as defined in the table on the next page. The Texas Health Benefits Department administers the Tuition Reimbursement Program.

The table below explains the program and shows the benefits available to eligible employees. To access the Tuition Reimbursement application go to **www.MyTHR.org**. If you have questions, call 1-877-MyTHRLink (1-877-698-4754), prompt 6, press 2 or send an email to THRTuitionReimbursement@texashealth.org.

To submit reimbursement forms and documentation, either fax them to (682) 236-7291, email THRTuitionReimbursement@texashealth.org or mail or deliver copies to:

Texas Health Tuition
Reimbursement Program
612 E. Lamar Blvd.
Suite 400
Arlington, TX 76011-4014

This section gives you important information about your Texas Health Tuition Reimbursement Program so you can make informed decisions. Here is a checklist of key actions you need to take:

- Verify that you are eligible to participate in the Tuition Reimbursement Program.
- Determine if your coursework or field of study is eligible for reimbursement through the program.
- Submit an online application *before* the beginning of each semester or set of courses.
- Submit your request for reimbursement no later than 60 days after completing the courses.

ELIGIBILITY

Topic	Description
Eligibility	Full-time and part-time benefits-eligible employees (as defined on page 5) may participate. The following are not eligible: • Medical directors employed under contract • Medical residents or interns • Administrative residents or interns • Fellows or interns • Dependents of employees. To be eligible for the Tuition Reimbursement Program, you must have six or more months of service before the start of the courses. (This rule is waived for employees pursuing clinical degrees.) You may be on a leave of absence while taking the courses, but you must be actively at work when any of the following occur: • You submit your application • Your application is approved • You submit your reimbursement request • Your grades and itemized statements are processed for payment. Exceptions are made for employees on military leave.

ELIGIBILITY (CONTINUED)

Topic	Description
Approved accrediting agencies	**All Degrees**
	To be eligible, courses must be taken from a university, college, vocational or technical school in the U.S. that is accredited by one of the following associations: • Southern Association of Colleges and Schools (SACS) • Middle States Association of Colleges and Schools (MSA-CHE) • New England Association of Schools and Colleges (NEASC-CIHE) • North Central Association of Colleges and Schools (NCA-HLC) • Northwest Commission on Colleges and Universities (NWCCU) • Western Association of Schools and Colleges – Senior Colleges (WASC-ACSCU) • Western Association of Schools and Colleges – Junior Colleges (WASC-ACCJC) • Association of Biblical Higher Education (ABHE) • Accrediting of the Association of Theological Schools (ATS) (recognized at the undergraduate level only) This list of associations is not all-inclusive. If your school or university is not accredited by one of these associations, contact Tuition Reimbursement.
	Clinical Degrees
	In addition to one of the above accreditations for all degrees, clinical courses must be taken from a school that is accredited by one of the following associations: **Nursing** • National League for Nursing Accreditation Commission (NLNAC) – All levels of nursing education • American Association of Colleges of Nursing – Commission on Collegiate Nursing Education – BSN or higher degree programs **Allied Health Professions** • Radiologic Science – Joint Review Committee on Education Radiologic Technology (JRCERT) • Clinical Lab Sciences – National Accreditation Association for Clinical Lab Sciences (NAACLS) • Commission on Accreditation of Allied Health Education Programs (CAAHEP) • Speech Language Pathologist – American Speech Language Hearing Association (ASHA) • Physical Therapy – Commission on Accreditation of Physical Therapy Education (CAPTE) • Occupational Therapy – Accreditation Council for Occupational Therapy Education (ACOTE)

ELIGIBLE DEGREES AND COURSEWORK

Topic	Description
Clinical degrees	Employees are eligible for reimbursement of coursework for clinical degrees including all registered nursing positions, respiratory therapist, radiographer, pharmacist, social work, PT, OT, ST, pre-med students and other licensed or professional health care positions for which Texas Health typically hires. Reimbursement of clinical coursework, up to: • $5,250 per year for full-time employees and part-time benefits-eligible employees who are considered full-time students under their degree plan (usually 12 credit hours per semester) and enrolled in clinical courses • $2,625 per year for part-time employees. In addition to tuition, you may submit receipts for reimbursement of textbooks (books purchased from individuals are not covered) and an invoice for recurring mandatory fees not to exceed the allowable maximum reimbursement amount. Books for clinical nurse leader programs are not eligible for reimbursement. Recurring fees do not include fees for parking, insurance, or transportation fees. We may request verification of your degree plan prior to approval of your tuition application or reimbursement request.
Non-clinical degrees	Benefits-eligible employees who have completed six months of service are eligible for tuition, up to the following maximums: • $4,000 per year for full-time employees • $2,000 per year for part-time employees. Textbooks are not reimbursable for non-clinical degree plans, however recurring mandatory fees are eligible to be paid.
Graduate Equivalency Diploma (GED)	Benefits-eligible employees are eligible for reimbursement of expenses related to completing a high school education through a Graduate Equivalency Diploma (GED).
Online courses	Clinical degrees may be earned online. If you do not already possess a license or are not already registered, you must have approval in advance of attending these courses. Contact Tuition Reimbursement for additional qualification information. Online courses for non-clinical degrees are covered for approved degrees taken at a school that is accredited by one of the agencies listed above.

HOW THE PROGRAM WORKS

Topic	Description
Minimum grade requirements	To be eligible for reimbursement of a course, you must earn a grade of C or better (or passing grade in a pass/fail course).
How to apply	You must submit an online application before beginning every semester (or a new set of classes if your school is not on a semester plan). After classes begin, you have 10 calendar days for late applications to still be considered for approval. You must be an active benefits-eligible Texas Health employee when you submit your application. All repeated courses require a new application prior to the course start date. • Log on to www.MyTHR.org. • Scroll down to Tuition Reimbursement and click "To access Tuition Reimbursement (new applications, application status, submit grades or reimbursement requests), click here." • Click "Yes" to the security question and answer the questions regarding your degree plan (if applicable). • Select your school name and number of courses you are taking from the dropdown boxes. • Click "Create a new application", then follow directions on the form and click "Submit." You will receive an email acknowledging submission of this form and a second email once the form is reviewed for approval. If you have submitted your tuition reimbursement application and do not receive one of these notifications in 3 – 5 business days, please contact the Tuition Reimbursement department at 1-877-MyTHRLink (1-877-698-4754), prompt 6, press 2, or at THRTuitionReimbursement@TexasHealth.org. If you have a change in your classes, you must submit a revision to your original application online or contact the Tuition Reimbursement department by email at THRTuitionReimbursement@TexasHealth.org or call 1-877-MyTHRLink (1-877-698-4754), prompt 6, press 2. If you are participating in a clinical degree program, when you apply for tuition reimbursement you may submit an estimate of the cost of textbooks before the start of the course and then edit the application once books are purchased. Books purchased from individuals are not covered.
How you are reimbursed	You must have an approved Tuition Reimbursement application on file and be actively at work in a benefits-eligible position at the time you submit your reimbursement request and at the time your reimbursement is processed. If your job is eliminated during your semester, you are eligible to receive Tuition Reimbursement if you meet all other requirements of the program. Within 60 days after completing the courses, you must submit your grades with your name pre-printed on the grade notification and itemized receipts (including receipts for textbooks, if enrolled in a clinical program) along with the Reimbursement Request Form. Always include your name and ID number on all documents. To request reimbursement for tuition: • Log on to www.MyTHR.org • Scroll down to Tuition Reimbursement and click "To Request Reimbursement, click here." • Scroll down to the application from which you are requesting reimbursement. • Click the "Reimbursement" tab and answer the questions regarding your degree plan (if applicable). • Input your correct email address. • Input the amounts for requested Tuition, Lab/Fees and books if applicable and click "Submit." • Print the form. • Read, sign, date, and fax or email the form along with an invoice from the school, a letter grade report with your name preprinted on it to (682) 236-7291. If you are in a clinical degree plan and are requesting book reimbursement, please send an itemized book receipt along with the other requested documents. Upon submitting the form, you will receive a confirmation email and an acknowledgment email once the faxed copies have been received by our office. Please allow 3 – 5 business days for an acknowledgment email to be sent. Reimbursements are usually processed within 1 – 2 pay periods. If a career development plan (CDP) is required, you will receive an email from the Center for Learning after you have an approved application on file. This email will include instructions on how to complete your CDP. Your reimbursement will not be processed until our records indicate that you have an approved CDP on file. Contact the Center for Learning at 682-236-6161 for additional information. Please note that you do not need to submit a CDP each semester.

HOW THE PROGRAM WORKS (CONTINUED)

Topic	Description
How to submit your reimbursement forms and documentation	Either fax them to 682-236-7291, email to THRTuitionReimbursement@TexasHealth.org, mail or deliver copies to: Texas Health Tuition Reimbursement Program 612 E. Lamar Blvd., Suite 400 Arlington, TX 76011-4014
Requesting advance funds	You may request advance tuition assistance if you are a full-time employee with an annual base benefits pay of $25,000 or less or a part-time benefits-eligible employee with an annual base benefits rate of pay of less than $12,250. All eligibility, maximums, and other policy requirements apply to advances. More information about advance funds is provided later in this section.
Expenses that are not covered	The Tuition Reimbursement Program does not reimburse charges for professional meetings, workshops, drop fees, exam fees, late fees, supply kits, conventions, licensures, room and board, parking fees, uniforms, drug screen, background check, professional certification courses, CEUs, shipping and handling, supplies, lab packs, laptops, software, nurse skills pack, insurance costs, review courses, tests or preparation for tests (such as NCLEX, GMAT, LMAT, MCAT, and TASP), or fees to CLEP. Books purchased from individuals. Tuition and fees for degree plans that do not benefit Texas Health or your position at Texas Health.
Taxation of tuition reimbursement	Reimbursements of up to $5,250 per tax year are not taxable income. Any paid reimbursement that exceeds $5,250 in a calendar year will be taxed even if the payment was for the prior benefit year.

CHANGES IN EMPLOYMENT

Topic	Description
If you are hired by Texas Health in a clinical position	Non-clinical employees who currently participate in the Tuition Reimbursement Program may qualify for a $4,000 transition assistance if they are hired by Texas Health in a clinical position (if they are .8 FTE or more) within six months of graduation. The assistance, which is taxable income, is intended to help with the transition into the work setting and cover expenses such as housing deposits and relocation costs. If you leave Texas Health or transfer to a non-clinical position or non-benefits-eligible position before completing two years employment in a full-time clinical position, you are required to repay the full $4,000. Texas Health will make every effort to recover all outstanding Tuition Reimbursement funds (including transition assistance). This includes deducting any amount due from available funds in the possession of Texas Health (payroll checks, PTO), as well as utilizing outside collection agencies. After two years of service in a full-time clinical position with Texas Health, the assistance will be completely forgiven. Employees must apply for the assistance within one year of being hired by Texas Health in a full-time clinical position. You can obtain a transition assistance application from Human Resources. Assistance will not be paid until you provide proof that you have passed your boards and you are actively at work in a clinical position at the time the assistance is requested and processed.
If your employment status changes	If your employment terminates or you change to a non-benefits-eligible status (such as PRN or part-time benefits-ineligible, as defined on page 165) within 12 months of completing the courses, you will be required to repay the reimbursed funds paid on your behalf (including transition assistance and educational assistance payments) to Texas Health. However, if your position is eliminated and you are eligible for separation pay or if your position is changed to non-benefits-eligible status, you will not be required to repay the funds as long as you searched for a position and did not turn down a reasonable offer. If you terminate or give notice that you will terminate or change to a non-benefits-eligible position before completing the course, you will not receive the tuition reimbursement for your courses, even if you have prior approval. All advance funds paid to you or your school could be deducted from your final regular paycheck (this includes any PTO payout you might receive). You will be responsible to reimburse Texas Health for any uncollected amounts.

ADVANCE FUNDS

If you are a full-time employee with an annual benefits base rate of $25,000 or less or a part-time employee with an annual benefits base rate of $12,250 or less, you qualify for advance funds. Texas Health will pay for your coursework in advance once your application is approved. You will need to print a voucher and give it to the school as your source of payment.

If you have already paid for your classes and want to request advance funds, you may ask for immediate reimbursement of the payment by submitting your class schedule and paid invoice itemizing the cost of tuition and recurring mandatory fees. Recurring fees do not include fees for parking, insurance, or transportation fees. Fax these documents, along with the Reimbursement Request Form. Write "Advance Funds Requested" in large letters on the form and fax it to 682-236-7291.

If you are in a clinical degree plan and eligible for advance funds, you may also request advance reimbursement for your textbooks. Buy your books and submit a copy of the itemized book receipt listing the names of the books along with a Tuition Reimbursement Request form.

If your final grade is not a C or above (or passing in a pass/fail class) or you do not submit your grades within 60 days after completing the course, the advance funds and book reimbursement that Texas Health paid in advance will be deducted from your pay over a number of pay periods, listed in the table below.

If you received advance funds and you are required to repay Texas Health, your payments will be deducted from your pay over a number of pay periods based on the amount you owe Texas Health.

If you owe this amount:	Your repayments will be over:
$2,000 or more	15 pay periods
$1,000 – $1,999	10 pay periods
$500 – $999	8 pay periods
$300 – $499	6 pay periods
$200 – $299	4 pay periods
$199 or less	$50 a pay period

Payroll deductions will be at least $50. However, the final deduction may be lower if you owe less than $50. You are not eligible for further advance funds until you have completely repaid the amount you owe. If you terminate your employment with Texas Health, the amount you still owe to Texas Health will be deducted from your final paycheck (this includes any PTO payout you might receive). If your final paycheck is less than the amount you owe, you must repay Texas Health for any remaining balance.

MAKE THE MOST OF TUITION REIMBURSEMENT

Texas Health's Tuition Reimbursement Program is designed to encourage you to further your education. Whether you are pursuing a clinical or non-clinical degree or a GED, Texas Health encourages you to participate in this generous program.

If you have questions call 1-877-MyTHRLink (1-877-698-4754), prompt 6, press 2 or send an email to THRTuitionReimbursement@texashealth.org.

PROGRAMS SPONSORED BY THE CENTER FOR LEARNING

If you are in a clinical program sponsored by the Center for Learning, you may be eligible for advancement of funds for books at beginning of the semester. Reimbursement will be made directly to the book distributor. You must have an approved tuition reimbursement application on file at the beginning of the semester or start of courses. If you withdraw or do not pass the course, you will be required to reimburse Texas Health for the advanced amounts.

Prodigy students who remain in a benefits-eligible status will be eligible for Tuition Reimbursement of up to $5,520 per year regardless of student status.

If you are in a Texas Health sponsored accelerated clinical degree program, you may be eligible for a $4,000 educational allowance if you meet the requirements of the program. Contact your career counseling specialist in The Center for Learning at 682-236-6161 for additional information.

Adoption Assistance Program

You may receive reimbursement of costs for legally adopting a child under age 18, unless mentally impaired, while you are employed at Texas Health. The Adoption Assistance Program will reimburse you up to $2,000 per adoption, per year, per family, after you submit the necessary documentation to Human Resources and the adoption is final. You must submit your request within 90 days of the date of adoption.

You must include the final Decree of Adoption, a Letter of Possession (if applicable) and a copy of itemized bills along with the adoption assistance application found online at **www.MyTHR.org**. The amount you are reimbursed will not exceed the actual expenses you have incurred.

WHO IS ELIGIBLE

Full-time and part-time benefits-eligible employees (as defined on page 5) are eligible for this benefit. You must have at least one year of service and be in a benefits-eligible position at the time you make the application and the child is placed in your home. You must be in benefits-eligible active status in the HR/Payroll System at the time payment is made.

You may not be reimbursed for adoption expenses for one spouse to adopt the other spouse's children (for example, children from a previous marriage).

Leaving Texas Health

When Coverage Ends

Coverage for you and your covered dependents under the Texas Health Medical, Dental, Vision, STD, LTD, Life Insurance, AD&D, and Flexible Spending Accounts Plans ends when you:

- No longer meet the eligibility requirements (see page 5)
- Terminate employment (Texas Health Medical, Dental, and Vision coverages, as well as participation in FSA, end on the last day of the pay period in which you terminate.)
- Die
- Retire
- Cancel or drop coverage (includes failing to re-enroll)
- Become a full-time, active-duty member of the armed forces of any country for more than 30 days. The disability plan extends coverage for up to two months if you pay the premium.
- Commit an act, practice, or omission that constitutes fraud, or an intentional misrepresentation of a material fact including, but not limited to, false information relating to another person's eligibility or status as a dependent. Texas Health has the right to request complete documentation of dependent status, eligibility for coverage or change in coverage or of a claim for benefits.
- Knowingly provide incorrect information or submit false or fraudulent claims information (termination is retroactive to the first day of coverage). Texas Health has the right to request complete documentation of dependent status, eligibility for coverage or change in coverage or of a claim for benefits. Texas Health reserves the right to refuse coverage of benefits if we don't believe the facts are accurate
- Fail to make the required contributions
- Fail to comply with the plan's subrogation provisions.

Coverage for you and your dependents will also end on:

- The date the plan is terminated
- The date the plan is modified, eliminating any benefits for your employment classification.

Coverage for your dependents also ends when:

- The dependent no longer meets the eligibility requirements or dies
- You have failed to provide timely documentation of your dependent's eligibility
- You terminate employment or cease to be eligible for coverage
- The plan no longer covers dependents
- The dependent knowingly provides incorrect information or submits a false or fraudulent claim, in which case coverage ends retroactively
- The dependent fails to comply with the plan's subrogation provisions.

In some cases, you and your covered dependents may be eligible for COBRA continuation coverage, as explained on the next page.

For 12 weeks following your termination, you and your eligible covered dependents may continue to use the Employee Assistance Program. The program is explained on page 60.

Coverage After Termination

Under certain circumstances, you may have the right to request a temporary extension of coverage under Texas Health's medical, dental, and vision plans and the health care spending account. This section describes that right to continuation coverage. It generally explains when continuation may become available to you and your family and what you need to do to protect the right to receive it.

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) is a federal law that requires Texas Health to offer continuation coverage.

What is COBRA?

COBRA continuation coverage is coverage under Texas Health's medical, dental, and vision plans and the health care spending account that may be available if your coverage would otherwise end because you experience a ***qualifying event*** (described under "Who Is Eligible" on this page). Depending on the event, you and your covered dependents may be eligible for COBRA continuation coverage. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You must elect the same coverage when you initially elect COBRA.

All rules and procedures for filing claims and determining benefits under the plan for active employees also apply to continuation coverage.

Qualified beneficiaries who elect COBRA continuation coverage must pay for the coverage.

Who Is Eligible?

If you and/or your covered family members would otherwise lose coverage under the plan after a qualifying event, each person considered a qualified beneficiary (including you, your spouse, and your dependent children) may elect COBRA.

If you are an employee of Texas Health, you will become a qualified beneficiary if you lose your coverage under the plan because you experience one of these qualifying events:

- Your hours are reduced to part-time, non-benefits-eligible
- Your employment ends for any reason other than your gross misconduct
- Texas Health begins bankruptcy.

Your spouse will become a qualified beneficiary if he or she loses your coverage under the plan because you experience one of these qualifying events:

- You die
- You no longer meet the eligibility requirements for benefits, as explained on page 5
- Your employment ends for any reason other than your gross misconduct
- You become entitled to Medicare benefits (under Part A, Part B, or both)
- You and your spouse divorce.

You will be notified of your rights to COBRA continuation coverage only after the COBRA administrator has been notified that one of the above qualifying events has occurred. Texas Health must notify the COBRA administrator of these qualifying events.

Your dependent children will become qualified beneficiaries if they lose coverage under the plan because:

- You (the parent-employee) die
- You no longer meet the eligibility requirements for benefits, as explained on page 5
- Your employment ends for any reason other than your gross misconduct
- You become entitled to Medicare benefits (Part A, Part B, or both)
- You and your spouse divorce
- The child stops being eligible for coverage as a dependent child under the plan.

Sometimes, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a qualifying event. If Texas Health files a bankruptcy proceeding that results in the loss of coverage for retired employees covered under the plan, the retired employee, employee's spouse, and dependent children also become qualified beneficiaries.

Your Responsibility for Notifying the COBRA Administrator

For some qualifying events, you must notify Texas Health within 31 days after the event occurs. You must provide this notice to the Human Resources Department at your entity if:

- You and your spouse divorce
- A dependent child loses eligibility for coverage as a dependent child.

When Continuation Coverage Is Effective

If you or your dependents elect to continue coverage, after the COBRA administrator receives your premium payment, the coverage becomes effective on the date coverage would otherwise end.

How to Elect COBRA Continuation

You will automatically receive a letter and election form from Texas Health's COBRA administrator after your employment with Texas Health ends or you lose coverage because of a reduction in scheduled work hours. The letter will explain the available COBRA coverage and cost to continue coverage.

If you divorce or your dependent child no longer meets the requirements of a "dependent" under the plans, you, your spouse, your dependent, or your representative will receive a letter and election form from PayFlex after you go online to drop the dependent from coverage.

If your entity's Human Resources Department does not receive notice within 60 days of the event, your dependent will not be offered continuation coverage.

When Human Resources receives notice that a qualifying event has occurred, it will advise the COBRA administrator. You and/or your dependents will be notified by the COBRA administrator (at the address on record if you have not provided an updated address using the Benefits Change Form) of your right to continue coverage. You should receive the paperwork to elect continuation coverage within 44 days of your qualifying event. Within 60 days of the postmark date on the notice, you or your dependent must inform the COBRA administrator if you want to purchase continuation coverage.

If you do not elect to continue coverage within the 60-day time limit, your benefits under the medical, dental, and vision plans will end on the date of the qualifying event. You or your dependent cannot later elect to continue coverage.

HCSA Continuation

If you have the Health Care Spending Account (HCSA) plan as an active employee, you can elect to continue this plan under COBRA until the end of the plan year (which ends December 31). However, you may not elect the HCSA during Open Enrollment. If you elect to continue the health care spending account, you must continue making the full contribution to the account.

Although your contributions will be on an after-tax basis, you will still have the opportunity to file claims for reimbursement based on your account balance for the year. Continued coverage under the health care account will last until March 15 following the end of the plan year. The use it or lose it rule will continue to apply, so any unused amounts will be forfeited and coverage will terminate at the end of the plan year.

Paying for Continuation Coverage

To keep your COBRA continuation coverage, you must pay the full cost of continuation coverage on time, including any additional expenses permitted by law. If you elect continuation coverage, you will receive a statement from the COBRA administrator indicating when each payment is due.

The cost of continuation coverage is typically 102% of the total premium (the employee's and the company's combined cost, plus a 2% fee for administrative expenses). However, if continuation coverage is extended from 18 months to 29 months due to disability, the cost increases to 150% of the total premium.

How Long Coverage Continues

After the COBRA administrator receives notice of a qualifying event, they will send information about electing COBRA to each qualified beneficiary. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is temporary.

18 MONTHS

You, your spouse, and dependent children may elect continuation coverage for up to 18 months if:

- You end your employment with Texas Health
- You no longer meet the eligibility requirements for benefits as explained on page 5.

36 MONTHS

Your spouse and dependent children may elect continued coverage for up to 36 months if:

- You die
- You become entitled to Medicare benefits (under Part A, Part B, or both)
- Your and your spouse divorce
- Your dependent child loses eligibility as a dependent child.

If you become entitled to Medicare benefits less than 18 months before the end of employment or before you lose eligibility for benefits (as explained on page 5) qualified beneficiaries (other than the employee) may elect continuation coverage for up to 36 months after the date of Medicare entitlement.

For example, if your employment ends eight months after you become entitled to Medicare, your spouse and children can continue coverage for up to 28 months after the date of the qualifying event (36 months minus 8 months).

EXTENDING COBRA FOR DISABILITY

In case of disability, you and your entire family may be entitled to receive up to 11 additional months of COBRA continuation coverage (for a maximum of 29 months).

The disability must have started before the 60th day of the COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

To qualify for the extension, you must timely notify the COBRA Administrator in writing and provide documentation of the disability from the Social Security Administration within 60 days of the later of the following:

- The date of the Social Security disability determination,
- The date the qualifying event occurs,
- The date you lose (or would lose) coverage as a result of the qualifying event, or
- The date you receive the general COBRA notice.

EXTENDING COBRA FOR A SECOND QUALIFYING EVENT

If your family experiences another qualifying event while receiving 18 months of continuation coverage, your spouse and dependent children can get up to 18 additional months of continuation coverage—for a maximum of 36 months if the plan receives proper notice of the second qualifying event.

You must make sure that the COBRA administrator is notified in writing of the second qualifying event within 60 days of that event. This notice should include a death certificate or divorce decree, if applicable. You may mail, fax, or hand-deliver the notice.

This extension may be available to your spouse and dependent children if the event would have caused them to lose coverage under the plan if the first qualifying event had not occurred.

Your spouse and any dependent children may receive an extension if you (the employee or former employee):

- Die
- Become entitled to Medicare benefits (under Part A, Part B, or both)
- Become divorced.

A dependent child may also receive an extension if he or she stops being eligible under the plan as a dependent child and Texas Health is notified timely.

Changing Your Coverage

When you elect COBRA continuation coverage, you must keep the same plan you had as an active employee or dependent of an employee. For example, if you elected the Choice Plan 500 High as a benefits-eligible employee with Texas Health, you must continue that plan under COBRA. You have an opportunity to change your plan during open enrollment, which is generally in November.

Prior to open enrollment, an enrollment guide is mailed to the home of a COBRA participant explaining the plan changes beginning January 1 of the next year. Also included with the guide is an enrollment form. If you want to keep the same plan, you do not need to complete the form. To change your plan, you need to complete the form and mail it to PayFlex by the deadline for open enrollment. Your new election will take effect on January 1. You may not re-enroll in an HCSA.

If You Gain a New Dependent

If you elect continuation coverage for yourself and later marry, a child is born to you, or you adopt a child while covered by continuation coverage, you may elect coverage for your newly acquired dependents after the qualifying event. To add your dependents, notify the COBRA administrator within 60 days of the marriage, birth, or adoption.

If you get married after your COBRA coverage takes effect, you may only add coverage under the Total Health Medical Plan for your stepchild(ren) if you also elect coverage for the child's parent (your spouse). This provision does not apply to dental and vision.

A new dependent may be a participant under this coverage for the remainder of your continuation period (18, 29, or 36 months, depending on the qualifying event). This new dependent will not have the right to continue coverage on his or her own if a divorce or other event causes loss of coverage.

If Your Address Changes

To protect your family's rights, you should keep the plan administrator informed of any address changes of family members. You should also keep a copy, for your records, of any notices you send to Texas Health or the COBRA administrator.

When Continuation Coverage Ends

Coverage automatically ends on the earliest of the following dates:

- The maximum continuation period (18, 29, or 36 months) expires.
- Full premium payment for continuation coverage is not received by the COBRA administrator within 30 days after the payment due date. Partial payment or checks returned for non-sufficient funds ("NSF" or "bounced") are considered non-payment of premium.
- The person who is continuing coverage becomes covered under any other group medical, dental, or vision plan, unless that plan contains a pre-existing condition limitation that affects the plan participant. In that event, the participant is entitled to continuation coverage up to the maximum time period.
- The person continuing coverage becomes entitled to Medicare.
- Texas Health no longer provides the coverage for any of its employees or their dependents.
- The person continuing coverage is no longer disabled after he or she has already received 18 months of continuation coverage.

If You Have Questions

Questions concerning your plan or your COBRA continuation coverage rights should be addressed to the plan administrator, Texas Health, or the COBRA administrator (PayFlex). Their addresses and phone numbers are listed on the back cover of this Handbook. You may also contact them for information about your rights and obligations under each plan and under federal law.

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) or visit the EBSA website at **www.dol.gov/ebsa**. (The address and phone number of Regional and District EBSA Offices are available on the website.)

Separation Pay Plan

Overview

The Texas Health Separation Pay Plan is designed to provide a consistent process to help employees whose positions have been eliminated as a result of a restructuring, redesign, the sale/divestiture of a company or entity, or other changes in operations or business conditions.

Who is Eligible

The Separation Pay Plan applies to full- and part-time benefits-eligible employees (as defined on page 5) whose positions are eliminated. PRN and part-time benefits-ineligible employees, administrative residents/interns/fellows, medical directors, medical residents/interns, interns, THPG physicians, and employees under contract are not eligible for the plan. Employee status, base pay, and years of service are determined by Texas Health's HR/Payroll system.

When a Position Is Eliminated

Under this plan, you are considered to have your position eliminated if you are involuntarily separated because all or part of an entity, department, division, operating unit, or function is being outsourced, restructured, or closed. Employees who are terminated for cause (such as poor performance or violation of policy) will not be eligible for Separation Pay.

Transition Plan

A transition plan is required whenever positions are being eliminated because of outsourcing, restructuring, or closing of an entity, department, division, operating unit or function. The plan helps determine what will happen to the affected employees.

When management anticipates the need for a transition plan, they will consult with Human Resources to develop a plan that includes a summary of the need for transition, as well as the names and other information regarding employees who are potentially affected.

Notice

If your position is eliminated, as defined under the plan, you will receive notification and transition information when management and Human Resources have evaluated each employee's specific information. Options that may be available include transfer opportunities, career center services and, in certain situations, separation pay (as defined in the plan).

Generally, you will be given a minimum of 30 calendar days' notice before your position is eliminated. During this period, if you are in a staff or management position (not directors or officers) you will continue in your current position while pursuing other employment opportunities. You are required to actively search for other positions within Texas Health during the notice period, regardless of work status.

If you are a director or officer, you are not eligible for the notice period. In this case, your separation will be on the date agreed by your manager and Human Resources.

In certain situations, with the approval of the entity Human Resources Director, management may deem it necessary to separate an employee immediately. The employee will cease to be an active employee as of the date of separation.

Resignation During Notice Period

If you resign during the 30-day notice period, you will not be entitled to separation pay or pay for the remainder of the notice period.

Reasonable Offer

If, during the 30-day notice period, you fail to apply for a full-time or part-time position or refuse or decline one reasonable offer from Texas Health or an acquiring employer, you will be treated as having voluntarily separated and will not be eligible for separation pay.

Reasonable offer from Texas Health means an offer in which the employee meets minimum qualifications of the position (some additional training may be necessary) and the midpoint/marketpoint of the salary range for the new position is 80% or more of the salary range midpoint/marketpoint (based on the employee's hourly rate) for the employee's current position. An offer of a PRN position is not considered a reasonable offer.

A reasonable offer may include an offer that involves a change in your benefits status. You incur a change in benefits status if—before the elimination of your position you are full-time benefits-eligible—and after the elimination your new position will be:

- Part-time benefits-eligible or
- Part-time not benefits eligible.

You incur a change in benefits status if—before your position was eliminated, you were part-time benefits-eligible—and after the elimination in the new position will be part-time not benefits-eligible.

MARKETPOINT: a data point representing the 50th percentile of the market for a specific position

If you incur a change in your benefits status but you received an offer from Texas Health which meets the salary requirement, you have received a reasonable offer for purposes of the Separation Pay Plan. In this case, you may be eligible for transition pay. If you accept a PRN position (after researching and applying for full-time or part-time positions), you will not receive transition pay, but may be eligible for separation pay.

Transition pay is a percentage of the separation pay you would have received if you had not received a reasonable offer from Texas Health. The percentage is determined by a fraction:

- The numerator is the difference between:
  - The number of assigned hours before the position was eliminated
  - The number of assigned hours after the position was eliminated
- The denominator is the number of assigned hours before the position was eliminated.

The percentage is based on the change in your assigned number of hours as classified in the HR / Payroll system. Pay for the notice period is not taken into account in determining transition pay. An employee receiving transition pay is not entitled to the notice period. Transition pay is paid over a maximum period of six months with your regular paycheck. If you leave before the end of the six month period, you will lose the remainder of the transition pay.

If you are receiving transition pay and change to full-time benefits eligible employment status during the six-month period, you will stop receiving transition pay.

A reasonable offer from an acquiring employer means an offer for a position for which the employee meets the minimum qualifications (some additional training may be necessary) and the base pay offered is 95% or more of the employee's current base pay (as defined on the next page).

"Acquiring employer" for purposes of the plan, is an entity or person:

- To whom all or part of an entity, department, division, operating unit or function is outsourced
- That purchases or acquires all or part of the assets of an entity, department, division, operating unit or function to which the employee's job relates
- That performs the functions of the entity, department, division, operating unit or function; or
- That contracts with Texas Health to offer employment to employees whose positions have been eliminated.

A reasonable offer (either type) may also include a shift change, schedule change, or reassignment to a different department or operating unit if that operating unit is located no more than 49 miles from the employee's current work location.

The Career Center assists employees in identifying job opportunities for which they may be qualified. Employees are expected to actively pursue reasonable opportunities for which they are qualified. If, during the 30-day notice period, an employee fails to, does not or refuses to interview for an open position with Texas Health or an acquiring employer, he or she will not be eligible for separation pay.

Employees who continue working through their 30-day notice period are expected to meet and maintain all conditions of performance for their assigned job. Failure to do so may result in immediate separation with no separation pay.

Leave of Absence

If you receive a reasonable offer from an acquiring employer, your position may be eliminated even if you are on a protected leave of absence. If you are on a protected leave of absence and do not receive a reasonable offer from an acquiring employer, your position may not be eliminated during the leave. If your position is eliminated before you begin your protected leave of absence, the notice period will be extended by the time period of the protected leave of absence.

If you are on a leave of absence of any kind, other than a protected leave of absence, your position may be eliminated or terminated and you will not be entitled to notice or separation pay.

A "protected leave of absence" is an approved military leave or Family and Medical Leave Act leave at the end of which the employee has the right to be reemployed according to federal law. Any other type of leave of absence is not considered a protected leave of absence.

Failure to Investigate, Apply or Interview

During the notice period, you are expected to actively pursue job opportunities within Texas Health for which you are qualified and that may result in a reasonable offer. If you fail to investigate, apply or interview for open positions that could result in a reasonable offer, you will not be eligible for separation pay.

Transfer Pay Guidelines

If an employee accepts an offer within the Texas Health system, his or her pay will be determined as follows:

- If an employee accepts a position with the same or higher salary grade, Texas Health's compensation guidelines concerning lateral or promotional transfers will apply.
- If an employee accepts a position that is in a lower salary grade, and the employee's current base pay falls within the salary range for the position, the employee's base pay will not change.
- If the employee's current base pay is above the maximum of the new salary grade range, the employee's base pay will be adjusted to equal the maximum of the new salary range.

Benefits base pay will be adjusted according to the terms of the applicable benefits plan.

Separation Pay

Employees who have been unsuccessful in securing a new position may be eligible for separation pay (based on the level of the affected position and the employee's years of service) and internal Career Center services if he or she does not:

- Have a new position at the end of the 30-day notice period or
- Receive one reasonable offer from Texas Health or a Texas Health entity or
- Receive a reasonable offer from an acquiring employer.

An employee who meets all the requirements of the Separation Pay Plan will be entitled to separation pay according to the following table.

Employee's Base Pay	Amount of Separation Pay
Less than $45,000	1 week of base pay per year of service • 4 weeks of base pay minimum • 12 weeks of base pay maximum
$45,001 to $70,000	2 weeks of base pay per year of service • 4 weeks of base pay minimum • 26 weeks of base pay maximum
$70,001 to $100,000	4 weeks of base pay per year of service • 8 weeks of base pay minimum • 52 weeks of base pay maximum
$100,001 to $150,000	12 weeks of base pay per year of service • 26 weeks of base pay minimum • 78 weeks of base pay maximum
Over $150,000	12 weeks of base pay per year of service • 52 weeks of base pay minimum • 104 weeks of base pay maximum

Base pay is the employee's hourly pay rate multiplied by the number of hours per week the employee is classified to work in HR/ Payroll System. Base Pay does not include differentials, bonuses, overtime, or commissions.

Years of service is calculated beginning with the employee's most recent date of hire, each three hundred and sixty-five (365) day period that elapses or has elapsed while the employee is employed with THR. For purposes of determining an employee's years of service, the years of service before the employee's most recent hire date will not be taken into account unless crediting is required under THR's "Bridging of Service Policy" and the employee has not previously received separation pay from Texas Health for that service.

The receipt of separation pay is conditioned upon completion of the Agreement for Separation Pay and Release of Claims document and any other documents requested by Human Resources. The employee must sign and return the Agreement in the format required by Texas Health within 50 days after receiving the Agreement. In the event the employee does not sign and return the Agreement to Texas Health within 50 days or chooses to revoke the release in the seven-day period allowed by law, the employee is not eligible for separation pay.

Employment and Consulting

You will be required to repay all or part of your separation pay if you receive separation pay from Texas Health and then are either employed or engaged to do consulting work for Texas Health, the acquiring entity, or any entity that was part of the transaction that resulted in the elimination of your position.

The amount you will be required to repay is described in the Separation Pay Plan and is based on the number of weeks of separation pay you received and when you began employment or consulting. The Executive Vice President of People & Culture must approve all exceptions to the requirements of this section.

You are not required to repay any part of the separation pay if you are employed in a PRN position, provided you are accurately classified as a PRN. This determination will be at the discretion of the Executive Vice President of People and Culture.

Payment

After you satisfy all of the conditions of the Separation Pay Plan, you will receive separation pay in a lump sum, less applicable withholding, within 90 days of your termination of employment (and not less than seven days) after returning the completed and signed agreement to Texas Health.

FOR MORE information, please see the Texas Health Separation Pay Policy that can be found on MyTexasHealth or request a copy of the plan from Human Resources.

Claims and Administration

Claims Information

Payment of Benefits

Your benefit plans are intended to pay benefits only to you or your beneficiaries. Your benefits cannot be used as collateral for loans or be assigned in any other way. However, benefits under the Texas Health Retirement Program may be divided under a Qualified Domestic Relations Order (described on page 7) and medical, dental, and vision claims may be assigned to the health care provider.

If you are unable to receive any payment due to you under any of the plans, payment may be made to any person providing for your care, your guardian, your beneficiaries, or your estate. Such payments will release Texas Health of its obligation with regard to that claim.

Right of Recovery

If you receive any overpayment of benefits by a Texas Health plan, the plan will have the right to recover the overpayment from you. If you receive a benefit greater than allowed by the plan, you will be requested to refund the overpayment. If you do not submit the refund, the amount of overpayment will be deducted from future benefits you receive from the plan.

Reimbursement

If you recover damages for an injury or illness (for example, if you receive a settlement from your insurance company, the person who caused the injury or illness or that person's insurance carrier), the Texas Health plans (other than under the Texas Health Retirement Program or the Texas Health Dental Plan) have a right to be reimbursed for the amount of benefits it has paid on your behalf for treatment of the injury or illness.

As a condition for receiving benefits, you:

- Grant the plan a first lien against any settlement, verdict, or other amounts you receive
- Assign to the plan any medical benefits you are eligible to receive under an automobile policy or other coverage, up to the amount the plan has paid in benefits
- Agree to sign and deliver any documents necessary to help the plan protect its rights (refusal to sign these documents does not diminish the plan's reimbursement rights)
- Assist the plan by complying with any reasonable request to help the plan recover any benefits it has paid, without taking any action that may prejudice the plan's right to reimbursement.

Misstatements of Fact

Any material misstatement you make regarding the age, sex, marital status, or other condition or status of any person covered under a Texas Health plan may be grounds for adjustment of payments due under any plan.

Subrogation

If you receive benefits under the Texas Health benefit plans (other than the Texas Health Retirement Program) for an injury or illness resulting from any negligent or any willful act or omission by any person, company or organization, the plan will be subrogated to all rights of recovery that you may have against that third party. This means that when you accept payment of benefits under the Texas Health benefit plan, you assign your rights of recovery from the third party to the plan and agree to do whatever may be necessary to secure recovery, including execution of all appropriate agreements or other papers.

By accepting benefits under the Texas Health plans, you agree to assign to Texas Health the right to the first dollars you receive—including for general damages—up to the full amount paid by the plan. If you fail to comply with this requirement, your benefits under the Texas Health plan will stop and your coverage will terminate.

Denial of Claims

Please refer to each section of this Handbook to determine how to submit a claim for that plan (medical, dental, vision).

NON-DISABILITY CLAIMS

If you file a claim under any of the following plans and any portion of that claim is denied, you will receive a written notice. Plans include:

- Dependent Care Flexible Spending Account
- Life Insurance
- AD&D Insurance
- Business Travel Accident Insurance
- Texas Health Retirement Program (except for disability benefits)
- Separation Pay Program.

The notice will be sent to you within 90 days from the date the claims administrator received your claim. If more time is needed (up to a total of 180 days), you will be notified within the first 90 days (except for disability claims).

Any denial notice you receive will explain:

- Specific reasons for the denial
- Specific reference to pertinent plan provisions upon which the denial was based
- Description of any additional information or material necessary to complete the claim and an explanation of why such information or material is necessary
- The steps to take if you wish to submit the claim for further review.

REQUESTING A SECOND REVIEW FOR NON-DISABILITY

If you wish to request a second review of a denied claim (except for disability benefits under the STD, LTD, and Texas Health Retirement Plan), you have 60 days after receiving the denial to request a review by the People and Culture Committee or, in the case of a fully insured plan, the appropriate insurance carrier. You must make your request in writing. You also have the right to review pertinent documents, submit comments and have a representative act on your behalf.

You will receive a written notice of the Committee's or insurance company's decision within 60 days after a review is requested. In special cases, the review can take an additional 60 days, and you will be notified if this additional time is necessary. The Committee has the sole right to determine whether or not you or your representative will personally appear in any review.

The decision of the Committee or insurance carrier is final. You will receive a written notice of the decision. If you still feel that your claim has been improperly denied, refer to the section of this guide entitled "Your ERISA Rights" (beginning on page 152) for a description of your legal rights.

DISABILITY CLAIMS

This applies to STD, LTD, and the Texas Health Retirement Plan. The claims administrator will make a decision no more than 45 days after receipt of your claim. The claims administrator may extend the time period for two additional 30-day periods provided they:

- Give you written notification in advance that the extension is necessary for reasons beyond the control of the plan
- Explain the reason for the extension, and
- Give the date by which they expect to render a decision.

If your claim is extended because you have failed to submit information necessary to decide your claim, the time period for the decision will be counted from the date the claims administrator sends you notification of the extension until the date the claims administrator receives your response to its request.

The written decision from the claims administrator will include:

- Specific reasons for the decision
- Specific references to the plan provisions on which the decision is based
- A description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary
- A description of the review procedures and applicable time limits for those procedures
- A statement that you have the right to bring a civil action under section 502(a) of ERISA after you have appealed the decision and received a written denial on appeal, and
- If the denial was based on:
  - An internal rule, guideline, protocol, or other similar criterion, either:
    - The specific rule, guideline, protocol or other similar criterion or
    - A statement that the rule, guideline, protocol or other similar criterion was relied upon in making the denial and that a copy will be provided to you free of charge upon request.
  - Medical judgment, either:
    - An explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to your medical circumstances or
    - A statement that an explanation will be provided to you free of charge upon your request.

REQUESTING A SECOND REVIEW FOR DISABILITY

If all or part of your claim for disability benefits under the STD, LTD, and Texas Health Retirement Program is denied, you or your representative may appeal to the claims administrator for a full and fair review. You may:

- Make a written application for review within 180 days of the claim denial
- Request, free of charge, copies of all documents, records, and other information relevant to your claim, and
- Submit written comments, documents, records and other information relating to your claim.

The claims administrator will make a decision no more than 45 days after it receives your appeal. The time for decision may be extended for one additional 45-day period provided that, before the extension, the claims administrator notifies you in writing that an extension is necessary because of special circumstances, identifies those circumstances, and gives the date by which it expects to render its decision.

If your claim is extended because you have failed to submit information necessary to decide your claim on appeal, the time for decision will be counted from the date the notification of the extension is sent to you until the date the insurance company receives your response to the request. The written decision will include specific references to the plan provisions on which the decision is based and any other notice, statement, or information required by applicable law.

You may file a lawsuit for benefits only after you have exercised all appeals described in this section and all or part of the benefits you request on appeal have been denied.

WAIVER OF PREMIUM FOR LIFE INSURANCE

If you feel you are entitled to a waiver of premium for disability under Basic or Additional Life Insurance, you must file a claim with the life insurance claims administrator. The claims administrator will advise you of its decision within 45 days. The claims administrator may extend this time period for two additional 30-day periods while gathering information needed to make a decision, but only if the reason for delay is beyond its control.

You have up to 180 days to appeal an adverse benefit determination. You must make your appeal in writing and address it to the appeals unit of the claims administrator. The claims administrator will decide your appeal within 45 days. Under special circumstances, the claims administrator may extend the period for an additional 45 days.

Administrative Information

Following are some important administrative details concerning the benefit plans offered by Texas Health that are subject to the Employee Retirement Income Security Act of 1974 (ERISA), as amended from time to time. These plans are listed on pages 154 – 155.

Your ERISA Rights

This section contains statements of your rights under ERISA. This notice follows the format provided by federal regulations and summarizes your rights under the law. As a participant in a plan governed by ERISA, you have been given information about such plan coverages and benefits.

To help plan participants reduce disputes and to avoid inconvenience or delay of payment for eligible expenses, this Handbook provides descriptions of claim and appeal procedures on pages 41 - 49, 71 - 73, 76 - 77 and 149 - 150, as well as addresses, telephone numbers, and other references where you may obtain additional information and assistance.

This Handbook summarizes the benefits offered by Texas Health. The Handbook does not attempt to cover all details.

All participants in ERISA plans may:

- Examine all plan documents and copies of all documents, such as the annual report (Form 5500) and plan description. These documents can be examined without charge in the plan administrator's office.
- Receive, upon written request, plan documents, contracts, and other plan information from the plan administrator. The plan administrator may make a reasonable charge for the copies. Any materials requested should be received within 30 days of receipt of your request unless the materials are not sent because of circumstances beyond the control of the plan administrator.
- Receive a summary of each benefit plan's annual report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.
- Continue health coverage for yourself, your spouse, and/or your eligible dependents if any of you lose coverage because of a qualifying event. You must pay for this continued coverage.
- Reduce or eliminate any pre-existing condition limitations of this plan if you have a certificate of creditable coverage from another plan. Your former plan should provide this certificate at no cost when you lose coverage under that plan, become eligible for COBRA coverage, or when COBRA coverage ends. If you do not provide a certificate of creditable coverage, you may be subject to a pre-existing condition limitations for 12 months after you enroll (or 18 months if you do not enroll when first eligible).

The plan administrator makes available all documents required by law, including a summary of the plan's Annual Financial Report. Additional information is also provided that may be helpful to you in making the best use of your benefits.

PLAN FIDUCIARIES

ERISA imposes obligations upon those persons responsible for the operation of the plans. Such persons are called "fiduciaries." Fiduciaries must act solely in the interest of the plan participants, and they must act prudently in the performance of their duties. Fiduciaries may be removed for violating these rules and are required to make good any losses they have caused the plans.

In carrying out their respective responsibilities under the plan, the plan administrator and other plan fiduciaries shall have discretionary authority to interpret the terms of the plan and to determine eligibility for and entitlement to plan benefits in accordance with the terms of the plan. Any interpretation or determination made pursuant to such discretionary authority shall be given full force and effect under the plan, unless it can be shown that the interpretation or determination was arbitrary and capricious.

No one may discharge you, or otherwise discriminate against you, to prevent you from receiving a benefit or from exercising rights under ERISA.

If your claim for benefits is denied or ignored, in whole or in part, you have a right to know the reason, to obtain copies of documents (free of charge) relating to the decision, and to appeal any denial—all within certain time schedules.

Under ERISA, there are steps you can take to enforce your rights. For example, if you request a copy of the plan documents or the latest annual report from the plan and you do not receive them within 30 days, you may file suit in a federal court. In this case, the court may require the plan administrator to provide the materials and pay up to $110 a day until you receive the materials (unless the materials were not sent for reasons beyond the control of the administrator).

If your claim for benefit was denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision (or lack of decision) concerning the qualified status of a domestic relations order or medical child support order, you may file suit in a federal court.

If the fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay the court costs and legal fees. If you are successful, the court may order the person you have sued to pay theses costs and fees. If you lose, the court may order you to pay these costs and fees—for example if it finds your claim is frivolous.

If you have any questions about this statement or about your rights under ERISA or the Health Insurance Portability and Accountability Act of 1996 (HIPAA), contact the plan administrator or:

- The nearest area office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory
- The Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

You may also request certain publications about your rights and responsibilities by calling the publications hotline at the Employee Benefits Security Administration (formerly called the Pension and Welfare Benefits Administration) at 1-866-444-3272.

Plan Amendments

The People and Culture Committee, under the authority granted to it by the Board of Trustees, has the sole authority to adopt and/or amend benefit plans. The People and Culture Committee, in consultation with actuaries, consultants, Human Resources, and the Legal Department, has the discretion to adopt such rules, forms, procedures, and amendments it determines are necessary for the administration of employee benefit plans according to their terms, applicable law, regulation, or to further the objectives of the employee benefit plans.

Plan Sponsor

Texas Health is the plan sponsor for all plans described in this Handbook.

Attn: Plan Administrator
Texas Health
612 E. Lamar Blvd., Suite 900
Arlington, Texas 76011

Plan Administration

Texas Health is the plan administrator for all the benefit plans listed in this Handbook. The People and Culture Committee acts on behalf of Texas Health in its capacity as plan administrator. The People and Culture Committee can be reached at:

People and Culture Committee
Attn: Executive Vice President, People & Culture
Texas Health
612 E. Lamar Blvd., Suite 900
Arlington, Texas 76011
682-236-7900

Members of the People and Culture Committee are appointed by the Board of Trustees of Texas Health. The current members of the People and Culture Committee are:

- Richard M. Vigness, M.D.—Chair and Texas Health Board Member

  1307 8th Avenue, #601
  Fort Worth, TX 76104

- Rev. Jay L. Beavers, DMin—Texas Health Board Member

  517 Castlebrook Court
  Saginaw, TX 76179-0994

- Feliz Jarvis—Texas Health Board Member

  1235 N. Winnetka Ave.
  Dallas, TX 75208

- Jimmy C. Payton, Jr.—Texas Health Harris Methodist Hospital HEB Board Member

  P.O. Box 1662
  Euless, TX 76039

- Michael P. West, Ed.D., FACHE—External Community Member

  U.T. Arlington/Fort Worth Center
  1401 Jones Street
  Fort Worth, TX 76102

The People and Culture Committee has the authority, as outlined in each plan, to employ personnel and professionals as it deems advisable to assist in administration. It is the People and Culture Committee's duty to interpret each plan's provisions and make final decisions on matters such as eligibility and payment of benefits.

EMPLOYER IDENTIFICATION NUMBER

Texas Health's employer identification number is 75-2702388.

PLAN TRUSTEES

The current trustees of the Texas Health Retirement Program are:

- Richard M. Vigness, M.D.—Chair and Texas Health Board Member

  1307 8th Avenue, #601
  Fort Worth, TX 76104

- Rev. Jay L. Beavers, DMin—Texas Health Board Member

  517 Castlebrook Court
  Saginaw, TX 76179-0994

- Feliz Jarvis—Texas Health Board Member

  1235 N. Winnetka Ave.
  Dallas, TX 75208

- Jimmy C. Payton, Jr.—Texas Health Harris Methodist Hospital HEB Board Member

  P.O. Box 1662
  Euless, TX 76039

- Michael P. West, Ed.D., FACHE—External Community Member

  U.T. Arlington/Fort Worth Center
  1401 Jones Street
  Fort Worth, TX 76102

AGENT FOR SERVICE OF LEGAL PROCESS

Texas Health Resources
Charles Boes, General Counsel
612 E. Lamar Blvd., Suite 900
Arlington, TX 76011

Service of process may also be made upon a plan trustee or plan administrator.

PLAN YEAR

The plan year is January 1 through December 31 for all plans listed in this Handbook.

CLAIMS ADMINISTRATORS

Texas Health administers the plans listed below. The hospitals, physicians, dentists, and other service providers that participate in the Medical, Dental, and Vision Plan networks are completely independent of the company. Neither Texas Health, your employer nor the network administrators are responsible for the services provided.

Plan Name	Plan Number	Plan Type	Plan Funding	Administrator
Total Health Medical Plan				
• UHC Choice and Choice Plus	501	Self-funded medical plans [1]	Self-funded	UnitedHealthcare [2]
• Caremark	501	Self-funded [1]	Self-funded	Caremark [2]
Be Healthy	501	Wellness	Funded by company	UnitedHealthcare
MHN Employee Assistance Program (EAP)	501	Employee Assistance Program	Funded by company	MHN
Texas Health Dental Plan • Aetna® Managed Dental Plan (DMO®) • Aetna PPO (Low Option) • Aetna PDN (High Option)	502	Fully insured dental plans	Premiums are paid by employee contributions	• Aetna Managed Dental Plan (DMO)®[3] • Aetna PPO (Low Option) [3] • Aetna PDN (High Option) [3]
Superior Vision Plan	514	Fully insured vision plan through National Guardian Life Insurance Company	Premiums are paid by employee contributions	Superior Vision Plan [3]
Texas Health Short Term Disability Plan	503	Fully insured disability plan	Premiums are paid by employee contributions	CIGNA Group Insurance [3]
Texas Health Long Term Disability Plan	504	Fully insured disability plan	Basic LTD premiums are paid by the company and Additional LTD premiums are paid by employee contributions	CIGNA Group Insurance [3]

[1] Self-funded benefits are paid with company assets and employee contributions.

[2] Contract claims administrators are independent companies that provide claim payment services. They do not insure self-funded benefits.

[3] Insured claims administrators insure the benefits and provide claim payment services.

(Claims Administrators continue on next page)

CLAIMS ADMINISTRATORS (CONTINUED)

Plan Name	Plan Number	Plan Type	Plan Funding	Administrator
Texas Health Life and Accident Insurance Plan	505	Fully insured life, AD&D and business travel accident plans	Basic Life, Basic AD&D, and Business Travel Accident premiums are paid by the company. Additional Life, Dependent Life, and Additional AD&D premiums are paid by employee contributions	CIGNA Group Insurance [3] Life Insurance Company of North America (BTA) [3]
Long Term Care Insurance Plan	516	Fully insured long term care plan	Premiums are paid by employee contributions	Genworth Life Insurance Company [3]
Texas Health Flexible Benefits Plan	506	Self-funded cafeteria plan, Health Care Spending Account, and Day Care Spending Account	Funded by company and employee contributions	PayFlex [2]
Texas Health Separation Pay Plan	507	Self-funded severance pay plan	Funded by company	Texas Health
Texas Health Tuition Reimbursement Plan	508	Tuition Reimbursement Plan	Funded by company	Texas Health
Texas Health Adoption Assistance Plan	512	Adoption Assistance Plan	Funded by company	Texas Health

[1] Self-funded benefits are paid with company assets and employee contributions.

[2] Contract claims administrators are independent companies that provide claim payment services. They do not insure self-funded benefits.

[3] Insured claims administrators insure the benefits and provide claim payment services.

TEXAS HEALTH RETIREMENT PROGRAM PLAN ADMINISTRATION

The plans listed below have been adopted by specific affiliates of Texas Health. A complete list of employers who have adopted the plan is available from Human Resources at no cost to you. JPMorgan is the recordkeeper and contract administrator for the Texas Health Retirement Program. Plan expenses are paid by Texas Health, participating companies, or the plan. Plans are funded by contributions from employees, Texas Health, and other participating employers. Funds are invested by participant direction and held by JPMorgan. Employer and employee contributions are held in a trust/custodial account (403(b) only).

Plan Name	Plan Number	Plan Type
Texas Health 401(k) Retirement Plan	008	Salary deferral defined contribution plan
Frozen PHS and HMHS 403(b) Annuity Plan	006	Salary deferral defined contribution plan
Frozen PHS and HMHS 401(k) Plan	005	Salary deferral defined contribution plan
Frozen PHS 401(a) Plan	001	Money purchase plan
Frozen Prior Employer 401(k) Plan	009	Salary deferral defined contribution plan

Important Notice from Texas Health About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Texas Health and prescription drug coverage available for people with Medicare. It also explains the options you have under Medicare prescription drug coverage and can help you decide whether or not you want to enroll. At the end of this notice is information about where you can get help to make decisions about your prescription drug coverage.

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare through Medicare prescription drug plans and Medicare Advantage Plans that offer prescription drug coverage. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Texas Health has determined that the prescription drug coverage offered by the Total Health Medical Plan is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay and is considered Creditable Coverage.

Because your existing coverage is on average at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay extra if you later decide to enroll in Medicare prescription drug coverage.

Individuals can enroll in a Medicare prescription drug plan when they first become eligible for Medicare and each year from November 15 through December 31. Beneficiaries leaving employer/union coverage may be eligible for a Special Enrollment Period to sign up for a Medicare prescription drug plan.

You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

If you do decide to enroll in a Medicare prescription drug plan and drop your Texas Health prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back.

Please contact us for more information about what happens to your coverage if you enroll in a Medicare prescription drug plan.

See the 2013 Employee Benefits Guide or beginning on pages 23 and 39 – 41 of this Benefits Handbook for a description of the prescription drug coverage available under the Total Health Medical Plan.

Your Total Health Medical Plan coverage pays for other medical expenses, in addition to prescription drugs, and you will still be eligible to receive all of your current medical and prescription drug benefits if you choose to enroll in a Medicare prescription drug plan.

You should also know that if you drop or lose your coverage with Texas Health and don't enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more (a penalty) to enroll in Medicare prescription drug coverage later.

If you go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go 19 months without coverage, your premium will always be at least 19% higher than what many other people pay. You'll pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to enroll.

For more information about this notice or your current prescription drug coverage contact Human Resources or call 1-877-MyTHRLink (1-877-698-4754) prompt 3.

You will receive this notice annually and at other times in the future such as before the next period you can enroll in Medicare prescription drug coverage and if this coverage through Texas Health changes. You also may request a copy.

FOR MORE INFORMATION ABOUT YOUR OPTIONS UNDER MEDICARE PRESCRIPTION DRUG COVERAGE

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. For more information about Medicare prescription drug plans:

Visit **www.medicare.gov**.

- Call your State Health Insurance Assistance Program (see your copy of the Medicare and You handbook for their telephone number) for personalized help.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for Medicare prescription drug coverage is available. Information about this extra help is available from the Social Security Administration (SSA) online at **www.socialsecurity.gov**, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this notice. If you enroll in one of the new plans approved by Medicare which offers prescription drug coverage, you may be required to provide a copy of this notice when you join to show that you are not required to pay a higher premium amount.

Date:	10/20/12
Name of Sender:	Texas Health
Contact/Office:	Benefits Department
Address:	612 E. Lamar Blvd., Suite 400 Arlington, TX 76011
Phone number:	682-236-7236

Texas Health Group Health Plan 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.

Texas Health contracts with third party administrators (TPAs) to manage the administration of its medical, dental, vision, and health care spending account plans. In 2013, the medical TPA is UnitedHealthcare. The dental TPA is Aetna, the vision TPA is Superior Vision and the health care spending account TPA is PayFlex.

Demographic information about you and your family members (such as name, address, dependent names, date of birth and coverage levels) is provided to the appropriate TPA each pay period so their files contain the most current information. To protect your privacy even more, Texas Health may now require you to complete an Authorization form when you need assistance with a specific claim; to help you with an issue or in order to better administer other Texas Health benefit plans as described below. The following information describes how medical information about participants may be used and disclosed and how you can access this information.

UNDERSTANDING YOUR HEALTH INFORMATION

This Notice of Privacy Practices describes the privacy practices of Texas Health's Group Health Plan (GHP) for employees providing for medical, dental, vision, and health care spending account reimbursement. Federal law requires that any health information the GHP maintains that identifies participants remain private. Specifically, this notice describes your rights concerning your health information, the responsibilities of the GHP regarding your health information, how the GHP may use or disclose your health information, and whom you may contact regarding the GHP's privacy policies.

YOUR HEALTH INFORMATION RIGHTS

If you are a participant in Texas Health's medical, dental, vision, or health care spending account plan, you have the right to:

- Request, in writing, a restriction on certain uses and disclosures of your health information. However, agreement with the request is not required by law when compliance with the restriction cannot be guaranteed
- Inspect or obtain a copy of your health information
- Request, in writing, that your health information be amended if you feel the health information about you is incorrect or incomplete. You will be notified if the request cannot be granted.
- Request that your health information be communicated with you in a specific way or at a specific location. Reasonable requests will be accommodated.
- Obtain an accounting of disclosures of your health information
- Obtain a paper copy of this Notice of Privacy Practices on request.

You may exercise these rights as follows:

- The majority of information regarding the processing of health claims is maintained by third party administrators, contracted by the GHP to perform claims administration, payment, and coverage verification. As a result, you should direct your requests regarding this information to the third party administrators listed in the Important Contacts (inside back cover) of this Employee Benefits Handbook.
- All other requests may be directed to the Privacy Contact listed on this notice.

TEXAS HEALTH'S RESPONSIBILITIES

The GHP has certain responsibilities regarding your health information, including the requirement to:

- Maintain the privacy of your health information
- Provide you with this notice that describes the GHP's legal duties and privacy practices regarding the information it maintains about you
- Abide by the terms of the notice currently in effect.

The GHP reserves the right to change its information privacy policies and practices and to make the changes applicable to any health information that it maintains. If changes are made, the revised Notice of Privacy Practices will be made available on the Benefits website (**MyTexasHealth**) and will be supplied when requested by participants.

Use and Disclosure of Health Information Without Authorization

Certain use and disclosure of your health information is necessary and permitted by law to treat you, process payments for your treatment, and support the operations of the GHP and other involved entities. The following categories describe ways that the GHP may use or disclose your information. It provides some representative examples. All of the ways your health information is used or disclosed should fall within one of these categories:

- Treatment—your health information may be disclosed to a health care provider for your medical treatment.
- Payment—your health information may be used or disclosed to determine premiums under the GHP, establish whether the GHP is responsible for payment of your health care, and make payments for your health care. For example, before paying a doctor's bill, your medical information may be used to determine whether the terms of the GHP cover the medical care you received. Your medical information may also be disclosed to a health care provider or other person as needed for that person's payment activities.
- Health Care Operations—health care operations are activities that federal law considers important to the GHP's successful operation. Here are some examples. The GHP may:
  - Use your medical information to evaluate the performance of participating doctors under the GHP
  - Disclose your medical information to an auditor who will make sure that the GHP is following applicable laws
  - Contact you to give you information about treatment alternatives or other health-related benefits and services that may interest you
  - Disclose your medical information to a health care provider or health plan that is involved with your health care, as needed for that person's quality-related health care operations
  - Provide some services through contracts with third party business associates. An example is a TPA who performs claims administration, payment, and coverage verification. To protect your health information, the GHP requires these business associates to appropriately protect your information.

Disclosures Requiring Verbal Agreement

Your health information may be used or disclosed to tell someone responsible for your care about your location or condition. Your health information may be disclosed to your relative, friend, or other person you identify, if the information relates to that person's involvement with your health care or payment for your health care. In certain circumstances, you may need to provide authorization.

Disclosures Required by Law

The following disclosures of health information may be made without your written authorization or verbal agreement:

- When a disclosure is required by federal, state or local law, judicial or administrative proceedings, or for law enforcement (for example when responding to court orders)
- To persons authorized by law to receive public health information, including reports of disease, injury, birth, death, child abuse or neglect, food problems, or product defects
- To health oversight agencies, if authorized by law, to monitor the health care system, government benefit programs, or compliance with civil rights laws
- To organ procurement organizations for tissue donation and transplant
- For research purposes, when the research has been approved by an institutional review board that has reviewed the research proposal and established guidelines to provide for the privacy of your health information or the disclosure is of a limited data set, where personal identifiers have been removed
- To coroners and funeral directors for identification, determining the cause of death, or performing their duties as authorized by law
- To avoid a serious threat to the health or safety of a person or the public
- For specific government functions, such as protection of the President of the United States
- For workers' compensation purposes
- To military command authorities as required for members of the armed forces
- To authorized federal officials for national security and intelligence activities, as authorized by law
- To correctional institutions or law enforcement officials concerning the health information of inmates, as authorized by law.

Disclosures to the Plan Sponsor

The TPA, on behalf of the GHP, may disclose your health information to Texas Health as the Plan Sponsor if the disclosure is permitted by the plan document or by law. Also, the TPA may disclose summary medical information, from which information that identifies you has been removed, so Texas Health may change or terminate the GHP or obtain new premium bids. The TPA may disclose to Texas Health whether you are participating or enrolled in a benefit option offered by the GHP.

Required Uses and Disclosures

Under the law, the GHP must make disclosures when required by the Secretary of the Department of Health and Human Services to investigate or determine Texas Health's compliance with federal privacy law.

Uses and Disclosures Requiring Written Authorization

With your authorization, your personal health information may be disclosed to Texas Health, the Group Health Plan Sponsor, and used by Texas Health in connection with other benefit plans in the Texas Health system for the purpose of managing those plans and determining their effectiveness. For example, to evaluate the design and operation of the medical plan and other benefit plans/programs; to determine whether the disability program is being administered correctly; to determine whether the leave programs are being used appropriately; to review and evaluate the quality of the service provided by vendors for the various programs; and to determine the effectiveness of the disease management program and the wellness programs.

Any other uses or disclosures of your health information not addressed in this notice or otherwise required by law will be made only with your written authorization. You may revoke such authorization at any time.

Privacy Complaints

You have the right to file a complaint if you believe your privacy rights have been violated. This complaint may be addressed to the Privacy Contact listed in this notice, or to the Secretary of the Department of Health and Human Services. There will be no retaliation for registering a complaint.

Privacy Contact

Address any questions about this notice or how to exercise your privacy rights to the Texas Health Benefits office at (866) 35-HIPAA (866-354-4722).

Effective Date

April 14, 2003
Updated January 2007
Updated January 2008
Updated January 2009
Updated January 2010
Updated January 2011
Updated January 2012
Updated January 2013

Resources

Glossary

The following terms are important for understanding your benefits.

Active employee: An employee that is not in an unpaid or terminated status in PeopleSoft.

Assignment of benefits: You may authorize the claims processor to directly reimburse your medical service provider for your eligible expenses by requesting that the provider accept assignment of benefits. When you request assignment of benefits, you avoid paying the full cost of the medical service up front, filing a claim, and waiting for reimbursement. Your medical service provider generally files your medical claim for you if he or she accepts assignment.

Base pay: Your current hourly rate times the number of hours you are classified in the HR/Payroll system to work. Base pay does not include shift differentials, bonuses, overtime earnings, commissions, or any other compensation.

Benefits base rate (also called ABBR): Your annual base pay on the latest of: your hire date, your rehire date if rehired within 180 days of termination, October 1 of the previous year, or the date of your last change in job status.

Birthing center: A facility staffed by physicians which is licensed as a birthing center in its jurisdiction to provide prenatal, birth, postpartum, newborn, and gynecologic services to pregnant women.

Claims administrator: The third party or parties with whom Texas Health has contracted to process the claims for medical, dental, and prescription drug benefits under this plan.

Close relative: Your spouse, mother, father, sister, brother, child, grandparent, or in-laws.

COBRA: Consolidated Omnibus Budget Reconciliation Act (COBRA) gives workers and their families who lose their health benefits the right to choose to continue group health benefits provided by their group health plan for a limited period of time under certain circumstances. Examples include voluntary or involuntary job loss, reduction in the hours worked, transition between jobs, death, divorce, and other life events.

Coinsurance: The portion of an eligible expense you are required to pay. The medical plan pays the remaining percentage. For example, after you satisfy your deductible under the Texas Health Choice 500 plan, you pay 10% coinsurance for network hospitalization in a Texas Health Preferred Hospital and the plan pays 90%. Your coinsurance is applied toward your out-of-pocket maximum for the medical plan.

Complications of pregnancy: For any covered person, the word "illness" includes "complications of pregnancy."

Included are conditions distinct from, but caused or affected by pregnancy:

- Acute nephritis or nephrosis
- Cardiac decompensation or missed abortion
- Similar conditions as severe as these.

Also included are complications of the pregnancy itself:

- A non-elective Cesarean delivery
- An ectopic pregnancy
- Spontaneous termination when a live birth is not possible.

Concurrent Care Claims: If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an Urgent Care request for Benefits as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. UnitedHealthcare will make a determination on your request for the extended treatment within 24 hours from receipt of your request.

If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an Urgent Care request for Benefits and decided according to the time frames described above. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new request and decided according to post-service or pre-service time frames, whichever applies.

Convalescent or skilled nursing facility: An institution operated and licensed by the state as a skilled nursing facility, extended care facility or convalescent nursing home that meets all of the following conditions:

- Licensed to provide and is providing inpatient care for patients recovering from an injury or illness, professional nursing services rendered by a registered graduate nurse (R.N.), licensed practical nurse (L.P.N.), or licensed vocational nurse (L.V.N.) under the direction of a registered graduate nurse
- Licensed to provide and is providing physical restoration services to help patients reach a degree of body functioning to permit self-care in essential daily living activities

- Provides services for compensation from its patients and under the full-time supervision of a physician or registered graduate nurse
- Provides 24-hour nursing services by licensed nurses, under the direction of a full-time registered graduate nurse
- Maintains a complete medical record on each patient
- Is approved and licensed by Medicare
- Is not a place (other than incidentally) for the elderly, a place for rest, drug addicts, alcoholics, custodial or educational care, care of mental disorders or of the mentally retarded.

This term also applies to expenses incurred in an institution referring to itself as a skilled nursing facility, extended care facility, convalescent nursing home, or any similar name.

Copay: This is the specific dollar amount you pay for many covered service providers. For example, you pay $25 for an office visit to your primary physician or family doctor. Copays do not apply toward your deductible or out-of-pocket maximum. This is the portion of the charge collected when the service or supply is provided and before the plan pays benefits.

Cosmetic procedure: A procedure performed solely for the improvement of your appearance rather than for the improvement or restoration of bodily function. A cosmetic procedure includes any expense that does not qualify as a medical expense that is deductible under Section 213(d) of the Code.

Covered health services: Covered health services must be ordered by a physician and determined by the claims administrator to meet all of the following conditions:

- Provided to prevent, diagnose, or treat a sickness, injury, mental illness, or substance abuse, or any of their symptoms
- Not excluded by the plan and is not considered experimental, investigational, or unproven
- Appropriate and consistent with the symptoms and findings or diagnosis and treatment of the injury or illness
- The most appropriate supply or level of service that can be provided on a cost-effective basis (including, but not limited to, inpatient vs. outpatient care, electric vs. manual wheelchair, surgical vs. medical or other types of care)
- Performed in the least costly setting where the services can be solely and appropriately provided
- Not provided for the convenience of the covered person, physician, facility or any other person
- Under generally accepted medical standards, the service or treatment cannot be omitted without adversely affecting the patient's condition or the quality of medical care rendered.

The fact that the patient's physician prescribes services or supplies does not automatically mean they are covered health services.

For the health service to be covered, it must be provided:

- While the plan is in effect
- Before any individual termination conditions take effect, as explained in this Handbook
- To a person who is covered by this plan and meets all of the plan's eligibility requirements.

In addition, to be a covered health service, it must be consistent with nationally recognized scientific evidence, and prevailing medical standards and clinical guidelines as described below.

"Scientific evidence" means the results of controlled clinical trials or other studies published in peer-reviewed medical literature generally recognized by the relevant medical specialty community.

"Prevailing medical standards and clinical guidelines" means nationally recognized professional standards of care including, but not limited to, national consensus statements, nationally recognized clinical guidelines, and national specialty society guidelines.

The claims administrator maintains clinical protocols that describe the scientific evidence, prevailing medical standards and clinical guidelines supporting its determinations regarding specific services. You can access these clinical protocols (as revised from time to time) on **www.myuhc.com** or by calling the number on the back of your ID card. This information is available to physicians and other health care professionals on UnitedHealthcareOnline. In determining whether new technologies, procedures, and treatments are covered, the plan will make decisions that are consistent with prevailing medical research, based on well-conducted randomized trials or cohort studies.

Covered person: A covered employee, a covered dependent, an alternate recipient receiving benefits under a Qualified Medical Child Support Order (QMCSO), or a participating COBRA beneficiary meeting the eligibility requirements for coverage as specified in this plan, and who is properly enrolled in the plan.

Custodial care: Care designed primarily to assist in the activities of daily living, such as 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: The amount of eligible expenses a person or family must incur and pay during the plan year before a plan will begin reimbursing eligible expenses. The plan administrator has the right to allocate the deductible and benefits among covered family members.

Dispense as written (DAW): This is when your doctor prescribes a preferred or non-preferred drug and specifies that the pharmacy may not substitute a generic drug of the same formula if one is available.

Dispense as written penalty: A charge you pay for a prescription, in addition to the preferred or non-preferred copay. The amount of this penalty is the difference in cost between the preferred or non-preferred and generic drug.

Durable medical equipment (DME): Equipment that is ordered or provided by a physician for outpatient use, for medical purposes, is not consumable or disposable, and not of use to a person in the absence of an illness or injury.

Emergency: A serious medical condition or symptom resulting from injury, sickness or mental illness which arises suddenly, and in the judgment of a reasonable person, requires immediate care and treatment, generally received within 24 hours of onset, to avoid jeopardy to life or health.

EOB: See Explanation of benefits.

Experimental service or treatment: A drug, device, treatment, or procedure that meets one or more of the following conditions:

- It cannot be lawfully marketed without the approval of the U.S. Food and Drug Administration and has not been so approved for marketing at the time it is furnished or
- It was reviewed and approved (or is required by federal law to be reviewed and approved) by the treating facility's Institutional Review Board or other body serving a similar function or
- It was used with a patient informed consent document that was reviewed and approved (or is required by federal law to be reviewed and approved) by the treating facility's Institutional Review Board or other body serving a similar function or
- Reliable evidence (see below) shows it is the subject of an ongoing Phase I, II or III clinical trial or is under study to determine its maximum tolerated dose, toxicity, safety, efficacy, or efficacy as compared with a standard means of treatment or diagnosis or
- Prevailing opinion among experts, as shown by reliable evidence, is that further studies or clinical trials are necessary to determine its maximum tolerated dose, toxicity, safety, efficacy, or efficacy as compared with a standard means of treatment or diagnosis or
- It is less effective than conventional treatment methods or
- A review shows that patients have received the treatment or procedure during Phase I, II or III of the clinical trial of the development of the treatment or procedure or
- It is currently undergoing review by the Institutional Review Board (or similar body) for the treating health care facility or
- The language appearing in the consent form or in the treating hospital's protocol for treatment indicates that the hospital or physician regards the treatment or procedure as experimental.

"Reliable evidence" means only:

- Published reports and articles in the authoritative medical and scientific literature or
- The written protocol or protocols used by the treating facility or the protocol or protocols of another facility studying substantially the same drug, device, treatment or procedure or
- The written informed consent form used by the treating facility or by another facility studying substantially the same drug, device, treatment or procedure with respect to the condition of the covered person in question.

All determinations of experimental service or treatment for all medical plans will be made by the claims administrator.

Explanation of benefits (EOB): A statement provided by the claims administrator that shows how a service was covered by the plan, how much is being reimbursed, and what portion (if any) is not covered.

Foster child: A child who is placed with you by an authorized placement agency or by a judgment, decree or other order of any court of competent jurisdiction.

Generic drug: Drugs or substances that are not trademarked, are legally substituted for trademark drugs or substances, and must be prescribed by and can only be obtained with a prescription from a qualified prescriber as a legal substitute for trademarked drugs.

Home health care agency: A public or private agency or organization that specializes in providing medical care and treatment in the patient's home and meets all of the following conditions:

- It is primarily engaged in and licensed, if such licensing is required, by the appropriate licensing authority to provide skilled nursing services and other therapeutic services.
- It has policies established by a professional group associated with the agency or organization. This professional group must include at least one registered graduate nurse (R.N.) to govern the services provided and it must provide for full-time supervision of such services by a physician or registered graduate nurse.
- It maintains a complete medical record on each individual.
- It has a full-time administrator.

Home health care does not include:

- Home health care visits in excess of any applicable home health care agency limit listed in the Medical Plan Comparison table on pages 20 – 22. Each visit by an employee of a home health care agency will be considered one home health care visit, and each four hours of home health aide services will be considered one home health care visit.
- Care or treatment not stated in the home health care plan
- Services provided by a person who is a member of your family or your dependent's family or who normally lives in your home or your covered dependent's home
- A period when you are not under the continuing care of a physician.

Hospice care: A health care program that provides coordinated services at home, in outpatient facilities or institutional settings for terminally ill patients. A hospice must:

- Have an interdisciplinary group of providers including at least one physician and one R.N.
- Maintain central clinical records on all patients
- Meet the standards of the National Hospice Organization (NHO)
- Meet applicable state licensing requirements.

Hospice care does not include:

- Services provided by a person who is a member of your family or your dependent's family or who normally lives in your home or your covered dependent's home
- Any period when you are not under the continuing care of a physician
- Any curative or life-prolonging procedures
- Any other benefits that are payable for hospice care expenses under the policy
- Services or supplies that are primarily to aid you or your covered dependent in daily living
- More than three bereavement counseling sessions.

Hospital: An institution primarily engaged in inpatient medical care or treatment at the patient's expense and that is:

- Licensed by the applicable state authority
- Accredited as a hospital by The Joint Commission, Medicare or its designated reviewing agency and the applicable state authority
- Supervised by a staff of physicians, has 24-hour nursing services by registered professional nurses, provides diagnostic and therapeutic facilities for surgical and medical diagnosis and treatment, and operates continuously; or, if primarily a facility for treatment of mental or nervous conditions, drug addiction or alcoholism, it has a contract with a hospital to perform surgical procedures when necessary
- Not, other than incidentally, a place for rest or the aged, a nursing home, or a hotel.

Hospitalization or hospital stay: See inpatient.

Illness: A bodily disorder, disease, or physical illness of a covered person.

Injury: A condition caused by accidental means which results in damage to the covered person's body from an external force or self-inflicted.

In-network: A provider who has contracted to be part of the UHC Choice network.

Inpatient: Medical treatment or services provided at a hospital when a patient is admitted and confined for treatment, for which a room and board charge is incurred.

Institute of higher education: An institution accredited in the current publication of Accredited Institutions of Higher Education.

Maintenance medications: Medications that your physician prescribes for chronic or long-term conditions (such as diabetes, high blood pressure, heart conditions, allergies, thyroid conditions, etc.). If you are not sure if the prescription is for a chronic condition, please check with your pharmacist.

Medical necessity or medically necessary: Dental or vision care services, supplies or treatment ordered by a physician or dentist and determined by the claims administrator to meet all of the following conditions:

- Provided for the diagnosis or direct treatment of an injury, illness or dental or vision condition
- Appropriate and consistent with the symptoms and findings or diagnosis and treatment of the injury, illness or condition
- Provided in accordance with national generally accepted medical or dental practice
- Not for the convenience of the patient, treating physician, or facility
- Under generally accepted medical or dental standards, the service or treatment cannot be omitted without adversely affecting the patient's condition or the quality of care.

The fact that the patient's physician or dentist prescribes services or supplies does not automatically mean they are medically necessary or covered by the medical plan.

Mental health disorder/condition/illness: Treatment for mental health disorder/condition/illness evidenced by symptoms of abnormal behavior, behavioral disturbances, nervous conditions, mood swings, anorexia nervosa or bulimia nervosa or other aberrant behavior regardless of whether the origin of the symptoms is traceable to an organic abnormality, cause or origin, or is traceable to an environmental cause or experience, excluding treatment for alcoholism, drug and/or substance abuse dependency or addiction.

Midwife: A registered nurse (R.N.) who is certified after receiving specialized training in the field of midwifery who performs services in the home or birthing center. If the state in which the midwife performs services licenses midwives, the midwife must be licensed by the appropriate state licensing agent.

Network: A group of physicians, hospitals, pharmacies, and other medical service providers who have agreed to provide discounted fees for their services.

Non-preferred drug: Brand name prescription drugs that are covered under the Texas Health Medical Plan at a higher copay than generic drugs or preferred drugs.

Nurse: An individual who has received specialized nursing training and is authorized to use one of the following professional designations:

- Registered nurse (R.N.)
- Licensed practical nurse (L.P.N.)
- Licensed vocational nurse (L.V.N.)

Nursing services are covered only when they meet the definition of a covered health service (as defined on page 162) and the nurse is licensed by the Texas State Board of Nursing, and if the nurse is not living with you or related to you or your spouse.

Out-of-network: A provider who has not contracted to be part of the UHC Choice network.

Outpatient: Medical treatment or services provided at a hospital or clinic for a patient who is not admitted to the hospital for an overnight stay.

Over-the-counter: Drugs, products, and supplies that do not require a prescription by federal law.

Part-time benefits-ineligible employee: An employee of Texas Health who is classified in the HR/Payroll system as part-time benefits-ineligible and classified to work less than 48 hours per pay period.

Physician: A legally licensed medical or dental doctor or surgeon, chiropractor, osteopath, podiatrist, certified consulting psychologist, licensed professional counselor or psychiatrist, permitted to perform services within scope of his or her license.

Pre-admission testing: The actual charges for covered health services made by a hospital for services rendered on an outpatient basis before a scheduled inpatient confinement at the same facility.

Preferred drug: These are brand name medications that have been chosen based on their high level of clinical efficacy and cost effectiveness. The preferred drug list is regularly reviewed and updated by a committee of physicians, pharmacists and other allied health professionals.

Pregnancy: The physical state which results in childbirth, life-threatening abortion, or miscarriage, and any medical complications arising out of, or resulting from, such state.

Prescription drugs: Drugs and medicines that must be accompanied by a physician's written order and dispensed only by a licensed pharmacist for the treatment of an illness, injury, or pregnancy. Prescription drugs include injectable insulin, oral contraceptives, and prenatal vitamins.

Primary physician: A network physician who specializes in general practice, family practice, internal medicine, or pediatrics. You are not required to select a primary physician or to get a referral from your primary physician before seeing a network specialist. However, the office visit copay is lower for primary physicians under all the Total Health Medical Plan options.

Private duty nursing: Continuous skilled care or intermittent care by a Registered Nurse or Licensed Practical Nurse while the patient is not confined to an institution.

Provider: The individual or institution which provides medical services or supplies. Providers include physicians, hospitals, pharmacies, surgical facilities, dentists, and other covered medical or dental service and supply providers.

Registered nurse: An individual who has received specialized nursing training and is authorized to use the designation "R.N." and who is duly licensed by the state or regulatory agency responsible for such licensing in the state in which the individual performs such nursing services.

Regularly scheduled to work: The hours and full-time equivalent (FTE) that are assigned to the employee in Texas Health's HR/Payroll system.

Rehabilitation facility: A legally operating institution or distinct part of an institution which has a transfer agreement with one or more hospitals and which is primarily engaged in providing comprehensive multi-disciplinary physical restorative services, post-acute hospital, and rehabilitative inpatient care, and is duly licensed by the appropriate governmental agency to provide such services.

It does not include institutions which provide only minimal care, custodial care, ambulatory or part-time care services, or an institution which primarily provides treatment of mental disorders, chemical dependency, or tuberculosis, except if such facility is licensed, certified, or approved as a rehabilitation facility for the treatment of medical conditions, drug addiction or alcoholism in its jurisdiction or is accredited by The Joint Commission, Medicare, or Commission on the Accreditation of Rehabilitation Facilities.

Room and board: All charges, by whatever name called, which are made by a hospital, hospice, rehabilitation facility, or convalescent nursing facility or other covered facilities as a condition of occupancy. Such charges do not include the professional services of physicians, intensive nursing care, or any other rehabilitative therapy, occupational therapy, physical therapy, or speech or hearing therapy, by whatever name called.

Routine newborn care: Inpatient charges for a well newborn baby for nursery room and board and pediatric services including circumcision.

Semi-private: A class of accommodations in a hospital or skilled nursing facility or other facility providing services on an inpatient basis in which at least two patient beds are available per room.

Skilled nursing facility/extended care facility: An institution that primarily provides skilled, as opposed to custodial, nursing service to patients, and is approved by The Joint Commission, the applicable state licensing authority and/or Medicare.

Substance abuse/chemical dependency/alcoholism conditions: A condition, illness, or diagnosis of alcoholism, drug use or abuse, or chemical dependency or substance abuse requiring medical or psychiatric care, including detoxification services. Any treatment for overdose of alcohol or other substances will be treated as a medical claim and not a mental health or substance abuse claim. Any treatments following the initial treatment of the overdose will be classified by the illness or diagnosis for which the care is provided.

Temporomandibular joint syndrome: A condition that is also known as myofascial pain-dysfunction syndrome, a disorder that affects the two joints at either side of the jaw (the temporomandibular joints).

Texas Health entity: Any hospital wholly owned or controlled by Texas Health.

Texas Health Preferred Hospitals: A list of Texas Health hospitals and other select hospitals. It is your responsibility to verify whether a hospital is a Texas Health Preferred Hospital before you receive care. Your cost for medical care is lower when you use a Texas Health Preferred Hospital.

Urgent care clinic or center: A free-standing facility, other than a hospital, which is engaged primarily in providing minor emergency and episodic medical care to a person. A board-certified physician, a registered nurse, and a registered X-ray technician must be in attendance at all times that the clinic is open. The clinic's facilities must include X-ray and laboratory equipment and a life-support system. For the purposes of this Plan, a clinic meeting those requirements will be considered to be an urgent care medical clinic, by whatever actual name it may be called. However, a clinic located on the premises of or in conjunction with or in any way a part of a regular hospital will be excluded from terms of this definition.

Well-baby care: Medical treatment, services, or supplies rendered to a child solely for the purpose of health maintenance and not for the treatment of an illness of injury.

2013 Cost of Coverage

MEDICAL COVERAGE (PAID BEFORE-TAX)

Following is you cost per pay period for medical coverage with Low Rx and the additional cost each pay period if you elect the High Rx.

Plan Name	Employee Only		Employee + Spouse		Employee + Child(ren)		Employee + Family	
	Employee	Texas Health	Employee	Texas Health	Employee	Texas Health	Employee	Texas Health
FULL-TIME EMPLOYEES WHO EARN LESS THAN $25,000								
Choice Plan 500/Low Rx	$2.62	$268.83	$51.52	$483.75	$30.92	$466.09	$74.54	$752.71
Choice Plan 1000/Low Rx	$0.96	$232.33	$28.67	$430.86	$17.86	$409.44	$42.05	$668.48
Choice Plan 1500 Plus/Low Rx	$12.48	$224.30	$113.92	$355.63	$85.69	$351.15	$157.13	$568.73
Additional cost for High Rx	$0.75	$8.00	$5.25	$12.00	$2.75	$10.25	$10.75	$17.50
FULL-TIME EMPLOYEES WHO EARN $25,000 - $49,999								
Choice Plan 500/Low Rx	$13.30	$258.15	$87.18	$448.09	$85.50	$411.51	$155.20	$672.05
Choice Plan 1000/Low Rx	$4.91	$228.38	$41.57	$417.96	$41.59	$385.71	$75.21	$635.32
Choice Plan 1500 Plus/Low Rx	$39.98	$196.80	$176.06	$293.49	$163.09	$273.75	$290.89	$434.97
Additional cost for High Rx	$2.50	$6.25	$8.00	$9.25	$4.00	$9.00	$16.00	$12.25
FULL-TIME EMPLOYEES WHO EARN $50,000 - $74,999								
Choice Plan 500/Low Rx	$13.47	$257.98	$90.60	$444.67	$89.95	$407.06	$161.70	$665.55
Choice Plan 1000/Low Rx	$4.72	$228.57	$42.33	$417.20	$42.53	$384.77	$75.64	$634.89
Choice Plan 1500 Plus/Low Rx	$41.34	$195.44	$183.55	$286.00	$169.88	$266.96	$303.52	$422.34
Additional cost for High Rx	$3.25	$5.50	$9.25	$8.00	$4.75	$8.25	$18.50	$9.75
FULL-TIME EMPLOYEES WHO EARN $75,000 - $99,999								
Choice Plan 500/Low Rx	$21.60	$249.85	$140.83	$394.44	$129.18	$367.83	$239.91	$587.34
Choice Plan 1000/Low Rx	$7.84	$225.45	$61.47	$398.06	$62.17	$365.13	$113.75	$596.78
Choice Plan 1500 Plus/Low Rx	$66.05	$170.73	$284.96	$184.59	$262.46	$174.38	$471.09	$254.77
Additional cost for High Rx	$4.00	$4.75	$13.25	$4.00	$6.75	$6.25	$21.25	$7.00
FULL-TIME EMPLOYEES WHO EARN $100,000 AND ABOVE								
Choice Plan 500/Low Rx	$22.64	$248.81	$146.74	$388.53	$135.10	$361.91	$252.53	$574.72
Choice Plan 1000/Low Rx	$8.17	$225.12	$65.50	$394.03	$65.39	$361.91	$119.67	$590.86
Choice Plan 1500 Plus/Low Rx	$69.46	$167.32	$299.21	$170.34	$275.60	$161.24	$494.63	$231.23
Additional cost for High Rx	$4.25	$4.50	$14.00	$3.25	$7.00	$6.00	$22.25	$6.00
PART-TIME EMPLOYEES*								
Choice Plan 500/Low Rx	$91.74	$179.71	$216.16	$319.11	$200.52	$296.49	$310.23	$517.02
Choice Plan 1000/Low Rx	$36.58	$196.71	$92.55	$366.98	$90.99	$336.31	$142.91	$567.62
Choice Plan 1500 Plus/Low Rx	$135.07	$101.71	$317.18	$152.37	$288.23	$148.61	$455.45	$270.41
Additional cost for High Rx	$8.50	$0.25	$17.00	$0.25	$12.25	$0.75	$26.75	$1.50

*If you are a part-time employee over age 55, Texas Health provides you with a subsidy for medical coverage equal to the difference between the cost of coverage for a full-time employee earning between $50,000 and $74,999 a year and a part-time employee's cost. When you enroll online, the premium amount you see will have the part-time over age 55 subsidy included. However, your paycheck will show the regular part-time premium amount on one line and the over age 55 subsidy on a separate line.

DENTAL (PAID BEFORE-TAX)

Coverage Level	Aetna Managed (DMO)	Aetna PPO (Low Option)	Aetna PDN (High Option)
Employee Only	$5.75	$7.02	$17.84
Employee + Spouse	$11.49	$14.05	$35.67
Employee + Child(ren)	$15.38	$18.79	$47.72
Employee + Family	$19.51	$23.84	$60.57

VISION (PAID BEFORE-TAX)

Coverage Level	Superior Vision
Employee Only	$3.68
Employee + Spouse	$7.93
Employee + Child(ren)	$5.97
Employee + Family	$10.87

ADDITIONAL LIFE [1] (PAID AFTER-TAX)

Your Age	Cost per pay period per $1,000 of coverage
Under 30	$0.0176
30 - 34	$0.0220
35 - 39	$0.0309
40 - 44	$0.0397
45 - 49	$0.0617
50 - 54	$0.0970
55 - 59	$0.1455
60 - 64	$0.1895
65 - 69	$0.2821
70 - 74	$0.3835
75 - 79	$0.5510

SPOUSE LIFE [1] (PAID AFTER-TAX)

Your Age	Cost per pay period per $1,000 of coverage
Under 30	$0.0264
30 - 34	$0.0353
35 - 39	$0.0397
40 - 44	$0.0441
45 - 49	$0.0661
50 - 54	$0.1014
55 - 59	$0.1895
60 - 64	$0.2909
65 - 69	$0.5598
70 - 74	$0.9080
75 - 79	$0.9080

CHILD LIFE (PAID AFTER-TAX)

Coverage	Cost
All of your eligible children	$0.2689 for $10,000 of coverage

ADDITIONAL AD&D (PAID BEFORE-TAX)

Coverage	Cost per pay period per $1,000 of coverage
Employee Only	$0.0055
Employee + Family	$0.0102

[1] Additional and Spouse Life rates are based on the employee's age as of Jan. 1, 2013.

Cost of Disability Coverage (Paid After-Tax)

To calculate your premiums for Disability, multiply your hourly base rate by the cost of your benefit elections listed in the tables below. For example, if you earn $8 per hour, multiply $8 x $0.7643 = $6.11 per paycheck.[2]

[2] Example for part-time employees: multiply $8 x $0.7643 x [hours you are regularly scheduled to work per pay period ÷ 80].

STD (PAID AFTER-TAX)

Waiting Period	Rate Multiplier
14 days	$0.7643
30 days	$0.5317

ADDITIONAL LTD (PAID AFTER-TAX)

Coverage	Rate Multiplier
Additional LTD ("Buy-Up" Plan)	$0.3360

Cost of Long Term Care Coverage (Paid After-Tax)

Contact Genworth Life at 1-800-416-3624 for rate information and to enroll.

Important Contacts

For Information About:	Contact:	At:
Flexible Benefits General questions and to request forms	Human Resources	Human Resources (see page 35 of your 2013 Benefits Guide for phone numbers to HR)
Medical Plan	UnitedHealthcare Services Inc. 185 Asylum St. Hartford, CT 06103-3408	1-877-MyTHRLink, prompt 1 www.myuhc.com
Health Advocacy	UnitedHealthcare P.O. Box 30555 Salt Lake City, UT 84130-0555	1-877-MyTHRLink, prompt 2
Pharmacy Benefits	Caremark P.O. Box 659529 San Antonio, TX 78265-9529	1-877-MyTHRLink, prompt 3 www.caremark.com
Be Healthy	OptumHealth	1-877-MyTHRLink, prompt 4, press 3
Dental Plan Participating Dental Network (PDN) Aetna Managed Dental Plan (DMO)	Aetna P.O. Box 14094 Lexington, KY 40512-4094	1-877-MyTHRLink, prompt 6, press 3 www.aetna.com
Vision Plan	Superior Vision Services 11101 White Rock Road, Suite 150 Rancho Cordova, CA 95670	1-877-MyTHRLink, prompt 6, press 4 www.superiorvision.com
Life and Accident Insurance Life Insurance and Accidental Death & Dismemberment	CIGNA Group Insurance P.O. Box 22328 Pittsburgh, PA 15222-0328	1-(800) 238-2125
Business Travel Accident	Life Insurance Company of North America	1-877-MyTHRLink, prompt 6, press 5
Disability Short Term Disability Long Term Disability	CIGNA Group Insurance P.O. Box 29063 Glendale, CA 91209	1-(800) 781-2006 1-(800) 36-CIGNA or 1-(800) 362-4462 to report a claim
Long Term Care Insurance	Genworth Life Insurance Company P.O. Box 64010 St. Paul, MN 58164-0010	1-877-MyTHRLink, prompt 6, press 7 www.genworth.com/groupltc Group ID: thr Code: groupltc
Flexible Spending Accounts Health Care Spending Account and Day Care Spending Account	PayFlex Systems USA, Inc. Flex Dept. P.O. Box 3039 Omaha, NE 68103-3039	1-877-MyTHRLink, prompt 6, press 6 Fax: (402) 231-4310 www.healthhub.com to track expenses
Paid Time Off	Human Resources	Human Resources
Texas Health Retirement Program	JPMorgan Retirement Plan Services 11500 Outlook St. Overland Park, KS 66211	1-877-MyTHRLink, prompt 5 www.retireonline.com
Tuition Reimbursement	Texas Health Tuition Reimbursement	1-877-MyTHRLink, prompt 6, press 2 or e-mail at THRTuitionReimbursement@texashealth.org
COBRA Continuation of Coverage	PayFlex Systems USA, Inc. COBRA & Direct Billing Department P.O. Box 2239 Omaha, NE 68103-2239	1-(800) 359-3921
People and Culture Committee	Texas Health 612 E. Lamar Blvd, Suite 900 Arlington, TX 76011	(682) 236-7900
Employee Assistance Program (EAP)	MHN	1-877-MyTHRLink, prompt 4, press 4
Tobacco Cessation	Alere	1-877-MyTHRLink, prompt 4, press 2
Leave of Absence (LOA)	Your entity's IDM representative	1-877-MyTHRLink, prompt 6, press 1 or e-mail at THRIDM@texashealth.org
Weight Watchers	Weight Watchers	1-877-MyTHRLink, prompt 4, press 1
Discount Program	Beneplace	www.Beneplace.com/texashealth

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