A Guide for Texas Health Employees

2021 Benefits Handbook

Texas Health Resources®

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 Total Rewards 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 reference it 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 sponsored by 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 225. It defines many important terms for understanding your benefits under the plans.

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

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

OUR TEXAS HEALTH PROMISE℠

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

Our Texas Health Promise® is valued throughout our organization—and that includes providing you and your family great benefits. Texas Health covers, on average, 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

Partnering with you for a lifetime of health and well-being.

VALUES

Respect, Integrity, Compassion, Excellence (RICE).

We will provide and maintain a fair and equitable environment for all by valuing and respecting individual differences for our enrichment and for the enrichment of the communities we serve.

TEXAS HEALTH POLICIES AND PROCEDURES

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

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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, check your PTO balance, request a leave of absence, and much more.
- **www.BeHealthyTHR.org**: Accessible anytime, anywhere. Pull up your online benefits guide for information about your benefits at home, at work, or even on your mobile device.

BY PHONE

- 1-877-MyTHRLink (1-877-698-4754): Calling this number gives you direct access to all of our benefits providers, including Texas Health Aetna, UnitedHealthcare, CVS Caremark (prescription), Aetna (dental), EAP, Tuition Reimbursement, and more.

Press	To Hear About	Then Choose from These Additional Options
9	**THR Benefits Support** For assistance with online enrollment, dependent verification, or general benefit plan information	None
1	**Texas Health Aetna Medical Benefits and Eligibility**	None
2	**UnitedHealthcare (UHC) Medical Benefits and Eligibility**	None
3	**Pharmacy Plan**	None
4	**Wellness Benefits**	**Press 1:** Real Appeal **Press 2:** Quit for Life tobacco cessation program **Press 3**: *Be Healthy* rewards **Press 4:** Employee Assistance Program (EAP) **Press 5:** Diabetes Educators **Press 6:** To repeat these options
5	**401(k) Retirement Plan**	None
6	**Other Total Health Questions**	**Press 1:** Leaves of Absence, Workplace Injuries **Press 2:** Tuition Reimbursement **Press 3:** Dental Benefits **Press 4:** Vision Benefits **Press 5:** Employee Discounts **Press 6:** Flexible Spending Accounts and Health Savings Account **Press 7:** Disability Benefits **Press 8:** Life Insurance Benefits **Press 9:** To repeat these options
7	**To Repeat All Options**	None
8	**Español** Marque el 8 para ayuda en español.	None

IN PERSON

- Human Resources: Each entity has a Human Resources office available to assist with your benefit questions. Go to **BeHealthyTHR.org** for a list of phone numbers for each Human Resources office.

Welcome to Total Health, Where Well-being 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 retirement 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 return for reasonable 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 well-being a way of life.

GET REWARDED FOR GETTING HEALTHY

Be Healthy is a well-being 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 well-being a way of life.

If you are a benefits-eligible employee, you receive a reward each time you complete a *Be Healthy* element with an incentive. 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 or immediately accessible e-gift cards.

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* well-being programs, check online at **BeHealthyTHR.org** or see page 75 of this handbook.

For answers to your benefit questions or to access Total Health program information: Call 1-877-MyTHRLink (1-877-698-4754) prompt 9 or go online to **BeHealthyTHR.org.**

Overview

Texas Health offers eligible employees a comprehensive Flexible Benefits Plan that includes Medical, Dental, Vision, Life, Disability, Flexible Spending Accounts and Health Savings Account. These benefits help protect you and your family from the financial hardships of illness, injury, disability, and death. Read "Eligibility Requirements" 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 dependents 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 – 8)	• Texas Health Aetna Select 1000 High Rx • Texas Health Aetna Select 1000 Low Rx • Texas Health Aetna Select 3000 High Rx • Texas Health Aetna Select 3000 Low Rx • 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
Health Savings Account	You and your eligible family members (as defined on pages 5 – 8)	• Contribute up to $3,600 for an individual and $7,200 for a family if you enroll in the UHC Choice Plus 1500 or the Texas Health Aetna 3000 plan options.
Dental	You and your eligible family members (as defined on pages 5 – 8)	• Aetna® Managed Dental Plan Dental Maintenance Organization (DMO®) • Participating Dental Network (PDN; 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 – 8)	• Texas Health Vision Plan
Short Term Disability[1]	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 – 8)	• 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] Benefits-eligible physicians employed by Texas Health Physician's Group (THPG) and Texas Health Back Care (THBC) are covered through separate policies and are not eligible for the Texas Health Long Term Disability Plan. Resident interns are not eligible for the Short Term Disability Plan or the Long Term Disability Plan. Executives are not eligible for the Texas Health Short 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 – 8)	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 Flexible Spending Account	You and your eligible family members (as defined on pages 5 – 8)	• You may contribute up to $2,750 per year before-tax.
Day Care Flexible Spending Account	Your eligible family members (as defined on pages 5 – 8)	• 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
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 on the first pay period after you are hired by Texas Health. • For 2021, the Texas Health 401(k) Retirement Plan allows you to save up to $19,500 per year ($26,000 if you are age 50 or older) of your pay.
Paid Time Off (PTO)[1, 2]	• Full-time and part-time benefits-eligible employees receive PTO per pay period, depending on years of service. • 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 2021 (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 2021 program year.
Additional Benefits	• Business Travel Accident Insurance • Tuition reimbursement • Adoption assistance • Parental leave • EAP • Tobacco cessation program • Employee Discount Program • Student Loan Repayment Program • Supplemental benefits (hospital indemnity, accident insurance and critical illness insurance) • Employee Relief Fund • Helping Hands Fund

[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 and the Employee Relief Fund do not count toward the 100 hour annual maximum.

[2] Physicians, advance practice professionals of THPG, executives, and resident interns are not eligible for PTO and PTO Conversion. Time away from work for physicians and advance practice professionals is based on their contract. THPG Clinic Practice and Urgent Care Staff have a different program as explained on page 159. Texas Health executives should review the Executive Time Off Guidelines for further information.

Participation

Eligibility for Benefits

Your eligibility for benefits is determined by your job status (full-time or part-time benefits eligible) in the HR/payroll system.

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

- Long Term Disability
- Paid Time Off (PTO)
- Separation Pay.

The following exclusions also apply:

- Advance Practice professionals employed by THPG/THBC or anyone under contract are not eligible to participate in the Texas Health PTO Plan or the Separation Pay Plan.
- Research fellows are not eligible for the Separation Pay Plan.
- Resident interns are not eligible for PTO, disability or Separation Pay plans.
- Off duty police officers who are working at Texas Health are not eligible for any Plan or Program.
- Texas Health Executives, which are Vice President and above, are excluded from the Texas Health Short Term Disability program and the Texas Health PTO Plan. The Executive Time Off Guidelines contain further details.

EMPLOYEES

Eligibility Requirements

Unless otherwise noted in this Handbook, eligibility for benefits is determined by your job status 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 30 hours per week
- Part-time benefits-eligible employee—an employee of Texas Health who is classified to work 24-29 hours per week
- Part-time benefits-ineligible employee—an employee of Texas Health who is classified to work less than 24 hours per week
- PRN employee—an employee of Texas Health who does not have a set number of hours per week.

For those employees with more than one job, benefit eligibility is determined by the total combined hours from all active jobs.

Part-time benefits-ineligible employees and PRN employees are eligible to participate in the Texas Health 401(k) Retirement Plan, EAP, and 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 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.

Your benefits will be effective the first of the pay period following the date you make an online election and provide required documentation.

FAMILY MEMBERS

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

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

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 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 page 5 – 6)
- 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 – 8).

You may 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

For purposes of the Handbook, coverage for a spouse refers to opposite and same-sex legally married couples and common-law spouses who legally reside in the United States.

Footnotes are on the next page.

In the case of a common law marriage, you must have filed a declaration of informal (common law) marriage with the county clerk in order for your spouse to be eligible for benefits.

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.

Child

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

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

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

- Be under age 25 (or any age if physically or mentally incapable of self-support)[2]

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 and provide dependent verification within 31 days of the child's birth. A Social Security number is required within 6 months of birth date.*

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 submit 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 or physical disability 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 the medical claims administrator 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. This form is located on **BeHealthyTHR.org**. Before the medical claims administrator agrees to this extension of coverage, they may require that a physician chosen by the medical claims administrator examine the child. The medical claims administrator will pay for that examination.

The medical claims administrator 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 the medical claims administrator'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 and the definition of incapacitated child (described above) and either:

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

[2] For Life Insurance, the term "child" means a child born or legally adopted by you. It includes a child during any waiting period prior to the finalization of the child's adoption. It also means stepchild living with you and financially dependent upon you. Coverage is from live birth to age 25.

- 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 Total Health Medical Plan as a new employee, during open enrollment or due to a qualifying life event.

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 the 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.

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 that the order has been received. The notification describes the procedures that will be used to determine its qualification.

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. Dependents missing or having invalid Social Security numbers may be dropped from coverage if you do not provide requested information within 31 days of enrollment at Texas Health.

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:

- Legally married opposite sex or same sex spouse: **Both** of the following need to be provided for your spouse:
  - Photocopy of marriage license, marriage certificate provided by your religious organization, or most recent tax return ***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
- Common-law opposite sex or same sex spouse: **Both** of the following need to be provided for your common-law spouse:
  - Photocopy of declaration of informal marriage filed with the county clerk

    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 the verification of birth facts document from the 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 THR Benefits Support by email to **THRBenefitsSupport@texashealth.org** or fax to 682-236-6997. Be sure to include your employee ID number on all documents. A cover sheet is available on **BeHealthyTHR.org** and should be sent with your documentation 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 and dependents will be dropped from coverage, including Life Insurance and Supplemental Benefits.

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 **THRBenefitsSupport@texashealth.org** or sending a written request to the plan administrator at the address on page 215 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 eligibility 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 eligibility 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 eligibility claim is denied in whole or part, you (or your authorized representative) may request review by writing to the Governance Committee of the Texas Health Board (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 eligibility 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 eligibility 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 no 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. 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 197 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 Benefits

You have the opportunity to enroll in benefits as a new hire or newly eligible employee 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 13 – 14.

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 13 – 14.

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 benefits (only Basic Benefits) unless you later enroll because you have a status change or qualify for special enrollment rights as explained on pages 13 – 14.*
- Your participation in benefits begins the first pay period after you complete one month of service.
- You will be required to provide documentation (as described on page 7) of all dependents you cover under medical, dental or vision within 31 days of your hire date.

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).

Flexible Benefits

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

- Medical
- Health Savings Account
- Dental
- Vision
- Short Term Disability
- Additional Long Term Disability
- Additional Life Insurance
- Dependent Life Insurance
- Additional AD&D Insurance
- Flexible Spending Accounts
- Hospital Indemnity
- Accident Insurance
- Critical Illness Insurance.

NEWLY ELIGIBLE EMPLOYEE ENROLLMENT

A newly eligible employee is a current employee in a non-benefits-eligible position who is hired into a part-time benefits-eligible or full-time position. You may enroll online within 31 calendar days of your status change. Your benefits are effective the first of the pay period following your status change and online election, along with dependent verification (if applicable), if you have completed one month of service.

You will be required to provide documentation (as described on page 7) of all dependents you cover under medical, dental or vision within 31 days of your status change date.

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 benefits during the open enrollment period typically held in November. Your elections become effective January 1.
- Documentation will be required for dependents newly added to medical, dental or vision. The due date for this documentation to be submitted will be included with open enrollment materials.

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 THR Benefits Support within 60 days of your missed deadline. Within the 60 day period, you may choose a medical plan option and pay the premium 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 THR Benefits Support for information on how to make this election. If you missed the enrollment deadline at open enrollment, your effective date for the after-tax plan will be January 1. If you missed the enrollment deadline for any other reason, your after-tax plan will be effective the first day of the following pay period after complete forms and documentation are received, if you have completed one month of service.

You must provide documentation for your dependents you cover under medical, dental or vision.

Missed Dependent Verification Deadline

If you miss the deadline for dependent verification and you still want medical coverage for your dependents, you must contact Texas Health Benefits Support prior to January 1 (if for open enrollment) or within 60 days of your missed deadline. You may choose a medical plan option and pay the premiums on an after-tax basis. You may not enroll dependents in any other benefits until the next open enrollment period unless you have a qualified status change. Contact Texas Health Benefits Support (877-MyTHRLink, prompt 9) 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, if you have completed one month of service.

BRIDGING OF SERVICE

Rehired Employee Enrollment

If you are rehired by Texas Health within 13 weeks of your termination, you qualify for "bridging of service." Bridging service means the time gap is closed and your PTO picks up at the rate when you terminated. Because your service is bridged, you must continue the same coverage in effect before you left. You are eligible to make changes to medical insurance if you experience a status change. The rule to continue the same medical coverage in effect before you left does not apply if:

- you were full-time before your termination and are rehired in a part-time benefits-eligible position
- you were in a part-time benefits-eligible position prior to termination and are rehired as a full-time employee
- you were in a full-time or part-time benefits-eligible position prior to termination and rehired as PRN
- annual benefits enrollment (normally occurring in November) occurs during a break in service.

If you can make changes to medical coverage as defined above, you have 14 days after your rehire date to elect different medical coverage.

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 13 weeks 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 after you have completed one month of service.

Status Change Eligibility

If you regain eligibility for benefits within 13 weeks 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 rate 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. The rule to continue the same coverage in effect before you left does not apply to medical for employees who go from full-time to non-benefits-eligible and then to part-time benefits-eligible. The rule also does not apply if you go from part-time benefits-eligible to non-benefits-eligible and then to full-time within 13 weeks. Employees who change status can make a new medical election. 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 13 weeks after your loss of benefits due to a status change, 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 and provide required documentation.

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 may include:

- You or your eligible family member becomes covered by one of the Total Health Medical Plan options because of special enrollment rights as explained beginning on page 13.
- 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 after 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 outside of the service area of the plan (medical plan options and dental DMO only).
- 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 or child's employer offers benefit plans with a different plan year that affects your coverage or your dependent's 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; and you may change medical or dental plans (for example, you can change from 500 High Rx to 1000 High Rx; and you can change from employee only coverage to employee + children) when you experience a family status change.

A court order requiring you to provide coverage for your spouse is not binding on Texas Health.

You may change or revoke your previous election for the Day Care Flexible Spending Account during the year and make a new election (you must 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 page 11.

Due to COVID-19, the rules on when you can make a change to your flexible spending accounts are temporarily expanded for 2020 and 2021. You are not required to have a change in status to enroll, revoke elections or make a new election to your Health Care Flexible Spending Account or Day Care Flexible Spending Account.

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 Texas Health Benefits Support within 60 days of your missed deadline. Within the 60 day period, you may choose a medical plan option and pay the premiums on an after-tax basis. You may not enroll dependents in any other benefits until the next open enrollment period unless you have a qualified status change. Contact Texas Health Benefits Support for information on how to make this election.

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

See page 15 for a table that summarizes the changes you may make based on your life event.

Requesting a Change in Coverage and Your Responsibility for Notification

To change your coverage, you must make changes online at ***MyTHR.org*** *within 31 days of your event date.* When you initially notify Human Resources of your event, they will explain how to enroll or discontinue coverage. After you enroll, you must submit documentation to Texas Health Benefits Support by email to **THRBenefitsSupport@texashealth.org** within 31 days of the event. Your documentation must show your name, the date of the change and, if applicable, any dependents affected by the change. Insurance cards will not be accepted as documentation.

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 verify the event.

You are also responsible for notifying Human Resources when your divorce is final so coverage can be stopped. To do so, make online elections and provide the finalized divorce decree within 31 days of the finalized divorce. If you miss the 31-day deadline, your ex-spouse will be dropped from coverage as he/she is no longer eligible. 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

You must notify Human Resources within 31 days of the event that resulted in the status change by making online elections and providing documentation. All changes are effective the following pay period after the date of the status change after online elections are entered and acceptable documentation is received.

See page 15 for a table that summarizes the changes you may make based on your life event.

If you do not complete all the steps listed above within 31 days of your event, 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, provide dependent verification documentation, and complete one 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.

In the event of divorce, the effective date of change in coverage is the date of the divorce. The effective date of change in deduction is the first of the pay period following receipt of online elections and acceptable documentation.

Note: A divorce decree requiring the employee of Texas Health to continue providing medical coverage for the ex-spouse is not binding to Texas Health. Due to the divorce, the ex-spouse will be dropped from coverage as they are no longer an eligible dependent.

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 option 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 the 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 the 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 by making an election online and providing 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.

Due to COVID-19, Texas Health was able to temporarily expand the time period in which you may add coverage for you or a dependent if you lost coverage or gained a dependent. This extended enrollment period applies beginning March 1, 2020 through 60 days after the end of the federal declaration of national emergency or one year following your event date whichever is earlier.

Your documentation must show your name, the date of the change and, if applicable, your new dependent's name.

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 by making an online election and providing the appropriate documentation. 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 232 – 236 for the 2021 cost of coverage.

If you do not request your change and/or provide documentation within the guidelines above, you may elect to change your benefits only during the next open enrollment period or if you have additional special enrollment rights, as explained on the previous page. 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.

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.** Changes can be made to the Health Savings Account at any time.

Event	Medical, Dental & Vision					Life (Additional, Spouse & Child)		STD/LTD		Additional AD&D		Health & Day Care FSA*	
	Add Plan	Drop Plan	Add Dep	Drop Dep	Change Option	Add Plan	Drop Plan	Add Plan	Drop Plan	Add Plan	Drop Plan	Add Plan	Drop Plan
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 13 weeks or more following termination[1]	√		√			√		√ [2]		√		√	
Employee changes from part-time to full-time	√ [3]		√ [3]		√ [3]								
Employee changes from full-time to part-time		√ [3]		√ [3]	√ [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]	√		√		√	√		√		√		√	
Employee goes on unpaid LOA		√		√			√				√		√
Employee returns from unpaid LOA[5]	√					√				√		√	
Employee marries	√ [6]	√	√	√	√ [3]	√		√ [2]		√	√	√	√
Employee divorces	√		√	√		√ [14]	√ [7]	√ [2]		√	√	√	√
Spouse dies	√		√	√	√	√ [8]	√ [7]			√	√	√	√
Employee gains a child due to birth, adoption, etc.	√ [6]		√		√ [3]	√ [9]		√ [2]		√		√ [13]	√
Child is no longer eligible due to other coverage, (CHIP, Medicaid or other insurance) divorce, death				√			√ [10]				√ [10]	√	√
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	√		√		√ [3]	√ [7]		√ [2]		√ [7]		√	√ [11]
Employee and/or dependent moves to location outside the plan's service area	√ [12]	√ [12]			√ [12]								
Cost of day care changes (and care is not provided by relative)												√ [11]	√ [11]

* Due to COVID-19, the rules on when you can make a change to your flexible spending accounts are temporarily expanded for 2020 and 2021. See page 106 for details. Your ability to change your elections due to Special Enrollment Rights is also expanded. See page 13 for details.

1 An employee who is rehired less than 13 weeks following termination will have the same coverage as before termination, unless rehired in a new plan year.

2 Pre-existing condition limitations apply.

3 Medical only

4 An employee who loses eligibility for benefits and again becomes eligible for benefits within 13 weeks will have the same coverage as before the loss of eligibility.

5 You are re-enrolled in your previous coverage if you request re-enrollment.

6 Employee can only add plan if adding dependents.

7 Spouse event only

8 Additional or Child life only

9 Child life only if this is not your first child. If this is your first child, you may add Spouse Life, as well.

10 You may not drop spouse life, additional life or AD&D and can only drop child life coverage for the affected child.

11 Day Care FSA only

12 Medical and Dental only; must be 50 miles outside of primary providers network

13 If on leave of absence, you must wait until you return from leave to add a Day Care FSA.

14 Additional life only

You are required to provide documentation for your dependents within the timelines listed on page 7.

Paying for Your Benefits

You and Texas Health both pay the cost of your benefits. Your cost for benefits is deducted from 26 paychecks of each calendar year. Any missed premiums will be deducted from the next paycheck or you will be billed.

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
- Parental Leave
- Student Loan Repayment Program

BENEFITS PAID BY YOU AND TEXAS HEALTH

- Medical/Prescription
- Health Savings Account
- 401(k) Retirement Plan

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
- Hospital Indemnity Insurance
- Accident Insurance
- Critical Illness Insurance

If you take a leave of absence, you must pay your portion of the cost for benefits biweekly 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
- Health Savings Account
- 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
- Hospital Indemnity Insurance
- Accident Insurance
- Critical Illness Insurance

Per IRS regulations, Texas Health is required to add the value of certain benefits provided to you as taxable income on your W-2. This is called imputed income. Examples of benefits paid by Texas Health that you may be taxed on include *Be Healthy* rewards and the Student Loan Repayment Program.

Texas Health makes the student loan payment on a pretax basis, meaning you are not taxed on this payment. Pretax treatment applies through 2025 if the combined total of payments for both the Student Loan Repayment Program and the Tuition Reimbursement Program is under $5,250.

PAYROLL DEDUCTIONS

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

Premiums are based on your annual base pay for the following benefits:

- 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.

Annual base pay is your hourly rate of pay times the number of hours you are classified to work in the HR/Payroll system. Base pay does not include variable pay, bonuses, overtime earnings, commission or other additional compensation paid to you. Anytime your annual base pay changes, your premiums will be recalculated based on the new annual base pay. Changes to your premiums will be effective in the same pay period as your change in pay.

Annual base pay for THPG physicians, nurse practitioners and physician assistants on a productivity model are based on the prior year's earnings. "Earnings" include regular earnings, quarterly true up, physician bonus (PBN) and physician quality bonus (PQB) amounts. For those not completing a full year of service due to hire date or a leave of absence in the prior year, annual base pay will be based on their contracted rate.

Payroll deductions for medical, dental, and vision benefits are based on the option 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 your current salary, 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 2021 costs are listed on pages 232 – 236.

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 UHC Choice 500 Low Rx plan for Employee + Spouse, the part-time premium listed on page 234 is $440.37. 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 $209.08. The difference of $231.29 will be shown on your paycheck as a medical subsidy from Texas Health.

$440.37	Part-time premium
–	Premium for full-time employees earning
$209.08	$50,000 – $74,999
$231.29	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 2021 benefits, you will have 60 hours of PTO available to sell or donate during 2021. See page 161 for details on converting PTO.

* Texas Health Executives, physicians and advance practice professionals employed by THPG in addition to all resident interns 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 administrator, 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.

The medical plan has five different options through two different administrators. Texas Health Aetna administers the Texas Health Aetna Select 3000 and Select 1000 plan options. UnitedHealthcare administers the Choice 500, Choice 1000 and Choice Plus 1500 plan options.

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.

You pay nothing for annual wellness exams on all plan options. You pay only a small in-network copay for doctor's office visits with all plan options except Texas Health Aetna Select 3000 and UHC Choice Plan 1500. Here are the differences among the five options:

- The plan administrator, which is Texas Health Aetna or UnitedHealthcare (UHC)
- Network coverage – only one plan option (the UHC Choice Plus 1500) covers out-of-network medical care, and both Texas Health Aetna plan options have a select, narrow network with local providers only
- The amount you pay for services, including your annual deductible and whether or not you have co-insurance
- The premiums you pay, which depend on the plan you choose and your salary tier (Texas Health pays a large percentage of the premiums for all employees – and pays more for employees who earn less)
- The Texas Health Aetna Select 3000 and the UHC Choice Plus 1500 plan options qualify as high deductible health plans and work differently than the other options due to the requirement to meet the deductible for office visits and prescriptions before the plan begins to share costs with you.

ADMINISTRATORS, NETWORKS & PLANS

You can choose medical coverage administered by Texas Health Aetna or UnitedHealthcare.

Texas Health Aetna coverage gives you access to the Open Access EPO Plus Network and the Texas Health Aetna plan options include the Select Plan 1000 and Select Plan 3000.

UnitedHealthcare (UHC) gives you access to the Choice or Choice Plus network, and you save money on your health care costs when you use Texas Health Preferred Hospitals. The three UHC medical options include the Choice Plans 500, 1000 and the Plus 1500.

Features of All Medical Options

No matter which medical option you choose, you have access to many of the same programs:

- *Prescription Drug Coverage*—you have two options that differ in the percentage they pay for covered prescription drugs.
- *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 Plan covers 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.
- *Employee Assistance Program (EAP)*—gives you 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 counseling sessions per issue per year. The EAP is available 24 hours a day, seven days a week.
- *Health Pregnancy (Maternity Management/Maternity Support) Program*— focuses on prevention and education to help employees and families have healthy, full-term babies. See page 79 for details.

Features of the Texas Health Aetna Medical Options

These features apply to the Texas Health Aetna Select Plan 1000 and Select Plan 3000 options:

- *Texas Health Aetna Anytime-MD*—gives 24/7 access to ER docs on the medical staff at a Texas Health hospital who communicate in texting format with you regarding non-emergency issues and can prevent long, inconvenient waits in an ER.
- *Holistic Care Team*—this approach to integrated care management includes a Medical Director, Care Management Supervisor, Pharmacist, RN Care Managers, Social Workers, Diabetic Educators and Care Manager Associates – all locally based who, when needed, will meet you wherever it is most convenient or advantageous, including your home or a physician's office – to help you with a complex diagnosis or treatment.
- *AbleTo*—a Cognitive Behavioral Therapy offering done in a virtual format that gives you weekly sessions over an 8-week period with a Licensed Therapist and Health Coach, as well as in-between sessions with the Health Coach.

- *Compassionate Care program* – offers case management and services to members and their families who are managing the complex and emotional issues involved with advanced illness. The program provides assistance in a culturally sensitive manner that supports and respects their decisions and choices. Support includes:
  - Providing clinical resources to assist you, your family and/or caregiver
  - Providing education, as appropriate, on your condition(s), and topics to discuss with your providers and family
  - Assisting in the coordination of care among providers
  - Assisting you with managing benefits
  - Assisting with pain and symptom management
  - Promoting continuity of care
  - Facilitating advance care planning
  - Providing compassionate support to you, your family and/or caregiver
  - Helping you access community-based resources
- *The member Navigator website* – is a fast, easy way to take care of benefits business and:
  - See who's covered under your plan
  - Check medical claims
  - Get a cost breakdown — your Explanation of Benefits
  - Find providers in your network
  - Get a digital ID card
  - Access your Personal Health Record to make informed decisions
  - Link to health information
  - Access a Health Decision Support Tool to help you understand your condition, learn about options, and make the right decision
  - While you're logged in, you can email or chat with Member Services

Features of UnitedHealthcare Medical Options

These features apply to medical options administered by UnitedHealthcare:

- *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.
- *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 **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.
- *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.
- *Benefits for Mental Health and Substance Use Disorder*—Mental health and Substance-Related and Addictive Disorders Services must be coordinated through United Behavioral Health (UBH) if you are covered by a medical plan option administered by UHC.

ADMINISTRATORS, NETWORKS, AND PLANS

Texas Health Aetna

The Texas Health Aetna medical plan options give you access to the Open Access EPO Plus Network. It's a smaller, local network, like a Health Maintenance Organization (HMO), but there's no gatekeeper or approvals to see a specialist.

Texas Health Aetna's local network has more than 23,000 participating providers, including primary care physicians and specialists. It also includes hospital systems such as Texas Health Resources, UT Southwestern, Methodist Health System, Scottish Rite System, and the local children's health systems – Cook Children's and Children's Medical Center.

To find a doctor or facility in the Texas Health Aetna network, simply visit **TexasHealthAetna.com** and click "Find a Doctor." Then, select "Employer Plan – Open Access EPO Plus" as your plan.

In the event you are not able to find your physician, it could be that he/she is affiliated with other health systems and is a component of the parent organization depending on the specialty or affiliation. For example, outpatient specialty care, diagnostic centers, rehabilitation centers, and mental health facilities including the Texas Health Resources' Breast Centers and Envision are providers that may not be listed but are in-network for Texas Health Aetna members.

The National Advantage Program (NAP) is a program in which providers can choose to participate. Texas Health Aetna contracts with third-party vendor networks of health care professionals and facilities. When members visit providers in these vendor networks, they can get negotiated rates for certain out-of-network services.

Not all non-participating providers have a NAP agreement. Texas Health Aetna's goal is to help a member become whole when possible. There are other ways that Texas Health Aetna attempts to negotiate with out of network providers when a contracted rate is not available i.e. Facility Claim Review (FCR).

To get the most up to date information, please contact Texas Health Aetna member services at 1-877-MyTHRLink (1-877-698-4754), prompt 1.

UnitedHealthcare

UnitedHealthcare (UHC) offers the 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. 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.

To find a doctor or facility in the UHC network or a Preferred Hospital, visit **http://welcometoUHC.com/THR**.

Depending on the geographic area and the service you receive, you may have access through UnitedHealthcare's Shared Savings Program to non-network providers who have agreed to discounts negotiated from their charges on certain claims for Covered Health Services. Refer to the definition of Shared Savings Program on page 231 for details about how the Shared Savings Program applies.

For a complete list of Texas Health Preferred Hospitals, go to **BeHealthyTHR.org.** You can also get the list of Texas Health Preferred Hospitals on **http://welcometouhc.com/thr**.

High Deductible Health Plans

- Texas Health offers two plans that qualify as High Deductible Health Plans (HDHP) – the Texas Health Aetna Select 3000 Plan option and the UHC Choice Plus 1500 Plan option. If you enroll in either HDHP option, you will be eligible to participate in a Health Savings Plan ("HSA"). See page 86 for more information on an HSA. In an HDHP, all costs are paid out of pocket by the employee until the deductible is met.
- There are special rules related to COVID-19 that affect participants in an HDHP. The HDHP temporarily covered virtual visits and other remote care services in 2020 prior to the deductible being met without impacting the HDHP. The HDHP also may temporarily cover COVID-19 testing and vaccines prior to the satisfaction of the applicable minimum deductible.

CHOOSE YOUR MEDICAL COVERAGE

Regardless of which network or medical plan option you choose, all the options cover the same medical services. Under all plan options, regardless of the plan administrator, there are some services that pay the same.

For example, under plan options Texas Health Aetna Select 1000 and UHC Choice Plans 500 and 1000, you pay:

- $0 copay for well-visits (see Preventive Care on page 37)
- $0 copay for virtual visits
- $30 copay for a PCP office visit
- $50 copay for a specialist office visit
- $50 copay for Urgent Care Center
- $100 copay, then 10% after the deductible for an Emergency room visit

The differences are in the premiums, the network composition, and the amount you pay out of your own pocket for medical care.

For the Texas Health Aetna Select 3000 and UHC Choice Plan 1500 plan options:

- Other than well-visits, you pay 100% for all medical and prescription costs until the deductible is met. How to meet the Texas Health Aetna 3000 deductible is shown on the chart on page 23 and individual vs. family deductibles are explained on page 34. How to meet the UHC Choice Plan 1500 deductible is shown on the chart on page 27 and individual vs. family deductibles are explained on page 35.
- After the deductible is met, you pay 10% of the cost for doctor's office visits and at in-network facilities. Your prescription costs will be determined by whether you chose the High or Low option. See page 61 for more information on how prescription costs work.

- Only the UHC Choice Plus 1500 option covers out-of-network doctors and facilities. The coinsurance amount at those facilities is 50% after your deductible is met.
- For virtual visits, you pay $0 with Texas Health Aetna when using Anytime-MD. If on the UHC Choice Plus 1500 Plan option, you pay the full cost until the member's deductible is met, then the cost for virtual visits is $0 for that member.

When choosing your option, you'll need to decide which factors are most important to you:

- Paying lower premiums but having a higher deductible and/or a smaller provider network
- Paying higher out-of-pocket costs, but having a Health Savings Account available to you
- Paying higher premiums but having a lower deductible
- Having coverage for out-of-network hospitals and doctors.

If you select the Texas Health Aetna network, you have the option of:

- Select Plan 3000
- Select Plan 1000.

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 options, see pages 23 – 31.

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. The UnitedHealthcare 500 and 1000 medical plan options and the Texas Health Aetna Select 1000 option have the same copay for generic drugs. With the Texas Health Aetna Select 3000 and UHC Choice Plus 1500 plan options, you pay the full cost of prescriptions, combined with medical costs, until the deductible is met.

The difference in the prescription options is in the premium you pay from your paycheck and the percentage of coinsurance you will pay for preferred and non-preferred drugs. But remember, you must meet the deductible first if you choose the Texas Health Aetna Select 3000 or the UHC Choice Plus Plan 1500 option. For a comparison of the plans, see page 32.

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 23 – 31.

Important terms that appear in this section are defined in the Glossary of Terms beginning on page 225.

WHO CAN BE COVERED

Benefits-eligible employees (as defined on page 5) or a COBRA participant (as defined on page 198), may elect one of the following levels of coverage under one of the medical plan options:

- 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 5 for information on eligibility.

You will be required to provide documentation that confirms the eligibility of dependents you cover, as explained on pages 5 – 7.

Out-of-Area Family Members

If you want to cover a family member who does not live in an area that has 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 network providers who practice in the location where your dependent lives, logon to **http://welcometouhc.com/thr**. 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.

Texas Health Preferred Hospitals for UHC Medical Plan Options

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.

2021 MEDICAL PLAN OPTIONS COMPARISON

The following pages compare the key features of the different medical options and the copays or coinsurance you must pay. There are differences among the plan option deductibles. Only the Choice 1500 Plus covers out-of-network care. All the plan provisions are subject to each plan option's copays, coinsurance and/or deductible amounts, as applicable. Some services require prior authorization. Excluded medical expenses are described on pages 52 – 58.

Your Cost for Covered Services – Texas Health Aetna Select 3000

Plan Feature	Texas Health Aetna EPO Plus Network Doctors, Hospitals, and Free-standing Facilities	Out of Network
Deductible	$3,000 individual / $6,000 family	Not covered
Annual Out-of-Pocket Maximum[2]	$6,750 individual / $13,500 family	Not covered
Outpatient Care		
Office Visits for Illness or Injury	10% after deductible	Not covered
Outpatient Diagnostic Lab & X-ray (excluding MRI, CT, PET scans)[3]	10% after deductible	Not covered
Chemotherapy Treatment	10% after deductible	Not covered
Radiation	10% after deductible	Not covered
MRI, CT & PET Scans[3]	10% after deductible	Not covered
Outpatient Surgery	10% after deductible	Not covered
Emergency Room[4]	10% after deductible	
Urgent Care Clinic	10% after deductible	Not covered
Walk-In Clinic (e.g., CVS Minute Clinic)	10% after deductible	Not covered
Virtual Visits[5]	$0	Not covered
Preventive Care		
Routine Physicals[6]	$0	Not covered
Well-Woman/Man Exams (Including Pap Test or PSA Test)[6]	$0	Not covered
Well-Child Care (Including Immunizations)[6]	$0	Not covered
Colonoscopy[7]	$0	Not covered
Mammography[7]	$0	Not covered
Maternity Care		
Office Visits for Pre- and Post-natal Care	10% after deductible	Not covered
In-hospital Delivery and Newborn Nursery Care including all physician charges	10% after deductible	Not covered
Inpatient Hospital Care		
Hospital Admission[9]	10% after deductible	Not covered
Family Planning		
Infertility Services—diagnostic testing[10]	10% after deductible	Not covered
Sterilization (tubal ligation)	$0	Not covered
Sterilization (vasectomy)	10% after deductible	Not covered

Footnotes are on page 31.

Your Cost for Covered Services – Texas Health Aetna Select 3000 (continued)

Plan Feature	Texas Health Aetna EPO Plus Network Doctors, Hospitals, and Free-standing Facilities	Out of Network
Mental Health Care and Substance-Related and Addictive Disorders Services		
Outpatient Mental Health Care and Substance-Related and Addictive Disorders Services, including Behavioral Health Televideo	10% after deductible	Not covered
Inpatient Mental Health Care and Substance-Related and Addictive Disorders Services	10% after deductible	Not covered
Partial Hospitalization/Intensive Outpatient Treatment	10% after deductible	Not covered
Hearing Care		
Hearing Evaluation	10% after deductible	Not covered
Hearing Aids (one new pair every 36 months)	10% after deductible	Not covered
Outpatient Therapy		
Cardiac Rehabilitation Therapy (up to 36 visits per year)	10% after deductible	Not covered
Chiropractic, Acupuncture and Spinal Manipulation (20 combined visits)	10% after deductible	Not covered
Pulmonary and Rehabilitative Services (20 combined visits)	10% after deductible	Not covered
Speech, Occupational, and Physical Therapy (combined 60 visits)	10% after deductible	Not covered
Care at Alternate Sites		
Home Health Care (up to 100 visits per year; one visit is up to four hours)	10% after deductible	Not covered
Skilled Nursing Care (up to 60 days per year)	10% after deductible	Not covered
Hospice Care	10% after deductible	Not covered
Other Services		
Ambulance	10% after deductible	
Allergy Tests and Treatment	10% after deductible	Not covered
Cosmetic Surgery[11]	10% after deductible	Not covered
Durable Medical Equipment (diabetic supplies are unlimited)[12]	10% after deductible	Not covered
Glasses or Contacts[13]	10% after deductible	Not covered
Organ and Tissue Transplants[14]	10% after deductible	Not covered
Orthognathic and TMJ[15]	10% after deductible	Not covered
Ostomy Supplies	10% after deductible	Not covered
Bariatric Surgery[16] (must meet specific guidelines described on page 47 under "obesity" and be at least 18 years old)	10% after deductible	Not covered
Nutrition Coaching (one initial assessment and up to three 30-minute sessions per year)[17]	10% after deductible (only at Texas Health or UTSW facilities)	Not covered
Diabetes Education[18]	10% after deductible	Not covered

Footnotes are on page 31.

Your Cost for Covered Services – Texas Health Aetna Select 1000

Plan Feature	Texas Health Aetna EPO Plus Network Doctors, Hospitals, and Free-standing Facilities	Out of Network
Deductible	$1,000 individual / $3,000 family	Not covered
Annual Out-of-Pocket Maximum[2]	$6,850 individual / $13,700 family	Not covered
Outpatient Care		
Office Visits for Illness or Injury	$30 copay for PCP; $50 copay for specialist	Not covered
Outpatient Diagnostic Lab & X-ray (excluding MRI, CT, PET scans)[3]	No additional charge if processed in doctor's office; 10% after deductible if not in doctor's office	Not covered
Chemotherapy Treatment	$50 copay for treatment in specialist's office; 10% after deductible if not in specialist's office	Not covered
Radiation	10% after deductible	Not covered
MRI, CT & PET Scans[3]	10% after deductible	Not covered
Outpatient Surgery	Office visit copay applies; 10% after deductible if not in doctor's office	Not covered
Emergency Room[4]	$100 copay, then 10% after deductible	
Urgent Care Clinic	$50 copay	Not covered
Walk-In Clinic (e.g., CVS Minute Clinic)	$30 copay	Not covered
Virtual Visits[5]	$0	Not covered
Preventive Care		
Routine Physicals[6]	$0	Not covered
Well-Woman/Man Exams (Including Pap Test or PSA Test)[6]	$0	Not covered
Well-Child Care (Including Immunizations)[6]	$0	Not covered
Colonoscopy[7]	$0	Not covered
Mammography[7]	$0	Not covered
Maternity Care		
Office Visits for Pre- and Post-natal Care	$30 copay for initial office visit; no cost for additional visits	Not covered
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	Not covered
Inpatient Hospital Care		
Hospital Admission[9]	10% after deductible	Not covered
Family Planning		
Infertility Services—diagnostic testing[10]	10% after deductible	Not covered
Sterilization (tubal ligation)	$0	Not covered
Sterilization (vasectomy)	Office visit copay applies; 10% after deductible if not in doctor's office	Not covered

Footnotes are on page 31.

Your Cost for Covered Services – Texas Health Aetna Select 1000 (continued)

Plan Feature	Texas Health Aetna EPO Plus Network Doctors, Hospitals, and Free-standing Facilities	Out of Network
Mental Health Care and Substance-Related and Addictive Disorders Services		
Outpatient Mental Health Care and Substance-Related and Addictive Disorders Services, including Behavioral Health Televideo	$30 per visit	Not covered
Inpatient Mental Health Care and Substance-Related and Addictive Disorders Services	10% after deductible	Not covered
Partial Hospitalization/Intensive Outpatient Treatment	10% after deductible	Not covered
Hearing Care		
Hearing Evaluation	Office visit copay applies; 10% after deductible if not in doctor's office	Not covered
Hearing Aids (one new pair every 36 months)	10% after deductible	Not covered
Outpatient Therapy		
Cardiac Rehabilitation Therapy (up to 36 visits per year)	$30 per visit	Not covered
Chiropractic, Acupuncture and Spinal Manipulation (20 combined visits)	$50 per visit	Not covered
Pulmonary and Rehabilitative Services (20 combined visits)	$30 per visit	Not covered
Speech, Occupational, and Physical Therapy (combined 60 visits)	$30 per visit	Not covered
Care at Alternate Sites		
Home Health Care (up to 100 visits per year; one visit is up to four hours)	10% after deductible	Not covered
Skilled Nursing Care (up to 60 days per year)	10% after deductible	Not covered
Hospice Care	10% after deductible	Not covered
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)	Not covered
Cosmetic Surgery[11]	10% after deductible	Not covered
Durable Medical Equipment (diabetic supplies are unlimited)[12]	10% after deductible	Not covered
Glasses or Contacts[13]	10% after deductible	Not covered
Organ and Tissue Transplants[14]	10% after deductible	Not covered
Orthognathic and TMJ[15]	10% after deductible	Not covered
Ostomy Supplies	10% after deductible	Not covered
Bariatric Surgery[16] (must meet specific guidelines described on page 47 under "obesity" and be at least 18 years old)	10% after deductible	Not covered
Nutrition Coaching (one initial assessment and up to three 30-minute sessions per year)[17]	$0 copay per session (only at Texas Health or UTSW facilities)	Not covered
Diabetes Education[18]	$10 copay (only at Texas Health or UTSW facilities)	Not covered

Footnotes are on page 31.

UnitedHealthcare Deductibles and Out-of-Pocket Maximums

OPTION NAME	Preferred Hospitals		UHC Choice Network		Out-of-Network[1]	
	Individual	Family	Individual	Family	Individual	Family
Choice 500						
Annual Deductible	$500	$1,500	$3,000	$9,000	Not covered	Not covered
Annual Out-of-Pocket Maximum[2]	$6,850	$13,700	$6,850	$13,700	Not covered	Not covered
Choice 1000						
Annual Deductible	$1,000	$3,000	$4,000	$12,000	Not covered	Not covered
Annual Out-of-Pocket Maximum[2]	$6,850	$13,700	$6,850	$13,700	Not covered	Not covered
Choice 1500 Plus						
Annual Deductible[19]	$1,500	$4,500	$4,000	$12,000	$5,000	$15,000
Annual Out-of-Pocket Maximum[2]	$6,750	$13,500	$6,750	$13,500	$18,000	$36,000

Your Cost for Covered Services – UHC Choice 500 and Choice 1000

Plan Feature	UHC Choice Network Doctors, Preferred Hospitals and Free-standing Facilities	UHC Choice Network Hospitals
Outpatient Care		
Office Visits for Illness or Injury	$30 copay for primary physician $50 copay for specialist	
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	70% after deductible
Chemotherapy Treatment	$50 copay for specialist	
Radiation	10% after deductible	70% after deductible
MRI, CT & PET Scans[3,8]	10% after deductible	70% after deductible
Outpatient Surgery	Office visit copay applies; 10% after deductible if not in doctor's office	70% after deductible if not in doctor's office
Emergency Room[4]	$100 copay, then 10% after deductible	
Urgent Care Clinic	$50 copay	
Walk-In Clinic (e.g., CVS Minute Clinic)	$30 copay	
Virtual Visits[5]	$0	
Preventive Care		
Routine Physicals[6]	$0	
Well-woman/man exams[6] (including pap test and PSA test)	$0	
Well-child exams (including immunizations)[6]	$0	
Mammography[7]	$0	
Colonoscopy[7]	$0	
Maternity Care		
Office Visits for Pre- and Post-natal Care	$30 for initial office visit; no cost for additional visits	
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	70% after deductible[7]

Footnotes are on page 31.

Your Cost for Covered Services – UHC Choice 500 and Choice 1000 (Continued)

Plan Feature	UHC Choice Network Doctors, Preferred Hospitals and Free-standing Facilities	UHC Choice Network Hospitals
Inpatient Hospital Care		
Hospital Admission[9]	10% after deductible	70% after deductible
Family Planning		
Infertility Services—diagnostic testing[10]	10% after deductible	70% after deductible
Sterilization (tubal ligation)	$0	$0
Sterilization (vasectomy)	Office visit copay applies; 10% after deductible if not in doctor's office	Office visit copay applies; 70% after deductible if not in doctor's office
Mental Health Care and Substance-Related and Addictive Disorders Services		
Outpatient Mental Health Care and Substance-Related and Addictive Disorders Services	$30 per visit	
Inpatient Mental Health Care and Substance-Related and Addictive Disorders Services	10% after deductible	
Partial Hospitalization/Intensive Outpatient Treatment	10% after deductible	
Hearing Care		
Hearing Evaluation	Office visit copay applies; 10% after deductible if not in doctor's office	Office visit copay applies; 70% after deductible if not in doctor's office
Hearing Aids (one new pair every 36 months)	10% after deductible	
Outpatient Therapy		
Cardiac Rehabilitation Therapy (up to 36 visits per year)	$30 per visit	$50 per visit
Chiropractic, Acupuncture and Spinal Manipulation (20 combined visits)	$50 per visit	
Pulmonary and Rehabilitative Services (20 combined visits)	$30 per visit	$50 per visit
Speech, Occupational, and Physical Therapy (combined 60 visits)	$30 per visit	$50 per visit
Care at Alternate Sites		
Home Health Care (up to 100 visits per year; one visit is up to four hours)	10% after deductible	
Skilled Nursing Care (up to 60 days per year)	10% after deductible	
Hospice Care	10% after deductible	
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)	
Cosmetic Surgery[11]	10% after deductible	70% after deductible
Durable Medical Equipment (diabetic supplies are unlimited)[12]	10% after deductible	
Glasses or Contacts[13]	10% after deductible	
Organ and Tissue Transplants[14]	10% after deductible	
Orthognathic and TMJ[15]	10% after deductible	70% after deductible

Footnotes are on page 31.

Your Cost for Covered Services – UHC Choice 500 and Choice 1000 (Continued)

Plan Feature	UHC Choice Network Doctors, Preferred Hospitals and Free-standing Facilities	UHC Choice Network Hospitals
Other Services		
Ostomy Supplies	10% after deductible	
Bariatric Surgery[16] (must meet specific guidelines described on page 47 under "obesity" and be at least 18 years old)	10% after deductible	Not covered
Nutrition Coaching (one initial assessment and up to three 30-minute sessions per year)[17]	$0 copay per session (only at Texas Health and UTSW facilities)	Not covered
Diabetes Education[18]	$10 copay (only at Texas Health or UTSW facilities)	

Out-of-network care is **not** covered under UHC Choice 500 or 1000, unless it is for an emergency.

Your Cost for Covered Services – UHC Choice Plus 1500

Plan Feature	UHC Choice Network Doctors, Preferred Hospitals and Free-standing Facilities	UHC Choice Network Hospitals	Out-of-Network[1] (Covered only Under Choice 1500 Plus)
Outpatient Care			
Office Visits for Illness or Injury	10% after deductible		50% after deductible
Outpatient Diagnostic Lab & X-ray[3] (excluding MRI, CT, PET scans)	10% after deductible		50% after deductible
Chemotherapy Treatment	10% after deductible		50% after deductible
Radiation	10% after deductible	50% after deductible	50% after deductible
MRI, CT & PET Scans[3,8]	10% after deductible	50% after deductible	50% after deductible
Outpatient Surgery	10% after deductible	50% after deductible	50% after deductible with notification[7]
Emergency Room[4]	10% after deductible		
Urgent Care Clinic	10% after deductible		50% after deductible
Walk-In Clinic (e.g., CVS Minute Clinic)	10% after deductible		50% after deductible
Virtual Visits[5]	$0 after deductible		
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[7]	$0		Not covered
Colonoscopy[7]	$0		Not covered
Maternity Care			
Office Visits for Pre- and Post-natal Care	10% after deductible		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[7]	

Footnotes are on page 31.

Your Cost for Covered Services – UHC Choice Plus 1500 (Continued)

Plan Feature	UHC Choice Network Doctors, Preferred Hospitals and Free-standing Facilities	UHC Choice Network Hospitals	Out-of-Network[1] (Covered only Under Choice 1500 Plus)
Inpatient Hospital Care			
Hospital Admission[9]	10% after deductible	50% after deductible	50% after deductible with notification[7]
Family Planning			
Infertility Services—diagnostic testing[10]	10% after deductible	50% after deductible	
Sterilization (tubal ligation)	$0		50% after deductible
Sterilization (vasectomy)	10% after deductible	50% after deductible	50% after deductible
Mental Health Care and Substance-Related and Addictive Disorders Services			
Outpatient Mental Health Care and Substance-Related and Addictive Disorders Services	10% after deductible		50% after deductible
Inpatient Mental Health Care and Substance-Related and Addictive Disorders Services	10% after deductible		50% after deductible[7]
Partial Hospitalization/Intensive Outpatient Treatment	10% after deductible		50% after deductible
Hearing Care			
Hearing Evaluation	10% after deductible	50% after deductible	50% after deductible
Hearing Aids (one new pair every 36 months)	10% after deductible		50% after deductible
Outpatient Therapy			
Cardiac Rehabilitation Therapy (up to 36 visits per year)	10% after deductible		50% after deductible
Chiropractic, Acupuncture and Spinal Manipulation (20 combined visits)	10% after deductible		50% after deductible
Pulmonary and Rehabilitative Services (20 combined visits)	10% after deductible		50% after deductible
Speech, Occupational, and Physical Therapy (combined 60 visits)	10% after deductible		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[7]
Skilled Nursing Care (up to 60 days per year)	10% after deductible		50% after deductible[7]
Hospice Care	10% after deductible		50% after deductible[7]

Footnotes are on page 31.

Your Cost for Covered Services – Choice Plus 1500 (Continued)

Plan Feature	UHC Choice Network Doctors, Preferred Hospitals and Free-standing Facilities	UHC Choice Network Hospitals	Out-of-Network[1] (Covered only Under Choice 1500 Plus)
Other Services			
Ambulance	10% after deductible		
Allergy Tests and Treatment	10% after deductible		50% after deductible
Cosmetic Surgery[11]	10% after deductible	50% after deductible	50% after deductible[7]
Durable Medical Equipment (diabetic supplies are unlimited)[12]	10% after deductible		50% after deductible[7]
Glasses or Contacts[13]	10% after deductible		50% after deductible
Organ and Tissue Transplants[14]	10% after deductible		Not covered
Orthognathic and TMJ[15]	10% after deductible	50% after deductible	
Ostomy Supplies	10% after deductible		50% after deductible
Bariatric Surgery[16] (must meet specific guidelines described on page 47 under "obesity" and be at least 18 years old)	10% after deductible	Not covered	
Nutrition Coaching (one initial assessment and up to three 30-minute sessions per year)[17]	10% after deductible (only at Texas Health and UTSW facilities)	Not covered	
Diabetes Education[18]	10% after deductible (only at Texas Health or UTSW facilities)		Not covered

[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 includes the annual deductible, medical coinsurance, medical copays, prescription coinsurance and prescription copays. It does not include non-compliance penalties, your premiums, or expenses that are not covered by the plan.

[3] Whenever you have an X-ray or lab service, you may 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 Texas Health Aetna Select 3000, Texas Health Aetna Select 1000, UHC Choice 500 and UHC Choice 1000.

[4] Non-emergency use of the emergency room is not covered

[5] For the purposes of this Handbook, a virtual visit is a visit to provide medical information in real-time between a patient and a provider through use of interactive audio with video communications or audio-only equipment outside of a medical facility (for example, from home or from work). The Virtual Visit service provided by Texas Health Aetna is called AnytimeMD and the virtual visit services provided by UHC are through DocOnDemand, TelaDoc, and AmWell.

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

[8] Prior authorization is required. Denial or $1,000 penalty may apply for failure to obtain prior authorization.

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

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

[11] 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).

[12] You must pre-notify the claims administrator for durable medical equipment that costs more than $1,000.

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

[14] Coverage is limited to non-experimental transplants at approved hospitals, as explained on page 51.

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

[16] Bariatric surgery can only be performed at Texas Health hospitals that are designated as a Texas Health Aetna Institute of Excellence or a Center of Excellence by UHC.

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

[18] You must have a physician's referral. If you visit a Texas Health or UTSW diabetes educator, you may receive free test strips.

[19] The UHC Choice 1500 plan option has a non-embedded deductible. This means the family deductible must be paid out-of-pocket before the plan starts paying for health care services for any individual member.

PRESCRIPTION DRUG COMPARISON

Type of Prescription	High Rx		Low Rx	
	Retail[20]	**Mail Order[21]**	**Retail[20]**	**Mail Order[21]**
Generic[22]	$10 copay	$20 copay	$10 copay	$20 copay
Preferred	25% of cost of 30-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 30-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 (Drugs Not on the Value Formulary)	Not covered. You pay 100% of the cost. If an exception is approved, you pay 40% of cost of 30-day supply ($40 minimum and $300 maximum copay per prescription)	Not covered. You pay 100% of the cost. If an exception is approved, you pay 40% of cost of 90-day supply ($80 minimum and $400 maximum copay per prescription)	Not covered. You pay 100% of the cost. If an exception is approved, you pay 50% of cost of 30-day supply ($40 minimum and $300 maximum copay per prescription)	Not covered. You pay 100% of the cost. If an exception is approved, you pay 50% of cost of 90-day supply ($80 minimum and $600 maximum copay per prescription)
Annual Out-of-Pocket Maximum[23]	$6,850 individual, $13,700 family for all plan options except Texas Health Aetna Select 3000 and UHC Choice 1500 $6,750 individual, $13,500 family for Texas Health Aetna Select 3000 and UHC Choice 1500		$6,850 individual, $13,700 family for all plan options except Texas Health Aetna Select 3000 and UHC Choice 1500 $6,750 individual, $13,500 family for Texas Health Aetna Select 3000 and UHC Choice 1500	

[20]Up to a 30-day supply

[21]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, Texas Health Plano, Texas Health Infusion Pharmacy, or any CVS pharmacy. Otherwise you pay double the retail charge.

[22]In order to have coverage for prescription drugs in certain drug classes, you must try a generic drug first (see page 62 for more information).

[23]Maximum combined for retail and mail-order prescriptions. Prescription drug annual out-of-pocket maximum is combined with medical annual out-of-pocket maximum. Copays for generic drugs, as well as coinsurance for drugs, apply toward the out-of-pocket maximum.

Prescription Drug Deductibles

For Texas Health Aetna Select 3000 and the UHC Choice Plus 1500 plan options, you pay the full cost of your prescription drugs until you reach your deductible. After you pay your deductible, your insurance benefits kick in and you pay the copay or coinsurance amount shown in the chart above. How to meet the Texas Health Aetna 3000 deductible is shown on the chart on page 23 and individual vs. family deductibles are explained on page 34. How to meet the UHC Choice Plan 1500 deductible is shown on the chart on page 27 and individual vs. family deductibles are explained on page 35.

Extracare Health Discount Cards

Caremark has made available via electronic means ExtraCare Health discount cards ("ExtraCare Card"). The ExtraCare Card provides the ability to earn rewards for purchases at CVS/pharmacy stores or online at **CVS.com** and to receive a 20% discount on all CVS-branded health care-related items that are FSA-eligible at CVS/pharmacy stores, provided that no rewards or discounts are available for the purchase of certain items, such as prescription drugs.

TEXAS HEALTH AETNA PLAN OPTIONS

The Texas Health Aetna plan options include the Select 3000 and the Select 1000. The plan options pay benefits when you use providers who are part of the Open Access EPO Plus Network. It's a smaller, local network, like a Health Maintenance Organization (HMO), but there's no gatekeeper or approvals to see a specialist.

Well-care visits and visits through Texas Health Aetna Anytime-MD are $0. These plan options generally pay no benefits if you use out-of-network providers, except in the event of an emergency (as defined on page 227). You do not file any claims.

With the Select 3000, a qualifying high deductible health plan, you must meet an annual deductible before the plan pays for most services including office visits, urgent care and prescriptions. After meeting the deductible, all medical services require coinsurance except virtual visits and preventive visits.

Advantages of this plan include:

- No claims to file
- Lowest premiums
- Comes with a Health Savings Account.

With the Select 1000, 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. All services require coinsurance except office visits, routine physicals, urgent care and walk-in care, virtual visits, and preventive visits.

Advantages of this plan include:

- No claims to file
- Low premiums.

UHC CHOICE PLAN OPTIONS

The UHC Choice 500 and 1000 pay benefits only when you use providers who are part of the UHC Choice network. Virtual Visits are $0 cost. 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 227).

Advantages of these plan options include:

- Lower deductible
- Lower out-of-pocket expenses
- No claims to file
- Larger network of providers.

UHC CHOICE PLUS OPTION

The UHC Choice Plus 1500 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.

Doctors office visits and urgent care are 10% after deductible. Virtual visits are $0 after deductible. For most other services, you must meet an annual deductible and pay your coinsurance before the plan pays benefits. 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 1500 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
- No claims to file when you use network providers
- Comes with a Health Savings Account.

HOW THE TEXAS HEALTH AETNA PLAN OPTIONS WORK

The Texas Health Aetna Select 1000 and 3000 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. All medical treatment must be considered a covered health service (as explained on page 226) to be eligible for coverage by the plan. The plan will not pay more than the allowable expenses.

See pages 41 – 52 for a list of covered medical expenses under the Texas Health Aetna options.

You may use any Texas Health Aetna network provider or facility you wish. However, if your Texas Health Aetna network doctor refers you to a hospital that is not in-network, there is no coverage. Because network providers may change, you should always verify that the hospital and/or provider is in the network before receiving services.

For a list of in-network providers and hospitals, you can use the Texas Health Aetna Call Center at 1-877-698-4754, option 1 or go to **TexasHealthAetna.com**.

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.

If you receive prior approval from the claims administrator, benefits will be paid as though you had used a network 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 certain covered health services. Copays do not count towards the deductible. After you satisfy the deductible, the plan pays a percentage of eligible expenses. For the Texas Health Aetna Select 1000 plan option, your prescription copays are not subject to deductibles. For the Texas Health Aetna Select 3000 plan option, prescription costs will not be paid until the deductible is met and then copays and coinsurance apply.

Family Deductible

In a family of two, both family members must meet their separate individual annual deductible in order to satisfy the family deductible. In a family of three or more members, each family member contributes to his or her own individual annual deductible. After two covered family members meet their individual annual deductible, family members together can satisfy the family deductible.

Coinsurance

Coinsurance is the percentage of medical expenses you are responsible for paying after you meet the annual deductible. You pay your coinsurance and the plan pays the remaining percentage until you reach your out of pocket maximum.

Out-of-Pocket Maximum

You will not pay more than the annual out-of-pocket maximum in one year for covered services when you use network providers. After your coinsurance, deductible and medical/prescription copay costs reach the applicable out-of-pocket maximum, the plan pays the full cost of covered expenses for the rest of the year.

Your premiums, non-notification penalties, and non-covered medical expenses do not count toward the out-of-pocket maximum.

Fee Limits

The Texas Health Aetna Select 1000 and 3000 plan options pay in-network benefits based on contracted rates. Out-of-network claims are not covered under the plan unless it is an emergency. Network doctors and hospitals agree to keep their fees within the plan's eligible expenses or allowable amount for your area.

Eligible Expenses

Texas Health Resources has delegated to the claims administrator the discretion and authority to decide whether a treatment or supply is a covered health service and how the eligible expenses will be determined and otherwise covered under the Plan.

Eligible expenses are the amount the claims administrator determines that the claims administrator will pay for benefits. For in-network benefits, you are not responsible for any difference between the eligible expense and the amount the provider bills. Eligible expenses are determined solely in accordance with the claims administrator's reimbursement policy guidelines.

For In-Network Benefits

Eligible expenses are based on the following:

- When covered health services are received from a network provider, eligible expenses are the claims administrator's contracted fee(s) with that provider.
- When covered health services are received from a non-network provider as a result of an emergency or as arranged by the claims administrator, eligible expenses are billed charges unless a lower amount is negotiated or authorized by law. Please contact Texas Health Aetna if you are billed for amounts in excess of your applicable coinsurance, copayment or any deductible. The medical plan will not pay excessive charges or amounts you are not legally obligated to pay.

For Non-Network Benefits*

Eligible expenses are based on either of the following:

- When covered health services are received from a non-network provider, allowable expenses are determined, based on:
- Negotiated rates agreed to by the non-network provider and either the claims administrator or one of the claims administrator's vendors, affiliates or subcontractors, at the claims administrator's discretion.
- If rates have not been negotiated, eligible expenses are determined based on reasonable and customary rates for the same or similar service within the geographic market.

* Non-network providers are covered as the result of an emergency or if arranged and approved by the claims administrator.

HOW THE UHC PLAN OPTIONS WORK

UHC Choice 500 and 1000, and Choice Plus 1500 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 226) to be eligible for coverage by the plan. The plan will not pay more than the eligible expenses.

See pages 41 – 52 for a list of covered medical expenses.

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 (70% of the cost of covered services with the Choice 500 and 1000 plan options) 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.

For a list of Preferred Hospitals, go to **BeHealthyTHR.org**. 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.

If you receive prior approval from the claims administrator, 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.

For the UHC Choice Plus 1500 plan option, prescription costs will not be paid until the deductible is met and then copays and coinsurance apply. If you are enrolled in the UHC Choice 1500 plan option and have any dependents covered, please see the description within *Family Deductible* below.

Family Deductible

For those enrolled in the 500 and 1000 plan options, in a family of two, both family members must meet their separate individual annual deductible in order to satisfy the family deductible. In a family of three or more members, each family member contributes to his or her own individual annual deductible. After two covered family members meet their individual annual deductible, family members together can satisfy the family deductible.

For those enrolled in the UHC Choice 1500 plan option, this plan has a non-embedded deductible. This means the family deductible must be paid out-of-pocket before the plan starts paying for health care services for any individual member. Expenses paid for all family members combine to meet the deductible.

How Deductibles Cross-apply

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

If you participate in the UHC Choice 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. 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 1500 option.

Out-of-Pocket Maximum

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 UHC Choice Plus.

After your coinsurance, deductible and medical/prescription copay 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 UHC Choice 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 UHC Choice 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.

Your premiums, non-notification penalties, and non-covered medical expenses do not count toward the out-of-pocket maximum.

Fee Limits

The UHC Choice and Choice Plus options pay in-network benefits based on contracted rates. Out-of-network claims for the UHC Choice Plus 1500 option 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. 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.

Eligible Expenses

Texas Health Resources has delegated to the claims administrator the discretion and authority to decide whether a treatment or supply is a covered health service and how the eligible expenses will be determined and otherwise covered under the Plan.

Eligible expenses are the amount the claims administrator determines that the claims administrator will pay for benefits. For in-network benefits, you are not responsible for any difference between eligible expenses and the amount the provider bills. For non-network benefits, you are responsible for paying, directly to the non-network provider, any difference between the amount the provider bills you and the amount the claims administrator will pay for eligible expenses. Eligible expenses are determined solely in accordance with the claims administrator's reimbursement policy guidelines.

Reimbursement Policies

UnitedHealthcare develops its reimbursement policy guidelines, in its sole discretion, in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association, and/or the Centers for Medicare and Medicaid Services (CMS)
- As reported by generally recognized professionals or publications
- As used for Medicare
- As determined by medical staff and outside medical consultants pursuant to other appropriate sources or determinations that UHC accepts

Following evaluation and validation of certain provider billings (e.g., error, abuse and fraud reviews), UHC reimbursement policies are applied to provider billings. UHC shares its reimbursement policies with Physicians and other providers in UHC's network through UHC's provider website. Network physicians and providers may not bill you for the difference between their contract rate (as may be modified by UHC's reimbursement policies) and the billed charge. However, non-network providers are not subject to this prohibition, and may bill you for any amounts the plan does not pay, including amounts that are denied because one of UHC's reimbursement policies does not reimburse (in whole or in part) for the service billed. You may obtain copies of UHC's reimbursement policies for yourself or to share with your non-network physician or provider by going to **myUHC.com** or by calling the telephone number on your ID card.

For In-Network Benefits

Eligible expenses are based on the following:

- When covered health services are received from a network provider, eligible expenses are the claims administrator's contracted fee(s) with that provider.
- When covered health services are received from a non-network provider as a result of an emergency or as arranged by the claims administrator, eligible expenses are billed charges unless a lower amount is negotiated or authorized by law. Please contact UnitedHealthcare if you are billed for amounts in excess of your applicable coinsurance, copayment or any deductible. The medical plan will not pay excessive charges or amounts you are not legally obligated to pay.

For Non-Network Benefits

Eligible expenses are based on either of the following:

- When covered health services are received from a non-network provider, eligible expenses are determined, based on:
  - Negotiated rates agreed to by the non-network provider and either the claims administrator or one of the claims administrator's vendors, affiliates or subcontractors, at the claims administrator's discretion.
  - If rates have not been negotiated, then one of the following amounts:
    - Eligible expenses are determined based on 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, with the exception of the following:
      - 50% of CMS for the same or similar laboratory service.

- 45% of CMS for the same or similar durable medical equipment, or CMS competitive bid rates.

- 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 pharmaceutical products, the claims administrator uses a gap methodology established by OptumInsight and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale(s) currently in use become no longer available, the claims administrator will use a comparable scale(s). UnitedHealthcare and OptumInsight are related companies through common ownership by UnitedHealth Group. Refer to UnitedHealthcare's website at **MyUHC.com** for information regarding the vendor that provides the applicable gap fill relative value scale information.
  - For pharmaceutical products, the claims administrator uses gap methodologies that are similar to the pricing methodology used by CMS, and produce 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 UnitedHealthcare 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, the eligible expense is based on 50% of the provider's billed charge.

- For mental health services and substance-related and addictive disorder services, the eligible expense will be reduced by 25% for covered health services provided by a psychologist and by 35% for covered health services provided by a masters level counselor.

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

RECEIVING CARE

Preventive Care

The Texas Health Aetna and UHC Choice and Choice Plus plan options 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 49 for more information about preventive care.

Virtual Visits with Texas Health Aetna Plan Options: Anytime-MD

At zero cost to you, Texas Health Aetna Anytime-MD gives 24/7 access to ER docs on the medical staff at a Texas Health hospital who communicate in texting format with you regarding non-emergency situations and can prevent long, inconvenient waits in an ER in most cases and a facilitated, more expedited Texas Health ER visit in those cases where it is deemed necessary and appropriate.

To access the Texas Health Aetna Anytime-MD:

- Simply register for your Texas Health Aetna Anytime-MD app account by going to **Anytime-MD.com**.
- Complete the short form.
- You can also access the app by downloading it to your mobile device from the App Store or Google Play™.

Virtual Visits with UHC Plan Options:

Virtual Visits are a convenient way to access care, when covered by a UHC medical plan option. When you have a minor illness (such as cold/flu, bladder infection, pink eye, stomach ache, sinus infection, rash, etc.), you can see a board-certified doctor by video chat. Most visits take about 15 minutes, and the doctor can send a prescription to your local pharmacy, if needed. The best part is Texas Health pays the entire cost for all UHC plans except the UHC Choice Plus 1500 plan option. You must pay 100% of Virtual Visits under the UHC Choice Plus 1500 plan option until the deductible is met and then they are a $0 copay.

Download the Doctors on Demand, Teladoc, or Amwell apps. The first time you visit, set up an account. You'll be asked to provide medical history, insurance information, pharmacy preference, etc.

Each time you visit, you'll be asked brief medical questions about your current medical concern. Then, you'll enter a virtual waiting room until you are connected with a board-certified doctor. The doctor will discuss your medical issue and send a prescription to your pharmacy, if appropriate. You can learn more about Virtual Visits at **myUHC.com**.

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 231) are listed on **TexasHealthAetna.com** for Texas Health Aetna medical option participants, and in the UHC directory on **MyUHC.com** for UHC medical option participants.

Emergency Care

The plan options cover emergency care worldwide. When you have a medical emergency (as defined on page 227), your visit to a hospital emergency room is covered as shown in the tables on pages 23 – 31.

For UHC medical plan options, 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 Prior Authorization

Prior authorization is required before you receive certain covered services or supplies. In general, network providers are responsible for receiving prior authorization from Texas Health Aetna or UHC before they provide these services to you. However, you are responsible for notifying Texas Health Aetna or UHC for certain network benefits.

For mental health/substance-related and addictive disorder services, you are responsible for notifying Texas Health Aetna or UHC.

If you elected the UHC Choice 1500 Plus and you receive certain covered services or supplies from non-network providers, you are responsible for notifying UHC before you receive these covered health services. You will be subject to a $1,000 penalty if you do not obtain prior authorization.

You are required to obtain prior authorization for the services listed in the box on the next page.

To notify Texas Health Aetna or UHC, call the telephone number on your ID card.

If covered by one of the UHC plan options, the following will also require prior authorization to be covered:

- Arthroscopy
- Hysterectomy
- Inflammatory Injectable Medications at the Site of Care
- Sinuplasty
- Site of Service Outpatient Surgical
- Foot Surgery
- Functional Endoscopic Sinus Surgery (FESS)
- Genetic Testing - BRCA
- Chemotherapy
- Major Diagnostic (CT scans, PET scans, MRI, MRA, and Nuclear Medicine)
- Stress Echocardiography
- Transthoracic Echocardiogram

When you receive services from non-network providers, you should confirm with Texas Health Aetna or UHC that the services you plan to receive are covered. If you are not in the UHC 1500 Plus option, they will not be covered.

You must obtain prior authorization from 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.

In the rare circumstance that Medicare is primary for you and the coverage through Texas Health is secondary, the prior authorization requirements above do not apply to you.

Texas Health Aetna Holistic Care Team

Texas Health Aetna's Holistic Care Team approach to integrated care management includes a Medical Director, Care Management Supervisor, Pharmacist, RN Care Managers, Social Workers, Diabetic Educators and Care Manager Associates – all locally based who, when needed, will meet you wherever it is most convenient or advantageous – including your home or a physician's office. To access the Holistic Care Team, call 1-877-MyTHRLink (1-877-698-4754) and select prompt 1.

Texas Health Aetna Member Services

Contact Member Services for help. Your plan includes the Concierge program, which provides access to health care resource consultants who have been specifically trained in the details of your plan. To contact a Concierge, call the Texas Health Aetna Call Center at 1-877-698-4754, option 1, 8 a.m. to 6 p.m. Monday through Friday.

The Cancer Support Service is available to assist members who have certain types of cancer: colorectal, lung, prostate, breast or women's reproductive system.

Texas Health Aetna Plan Benefits Navigator®

Register for the Plan Benefits Navigator, Texas Health Aetna's secure internet access to reliable health information, tools and resources. From the **TexasHealthAetna.com** home page, select Member Log In, then Log In Now. Then click, Register.

Log on to Plan Benefits Navigator to:

- See who's covered under your plan
- Check medical claims
- Get a cost breakdown — your Explanation of Benefits
- Find providers in your network
- Get a digital ID card
- Access your Personal Health Record to make informed decisions

* Wellness exams are 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.

SITUATIONS REQUIRING AUTHORIZATION

You must receive prior authorization from Texas Health Aetna or 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 use disorder conditions
- 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)
- Sleep studies
- ABA Therapy for Autism

If you do not follow the plan's requirement for authorization as explained on the previous page under "Your Responsibility for Prior Authorization" and/or you use non-network providers, you may be subject to a penalty.

Prior authorization is not a guarantee or a determination of benefits.

- Link to health information
- Access a Health Decision Support Tool to help you understand your condition, learn about options, and make the right decision
- While you're logged in, you can email or chat with Member Services.

UHC Personal Health Support℠

UHC Personal Health Support provides you with support to help you improve your health care experience. It is designed to encourage personalized, efficient care for you and your covered dependents. Personal Health Support Nurses center their efforts on prevention, education, and closing any gaps in your care. It can help when you require prior authorization, need to be admitted to a hospital or have an outpatient procedure. The program is available at 1-877-MyTHRLink (877-698-4754), prompt 2.

Personal Health Support includes:

- *Prior Authorization:* If you have a situation that requires prior authorization (listed in the box on this 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:* Nurse Advocates are available to help you prepare for a successful surgical admission and recovery.
- *Inpatient Care Management:* If you are hospitalized, a nurse will work with your physician to make sure you are getting the care you need and that your physician's treatment is being carried out effectively.
- *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.
- *Readmission Management:* This program serves as a bridge between the hospital and your home if you are at high risk of being readmitted. After leaving the hospital, if you have a certain chronic or complex condition, you may receive a phone call from a Personal Health Support Nurse to confirm that medications, needed equipment, or follow-up services are in place. The Personal Health Support Nurse will also share important health information, reiterate and reinforce discharge instructions, and support a safe transition home.

  If you do not receive a call from a Personal Health Support Nurse but feel you could benefit from any of these programs, please call UHC at 1-877-MyTHRLink (877-698-4754), prompt 2 and ask to be connected with Personal Health Support.

- *UHC 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.
- *UHC HealtheNote:* 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.
- *UHC Dedicated Team of Nurses:* A dedicated team of nurses is available to help you manage your pregnancy, as well as chronic and complex conditions.
- *Neonatal Resource Services (NRS)*: Specialized nurse and NICU provider consulting services to help manage your newborns NICU admission when the newborn's stay is longer than the mother's stay. You can call NRS toll-free at 888-936-7246 to receive this extra support.

Second Opinion Services

Second Opinion is a service that gives members access to experienced specialists via phone or video conference for education and guidance on: new diagnoses, possible surgery or procedure, questions about treatment plans or medications and ongoing chronic conditions. Second Opinion services are available for musculoskeletal, cardiac, gastrointestinal, and women's health diagnoses. To use this service, members may call 866-269-3534 or go to **https://www.2nd.md/behealthy**.

Health Advocacy with UHC

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.

Cancer Resource Services (CRS) Program

Texas Health offers the Cancer Resource Services (CRS) program to provide you with access to information and member assistance through a team of specialized cancer nurse consultants and access to one of the nation's leading cancer programs.

To learn more about CRS, visit **www.myoptumhealthcomplexmedical.com** or call the number on your ID card or call the program directly at 1-866-936-6002.

Coverage for oncology services and oncology-related services are based on your health plan's terms, exclusions, limitations and conditions, including the plan's eligibility requirements and coverage guidelines. Participation in this program is voluntary.

Texas Health Consumer Contact Center and TexasHealth.org

Texas Health offers you three resources to make it easier for you to use Texas Health hospitals for your own health care—the Consumer Contact Center, TexasHealth.org and Texas Health MyChart.

TexasHealth.org

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

- Schedule an appointment for mammograms at Texas Health breast centers, primary care physician visit and behavioral health or addiction screening

- Pre-registration for elective surgery, maternity stay, or outpatient surgery at Texas Health hospitals
- Information on family and community education classes
- Hospital bill payment
- Find an in-network primary care or specialty physician near your home or work {Also via contact center}

Consumer Contact Center

You can access free Texas Health 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 Texas Health Aetna or 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 Texas Health Aetna or UHC network.)
- Family and community class information and registration
- Information on Texas Health hospital departments and services

You can call and speak to a call center agent between 7:30 a.m. and 6:30 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.

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 plan, you do not need to be concerned that our medical plan 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.

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 23 – 31 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 regardless of gender identity. All services are subject to the excluded expenses listed on pages 52 – 58.

- Acupuncture—combined with chiropractic care, up to 20 visits per year (see chiropractic care for details)
- 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 46 under "Mental health services" 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—covered expenses include benefits for behavioral services for Autism Spectrum Disorder including Intensive Behavioral Therapies such as Applied Behavior Analysis (ABA) that are the following:
  - Focused on the treatment of core deficits of Autism Spectrum Disorder.
  - Provided by a *Board Certified Applied Behavior Analyst (BCBA)* or other qualified provider under the appropriate supervision.

  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 your claims administrator at 1-877-MyTHRLink (1-877-698-4754), prompt 1 for Texas Health Aetna and prompt 2 for UHC 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 purchasing one breast pump per pregnancy in conjunction with childbirth. Benefits are only available if breast pumps are obtained from a DME provider. Call your medical plan at 1-877-MyTHRLink (1-877-698-4754), prompt 1 for Texas Health Aetna and prompt 2 for UHC to get a breast pump at no cost.
- 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.
- Cellular and Gene Therapy—received on an inpatient or outpatient basis at a hospital or on an outpatient basis at an alternate facility or in a physician's office. Benefits for CAR-T therapy for malignancies are provided as described under *Transplantation Services*. For network benefits, you must provide pre-service notification as soon as the possibility of a cellular or gene therapy arises. If you do not obtain prior authorization and if, as a result, the services are not received from a designated provider, network benefit will not be paid.
- Chemotherapy—including wigs for alopecia following chemotherapy
- Chiropractic care/acupuncture/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.
- Clinical Trials—Covered Expenses include routine patient care costs incurred during participation in a qualifying clinical trial for the treatment of cancer or other life threatening conditions. Consistent with Centers for Medicare & Medicaid Services (CMS) policy and Patient Protection and Affordable Care Act (PPACA) requirements, Texas Health covers medically necessary routine patient care costs in clinical trials (in the same way that it reimburses routine care for members not in clinical trials) according to the limitations outlined below. All of the following limitations apply to such coverage:
  - All applicable plan limitations for coverage of out-of-network care will apply to routine patient care costs in clinical trials; and
  - All utilization management rules and coverage policies that apply to routine care for members not in clinical trials will also apply to routine patient care for members in clinical trials; and
  - Members must meet all applicable plan requirements for precertification, registration, and referrals; and
  - To qualify, a clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before participants are enrolled.

  With respect to cancer or other life-threatening diseases or conditions, a qualifying clinical trial is a Phase I, Phase II, Phase III, or Phase IV clinical trial that is conducted in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition and which meets any of the following criteria in the bulleted list below.
  - Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following: National Institutes of Health (NIH) which includes National Cancer Institute (NCI); Centers for Disease Control and Prevention (CDC); Agency for Healthcare Research and Quality (AHRQ); Centers for Medicare and Medicaid Services (CMS); a cooperative group or center of any of the entities described above or the Department of Defense (DOD) or the Veterans Administration (VA); a qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants; or the Department of Veterans Affairs, the Department of Defense or the Department of Energy, as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the Secretary of Health and Human Services to meet both of the following criteria:

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

comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
  - The study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration;
  - The study or investigation is a drug trial that is exempt from having such an investigational new drug application;
  - Written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the trial. We may, at any time, request documentation about the trial;
  - The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a covered health service and is not otherwise excluded under the Plan.
- 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 preventive or diagnostic colonoscopy per calendar year is covered at 100% with no copay or deductible. However, copays may apply to other services not billed as preventive. Additional colonoscopies are covered at the coinsurance/deductible level with no limit per calendar year.
- Congenital heart disease services—Benefits are covered for Congenital Heart Disease (CHD) services which are ordered by a physician. CHD surgical procedures include surgeries to treat conditions such as coarctation of the aorta, aortic stenosis, tetralogy of fallot, transposition of the great vessels and hypoplastic left or right heart syndrome. The claims administrator has specific guidelines regarding benefits for CHD services. Contact Personal Health Support at the number on your ID card for prior authorization and information about these guidelines.

  CHD services must be received at a CHD Resource Services program. Benefits include the facility charge and the charge for supplies and equipment.

  Surgery may be performed as open or closed surgical procedures or may be performed through interventional cardiac catheterization.

  Benefits are available for the following CHD services:
  - Outpatient diagnostic testing
  - Evaluation
  - Surgical interventions
  - Interventional cardiac catheterizations (insertion of a tubular device in the heart).
  - Fetal echocardiograms (examination, measurement and diagnosis of the heart using ultrasound technology).
  - Approved fetal interventions.

  CHD services other than those listed above are excluded from coverage, unless determined by the Claims Administrator to be proven procedures for the involved diagnoses. Contact CHD Resource Services at 1-888-936-7246 before receiving care for information about CHD services.
- Contact lenses—initial pair prescribed and purchased within 12 months after cataract surgery
- Cornea transplant
- COVID-19 testing and vaccines—will be treated as a covered expense as required or permitted under federal law
- Dental care/oral surgery—Services must be performed by a doctor of dental surgery (DDS) or a Doctor of Medical Dentistry (DMD).

  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.

  Dental services for final treatment to repair the damage caused by accidental injury must be started within 3 months of the accident, or if not a covered person at the time of the accident, within the first three months of coverage under the plan, unless extenuating circumstances exist (such as prolonged hospitalization or the presence of fixation wires from fracture care) and completed within 12 months of the accident, or if not a covered person at the time of the accident, within the first 12 months of coverage under the plan.

  Anesthesia and hospitalization services including covered health services provided in a hospital or alternate facility for dental conditions likely to result in a medical condition if left untreated, and performed on a covered person who is under 8 years of age and determined by a physician to require dental treatment in a hospital or alternate facility, due to a complex dental condition or a developmental disability that prevents effective treatment in a dental office; or has one or more medical conditions that would create undue medical risk if dental treatment were provided in a dental office. Benefits do not include expenses for diagnosis or treatment of

* Wellness exams are 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.

dental disease. Depending on where the covered health service is provided, any applicable notification or authorization requirements will be the same as those stated under each covered health service category.
  - 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— For all plan options except the Texas Health Aetna Select 3000 and the UHC Choice Plus 1500 plan options, after a $10 copay, the individual and group education sessions for both adult and pediatric diabetes patients are covered 100% at Texas Health and UTSW hospitals, 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 or UTSW diabetes educators at least quarterly.

  For the Texas Health Aetna Select 3000 and UHC Choice plus 1500 plan options, diabetes education at Texas Health and UTSW is covered but the full cost must be paid until the deductible is met. Then you pay 10% coinsurance.

  For children, pre-determination is required. The plan requires the physician to submit pre-determination including clinical notes for review and approval for medical appropriateness. If deemed medically necessary, the plan will cover diabetic education for children at a $10 copay then 100%, for individual or group education sessions by an in-network provider or in-network facility when services cannot be performed at Texas Health Preferred Hospitals (including UT Southwestern University Hospital and UT Southwestern University Hospital - Zale Lipshy); but only with a physician's referral.
- Diabetes supplies—the CVS Caremark prescription drug plan covers oral medications, insulin, syringes, blood glucose monitors, test strips, lancets, and chem strips. You can receive a glucose monitor free through CVS Caremark.
  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. Continuous Glucose Monitors (CGM), pieces of equipment that dispense glucose along with the observing/monitoring of how the CGM is working on a member, are covered by the medical plan based on the place of service. External pumps that deliver insulin into the intraperitoneal cavity are not covered.
- Diagnostic X-ray and lab
- Dialysis—when done on an outpatient basis, notification is not required by the claims administrator
- 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.
- Drug tests—Presumptive and definitive drug tests will be limited to 18 presumptive drug tests per calendar year and 18 definitive drug tests per calendar year.
- Durable medical equipment—for equipment that costs $1,000 or more, prior authorization is required. The Plan pays for Durable Medical Equipment (DME) that is:
  - ordered or provided by a physician for outpatient use;
  - used for medical purposes;
  - not consumable or disposable;
  - not of use to a person in the absence of a sickness, injury or disability;
  - durable enough to withstand repeated use; and
  - appropriate for use in the home.

  If more than one piece of DME can meet your functional needs, you will receive benefits only for the most cost-effective piece of equipment. Benefits are provided for a single unit of DME (example: one insulin pump) and for repairs of that unit. If you rent or purchase a piece of Durable Medical Equipment that exceeds this guideline, you may be responsible for any cost difference between the piece you rent or purchase and the piece the plan administrator has determined is the most cost-effective.

  Examples of DME include but are not limited to:
  - equipment to administer oxygen;
  - equipment to assist mobility, such as a standard wheelchairs;
  - hospital beds;
  - delivery pumps for tube feedings;
  - burn garments;
  - insulin pumps and all related necessary supplies as described under *Diabetes Supplies* above;
  - external cochlear devices and systems. Surgery to place a cochlear implant is also covered. Cochlear implantation can either be an inpatient or outpatient procedure;

- braces that stabilize an injured body part, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a covered health service. Braces that straighten or change the shape of a body part are orthotic devices and are excluded from coverage. Dental braces are also excluded from coverage.; and
- equipment for the treatment of chronic or acute respiratory failure or conditions.

The plan also covers tubings, nasal cannulas, connectors and masks used in connection with DME.

Benefits also include speech aid generating and tracheo-esophageal voice devices required for treatment of severe speech impediment or lack of speech directly attributed to sickness or injury. Benefits for the purchase of these devices are available only after completing a required three-month rental period.

Benefits for dedicated speech generating devices and tracheo-esophageal voice devices are limited to the purchase of one device during the entire period of time a covered person is enrolled under the plan.

To receive network benefits, you must purchase or rent the DME from the vendor the claims administrator identifies or purchase it directly from the prescribing network physician.

Benefits are provided for the repair/replacement of a type of DME once every three calendar years.

At the claims adminstrator's discretion, replacements are covered for damage beyond repair with normal wear and tear, when repair costs exceed new purchase price, or when a change in the covered person's medical condition occurs sooner than the three year timeframe. Repairs, including the replacement of essential accessories, such as hoses, tubes, mouth pieces, etc., for necessary DME are only covered when required to make the item/device serviceable and the estimated repair expense does not exceed the cost of purchasing or renting another item/device. Requests for repairs may be made at any time and are not subject to the three year timeline for replacement.

- Emergency care—for medical emergencies (see page 227 for a definition). The plan administrator must be notified within 48 hours.
- Enteral nutrition—benefits are provided for enteral formulas and low protein modified food products, administered either orally or by tube feeding as the primary source of nutrition, for certain conditions which require specialized nutrients or formulas. Examples of conditions include:
  - Metabolic diseases such as phenylketonuria (PKU) and maple syrup urine disease.
  - Severe food allergies.
  - Impaired absorption of nutrients caused by disorders affecting the gastrointestinal tract.

  Benefits for prescription or over-the-counter formula are available when a physician issues a prescription or written order stating the formula or product is medically necessary for the therapeutic treatment of a condition requiring specialized nutrients and specifying the quantity and the duration of the prescription or order. The formula or product must be administered under the direction of a physician or registered dietitian.

  For the purpose of this benefit, "enteral formulas" include:
  - Amino acid-based elemental formulas.
  - Extensively hydrolyzed protein formulas.
  - Modified nutrient content formulas.

  For the purpose of this benefit, "severe food allergies" mean allergies which if left untreated will result in:
  - Malnourishment.
  - Chronic physical disability.
  - Intellectual disability; or
  - Loss of life.
- 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 84 for services offered by the 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 the claims administrator
- Hearing care—hearing screening as part of a routine preventive office visit; purchase of aid (or pair) 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 authorization 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). Prior authorization 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 and UT Southwestern 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 Texas Health Aetna or UHC before hospitalization except in emergencies.
- Infant formula and donor breast milk—if they are the only source of nutrition or if they are specifically created to treat inborn errors of metabolism such as phenylketonuria (PKU)
- 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 use 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; prior authorization 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.
- Mental health services—coverage includes those services received on an inpatient or outpatient basis in a hospital and an alternate facility or in a provider's office. All services must be provided by or under the direction of a properly qualified behavioral health provider. Benefits include the following levels of care: inpatient treatment, residential treatment, partial hospitalization/day treatment, intensive outpatient treatment, and outpatient treatment. Services include the following: diagnostic evaluations, assessments and treatment planning; treatment and/or procedures; medication management and other associated treatments; individual, family and group therapy; provider-based case management services; and crisis intervention.

The Mental Health/Substance-Related and Addictive Disorders Administrator determines coverage for all levels of care. You must contact the Substance-Related and Addictive Disorders Administrator before receiving any inpatient or outpatient services or as soon as is reasonably possible for non-scheduled services (includes emergency admissions). You may contact the Administrator at 1-877-MyTHRLink (1-877-698-4754) prompt 1 for Texas Health Aetna and prompt 2 for UHC.

The mental health services benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, partial hospitalization/day treatment, intensive outpatient treatment, outpatient or a transitional care category. If an inpatient stay is required, it is covered on a semi-private room basis.

- 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
- Neurobiological disorders/autism spectrum disorder services — psychiatric services for autism spectrum disorder (otherwise known as neurodevelopmental disorders) that are both of the following: (1) provided by or under the direction of an experienced psychiatrist and/or an experienced licensed psychiatric provider; and (2) focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property and impairment in daily functioning. These benefits describe only the psychiatric component of treatment for autism spectrum disorder. Medical treatment of Autism Spectrum Disorder is a covered health service for which benefits are available under the applicable medical covered health services categories as described in this section.

  Benefits include the following levels of care: inpatient treatment, residential treatment, partial hospitalization/day treatment, and outpatient treatment.

  Benefits include the following: diagnostic evaluations, assessments and treatment planning; treatment and/or procedures; medication management and other associated treatments; individual, family and group therapy; provider-based case management services; and crisis intervention.

  The Mental Health/Substance-Related and Addictive Disorders Administrator determines coverage for all levels of care. If an inpatient stay is required, it is covered on a semi-private room basis. You must contact the Mental Health/Substance-Related and Addictive Disorders Administrator before receiving any inpatient or outpatient services or as soon as is reasonably possible for non-scheduled services (includes emergency admissions). The administrator may be contacted at 1-877-MyTHRLink (1-877-698-4754) prompt 1 for Texas Health Aetna and prompt 2 for UHC.
- Nutrition Coaching—coverage for participants with body mass index (BMI) of 28 or more; requires physician referral; therapy covered only if provided by a clinical dietitian at a Texas Health or UTSW hospital. You may receive one initial 90-minute assessment and up to three 30-minute sessions each year. BMI can be less than 28 if ordered by a physician.
- 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+ without co-morbidities or 35-39.9 with co-morbitities. You must have participated in a physician-directed diet and exercise program or a multi-disciplinary weight-loss program (such as Real Appeal). Counseling is required before and after surgery.

  The surgery is covered only at Texas Health hospitals that are either a Texas Health Aetna Institute of Excellence or a UHC Center of Excellence, and only for participants who are at least age 18. See **BeHealthyTHR.org** for a current list of covered facilities.

  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 your claims administrator when using an out-of-network provider or facility
- Panniculectomy—Removal of excess skin will be covered if deemed medically necessary by the claims administrator if you maintain a weight loss of at least 20% for at least two years by any means of weight loss.
- Pharmaceutical products (outpatient)— Pharmaceutical products that are administered on an outpatient basis in a hospital, alternate facility, physician's office, or in your home. Examples of what would be included under this category are antibiotic injections in the physician's office or inhaled medications in an urgent care center for treatment of an asthma attack. Benefits as described here are provided only for pharmaceutical products which, due to their characteristics, must typically be administered or directly supervised by a qualified provider or licensed/certified health professional. Where the pharmaceutical product is administered will determine the cost. This does not include medications for the treatment of infertility.

  If you require certain pharmaceutical products, including specialty pharmaceutical products, you may be directed to a designated dispensing location with whom the claims administrator has an arrangement to provide those products. Such dispensing locations may include an outpatient pharmacy, specialty pharmacy, home health agency provider, hospital-affiliated pharmacy or hemophilia treatment center contracted pharmacy. If you or your provider are directed to a designated dispensing location and you/your provider choose not to obtain your pharmaceutical products from a designated dispensing location, network benefits are not available for that pharmaceutical product

  Certain pharmaceutical products are subject to step therapy requirements. This means that in order to receive benefits for such pharmaceutical products, you must use a different pharmaceutical product and/or prescription drug product first. You may find out whether a particular pharmaceutical product is subject to step therapy requirements by contacting the claims administrator.
- 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 CVS Caremark (see page 61)

- Preventive care—wellness exams are 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.

  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
- Private rooms—covered only at Texas Health and UTSW 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 rehabilitation 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. Prior authorization is required. 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 opinion service—the UHC plan options offer a service providing access to specialists for education and guidance on certain conditions, including musculoskeletal, cardiac, gastrointestinal, and women's health diagnoses. See page 40 for more information.
- 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. Prior authorization is required.
- Sleep disorders—therapy to treat sleep apnea or narcolepsy. For sleep studies, prior authorization to the claims administrator is required. Failure to obtain prior authorization will result in a $1,000 penalty
- 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-Related and Addictive Disorders Services include those received on an inpatient or outpatient basis in a hospital, an alternate facility or in a provider's office. Benefits include the following levels of care: inpatient treatment, residential treatment, partial hospitalization/day treatment, intensive outpatient treatment, and outpatient treatment.

  Services include the following: diagnostic evaluations, assessments and treatment planning; treatment and/or procedures; medication management and other associated treatments; individual, family and group therapy; provider-based case management services; crisis intervention; and transitional living services.

  The mental health/substance use disorder administrator determines coverage for all levels of care. If an inpatient stay is required, it is covered on a semi-private room basis. You must contact the Mental Health/Substance-Related and Addictive Disorders Administrator before receiving any inpatient or outpatient services or as soon as is reasonably possible for non-scheduled services (includes emergency admissions). The administrator may be contacted at 1-877-MyTHRLink (1-877-698-4754) prompt 1 for Texas Health Aetna and prompt 2 for UHC.
- Support garments—covered if the claims administrator determines them to be necessary, subject to limitations (see page 44 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 are covered only at select facilities approved in advance by a Texas Health Aetna Institute of Excellence or a UHC Center of Excellence; prior authorization is required; includes donor's expenses to the extent they are not covered by donor's own medical benefits.

  Transplant services include CAR-T cell therapy. 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 the claims administrator 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.

  Your plan sponsor may provide you with travel and lodging assistance. Travel and lodging assistance is only available for you or your eligible family member if you meet the qualifications for the benefit, including receiving care at a designated provider and the distance from your home address to the facility. Eligible expenses are reimbursed after the expense forms have been completed and submitted with the appropriate receipts. If you have specific questions regarding the Travel and Lodging Assistance Program, please call the claims administrator.

  The Plan covers expenses for travel and lodging for the patient, provided he or she is not covered by Medicare, and a companion as follows:
  - Transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the qualified procedure provided by a designated provider for the purposes of an evaluation, the procedure or necessary post-discharge follow-up.
  - The Eligible Expenses for lodging for the patient (while not a hospital inpatient) and one companion
  - If the patient is an enrolled dependent minor child, the transportation expenses of two companions will be covered
  - Travel and lodging expenses are only available if the patient resides more than 50 miles from the Designated Provider
  - Reimbursement for certain lodging expenses for the patient and his/her companion(s) may be included in the taxable income of the plan participant if the reimbursement exceeds the per diem rate
  - The bariatric, cancer, congenital heart disease and transplant programs offer a combined overall lifetime maximum of $10,000 per covered person for all transportation and lodging expenses incurred by you and reimbursed under the plan in connection with all qualified procedures.
  - The Claims Administrator must receive valid receipts for such charges before you will be reimbursed. Reimbursement is as follows:
    - Lodging–a per diem rate of up to $50 per day for the patient or the caregiver if the patient is in the hospital; or up to $100 per day, for the patient and one caregiver. If the patient is a child, two caregivers may accompany the child. Examples of items that are not covered: groceries, alcoholic beverages, personal or cleaning supplies, meals, over-the-counter dressings or medical supplies, deposits, utilities and furniture rental when billed separate from the rent payment, phone calls, newspapers, or movie rentals
    - Transportation–automobile mileage (reimbursed at the IRS medical rate) for the most direct route between the patient's home and the designated facility, including: taxi fares (not including limos or car services), economy or coach airfare, parking, trains, boat, bus, tolls

- Urgent care clinic or center
- Urinary catheters—benefits for indwelling and intermittent urinary catheters for incontinence or retention. These include related urologic supplies for indwelling catheters limited to:
  - urinary drainage bag and insertion tray (kit)
  - anchoring device
  - irrigation tubing set.
- Virtual Visit—a visit to provide medical information in real-time between a patient and a provider through use of interactive audio with video communications or audio-only equipment outside of a medical facility (for example, from home or from work). The Virtual Visit service provided by Texas Health Aetna is called AnytimeMD and the virtual visit services provided by UHC are through DocOnDemand, TelaDoc, and AmWell.
- 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 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 226). 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 Treatments

- Acupressure
- Aromatherapy
- Hypnotism
- Massage therapy and soft-tissue therapy, regardless of who performs the service
- Rolfing
- Herbal, holistic, and homeopathic medicine
- Art therapy, music therapy, dance therapy and other forms of alternative treatment as defined by the National Center for Complementary and Alternative Medicine (NCCAM) of the National Institutes of Health. This exclusion does not apply to Manipulative Treatment and non-manipulative osteopathic care for which benefits are provided as described on page 42.
- Maintenance care
- Naturopath

Comfort and Convenience

Supplies, equipment and similar incidentals for personal comfort. Examples include:

- Television
- Telephone
- Air conditioners
- Beauty/barber service
- Air purifiers and filters
- Dehumidifiers and humidifiers
- Ergonomically correct chairs
- Devices and computers to assist in communication and speech except for speech aid devices and tracheo-esophageal voice devices for which benefits are provided as described under Durable Medical Equipment on page 44.
- Incontinence briefs, lines, or diapers when used for custodial purposes
- Therapeutic devices

Dental

- Dental care (which includes dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia

  This exclusion does not apply to accident-related dental services for which benefits are provided as described under Dental care/oral surgery on page 43.

  This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which benefits are available under the plan, limited to:
  - Transplant preparation
  - Prior to the initiation of immunosuppressives drugs
  - The direct treatment of acute traumatic Injury, cancer or cleft palate
- Preventive care, diagnosis, treatment of the teeth or gums. Examples include:
  - Extractions (including wisdom teeth), restoration and replacement of teeth
  - Medical or surgical treatments of dental conditions
  - Services to improve dental clinical outcomes

  This exclusion does not apply to preventive care for which benefits are provided under the United States Preventive Services Task Force requirement or the Health Resources and Services Administration (HRSA) requirement.

  This exclusion does not apply to accident-related dental services for which benefits are provided as described under Dental care/oral surgery on page 43.

- Dental implants and braces
  This exclusion does not apply to accident-related dental services for which benefits are provided as described under Dental care/oral surgery on page 43.
- Dental braces (orthodontics)
- Treatment of missing, malpositioned, or supernumerary (extra) teeth, even if part of a congenital anomaly
- Fluoride preparations
- Jawbone surgery – upper or lower jawbone surgery except as required for direct treatment of acute traumatic injury or cancer
- 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 (dental and therefore not a covered medical service)

Drugs

- Prescription drugs – covered through a separate prescription drug plan as explained on page 61
- Over-the-counter drugs, supplies, and treatments
- Growth hormone therapy which is covered by the prescription plan described on page 61
- Compounded drugs that contain certain bulk chemicals. Exclusions include any compounded medication for which there is a commercially available pharmaceutical product.
- Select Specialty Medications will be covered only under the pharmacy benefit and not the medical plan. Additionally, the location of infusion services may be changed based on variables as determined by the CVS specialty team.

Experimental or Investigational or Unproven Services

Experimental or investigational services—medical, surgical, diagnostic, psychiatric, mental health, substance use disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time the claims administrator and Texas Health Resources makes a determination regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use;*
- Subject to review and approval by any institutional review board for the proposed use (Devices which are FDA approved under the Humanitarian Use Device exemption are not considered to be Experimental or Investigational); or
- The subject of an ongoing clinical trial that meets the definition of a phase 1, 2 or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

Exceptions:

- Clinical trials for which benefits are available as described under Clinical trials on page 42
- If you are not a participant in a qualifying clinical trial as described on page 42 and have a sickness or condition that is likely to cause death within one year of the request for treatment, the claims administrator and Texas Health Resources may, at their discretion, consider an otherwise experimental or investigational service to be a covered health service for that sickness or condition. Prior to such consideration, the claims administrator and Texas Health Resources must determine that, although unproven, the service has significant potential as an effective treatment for that sickness or condition.

Foot Care

- Routine foot care, except when needed for severe systemic disease or preventive foot care for covered persons with diabetes for which benefits are provided as described under Foot care on page 45. Routine foot care services that are not covered include:
  - Cutting or removal of corns and calluses
  - Nail trimming or cutting
  - Debriding (removal of dead skin or underlying tissue)
- Hygienic and preventive maintenance foot care. Examples include:
  - Cleaning and soaking the feet
  - Applying skin creams in order to maintain skin tone
  - Other services that are performed when there is not a localized sickness, injury or symptom involving the foot

  This exclusion does not apply to preventive foot care for covered persons who are at risk of neurological or vascular disease arising from diseases such as diabetes.
- Treatment of flat or pronated foot/feet
- Shoe inserts
- Arch supports
- Shoes (standard or custom), lifts and wedges
- Shoe orthotics
- Treatment of subluxation of the foot

* Not applicable to COVID-19 vaccine.

Home Health Care

- Services and supplies not included in the home health care plan recommended by the attending physician
- Services or supplies not included in the hospice care program
- Services of your close relative or a person who ordinarily lives 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 lives in your home
- Curative or life-prolonging procedures
- For any period not under the care of a physician

Medical Supplies and Appliances

- Devices used specifically as safety items or to affect performance in sports-related activities
- Tubings, nasal cannulas, connectors and masks that are not used in connection with DME
- Orthotic Devices – covered when linked with a medical diagnosis such as wrist/hand, elbow, and lower extremity orthotics (excluding foot)
- Prostheses – replacement for theft or loss, wear and tear, destruction, or any biomechanical external prosthetic device

Mental Health, Neurobiological Disorders, and Substance-Related & Addictive Disorders

- Services performed in connection with conditions not classified in the current edition of the International Classification of Disorders section on Mental and Behavioral Disorders or the Diagnostic and Statistical Manual of the American Psychiatric Association
- Services or supplies for the diagnosis or treatment of mental illness, alcoholism or substance use disorders that, in the reasonable judgment of the Mental Health/ Substance-Related and Addictive Disorder Services Administrator, are any of the following: (1) not consistent with generally accepted standards of medical practice for the treatment of such conditions; (2) not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental; (3) not consistent with the mental health/substance use disorder administrator's level of care guidelines or best practices as modified from time to time; (4) not clinically appropriate for the patient's mental illness, substance use disorder or condition based on generally accepted standards of medical practice and benchmarks
- Health services or supplies that do not meet the definition of a covered health service as defined on page 226. Covered health services are those health services, including services, supplies, or pharmaceutical products, which the claims administrator determines to be medically necessary
- Mental Health Services as treatments for R and T code conditions as listed within the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association
- Mental health services as treatment for a primary diagnosis of insomnia and other sleep-wake disorders, feeding disorders, sexual dysfunctions, binge eating disorders, neurological disorders and other disorders with a known physical basis
- Outside of initial assessment, services as treatments for the primary diagnoses of learning disabilities, conduct and disruptive impulse control and conduct disorders, pyromania, kleptomania, gambling disorder and paraphilic disorder.
- Services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes
- Tuition for or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act
- Learning, motor disorders and primary communication disorders as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association
- Intellectual disabilities as a primary diagnosis defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association
- Outside of an initial assessment, services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention, but are specifically noted not to be mental disorders within the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.
- Outside of initial assessment, unspecified disorders for which the provider is not obligated to provide clinical rationale as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
- Any treatments or other specialized services designed for autism spectrum disorder that are not backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome and therefore considered experimental or investigational or unproven services
- Marriage counseling except as covered by the EAP as described on page 84
- Non-medical 24-Hour withdrawal management (see page 229)

- High intensity residential care including *American Society of Addiction Medicine (ASAM)* criteria for covered persons with substance-related and addictive disorders who are unable to participate in their care due to significant cognitive impairment.

Nutrition and Health Education

- Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements, and other nutrition based therapy. Examples include supplements, electrolytes and foods of any kind (including high protein foods and low carbohydrate foods)
- Food of any kind. Foods that are not covered include:
  - Infant formula, standard milk-based formula, and donor breast milk. This exclusion does not apply to enteral formula and other modified food products for which are provided as described under *Enteral Nutrition* on page 45
  - Foods to control weight, treat obesity (including liquid diets), lower cholesterol or control diabetes
  - Oral vitamins and minerals
  - Meals you can order from a menu, for an additional charge, during an inpatient stay
  - Other dietary and electrolyte supplements.
- Health club memberships and programs, and spa treatments
- Nutritional counseling for individuals or groups

Physical Appearance

- Cosmetic procedures. See the definition on page 226. Examples include:
  - Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple
  - Pharmacological regimens, nutritional procedures or treatments
  - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
  - Skin abrasion or other procedures performed as a treatment for acne or acne scars
- Replacement of an existing intact breast implant if the earlier breast implant was performed as a cosmetic procedure. Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy.
- Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility and diversion or general motivation, or any therapy to improve general physical condition
- Weight loss programs whether or not they are under medical supervision or for medical reasons, even if for morbid obesity
- Well-being items – items that promote well-being and are not medical in nature, such as bicycles, exercise equipment, and whirlpool spas
- Wigs and other scalp hair prosthesis unless following chemotherapy
- Treatments for hair loss
- A procedure or surgery to remove fatty tissue such as panniculectomy (except as defined on page 48) abdominoplasty, thighplasty, brachioplasty, or mastopexy
- Varicose vein treatment of the lower extremities, when it is considered cosmetic (sclerotherapy)
- Treatment of benign gynecomastia (abnormal breast enlargement in males)

Pregnancy and Infertility

- Health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment.

  This exclusion does not apply to services required to treat or correct underlying causes of infertility.
- Storage and retrieval of all reproductive materials (examples include eggs, sperm, testicular tissue and ovarian tissue)
- In vitro fertilization regardless of the reason for treatment
- Artificial insemination, gamete intra-fallopian transfer (GIFT), zygote intra-fallopian transfer (ZIFT)
- Surrogate parenting, donor eggs, donor sperm, and host uterus
- Feed or direct payments to a donor or doctor for sperm or ovum donations
- The reversal of voluntary sterilization or any form of contraception not specifically covered
- Artificial reproductive treatments done for genetic or eugenic (selective breeding) purposes
- Services provided by a doula (labor aide)
- Parenting, pre-natal or birthing classes
- Fetal reduction surgery
- Health services and associated expenses for elective abortion, termination of pregnancy, contraceptive supplies and services
- 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

Providers

- Services performed by a provider who is a family member by birth or marriage, including your spouse, brother, sister, parent, child or grandparent. This includes any service the provider may perform on himself or herself.
- Services performed by a provider with your same legal residence
- Services performed by an unlicensed provider or a provider who is operating outside of the scope of his/her license
- Physician fees for any treatment not rendered by or provided under the supervision of a physician
- Services provided at a diagnostic facility (hospital-based or free-standing) without a written order from a physician or other provider.
- Services which are self-directed to a free-standing or hospital-based diagnostic facility

- Services ordered by a physician or other provider who is an employee or representative of a diagnostic facility (hospital-based or free-standing), when that provider is not actively involved in your medical care:
  - Prior to ordering the service
  - After the service is received

  This exclusion does not apply to mammography.

Services Provided Under Another Plan

Services for which coverage is available:

- Under another plan, except for eligible expenses payable as described on page 58, Coordination of Benefits (COB)
- Under workers' compensation (treatment or drug for any illness or injury that occurs during or as a result of work for pay or profit), no-fault automobile coverage or similar legislation if you could elect it, or could have it elected for you
- By a mandatory auto insurance policy written to comply with a "no-fault" or uninsured-motorist insurance law
- While on active military duty
- For treatment of military service-related disabilities when you are legally entitled to other coverage, and facilities are reasonably available to you
- For injury or sickness for which there is non-group coverage (except individual health insurance plans) providing medical payments or medical expense coverage. If benefits subject to this provision are paid or provided, the claims administrator reserves the right to cover the reasonable value of such benefits as provided in the Subrogation and Reimbursement section found on page 72.

Transplants

- Health services for organ and tissue transplants:
  - Except as identified under Transplants in covered medical expenses found on page 51
  - Determined by Personal Health Support not to be proven procedures for the involved diagnoses
  - Not consistent with the diagnosis of the condition
  - Experimental transplants
  - Artificial organ transplants
  - Cross-species organ transplants
- Health services for transplants involving permanent mechanical or animal organs, except services related to the implant or removal of a circulatory assist device (a device that supports the heart while the patient waits for a suitable donor heart to become available)
- Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs for removal are payable for a transplant through the organ recipient's benefits under the plan.)
- Organ donor costs not directly related to organ procurement
- Transplants performed at a facility not approved by the claims administrator

Travel

- Health services provided in a foreign country, unless required as emergency health services
- Travel or transportation expenses, even if ordered by a physician, except as identified Additional travel expenses related to covered health services received from a designated facility or designated physician may be reimbursed at the plan's discretion. This exclusion does not apply to ambulance transportation for which benefits are provided as described under Ambulance on page 41.

Vision and Hearing

- Routine vision examinations, including refractive examinations to determine the need for vision correction
- Implantable lenses used only to correct a refractive error (such as Intacs corneal implants)
- Purchase cost and associated fitting charges for eyeglasses or contact lenses except the first pair prescribed and purchased within 12 months following cataract surgery
- Bone anchored hearing aids except when either of the following applies:
  - For covered persons with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid
  - For covered persons with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid
- Eye exercise or vision therapy other than as a treatment for strabismus (misalignment of the eyes)
- Surgery and other related treatment that is intended to correct nearsightedness, farsightedness, presbyopia and astigmatism including, but not limited to, procedures such as laser and other refractive eye surgery and radial keratotomy

All Other Exclusions

- Autopsies and other coroner services and transportation services for a corpse
- Biofeedback therapy
- Charges for:
  - Missed appointments
  - Room or facility reservations
  - Completion of claim forms
  - Record processing
  - Care, treatment, services, supplies or equipment that are advertised by the provider as free, not legally required or which the provider offers to waive
  - Services incurred before the effective date of coverage
  - Emergency room visits for non-emergencies
  - 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

  - Routine exams and immunizations, except those listed as covered expenses
  - That others are responsible for paying
- Charges by a provider sanctioned under a federal program for reason of fraud, abuse or medical competency
- Charges prohibited by federal anti-kickback or self-referral statutes
- Charges resulting from or occurring during the commission of a crime or while engaging in an illegal act, illegal occupation or aggravated assault unless injuries result from a medical condition or domestic violence
- Chelation therapy, except to treat heavy metal poisoning
- Custodial care or services provided by a personal care assistant
- Diagnostic tests that are:
  - Delivered in other than a physician's office or health care facility
  - Self-administered home diagnostic tests, including but not limited to HIV and pregnancy tests
- Domiciliary Care
- Duplicate coverage – dependent's expenses if he or she is receiving benefits for the same expense as a covered employee
- Ecological and environmental medicine
- 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
- Government-paid care – care, treatment, services, or supplies provided or paid for by any government 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 grandchild meets eligibility requirements described on page 6
- Expenses for health services and supplies:
  - That are received as a result of war or any act of war, whether declared or undeclared, while part of any armed service force of any country. This exclusion does not apply to covered persons who are civilians injured or otherwise affected by war, any act of war or terrorism in a non-war zone.
  - That are received after the date your coverage under this plan ends, including health services for medical conditions which began before the date your coverage under the plan ends
  - For which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under this benefit plan
- That exceed eligible expenses or any specified limitation in this Handbook
- For which a non-network provider waives the annual deductible or coinsurance amounts
- 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
- Immunizations agents – prescriptions for immunizations agents, biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions and medications used for travel prophylaxis
- IQ Testing
- Foreign language and sign language services
- Long term (more than 30 days) storage of blood, umbilical cord or other material
- Health services and supplies that do not meet the definition of a covered health service on page 226. Covered health services are those health services including services, supplies or pharmaceutical products, which the claims administrator determines to be all of the following:
  - Medically necessary
  - Described as a covered health service in this Handbook on page 226
  - Not otherwise excluded in this section, Exclusions

  This exclusion does not apply to breast pumps for which benefits are provided under the Health Resources and Services Administration (HRSA) requirement.
- Health services related to a non-covered health service: When a service is not a covered health service, all services related to that non-covered health service are also excluded. This exclusion does not apply to services the plan would otherwise determine to be covered health services if they are to treat complications that arise from the non-covered health service.

  For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a cosmetic procedure, that require hospitalization.
- Manipulative treatment to treat a condition unrelated to alignment of the vertebral column, such as asthma or allergies
- Medical and surgical treatment of snoring, except when provided as a part of treatment for documented obstructive sleep apnea (a sleep disorder in which a person regularly stops breathing for 10 seconds or longer). Appliances for snoring are always excluded.

- 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
- Penile prostheses
- Physical examinations not required for health reasons – including employment, insurance, government license, court-ordered, forensic, or custodial evaluations
- Private duty nursing
- Respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which benefits are described under Hospice care on page 46
- Sex transformation operations and related services
- Sexual dysfunctions, deviations or disorders – all drugs and treatment are excluded (except limited drugs for erectile dysfunction)
- Smoking cessation aids – except for those covered by the wellness program as described on page 81
- Speech therapy, except when required for treatment of a speech impediment or speech dysfunction that results from injury, sickness, stroke, cancer, autism spectrum disorder or a congenital anomaly, or is needed following the placement of a cochlear implant as identified under speech therapy on page 50. Not covered if:
  - Considered custodial and educational
  - Therapy to improve speech skills not fully developed (non-restorative)
  - To maintain speech communication
  - To treat stuttering, stammering, or other articulation disorders
- Storage of blood, umbilical cord or other material for use in a covered health service, except if needed for an imminent surgery
- The following treatments for obesity:
  - Non-surgical treatment, even if for morbid obesity
  - Surgical treatment of obesity even if there is a diagnosis of morbid obesity
- Treatment of hyperhidrosis (excessive sweating)
- Multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain

COORDINATION OF BENEFITS (COB)

Your medical plan is designed to integrate benefits with other group or individual plans or policies or government programs, including any of the following:

- Another employer sponsored health benefits plan
- A medical component of a group long-term care plan, such as skilled nursing care
- No-fault or traditional "fault" type medical payment benefits or personal injury protection benefits under an auto insurance policy
- Medical payment benefits under any premises liability or other types of liability coverage
- Medicare or other governmental health benefit.

If you are eligible, either as the insured or a dependent, to receive medical benefits from another plan, 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. How much your Texas Health plan will reimburse you, if anything, will also depend in part on the allowable expense.

Order of Benefit Determination Rules

If you are covered by two or more plans, the benefit payment follows the rules below in this order:

- Your Total Health Medical Plan will always be secondary to medical payment coverage or personal injury protection coverage under any auto liability or no-fault insurance policy.
- 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 you are receiving COBRA continuation coverage under another employer plan, your Texas Health plan will pay benefits first.
- Your dependent children will receive primary coverage from the parent whose birth date occurs first in a calendar year. If both parents have the same birth date, the plan that pays benefits first is the one that has been in effect the longest. This birthday rule applies only if:
  - The parents are married or living together whether or not they have ever been married and not legally separated
  - A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage
- If two or more plans cover a dependent child of divorced or separated parents and if there is no court decree stating that one parent is responsible for health care, the child will be covered under the plan of:
  - The parent with custody of the child; then
  - The spouse of the parent with custody of the child; then
  - The parent not having custody of the child; then
  - The spouse of the parent not having custody of the child.
- Plans for active employees pay before plans covering laid-off or retired employees.
- The plan that has covered the individual claimant the longest will pay first.
- Finally, if none of the above rules determines which plan is primary or secondary, the allowable expenses shall be shared equally between the plans. In addition, the Texas Health plan will not pay more than it would have paid had it been the primary plan.

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.

When Your Texas Health Medical Plan is Secondary

If your Total Health Medical plan is secondary, it determines the amount it will pay for a covered health service by following the steps below.

- The plan determines the amount it would have paid based on the allowable expense.
- If this plan would have paid the same amount or less than the primary plan paid, this plan pays no benefits.
- If this plan would have paid more than the primary plan paid, the plan will pay the difference.

You will be responsible for any copay, coinsurance or deductible payments as part of the coordination of benefits (COB) payment. The maximum combined payment you can receive from all plans may be less than 100% of the allowable expense.

Here's an example:

Let's say your spouse has coverage at work offering a 70% coinsurance and coverage as a dependent on your plan with Texas Health, which covers 90% of the bill after a deductible. Your spouse's coverage at his/her work is primary, with the coverage from Texas Health paying as secondary. The claims administrator calculates the benefit as if the spouse only had coverage at Texas Health and then subtracts the amount paid by the primary coverage. Assuming the deductible has been met and services were performed at a Preferred Hospital, the plan would pay an additional 20% of the bill.

Determining the Allowable Expense

For purposes of COB, an allowable expense is a health care expense that is covered at least in part by one of the health benefit plans covering you.

When the provider is a network provider for both the primary plan and your Texas Health plan, the allowable expense is the primary plan's network rate. When the provider is a network provider for the primary plan and a non-network provider for this plan, the allowable expense is the primary plan's network rate. When the provider is a non-network provider for the primary plan and a network provider for this Plan, the allowable expense is the reasonable and customary charges allowed by the primary plan. When the provider is a non-Network provider for both the primary plan and your Texas Health plan, the allowable expense is the greater of the two plans' reasonable and customary charges.

When a covered person Qualifies for Medicare

There are Medicare-eligible individuals for whom the plan pays benefits first and Medicare pays benefits second:

- Employees with active current employment status age 65 or older and their spouses age 65 or older
- Individuals with end-stage renal disease, for a limited period of time
- Disabled individuals under age 65 with current employment status and their dependents under age 65.

Determining the Allowable Expense

If the Texas Health plan is secondary to Medicare, the Medicare-approved amount is the allowable expense, as long as the provider accepts reimbursement directly from Medicare. If the provider accepts reimbursement directly from Medicare, the Medicare-approved amount is the charge that Medicare has determined that it will recognize and which it reports on an "explanation of Medicare benefits" issued by Medicare (the "EOMB") for a given service. Medicare typically reimburses such providers a percentage of its approved charge – often 80%.

If the provider does not accept assignment of your Medicare benefits, the Medicare limiting charge (the most a provider can charge you if they don't accept Medicare – typically 115% of the Medicare approved amount) will be the allowable expense. Medicare payments, combined with plan benefits, will not exceed 100% of the allowable expense.

If you are eligible for, but not enrolled in, Medicare, and your Texas Health plan is secondary to Medicare, or if you have enrolled in Medicare but choose to obtain services from a provider that does not participate in the Medicare program (as opposed to a provider who does not accept assignment of Medicare benefits), Benefits will be paid on a secondary basis under the Texas Health plan and will be determined as if you timely enrolled in Medicare and obtained services from a Medicare participating provider.

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 or UTSW facility

When calculating the plan's benefits in these situations, for administrative convenience the claims administrator will treat the provider's billed charges for covered services as the allowable expense for both the plan and Medicare, rather than the Medicare-approved amount or Medicare limiting charge.

Medicare Crossover Program

The plan offers a Medicare Crossover Program for Medicare Part A and Part B and Durable Medical Equipment (DME) claims. Under this program, you no longer have to file a separate claim with the plan to receive secondary benefits for these expenses. Your dependent will also have this automated crossover, as long as he or she is eligible for Medicare and this plan is your only secondary medical coverage.

Once the Medicare Part A and Part B and DME carriers have reimbursed your health care provider, the Medicare carrier will electronically submit the necessary information to the Claims Administrator to process the balance of your claim under the provisions of this plan.

You can verify that the automated crossover is in place when your copy of the explanation of Medicare benefits (EOMB) states your claim has been forwarded to your secondary carrier.

This crossover process does not apply to expenses that Medicare does not cover. You must go on to file claims for these expenses.

For information about enrollment, or if you have questions about the program, call 1-877-MyTHRLink, prompt 1 for Texas Health Aetna and prompt 2 for UHC.

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.

Overpayment and Underpayment of Benefits

If the plan pays you more than it owes under the coordination of benefits provision, you should pay the excess back promptly. Otherwise, Texas Health may recover the amount in the form of salary, wages, or benefits payable under any company-sponsored benefit plans, including this plan. Texas Health also reserves the right to recover any overpayment by legal action or offset payments on future eligible expenses. If the plan overpays a health care provider, the claims administrator reserves the right to recover the excess amount from the provider.

Refund of Overpayments

If the plan pays for eligible expenses incurred on account of a covered person, that covered person, or any other person or organization that was paid, must make a refund to the plan if:

- The plan's obligation to pay benefits was contingent on the expenses incurred being legally owed and paid by the covered person, but all or some of the expenses were not paid by the covered person or did not legally have to be paid by the covered person.

- All or some of the payment the plan made exceeded the benefits under the plan.
- All of some of the payment was made in error.

The amount that must be refunded equals the amount the plan paid in excess of the amount that should have been paid under the plan. If the refund is due from another person or organization, the covered person agrees to help the plan get the refund when requested.

If the covered person, or any other person or organization that was paid, does not promptly refund the full amount owed, the plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, (i) future benefits for the covered person that are payable under the plan; (ii) future benefits that are payable to other covered persons under the plan; or (iii) future benefits that are payable for services provided to persons under other plans for which the claims administrator makes payments, with the understanding that the claims administrator will then reimburse the plan the amount of the reallocated payment. The reallocated payment amount will equal the amount of the required refund or, if less than the full amount of the required refund, will be deducted from the amount of refund owed to the plan. The plan may have other rights in addition to the right to reallocate overpaid amounts and other enumerated rights, including the right to commence a legal action.

PRESCRIPTION DRUG BENEFITS

The Total Health Medical Plan offers two prescription drug options—a High Rx and a Low Rx program (see page 32 for details). Both are administered by CVS Caremark and have the same formulary. The difference is in the premium and coinsurance you pay.

Texas Health's prescription drug plan options offer benefits for generic drugs and Preferred drugs, which are drugs listed on the Value Formulary. Each calendar quarter, CVS Caremark updates the formulary. Before you fill a prescription, check **Caremark.com** to be sure the medication is on the Value Formulary list. The Value Formulary excludes brand drugs with generic alternatives.

The plan's minimum and maximum copays for preferred prescriptions 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 maximum.

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, Texas Health Plano, Texas Health Infusion Pharmacy, CVS Caremark mail order, or any CVS or Target pharmacy.

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, you can check with your pharmacist or physician.

Preventive Drugs

The Total Health Medical Plan 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 **Caremark.com** and use the Check Drug Coverage and Cost tool or call 1-877-797-9847.

Drugs With Generic Equivalents

The Total Health Medical Plan excludes drugs with generic alternatives. If a generic drug is available and you elect or your doctor prescribes a preferred or non-preferred drug, it will be denied. If you have a unique medical situation where the generic equivalent doesn't work well for you, your doctor must contact CVS Caremark and confirm that a specific brand-name medication is medically necessary for your condition.

Medications with Clinical Requirements

Certain medications have requirements that must be met before the plan provides coverage.

Prior Authorization

This means that your doctor must contact CVS Caremark and confirm that a specific medication meets plan guidelines for covering your condition.

Step Therapy with Post-Step Prior Authorization

You must first try a lower-cost alternative before a higher-cost medication will be covered. If you have a unique medical situation where the lower-cost alternative is ineffective for you, your doctor must contact CVS Caremark and confirm that the specific medication is medically necessary for your condition.

Quantity Limit

The plan limits the amount of a specific medication that you can fill in a 30-day or 90-day period. If you have a unique medical situation that requires you to exceed the limit, your doctor can contact CVS Caremark and confirm that a higher quantity is clinically necessary for your condition.

You can find a comprehensive list of covered drugs along with any specific criteria at **Caremark.com**.

CVS 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, CVS Caremark provides an online tool called "Check Drug Costs" on **Caremark.com**. "Check Drug Costs" is a tool that you can use to check the cost of your medications before filling them at the pharmacy.

Before you fill a prescription, check to be sure the medication is on the formulary list. CVS Caremark updates the formulary list each quarter. You can view the formulary list online at **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 (pre-authorization may be required and limits may apply)
- 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 CVS 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 (unless related to a covered clinical trial)
- 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
- Off-label drugs (pharmaceutical drugs unapproved by the FDA for indication or in an unapproved age group, unapproved dosage, or unapproved form of administration)
- 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 81
- Therapeutic devices or appliances, including needles, syringes, support garments (unless they are a covered health service, as defined on page 226), 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. You can call CVS Specialty Customer Care at 1-888-265-7790 with any questions.

Select Specialty Medications will be covered only under the pharmacy benefit. As part of this policy, these Specialty Medications will be excluded from coverage under the medical plan. Additionally, the location of infusion services may be changed based on variables as determined by the CVS specialty team.

If you would like to utilize the Texas Health Specialty Pharmacy, you may call 682-236-2500. The THR Specialty Pharmacy team helps provide ongoing support throughout your treatment plan, including:

- Access to counseling by a team of pharmacists trained in your condition
- Pharmaceutical counseling and medication reconciliation before every refill
- Collaborative coordination of care with your health care provider
- Coordination of home infusion services or injection/infusion training, as needed
- Assistance with insurance and financial coordination.

Grace Fill

If the medical plan denies coverage for a physician-administered drug that was formerly covered by the medical plan, the medical plan may allow a one-time exception (grace fill) via the appeals process. If you wish to obtain this medication in the future, contact CVS Specialty Customer Care at 1-888-265-7790 or Texas Health Specialty Pharmacy at 682-236-5200.

Mail Order

CVS Caremark has its own mail order service. Please refer to your CVS Caremark packet for your mail order prescription form, mailing address and phone number. You may also get information and forms online at **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, Plano, Texas Health Infusion Pharmacy, through CVS Caremark mail order or at any CVS or Target 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. Texas Health Aetna, UHC and CVS Caremark provide claims services, but do not insure the plan.

Claims

Texas Health Aetna and UHC are the claims processors for the medical plan options. The following summarizes how to file claims under the Texas Health Aetna and the UHC Choice and Choice Plus plan options.

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 the claims administrator. 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 Texas Health Aetna or UHC Choice plan options. When you use out-of-network providers under the Choice Plus 1500 plan option, you must file a claim for reimbursement as follows:

- Complete a medical claim form (available on the Internet at **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.

*Includes retail pharmacies located at Texas Health Dallas, Texas Health Plano, and Texas Health Infusion Pharmacy.

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.

If you do not have a claim form, simply attach a brief letter of explanation to the bill, and verify that the bill contains the information listed below. If any of these items are missing from the bill, you can include them in your letter:

- Your name and address;
- The patient's name, age, and relationship to the employee;
- The number of as shown on your ID card;
- The name, address, and tax identification number of the provider of the service(s);
- A diagnosis from the physician;
- The date of service;
- An itemized bill from the provider that includes:
  - The current procedural terminology (CPT) codes.
  - A description of, and the charge for, each service.
  - The date the sickness or injury began.
  - A statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled in other coverage, you must include the name and address of the other carrier(s).

Failure to provide all the information listed above may delay any reimbursement that may be due you.

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 225). 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.

When you assign your benefits to a non-network provider with the claims administrator's consent, and the non-network provider submits a claim for payment, you and the non-network provider represent and warrant that the covered health services were actually provided and were medically appropriate.

To be recognized as a valid assignment of benefits, the assignment must reflect your agreement that the non-network provider will be entitled to all of your rights under the plan and applicable state and federal laws, including legally required notices and procedural reviews concerning your benefits, and that you will no longer be entitled to those rights. If an assignment form does not comply with this requirement, but directs that your benefit payment should be made directly to the provider, the claims administrator may in its discretion make payment of the benefits directly to the provider for your convenience, but will treat you, rather than the provider, as the beneficiary of your claim. If benefits are assigned or payment to a non-network provider is made, Texas Health Resources reserves the right to offset benefits to be paid to the provider by any amounts that the provider owes Texas Health Resources (including amounts owed as a result of the assignment of other plans' overpayment recovery rights to the plan).

The claims administrator will pay benefits to you unless:

- The provider submits a claim form to the claims administrator that you have provided signed authorization to assign benefits directly to that provider.
- You make a written request for the non-network provider to be paid directly at the time you submit your claim.

The claims administrator will only pay benefits to you or, with written authorization by you, your provider, and not to a third party, even if your provider purports to have assigned benefits to that third party.

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 CVS Caremark member ID card at a network pharmacy or when you use the mail-order prescription program. You may also use your CVS 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 12 months after the date of service.

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 on this page, 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. 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	
Claims administrator must notify you within:	24 hours
You must then provide completed claim information to claims administrator within:	48 hours after receiving notice
Notification of Determination	
Claims administrator must notify you of the benefit determination:	
• If the initial claim is complete, within:	72 hours
• After receiving the completed claim (if the initial claim is incomplete), within:	48 hours
You must appeal a claim denial no later than:	180 days after receiving the denial
Claims administrator 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 the claims administrator as soon as possible to appeal an urgent care claim.

Pre-Service Claims

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

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

[3] The claims administrator 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 administrators:
Texas Health Aetna
PO Box 981106
El Paso, TX 79998-110
www.TexasHealthAetna.com

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 option. 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 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.

*The claims administrator may require a one-time extension for the initial claim determination, of no more than 15 days, only if more time is needed due to circumstances beyond control of the Plan.

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 for review to your claims administrator:

Texas Health Aetna Appeals
THA Appeals-CRT
P. O. Box 14463
Lexington, KY 40512
www.TexasHealthAetna.com

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

(Go to **MyUHC.com** to print the member service request form for medical appeal.)

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.

*Pre-Service Request for Benefits**

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 1 for Texas Health Aetna and prompt 2 for UHC, asking 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.

If your situation is urgent, you may call your claims administrator at the number listed on your health plan ID card. Generally, an urgent situation is when your life or health may be in serious jeopardy. Or when, in the opinion of your doctor, you may be experiencing severe pain that cannot be adequately controlled while you wait for a decision on your claim or appeal.

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

If, after exhausting your internal appeals, you are not satisfied with the determination, or if a timely response is not made to your appeal in accordance with applicable regulations regarding timing, you may be entitled to request an external review of the determination. The process is available at no charge to you.

If one of the above conditions is met, you may request an external review of adverse benefit determinations based upon any of the following:

- clinical reasons;
- the exclusions for experimental or investigational services or unproven services;
- rescission of coverage (coverage that was cancelled or discontinued retroactively); or
- as otherwise required by applicable law.

You or your representative may request a standard external review by sending a written request to the address set out in the determination letter. You or your representative may request an expedited external review, in urgent situations as detailed below, by calling the toll-free number on your ID card or by sending a written request to the address set out in the determination letter. A request must be made within four months after the date you received a decision.

An external review request should include all of the following:

- a specific request for an external review;
- the covered person's name, address, and insurance ID number;
- your designated representative's name and address, when applicable;
- the service that was denied; and
- any new, relevant information that was not provided during the internal appeal.

An external review will be performed by an Independent Review Organization (IRO).

There are two types of external reviews available:

- a standard external review; and
- an expedited external review.

Standard External Review

A standard external review is comprised of all of the following:

- a preliminary review by the claims administrator of the request;
- a referral of the request by the claims administrator to the IRO; and
- a decision by the IRO.

Within the applicable time frame after receipt of the request, the claims administrator will complete a preliminary review to determine whether the individual for whom the request was submitted meets all of the following:

- is or was covered under the plan at the time the health care service or procedure that is at issue in the request was provided;
- has exhausted the applicable internal appeals process; and
- has provided all the information and forms required so that the claims administrator may process the request.

After the claims administrator completes the preliminary review, the claims administrator will issue a notification in writing to you. If the request is eligible for external review, the claims administrator will assign an IRO to conduct such review. The claims administrator will assign requests by either rotating claims assignments among the IROs or by using a random selection process.

The IRO will notify you in writing of the request's eligibility and acceptance for external review. You may submit in writing to the IRO within ten business days following the date of receipt of the notice additional information that the IRO will consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted by you after ten business days.

The claims administrator will provide to the assigned IRO the documents and information considered in making the claims administrator's determination. The documents include:

- all relevant medical records;
- all other documents relied upon by the claims administrator; and
- all other information or evidence that you or your physician submitted. If there is any information or evidence you or your physician wish to submit that was not previously provided, you may include this information with your external review request and the claims administrator will include it with the documents forwarded to the IRO.

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by the claims administrator. The IRO will provide written notice of its determination (the "Final External Review Decision") within 45 days after it receives the request for the external review (unless they request additional time and you agree). The IRO will deliver the notice of Final External Review Decision to you and the claims administrator, and it will include the clinical basis for the determination.

Upon receipt of a Final External Review Decision reversing the claims administrator determination, the plan will immediately provide coverage or payment for the benefit claim at issue in accordance with the terms and conditions of the plan, and any applicable law regarding plan remedies. If the Final External Review Decision is that payment or referral will not be made, the plan will not be obligated to provide benefits for the health care service or procedure.

Expedited External Review

An expedited external review is similar to a standard external review. The most significant difference between the two is that the time periods for completing certain portions of the review process are much shorter, and in some instances you may file an expedited external review before completing the internal appeals process.

You may make a written or verbal request for an expedited external review if you receive either of the following:

- an adverse benefit determination of a claim or appeal if the adverse benefit determination involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function and you have filed a request for an expedited internal appeal; or
- a final appeal decision, if the determination involves a medical condition where the time frame for completion of a standard external review would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function, or if the final appeal decision concerns an admission, availability of care, continued stay, or health care service, procedure or product for which the individual received emergency services, but has not been discharged from a facility.

Immediately upon receipt of the request, the claims administrator will determine whether the individual meets both of the following:

- is or was covered under the plan at the time the health care service or procedure that is at issue in the request was provided.
- has provided all the information and forms required so that the claims administrator may process the request.

After the claims administrator completes the review, the claims administrator will immediately send a notice in writing to you. Upon a determination that a request is eligible for expedited external review, the claims administrator will assign an IRO in the same manner the claims administrator utilizes to assign standard external reviews to IROs. The claims administrator will provide all necessary documents and information considered in making the adverse benefit determination or final adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the same type of information and documents considered in a standard external review.

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by the claims administrator. The IRO will provide notice of the final external review decision for an expedited external review as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request. If the initial notice is not in writing, within 48 hours after the date of providing the initial notice, the assigned IRO will provide written confirmation of the decision to you and to the claims administrator.

You may contact the claims administrator at the toll-free number on your ID card for more information regarding external review rights, or if making a verbal request for an expedited external review.

SUBROGATION AND REIMBURSEMENT

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 right to subrogation means that the plan is substituted to and shall succeed to any and all legal claims that you may be entitled to pursue against any third party for the benefits that the plan has paid that are related to the sickness or injury for which a third party is alleged to be responsible. The right to reimbursement means that if a third party causes or is alleged to have caused a sickness or injury for which you receive a settlement, judgment, or other recovery from any third party, you must use those proceeds to fully return to the plan 100% of any benefits you received for that sickness or injury.

Subrogation – Example

Suppose you are injured in a car accident that is not your fault, and you receive benefits under the plan to treat your injuries. Under subrogation, the plan has the right to take legal action in your name against the driver who caused the accident and that driver's insurance carrier to recover the cost of those benefits.

Reimbursement – Example

Suppose you are injured in a boating accident that is not your fault, and you receive benefits under the plan as a result of your injuries. In addition, you receive a settlement in a court proceeding from the individual who caused the accident. You must use the settlement funds to return to the plan 100% of any benefits you received to treat your injuries.

The following persons and entities are considered third parties:

- A person or entity alleged to have caused you to suffer a sickness, injury or damages, or who is legally responsible for the sickness, injury or damages

- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the sickness, injury or damages.
- The plan sponsor (for example workers' compensation cases).
- Any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for under-insured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third-party administrators.
- Any person or entity that is liable for payment to you on any equitable or legal liability theory.

You agree as follows:

- You will cooperate with the plan in protecting its legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:
  - Notifying the plan, in writing, of any potential legal claim(s) you may have against any third party for acts which caused benefits to be paid or become payable
  - Providing any relevant information requested by the plan
  - Signing and/or delivering such documents as the plan or its agents reasonably request to secure the subrogation and reimbursement claim
  - Responding to requests for information about any accident or injuries
  - Making court appearances
  - Obtaining the plan's consent or its agents' consent before releasing any party from liability or payment of medical expenses
  - Complying with the terms of this section.

  The plan has the right to terminate your benefits, deny future benefits, take legal action against you, and/or set off from any future benefits the value of benefits the plan has paid relating to any sickness or injury alleged to have been caused or caused by any third party to the extent not recovered by the plan due to you or your representative not cooperating with the plan. If the plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the plan.
- The plan has a first priority right to receive payment on any claim against a third party before you receive payment from that third party. Further, the plan's first priority right to payment is superior to any and all claims, debts or liens asserted by any medical providers, including but not limited to hospitals or emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.
- The plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, and punitive damages. The plan is not required to help you to pursue your claim for damages or personal injuries and no amount of associated costs, including attorneys' fees, shall be deducted from the plan's recovery without the plan's express written consent. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.
- Regardless of whether you have been fully compensated or made whole, the plan may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable limitation shall limit the plan's subrogation and reimbursement rights.
- Benefits paid by the plan may also be considered to be benefits advanced.
- If you receive any payment from any party as a result of sickness or injury, and the plan alleges some or all of those funds are due and owed to the plan, you shall hold those funds in trust, either in a separate bank account in your name or in your attorney's trust account. You agree that you will serve as a trustee over those funds to the extent of the benefits the plan has paid.
- The plan's rights to recovery will not be reduced due to your own negligence.
- Upon the plan's request, you will assign to the plan all rights of recovery against third parties, to the extent of the benefits the plan has paid for the sickness or injury.
- The plan may, at its option, take necessary and appropriate action to preserve its rights under these subrogation provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party and filing suit in your name, which does not obligate the plan in any way to pay you part of any recovery the plan might obtain.

- You may not accept any settlement that does not fully reimburse the plan, without its written approval
- The plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- In the case of your wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries.
- No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse the plan for 100% of its interest unless the plan provides written consent to the allocation.
- The provisions of this section apply to the parents, guardian, or other representative of a dependent child who incurs a sickness or injury caused by a third party. If a parent or guardian may bring a claim for damages arising out of a minor's sickness or injury, the terms of this subrogation and reimbursement clause shall apply to that claim.
- If a third party causes or is alleged to have caused you to suffer a sickness or injury while you are covered under this plan, the provisions of this section continue to apply, even after you are no longer covered.
- The plan and all administrators administering the terms and conditions of the plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the plan.

Right of Recovery

The plan also has the right to recover benefits it has paid on you or your dependent's behalf that were:

- Made in error
- Due to a mistake in fact
- Advanced during the time period of meeting the calendar year deductible
- Advanced during the time period of meeting the out-of-pocket maximum for the calendar year
- Benefits paid because you or your dependent misrepresented facts are also subject to recovery.

If the plan provides a benefit for you or your dependent that exceeds the amount that should have been paid, the plan will:

- Require that the overpayment be returned when requested.
- Reduce a future benefit payment for you or your dependent by the amount of the overpayment.

If the plan provides an advancement of benefits to you or your dependent during the time period of meeting the deductible and/or meeting the out-of-pocket maximum for the calendar year, the plan will send you or your dependent a monthly statement identifying the amount you owe with payment instructions. The plan has the right to recover benefits it has advanced by:

- Submitting a reminder letter to you or a covered dependent that details any outstanding balance owed to the plan.
- Conducting courtesy calls to you or a covered dependent to discuss any outstanding balance owed to the plan.

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
- At the end of the month your dependent reaches the plan's maximum age.
- When your termination date falls on the first day of a pay period, your benefits will end on the last day of the previous pay period.

See page 197 for more information.

Other Events Ending Your Coverage

The Plan will provide at least thirty days' prior written notice to you that your coverage will end on the date identified in the notice if you commit an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact including, but not limited to, knowingly providing incorrect information relating to another person's eligibility or status as a dependent. You may appeal this decision during the 30-day notice period. The notice will contain information on how to pursue your appeal.

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 198.

Be Healthy Wellness Program

Texas Health offers the *Be Healthy* wellness program to give you the tools to improve your well-being and help make healthy choices easier. 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 offers a variety of programs to help you personalize your well-being journey.

Be Healthy provides many opportunities to improve your health—and your life. Several of the programs also allow you to earn rewards for completing them.

Eligible employees can earn up to $300 in *Be Healthy* rewards and eligible spouses can earn up to $175 in *Be Healthy* rewards in 2021. Eligible employees can also earn up to $520 in wellness credits added to their paychecks in 2022 for completing their wellness credit screening prior to September 30, 2021.

Eligibility

The table below describes eligibility for each program. Keep the following in mind as you review the table:

- Benefits-eligible employees are all full-time and part-time employees who are classified to work 24 hours or more per week.
- 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.
- COBRA participants and retirees are not eligible for *Be Healthy* rewards.

ELIGIBILITY FOR *BE HEALTHY* WELLNESS PROGRAMS

Program Name	Enrolled in the Total Health Medical Plan			Benefits-eligible but not enrolled in the Total Health Medical Plan			Not benefits-eligible (including PRN employees)		
	Employees	Spouses	Children	Employees	Spouses	Children	Employees	Spouses	Children
Health Check Survey	√[1]	√[1]							
Wellness Credit Screening	√[2]								
Preventive/Wellness Exam	√	√	√[3]						
Age Appropriate Cancer Screenings									
• Colonoscopy	√	√[3]							
• Mammogram	√	√[3]							
Healthy Pregnancy	√	√							
Virgin Pulse Activities and Rewards[1]	√[1]	√[1]							
Diabetes Care	√	√	√						
Tobacco Cessation	√	√	√	√	√	√	√	√	√
Employee Assistance Program	√	√	√	√	√	√	√	√	√
Health Advocacy	√[4]	√[4]	√[4]						
Nutrition Coaching	√	√	√						
Employee Discounts[3]	√	√	√	√	√	√			
Fitness Center Memberships[3]	√	√	√	√	√	√	√	√	√
Real Appeal	√[4]	√[4]	√[4]						

1 This program can be accessed through the Virgin Pulse website/app.

2 Employees must schedule a screening on the Virgin Pulse website to either go to a Quest facility or to obtain a Provider/Physician form to be completed by their doctor.

3 Dependents can participate in the program but do not receive an incentive.

4 Must be at least 18 to participate. Only for participants in the UHC medical plan options.

BE HEALTHY REWARDS

If you have active coverage through the Total Health medical plan, you can earn the rewards listed in the chart below.

Be Healthy rewards can only be redeemed through your Virgin Pulse account. The rewards can be redeemed online for e-gift cards such as Visa and popular merchants.

Your privacy is protected in all parts of the *Be Healthy* program.

You have a variety of programs and activities to choose from to earn up to $300 in *Be Healthy* rewards in 2021. If your spouse is enrolled in coverage, they can choose from programs and activities to earn up to $175 in *Be Healthy* rewards in 2021.

For active members of the Total Health medical plan, *Be Healthy* rewards earned do not expire. However, if you leave the company, lose your eligibility to participate, or end coverage under the Total Health Medical Plan, you are given a 30-day grace period to redeem any rewards you have already earned, but you will not be able to earn additional rewards during the grace period.

To find previous-year rewards in Virgin Pulse, log in to your account. On the home page, select **Statement**. Then, select the year you want to see from the dropdown.

The IRS considers incentive rewards a part of your pay. That means you will have to pay taxes on the rewards you receive. The tax for your reward (and your spouse's, if applicable) will be shown on your paycheck as additional pay. On average, the tax on a $25 reward will be around $5. You will be taxed upon redeeming rewards.

HEALTH CHECK SURVEY

For employees with active Total Health medical coverage: When you log on to **MyTHR.org**, you can complete an online health check survey on Virgin Pulse. Most of the questions on the survey 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 biometric screening results such as your cholesterol, blood sugar (glucose) and blood pressure. Even if you don't have these results, you can still complete the survey. Your answers allow us to recommend programs and Virgin Pulse activities that are personalized to help you make small changes to improve your health. To complete the Health Check Survey, you have a few options. You can go to **MyTHR.org** and click the **Benefits** tile. Then click **Be Healthy Rewards**. You may also use your Virgin Pulse mobile app or log on directly to **join.virginpulse.com/behealthy**.

How to Participate in the *Be Healthy* Rewards Program

Program	When and How to Complete It[1]	Earn:	Details on Page:
Health Check Survey	Employees and spouses may complete the online Health Check Survey through their Virgin Pulse account at any time in 2021.	$75 for employees and $25 for spouses[2]	76 - 77
Wellness Credit Screening Deadline: Sept. 30, 2021	Employees can get screened from Jan. 1 through Sept. 30, 2021 to earn wellness credits on 2022 paychecks. After joining Virgin Pulse and creating an account, you have two screening options: • Quest patient service centers • Provider/Physician Form (copay may apply; use in-network lab provider to avoid additional charges).	Up to $520 in credits in 2022	77
Preventive/ Wellness Exam	Employees and eligible spouses may complete this exam anytime during 2021 with their primary care physician or women may get a well-woman exam with their gynecologist.	$75 for employees and $25 for spouses[2]	78
Cancer Screenings	Employees meeting the screening criteria for a mammogram or colonoscopy may complete this screening anytime during 2021.	$25[2]	83
Healthy Pregnancy	Pregnant employees and eligible family members may complete this program by enrolling in a Healthy Pregnancy Program by the 16th week of pregnancy and actively participating through the 6th week of the program after the baby is born. To enroll, call your medical plan provider – Texas Health Aetna or UHC.	$100[2]	79
Virgin Pulse Activities and Rewards	At any time throughout 2021, eligible employees and spouses can complete the online activities defined on page 79. Rewards are earned one time per year for each completed activity.	$50 for employees and $25 for spouses[2]	79

1 Employees and spouses must have active Total Health medical coverage to participate.

2 Not including wellness credit screening credits, all other *Be Healthy* Rewards are limited to an annual maximum. For employees, the annual maximum is $300. For spouses, the annual maximum is $175.

Spouse Health Check Survey

Spouses with active Total Health medical coverage are eligible to earn a $25 reward for completing the Health Check Survey.

Spouses can take the Health Check Survey at **join.virginpulse.com/behealthy**.

WELLNESS CREDIT SCREENING

Wellness Credit Screenings are biometric screenings that can provide important information about your health. By checking four basic numbers, you and your doctor can learn about your current wellbeing and can identify risks that can be managed sooner rather than later.

For Wellness Credit Screening numbers met in 2021, you can earn up to $520 in wellness credits as income on your 2022 paychecks. To earn credits:

- Complete the screening — earn $130 ($5 per paycheck)
- Meet 2 of the numbers — earn another $130 for a total of $260 credits ($10 per paycheck)
- Meet 3-4 of the numbers and earn the additional bonus credit of $260 for a total of $520 (max) in 2021. ($20 per paycheck)

Numbers to be less than to earn credits:

- LDL cholesterol is less than 130 mg/dl
- Blood pressure is less than 141/90 (both diastolic and systolic must meet criteria)
- Your abdominal circumference is less than 35 in. for women and less than 40 in. for men
- Your fasting blood sugar is less than 100

Numbers Met	Wellness Credits
3-4	$20 per paycheck ($520 per year)
2	$10 per paycheck ($260 per year)
Get screened (must go through Virgin Pulse to sign up)	$5 per paycheck ($130 per year)

If you get screened and your numbers are outside of the rewardable range, you can still earn additional credits by participating in a reasonable alternative. Reasonable alternatives to obtain this credit (after getting screened) are completing a Virgin Pulse Journey related to each health metric number you didn't meet (see Reward page in your Virgin Pulse account) or by submitting a doctor's exception form by September 30, 2021. Plan ahead to complete Journeys so you finish prior to the September 30, 2021 deadline.

Screening results obtained between Jan. 1, 2021 and Sept. 30, 2021 will count toward 2022 wellness credits applied as income to your paychecks.

Sign in to your Virgin Pulse account and go to Wellness Credit Screening. Select **Benefits** to find the Start Now button to go to Quest where you can select and complete one of the following screening options:

- Quest Patient Service Center
- Physician/Provider Form (copay may apply; use in-network lab provider to avoid additional charges; must download form and take it with you).

Any screening completed before your medical coverage is active in 2021 through Texas Health will not count toward this program.

If it is medically inadvisable for you to satisfy the Wellness Credit Screening requirements, you can still receive your credits by completing a screening. Then simply work with your personal physician to complete the Physician Reasonable Alternative Process Form, which can be found on the Wellness Credit Screening page of **BeHealthyTHR.org.**

Wellness Credit Screening Options

To receive credit for getting your Wellness Credit Screening, you have two convenient options detailed below. For either, you will need to go to **join.virginpulse.com/behealthy** to select your method of screening before your appointment. Also remember to fast for your appointment. Fasting means do not eat or drink anything except water for 9-12 hours prior to the blood test.

Visit a Quest Patient Service Center

- Go to **join.virginpulse.com/behealthy** and register/login. You can also go to **MyTHR.org** and click **Be Healthy Rewards**.
- Click **Benefits**, then find **Wellness Credit Screening** and click **Start Now**.
- Click **Schedule a Screening.**
- Select a location near you, then choose a date/time. Click **Confirm**.
- After your appointment, Quest will send your results to Virgin Pulse.
- Check the Virgin Pulse website/app to make sure your results are showing. Only results showing completed on the Virgin Pulse website/app count toward wellness credits. Note: The updates to all four measures may occur at different times. It may take an additional two weeks to see the full results in your account.

See Your Doctor

- Schedule an appointment with your doctor.
- Go to **join.virginpulse.com/behealthy** and register/login. You can also go to **MyTHR.org** and click **Be Healthy Rewards** to avoid remembering your password.
- Click **Benefits**, then find **Wellness Credit Screening** and click **Start Now**.
- Click **Order Form** under **Physician Results Form**.
- Click **Download Form**.
- Print the form and take it to your appointment for your physician to complete.

- The form needs to be uploaded to your Quest account once completed or faxed to 844-560-5221 (by September 30, 2021).

If your doctor is referring you to a lab to complete your screening for the wellness credits, make sure you go to a lab that is in-network to avoid additional charges. Additional lab codes not associated with the four Wellness Credit Screening numbers may incur additional costs.

Make sure to review your Physician Results Form to ensure all required data are completed. Forms can take up to 21 business days to process. If a form does not have all required data filled in, it will be rejected and not processed. Forms can be resubmitted; however, all forms including resubmitted forms need to be received by 9/30/2021. It is your responsibility to ensure the form is complete and submitted by the due date.

Note: If getting screened at your doctor's office, the form is used to submit your wellness credit results only rather than for full lab work. You can upload the results to your Quest Diagnostics account once completed. Your Quest account is found by searching "wellness credit screening" on your Virgin Pulse dashboard. This is the site where you selected your screening option previously.

Number of Screenings Allowed

Eligible employees may re-screen once a quarter through Sept. 30, 2021.

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 by their gynecologist. Be sure to 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 have active Total Health medical coverage during the time of service, you will receive a $75 reward for getting an annual preventive/wellness exam at any time in 2021. Spouses with active Total Health medical coverage at the time of service are eligible to earn a $25 reward for getting their annual preventive/wellness exam at any time in 2021.

Be sure to sign up for Virgin Pulse at **join/virginpulse.com/behealthy** to receive your Preventive/Wellness Exam reward. Or you can get to Virgin Pulse through **MyTHR.org** (select the **Benefits** tile, then **Be Healthy Rewards**).

Your completion of the wellness exam will be automatically reported through claims processing by your medical plan provider. It takes an average of six weeks to receive your reward email notification. If you have not received your award notification within 12 weeks please contact **BeHealthyTHR@texashealth.org**.

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.

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 $75 reward per year for the preventive/wellness exam as one of the choices to earn up to $300 ($175 for spouses) in *Be Healthy* rewards.

Be sure:

- You select a doctor who is part of your medical plan option's network
- That they send bloodwork to an in-network lab, and
- That they code your visit as a wellness exam to avoid additional charges.

VIRGIN PULSE ACTIVITIES

The *Be Healthy* program is powered by Virgin Pulse. In this online and mobile wellness platform, you can redeem *Be Healthy* rewards and complete a variety of wellness activities to earn rewards. Virgin Pulse is designed to meet you where you are on your well-being journey so you can take care of yourself—body, mind and spirit. In 2021, you have a variety of *Be Healthy* programs and activities to choose from to earn up to $300 ($175 for spouses) in *Be Healthy* rewards. You have the choice to participate in whichever programs and activities work best for your health journey (and your schedule) to earn rewards the way you want to. One of the ways you can earn rewards is by completing Virgin Pulse Activities, described below. Call 1-877-MyTHRLink (1-877-698-4754) prompt 4, then prompt 3 to reach support at Virgin Pulse or email **support@virginpulse.com**.

Track sleep 20 days in a month

Sync a compatible device with your Virgin Pulse account. Pick a sleep profile, get customized tips, and see all your sleep data in one place. Track your sleep 20 days in a month to earn *Be Healthy* rewards.

Track calories 20 days in a month

Got a sweet tooth? Eat whatever's easy? Pick your nutrition profile and Virgin Pulse will serve up healthy tips and great recipes from Zipongo — just for you. Track your calories 20 days in a month to earn *Be Healthy* rewards.

Complete a Whil Program

Complete a mini-course in yoga, mindfulness, or emotional intelligence to help reduce stress, increase resilience and improve your mental well-being. Complete one of these courses to earn *Be Healthy* rewards.

Track Healthy Habits 20 days in a month

With 300+ habits to choose from, it is easy to find Healthy Habits that match your interests and goals. Start tracking and watch these small daily habits help boost your energy, focus and drive. Track Healthy Habits 20 days in a month to earn *Be Healthy* rewards.

Complete 20 daily cards in a month

Complete the GOT IT! daily cards on your member dashboard. These cards share simple activities and pro tips on eating healthier, staying active, etc. Click on GOT IT! to complete the card. Complete 20 daily cards in a month to earn *Be Healthy* rewards.

Track 7,000 steps or 15 active minutes or 15 workout minutes 20 days in a month

Connect a compatible device to track your steps, active minutes, workout minutes, sleep, etc. Track 7,000 steps or 15 active minutes or 15 workout minutes 20 days in a month to earn *Be Healthy* rewards.

HEALTH TEAM

If you're living with a complex or chronic health condition and you have active Total Health medical coverage, you can receive ongoing support from a nurse. Your Holistic Care team through Texas Health Aetna or Total Health Nurses through UnitedHealthcare will get to know you and develop an action plan to help you coordinate care and resources. You can meet with your nurse in person or by phone, and he or she can even attend doctor appointments with you to make sure all your questions are answered.

Your nurse is here to help you:

- Follow your doctor's treatment plan
- Manage medications
- Get answers to your questions
- Coordinate your health care appointments
- Learn tips for self-care
- Access resources or programs that you need
- Navigate the health care system

Your Health Team is dedicated to making sure you have the support you need so you can focus on your health. To learn more, call 1-877-My-THRLink (1-877-698-4754), select prompt 1 for the Texas Health Aetna Holistic Care Team or prompt 2 and ask to be connected to a Total Health Nurse.

HEALTHY PREGNANCY PROGRAMS

If you are pregnant or thinking about becoming pregnant and you or your spouse is enrolled in the Total Health Medical Plan, you can get valuable educational information, rewards, advice, and comprehensive case management by enrolling in a Healthy Pregnancy Program. Texas Health Aetna offers the Maternity Management Program and UHC offers the Maternity Support Program.

The programs are 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 a Healthy Pregnancy Program by your 16th week and complete the post-partum call after your baby is born, you will receive a $100 reward as one of the choices to earn up to $300 ($175 for spouses) in *Be Healthy* rewards.

There is no cost to enroll in a program.

Texas Health Aetna's Maternity Management Program

The Maternity Management maternity program focuses on prevention and education to help employees and families have healthy, full-term babies. You'll get:

- Tools and resources to help you have a healthy pregnancy
- Information about prenatal care, labor and delivery, newborn and baby care and more
- Follow-up calls after your delivery
- Screenings for depression
- Extra support for lactation and breastfeeding, if you need it
- Mayo Clinic Guide to Healthy Pregnancy, if you complete the program

If you have risk factors that need special attention, our nurses can help you find ways to manage your risks such as stopping smoking or getting special support if you are at risk for an early birth.

You can participate by:

- Calling a Maternity Management nurse anytime during your pregnancy or after your delivery us at 1-800-CRADLE-1 (1-800-272-3531), weekdays from 7 a.m. to 6 p.m. C.T.
- Logging in to your Texas Health Aetna member website at **TexasHealthAetna.com**. Look under Stay Healthy and choose Maternity Program. Complete a short survey so we can get to know about you and your pregnancy. If we see we can provide additional help, we will call you. We will also call you 3-4 weeks after you deliver to check on you and your newborn.

If you are an employee or spouse, be sure to complete:

- The survey prior to 16 weeks and
- The post-partum call by the 4th week after the baby is born to earn a $100 incentive through your wellness program as one of the choices to earn up to $300 ($175 for spouses) in *Be Healthy* rewards.

If you have any questions or problems with the processing of your $100 reward, please contact 1-877-MyTHR Link (1-877-698-4754) prompt 4 then 3.

UHC's Maternity Support Program

Pregnancy is an exciting time in your life whether it's your first baby or you're adding another little one to your family. If you're expecting, our Maternity Support nurses are available to personally support your journey. The nurse will check in with you regularly to answer questions and help calm any worries.

To enroll or find out about any of these programs, visit **MyTHR.org** or **BeHealthyTHR.org**.

Some of the UHC 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
- Mobile application personalized to your delivery date (download the UnitedHealthcare Healthy Pregnancy app)
- 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), prompt 2.

REAL APPEAL

Real Appeal is a clinical weight management program that helps UHC medical plan option members lose weight by focusing on lasting lifestyle changes with small, steady sustainable steps. Real Appeal consists of up to 52 weeks of online support from a Real Appeal transformation coach and a success kit, both provided at no additional cost to eligible participants.

Eligibility

If you, your covered spouse, or your covered dependent(s) have active UHC medical coverage, are at least 18 years old, and have a BMI of 23 or higher, you can enroll in Real Appeal.

Some exclusions apply:

- Pregnant
- Nursing an infant (may enroll when baby is eating)
- Anorexia or Bulimia Nervosa (present or recent history)
- Severe liver, heart, kidney, neurologic, psychiatric or any severe chronic or acute illness.

Participation

To enroll in the program, visit **THR.realappeal.com**. After enrolling, participants receive:

- *52 weeks of access to a Transformation Coach*—Your online coach guides you through the program and develops a simple, customized plan that fits your needs, preferences and goals.
- *Digital tools*—24/7 access to tools and dashboards that help you track your food, activity and weight.
- *Success kit*—full of healthy weight management tools, including fitness guides, a recipe book (with quick family meal ideas and fast-food eating tips), digital weight scale and more.
- *Support from weekly online group glasses*—to learn healthy ideas from your coach and other members who share what's helped them achieve success.

If you experience issues with enrollment or the products in the Success Kit, please contact the Real Appeal technical team by emailing **help@realappeal.com** or calling 1-844-344-REAL (7325).

DIABETES CARE

Texas Health offers a program that includes diabetes education and support. Diabetes Care sessions for adults or children (not available at all locations) are covered after a $10 copay at a Texas Health or UTSW facility.* Coverage includes either individual or group sessions with a certified diabetes educator. A physician's referral is required.

* Under the Texas Health Aetna Select 3000 and UHC Choice Plus 1500 plan options, the full cost of the sessions must be paid until you meet your deductible. Then the cost is 10% at Texas Health and UTSW facilities.

Eligibility

Employees and eligible family members with active Texas Health medical coverage are eligible for Diabetes Care.

Participation

You can receive free test strips for self-monitoring of your blood glucose when you visit with a Texas Health or UTSW 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 One Touch monitor through CVS Caremark with a prescription from your doctor. 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. Pediatric (under age 16) members obtain test strips through Optum Nurses by contacting CVS Caremark for an override.

For assistance with the program and referrals, employees can call Texas Health Diabetes Education Center at 1-800-804-3399 or UTSW at 214-645-5305.

NUTRITION COACHING

Employees and eligible family members with active medical coverage with a BMI greater than 28 can participate in the Nutrition Coaching program which provides one initial 90-minute 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 or UTSW 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.

To participate, contact one of the Texas Health registered dietitians listed at **BeHealthyTHR.org/be-healthy/medical-nutrition-therapy**.

TOBACCO CESSATION

Texas Health has retained Consumer Wellness Solutions Inc. through OptumHealth, a company specializing in tobacco cessation, 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 CVS Caremark pharmacy (at no cost 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). For those not enrolled in the Total Health Medical Plan, there is a 40% copay at these pharmacies only.
- Prescription medication Chantix™ is covered for participants enrolled in the Quit for Life 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.
  - Chantix is available with a prescription at any CVS Caremark pharmacy (at no cost 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, there is a 40% copay for these pharmacies only).

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 **BeHealthyTHR.org/be-healthy/quit-for-life** for more information.

FITNESS MEMBERSHIPS

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

- Convenient on-site fitness centers: See **BeHealthythr.org/be-healthy/fitness-memberships** for a full list of on-site fitness centers. All employees and their eligible household family members can now take advantage of the same low individual rate for either the All Access membership or the Virtual Access membership managed through FX Well at our onsite Texas Health Fitness Centers.

  To participate, you can use your smartphone with access to an app store. To access any participating fitness center, you will use the ASF Self Check-In mobile app as your entry key. If you don't have a smartphone, simply visit a gym to sign up with Guest Relations.

  To get started, the employee will select a primary fitness center to sign up through at **LiveFXWell.com**. If you need more information, go to Fitness Center Locations for each centers' address and phone number to call for hours of operation, amenities and classes offered at each location.

  Once you are in **LiveFXWell.com**, scroll down and select your chosen primary location.

  There are two membership options, *All Access* and *Virtual Access*. Select the membership type you want with the payment type you will use.

  Follow the prompts to complete your membership agreement.

  For both memberships, find and download the two free mobile phone apps to participate: *ASF Self Check-In* app and *FX Well Digital Fitness*.

  What you get:

  – 50% off the enrollment fee

  – No annual enhancement fee

  All Access membership includes access to all participating Fitness Center Locations at the low cost of $15 bi-weekly via payroll deduct or credit card.

  Virtual Access memberships are available at the even lower cost of $7.00 bi-weekly.

  Any eligible member of your household can now join at the same discounted rates.

  All Access memberships includes access to all of our participating fitness center amenities plus access to our FX Well Digital Fitness app and all virtual fitness classes too.

  Virtual Access memberships include access to our FX Well Digital Fitness app and all virtual fitness classes.

  You get memberships that are month-to-month and that can be canceled with no early termination fees.

  $15 bi-weekly members will receive a free 60-minute fitness assessment with a personal trainer. One-on-one personal training and small group training are also offered in 30 and 60-minute increments at additional cost.

  All participating locations have locker rooms with showers that are stocked with shampoo, conditioner and body wash.

- Find a fitness center near you at rates lower than retail. Visit **texashealth.savings.beneplace.com** and look for corporate fitness discounts.

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. You must meet the age requirements listed in the chart below to be eligible for a reward.

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	You earn[3]
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]	$25
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]	$25

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

[2] Well exams are 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.

[3] As one of the choices to to earn up to $300 ($175 for spouses) in *Be Healthy* rewards

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, THR EAP, CVS Caremark Pharmacy, Quit for Life™ tobacco cessation program, Virgin Pulse, Real Appeal, Texas Health Aetna and UnitedHealthcare. They must take the necessary steps to protect your information and give you appropriate information and education.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

Overview

The Texas Health Resources Employee Assistance Program provides professional support and resources to help you manage life's challenges, maximize your potential, and enhance your emotional and physical well-being. Self-care isn't selfish, and a big part of taking care of yourself is getting the right help when facing life's challenges. The Employee Assistance Program is here for you and your family 24/7/365. Whether you're facing emotional, physical, legal or financial hurdles, we've got resources just for you.

You can receive up to six in-person, telephonic or web-video EAP counseling sessions per issue per year, at no cost to you. THR EAP counselors are available to assess your concerns, provide guidance and develop an action plan to help resolve personal issues.

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

Clinical Support

Between a busy home life and a busy career, things can get a little overwhelming sometimes. At times, personal challenges can even start to impact our emotional and physical health, as well as our overall productivity. But as a Texas Health Resources employee, you've got help at your fingertips. THR EAP can assist with:

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

Clinical support comes in three ways: face-to-face, telephonic and web-video counseling.

All THR EAP clinicians are licensed by the State of Texas as either social workers, professional counselors or psychologists.

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

Work and Life Services

THR EAP Work-Life services save you time by assisting with personal life issues that can otherwise cause stress and distract you from work, such as concerns related to child and elder care, financial/ legal issues, identity theft and everyday responsibilities. Let our team do the work for you by finding local resources and support services.

THR EAP's Website

THR's website has tools to help you take charge of your wellbeing. You can explore the free and confidential resources available to you for a variety of work-life related needs, review our extensive library of articles and resources on a variety of health, wellness and self-help topics. Visit **BeHealthyTHR.org/EAP** to access the site or look at the **MyTexasHealth** intranet for the Employee Assistance Program.

Examples of Available Work-Life Services:

Legal Assistance: THR EAP offers employees a 30-minute in-person or telephonic consultation with a lawyer or mediator per separate matter, and also includes a 25% discount on rates if the legal consultant is hired for additional services. Services are for issues related to civil, consumer, personal and family law, financial matters, business law, real estate planning and more. This plan excludes issues related to labor and employment law, medical malpractice or disputes between employees and Texas Health Resources.

Identity Theft Services: If you would like more information about identity theft or if you have been a victim of identity theft, THR EAP Identity Theft Services are for you. You can speak with a fraud specialist who will help determine if you are a victim of identity theft and recommend options on how to place fraud alerts, freeze credit, file police reports, and contact other resources as necessary to resolve fraud concerns. THR EAP will also give you information on identity theft prevention and provide you with an identity theft emergency response kit.

Child and Eldercare Resource and Referral: Let THR EAP do the work of locating available childcare and eldercare providers. We'll find out what kind of help you need caring for the child/children and elders in your life. Then, we'll give you the names and numbers of at least five local providers with confirmed openings and/or community resources, all within 1-2 business days.

Financial Services: Do you have questions about or need assistance with credit counseling, debt and budgeting assistance, tax planning, financial planning for college and retirement planning? Take the time to speak with a financial counselor, who will offer telephonic consultation to help with an array of financial concerns. This service includes one 60-minute telephonic consultation per separate matter. This is not a tax representation/preparation service. Investment advice and loan/bill payments are not included.

Concierge Services: Our personalized concierge service will assist in tracking down businesses and consultants to help you plan an event, vacation or set dinner reservations. We can also find local contractors to help you manage home repairs. However, THR EAP does not cover the cost, nor guarantee delivery of the vendors' services.

Health Savings Account

Health Savings Account

OVERVIEW

Texas Health has made available to employees the ability to be a participant in a Health Savings Account (HSA) if you also enroll in one of the qualifying high-deductible health plan (HDHP) options through Texas Health Resources. By combining the HDHP with an HSA, you'll enjoy the benefits of pre-tax contributions, tax-free withdrawals, and even the potential for tax-free interest and investment earnings – all while taking care of eligible healthcare expenses for yourself and your family. This is not an ERISA plan.

WHO CAN BE COVERED

You are eligible to enroll in the Health Savings Account if you also enroll in a qualified high-deductible health plan. At Texas Health, the two health plan options that meet the requirement of being a high-deductible health plan are the Texas Health Aetna Select 3000 or UHC Choice Plus 1500 plan options. Please note, you must meet the following eligibility requirements as well to be a participant in the Health Savings Account:

- Cannot be covered by any other non-HSA-compatible health plan
- Cannot be claimed as a dependent on another person's tax return (excluding spouse per Internal Revenue Code)
- Cannot be enrolled in Medicare
- You cannot receive health benefits under TRICARE
- Have not received Veteran's Administration (VA) benefits within the past three months
- Native Americans cannot be utilizing IHS or tribal medical services
- Cannot be covered by a general-purpose health care flexible spending account (FSA) or health reimbursement account (HRA)

If you are not eligible to participate, Texas Health will not make employer contributions to the Health Savings Account on your behalf.

CONTRIBUTIONS

Texas Health Resources will make employer contributions equal to $19.23 (Individual) and $38.46 (Family) for you each pay period you are enrolled in a Total Health Medical Plan option that qualifies as a High Deductible Health Plan. This contribution is made to your Health Savings Account on a pro rata basis during the year. You may also elect to contribute to your Health Savings Account on a pre-tax basis. The maximum annual amount you can contribute to your Health Savings Account in 2021 is $3,600 for employee only coverage or $7,200 for all other coverage levels. This includes the contribution made by Texas Health. Those over the age of 55 are allowed to contribute an additional $1,000 each year above the IRS annual contribution max.

How Much You Can Contribute in 2021	
55 or under	$3,600/individual $7,300/family
Over 55	$4,600/individual $8,300/family

The portion of your pay that is contributed to a Health Savings Account is not subject to Federal income or Social Security taxes. Your Social Security benefits may be slightly reduced because when you receive tax free benefits under our Plan, it reduces the amount of contributions that you make to the Federal Social Security system as well as our contribution to Social Security on your behalf.

The Health Savings Account allows you to make changes to your contribution election at any point during the plan year while you are enrolled in a qualifying High Deductible Health Plan, as long as you do not exceed the annual contribution limits established by the IRS to include the amount contributed by Texas Health to your account. To make a change to your HSA contribution, contact THR Benefits Support at 1-877-MyTHRLink (1877-698-4754). (Note: to be able to make changes to your medical plan, see page 11 to learn about "qualified life events" per IRS regulations.)

LIMITS ON YOUR ABILITY TO CONTRIBUTE TO YOUR HSA

If you have money remaining in your Health Care Flexible Spending Account on January 1, neither you nor Texas Health may contribute to your HSA for the entire plan year, even if you spend the funds before then. You may complete a waiver of funds prior to January 1 to begin your HSA contributions right away and forfeit your Health Care Flexible Spending Account.

HIGHLY COMPENSATED EMPLOYEES

Highly compensated employees are defined by the Internal Revenue Code.

If you are a highly compensated employee, the amount of contributions and benefits for you may be limited so that the plan as a whole does not unfairly favor those who are highly paid, their spouses or their dependents. Plan experience will dictate whether contribution limitations on highly compensated employees will apply. You will be notified of these limitations if you are affected.

COVERAGE AFTER EMPLOYMENT ENDS

The employer contribution and your payroll deducted contributions to the Health Savings Account will end when you leave employment, are no longer enrolled in a qualifying HDHP, are not in a benefits-eligible position at Texas Health, are not eligible under the terms of any insurance policies, or when insurance terminates.

If you terminate employment with Texas Health, your Health Savings Account amounts will remain yours even after your termination of employment. To find out more about how the Health Savings Account works, see IRS Publication 969.

FOR MORE INFORMATION

HealthEquity, formerly WageWorks, is the administrator of the Health Savings Account made available by Texas Health Resources. The administrator keeps the records and is responsible for the administration of your account. The administrator will also answer any questions you may have.

You may reach HealthEquity at the following:

HealthEquity
P.O. Box 14053
Lexington, KY 40512

Phone: 877-MyTHRLink, Prompt 6, then prompt 6 again

www.WageWorks.com

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®)
- Participating Dental Network (PDN) 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 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 **BeHealthyTHR.org.**

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 **BeHealthyTHR.org**. COBRA participants can call 1-877-MyTHRLink (877-698-4754), prompt 9.

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 **BeHealthyTHR.org**.

AETNA PDN (LOW OPTION)

Aetna Participating Dental Network 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 PDN (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 PDN. Members may be responsible for the difference between Aetna's negotiated fees and the out-of-network dentist's actual charge.

Advantages of the PDN Low 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.

PDN Low Plan Features

Dental coverage under the PDN Low 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.
- *Bitewing X-rays* (limited to twice 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 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 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 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.

Summary of Benefits

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

Plan Feature	PDN (Low Option) Network or Out-of-network[1]
Deductible	$50 per person $150 per family
Preventive care (Two visits per year) • Routine checkups • X-rays • Cleaning and polishing • Space maintainers	80%
Basic care • Fillings • Extractions • Anterior/bicuspid root canal therapy • Oral surgery[2]	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

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

2 Some oral surgeries may fall under the category of major care.

WHAT THE PDN (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 twice 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
- 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

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
- Full and partial denture repairs
  - Broken dentures, no teeth involved
  - Partial denture repairs (metal)
  - Replacing missing or broken teeth.

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
- Crown exposure to aid eruption
- Removal of impacted tooth – partially bony/completely bony
- Removal of impacted tooth – completely bony, with unusual surgical complications

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 (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 PDN (Low 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 (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 PDN (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 PDN (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 (High Option) 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 (High Option) Plan Features

Dental coverage under the PDN (High Option) 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[1]
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[2]	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

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

2 Some oral surgeries may fall in the category of major care.

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

- 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 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
- 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 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

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
- Full and partial denture repairs
  - Broken dentures, no teeth involved
  - Partial denture repairs (metal)
  - Replacing missing or broken teeth.

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
- Crown exposure to aid eruption
- Removal of impacted tooth – partially bony/completely bony
- Removal of impacted tooth – completely bony, with unusual surgical complications

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 PDN (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 PDN

Under the 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 PDN provider, you pay a coinsurance amount for basic care. For major and orthodontia, you must satisfy a deductible and then pay a coinsurance. Network providers will normally file your claims for benefits with Aetna 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 **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 provided 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. 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: **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 Texas Health Dental Plan ends on the last day of the pay period in which you terminate employment. See page 197 for more information. For dependents reaching the maximum age, coverage ends at the end of the month containing the dependent's birthdate.

In some cases, you and your covered dependents may be eligible for COBRA continuation coverage, as explained on page 198.

Vision Plan

OVERVIEW

You may elect coverage for vision care through the Texas Health Vision Plan. The plan pays benefits for annual eye exams and corrective glasses or contact 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 Texas Health 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) every 12 consecutive months	Covered in full after $35 copay	Not covered
Contact lens fitting (specialty) every 12 consecutive months	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)[3]

You receive 20% off retail, up to the dollar amount listed:

- Factory scratch coat – $13[4]
- Ultraviolet coat – $15[4]
- Standard anti-reflective coat – $50[4]
- High index 1.6 – $55[5]
- Polycarbonate – $40[5]
- Standard transitions and other photochromic – $80[5]
- Glass coloring – $35[6]
- Plastic tints solid or gradient – $25[6]
- Retinal imaging – $39

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] Providers may at times choose to reduce the 20% discount related to add-ons.

[4] Single-vision and standard lined multifocal lenses

[5] Single-vision lenses only

[6] Any type of lenses

NETWORK PROVIDERS

To find a list of network providers, visit **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 **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.

Use your vision benefits when you shop online for glasses or contacts! Through **1-800 Contacts**, **Befitting**, **Glasses.com**, and **ContactsDirect**, you'll be able to use your vision benefits at your convenience from your home or on the go.

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 in-network, up to $100 allowance out-of-network
  - You may order contact lenses online at **contactsdirect.com.**

Options at an Additional Cost

The Texas Health 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 lens 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 the Texas Health Vision Plan—more information is available at **Superiorvision.com**.

How Often You Can Get Glasses or Contact Lenses	
You are eligible for a vision exam and glasses or contact lenses once per rolling 12-month period. For example:	
If you got new glasses or contacts in April 2020:	You will be eligible again in April 2021.
If you got new glasses or contacts in December 2020:	You will be eligible again in December 2021.

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 (reimbursed at out-of-network values)
- 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 Texas 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 Texas 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 197 for more information. For dependents reaching the maximum age, coverage ends at the end of the month containing the dependent's birthdate.

In some situations you may continue vision coverage after you leave Texas Health. See page 198 for information on electing COBRA continuation coverage.

Flexible 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 (FSA) 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.

Texas Health has contracted with HealthEquity, formerly WageWorks, to administer the Flexible Spending accounts for our employees.

The Health Care Flexible Spending Account (HCFSA) 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 Flexible Spending Account (DCFSA) 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, as long as you are not enrolled in a High Deductible Health Plan. If enrolled in a High Deductible Health Plan, you are eligible for the Dependent Care Flexible Spending Account. During enrollment, you decide how much to deposit on a before-tax basis for the year, up to:

- $2,750 per year into your Health Care Flexible Spending Account (a minimum of $130 per year)
- $5,000 per year into your Day Care Flexible Spending Account. If you are married and your spouse's employer offers a Dependent Care Flexible 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.

Generally, your expenses claimed for reimbursement must be for health care or child care services incurred between January 1 and December 31, and only during the months that you are eligible to participate. If you participate in the Health Care and Day Care Flexible Spending Accounts, keep in mind that the accounts are maintained separately. You may not transfer money between the accounts.

Texas Health has adopted the grace period feature allowed by the IRS, which extends the amount of time you can use your remaining Flexible Spending Accounts funds after the end of the year.

Due to COVID-19, the rules regarding the deadline to use any remaining 2019 Flexible Spending Accounts were temporarily disregarded. The deadline to submit claims for your 2019 Flexible Spending Account expired March 1, 2021.

Also due to COVID-19, the rules regarding deadlines for your 2020 Flexible Spending Accounts have been extended. You can incur claims between January 1, 2020 and December 31, 2021. Claims must be submitted within 60 days of the end of national declaration of emergency or March 1, 2022, whichever is earlier.

Due to COVID-19, you are also able to incur claims and submit claims for your 2021 Health Care and Day Care Flexible Spending Accounts until December 31, 2022.

Limits on Your Ability to Contribute to Your HSA

If you decide to enroll in a High Deductible Health Plan and have money remaining in your Health Care Flexible Spending Account at the end of the year, neither you nor Texas Health may contribute to a Health Savings Account (HSA) for the entire plan year, even if you spend the funds before then. However, you may complete a waiver of funds prior to January 1 to forfeit your Health Care Flexible Spending Account balance and begin your HSA contributions right away.

What You Need to Remember

- Make sure to spend all of the remainder of the funds in your current health care FSA before the end of the year.
- This includes any account repayments from unverified card transactions.
- Please allow for the fact that approved claims and cards transactions may take up to 72 hours to be processed and settled to your account.
- If you have health care FSA funds at the end of the year but enrolled in the Health Savings Account (HSA) for the following year, you may forfeit your Health Care Flexible Spending Account balance. You may do this by completing a form to waive the grace period to use remaining FSA funds into the following year. This allows you and Texas Health to begin making contributions to your HSA on January 1.

HEALTH CARE FLEXIBLE SPENDING ACCOUNT

The Health Care Flexible Spending Account can be used to pay for certain health care expenses that are not covered by insurance. Eligible expenses include medical, prescription, 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 Flexible 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 contributions. 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.

Due to COVID-19, the rules regarding mid-year changes for both 2020 and 2021 are temporarily expanded to allow you to enroll, make changes to, or revoke your Health Care Flexible Spending Account elections without the requirement of a qualified status change. If you change your annual contribution amount, it cannot be lower than what you have contributed year to date. It also cannot be lower than what you have already spent for the year.

Also due to COVID, if you enroll in the plan at any time in 2021, you will be able to submit claims back to January 1, 2021.

Rehires

If you terminate your employment or lose eligibility and then you are rehired within 13 weeks of your termination, you will be reinstated in the plan at the same contribution rate.

HCFSA Debit Card

You will receive a Benefits Card which is a Visa Card that provides you immediate access to your health care 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. Due to COVID-19, the deadline to use remaining funds has been extended. When you use your card after December 31, 2021, it will withdraw from your 2020 or 2021 account first, then access your 2022 funds. Your Benefits Card can be used for medical, prescription, 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. Any amounts not repaid are subject to taxation.

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 CVS 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, Plano, and the Texas Health Infusion Pharmacy.

If your provider does not accept Visa Card, 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 HealthEquity and your eligible claims will be reimbursed to you.

Go to **WageWorks.com** or download the WageWorks EZ Receipts mobile app to track your Health Care Flexible 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 HealthEquity at 1-877-MyTHRLink (1-877-698-4754), select prompt 6, then press 6.

COBRA Participants HCFSA Debit Card

Upon termination, you will no longer be able to use your HCFSA debit card. As a COBRA participant, to receive reimbursement for eligible expenses, you will need to file claims as explained on page 199.

Eligible Health Care Expenses

In general, your Health Care Flexible 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. You can also find helpful information at **WageWorks.com**. The list below gives examples of the expenses that qualify for reimbursement. For a more comprehensive listing of eligible expenses, go to **https://www.wageworks.com/employees/healthcare-benefits/healthcare-flexible-spending-account/**. Excluded expenses are listed on the following 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
- Menstrual care products
- Nursing home care
- Over-the-counter medications without a prescription
- Personal protective equipment related to COVID-19 such as masks, hand sanitizer, and sanitizing wipes
- 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 Texas 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.

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 flexible 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
- 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
- Personal care items such as cosmetics and toiletries (menstrual care products are eligible)
- 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 Flexible Spending Account vs. Tax Deduction

If you pay eligible health care expenses through your Health Care Flexible 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 7.5% 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 $1,500 can be deducted on your income tax return: 7.5% of $20,000 = $1,500

If you are in a combined 22.65% tax bracket (15% income tax + 7.65% FICA tax), that means you pay $339.75 more in taxes by not reimbursing these expenses through the Health Care Flexible Spending Account: 22.65% of $1,500 = $339.75.

DAY CARE FLEXIBLE SPENDING ACCOUNT

The Day Care Flexible 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 Flexible Spending Account during the year and make a 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 11 – 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.

Due to COVID-19, the rules regarding mid-year changes for both 2020 and 2021 are temporarily expanded to allow you to enroll, make changes to, or revoke your elections in the Day Care Flexible Spending Account without the requirement of a qualified status change. If you change your annual contribution amount, it cannot be lower than what you have contributed year to date. It also cannot be lower than what you have already spent for the year.

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 Flexible Spending Account. If you are married and you and your spouse are both contributing to a Day Care Flexible 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 among your paychecks. Unlike your Health Care Flexible 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 $2,750 during open enrollment, that amount is divided by 26 pay periods to figure your per-pay-period deduction of $105.77. 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.

If you go on a leave of absence, payroll deductions will be stopped. When you return from leave, the annual per pay period contribution will be recalculated based on the number of pay periods left in the 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.

Federal law imposes certain non-discrimination tests that can limit the amount that highly compensated employees (as defined by the IRS) can contribute to the Day Care Flexible Spending Account. Generally, employees earning more than $130,000 in 2021 are considered highly compensated employees. If you are affected by these limits, the plan administrator will notify you if and when the maximum amount has been reached. Your contributions into the Day Care Flexible Spending account will be stopped for the remainder of the year. You may be taxed on the amount of your remaining contributions.

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 baby sitter 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 actively at work (unless your spouse is a full-time student or is mentally or physically disabled).

Day Care Flexible Spending Account vs. Federal Tax Credit

Federal tax laws allow you to take a tax credit for eligible dependent care expenses. You may use both the dependent day care tax credit and the Day Care Flexible 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 Flexible 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: **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 HealthEquity to receive reimbursement for eligible health care and dependent day care expenses.

Claims can be submitted multiple ways.

- Log in to **WageWorks.com** and select File A Claim
- HealthEquity WageWorks EZ Receipts Mobile App
- Fax to 877-353-9236
- Mail to:
  HealthEquity
  P.O. Box 14053
  Lexington, KY 40512

You may file claims for eligible expenses at any time during the plan year. Reimbursements are processed Monday through Friday. 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 Flexible 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 Flexible 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 at **BeHealthyTHR.org** and **WageWorks.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 or fax the completed claim form with the original itemized bills, Explanation of Benefits (EOB) and receipts to HealthEquity at the address or fax number on the claim form.
- The claims processor will determine whether the expense is eligible for reimbursement.

Day Care Flexible 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 or fax the completed claim form and documentation to HealthEquity at the address or fax number on the claim form.

Claim Filing Deadline

Your deadlines to submit claims for 2019, 2020, and 2021 health care or day care expenses incurred have been extended due to COVID-19.

- For your 2019 Flexible Spending Accounts, the extended deadline expired on March 1, 2020.
- For your 2020 Flexible Spending Accounts, you have until 60 days following the end of the national declaration of emergency or March 1, 2022, whichever is first.
- For your 2021 Flexible Spending Accounts, you have until December 31, 2022.
- Before you stopped making contributions because you experienced a status change during the year.

Filing and Appealing Health Care and Dependent Care Flexible 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 flexible spending account claims using the claim form found on **BeHealthyTHR.org** and **WageWorks.com** and send claims to:

HealthEquity
P.O. Box 14053
Lexington, KY 40512
www.WageWorks.com

You appeal spending account claims in the same way you appeal medical claims (described beginning on page 68) except you send a spending account appeal to HealthEquity at the above address.

For information on how to appeal a denied claim, see pages 68 – 72.

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 the deadlines defined on this page 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 Flexible Spending Account by electing COBRA continuation coverage (see page 198). 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 illness. 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 Prudential. 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 230), or medical resident/intern, you are not eligible for STD, Basic LTD, or Additional LTD. Physicians employed by THPG and THBC 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. Executives are eligible for the Long Term Disability Plans described in this section but are not eligible for the Short Term Disability policy and should see the Executive Time Off Guidelines for further details.

Coverage is effective on the first day of eligibility (see page 5).

SUMMARY OF DISABILITY BENEFITS

The table on this 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 illness 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. The requirement to be actively at work also applies to increases in coverage. Any increases to STD or LTD would take effect upon your return to work.

Comparison of Disability Plans

Coverage	When Benefits Begin	When Benefits End	Amount of Gross Benefit
Short Term Disability 14-day elimination period	After 14 continuous calendar days of disability	See page 119 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 119 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 122 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

Plan Administration

The Plan Administrator has delegated authority to the Prudential Insurance Company of America to provide claim processing, claim investigation, claim control and the daily administration of the plan.

All decisions concerning the payment of claims under the plan are at the sole discretion of the insurance company.

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 for Short Term Disability).

A pre-existing condition is any injury or sickness for which you incurred expenses, received medical treatment, consultation, 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 STD benefit will be limited to 4 weeks (if you were not covered by STD within 12 months before your disability began).

If you elected the 30-day waiting period in 2020 and changed to the 14-day waiting period in 2021, your 2021 benefits for a pre-existing condition will be subject to the 30-day waiting period. If you become disabled in 2021 due to a condition that is not a pre-existing condition, the 14-day waiting period will apply.

Example: If you become pregnant in 2020 and have the 30-day waiting period and then elect the 14-day waiting period during open enrollment for 2021, your STD benefits related to the birth of your baby in 2021 will be subject to the 30-day waiting period.

LTD plan benefits will not be paid for any period of disability caused by, contributed to, or resulting from a pre-existing condition.

APPLICABLE TERMS

Regular care means you personally visit a doctor as frequently as is medically required, according to generally accepted medical standards, to effectively manage and treat your disabling condition(s); and you are receiving the most appropriate treatment and care, which conforms to generally accepted medical standards, for your disabling condition(s) by a doctor whose specialty or experience is the most appropriate for your disabling condition(s), according to generally accepted medical standards.

Regular occupation means the occupation you are routinely performing when your disability begins. Prudential will look at your occupation as it is normally performed instead of how the work tasks are performed for a specific employer or at a specific location.

Gainful occupation means occupation, including self-employment, that is or can be expected to provide you with an income within 12 months of your return to work, that exceeds:

- 80% of your indexed monthly earnings, if you are working; or
- 50% (60% if you enrolled in additional LTD) of your monthly earnings, if you are not working.

Material and substantial duties means duties that:

- Are normally required for the performance of your regular occupation; and
- Cannot be reasonably omitted or modified.

Illness means any disorder of your body or mind, but not an injury; pregnancy including abortion, miscarriage, or childbirth. Disability must begin while you are covered under the plan.

Injury means a bodily injury that:

- Is the direct result of an accident;
- Is not related to any cause other than the accident; and
- Results in immediate disability.

DEFINITION OF DISABILITY

STD

The STD plan considers you to be disabled if you are not able to perform the material and substantial duties of your regular occupation only because of disease or injury and you are not working at any job. After the elimination period, 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. Prudential can request examinations as often as it is reasonable to do so. You may also be required to be interviewed by an authorized Prudential representative. Refusal to be examined or interviewed may result in denial or termination of your claim.

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 and substantial duties of your regular occupation due to sickness or injury and
- Your work earnings are 80% or less of your adjusted pre-disability base pay, and
- You are under the regular care of a doctor.

After 24 months of payments, you are disabled when Prudential determines that due to the same sickness or injury:

- You are unable to perform the duties of any gainful occupation for which you are reasonably fitted by education, training or experience; and
- You are under the regular care of a doctor.
- 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. Prudential can request examinations as often as it is reasonable to do so. You may also be required to be interviewed by an authorized Prudential representative. Refusal to be examined or interviewed may result in denial or termination of your claim. 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.

DEDUCTIBLE SOURCES OF INCOME

Prudential will deduct from your gross disability payment the following deductible sources of income:

1. The amount that you receive or are entitled to receive as loss of time benefits under:
   a. A workers' compensation law;
   b. An occupational disease law; or
   c. Any other act or law with similar intent.
2. The amount that you receive or are entitled to receive as loss of time disability income payments under any:
   a. State compulsory benefit act or law
   b. Insurance or a health or welfare plan or other group insurance plan where Texas Health Resources, directly or indirectly, has paid all or part of the cost or made payroll deductions
3. The gross amount that you, your spouse, and children receive or are entitled to receive as loss of time disability payments because of your disability under:
   a. The United States Social Security Act
   b. Governmental Retirement Plan

c. The Railroad Retirement Act
d. The Canada Pension Plan
e. The Quebec Pension Plan or
f. Any similar plan or act.

Amounts paid to your former spouse or to your children living with such spouse will not be included.

4. The gross amount that you receive as retirement payments or the gross amount your spouse and children receive as retirement payments because you are receiving payments under:
   a. The United States Social Security Act
   b. Governmental Retirement Plan
   c. The Railroad Retirement Act
   d. The Canada Pension Plan
   e. The Quebec Pension Plan or
   f. Any similar plan or act.

   Benefits paid to your former spouse or to your children living with such spouse will not be included.

   Disability payments under a retirement plan will be those benefits which are paid due to disability and do not reduce the retirement benefits which would have been paid if the disability had not occurred.

   Amounts received do not include amounts rolled over or transferred to any eligible retirement plan. Prudential will use the definition of eligible retirement plan as defined in Section 402 of the Internal Revenue Code including any future amendments which affect the definition.
5. The amount you receive under the maritime doctrine of maintenance, wages and cure. This includes only the "wages" part of such benefits.
6. The amount that you receive, due to your disability, from a third party (after subtracting attorney's fees) by judgment, settlement or otherwise
7. The amount of loss of time benefits that you receive or are entitled to receive under any salary continuation or accumulated sick leave to the extent that your weekly payment and deductible sources of income, including any other group disability benefits, exceed or would exceed 100% of your weekly earnings
8. The amount that you receive from a partnership, proprietorship or any similar draws
9. The amount that you receive or are entitled to receive under any unemployment income act or law due to the end of employment with Texas Health Resources.

   With the exception of retirement payments, or amounts that you receive from a partnership, proprietorship or any similar draws, Prudential will only subtract deductible sources of income which are payable as a result of the same disability.

   We will not reduce your payment by your Social Security retirement payments if your disability begins after age 65 and you were already receiving Social Security retirement payments.

   If Prudential determines that you may qualify for benefits under 1, 2 or 3 in the deductible sources of income section, Prudential will estimate your entitlement to these benefits. Prudential can reduce your payment by the estimated amount if such benefits have not been awarded.

   However, Prudential will NOT reduce your payment by the estimated amount under item 1 or 2 in the deductible sources of income section if you:
   - Apply for the benefits
   - Appeal any denial to all administrative levels Prudential feels are necessary and
   - Sign Prudential's Reimbursement Agreement form. This form states that you promise to pay us any overpayment caused by an award.

   If your payment has been reduced by an estimated amount, your payment will be adjusted when Prudential receives proof:
   - Of the amount awarded or
   - That benefits have been denied and all appeals Prudential feels are necessary have been completed. In this case, a lump sum refund of the estimated amount will be made to you.

   If Prudential determines that you may qualify for benefits under item 6 or 8 in the deductible sources of income section, Prudential will estimate your entitlement to these benefits. Prudential can reduce your payment by the estimated amount if such benefits have not been received.

   If your payment has been reduced by an estimated amount, your payment will be adjusted when we receive proof:
   - Of the amount received or
   - That benefits have been denied. In this case, a lump sum refund of the estimated amount will be made to you.

   Prudential will not deduct from your gross disability payment income you receive from, but not limited to, the following sources:
   - 401(k) plans
   - Profit sharing plans
   - Thrift plans
   - Tax sheltered annuities
   - Stock ownership plans
   - Non-qualified plans of deferred compensation
   - Pension plans for partners
   - Military pension and disability income plans
   - Credit disability insurance
   - Franchise disability income plans
   - No-fault motor vehicle insurance
   - A retirement plan from another employer
   - Individual retirement accounts (IRA).

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 current annual base pay. If you receive an increase or decrease in pay during the year, your STD payroll deduction will change at the same time.

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 before you qualify to receive benefits (either 14 or 30 days). The elimination period begins on the first day you are determined to be 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 not guaranteed. Contributions are required for your coverage while you are receiving payments under this plan.

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 116 under "Deductible Sources of Income"). 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 health care provider has submitted necessary proof of medical care to support the claim. Please note: Disability coverage does not apply to time off work when an employee is no longer deemed disabled by their physician. For example, if you have a baby and your doctor indicates you are disabled for six weeks but you wish to take off work for 12 weeks. Disability benefits in this example would only be available for six weeks (including the waiting period), and the other six weeks would be considered bonding time under FMLA.

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.

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. Parental leave pay must be used in one week increments during your STD benefit waiting period or after the bonding period.

After meeting the waiting period, you may only receive a PTO amount (40%) that, when combined with STD benefit, does not exceed 100% of your pre-disability earnings.

Prudential has the right to recover any overpaid benefits. To collect an overpayment, Prudential 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. The minimum weekly payment is $25. Prudential may apply this amount toward an outstanding payment.

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 Prudential determines you are able to work under a modified work arrangement and you refuse to do so without good cause.

Successive Disabilities

A successive disability is a second disability due to the same cause as the first disability, you return to active employment at Texas Health for 30 consecutive days or less, 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
- Prudential 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 Prudential 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.
- During a period of incarceration as a result of a conviction.

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, consultation 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 current annual base pay. If you receive an increase or decrease in pay during the year, your LTD payroll deduction will change at the same time.

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. Contact Human Resources for more information on the Physician LTD policy.

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 this page.
- 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.

Duration of Benefits

Prudential will send you a payment each month up to the maximum period of payment. Your maximum period of payment is:

Your Age on Date Disability Begins	Your Maximum Period of Benefits
Under age 61	To your normal retirement age*, but not less than 60 months
Age 61	To your normal retirement age*, but not less than 48 months
Age 62	To your normal retirement age*, but not less than 42 months
Age 63	To your normal retirement age*, but not less than 36 months
Age 64	To your normal retirement age*, but not less than 30 months
Age 65	24 months
Age 66	21 months
Age 67	18 months
Age 68	15 months
Age 69 and over	12 months

*Your normal retirement age is your retirement age under the Social Security Act where retirement age depends on your year of birth.

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 24 months of payments, while working, you will receive payments based on the percentage of income you are losing due to your disability.

1. Subtract your disability earnings from your indexed monthly earnings.
2. Divide the answer in item 1 by your indexed monthly earnings. This is your percentage of lost earnings.
3. Multiply your monthly payment by the answer in item 2.

This is the amount Prudential will pay you each month.

If your monthly disability earnings exceed 80% of your indexed monthly earnings, Prudential will stop sending you payments and your claim will end.

Prudential may require you to send proof of your monthly disability earnings on a monthly basis. We will adjust your payment based on your monthly disability earnings. As part of your proof of disability earnings, Prudential can require that you send appropriate financial records, including copies of your IRS federal income tax return, W-2's and 1099's, which we believe are necessary to substantiate your income. Salary continuance paid to supplement your disability earnings will not be considered payment for work performed.

Periodically, Prudential will review your status and will require satisfactory proof of earnings and continued disability.

If Prudential 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.

Worksite Modification Benefit

A worksite modification might be what is needed to allow you to perform the material and substantial duties of your regular occupation with Texas Health Resources. One of Prudential's designated professionals will assist you and Texas Health to identify an agreeable modification that is likely to help you remain at work or return to work. This agreement will be in writing and must be signed by you, Texas Health Resources, and Prudential.

When this occurs, Prudential will reimburse Texas Health Resources for the cost of the modification up to the greater of:

- $1000 or
- The equivalent of two months of your gross disability payment.

This benefit is available to you on a one-time-only basis.

Rehabilitation During Disability

Prudential will review your file, medical and vocational information to determine if rehabilitation services might help you return to work.

Once the initial review is completed by our rehabilitation program specialists working along with your doctor and other appropriate specialists, Prudential may elect to offer you and pay for a rehabilitation program. If the rehabilitation program is not developed by Prudential's rehabilitation program specialists, you must receive written approval from Prudential for the program before it begins.

The rehabilitation program may include, but is not limited to, the following services:

- Coordination with Texas Health to assist you to return to work
- Evaluation of adaptive equipment to allow you to work
- Vocational evaluation to determine how your disability may impact your employment options
- Job-placement services
- Resume preparation
- Job seeking skills training
- Retraining for a new occupation or
- Assistance with relocation that may be part of an approved rehabilitation program.

If at any time, you decline to take part in or cooperate in a rehabilitation evaluation/assessment or program that Prudential feels is appropriate for your disability and that has been approved by your doctor, Prudential will cease paying your monthly benefit.

Rehabilitation, Spouse/Elder Care and Day Care Payment

Prudential will send you a rehabilitation payment, day care payment, or Spouse/Elder Care payment each month up to the maximum period of eligible payment while you are:

- Receiving long term disability benefits under the plan; and
- Participating in a rehabilitation program that has been approved by Prudential.

Your maximum period of rehabilitation payment, day care payment, or spouse/elder care payment is 6 months.

- The monthly rehabilitation payment is equal to 5% of your monthly payment. But the monthly rehabilitation payment, together with your monthly payment, will not exceed the maximum monthly benefit.
- The monthly day care payment is equal to the amount of your eligible day care expenses up to the maximum monthly day care amount which is $500 times the number of eligible children. Eligible children means your children age 12 and under who live with you.
- The monthly spouse and elder care payment is equal to the amount of your eligible spouse and elder care expenses up to the maximum monthly spouse/elder care amount which is $500 times the number of eligible family members. Eligible family member means each of the following family members who have a chronic illness or disability: spouse, parents/grandparents who live with you; and spouse's parents/grandparents who live with you.

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:** Disabilities which, as determined by Prudential, are due in whole or part to mental illness have a limited pay period during your lifetime. The limited pay period for mental illness is 24 months during your lifetime. Prudential will continue to send you payments for disabilities due in whole or in part to mental illness beyond the 24-month period if you meet one or both of the following conditions:
  - If you are confined to a hospital or institution at the end of the 24-month period, Prudential will continue to send you payments during your confinement. If you are still disabled when you are discharged, Prudential will send you payments for a recovery period of up to 90 days. If you become reconfined at any time during the recovery period and remain confined for at least 14 days in a row, Prudential will send payments during that additional confinement and for one additional recovery period up to 90 more days.
  - If, after the 24-month period for which you have received payments, you continue to be disabled and subsequently become confined to a hospital or institution for at least 14 days in a row, Prudential will send payments during the length of the confinement.

  Mental illness means a psychiatric or psychological condition regardless of cause. Mental illness includes but it is not limited to schizophrenia, depression, manic depressive or bipolar illness, anxiety, somatization, substance related disorders and/or adjustment disorders or other conditions. These conditions are usually treated by a mental health provider or other qualified provider using psychotherapy, psychotropic drugs, or other similar methods of treatment as standardly accepted in the practice of medicine.

  Prudential will not apply the mental illness limitation to dementia if it is a result of: stroke; trauma; viral infection; Alzheimer's disease; or other conditions not listed which are not usually treated by a mental health provider or other qualified provider using psychotherapy, psychotropic drugs, or other similar methods of treatment as standardly accepted in the practice of medicine.

Catastrophic Disability Benefit

Prudential will pay an additional 10% of your monthly earnings, but not more than $5,000 if you suffer from a Catastrophic Disability due to the same sickness or injury that caused your disability. You are catastrophically disabled when you:

- Are unable to perform, without substantial assistance, at least two activities of daily living or
- Have a severe cognitive impairment, which requires substantial supervision to protect you from threats to health and safety.

You will begin to receive catastrophic disability payments when Prudential approves your claim, providing:

- You are receiving long term disability benefits under the plan and
- You have had your catastrophic disability for a period of at least 30 consecutive days.

Substantial assistance means:

- The physical assistance of another person without which you would not be able to perform an activity of daily living or
- The constant presence of another person within arm's reach which is necessary to prevent, by physical intervention, injury to you while you are performing an activity of daily living.

Activities of daily living means:

- *Bathing* – washing oneself by sponge bath, or in either a tub or shower, including the task of getting in or out of the tub or shower
- *Continence* – the ability to maintain control of bowel and bladder function; or when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag)
- *Dressing* – putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs
- *Eating* – feeding oneself by getting food into the body from a receptacle (such as a plate, cup, or table) or by feeding tube or intravenously
- *Toileting* – getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene
- *Transferring* – sufficient mobility to move into or out of bed, chair, or wheelchair or to move from place to place, either by walking, using a wheelchair or by other means.

Cognitive impairment means a loss or deterioration in intellectual capacity that is:

- Comparable to and includes Alzheimer's disease and similar forms or irreversible dementia and
- Measured by clinical evidence and standardized tests that reliably measure impairment in the individual's short-term or long-term memory, orientation as to person, place or time; and deductive or abstract reasoning.

Substantial supervision means continual oversight that may include cueing by verbal prompting, gestures, or other demonstrations by another person, and which is necessary to protect you from threats to your health and safety.

Social Security Claimant Assistance Program

Prudential can arrange for expert advice regarding your Social Security disability benefits claim and assist you with your application or appeal, if you are disabled under the plan.

Receiving Social Security disability benefits may enable:

- You to receive Medicare after 24 months of disability payments
- You to protect your retirement benefits and
- Your family to be eligible for Social Security benefits.

We can assist you in obtaining Social Security disability benefits by:

- Helping you find appropriate legal representation
- Obtaining medical and vocational evidence and
- Reimbursing pre-approved case management expenses.

Survivor Income Benefit

If you die while disabled, a single, lump sum benefit will be paid under this provision if your disability had continued for 180 or more consecutive days and you were receiving, or were entitled to receive, payments under the plan. 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) under age 25. 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 Prudential receives the necessary written proof of your death and disability status.

If your monthly benefit payments are 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 Prudential 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.
- During incarceration as a result of a conviction
- During the first 24 months of payments, when you are able to work in your regular occupation on a part-time basis but you choose not to
- After 24 months of payments, when you are able to work in any gainful occupation on a part-time basis but you choose not to.

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 crime for which you have been convicted under state or federal law

The following exclusions apply only to STD:

- Work-related injury or sickness and/or one in which you are entitled to benefit 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 page 121. 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 use disorder related disability (drug or alcohol). In no event will LTD monthly benefits be paid for substance use disorder 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.

Important Information for Residents of Certain States

There are state-specific requirements that may change the provisions under the coverage(s) described in this handbook. If you live in a state that has such requirements, those requirements will apply to your coverage(s) and are made a part of your group insurance certificate. Prudential has a website that describes these state-specific requirements. You may access the website at **www.prudential.com/etonline**. When you access the website, you will be asked to enter your state of residence and your Access Code. **Your Access Code is 52002.**

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 Prudential.

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 Prudential at 1-877-MyTHRLink, prompt 6, then 7 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 Prudential.

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. You must notify Prudential immediately when you return to work in any capacity.

Claim Filing Deadline

You must call Prudential 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. Prudential 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 211 for information on what to do if your claim is denied.

Your written description may include:

- 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 doctor, 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.

Prudential will send a payment to you every two weeks for any period for which Prudential is liable.

Your benefits are not assignable, which means you may not transfer your benefits to anyone else.

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 60 days after coverage under the Texas Health group LTD plan ends.
- Pay the first premium to Prudential within 31 days after the date of the first billing statement.

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 Prudential agrees in writing to insure you.

Prudential will determine the coverage you will have under the conversion policy. The conversion policy may not be the same coverage we offered you under your Employer's group plan. 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 age 70 or older;
- You are disabled under the terms of the plan
- The policy is cancelled for any reason
- You are no longer in an eligible class of employees, even though you work for Texas Health.
- You are or become insured under another group long term disability plan within 60 days after employment ends.

Life and AD&D 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:	This policy:	Pays this benefit:	To:
You die	Life Insurance	Full benefit amount	Your beneficiary
You die in an accident	Life Insurance and AD&D Insurance	Full benefit amount	Your beneficiary
You suffer a covered dismemberment	AD&D	Percentage of total benefit amount	You
Your dependent spouse or child dies	Spouse or Child Life	Full benefit amount	You
Your dependent spouse or child dies in an accident	Spouse Life, Child Life, and AD&D Family	Full benefit for Life, partial benefit for AD&D	You
Your dependent spouse or child suffered a covered dismemberment	AD&D Family	Partial benefit	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.

Plan Administration

The Plan Administrator has delegated authority to the Prudential Insurance Company of America to provide claim processing, claim investigation, claim control and the daily administration of the plan.

All decisions concerning the payment of claims under the plan are at the sole discretion of the insurance company.

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 annual base pay.[1] If you receive an increase or decrease in your base pay during the year, your Life Insurance coverage will change at the same time. Your new rate for coverage will become effective the same pay period as your change in pay.

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 an Accelerated Payment of Death Benefits, as explained later in this section.

[1] Base pay for physicians employed by THPG is based on the previous year's earnings. THPG physician's life insurance premium will not change during the year unless there is a loss of benefits eligibility or the physician is within the first year of employment.

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 annual base pay, 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 (including qualifying life events) after your initial enrollment, you may increase your coverage by only one level, but you may decrease your coverage to any level.

Newly-eligible employees are guaranteed issue of coverage up to $1,000,000 (Basic and Additional combined). Coverage amounts over the $1,000,000 guaranteed issue amount require employees complete an Evidence of Insurability insurance application, which contains health related questions. Note that Texas Health will not have access to any of the health-related information you provide.

If you chose a coverage level that exceeds the guaranteed issue amount during your initial enrollment or during open enrollment, you will be directed to the Prudential website to complete an online Evidence of Insurability Short Form insurance application. Once you complete the application, you can return to the enrollment website.

If your application is automatically approved after completing the initial questions on the Evidence of Insurability Short Form, you will receive online confirmation of your approval immediately. You will have the option of printing or emailing that approval confirmation. The new coverage amount goes into effect as of the approval date.

If based on your answers to the Evidence of Insurability Short Form you are not automatically approved, you will be required to complete additional questions, referred to as the Evidence of Insurability Long Form. You will receive an approval or denial letter in the mail once Prudential has reviewed your information. During this waiting period your coverage amount will be $950,000.

If the application is approved, coverage for the total amount goes into effect as of the approval date. If you do not meet the medical evidence requirements and the additional coverage is not approved, your benefit amount for additional life insurance will remain at $950,000.

If you have been diagnosed as terminally ill, you may also qualify for an Accelerated Payment of Death Benefits, 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, be unmarried or live in the U.S. Dependent Life coverage pays a benefit to you if your covered dependent dies.

You may cover your dependent children from live birth or older but under age 25, regardless of student or marital status.

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.

You must submit proof of the child's condition and dependence to Prudential within 31 days after your child reaches the maximum age.

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 for medical care or treatment at home or elsewhere. Coverage will be effective on the final medical release from all such confinement. This does not apply to an infant that is six months old or less.

[1] Coverage over $1,000,000 (including basic) is subject to evidence of insurability.

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.

In the event of a child's death within the first 31 days, contact Prudential to inquire about coverage.

If your covered spouse has been diagnosed as terminally ill, he or she may also qualify for an Accelerated Payment of Death Benefits, 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 are totally disabled, coverage will be extended until you reach age 65. Dependent coverage is not eligible for waiver of premium.

Premiums will be waived from the date Prudential 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.

Amount of Insurance

If you die while disabled and while coverage is continued under this provision, Prudential 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. Prudential 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 Prudential
- 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 65th 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.

Accelerated Payment of Death Benefits

If you or a covered spouse has a terminal illness, you may be eligible to receive up to 90% of your Basic Life and Additional Life or Spouse Life Insurance benefit (to a maximum of $500,000) during your lifetime under the Accelerated Payment of Death Benefits.

You must be terminally ill (for example, have a prognosis of six 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.

You must furnish a certification by a doctor that your life expectancy is six months or less. You should furnish the Attending Physician Certification part of your claim to your doctor and have your doctor complete the form.

Prudential 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 Accelerated Payment of Death Benefits paid will be deducted from the amount of life insurance payable upon your death or your spouse'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 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 (cont. 12 months)	100%
Quadriplegia	100%
One burn[2] covering 75% or more of person's body	100%
Paraplegia	75%
Triplegia	75%
Burn[2] covering 50 – 74% of person's body	75%
One arm or one leg	75%
Hemiplegia	50%
One hand or one foot	50%
Sight in one eye	50%
Speech	50%
Hearing in both ears	50%
Burn[2] 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%
Hearing in one ear	25%
Uniplegia	25%
All the toes of the same foot	25%
Big toe	13%

[1] Benefit as a percentage of total coverage amount

[2] Burns classified by a doctor as being second degree or higher

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 this page. 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 to cover only yourself, or you can elect Additional Family AD&D coverage to cover eligible family members. Additional AD&D coverages pay 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 coverages for one to 10 times your annual base pay, up to $750,000.

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 this page and then applying the percentages in the table on the next page.

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, up to $300,000. • 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, up to $112,500.

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 128 = 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, Prudential will pay a default benefit of $1,000.

No benefit will be paid if the loss results from driving or riding in any automobile used in a race or a speed or endurance test, or for acrobatic or stunt driving, or for any illegal purpose.

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 under 13 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 5% of your total coverage amount (up to $5,000 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. Your child(ren) must be enrolled as a full-time student on your date of death or is at the 12th grade level on the date of your death and becomes a full-time student in a school within 365 days after that date. 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, 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, Prudential will pay the default benefit of $1,000 to your beneficiary.

Additional AD&D Features

- *Bereavement and Trauma Counseling Benefit*—Prudential 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*—Prudential will pay an additional monthly amount equal to the lesser of 10% of your amount of insurance and $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. Within 48 hours following the Occupational Accident you must:
  - Report the Occupational Accident to Prudential and to Texas Health in writing; and
  - Undergo a Food and Drug Administration (FDA) approved preliminary screening test for HIV which confirms that you do not have a positive test for HIV at the time of the Occupational Accident.
- *Hepatitis Occupational Duties Accident Benefit*—Prudential will pay an additional monthly amount equal to the lesser of 10% of your amount of insurance and $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 within one year of the injury. Within 48 hours following the Occupational Accident you must:
  - Report the Occupational Accident to Prudential and to Texas Health in writing; and
  - Undergo a Food and Drug Administration (FDA) approved preliminary screening test for Hepatitis which confirms that you do not have a positive test for Hepatitis at the time of the Occupational Accident.
- *Home Alteration and Vehicle Modification Benefit*—Prudential will pay the Home Alteration and Vehicle Modification Benefit of an amount equal to the least of: the actual cost charged for the alteration or modification; 10% of your amount of insurance; and $10,000, 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.
- *Monthly Mortgage Payment Benefit*—Prudential will pay a benefit, subject to conditions and exclusions, of an amount equal to the lesser of the amount of your monthly mortgage payment or $1,000. This benefit will be paid monthly until the first of these occurs: your spouse dies; your mortgage is paid in full; your house is sold or the benefit has been paid for 12 consecutive months. This benefit applies only if all of the following are true: you suffer an accidental bodily injury that results in loss of life within 365 days of an accident; you have a surviving spouse at the time of your death; your surviving spouse is a co-borrower on your mortgage; and you have an outstanding balance on your mortgage at the time of your death.
- *Motorcycle while Wearing Safety Equipment Benefit*—Prudential will pay a benefit, subject to conditions and exclusions, of an amount equal to the lesser of 10% of the amount of insurance on the person or $10,000. This benefit is applicable if the person sustains an accidental bodily injury while the person is wearing all of the following as verified in an official police accident report or medical examiner's report: a helmet, protective clothing, long pants and boots. The driver of the motorcycle must have a current and valid driver's license which includes motorcycles. This does not include a loss from driving or riding on any motorcycle used in a race or a speed or endurance test, or for acrobatic or stunt driving, or for any illegal purposes.
- *Rehabilitation Benefit*—Prudential 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 Prudential 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 point at which they are attached to the hand
Sight	Entire and Total and permanent loss of sight. Corrected visual acuity must be 20/200 or worse or the field of vision must be less than 20 degrees. irrecoverable loss
Speech	Total and permanent loss of speech that continues for at least 12 consecutive months following the covered accident
Hearing	Hearing loss of greater than 70 decibels at all frequencies or there is less than 50% speech discrimination at 70 decibels on an audiogram
Movement of limbs	Complete and irreversible paralysis of limbs
Toes	Severed at or above the point at which they attach to the foot
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;
- Participation in a riot, insurrection or terrorist act;
- Bungee jumping, parachuting, base jumping, scuba diving, zip-lining, paramotoring, parascending ballooning, skydiving, paragliding, or hang-gliding;
- Declared or undeclared war or act of war;
- Travel or flight in any vehicle used for aerial navigation, if any of these apply:
  - You are riding as a passenger in any aircraft not intended or licensed for the transportation of passengers
  - You are performing as a pilot or a crew member of any aircraft
  - You are riding as a passenger in an aircraft owned, operated, controlled or leased by or on behalf of Texas Health or any of its subsidiaries or affiliates
  - This includes getting in, out, on or off of any such vehicle.
- 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;
- An accident that occurs while engaged in the activities of full-time active duty service in the armed forces for more than 31 days. Reserve or National Guard training are not excluded.
- While operating a land, water, or air vehicle, being legally intoxicated or under the influence of alcohol or alcohol intoxication, including but not limited to having a blood alcohol level above the limit for permissible operation of a motor vehicle in the jurisdiction where the loss occurred, regardless of whether the person was convicted of an alcohol related offense.
- Being under the influence of or taking any non-prescription drug, medication, narcotic, stimulant, hallucinogen, barbiturate, amphetamine, gas, fumes or inhalants, poison or any other controlled substance as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as now or hereafter amended, unless prescribed by and administered in accordance with the advice of the insured's doctor.

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 below.

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 $500,000.

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, log on to **MyTHR.org** and select Benefits. From your Benefits Summary, select the benefit that you want to add/change beneficiary information for (Basic Life, Additional Life, Basic AD&D, Additional AD&D). Make sure you name a beneficiary for each life benefit you are enrolled in, including basic life and basic AD&D. Detailed step-by-step instructions are available on **BeHealthyTHR.org** in the Life section.

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 in equal shares
- Parents in equal shares
- Siblings in equal shares
- 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 Prudential. 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 211. Send your life insurance or AD&D appeal to:

Prudential Insurance Company of America
80 Livingston Avenue
Roseland, NJ 07068

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

Texas Health should be notified as soon as possible in the event of an employee death by calling the THR Benefits Support Center at 1-877-698-4754, prompt 9. Texas Health will submit the claim to Prudential on your behalf. Once Prudential receives the claim information, they will send a claim form to your beneficiary. The claim will be processed once your beneficiary mails the claim form, along with a legible copy of the death certificate, to the address on the form.

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, beneficiaries will receive a checkbook that can be used to withdraw the proceeds. You should consult a tax advisor to be sure you understand the tax consequences of life insurance proceeds. In either case, payment will be made as soon as possible after all information is received.

Claim Filing Deadline

The deadline for filing a claim is one year from the date of death. If more than one year after the death has passed, and you have not reported the death to Texas Health and returned your claim form and death certificate to Prudential, the claim will not be considered for payment.

Dependent Life Insurance

If your covered dependent dies, you should contact the THR Benefits Support Center at 1-877-698-4754, prompt 9 as soon as possible to report the death. You are the sole beneficiary for your spouse's or child's life insurance. Texas Health will submit the claim to Prudential on your behalf. Once Prudential receives the claim information, they will send a claim form to you. Your claim will be processed once you mail the completed claim form, along with a legible copy of the death certificate, to the address on the form. The Texas Health Benefits Department will make the appropriate changes to your Benefit coverages due to the death.

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, beneficiaries will receive a checkbook that can be used to withdraw the proceeds. You should consult a tax advisor to be sure you understand the tax consequences of life insurance proceeds. In either case, payment will be made as soon as possible after all information is received.

Accelerated Payment of Death Benefits for Basic and Additional Life

To file a claim for an Accelerated Payment of Death Benefits, you or your covered spouse must be totally disabled and terminally ill (not expected to live more than six months). Contact the THR Benefits Support Center at 1-877-698-4754, prompt 9 to file a claim for an Accelerated Payment of Death Benefits.

Claim Filing Deadline

The deadline for filing a claim is one year from the date of death. If more than one year after the death has passed, and you have not reported the death to Texas Health and returned your claim form and death certificate to Prudential, the claim will not be considered for payment.

Accidental Death and Dismemberment Insurance

If you or your covered dependent is injured or dies as a result of an accident, contact the THR Benefits Support Center at 1-877-698-4754, prompt 9. Texas Health will submit the claim to Prudential, and Prudential will send claim forms to the beneficiary. The claim will be processed once the beneficiary mails the claim form, along with a legible copy of the death certificate, to the address on the form.

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, beneficiaries will receive a checkbook that can be used to withdraw the processed. You should consult a tax advisor to be sure you understand the tax consequences of life insurance proceeds. In either case, payment will be made as soon as possible after all information is received.

Claim Filing Deadline

Claims for a covered dismemberment or death should be reported to the THR Benefits Support Center at 1-877-698-4754, prompt 9 within 90 days of the loss or death. If it is not reasonably possible to provide proof within 90 days, you must provide it as soon as possible, but no later than one year after the loss. If more than one year after the loss or death has passed, and you have not reported the claim to Texas Health and returned your claim form and death certificate (if applicable) to Prudential, the claim 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 the THR Benefits Support Center at 1-877-698-4754, prompt 9 as soon as possible. If you die, your beneficiary must provide a legible 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. 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. If more than one year after the loss or death has passed, and you have not reported the claim to Texas Health and returned your claim form and death certificate (if applicable) to CIGNA, the claim will not be considered for payment.

Important Information for Residents of Certain States

There are state-specific requirements that may change the provisions under the coverage(s) described in this handbook. If you live in a state that has such requirements, those requirements will apply to your coverage(s) and are made a part of your group insurance certificate. Prudential has a website that describes these state-specific requirements. You may access the website at **www.prudential.com/etonline**. When you access the website, you will be asked to enter your state of residence and your Access Code. **Your Access Code is 52002.**

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

See page 197 for additional information.

Death Benefit During Conversion Period

A death benefit is payable if you die:

- Within 31 days after you cease to be a covered person; and
- While entitled to convert your coverage under this coverage to an individual contract.

The amount of the benefit is equal to the amount of coverage you were entitled to convert (excludes AD&D). It is payable even if you did not apply for conversion. It is payable when Prudential receives written proof of death.

CONTINUING COVERAGE

Portability Options

You can choose to continue any of the following elected benefits after your benefits end with Texas Health:

- Additional life insurance (does not include basic life)
- elected spouse life (less than age 80)
- elected child life (if less than age 25)
- Additional AD&D (does not include basic AD&D)
- Additional AD&D Family

You must apply and become covered under the Portability Plan to continue benefits for dependents. Dependents must not be confined for medical care or treatment on the day your coverage ends. In no event can your amount of accidental death and dismemberment insurance under the Portability Plan exceed your amount of term life insurance under the Portability Plan.

You will have the right to apply for term life coverage under the Portability Plan if you meet all of these tests:

- Your coverage ends because for any reason other than:
  - Your failure to pay, when due, any contribution required for it; or
  - The end of your employment on account of your retirement; or
  - The end of coverage for all employees when coverage is replaced by group life insurance from any carrier for which you are or become eligible within the next 31 days.
- You meet the active work requirement on the day your insurance ends.
- You are less than age 80.

The terms and conditions of the Portability Plan will not be the same as those under the Texas Health Group Contract. You and/ or your dependent may continue life insurance coverage by submitting your application and payment to Prudential within 31 days of the date coverage ends with Texas Health. Proof of insurability is not required to become insured under the Portability Plan but if you submit evidence and Prudential decides the evidence is satisfactory, you will pay lower premium rates. The portability application may be requested from Prudential by calling 877-MyTHRLink (877-698-4754) and selecting prompt 6 then 8.

The coverage amount will be:

- Less than or equal to your amount of insurance when your insurance ends, but not less than $20,000.
- Maximum is the lesser of five times your annual earnings and $1,000,000.

Benefits for Your Dependents

A spouse under age 80 who is legally separated, divorced, or widowed from an insured employee may choose to continue their life or AD&D coverage. If your spouse continues coverage, coverage may also be continued for dependent children. Dependent child coverage ends when he or she no longer qualifies as a dependent child. Spouse and child(ren) cannot be confined for medical care or treatment, at home or elsewhere on the day coverage ends. AD&D coverage can be continued if and up to the amount of coverage under the term life Portability Plan.

Conversion Options

You can choose to convert any of the following elected benefits to an individual policy after your benefits end with Texas Health:

- Additional life insurance
- Elected spouse life
- Elected child life

The conversion option does not have age limits nor requirements to be actively at work. It is limited to the amount of coverage you had in effect at the time of your benefits ends including basic life coverage. Evidence of insurability is not required.

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 Prudential offers (except term life) to persons of the same age in the amount applied for, except you may not 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 Prudential and pay the required premium. The conversion application may be requested from Prudential by calling 877-MyTHRLink (877-698-4754) and selecting prompt 6 then 8.

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 151 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 Governance Committee acts on behalf of Texas Health in its capacity as plan administrator. The Governance Committee can be contacted at:

Governance Committee
Attn: Executive Vice President,
Chief People Officer
Texas Health
612 E. Lamar Blvd., Suite 900
Arlington, Texas 76011
682-236-7900

The members of the Governance Committee are listed on page 215.

The Governance Committee has contracted with Fidelity Investments 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 and off duty police officers who are working at Texas Health 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.

An enrollment letter will be sent to your home address inviting you to participate in the plan. It will contain details about the plan and instructions on how to enroll.

How Much You May Contribute

You may contribute from 2% 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 your eligible pay is $50,000 during 2021, you can contribute the full $19,500 (see "Defining Your Pay" and "Legal Limits" on the next page) to the plan by electing a 39% 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."

Age 50+ 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 2021 is $6,500, giving you a contribution maximum of $26,000 for 2021 (annual maximum contribution of $19,500 plus catch-up contribution of $6,500).

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 $290,000 for 2021. This limit may be adjusted annually. If you are a THPG physician, the quarterly true-up you receive is not treated as compensation for purposes of the Plan.

All bonuses, imputed income, Applause gifts, Student Loan Repayment Program payments, incentives related to the Total Health Medical Plan or the Texas Health Resources Incentive Plan, and similar compensation are excluded from the definition of pay in determining eligible before-tax and Roth 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 2021, your total annual contributions (both before-tax and Roth) are limited to $19,500 of your W-2 pay. The $19,500 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 2021 catch up amount for employees age 50 or older is $6,500. 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 $58,000, 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 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 $130,000 in 2021 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 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 2021 is $19,500 or $26,000 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 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 reaching age 59 1/2, 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 ($19,500 or $26,000 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.

Tax Information on Contributions and Distributions

	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. If you are age 65 or older and no longer working, your full vested account balance will be distributed to you.

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.

A conduit IRA is one that contains only money rolled over from an employer sponsored retirement plan that has not been mixed with regular IRA contributions.

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 an application.

Call the Fidelity Retirement Service Center at 800-343-0860 to request the application or log on to Fidelity NetBenefits® at **Netbenefits.com/thr** for details.

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 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. The match begins in the pay period containing your one-year anniversary. 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.

In general, your match will begin within the pay period that your retirement vesting date (hire date) falls within, once you have completed one year of service. For example, if your retirement vesting date is Jan. 6, 2020, your match would begin within the pay period that contains Jan. 6, 2021. To access the 2021 Payroll Schedule, visit MyTexasHealth and select Employee Resources. Then, select Working at Texas Health from the drop-down box. The 2021 Pay Period schedule is on the left-hand side.

Federal law limits eligible wages for the 401(k) employer match which may be adjusted annually. For 2021 it is $290,000. The table below shows the maximum employer match that may be received in 2021.

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.

2021 Employer Match Limits*	
Less than 5 Years of Service	$13,050.00
5 Years of Service, but less than 10 Years of Service	$17,400.00
10 or more Years of Service	$21,750.00

*The employer match limit is calculated using the current IRS maximum eligible compensation limit of $290,000, 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.

If you were employed by Texas Health Medsynergies on December 30, 2016, you will receive credit for all your years of service with them. Certain acquisitions of the Texas Health Physician Group also receive credit for all years of service. If you were employed by UT Southwestern on August 31, 2019, you will receive credit for all your years of service with them. 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 Fidelity Investments at 1-800-343-0860 or online at **Netbenefits.com/thr.**

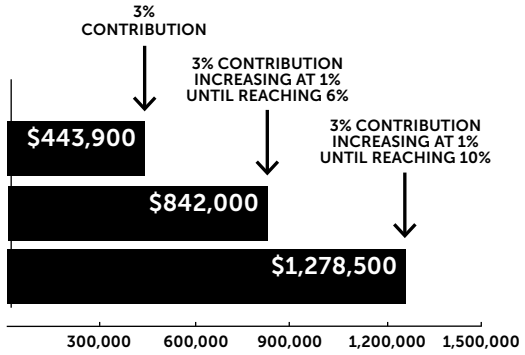
Your election to change or stop contributions will be effective as soon as administratively practical after Fidelity receives your change.

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.

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.

To sign up for this service or make any changes to your account, log on to **Netbenefits.com/thr**. Click on Quick Links in your plan name, then click on "Contribution Amount". Select the Annual Increase Program hotlink to make your selections. You also may call Fidelity at 1-800-343-0860.

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 Fidelity.

If you do not direct the investment of your account, the plan trustees will invest your contributions on your behalf in the JPMCB SmartRetirement 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, you can review your investment options at **Netbenefits.com/thr** under the Plans & Investment tab. If you would like more detailed information about the individual funds, you can contact Fidelity and request a prospectus for any of the funds.

These prospectuses have been prepared by 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 **Netbenefits.com/thr**.

If you do not choose any investment elections, your contributions will automatically be invested in the JPMCB SmartRetirement Fund* dated closest to the year you turn 65.

JPMCB SmartRetirement – 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:

- *Stable Value Funds* - The fund seeks safety of principal and consistency of returns while attempting to maintain minimal volatility. The Fund is designed for investors seeking more income than money market funds without the price fluctuation of stock or bond 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.

* The Commingled Pension Trust Fund (JPMCB SmartRetirement funds) of J.P. Morgan Chase Bank N.A. is a collective trust fund established and maintained by J.P. Morgan Chase Bank N.A. under a declaration of trust. The fund is not required to file a prospectus or registration statement with the SEC, and accordingly, neither is available. The fund is available only to certain qualified retirement and government plans and is not offered to the general public. Units of the fund are not bank deposits and are not insured or guaranteed by any bank, government entity, the FDIC or any other type of deposit insurance. You should carefully consider the investment objectives, risk, charges, and expenses of the fund before investing.

- *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.

***Professional Management Program*[1]**

The Plan also offers Fidelity® Personalized Planning & Advice, a managed account service that lets you delegate the day-to-day management of your workplace savings plan account to professional investment managers. Fidelity's experienced professionals evaluate the investment options available in your plan and identify a model portfolio of investments appropriate for an investor like you. The service then invests your account to align with this model portfolio and provides ongoing management of your account to address changes in the markets, your plan's investment lineup, and changes in your personal or financial situation.

With a managed account, you can take advantage of Fidelity's resources and experience to help ensure that:

- Your investments are managed through the ups and downs of the market.
- You're keeping your accounts aligned with your goals through annual reviews and check-ins.
- Your account is actively managed to create an opportunity for long-term gains while managing the risk associated with investing.

To see if Fidelity® Personalized Planning & Advice is right for you, log onto NetBenefits® at **Netbenefits.fidelity.com/pas** where you can easily enroll in the Service and learn more. Fidelity® Personalized Planning & Advice is a service of Strategic Advisers, Inc., a registered investment adviser and a Fidelity Investments company.

This service provides discretionary money management for a fee.

Please note that performance of the model portfolios depends on the performance of the underlying investment options. These investments are subject to the volatility of the financial markets in the U.S. and abroad and may be subject to additional risks with investing in high yield, small-cap, and foreign securities.

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 Fidelity at the phone number or website listed on the inside back cover. Changes made by 3:00 p.m. Central time take effect the same day. Changes made after 3:00 p.m. Central time will take effect the next business day. Transaction requests received after the close of the market, normally 3 p.m. CT, or on weekends or holidays will receive the next business day's (or next calculated) closing price.

A confirmation email will be sent to you after Fidelity 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 Fidelity 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] Fidelity Portfolio Advisory Service at Work is a service of Strategic Advisers, Inc., a registered investment adviser and a Fidelity Investments company. This service provides discretionary money management for a fee.

Fidelity Investments 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 Fidelity for specific trading activity rules allowed for each fund.

Rebalance Notification

If you're managing your retirement plan assets on your own, remember that a consistent, long-term savings strategy can help you reach your retirement goals once you stop working. As the market changes, you'll want to review your portfolio to make sure your current asset allocation is still in line with your goals, adjusting your investment mix and rebalancing your assets as necessary.

Consider the free Rebalance Notification service, which alerts you by email when your account's investment mix deviates from your original specification.

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 Fidelity.

Choosing Pre-tax or Roth 401(k) Contributions

Visit **Netbenefits.com/thr** for help in making the decision between pre-tax and Roth 401(k) contributions using the Roth Education Calculator located under Tools & Calculators on the Tools & Resources tab.

Account Statements

The notice of availability of your quarterly statement will be sent to you through email after the end of each quarter. Statements are available online after the end of the quarter. To view your statement online, log on to **Netbenefits.com/thr**, select the account from which you want to print a statement, then click on Statements under the Quick Links drop down. You can update your delivery preferences at any time under the Mail Preferences hotlink under Your Profile.

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 Fidelity or view your information online at **Netbenefits.com/thr**.

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.

The maximum applies to all current and outstanding loans from all plans, including frozen plans listed on pages 151 – 153. 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.

*Due to COVID-19, you were eligible to request for your 401(k) loan payments to be deferred. The ability to request loan payment deferrals was only applicable during 2020.

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. If you are active and your loan is defaulted, and you are over the age of 59 1/2, the defaulted loan will be treated as an in service distribution. 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 Fidelity at 1-800-343-0860. 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) in the HR/Payroll system may make loan payments directly to Fidelity while on leave. If employees on a leave of absence do not send their missed payments directly to Fidelity, 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 Fidelity to get the exact balance due and send a manual payment to Fidelity 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. Fidelity 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 59½

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 **Netbenefits.com/thr** or contact Fidelity 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). The minimum hardship withdrawal allowed is $200. Once you have taken a hardship, you are not eligible to take another one until 30 days have passed.

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.

Due to COVID-19, you were eligible to take a special early withdrawal of up to the maximum of $100,000 to meet specific needs as a result of COVID-19. The 10% early withdrawal penalty was waived and the taxes on the money taken out could be spread over 3 years. The deadline to take this withdrawal was December 31, 2020. The money withdrawn may be added back to the Plan as roll-over contributions during the 3-year period, beginning on the day after you receive the money.

If you want to take a hardship withdrawal, contact Fidelity at 1-800-343-0860.

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 Fidelity at 1-800-343-0860. or by going online to **Netbenefits.com/thr.** The table on the next 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 Fidelity. 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.

If you are an active employee, you are not required to take a minimum required distribution beginning the year you reach age 70 1/2. If you choose to take one at that time, you should contact Fidelity.

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 terminate employment due to retirement after age 65, a distribution of your total account balance (less any outstanding loan balance) will automatically be paid the quarter following the quarter you retire from Texas Health.

You will be notified by Fidelity before this distribution and given the opportunity to rollover your account as you wish.

Termination

Generally, within two weeks of your termination from Texas Health, Fidelity Investments will be notified of the event. At that time, you may request a distribution from your account by logging on to **Netbenefits.com/thr** or by contacting Fidelity Investments.

Following are restrictions on how your account can be distributed.

If Your Balance Is $5,000 or More

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, Fidelity 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 Less 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 less 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 Fidelity 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.

Distribution Options

Type of distribution	Online at Netbenefits.com/thr	By phone with Fidelity (800) 343-0860	Request paper form from Fidelity and return to Fidelity
Distribution due to termination	X	X	
PHS 401(a) distribution			X
Hardships			X
In-service – active employee over age 59½	X	X	
Qualified Domestic Relations Orders	X	X	
Beneficiary distribution (upon employee's death)			X

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 142), 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

Fidelity's Online Beneficiaries Service, available through Fidelity NetBenefits®, offers a straightforward, convenient process that takes just minutes. Simply log on to NetBenefits® at **Netbenefits.com/thr** and click on "Beneficiaries" in the About You section of Your Profile. If you do not have access to the Internet or prefer to complete your beneficiary information by paper form, please contact 800-343-0860.

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, 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 Fidelity QDRO Center is a website that was created to assist individuals in the preparation of domestic relations orders. The Fidelity QDRO Center website provides immediate access to a Glossary of Terms, Frequently Asked Questions, and each Plan's QDRO Approval Guidelines and Procedures ("QDRO Guidelines").

The Fidelity QDRO Center may be accessed by going to **https://qdro.fidelity.com** (then registering as a user and logging in). Specific step-by-step questions will guide you through the Order creation process.

Note: The Fidelity QDRO Center website is designed to assist in the creation of an Order. Use of the Fidelity QDRO Center website does not result in an automatic electronic submission of an Order to Fidelity. Orders created using the Fidelity QDRO Center website must be printed out and executed by a court of competent jurisdiction prior to submission to Fidelity for review.

Claims Procedures

For information on how to file a claim or appeal a claim that has been denied, see "Claims Information" beginning on page 210.

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 147 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 214 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 143
- Choosing Your Investment Options—see page 143
- Changing Your Investment Options—see page 144
- Rebalance Notification—see page 145
- Account Statements—see page 145
- Plan Loans—see page 145 (not applicable to the Frozen PHS 401(a) Plan)
- Plan Withdrawals—see page 146 (not applicable to the Frozen PHS 401(a) Plan)
- Naming a Beneficiary—see page 149
- Qualified Domestic Relations Orders—see page 149
- Claims Procedures—page 210
- Unclaimed Benefits—see page 150
- No PBGC Coverage—see page 150
- Limitations on Employment—see page 150
- Amendment of the Plan—see page 150
- Plan Termination—see page 150
- Your Rights Under the Plan—see page 150
- Your ERISA Rights—see page 214.

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 Fidelity 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 146– 148 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 146 – 148, 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 146 – 148 by contacting Fidelity 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 Fidelity 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 Fidelity.

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 **Netbenefits.com/thr** (see page 149 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 **Netbenefits.com/thr** (see page 149 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.
- MedicalEdge Healthcare Group PA, transferred on December 31, 2014.
- Texas Health Medsynergies transferred on December 30, 2016.
- North Texas Specialty Physicians transferred on July 14, 2020.

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 143
- Choosing Your Investment Options—see page 143
- Changing Your Investment Options—see page 144
- Rebalance Notification—see page 145
- Account Statements—see page 145
- Plan Loans—see page 145
- Plan Withdrawals—see page 146
- Naming a Beneficiary—see page 149
- Qualified Domestic Relations Orders—see page 149
- Claims Procedures—see page 210
- Unclaimed Benefits—see page 150
- No PBGC Coverage—see page 150
- Limitations on Employment—see page 150
- Amendment of the Plan—see page 150
- Plan Termination—see page 150
- Your Rights Under the Plan—see page 150
- Your ERISA Rights—see page 214.

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 page 146. 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

(THR Employees except THPG Clinic Practice Staff/Urgent Care Staff)

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, hours worked, 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 118 – 119.

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, part-time benefits-ineligible employees (as defined on page 230), Texas Health Executives (Vice President and above), and medical residents/interns are not eligible for PTO. Based on line of business, the PTO programs described on pages 155 – 158 are not applicable to THPG Clinic Practice Staff and Urgent Care staff. Time away from work for physicians and advance practice professionals employed by THPG is based on their contract. The PTO program for THPG Clinic Practice Staff and staff within Urgent Care facilities is described on page 159 – 160. For further details, Texas Health Executives should see the Executive Time Off Guidelines.

PTO RATE

You receive PTO each pay period beginning the first pay period after you complete one month of service.

The table below shows the PTO rate schedule for a full-time employee working 80 hours a pay period. Your PTO rate may be less if affected by one of two things: 1) your standard hours as classified in the HR/Payroll system are less than 80 hours a pay period or 2) your PTO Eligible Hours within a pay period are less than your standard hours as classified in the HR/Payroll system. To determine your PTO rate, you'll need to know your PTO Max Rate and understand PTO Eligible Hours.

PTO Max Rate for Full-time Employees

If your standard hours as classified in the HR/Payroll system equals 80 hours a pay period, your PTO Max Rate can be found in the table below under Per Pay Period.

If you are a full-time employee classified in the HR/Payroll system to work 60-79 hours per pay period, your rate (called your PTO Max Rate) is a percentage of the 80-hour PTO schedule. For example, if you are classified to work 64 hours per pay period, you will receive 80% of the 80-hour PTO schedule (64 hours is 80% of 80 hours).

PTO Max Rate for Part-time Employees

If you are a part-time benefits-eligible employee (as defined on page 5), your rate (called your PTO Max Rate) is a percentage of the 80-hour PTO schedule. For example, if you are classified to work 48 hours per pay period, you will receive 60% of the 80-hour PTO schedule.

Years of Service	THR PTO Rate Schedule			
	Positions Below Director		Directors & Above[1]	
	Annual	Per Pay Period	Annual	Per Pay Period
Less than 1	176 hours	6.77	216 hours	8.31
1	192 hours	7.38	232 hours	8.92
2 - 4	208 hours	8.00	248 hours	9.54
5 - 9	232 hours	8.92	272 hours	10.46
10 - 14	256 hours	9.85	296 hours	11.38
15 - 19	280 hours	10.77	312 hours	12.00
20 or more	296 hours	11.38	328 hours	12.62

1 Excludes Texas Health Executives

PTO Eligible Hours

Your PTO Rate in a pay period could be less than your PTO Max Rate. This happens when your actual hours worked (based on PTO Eligible hours) in a pay period are less than your standard hours as classified in the HR/Payroll system. PTO Eligible Hours are earnings codes entered by timekeepers in the HR/Payroll system that count as hours worked when calculating your actual PTO rate. A full list of the earnings codes can be found on **BeHealthyTHR.org**. If you are benefit eligible and you have a second job as PRN, the hours you work as PRN do count toward your hours worked/PTO Eligible Hours.

For example, your standard hours are 80 hours a pay period week with PTO Max Rate of 8.0 hours. You work 60 hours that pay period and do not have PTO to use. For that pay period, you will receive 75% of your PTO Max Rate making your actual PTO rate 6.0 hours. Your actual rate cannot be higher than your PTO Max Rate.

Employees on Leave of Absence

You do not receive PTO while on paid or unpaid leave of absence.

Maximum PTO

You may have up to 300 hours of PTO. You will forfeit hours in excess of the maximum. Accruals are forfeited for each pay period your balance is over 300. You may carry over up to 300 PTO hours at any time. Your PTO balance 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 PTO rate 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 when received, 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.

Generally, you must 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 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.

PTO is paid at your current regular hourly pay rate (excludes shift differential). Use of PTO while on suspension or unpaid administrative leave will be determined by the applicable Texas Health policy.

PTO can be used before or after parental pay leave.

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 you are away from work on a regularly scheduled day, you are required 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.

Employees on a schedule with different hours each week during a pay period must receive an exception from Human Resources.

For example, if your FTE is 100% (40 hours per week) and you work 32 hours during the week, you are required to use eight hours of PTO unless you qualify for one of the exceptions described in this section.

A non-exempt employee with intermittent FMLA absences is **not** required to use PTO.

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.

TERMINATING EMPLOYMENT

If you leave Texas Health, you will be paid for 100% of your unused PTO hours (up to 300 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 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.

PTO is paid at your current regular hourly pay rate at the time of termination (excludes shift differential).

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 unused PTO, up to 300 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.

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 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 receive hours, but employees may use their previously received 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 must 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 230) you will forfeit your EIB or Sick Bank time even if you are later rehired or move back into a benefits-eligible status.

COMMUNITY TIME OFF (CTO)

In keeping with its mission of service to the community, Texas Health Resources (Texas Health) encourages its employees to be involved in public or virtual community service that supports our mission and values. Community Time Off (CTO) provides Texas Health employees the opportunity to support, with paid time, a hospital/entity/ system-sponsored public or virtual community event or a non-profit organization in the community. All public or virtual CTO projects must be approved through **www.TexasHealth.org/CTO** and in compliance with Texas Health's Community Time Off and Volunteerism Policy.

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 do count toward the pay week hours and contribute to the calculation of overtime; however, it is not advised to place an employee into overtime by using CTO.

- Both exempt and non-exempt employees should report CTO time through Texas Health's Central Timekeeping systems for payroll purposes.
- 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:

- All employees are responsible for obtaining verbal or written manager approval before participating in a CTO project.
- To participate, log on to the CTO website located at **TexasHealth.org/CTO**.
- 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.
- After you volunteer, report CTO hours on your timekeeping website (RCH payroll code) before the next payroll Monday deadline.

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**.

Time Away From Work (THPG Clinic Practice Staff/Urgent Care)

WHO IS ELIGIBLE

The PTO program described on this page is applicable to both full-time and part-time benefits-eligible employees (as defined on page 5) that are THPG Clinic Practice Staff and Urgent Care staff). The PTO Program for other employees can be found on pages 155– 158.

Texas Health Resources is committed to providing THPG Clinic Practice and Urgent Care Staff the flexibility to balance work and personal goals. Paid time off (PTO) combines sick, vacation, personal days and holidays into one integrated program from which employees can schedule paid time off with agreement with his/her supervisor.

PTO RATE

You receive PTO each pay period beginning the first pay period after your hire date.

Employees will receive PTO in accordance with the schedule below. Employees working less than 35 hours per week will receive prorated PTO time, depending on hours worked. The amount of PTO an employee receives is determined by his/her years of service with the company. The higher rate is received effective on the employee's anniversary date.

USING PTO

PTO is available to use once it has been received and is approved at the manager's discretion based on the needs of the business.

All PTO must be requested through the timekeeping system, at least (2) two weeks in advance (except for sick days) and have supervisor approval prior to the start of PTO.

Employees are required to use PTO for pre-approved vacation, holidays, and time off. Pre-approved PTO may be rescinded if the employee does not have enough hours to cover it when the time comes for the employee to be out.

If an employee knows that he/she will be late or absent from work, he/she must verbally inform their supervisor (or preauthorized designee) as far in advance of the start of the workday as possible. If there is an urgent need that requires an employee to leave work early, the employee must get prior permission from their supervisor.

Employees are expected to manage PTO responsibly.

Employees will be required to use PTO for any unscheduled absences, instances of tardiness, pre-approved vacation, holidays, and personal time off.

Employees may not use PTO during any week if using it would cause them to exceed the number of hours they are classified to work in the HR/Payroll system. Use of PTO while on suspension or unpaid administrative leave will be determined by the applicable Texas Health policy.

PTO can be used before or after parental leave pay.

If PTO hours are exhausted and the employee needs to take a day off due to illness, it will be unpaid.

Employees may use PTO, but are not required to use it if they are on leave of absence.

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 are on military reserve training or duty.
- You are not scheduled to work or are sent home because of low census or other business reason.

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. If you are an exempt employee and you miss a full scheduled day, you must record PTO.

Time Off

EARNING SCHEDULE: 35.00 – 40.00 HRS/WEEK

Level	After Months	Hours Per Year	Hours Per Pay Period	THPG Clinic Maximum Balance	Urgent Care Maximum Balance
0-3 years	0	192.00	7.3846	80	300
4-8 years	48	232.00	8.9231	80	300
9+ year	108	272.00	10.4615	80	300

PRO-RATED EARNING: LESS THAN 35 HOURS

Hours Worked Per Week	Maximum Allotted PTO Time
30-34 hours	75% of earning schedule
24-29 hours	60% of earning schedule
Less than 24 hours	No PTO time allotted

MAXIMUM PTO FOR THPG CLINIC PRACTICE STAFF

Employees are encouraged to use PTO to maintain a good work life balance and may carry over up to eighty (80) hours of unused PTO. The PTO bank will be reduced to 80 hours in the last pay period of July.

In order to be paid for PTO, it must be correctly entered into the system prior to the payroll cut-off for that pay cycle.

MAXIMUM PTO FOR URGENT CARE

Employees are encouraged to use PTO to maintain a good work life balance and may carry over up to 300 hours of unused PTO. The PTO bank will be reduced to 300 hours in the last pay period of December. In order to be paid for PTO, it must be correctly entered into the system prior to the payroll cut-off for that pay cycle.

TERMINATING EMPLOYMENT

Upon separation of employment, THPG Clinic Practice Staff employees will be paid at straight time rate of pay for any unused PTO up to a maximum of eighty (80) hours, providing a two (2) week notice is given in writing.

Upon separation of employment, Urgent Care staff will be paid at straight time rate of pay for any unused PTO up to a maximum of three hundred (300) hours, provided a two (2) week notice is given in writing.

Employees must work the entire notice period in order to be paid out for PTO. Employees may not use PTO during the notice period unless it was previously scheduled and approved by the manager.

Employees who fail to work through the notice period or who are terminated for cause will not be eligible for unused PTO pay out.

Time Away From Work

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. When transferring to a THPG Clinic Practice Staff position, employee will be paid out any excess PTO balance over 80 hours.

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 year's 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.

Texas Health Executives and THPG providers are not eligible to convert PTO.

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 except the last paycheck of the 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 the year. However, if you have donated 40 hours and converted 40 hours this year, you only have 20 hours available to sell during the year.

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.

If you are interested in selling PTO, log on to **MyTHR.org**. Click My PTO Balance, then click the PTO Sell link located at the bottom of the PTO Balance page. You cannot be suspended at the time you choose to sell PTO or when the payment is made.

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.

Texas Health Executives and THPG providers are not eligible to use the PTO Sell program.

DONATING PTO TO CHARITY

You may sell your PTO hours to Texas Health and specify the net after-tax proceeds from the sale be donated to one or a combination of the following via the **Texas Health Together** employee giving campaign:

- Texas Health and Entity 365 Funds
- Nursing Excellence Fund
- Community Impact Fund
- Entity Specific Priority Funds
- United Way
- Active and strategically aligned non-profit partner(s) in North Texas

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.

Texas Health Executives and THPG providers are not eligible to use the donation of PTO to charity program.

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. 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.[1]

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, log on to **MyTHR.org**, select My PTO Balance and click the Helping Hands link at the bottom of the PTO Balance page.

Texas Health Executives and THPG providers are not eligible to donate to the Helping Hands fund.

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
- 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. Texas Health Executives and THPG providers are not eligible to receive PTO benefits from the Helping Hands fund.

When you apply for the Helping Hands Fund, you will also be referred to the Texas Health EAP (see page 84) 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.

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, and you are eligible immediately upon hire.

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 • Grandchild • Sibling, or spouse's sibling • 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 • Spouse's grandparent

* Includes current step relationships as well.

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.

[1] The 80-hour minimum does not apply to chaplain residents. THPG Clinic Practice Staff will need to have at least 40 hours left after making a donation.

If you are receiving Short Term Disability (STD) or workers' compensation temporary income benefits, the combined amounts cannot be more than 100% of your normal base pay.

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 scheduled 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

All employees may be eligible to take the following types of leave:

- Family and Medical Leave
- Military Leave
- ADA
- Personal Leave.

Employees on leave of absence are only eligible for the following pay options: Extended Illness Bank (EIB), paid time off (PTO), workers' compensation benefits, provider draw, parental leave pay, success sharing and/or disability benefits.

You do not accrue PTO while on a paid or unpaid leave of absence.

During your leave, you may keep your benefits 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 during your leave, you must pay your share of the premiums each pay period. If you do not pay your premiums, your benefits will be canceled.

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
- Accident Insurance
- Hospital Indemnity
- Critical Illness Insurance
- 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.texashealth.org** or email at **THRIntegratedDisabilityManagement@TexasHealth.org**.

EMPLOYEE RIGHTS & RESPONSIBILITIES UNDER THE FAMILY & MEDICAL LEAVE ACT (FMLA)

Basic Leave Entitlement

FMLA is a federal law that gives the opportunity to take up to 12 work weeks of unpaid, job -protected 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 your job
- Any qualifying exigency, i.e., the employee's spouse, son, daughter, or parent is a military member on covered active duty or call to covered active duty status.

In addition, eligible employees may take up to 26 workweeks of leave in a single 12-month period to care for a covered servicemember with a serious injury or illness if the employee is the spouse, son, daughter, parent, or next of kin of the servicemember (referred to as military caregiver leave). An eligible employee is limited to a combined total of 26 workweeks of leave for any FMLA-qualifying reasons during the single 12-month period. Texas Health calculates FMLA eligibility using a rolling 12-month period.

Benefits and Protections

During FMLA leave, Texas Health must maintain your health coverage under any "group health plan" on the same terms as if you had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's 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 11 – 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 11 – 12).

When returning from FMLA, you may resume participation in your Dependent Care Flexible Spending Account at your original annual election prior to beginning leave (and thus pay via the "catch up" option) or resume participation at a reduced level under the proration rule.

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.

Definition of Serious Health Condition

A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of Leave

Leave can be taken intermittently or on a reduced leave schedule when medically necessary. You must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt Texas Health operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave

You may use PTO while taking FMLA leave but are not required to use your PTO. In order to use PTO for FMLA leave, you must submit the PTO Supplement form to your timekeeper. PTO can be used before or after parental pay.

Paid parental leave of up to 3 weeks can be used during your FMLA leave.

Your Responsibilities

You must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 day's notice is not possible, you must provide notice as soon as practicable and generally must comply with Texas Health's normal call-in procedures.

You must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that you are unable to perform job functions, your family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave.

You also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified.

You also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities

Texas Health must inform you when requesting leave whether you are eligible under FMLA. If you are, the notice must specify any additional information required as well as your rights and responsibilities. If you are not eligible, Texas Health must provide a reason for the ineligibility.

Texas Health must inform you if leave will be designated as FMLA-protected and the amount of leave counted against your leave entitlement. If Texas Health determines that the leave is not FMLA-protected, Texas Health must notify you.

Unlawful Acts by Employers

FMLA makes it unlawful for any employer to:

- Interfere with, restrain, or deny the exercise of any right provided under FMLA; and
- Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

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 682-236-7278. An employee may file a complaint with the U.S. Department of Labor, Wage and Hour Division or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

Other Benefits

Other Benefits

TUITION REIMBURSEMENT

Program Overview

Attending school can open many doors for your career, but paying for school 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 degrees that benefit Texas Health or your position at Texas Health.

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 below. While certificate programs and certifications in general are not eligible for tuition reimbursement, certifications for Pharmacy Technician, Surgical Technician, Medical Assistant, and LVN are eligible.

The Texas Health Benefits Department administers the Tuition Reimbursement Program.

Key Actions 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.
- Complete a Career Development Inventory (CDI) if required
- Submit your request for reimbursement with all required documents no later than 60 calendar days after completing the courses, semester, or term.

Eligibility

Full-time and part-time benefits-eligible employees (as defined on page 5) may participate. You must earn a C or better (or pass in a pass/fail class) to receive reimbursement.

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 be an active employee before the start of the courses, semester, or term. You may be on a leave of absence while taking the courses, but you must be a benefits-eligible employee and actively at work when any of the following occur:

- You submit your reimbursement request
- Your payment is processed
- Course, semester, or term start date (applicable to advance funds only).

Exceptions are made for employees on military leave.

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)
- Distance Education Accrediting Commission
- Accrediting Bureau of Health Education Schools
- Accrediting Commission of Career Schools
- Transnational Association of Christian Colleges and Schools
- Higher Learning Commission

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

Nursing

In addition to one of the above accreditations for all degrees, nursing pre-licensing undergraduate (ADN, BSN) courses must be taken at colleges or universities that are accredited by one of the following nursing accrediting agencies:

- Accreditation Commission for Education in Nursing (ACEN), formerly National League for Nursing Accreditation Commission (NLNAC)
- American Association of Colleges of Nursing — BSN or higher degree programs
- Commission of Collegiate Nursing Education (CCNE)

If your college or university is not accredited by one of these associations, contact Tuition Reimbursement.

Required Clinical Rotations/Practicum

Texas Health has affiliations with certain schools for students to be able to complete clinical rotations or practicum at Texas Health Resources facilities. While your university or college may be eligible for our tuition reimbursement program, this does not mean that Texas Health also has or will have an affiliation for clinical rotations or practicum. To determine whether your school has an established affiliation with Texas Health, contact THRU at 682-236-6111.

Eligible Degrees and Coursework

Topic	Description
Maximum Reimbursement amounts	Benefits-eligible employees are eligible for reimbursement of coursework for degrees for which Texas Health typically hires. Reimbursement of up to: • $5,250 per calendar year for full-time employees • $5,250 per calendar year for part-time benefits-eligible employees who are considered full-time students under their degree plan (usually 12 credit hours per semester) • $2,625 per calendar year for part-time employees/part-time students. In addition to tuition, you may submit receipts for reimbursement of textbooks (books purchased from individuals are not covered). Books for clinical nurse leader (CNL) programs are not eligible for reimbursement.
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).
How you are reimbursed	You must be actively at work in a benefits-eligible position before the start of the course, at the time you submit your reimbursement request, and at the time your reimbursement is processed. All employees using the Tuition Reimbursement program are required to complete a Career Development Inventory (CDI) prior to requesting reimbursement. You may complete this inventory at any time. To complete, log on to **MyTHR.org.** Click the Benefits tile, click Tuition Reimbursement, then click Career Development Inventory. At the top of the page on the right-hand side, you will see a tile labeled "Career Development Inventory." Click on the green "Start/Edit" button to access the Career Development Inventory. There are seven sections on the inventory and a total of 36 questions to complete. Please allot adequate time to complete all sections. Once the inventory is completed, you will notice upon logging back in that your overall rating is reflected in the blue box. If you would like to go more in-depth with your career preparedness, you access the other sections of the portal at any time. If you have technical questions regarding the CDI, please contact **help@Fuel50.com**. If you have questions regarding Tuition Reimbursement, contact us at 682-236-6238 or email **THRTuitionReimbursement@texashealth.org**. Within 60 days after completing the courses, semester, or term, you must submit your request for reimbursement by following the steps below: • Download your documents to a drive on a computer or electronic device. • Log on to **MyTHR.org.** • Click the Benefits tile. • Click Access Tuition Reimbursement. • Click the Submit Request for Reimbursement box on the Tuition Reimbursement Program screen. • Select the **College or University**. • Select the number of course you completed. • Click **Continue**. • Enter all requested information. 1. Estimated graduation date 2. Major and degree 3. Course start and end dates 4. Email address (enter the one you use most often) 5. Course information • Enter any comments. • Click **Submit Application Request.** • Enter book information (if applicable). • Click **Continue.**

How the Program Works

Topic	Description
How you are reimbursed, continued	• Read the instructions and the participant certification. You may also view a copy of the program guide by clicking the link at the bottom of the page. • Type your full name and click the **Acknowledge** box. • Check the boxes verifying that your documents contain all the required information needed to process your request: – Itemized statement from the college or university with your name pre-printed on it that reflects the actual cost of the courses, not a payment receipt – Final grade report or unofficial/official transcript that has your name pre-printed on it – Copy of the course schedule, student schedule, or enrollment verification with your name pre-printed on it that lists the actual course start and end dates of the classes you just completed. (Please note general college calendars or college academic schedules are not accepted.) – Itemized book receipts (if applicable) – Financial aid award letter (if applicable) • Upload your documents (if one document contains all of the information needed, only attach it once). • Click the **Submit Request** box. • Read the message regarding your submission. • Click **OK**. After you click OK, you will receive a confirmation email. Make sure the email address you provided is correct. • Your request will be received in our office and processed in 1-2 payroll periods from receipt of complete information. This time frame may vary. If you receive a request for missing documentation, you will need to resend all documents together by clicking the Reimbursement edit button in the actions tab on the side of your application. This way you do not have to re-enter all of the previously entered information. • Reimbursement amounts are determined by your employment status as classified in the HR/payroll system at the time your request is paid. • Please make sure your email address is correct because you will receive a confirmation email once you click OK. Requests for further documentation, if needed, will also be sent to this email address. • Tuition reimbursement payments are deducted from your annual benefit maximum of the calendar year that your classes began. Scholarship, grant money, or waived or exempted tuition received by the student may reduce benefits payable through the Tuition Reimbursement Program. Please submit a copy of your financial aid award letter.
Requesting advance funds	You may request advance tuition assistance if you are a full-time employee or part-time benefits-eligible employee with a current annual base pay rate of less than $40,000.00. 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 waived or exempted tuition, professional meetings, workshops, conventions, drop fees, exam fees, late fees, supply kits, licensures, room and board, parking fees, uniforms, drug screens, background checks, certificate courses, CEUs, 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, shipping and handling, supplies, lab packs, laptops, software, calculators, nurse skills pack, college repeat fees, association fees, credit card convenience fees, pass through fees, administrative costs for research projects or studies, property deposits, continuing education classes, membership fees, or tuition and fees for degree plans that do not benefit Texas Health or your position at Texas Health, reimbursement requests submitted past the 60-day submission deadline, or requests for failing grades.
Taxation of tuition reimbursement	Reimbursements of up to $5,250 per tax year are not taxable income. In compliance with IRS regulations, any reimbursement you receive 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 your employment status changes	If you terminate employment or change to a non-benefits-eligible status (such as PRN or part-time benefits-ineligible, as defined on page 230) within 12 months of receiving payment for the courses, you will be required to repay the reimbursed funds paid on your behalf to Texas Health. The 12 months is from the paycheck date. If your position is eliminated and you are eligible for separation pay, or you did not voluntarily change to the 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. You are also eligible to receive tuition reimbursement for your current semester as long as you meet all other requirements for the program. 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 tuition reimbursement for your courses. All funds paid to you or the college/university could be deducted from your final regular paycheck as a full-time or part-time employee (this includes any PTO payout you might receive). Uncollected amounts owed to Texas Health may be sent to an outside agency to assist with collection efforts. Any funds that are recovered are not refundable, even if you return to a benefits-eligible position within the rehire period. Participation in the tuition reimbursement program does not guarantee job placement.

Advance Fund Eligibility

If you are a full-time or part-time benefits-eligible employee with an annual base rate of less than $40,000, you qualify for advance funds. Texas Health will pay for your coursework in advance once your application is approved. All employees who are eligible to receive advance funds must input an application prior to their course start date. You will have to print a voucher and give it to the college or university as your source of payment.

If you have already paid for your classes (and meet the above requirements) 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. Follow these steps to submit the documents:

- Log on to **MyTHR.org**.
- Click on the Benefits tile and then Tuition Reimbursement.
- Click the **Apply for Advance Funds** link.
- Click **Create New Application**.
- Select college or university.
- Select the number of courses you are taking.
- Click **Continue** and follow directions on the form.
- Click **Submit.**
- Once your application is reviewed and approved, print your voucher.
- Take your voucher to the college or university as payment for tuition. See page 169 for a list of fees not covered.

Advance Book Reimbursement (for voucher-eligible employees only)

Once your application is approved and you purchase your books or if you did not use your voucher and are requesting reimbursement paid directly to you, you can submit your request for reimbursement in advance by following the steps below:

- Purchase your books.
- Download a copy of your book receipt to a computer.
- Log on to **MyTHR.org.**
- Click on the Benefits tile and then Tuition Reimbursement. Then click **Apply for Advance Funds.**
- Click on **Reimbursement Request** under Actions on the right side of your application.
- Input the book information and the cost of the books (include taxes but not shipping).
- Click **Continue.**
- Read the participant certification.
- Type your name and click **Acknowledge**.
- Attach the book receipts
- Click **Submit Request**.

Your book reimbursement will be processed in one to two payroll periods from receipt of the documents.

Grade Submission

Once your courses end, save your grade report to a drive on your computer. Your name must be pre-printed on the document you submit. Log on to **MyTHR.org** and follow these steps:

- Click on the Benefits tile and then Tuition Reimbursement.
- Click Submit Grade Report under Actions on the right side of your application.
- Read the Participant Certification statement.
- Type your full name.
- Click the Acknowledge button.
- Click the Grades box.
- Upload the grade report.
- Click the Submit Request button.

You have 60 days after the course/semester end date to submit your final grade report.

Grades

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 has paid in advance will be deducted from your pay over a number of pay periods, listed in the table on the next page.

Additional advance funds will not be available until all funds due back to Texas Health have been repaid.

Repayment of Funds

If you receive advance funds and/or 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 all remaining paychecks (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. Uncollected amounts owed to Texas Health may be sent to an outside agency to assist with collection efforts.

Contact Information

If you have questions, you may contact the Tuition Reimbursement program using the contact information below.

Phone: 682-236-6238 or 1-877-698-4754 press 6, then 2

Fax: 682-236-7291

Email: THRTuitionReimbursement@TexasHealth.org

Address: 612 E. Lamar Blvd., Suite 400, Arlington, TX 76011

STUDENT LOAN REPAYMENT PROGRAM

Program Overview

Texas Health Resources will provide eligible employees with a company funded payment to your qualified higher education student loan. The goal of this program is to continue to provide you with market competitive benefits and help you reduce your student loan debt. This program is administered by SoFi on behalf of Texas Health Resources.

For eligible employees who sign up to participate and provide eligible loan information, Texas Health will make payments directly to your loan servicer. This is an additional payment designed to help you pay your student loans off faster and save on interest. Whether enrolling for the loan payment program or not, you can use the online Student Loan Repayment Program portal to help best manage student loan and other debt.

Employee Eligibility

- Must be a benefits-eligible employee as defined in the Texas Health Resources Employee Benefits Handbook.
- Must be an eligible employee when registering and when payment is approved.
- Cannot be on leave of absence as of the invoice approval date which occurs up to 5 days before the 22nd of each month.
- Eligible immediately upon hire.
- Must continue to make your monthly minimum payments on the loan (unless eligible for deferment or forbearance), even if your monthly payments are less than the $50 monthly payment.

Loan Eligibility

- Only qualified education loans issued to you by a U.S.-based financial institution and affiliated with a U.S.-based school of higher education are eligible for contributions.
- Qualified loans include:
  - Federal and private student loans in your name for your own higher education.
- Co-signed loans on behalf of dependents or a loan taken by a parent for their child's education are not eligible.
- Loans must be in good standing. Texas Health will not make payments to loans which are delinquent or in collections.
- Loans which are in deferment or forbearance are still eligible for the contribution benefit.
- Loans for certifications (e.g. CPA, CFA, CNA, six sigma, Series 7, etc.) are not eligible.

Benefit

Eligible employees can enroll at any time through **SoFi.com/TexasHealth** to receive the benefit. Enrollment must include accurate and timely loan information provided by you to be eligible for the payment to occur the next month.

Texas Health will make payments of $50 a month directly to your student loan servicer (Texas Health payment). For questions or assistance, you can call SoFi's customer service team at (833) 277-7634 or email **customerservice@sofi.com**.

Contribution Suspension

Texas Health maintains the right to suspend the Texas Health payment for any reason, including but not limited to leave of absence, administrative leave due to conduct or licensing, determination that contribution funds are not being used as intended, employee becomes ineligible, employee is not actively at work, etc.

When Benefit Ends

Texas Health will stop the Texas Health payments to the plan loan servicer in any of the following circumstances:

- You end employment with Texas Health Resources.
- You are no longer in a benefits-eligible position.
- You no longer have a qualifying loan entered in the vendor online portal for Texas Health to make payments toward.
- You choose to end Texas Health payments.

- The vendor has determined that all entered and eligible loans are paid-in-full.
- The vendor identifies inaccurate information being provided regarding the loan.
- Texas Health decides to terminate the program.

Tenure Requirement

- By electing to participate in the program, an employee agrees to continue employment with Texas Health Resources for 1 year after the date the last Texas Health payment was received. If you leave or change to a non-benefits-eligible position, you must pay back all Texas Health payments made on your behalf for the twelve month period immediately preceding your termination date or loss of benefit eligibility. By enrolling in the Student Loan Repayment Program, you agree that your final paycheck and PTO payout may be offset by the Texas Health payment owed.

Terms and Conditions

You are solely liable for errors made during enrollment and within the student loan contribution benefit portal, including the following:

- You provide incorrect student loan information;
- You provide incorrect student loan servicer information; or
- You change your mind about participating in the program after the vendor has submitted the payment.

You are solely liable for any missed or late payments on your student loans. The Texas Health payments are additional payments to your student loan servicers, which does not reduce or eliminate the need to make regular monthly payments on student loans.

Texas Health reserves the right to amend or terminate this program, at any time, with notice.

The Texas Health payments are non-taxable income for you, up to a maximum of $5,250 per year when combined with payments to you under the Texas Health Tuition Reimbursement Program. If you receive over $5,250 in both student loan and tuition reimbursement payments, taxes will be collected monthly and will reflect appropriately on yearly W-2 statements.

The Texas Health payments are not treated as compensation under the 401(k) retirement plan.

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 child after you submit the necessary documentation to THR Benefits Support 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 signed by a judge, a Letter of Possession (if applicable) and a copy of itemized bills along with the adoption assistance application found online at **BeHealthyTHR.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).

EMPLOYEE RELIEF FUND

The Texas Health Employee Relief Fund was formed to help employees affected by COVID-19. This fund will award grants to eligible employees to help cover basic needs, such as child care, food or hotel lodging; or for critical needs, such as housing, utilities or related medical expenses.

Employees who have tested positive for COVID-19 and missed more than two weeks of work or have lost an immediate family member, including parents, to COVID-19 can apply at **http://texashealthrelief.e4erelief.org** for a non-taxable grant to help cover eligible expenses.

Supplemental Benefits

To help lessen the burden of out of-pocket medical costs and other expenses associated with unexpected health emergencies, Texas Health offers three types of supplemental benefits: Accident Insurance, Critical Illness Insurance, and Hospital Indemnity Insurance. These products are available for you to purchase through MetLife.

You can purchase this coverage for yourself and your eligible dependents through payroll deductions, just like your other benefits. The cost of coverage is affordable, but depends on things like your age and who you cover.

Who Can Be Covered

You are eligible if you are actively at work in a benefits-eligible position at Texas Health Resources as described on page 5.

Dependents are eligible for coverage under this policy. A Dependent is:

- The legal spouse (as defined on page 5) of an employee or
- Your biological, adopted, or step child who is under age 26 (as defined on page 6)

You cannot be covered both as an employee and a spouse. The term child does not include an unborn or stillborn child. You cannot be covered both as an employee and a child. A dependent child cannot be insured as a dependent child of more than one employee.

A dependent child born to you while insurance is in effect will be eligible for newborn coverage which is coverage for 31 days from the moment of the child's birth. To continue coverage beyond the first 31 days, you must complete enrollment online at **MyTHR.org** to add the child to your policies. Enrollment must occur within 31 days of the child's birth.

Insurance for a dependent child may be continued past the age limit if that child is incapable of self-sustaining employment because of a mental or physical handicap as defined by applicable law. Proof of such handicap must be sent to MetLife within 31 days after the date the dependent child attains the max age and at reasonable intervals after such date, but not more often than annually after the two-year period following such dependent child's attainment of the limiting age.

Effective Date

Your effective date is as follows:

1. Your coverage will be effective (provided you are actively at work):
   a. January 1 if enrolling during open enrollment or
   b. The first of the pay period following completion of one month of service if enrolling as a new hire
   c. The first of the pay period following online elections and submitting required documentation if enrolling as a newly benefits eligible employee or due to qualifying life event.
2. If you are not actively at work on the date coverage would otherwise become effective, the effective date of coverage will be the date on which you first return actively to work. Except as provided for newborn coverage, if a dependent is under medical restriction on the date insurance for such dependent would otherwise take effect, insurance for the dependent will take effect on the date the dependent is no longer under a medical restriction. Please see page 189 for further details on the date dependent insurance takes effect regarding the critical illness insurance.

Benefit Increases

If you are enrolled in MetLife coverage and your enrollment election results in a benefit increase, your increase (provided you are actively at work and that you have not already attained the maximum benefit amount) will take effect on the later of:

- The date the benefit increase is scheduled to go into effect; and
- The date your online election is effective.

If you are not actively at work on the date the benefit increase would otherwise take effect under the paragraph above, your benefit increase will take effect on the date you return to active work in a benefits-eligible position.

Definitions

When the terms below are used in the Accident, Critical Illness, and Hospital Indemnity sections of this Handbook, the following definitions will apply.

- *Actively at work* means that you are performing all of the usual and customary duties of your job on a full-time or part-time basis. You will be deemed actively at work during weekends, approved vacations, holidays, and temporary business closures if you were actively at work on the last scheduled work day preceding such time off.
- *Accident* means an act or event which:
  – is unforeseen, unexpected and unanticipated;
  – is definite as to time and place;
  – is not a sickness; and
  – occurs while insurance is in effect.

  The term *accident* includes unavoidable exposure to the elements if such exposure was a direct result of an accident.
- *Benefit Increases* means a simultaneous increase in both the benefit amount and the total benefit amount.

- *Confined* or *confinement* means the assignment to a bed as a resident inpatient in a hospital (including an intensive care unit (ICU) of a hospital) on the advice of a physician or confinement in an observation area within a hospital for a period of no less than 20 continuous hours on the advice of a physician.
- *Covered person* means you and if insured under the group policy for the insurance described in the Handbook, your dependents.
- *Hospital* means a short-term, acute care, general facility which:
  - Is primarily engaged in providing, by or under the continuous supervision of physicians, to inpatients, diagnostic services and therapeutic services for diagnosis, treatment and care of injured or sick persons;
  - Has organized departments of medicine;
  - has facilities for major surgery either on its premises or through contractual arrangement with another hospital;
  - Has a requirement that every patient must be under the care of physician or dentist;
  - Provides 24-hour nursing service by or under the supervision of a registered professional nurse (R.N.);
  - Is duly licensed by the agency responsible for licensing such hospitals; and
  - Is not, other than incidentally, a place of rest, a place primarily for the treatment of tuberculosis, a place for the aged, a place for drug addicts, alcoholics, or a place for convalescent, custodial, educational or rehabilitative care.
- *Hospitalized* means:
  - Admission for inpatient care in a hospital;
  - Receipt of care in a hospice facility, an intermediate care facility or a long-term care facility; or
  - Receipt of the following treatment, wherever performed:
    - Chemotherapy;
    - Radiation therapy; or
    - Dialysis.
- *Injury* means any bodily harm:
  - That results directly from an accident; and
  - Is not specifically excluded.
- *Medical Restriction* means a person is:
  - restricted to the person's home under a physician's care;
  - receiving or applying to receive disability benefits from any source;
  - an inpatient in a hospital;
  - receiving care in a hospice facility, an intermediate care facility or a long-term care facility; or
  - receiving chemotherapy, radiation therapy or dialysis.
- *Proof* means written evidence satisfactory to MetLife that a claimant has satisfied the conditions and requirements for any benefit described. When a claim is made for any benefit described, proof must establish:
  - The nature and extent of the loss or condition;
  - MetLife's obligation to pay the claim; and
  - The claimant's right to receive payment.

  Except as provided in the examinations and autopsy provisions within the supplemental benefits section of this Handbook, proof must be provided at the claimant's expense.
- *Schedule* means the schedule of insurance that appears on page 184 of this Handbook.
- *Sickness* means:
  - A physical illness, physical infirmity, or physical disease;
  - Pregnancy; or
  - Infection, but not infection received through an accidental cut or wound.
- *Total Benefit Amount* means the maximum aggregate amount that MetLife will pay for any and all covered conditions combined, per covered person, per lifetime.

ACCIDENT INSURANCE

Overview

Just like the Accidental Death and Dismemberment (AD&D) Insurance also offered by Texas Health, the accident insurance policy through MetLife covers accidental death and loss of limb. However, unlike AD&D, accident insurance:

- Covers many other types of accidental injuries, from a cut requiring stitches to second-degree burns; and
- Pays flat dollar amounts directly to you not only for covered injuries, but for other expenses you incur as a result.

The policy also pays benefits for some medical fees, follow-up treatments, physical therapy, appliances such as crutches, and blood plasma. Under some circumstances, you receive a benefit for travel and lodging if a required service is far from home.

If you are injured as a result of a covered accident, submit a claim online at **mybenefits.metlife.com**.

Insureds are defined as those who might be eligible for coverage in the following categories under this policy:

- Employee Coverage
- Employee and Spouse Coverage
- Employee and Child(ren) Coverage
- Employee and Family Coverage

Accidental Death Benefits

Payment of the Accidental Death Benefits described in this section are subject to all conditions, maximums, limitations, exclusions, and proof requirements. The accidental death benefits described in the supplemental benefits sections of this Handbook are in addition to the benefits paid through the Prudential Life Insurance and Prudential Accidental Death and Dismemberment (AD&D) policies.

Basic Accidental Death Benefit

MetLife will pay the applicable basic accidental death benefit for a covered person's death if:

- The death results directly from an accident; and
- The death occurs within 180 days following the accident.

Reduction of the Basic Accidental Death Benefit

The basic accidental death benefit will be reduced by the following if paid for injuries sustained by the covered person in the same accident that resulted in the covered person's death:

- The amount of any benefits paid under the accidental dismemberment/functional loss/paralysis benefits; and
- The modification benefit under the accident – medical treatment & services benefits.

Accidental Death – Common Carrier Benefit

MetLife will pay the applicable accidental death – common carrier benefit, instead of the basic accidental death benefit for a covered person's death if:

- The death results directly from an accident sustained by the covered person while:
  - A fare paying passenger on a common carrier; or
  - A passenger on public transportation that is a common carrier, for which there is no fare; and
- The death occurs within 180 days following the accident.

MetLife will not pay both the accidental death – common carrier and the basic accidental death benefit for the same covered person.

Common carrier means airplanes, trains, buses, trolleys, subways, and boats that:

- Run on a regularly scheduled basis between predetermined points or cities; and
- Are operated by a government regulated entity.

The term common carrier does not include taxis, limousines, or privately chartered vehicles.

Reduction of the Accidental Death – Common Carrier Benefit

The accidental death – common carrier benefit will be reduced by the following if paid for injuries sustained by the covered person in the same accident that resulted in the covered person's death:

- The amount of any benefits paid under the accidental dismemberment/functional loss/paralysis benefits; and
- The modification benefit under the accident – medical treatment & services benefits.

Accidental Dismemberment/Functional Loss/Paralysis Benefits

Payment of the accidental dismemberment/functional loss/paralysis benefits are subject to all of the conditions, maximums, limitations, exclusions, and proof requirements. The accidental death benefits described in the supplemental benefits are in addition to the benefits paid through the Prudential Accidental Death and Dismemberment (AD&D) policies.

Basic Dismemberment/Functional Loss Benefit OR Catastrophic Dismemberment/Functional Loss Benefit

If a covered person sustains an injury that is a dismemberment or functional loss, MetLife will pay the basic dismemberment/functional loss benefit or the catastrophic dismemberment/functional loss benefit that applies to the type of dismemberment or functional loss the covered person sustained, subject to all of the following:

- The dismemberment or functional loss must be documented by a physician within 180 days after the accident occurs.
- In order for the catastrophic dismemberment/functional loss benefit to be payable, the injuries that qualify for such benefit must have been sustained by the covered person in a single accident.
- If a covered person sustains an injury that is a dismemberment or functional loss that falls under more than one classification on the schedule, MetLife will only pay the benefit that applies to the classification that pays the highest benefit.

Dismemberment means any of the following:

- Loss of an arm: the arm is permanently severed at or above the elbow.
- Loss of a hand: the hand is permanently severed at or above the wrist joint.
- Loss of a finger: the finger is permanently severed at the joint proximate to the first interphalangeal joint where it is attached to the hand.
- Loss of a foot: the foot is permanently severed at or above the ankle joint.
- Loss of a leg: the leg is permanently severed at or above the knee.
- Loss of a toe: the toe is permanently severed at the joint proximate to the first interphalangeal joint where it is attached to the foot.

Functional Loss means any of the following:

- Loss of hearing: permanent deafness in at least one ear, such that it cannot be corrected to any functional degree of any procedure, aid, or device. Loss of hearing must last for a continuous period of not less than 90 days as confirmed by a physician.
- Loss of sight: permanent loss of sight in an eye. With correction, visual acuity must be 20/200 or worse in the eye or the field of vision must be less than 20 degrees. Loss of sight must last for a continuous period of not less than 90 days as confirmed by a physician.

Paralysis Benefit

If a covered person sustains an injury that is a paralysis, MetLife will pay the paralysis benefit that applies to the type of paralysis the covered person sustained, subject to all of the following:

- Paralysis must be documented by a physician within 180 days after the accident occurs.
- If a covered person sustains an injury that is a paralysis that falls under more than one classification, MetLife will only pay the benefit that applies to the classification that pays the highest benefit.

Paralysis means the permanent total and irrecoverable loss of movement of two or more limbs:

- That has lasted for a continuous period of not less than 90 days as confirmed by a physician; or
- As a result of transected spinal cord with supporting clinical and radiological evidence and no expectation of return to function.

The term paralysis does not include a dismemberment or coma.

Accidental Injury Benefits

Payment of the accidental injury benefits are subject to all conditions, maximums, limitations, exclusions, and proof requirements.

Fracture Benefit

If a covered person sustains an injury that is a fracture, MetLife will pay the fracture benefit that is applicable to the type of fracture sustained by the covered person, subject to all of the following:

- The injury must be diagnosed and treated as a fracture by a physician within 180 days after the accident occurs.
- The fracture must require and be corrected by open (surgical) or closed (non-surgical) reduction by a physician. Closed reduction includes immobilization.
- MetLife will pay no more than one fracture benefit per bone, per accident.
- If more than one bone is fractured in a single accident, the amount MetLife will pay for all fractures combined will be no more than 2 times the highest fracture benefit that would otherwise be payable for any one of the bones involved.
- The chip fracture benefit will be 25% of the fracture benefit for the bone involved.
- If the same fracture is treated with both open reduction and closed reduction, MetLife will pay no more than the fracture benefit payable for the open reduction.

Fracture means a break in bone of a body part that is listed on the schedule under fracture benefit, which can be detected by an x-ray or a similar diagnostic exam.

Chip fracture means a fracture in which a small fragment of the bone is broken off.

Dislocation Benefit

If a covered person sustains an injury that is a dislocation, MetLife will pay the dislocation benefit that is applicable to the type of dislocation the covered person sustained, subject to all of the following:

- The injury must be diagnosed and treated as a dislocation by a physician within 180 days after the accident occurs.
- The dislocation must require, and be corrected by, open (surgical) or closed (non-surgical) reduction by a physician.
- If more than one joint is dislocated in a single accident, the amount MetLife will pay for all dislocations combined will be no more than 2 times the highest dislocation benefit that would otherwise be payable for any one of the joints involved.
- The partial dislocation benefit will be 25% of the dislocation benefit for a full dislocation of the joint involved.
- If a partial dislocation was paid, or becomes payable, and the covered person subsequently sustains an injury that is a full dislocation, MetLife will reduce what is paid for the full dislocation by the amount that was paid or is payable for the partial dislocation.
- For each joint, MetLife will pay no more than one full dislocation benefit amount for all injuries combined that are dislocations of the same joint, regardless of whether the injuries are sustained in the same accident. Once the covered person has received an amount equal to one full dislocation benefit for a joint, no further dislocation benefits will be paid for that same joint, even if the same covered person subsequently sustains an injury that is a dislocation of the same joint in a new accident.
- MetLife will only pay benefits for those dislocations specifically listed on page 178.

Dislocation means a separated joint of a body part listed under dislocation benefit. The term dislocation does not include vertebral subluxation complex (misaligned vertebrae).

Full dislocation means a dislocation in which the joint is completely separated.

Partial dislocation means a dislocation in which the joint is not completely separated.

Burn Benefit

If a covered person sustains an injury that is a second or third-degree burn, MetLife will pay the burn benefit that is applicable to the size and severity of the burn, subject to all of the following:

- The burn must be treated by a physician within 96 hours after the accident occurs.
- If a burn meets more than one of the burn classifications, the amount MetLife pays will be based on the classification of the burn that pays the highest benefit.

- MetLife will pay the burn benefit no more than one time per covered person, per accident.
- No benefit is payable for a first-degree burn.

Skin Graft Benefit

MetLife will pay the applicable skin graft benefit if a covered person receives a skin graft for a burn for which MetLife paid a burn benefit. MetLife will pay a skin graft benefit no more than one time per covered person, per accident.

Concussion Benefit

If a covered person sustains an injury that is a concussion, MetLife will pay the concussion benefit, subject to all of the following:

- The injury must be diagnosed as a concussion by a physician within 96 hours after the accident occurs.
- MetLife will pay the concussion benefit no more than one time per covered person, per calendar year.

Coma Benefit

If a covered person sustains an injury that is a coma, MetLife will pay the coma benefit, subject to both of the following:

- The coma must begin within 180 days after the accident occurs.
- MetLife will pay the coma benefit no more than one time per covered person, per accident.

Coma means a continuous state of profound unconsciousness lasting for a period of 14 or more consecutive days, characterized by the absence of purposeful response to commands, including:

- Eye opening;
- Verbal response; and
- Motor response.

Ruptured Disc with Surgical Repair Benefit

If a covered person sustains an injury that is ruptured and undergoes surgery to repair it, MetLife will pay the ruptured disc with surgical repair benefit subject to all of the following:

- The covered person must be treated by a physician for the ruptured disc within 180 days after the accident occurs.
- The surgery to repair the ruptured disc must be performed by a physician within 365 days after the accident occurs.
- MetLife will pay the ruptured disc with surgical repair benefit no more than 1 time per covered person, per accident.

Ruptured disc means a tear in the spinal disc capsule. It does not include a bulging disc.

Torn Cartilage in Knee Benefit

If a covered person sustains an injury that is torn cartilage in the knee (meniscus) and undergoes surgery to repair or explore it, MetLife will pay the torn cartilage in knee benefit that is applicable to the type of surgery performed as follows:

- If the surgery performed is to repair the knee, MetLife will pay the torn cartilage in knee benefit with surgical repair; and
- If the surgery performed is exploratory surgery and either no repair is done or the cartilage is shaved or trimmed, MetLife will pay the torn cartilage in knee benefit for exploratory surgery without repair.

Payment of the torn cartilage in knee benefit is subject to all the following:

- The covered person must be treated by a physician for the torn cartilage in the knee within 180 days after the accident occurs.
- Surgery must be performed by a physician on the knee within 365 days after the accident occurs.
- MetLife will pay the torn cartilage in knee benefit no more than 1 time per covered person, per accident.

Laceration Benefit

If a covered person sustains an injury that is a laceration and receives treatment from a physician to repair it, MetLife will pay the laceration benefit that is applicable to the length of the laceration and the treatment received as follows:

- If the laceration is repaired with stitches, MetLife will pay the laceration benefit repaired with stitches; or
- If the laceration is not repaired with stitches, MetLife will pay the laceration benefit repaired without stitches.

Payment of the laceration benefit is subject to all of the following:

- The laceration must be treated by a physician within 96 hours after the accident occurs.
- A laceration repaired with sutures or staples will be deemed to be a laceration repaired with stitches for purposes of this laceration benefit.
- If the covered person has more than one laceration, the amount MetLife will pay will be based on the total length of all lacerations received in any one accident that are repaired with stitches. If some, but not all, of the lacerations require repair with stitches, MetLife will not pay any benefit for the laceration or lacerations that are repaired without stitches.
- MetLife will pay the laceration benefit no more than one time per covered person, per accident and no more than 3 times per covered person, per calendar year.

Laceration mean a cut.

Torn, Ruptured, or Severed Tendon/ Ligament/Rotator Cuff Benefit

If a covered person sustains an injury that is a torn, ruptured, or severed tendon, ligament, or rotator cuff and undergoes surgery to explore or repair it, MetLife will pay the torn, ruptured or severed tendon/ligament/ rotator cuff benefit, that is applicable to the type of surgery performed as follows:

- If the surgery is performed to repair the tendon, ligament, or rotator cuff, MetLife will pay the benefit for torn, ruptured, or severed tendon, ligament, or rotator cuff with surgical repair; or

- If the surgery performed is exploratory surgery and no repair is done, the benefit MetLife will pay will be for exploratory surgery without repair.

Payment of the torn, ruptured, or severed tendon/ligament/rotator cuff benefit is subject to all of the following:

- The covered person must be treated by a physician for torn, ruptured, or severed tendon, ligament, or rotator cuff within 180 days after the accident occurs.
- Surgery must be performed by a physician on the tendon, ligament or rotator cuff within 365 days after the accident.
- MetLife will pay the torn, ruptured, or severed tendon/ligament/rotator cuff benefit no more than one time per covered person, per accident.

Broken Tooth Benefit

If a covered person sustains an injury that is a broken tooth and the tooth is repaired by a dental crown or filling, or is extracted, MetLife will pay the broken tooth benefit that is applicable to the dental crown, filling, and/or extraction, subject to all of the following:

- No benefit will be payable for an injury that is not a sound, natural tooth.
- No benefit will be payable for an injury caused by biting or chewing.
- The dental services must begin within 180 days after the accident occurs.
- Regardless of the number of teeth involved, MetLife will pay the broken tooth benefit for no more than 1 dental crown, no more than 1 dental filling, and no more than 1 dental extraction per covered person, per accident.

Eye Injury Benefit

If a covered person sustains an injury to an eye, MetLife will pay the eye injury benefit subject to both of the following:

- The injury to the eye must require surgery or the removal of a foreign object by a physician within 180 days after the accident occurs.
- MetLife will pay the eye injury benefit no more than 1 time per covered person, per accident and no more than 3 times per covered person, per calendar year.

Accident - Medical Treatment & Services Benefits

Payment of the accident- medical treatment and services benefits are subject to all conditions, maximums, limitations, exclusions, and proof requirements.

Air Ambulance Benefit

MetLife will pay the air ambulance benefit if a licensed professional air ambulance service is required to transport a covered person by air to or from a hospital or between medical facilities, where treatment for an injury is received, subject to both of the following:

- The air ambulance transportation must be within 90 days after the accident occurs.
- MetLife will pay the air ambulance benefit no more than 1 time per covered person, per accident.

Ground Ambulance Benefit

MetLife will pay the ground ambulance benefit if a licensed professional ambulance service is required to transport a covered person by ground to or from a hospital or between medical facilities, where treatment for an injury is received, subject to both of the following:

- The ambulance transportation must be within 90 days after the accident occurs.
- MetLife will pay the ground ambulance benefit no more than 1 time per covered person, per accident.

Emergency Care Benefit or Non-Emergency Initial Care Benefit

If a covered person sustains an injury and receives initial care from a physician for the injury in an emergency room, a physician's office, or an urgent care facility, within 96 hours after the accident occurs, MetLife will pay the emergency care benefit that is applicable to the place where care is received.

If a covered person sustains an injury and receives initial care from a physician for the injury in an emergency room, a physician's office, or an urgent care facility, more than 96 hours but less than 180 days after the accident occurs, MetLife will pay the non-emergency care initial care benefit.

Payment of the emergency care benefit and the non-emergency initial care benefit is subject to both of the following:

- MetLife will never pay both the emergency care benefit and the non-emergency initial care benefit for the same covered person, for the same accident.
- If MetLife pays either the emergency care benefit or the non-emergency initial care benefit, MetLife will pay the benefit no more than one time per covered person, per accident.

Medical Testing Benefit

If a covered person sustains an injury and receives any of the following medical tests to evaluate the injury, MetLife will pay the medical testing benefit:

- X-rays;
- Magnetic resonance imaging (MRI) or magnetic resonance (MR);
- Ultrasound;
- Nerve conduction velocity test (NCV);
- Computed tomography scan (CT) or computed axial tomography (CAT); or
- Electroencephalogram (EEG).

Payment of the medical testing benefit is subject to both of the following:

- The test must be ordered by a physician and be performed within 180 days after the accident occurs.
- MetLife will pay the medical testing benefit no more than 1 time per covered person, per accident.

Physician Follow-Up Visit Benefit

If a covered person sustains an injury and receives follow-up care for the injury that is recommended by a physician or is a second opinion, MetLife will pay the physician follow-up visit benefit, subject to all of the following:

- Treatment must:
  - Begin within 180 days after the accident occurs and be provided within 365 days after the accident occurs;
  - Be specific to the injury;
  - Occur on an outpatient basis in a physician's office, urgent care facility or hospital; and
  - Not be for routine examinations, preventive testing, or any treatment for which a benefit is payable under the therapy services benefit.
- MetLife will pay the physician follow-up visit benefit no more than:
  - 2 times per covered person, per accident; and
  - 6 times per covered person, per calendar year.

Transportation Benefit

MetLife will pay the transportation benefit when a covered person travels more than 50 miles one way for follow-up treatment of an injury which MetLife pays a benefit for under the accident insurance at a hospital or other treatment facility, subject to all of the following:

- Mileage is measured from the covered person's primary residence to the facility where the follow-up treatment is provided.
- The follow-up treatment must be prescribed by a physician and not available within 50 miles of the covered person's primary residence.
- You must submit proof that the follow-up treatment was provided.
- MetLife will not pay the transportation benefit if the ground ambulance benefit or air ambulance benefit is payable for the trip.
- MetLife will pay the transportation benefit no more than:
  - 1 time per covered person, per accident; and
  - 3 times per covered person, per calendar year.

Therapy Service Benefit

If a covered person sustains an injury and receives therapy services, MetLife will pay the therapy services benefit that applies to the type of therapy service received, subject to all of the following:

- Therapy services must:
  - Begin within 180 days and be provided within 365 days after the accident occurs;
  - Be provided on an outpatient basis;
  - Be prescribed by a physician; and
  - Be provided by a practitioner licensed to provide the type of therapy services provided and operating within the scope of such license.
- MetLife will pay the therapy services benefit for therapy services received no more than 10 times per covered person, per accident.
- MetLife will not pay a therapy services benefit for therapy services received by the covered person on the same day for which the inpatient rehabilitation benefit is payable under accident – hospital benefits.

Therapy services means any of the following:

- Cognitive behavioral therapy;
- Occupational therapy;
- Physical therapy;
- Respiratory therapy;
- Speech therapy; and
- Vocational therapy.

Pain Management Benefit (for epidural anesthesia)

If a covered person sustains an injury and receives epidural anesthesia to manage the pain from the injury, MetLife will pay the pain management benefit, subject to all of the following:

- MetLife will not pay a benefit for epidural anesthesia administered more than 180 days after the accident occurs.
- MetLife will pay the pain management benefit no more than 1 time per covered person, per accident.

Prosthetic Device Benefit

If a covered person sustains an injury that is a loss of a limb, hand, foot, or sight in an eye and receives a prosthetic device as a result of the loss, MetLife will pay the prosthetic device benefit, that is applicable to the number of prosthetic devices the covered person receives, subject to all of the following:

- The prosthetic device must be received within 365 days after the accident occurs.
- No benefit will be payable for replacement of a prosthetic device.
- MetLife will not pay the prosthetic device benefit for a joint replacement such as an artificial hip or knee.
- MetLife will pay the prosthetic device benefit no more than 1 time per covered person, per accident.

Prosthetic device means an artificial device that replaces a missing body part. The term prosthetic device does not include hearing aids, dental aids (including false teeth), eyeglasses, or cosmetic prostheses such as wigs.

Medical Appliance Benefit

If a covered person sustains an injury for which a physician prescribes the use of a medical appliance as an aid in personal locomotion or mobility, MetLife will pay the medical appliance benefit, for the type of medical appliance that the physician prescribes, subject to all of the following:

- The use of such medical appliance must begin within 180 days after the accident occurs.
- The amount MetLife will pay for all medical appliances combined, per covered person, per accident, will be no more than the medical appliance benefit limit.
- MetLife will not pay the medical appliance benefit for the replacement of a medical appliance.

Medical appliance means any of the following:

- Brace for the neck, back or leg;
- Cane;
- Crutches;
- Walker;
- Walking boot that extends above the ankle;
- Wheelchair or motorized scooter for medical purposes; and
- Any other medical device used for mobility.

Modification Benefit

If a covered person sustains an injury which is a dismemberment, functional loss, or paralysis for which MetLife paid a benefit under the Accident Insurance policy, MetLife will pay the modification benefit for modifications made to the covered person's primary residence or vehicle, subject to all of the following:

- A physician must certify that because of the injury, the modification is necessary to help enable the covered person to live in his or her primary residence or travel in his or her personal vehicle
- The modification must be made within 365 days after the accident occurs.
- MetLife will pay the modification benefit no more than 1 time per covered person, per accident.

Blood/Plasma/Platelets Benefit

If a covered person sustains an injury for which the covered person receives a transfusion of blood, plasma or platelets, MetLife will pay the blood/plasma/platelets benefit, subject to all of the following:

- The blood, plasma, or platelets must be prescribed by a physician on an emergency basis or provided while the covered person is undergoing surgery and must be administered within 180 days after the accident.
- MetLife will pay the blood/plasma/platelet benefit no more than 1 time per covered person, per accident.

Inpatient Surgery Benefit

If a covered person undergoes covered surgery to treat an injury while the covered person is confined as an inpatient in a hospital, MetLife will pay the inpatient surgery benefit, for the type of covered surgery the covered person undergoes, subject to all of the following:

- The covered person must seek treatment for the injury within 180 days after the accident occurs.
- The surgery must be performed within 365 days after the accident occurs.
- If a covered person has open abdominal and hernia surgery, or open thoracic and hernia surgery as a result of the same accident, the benefit MetLife will pay will be based on the abdominal or thoracic surgery and MetLife will not pay a benefit for the hernia surgery.
- If a covered person has exploratory surgery at the same time as any other type of covered surgery, MetLife will not pay a benefit for the exploratory surgery.
- MetLife will not pay the inpatient surgery benefit if any of the following benefits are payable for the same surgery:
  - Broken tooth benefit;
  - Eye injury benefit;
  - Ruptured disc with surgical repair benefit;
  - Skin graft benefit;
  - Torn cartilage in knee benefit; or
  - Torn, ruptured, or severed tendon/ligament/rotator cuff benefit.

Covered surgery means:

- Cranial surgery;
- Exploratory surgery;
- Hernia repair; or
- Thoracic cavity and abdominal pelvic cavity surgery.

Outpatient Ambulatory Surgery Benefit

If a covered person sustains an injury and undergoes surgery required to treat the injury in an outpatient ambulatory surgery facility, MetLife will pay the outpatient ambulatory surgery benefit, subject to all of the following:

- The covered person must seek treatment for the injury within 180 days after the accident occurs.
- The surgery must be performed in an outpatient surgery facility within 365 days after the accident occurs.
- MetLife will pay the outpatient ambulatory surgery benefit no more than one time, per covered person, per accident.

Accident – Hospital Benefits

Payment of the Accident- Hospital Benefits are subject to all of the conditions, maximums, limitations, exclusions, and proof requirements.

Accident – Hospital Admission Benefit

If a covered person is admitted to a hospital for treatment of an injury, MetLife will pay the accident – hospital admission benefit that applies to the type of hospital admission, subject to all of the following:

- In order for the accident – hospital admission benefit to be payable, the admission must occur within 180 days after the accident occurs.
- This benefit does not apply to emergency room treatment, outpatient treatment, or a stay of less than 20 hours in an observation area.
- MetLife will only pay one Accident-hospital admission benefit per covered person, per accident. If the covered person moves from or to an ICU after initial admission to a hospital, MetLife will not pay an additional accident- hospital admission benefit.

Accident – Hospital Confinement Benefit

If a covered person is confined in a hospital for treatment of an injury, MetLife will pay the accident – hospital confinement benefit that applies to the type of hospital confinement for each day the covered person is confined to the hospital, subject to all of the following:

- In order for the accident – hospital confinement benefit to be payable, the initial confinement must occur within 180 days after the accident occurs.
- For a non-ICU hospital confinement, the Accident- hospital confinement benefit is payable for up to 365 days per covered person, per accident, and may be used over a two-year period following the date of accident.
- For an ICU confinement, the Accident- hospital confinement benefit is payable for up to 30 days per covered person, per accident, and may be used over a two-year period following the date of accident.
- MetLife will pay the accident-hospital confinement benefit for only one hospital confinement at a time, even if the confinement is caused by more than one accident.
- MetLife will only pay one accident-hospital confinement benefit per day. If the covered person has a non-ICU hospital confinement and an ICU confinement on the same day, MetLife will only pay the accident – hospital confinement benefit that applies to the ICU confinement.
- If a covered person exhausts the accident – hospital confinement benefit that applies to confinement in an ICU and remains confined in an ICU, the covered person may still be eligible for the accident – hospital confinement benefit that applies to a non-ICU hospital confinement.

Inpatient Rehabilitation Benefit

If a covered person is transferred to a rehabilitation facility immediately after a period of confinement for treatment of an injury for which MetLife paid an accident- hospital confinement benefit, MetLife will pay the inpatient rehabilitation benefit, subject to all of the following:

- MetLife will pay the inpatient rehabilitation benefit for each day of the covered person's continuous stay as a resident inpatient in a rehabilitation facility, up to a maximum stay of 30 days per covered person, per accident but not to exceed 60 days per calendar year.
- The covered person's inpatient stay in the rehabilitation facility must start within 365 days after the accident.
- After the covered person is discharged from the rehabilitation facility, MetLife will not pay the inpatient rehabilitation benefit for a subsequent admission to a rehabilitation facility for treatment of the same injury for which MetLife already paid the inpatient rehabilitation benefit.
- MetLife will not pay the inpatient rehabilitation benefit for any day for which MetLife paid an accident - hospital confinement benefit.

Accident – Other Benefits

Payment of the Other Benefits are subject to all of the conditions, maximums, limitations, exclusions, and proof requirements.

Lodging Benefit

If a covered person is confined in a hospital for treatment of an injury, and a companion who accompanies the covered person while the covered person is so confined stays in a lodging for which a charge is made, MetLife will pay the lodging benefit, subject to all of the following:

- MetLife will pay the lodging benefit for each day the companion stays in a lodging while the covered person is confined in a hospital for treatment of an injury, and for the 24 hours following the hospital confinement.
- MetLife will pay the lodging benefit for up to 31 days per calendar year.
- The lodging benefit is only payable on account of a hospital confinement for which MetLife is paying an accident – hospital confinement benefit.
- You must submit proof that the companion incurred an expense for staying at a lodging.

Lodging means an establishment licensed under the laws where it is located, such as motel, hotel, or other facility that provides sleeping accommodations to the general public in exchange for a fee and is located at least 50 miles from the covered person's primary residence.

Accident Exclusions

The exclusions apply to the benefits described in the following sections:

- Accidental death benefits
- Accidental dismemberment/ functional loss/paralysis benefits
- Accidental injury benefits
- Accident – medical treatments & services benefits
- Accident – hospital benefits

MetLife will not pay benefits for any loss for a covered person caused by the covered person's sickness, or the diagnosis or treatment of such sickness, except for the covered person's use of:

- any drug, medication or sedative that is taken or used as prescribed by a physician; or
- an "over the counter" drug, medication or sedative taken as directed.

MetLife will not pay benefits for any loss for a covered person caused or contributed to by:

- the covered person's voluntary use, by any means, of:

  - any drug, medication or sedative, unless it is:
    - taken or used as prescribed by a physician; or
    - an "over the counter" drug, medication or sedative taken as directed;
  - alcohol in combination with any drug, medication, or sedative; or
  - poison, gas, or fumes;
- the covered person's suicide or attempted suicide (while sane or insane);
- the covered person's intentionally self-inflicted injury;
- war, whether declared or undeclared; or act of war;
- the covered person's active participation in an insurrection, rebellion, riot, or terrorist act;
- the covered person's engagement in any activity that constitutes a felony under the laws of the jurisdiction in which the activity occurred;
- the covered person's infection, other than infection occurring in an external wound resulting from an injury;
- food poisoning;
- the covered person's operation, while intoxicated, of a motor vehicle involved in the incident. For purposes of this exclusion:
  - intoxicated means that the insured's blood alcohol level met or exceeded .08%; and
  - motor vehicle means any vehicle that is powered by a motor, including, but not limited to: an automobile; a boat; a motorcycle; a truck; an all-terrain vehicle; or a snow mobile;
- dental or plastic surgery for cosmetic purposes, except when such surgery is performed to:
  - treat an injury;
  - correct a disorder of normal bodily function or structure that was caused by an injury for which coverage is not otherwise excluded under the Accident Insurance; or
  - reconstruct a part of the body which was disfigured or removed as a result of an injury for which coverage is not otherwise excluded under the Accident Insurance;
- the covered person's mental illness, or the diagnosis or treatment of such mental illness, except for the covered person's use of:
  - any drug, medication or sedative that is taken or used as prescribed by a physician; or
  - an "over the counter" drug, medication or sedative taken as directed;
- activities required by the covered person's service in the armed forces or any auxiliary unit of the armed forces of any country or international authority;
- the covered person's travel or flight in any aircraft except as a fare-paying passenger on a regularly scheduled charter or commercial flight;
- the covered person parachuting or otherwise exiting from a motorized or non-motorized aircraft while such aircraft is in flight, except for self-preservation;
- the covered person riding in or driving any motor-driven vehicle in a race, stunt show or speed test;
- the covered person participating in any semi-professional or professional competitive athletic activity for which any type of compensation or remuneration is received;
- the covered person bungee jumping, base jumping, hang gliding, para-kiting, sail-gliding, scuba diving deeper than 130 feet; spelunking; or mountaineering including rock climbing using ropes and any other climbing equipment. For the purposes of this exclusion the term mountaineering does not include backpacking, mountain biking, hiking or trail running.

In addition, MetLife will not pay benefits for:

- a covered person while incarcerated in any type of penal or detention facility; or
- any of the following outside of the United States, Canada or Mexico:
  - medical treatment;
  - hospital admission or confinement; or
  - inpatient stay in a rehabilitation facility.

Claim Provisions

Filing a Claim

The insured must begin the claim process:

- within 60 days after a covered accident or
- as soon as reasonably possible by visiting **mybenefits.metlife.com** or calling 1-866-626-3705 and requesting a claim form.

Claim Forms

When MetLife receives notice of a claim, MetLife will send you a claims packet with forms to be completed and signed by you and your physician. You may return all necessary information to MetLife via fax (1-855-306-7350) or mail to:

Metropolitan Life Insurance Company
Attn: Accident Insurance Product
P.O. Box 80826
Lincoln, NE 68501-0826

Claim Review, Processing and Decision

Once a claim is set up, the claims examiner:

1. Validates eligibility and premium payments are current.
2. Reviews information to ensure no additional information is necessary.
   a. If additional information is needed, the claimant will be mailed a letter and/or the examiner will call them directly. They will ask for the details required to continue the review.
   b. MetLife will then request the necessary medical information from your doctor to make a claim determination.
3. The examiner will make a claim decision.
4. They will notify you of decision in writing.

   a. You may also check on status via MyBenefits (**https://mybenefits.metlife.com**) or call customer service (1-866-626-3705).
5. MetLife will issue benefits if claim approved.
   a. You can receive the claim amount from:
      i. MyBenefits (**https://mybenefits.metlife.com**, claims section, under specific product) or customer service (1-866-626-3705).
      ii. Direct Deposit (if you filled out your bank information on the claim form you received in your packet).
6. If claim is denied, you will be sent a letter. MetLife will include the denial and appeals process within the letter for next steps.

Your Beneficiary

You can change your beneficiary at any time by visiting **mybenefits.metlife.com**. The change will not have any bearing on payments made before MetLife approved the request. Once the request is recorded, the change will take effect as of the date you sign the request, whether or not you are living when we receive the request. The change will be subject to any legal restrictions. It will also be subject to any payment MetLife made or action MetLife took before MetLife recorded the change. If you designate two or more beneficiaries and their shares are not specified, they will share the benefit payable equally.

If there is no beneficiary designated or no surviving beneficiary at your death, MetLife will determine the beneficiary according to the following order:

1. Your Spouse, if alive;
2. Your child(ren) if there is no surviving spouse;
3. Your parent(s), if there is no surviving child;
4. Your sibling(s), if there is no surviving parent; or
5. Your estate, if there is no surviving sibling.

Instead of making payment in the order above, MetLife may pay your estate. Any payment made in good faith will discharge MetLife's liability to the extent of such payment. If a beneficiary or a payee is a minor or incompetent to receive payment, MetLife will pay that person's guardian.

You may name a beneficiary to receive a benefit payable due to the death of your spouse under the accidental death benefit. If no beneficiary is named, or if there is no surviving named beneficiary at the time of your spouse's death, MetLife will pay the benefit to you.

Examinations

At MetLife's expense, as often as is reasonably necessary, MetLife may require a covered person to have an independent examination by a physician of its choice.

At MetLife's expense, as often as is reasonably necessary, MetLife may have representatives conduct telephone or in-person interviews with you regarding your claim.

Time Limit on Legal Actions

A legal action on a claim may only be brought against MetLife during a certain period. This period begins 60 days after the date proof is filed and ends three years after the date such proof is required to be filed.

BENEFITS SCHEDULE (DIFFERENT COVERAGE FOR DEPENDENTS/SPOUSES)				
	Employee Low	Employee High	Spouse	Dependent
Accidental Death				
Basic Accidental Death	$25,000	$40,000	$12,500 Low $20,000 High	$5,000 Low $5,000 High
Accidental Death – Common Carrier	$75,000	$100,000	$37,500 Low $50,000 High	$15,000 Low $20,000 High
Basic Dismemberment/Functional Loss				
Loss of one finger or one toe	$625	$625	$250	$200
Loss of one arm or one leg	$6,250	$6,250	$2,500	$1,250
Loss of one hand or one foot	$6,250	$6,250	$2,500	$1,250
Loss of two or more fingers or toes in any combination	$625	$625	$250	$200
Loss of sight in one eye	$6,250	$6,250	$2,500	$1,250
Loss of hearing in one ear	$6,250	$6,250	$2,500	$1,250

BENEFITS SCHEDULE (SAME FOR ALL COVERED FAMILY MEMBERS)				
	Employee Low		Employee High	
Catastrophic Dismemberment/Functional Loss				
Loss of both arms or both legs or one arm and one leg	$15,000		$25,000	
Loss of both hands or both feet or one hand and one foot	$15,000		$25,000	
Loss of sight in both eyes	$15,000		$25,000	
Loss of hearing in both ears	$15,000		$25,000	
Loss of ability to speak	$15,000		$25,000	
Paralysis				
Two limbs (paraplegia or hemiplegia)	$5,000		$20,000	
Four limbs (quadriplegia)	$10,000		$40,000	
Fracture	Closed Reduction	Open Reduction	Closed Reduction	Open Reduction
Face or Nose (except mandible or maxilla)	$600	$1,200	$900	$1,800
Skull fracture – depressed (except bones of face or nose)	$1,500	$3,000	$2,250	$4,500
Skull fracture – non-depressed (except bones of face or nose)	$1,000	$2,000	$1,600	$3,200
Lower Jaw, Mandible (except alveolar process)	$800	$1,600	$1,200	$2,400
Upper Jaw, Maxilla (except alveolar process)	$700	$1,400	$1,050	$2,100
Upper Arm between Elbow and Shoulder (humerus)	$700	$1,400	$1,050	$2,100
Shoulder Blade (scapula), Collarbone (clavicle, sternum)	$800	$1,600	$1,200	$2,400
Forearm (radius and/or ulna), Hand, Wrist (except fingers)	$1,000	$2,000	$1,500	$3,000
Rib	$250	$500	$400	$800
Finger, Toe	$160	$320	$240	$480
Vertebrae, Body of (excluding vertebral processes)	$1,800	$3,600	$2,700	$5,400
Vertebral Processes	$400	$800	$600	$1200
Pelvis (includes ilium, ischium, pubis, acetabulum except coccyx)	$1,600	$3,200	$2,400	$4,800
Hip, Thigh (femur)	$2,000	$4,000	$3,000	$6,000
Coccyx	$250	$500	$400	$800
Leg (tibia and/or fibula)	$1,200	$2,400	$1,800	$3,600
Kneecap (patella)	$1,000	$2,000	$1,500	$3,000
Ankle	$1,000	$2,000	$1,500	$3,000
Foot (except toes)	$1,000	$2,000	$1,500	$3,000
Chip Fracture	25% of the applicable benefit for the bone involved			

BENEFITS SCHEDULE (SAME FOR ALL COVERED FAMILY MEMBERS)				
	Employee Low		Employee High	
Full Dislocation	Closed Reduction	Open Reduction	Closed Reduction	Open Reduction
Lower jaw	$450	$900	$750	$1,500
Collarbone (sternoclavicular)	$500	$1,000	$800	$1,600
Collarbone (acromioclavicular and separation)	$250	$500	$400	$800
Shoulder (glenohumeral)	$750	$1,500	$1,250	$2,500
Rib	$250	$500	$400	$800
Elbow	$300	$600	$500	$1,000
Wrist	$375	$750	$625	$1,250
Bone or Bones of the Hand (other than fingers)	$525	$1,050	$875	$1,750
Hip	$1,500	$3,000	$2,500	$5,000
Knee (except patella)	$1,000	$2,000	$1,625	$3,250
Ankle - Bone or Bones of the Foot (other than toes)	$600	$1,200	$1,000	$2,000
One Toe or Finger	$120	$240	$200	$400
Partial Dislocation	25% of the applicable benefit for the joint involved			
Burns (Percentage of total surface skin area that is burnt)	2nd Degree	3rd Degree	2nd Degree	3rd Degree
Less than 10%	$50	$500	$100	$1,000
At least 10% but less than 25%	$100	$2,500	$200	$5,000
At least 25% but less than 35%	$250	$5,000	$500	$10,000
35% or more	$500	$10,000	$1,000	$20,000
Skin Grafts for 2nd or 3rd Degree Burn	50% of the applicable Burn Benefit			
Concussion	$200		$300	
Coma	$5,000		$7,500	
Ruptured Disc with Surgical Repair	$500		$800	
Torn Cartilage in Knee				
With surgical repair	$500		$600	
Exploratory surgery without repair	$100		$120	
Laceration				
Repaired without stitches	$25		$40	
Repaired with stitches:				
Total of all lacerations is less than two inches (5.08 cm) long	$50		$80	
Total of all lacerations is two to six inches (5.08 to 15.24 cm) long	$100		$160	
Total of all lacerations is over six inches (over 15.24 cm) long	$200		$320	
Torn, Ruptured or Severed Tendon / Ligament / Rotator Cuff				
Surgical repair: one tendon/ligament/rotator cuff	$500		$600	
Surgical repair: two or more tendons/ligaments/rotator cuffs	$750		$800	
Exploratory surgery without repair	$100		$120	
Broken Tooth				
Crown	$100		$160	
Extraction	$50		$80	
Filling	$25		$40	
Eye Injury	$200		$240	
Air Ambulance	$750		$800	
Ground Ambulance	$200		$240	
Emergency Care				
Emergency Room	$100		$125	
Physician's Office	$25		$40	

BENEFITS SCHEDULE (SAME FOR ALL COVERED FAMILY MEMBERS)		
	Employee Low	Employee High
Urgent Care	$25	$40
Non-Emergency Initial Care	$25	$40
Medical Testing	$100	$180
Physician Follow-Up Visit	$25	$35
Transportation	$200	$320
Therapy Services		
Cognitive behavioral therapy	$15	$20
Occupational therapy	$15	$20
Physical therapy	$15	$20
Respiratory therapy	$15	$20
Speech therapy	$15	$20
Vocational therapy	$15	$20
Pain Management Benefit (for Epidural Anesthesia)	$50	$20
Prosthetic Devices		
One device only	$500	$600
More than one device	$1,000	$1,200
Medical Appliances		
Brace	$50	$75
Cane	$50	$75
Crutches	$50	$75
Walker (expected use less than 1 year)	$100	$160
Walker (expected use 1 year or longer)	$250	$400
Walking boot	$50	$75
Wheel chair or motorized scooter (expected use less than 1 year)	$100	$160
Wheel chair or motorized scooter (expected use 1 year or longer)	$500	$800
Other medical device used for mobility	$50	$75
Limit for all Medical Appliances combined, per Covered Person, per Accident	$500	$800
Modification Benefit	$500	$800
Blood/Plasma/Platelets	$300	$320
Inpatient Surgery		
Cranial surgery	$1,000	$1,600
Exploratory surgery	$125	$175
Hernia repair	$100	$160
Thoracic cavity or abdominal pelvic cavity surgery	$1,000	$1,600
Outpatient Ambulatory Surgery	$150	$240
Accident - Hospital Admission		
Non-ICU Hospital Admission	$500	$800
Intensive Care Unit Admission	$500	$800
Accident - Hospital Confinement		
Non-ICU Hospital Admission	$100	$150
Intensive Care Unit Admission	$200	$300
Inpatient Rehabilitation	$100	$160
Lodging	$100	$160

CRITICAL ILLNESS

Overview

To help provide extra financial protection, an individual critical illness insurance policy is available for you to purchase through MetLife. With this coverage, you receive a lumpsum benefit if you or a covered family member is diagnosed with a covered illness.

Definitions

When the terms below are used in the Critical Illness section of this Handbook, the following definitions will apply:

- *Benefit Amount i*s the amount used to determine the benefit payable for a covered condition.
- *Benefit Suspension Period* means the 365 day period following the date a covered condition, for which MetLife pays a benefit, occurs with respect to a covered person.
- *Clinical Diagnosis* means a diagnosis of partial benefit cancer or full benefit cancer based on the study of symptoms and diagnostic tests. MetLife will accept a clinical diagnosis of partial benefit cancer or full benefit cancer only if the following conditions are met:
  - Under generally accepted medical standards, a pathological diagnosis cannot be made because it would be medically inappropriate or life-threatening;
  - Medical diagnostic testing supports the diagnosis; and
  - A physician is treating the covered person for partial benefit cancer or full benefit cancer.
- *Coronary Artery Bypass Graft* means the undergoing of open heart surgery performed by a physician to bypass a narrowing or blockage of one or more coronary arteries using venous or arterial grafts. The procedure must be deemed medically necessary by a physician and be supported by preoperative angiographic evidence. Coronary Artery Bypass Graft does not include:
  - angioplasty (percutaneous transluminal coronary angioplasty);
  - laser relief;
  - stent insertion;
  - coronary angiography; or
  - any other intra-catheter technique.
- *Covered condition* means the following as they are defined in this Handbook:
  - Coronary Artery Bypass Graft;
  - Full Benefit Cancer;
  - Partial Benefit Cancer;
  - Heart Attack;
  - Kidney Failure;
  - Major Organ Transplant;
  - Occupational HIV;
  - Stroke.
- *Diagnosis* means the establishment of a covered condition by a physician through the use of clinical and/or laboratory findings.
- *Diagnose* means the act of making a diagnosis.
- *First Occurs* or *First Occurrence* means, with respect to:
  - Full Benefit Cancer, the first time after a covered person initially becomes insured under the group policy that such covered condition occurs;
  - Full Benefit Cancer, after an occurrence of Full Benefit Cancer while the covered person is insured under the group policy, an occurrence of a separate and unrelated Full Benefit Cancer;
  - Partial Benefit Cancer, the first time after a covered person initially becomes insured under the group policy that such covered condition occurs;
  - Partial Benefit Cancer, after an occurrence of Partial Benefit Cancer while the covered person is insured under the group policy, an occurrence of a separate and unrelated Partial Benefit Cancer; or
  - all other covered conditions, the first time after a covered person initially becomes insured under the group policy that such covered condition occurs.
- *Full Benefit Cancer* means the presence of one or more malignant tumors characterized by the uncontrollable and abnormal growth and spread of malignant cells with invasion of normal tissue provided that a physician has determined that:
  - surgery, radiotherapy, or chemotherapy is medically necessary;
  - there is metastasis; or
  - the patient has terminal cancer, is expected to die within 24 months or less from the date of diagnosis and will not benefit from, or has exhausted, curative therapy.
- *Heart Attack* (myocardial infarction) means the death of a portion of the heart muscle as a result of obstruction of one or more coronary arteries due to atherosclerosis, spasm, thrombus or emboli.
- *Initial Benefit* means the benefit that MetLife will pay for a covered condition that first occurs while coverage is in effect.
- *Kidney Failure* means the total, end stage, irreversible failure of both kidneys to function, provided that a physician has determined that such failure requires either:
  - immediate and regular kidney dialysis (no less often than weekly) that is expected by such physician to continue for at least 6 months; or
  - a kidney transplant.
- *Major Organ Transplant* means:
  - the irreversible failure of a covered person's heart, lung, pancreas, entire kidney or any combination thereof, for which a physician has determined that the complete replacement of such organ with an entire organ from a human donor is medically necessary, and either such covered person has been placed on the transplant list or such transplant procedure has been performed;

- the irreversible failure of a covered person's liver for which a physician has determined that the complete or partial replacement of the liver with a liver or liver tissue from a human donor is medically necessary by a physician and either such covered person has been placed on the transplant list or such procedure has been performed; or
- the replacement of a covered person's bone marrow with bone marrow from the covered person or another human donor, which replacement is determined to be medically necessary by a physician in order to treat irreversible failure of such covered person's bone marrow.

- *Maximum Benefit Amount* means the maximum amount of benefits for which an individual in an eligible class can apply under the group policy.
- *Occupational HIV* means that a covered person becomes HIV positive as a direct result of an accidental exposure.
- *Accidental Exposure* means that while coverage is in effect and during the normal course of the covered person's regular occupational duties for which remuneration is earned, that the covered person is accidentally exposed to blood or other bodily fluids of another person that are contaminated with Human Immunodeficiency Virus (HIV) through:
  - cutaneous exposure through abraded skin;
  - percutaneous exposure; or
  - mucocutaneous exposure.
- *Occurs* or *Occurrence* means:
  - with respect to Heart Attack, Stroke, Kidney Failure, Full Benefit Cancer, or Partial Benefit Cancer:
    1. experiences such covered condition; and
    2. is diagnosed with such covered condition.
  - with respect to Coronary Artery Bypass Graft, that the covered person undergoes a Coronary Artery Bypass Graft.
  - with respect to Major Organ Transplant, that the covered person
    1. is placed on the transplant list; or
    2. undergo[es] such Major Organ Transplant.
  - with respect to Occupational HIV, that the covered person:
    1. experiences such covered condition; and
    2. is diagnosed with such covered condition.
- *Partial Benefit Cancer* means one of the following conditions that meets the TNM staging classification and other qualifications specified below:
  - carcinoma in situ classified as TisN0M0, provided that surgery, radiotherapy or chemotherapy has been determined to be medically necessary by a physician;
  - malignant tumors classified as T1N0M0 or greater which are treated by endoscopic procedures alone;
  - malignant melanomas classified as T1N0M0, for which a pathology report shows maximum thickness less than or equal to 0.75 millimeters using the Breslow method of determining tumor thickness; and
  - tumors of the prostate classified as T1bN0M0, or T1cN0M0, provided that they are treated with a radical prostatectomy or external beam radiotherapy.
- *Recur* or *recurrence* means:
  - with respect to coronary artery bypass graft:
    - an occurrence of coronary artery bypass graft if MetLife has already paid an initial benefit for the first occurrence of coronary artery bypass graft;
  - with respect to full benefit cancer, an occurrence of full benefit cancer that:
    - occurs after an initial benefit was paid for first occurrence of that same full benefit cancer;
  - with respect to partial benefit cancer, an occurrence of partial benefit cancer that:
    - occurs after an initial benefit was paid for a first occurrence of that same partial benefit cancer;
  - with respect to heart attack:
    - an occurrence of heart attack after MetLife has already paid an initial benefit for the first occurrence of heart attack;
  - with respect to stroke:
    - an occurrence of stroke after MetLife has already paid an initial benefit for the first occurrence of stroke.
- *Separate & Unrelated* means a Full Benefit Cancer or a Partial Benefit Cancer that is:
  - not a metastasis of a previously Diagnosed Full Benefit Cancer; and
  - distinct from any previously Diagnosed Full Benefit Cancer or Partial Benefit Cancer.
- *Stroke* means a cerebrovascular accident or incident producing measurable, functional and permanent neurological impairment (not including transient ischemic attacks (TIA), or prolonged reversible ischemic attacks) caused by any of the following which results in an infarction of brain tissue:
  - hemorrhage;
  - thrombus; or
  - embolus from an extracranial source.
- *Supplemental Benefit(s)* are the following:
  - Health Screening Benefit
- *Surgery* means a procedure performed by a physician involving the cutting of the covered person's skin or tissue that in and of itself is intended to be curative or palliative. Surgery does not include endoscopic procedures.
- *Transplant List* means the Organ Procurement and Transportation Network (OPTN) list.

Benefit Provisions

Critical Illness Benefit

MetLife will pay this benefit when one of the critical illnesses first occurs while the covered person is insured. Proof of the covered condition must be sent to MetLife.

Benefits will be based on the benefit amount in effect on the critical illness date of diagnosis. MetLife will deduct any previously paid partial benefits from the appropriate critical illness benefit. MetLife will never pay more with respect to any covered persons than the total benefit amount.

Except as provided in the newborn children provision, dependent insurance for a dependent will take effect on the later of the date you are eligible for coverage and the date the dependent becomes your dependent, provided that on the date the dependent meets the following requirements:

- The dependent is not confined at home under a physician's care;
- The dependent is not receiving or applying to receive disability benefits from any source; and
- The dependent is not hospitalized.

If a dependent does not meet these requirements, insurance for the dependent will take effect on the date the dependent is no longer:

- Confined at home under a physician's care;
- Receiving or applying to receive disability benefits from any source; or
- Hospitalized.

Regarding coronary artery bypass graft, full benefit cancer, heart attack, kidney failure and stroke, payment of the benefit for these conditions reduces the total benefit amount.

MetLife will only pay for one major organ transplant per covered person while coverage is in effect under the Critical Illness benefit.

Occupational HIV Injuries are payable only once. After the benefit is paid, Occupational HIV injury coverage for that insured will terminate.

Reoccurrence Benefit

MetLife will pay the reoccurrence benefit for a reoccurrence subject to the following limitations:*

- MetLife will not pay a reoccurrence benefit for a covered condition that recurs during a suspension period; and
- MetLife will not pay a reoccurrence benefit for either a full benefit cancer or a partial benefit cancer unless the covered person has not, for a period of 180 days, had symptoms of or been treated for the full benefit cancer or partial benefit cancer for which MetLife paid an initial benefit.

Payment of this benefit will reduce the total benefit amount.

Reduction on Account of Prior Claims Paid

MetLife will reduce what they pay for a claim so that the amount they pay, when combined with amounts for all claims MetLife has previously paid for the same covered person, does not exceed the total benefit amount that was in effect for that covered person on the date of the most recent covered condition. This provision does not apply to claim payments for Supplemental Benefits.

Health Screening Benefit

MetLife will pay a $50 benefit for one of the screening/prevention measures tests performed while an insured's coverage is in force. MetLife will pay this benefit once per covered person per calendar year. Payment of this benefit will not reduce the total benefit amount.

Health Screening Tests

Screening/prevention measures include, but are not limited to, the following:

- Annual physical exam;
- Biopsies for cancer;
- Blood test to determine total cholesterol;
- Blood test for triglycerides;
- Bone marrow testing;
- Breast MRI;
- Breast ultrasound;
- Breast sonogram;
- CA 15-3 (blood test for breast cancer);
- CA 125 (blood test for ovarian cancer);
- CEA (blood test for colon cancer);
- Carotid doppler;
- Chest X-rays;
- Clinical testicular exam;
- Colonoscopy;
- Digital rectal exam (DRE);
- Doppler screening for cancer;
- Doppler screening for peripheral vascular disease;
- Echocardiogram;
- Electrocardiogram (EKG);
- Endoscopy;
- Fasting blood glucose test;
- Fasting plasma glucose test;
- Flexible sigmoidoscopy;
- Hemoccult stool specimen;
- Hemoglobin A1C;
- Human papillomavirus (HPV) vaccination;
- Lipid panel;
- Mammogram;
- Oral cancer screening;
- Pap smear or thin prep pap test;
- PSA (blood test for prostate cancer);
- Serum cholesterol test to determine LDL or HDL levels;
- Serum protein electrophoresis (blood test for myeloma);
- Skin cancer biopsy;
- Skin cancer screening;
- Skin exam;
- Stress test on a bicycle or treadmill;
- Successful completion of smoking cessation program;
- Tests for sexually transmitted infections (STIs);
- Thermography;
- Two hour post-load plasma glucose test;
- Ultrasounds for cancer detection;
- Ultrasound screening of the abdominal aorta for abdominal aortic aneurysms; or
- Virtual colonoscopy.

*Benefits are payable for the reoccurrence of a previously diagnosed cancer and/or carcinoma in situ as long as the covered person:
- Has been free from signs or symptoms of that cancer for a consecutive 12-month period before the date of diagnosis (for the reoccurrence) and
- Has been treatment-free from that cancer for the 12 consecutive months before the date of diagnosis (for the reoccurrence).

Pre-Existing Condition Exclusion

Preexisting condition means a sickness or injury for which, in the 3 months before a covered person becomes insured, or before any benefit increase with respect to such covered person medical advice, treatment or care was sought by such covered person, or recommended by, prescribed by or received from a physician or other practitioner of the healing arts.

MetLife will not pay benefits for a covered condition that is caused by or results from a preexisting condition if the covered condition occurs during the first 6 months that a covered person is insured.

With respect to a benefit increase, MetLife will not pay benefits for such benefit increase for a covered condition that is caused by or results from a preexisting condition if the covered condition occurs during the first 6 months after such increase in the Total Benefit Amount.

This provision does not apply to benefits for the following covered conditions: Heart Attack, Stroke and Occupational HIV.

Exclusions

Exclusions Related to Covered Conditions

MetLife will not pay benefits for any of the following:

- Coronary Artery Bypass Graft:
  - performed outside the United States; or
  - that does not involve median sternotomy (a surgical incision in which the sternum, also known as the breastbone, is divided down the middle from top to bottom).
- Diagnosis of Full Benefit Cancer for:
  - any condition that is Partial Benefit Cancer;
  - any benign tumor, dysplasia, intraepithelial neoplasia or premalignant growth;
  - any papillary tumor of the bladder classified as Ta under TNM Staging;
  - any tumor of the prostate classified as T1N0M0 under TNM Staging;
  - any papillary tumor of the thyroid that is classified as T1N0M0 or less under TNM Staging and is one centimeter or less in diameter unless there is metastasis;
  - any cancer in the presence of human immuno-deficiency virus (HIV) for which there is a known increased risk due to the presence of Acquired Immune Deficiency Syndrome (AIDS) or the presence of HIV;
  - any non-melanoma skin cancer unless there is metastasis; or
  - any malignant tumor classified as less than T1N0M0 under TNM Staging.
- Diagnosis of Partial Benefit Cancer for:
  - any benign tumor, dysplasia, intraepithelial neoplasia or premalignant growth;
  - any papillary tumor of the bladder classified as Ta under TNM Staging;
  - any tumor of the prostate classified as T1aN0M0 under TNM Staging;
  - any papillary tumor of the thyroid that is classified as T1N0M0 or less under TNM Staging and is one centimeter or less in diameter;
  - any cancer in the presence of human immuno-deficiency virus (HIV) for which there is a known increased risk due to the presence of Acquired Immune Deficiency Syndrome (AIDS) or the presence of HIV;
  - any non-melanoma skin cancer; or
  - any melanoma in situ classified as TisN0M0 under TNM Staging.
- Diagnosis of Stroke for:
  - cerebral symptoms due to migraine
  - cerebral injury resulting from trauma or hypoxia; or
  - vascular disease affecting the eye or optic nerve or vestibular functions.
- Major Organ Transplant:
  - performed outside the United States;
  - involving organs received from non-human donors;
  - involving implantation of mechanical devices or mechanical organs;
  - involving stem cell generated transplants; or
  - involving islet cell transplants.
- Occupational HIV if:
  - the Accidental Exposure takes place prior to the effective date of coverage;
  - the Accidental Exposure takes place after coverage for the covered person ends;
  - the covered person tested HIV positive prior to the Accidental Exposure, unless the covered person tested positive on an HIV screening test and subsequently tested negative for HIV before the date of the Accidental Exposure; or
  - the covered person becomes HIV positive as a result of intravenous drug use or sexual transmission.
  - No benefits for Occupational HIV will be paid for an Accidental Exposure that takes place outside the United States.
  - Metlife will not pay for any cost incurred for HIV tests or any related testing.

General Exclusions

MetLife will not pay benefits for covered conditions caused by, contributed to by, or resulting from a covered person:

- participating in a felony, riot or insurrection;
- intentionally causing a self-inflicted injury;
- committing or attempting to commit suicide while sane or insane;
- voluntarily taking or using any drug, medication or sedative unless it is:
  - taken or used as prescribed by a physician; an "over the counter" drug, medication or sedative taken according to package directions;

- engaging in an illegal occupation; or
- serving in the armed forces or any auxiliary unit of the armed forces of any country
- arising from war or any act of war, even if war is not delcared.

MetLife will not pay benefits for any covered condition for which diagnosis is made outside the United States unless the diagnosis is confirmed in the United States, in which case the covered condition will be deemed to occur on the date the diagnosis is made outside the United States.

Exclusion for Intoxication

- MetLife will not pay benefits for any covered condition that is caused by, contributed to by, or results from a covered person's involvement in an incident, where such covered person is intoxicated at the time of the incident and is the operator of a vehicle involved in the incident.
- Intoxicated means that the covered person's alcohol level met or exceeded the level that creates a legal presumption of intoxication under the laws of the jurisdiction in which the incident happened.

Claim Provisions

Filing a Claim

The insured must begin the claim process:

- within 30 days after a covered accident or
- as soon as reasonably possible by visiting **mybenefits.metlife.com** or calling 1-866-626-3705 and requesting a claim form.

Claim Forms

When MetLife receives notice of a claim, MetLife will send you a claims packet with forms to be completed and signed by you and your physician. You may return all necessary information to MetLife via fax (1-855- 306-7350) or mail to:

Metropolitan Life Insurance Company
Attn: Critical Illness Insurance Product
P.O. Box 80826
Lincoln, NE 68501-0826

Claim Review, Processing and Decision

Once a claim is set up, the claims examiner:

1. Validates eligibility and premium payments are current.
2. Reviews information to ensure no additional information is necessary.
   a. If additional information is needed, the claimant will be mailed a letter and the examiner will call them directly. They will ask for the details required to continue the review.
   b. MetLife will then request the necessary medical information from your doctor to make a claim determination.
3. The examiner will make a claim decision.
4. They will notify claimant of decision in writing.
   a. The claimant may also check on status via MyBenefits (**https://mybenefits.metlife.com**) or call customer service (1-866-626-3705).
5. MetLife will issue benefits if claim approved.
   a. Claimant can receive the claim amount from:
      i. MyBenefits (**https:// mybenefits.metlife.com**, claims section, under specific product) or customer service (1-866-626-3705).
      ii. Direct Deposit (if they filled out their bank information on the claim form they received in their packet).
6. If claim is denied, you will be sent a letter. MetLife will include the denial and appeals process within the letter for next steps.

Physical Examination and Autopsy

MetLife may have an insured examined as often as reasonably necessary while a claim is pending. In the case of death, MetLife may also require an autopsy, unless prohibited by law. MetLife will cover all costs for exams or autopsy.

Legal Action

The insured cannot take legal action against MetLife for benefits under this policy:

- Within 60 days after the insured has sent MetLife written proof of loss; or
- More than 3 years from the time written proof is required to be given.

Benefits Schedule

The face amount of your benefit election, either $15,000 or $30,000, is payable for the following employee or spouse critical illnesses:

BENEFITS SCHEDULE		
Covered Illness*	Low Amount ($15,000)	High Amount ($30,000)
Cancer (internal or invasive)	100%	100%
Heart Attack	100%	100%
Kidney Failure	100%	100%
Major Organ Transplant	100%	100%
Stroke	100%	100%
Occupational HIV	100%	100%
Coronary Artery Bypass Graft	100%	100%
Carcinoma in Situ**	25%	25%

* Benefits are paid for covered dependent children at 50% of the employee benefit amount. The benefit is payable for a spouse only if dependent critical illness coverage was elected.

**When this partial benefit is paid, it will reduce the cancer benefit by 25%.

Additional Benefits

- Health Screening Benefit Amount: $50 per insured employee or spouse per calendar year.

HOSPITAL INDEMNITY

Overview

Hospital indemnity insurance through MetLife helps you cover your out-of-pocket expenses (like deductibles and coinsurance) when you are admitted to the hospital.

The Hospital Indemnity policy pays benefits directly to you when you have an eligible hospital stay.

Insureds are defined as those who might be eligible for coverage in the following categories under this policy:

- Employee Coverage
- Employee and Spouse Coverage
- Employee and Child(ren) Coverage
- Employee and Family Coverage

Accident – Hospital Admission Benefit

If a covered person is admitted to a hospital for treatment of an injury, MetLife will pay the accident-hospital admission benefit that applies to the type of hospital admission, subject to all of the following:

- In order for the accident – hospital admission benefit to be payable, admission must occur within 180 days after the accident occurs.
- This benefit does not apply to emergency room treatment, outpatient treatment, or a stay of less than 20 hours in an observation area.
- MetLife will only pay one accident – hospital admission benefit per covered person, per accident. If the covered person moves from or to an ICU after initial admission to a hospital, MetLife will not pay an additional accident – hospital admission benefit.

Accident – Hospital Confinement Benefit

If a covered person is confined in a hospital for treatment of an injury, MetLife will pay the accident-hospital confinement benefit that applies to the type of hospital confinement for each day the covered person is confined in the hospital, subject to all of the following:

- In order for the accident – hospital confinement benefit to be payable, the initial confinement must begin within 180 days after the accident occurs.
- For a non-ICU hospital confinement, the accident – hospital confinement benefit is payable for up to 180 days per covered person, per accident, and may be used over a two-year period following the date of the accident.
- For an ICU confinement, the accident – hospital confinement benefit is payable for up to 30 days per covered person, per accident, and may be used over a two-year period following the date of the accident.
- MetLife will pay the accident – hospital confinement benefit for only one hospital confinement at a time, even if the confinement is caused by more than one accident.
- MetLife will only pay one accident – hospital confinement benefit per day. If the covered person has a non-ICU hospital confinement and an ICU confinement on the same day, MetLife will only pay the accident – hospital confinement benefit that applies to ICU confinement.
- If a covered person exhausts the accident – hospital confinement benefit that applies to confinement in an ICU and remains confined in an ICU, the covered person may still be eligible for the accident – hospital confinement benefit that applies to a non-ICU hospital confinement.

Sickness – Hospital Benefits

Pre-Existing Condition Limitation

Preexisting condition means a sickness for which, in the 12 months before a covered person becomes insured , medical advice, treatment or care was sought by the covered person, or, was recommended by, prescribed by or received from a physician.

MetLife will not pay any benefits for sickness caused by or resulting from a preexisting condition if the sickness occurs during the first 12 months that the covered person is insured.

Pregnancy is a "pre-existing condition" if conception was before the effective date of coverage.

Sickness – Hospital Admission Benefit

If a covered person is admitted to a hospital for treatment of a sickness, MetLife will pay the benefit that applies to the type of hospital admission, subject to all of the following:

- This benefit does not apply to emergency room treatment, outpatient treatment, or a stay of less than 20 hours in an observation unit.
- MetLife will only pay one sickness – hospital admission benefit per covered person, per sickness. If the covered person moves from or to ICU after initial admission to a hospital, MetLife will not pay an additional sickness – hospital admission benefit.
- MetLife will pay the sickness – hospital admission benefit no more than 1 time per covered person, per calendar year.

Sickness – Hospital Confinement Benefit

If a covered person is confined in a hospital for treatment of a sickness, MetLife will pay the sickness – hospital confinement benefit that applies to the type of hospital confinement for each day the covered person is confined in the hospital for treatment of a sickness, subject to all of the following:

- For a non-ICU hospital confinement, the sickness – hospital confinement benefit is payable for up to 180 days per covered person, per sickness.
- For an ICU confinement, the sickness – hospital confinement benefit is payable for up to 30 days per covered person, per sickness.

- MetLife will pay the sickness – hospital confinement benefit for only one hospital confinement at a time, even if the confinement is caused by more than one sickness.
- MetLife will only pay one sickness – hospital confinement benefit per day. If the covered person has a non-ICU hospital confinement and an ICU confinement on the same day, MetLife will only pay the sickness – hospital confinement benefit that applies to ICU confinement.
- If a covered person exhausts the sickness – hospital confinement benefit that applies to confinement in an ICU and remains confined in an ICU, the covered person may still be eligible for the sickness – hospital confinement benefit that applies to a non-ICU hospital confinement.

Additional Limitation

If a covered person is confined for both an injury and sickness at the same time, MetLife will only pay benefits for the admission and confinement under the accident – hospital benefits. In this case, if the covered person exhausts the benefits under the accident – hospital benefit for hospital confinement and remains confined for treatment of a sickness, the covered person may still be eligible for the sickness – hospital confinement benefit.

Exclusions

MetLife will not pay benefits for loss caused by pre-existing conditions (except as stated in the previous provision). These exclusions apply to the employee, spouse and covered children.

MetLife will not pay benefits for loss contributed to, caused by, or resulting from:

- the covered person's voluntary use, by any means, of:
  - any drug, medication or sedative, unless it is:
    - taken or used as prescribed by a physician; or
    - an "over the counter" drug, medication or sedative taken as directed;
  - alcohol in combination with any drug, medication, or sedative; or
  - poison, gas, or fumes;
- the covered person's suicide or attempted suicide (while sane or insane);
- the covered person's intentionally self-inflicted injury;
- war, whether declared or undeclared; or act of war;
- the covered person's active participation in an insurrection, rebellion, riot, or terrorist act;
- the covered person's engagement in any activity that constitutes a felony under the laws of the jurisdiction in which the activity occurred;
- dental or plastic surgery for cosmetic purposes, except when such surgery is performed to:
  - treat an injury or sickness;
  - correct a disorder of normal bodily function or structure that was caused by a injury or sickness for which coverage is not otherwise excluded; or
  - reconstruct a part of the body which was disfigured or removed as a result of an injury for which coverage is not otherwise excluded;
- the covered person's mental illness, or the diagnosis or treatment of such mental illness, except for the covered person's use of:
  - any drug, medication or sedative that is taken or used as prescribed by a physician; or
  - an "over the counter" drug, medication or sedative taken as directed;
- activities required by the covered person's service in the armed forces or any auxiliary unit of the armed forces of any country or international authority;

Related to accident exclusions only, not sickness:

- the covered person's infection, other than infection occurring in an external wound resulting from an Injury;
- food poisoning;
- the covered person's operation, while intoxicated, of a motor vehicle involved in the incident. For purposes of this exclusion:
  - intoxicated means that the Insured's blood alcohol level met or exceeded .08%; and
  - motor vehicle means any vehicle that is powered by a motor, including, but not limited to: an automobile; a boat; a motorcycle; a truck; an all terrain vehicle; or a snow mobile;
- the covered person's travel or flight in any aircraft except as a farepaying passenger on a regularly scheduled charter or commercial flight;
- the covered person parachuting or otherwise exiting from a motorized or non-motorized aircraft while such aircraft is in flight, except for self-preservation;
- the covered person riding in or driving any motor-driven vehicle in a race, stunt show or speed test;
- the covered person participating in any semi-professional or professional competitive athletic activity for which any type of compensation or remuneration is received; or
- the covered person bungee jumping, base jumping, hang gliding, para-kiting, sail-gliding, scuba diving deeper than 130 feet; spelunking; or mountaineering including rock climbing using ropes and any other climbing equipment. For the purposes of this exclusion the term mountaineering does not include backpacking, mountain biking, hiking or trail running.

In addition, MetLife will not pay benefits for:

- a covered person while incarcerated in any type of penal or detention facility;
- any hospital admission or confinement outside the United States, Canada or Mexico; or
- routine nursing or well baby care for a newborn child.

Claim Provisions

Filing a Claim

The insured must begin the claim process:

- within 30 days after a hospital admission or confinement or
- as soon as reasonably possible

by visiting **mybenefits.metlife.com** or calling 1-866-626-3705 and requesting a claim form.

Claim Forms

When MetLife receives notice of a claim, MetLife will send you a claims packet with forms to be completed and signed by you and your physician. You may return all necessary information to MetLife via fax (1-855-306-7350) or mail to:

Metropolitan Life Insurance Company
Attn: Hospital Indemnity Insurance Product
P.O. Box 80826
Lincoln, NE 68501-0826

Claim Review, Processing and Decision

Once a claim is set up, the claims examiner:

1. Validates eligibility and premium payments are current.
2. Reviews information to ensure no additional information is necessary.
   a. If additional information is needed, the claimant will be mailed a letter and the examiner will call them directly. They will ask for the details required to continue the review.
   b. MetLife will then request the necessary medical information from your doctor to make a claim determination.
3. The examiner will make a claim decision.
4. They will notify claimant of decision in writing.
   a. The claimant may also check on status via MyBenefits (https://mybenefits.metlife. com) or call customer service (1-866-626-3705).
5. MetLife will issue benefits if claim approved.
   a. Claimant can receive the claim amount from:
      i. MyBenefits (**https://mybenefits.metlife.com**, claims section, under specific product) or customer service (1-866-626-3705).
      ii. Direct Deposit (if they filled out their bank information on the claim form they received in their packet).
6. If claim is denied, you will be sent a letter. MetLife will include the denial and appeals process within the letter for next steps.

Benefit Schedule

Benefits Summary			
Benefit	Low Amount	High Amount	Maximum Days per Confinement
Hospital Confinement (Per Day)	$150	$250	180
Hospital Admission (Per Confinement)	$500	$1000	N/A
Hospital Intensive Care (Per Day)	$150	$250	30

GENERAL PROVISIONS

Misstatement of Age

If an age has been misstated, the correct age will be used to determine if insurance is in effect and as appropriate, MetLife will adjust the benefits and/or your payments.

Assignment

The benefits under this policy are not assignable, prior to a claim for benefits, except to a physician or other health care provider who provides health care services to you, or except as required by law.

Conformity with Law

Any policy provision that conflicts with state statutes where this policy was issued on its effective date is hereby amended to conform to the minimum requirements of those statutes.

When Coverage Ends

Your insurance will terminate on whichever occurs first:

- The date the group policy ends;
- The date you die;
- The end of the period for which the last full premium has been paid for you;
- The date your employment ends for any reason.

Insurance for a covered spouse or dependent child will terminate on the earliest of the listed above, or:

- The premium due date following the date the covered spouse or dependent child no longer qualifies as a dependent;
- The premium due date following the date the employee's online request to terminate coverage for a spouse or dependent child(ren).

In certain cases, insurance may be continued as stated in Continuation of Insurance with Premium Payment.

Continuation of Insurance with Premium Payment

When your employment ends with Texas Health Resources and your coverage would otherwise terminate, you may elect to continue your coverage under this policy. You may continue the coverage that you had on the date your employment ended, including any in-force spouse or dependent child coverage. Evidence of insurability will not be required to obtain continued insurance.

To keep your coverage in force, you must:

- Apply to MetLife in writing on a form approved by MetLife within 31 days after the date your insurance would otherwise terminate, and
- Pay the required premium to MetLife no later than 31 days after the date the coverage would otherwise end and on each premium due date thereafter.

Coverage will end on the earliest of the following dates:

- The date you die;
- 31 days after the date you fail to pay any required premium; or
- The date the group policy is terminated, whichever occurs first.

If you qualify for this continuation privilege, then MetLife will apply the same benefits, policy provisions, and premium rate as shown in your previously issued coverage.

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, Supplemental Plans, and Flexible Spending Account (FSA) Plans end when you:

- No longer meet the eligibility requirements (See page 5. Texas Health Medical, Dental, and Vision, Life, AD&D, and Disability coverages, as well as participation in FSA, end on the last day of the pay period in which you were in a benefits-eligible position.)*
- 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.

Employer contributions and your payroll deducted contributions to your Health Savings Account end on the last paycheck you receive for hours worked.

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 84.

* When your termination date falls on the first day of a pay period, your benefits will end on the last day of the previous pay period.

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 flexible 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 flexible 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/or 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 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.

Coverage termination due to non-payment while on leave is not considered a qualifying event to trigger a COBRA enrollment opportunity.

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 normally must notify Texas Health within 31 days after the event occurs. You generally have 60 days to elect COBRA coverage. Due to COVID-19, these deadlines have been extended until 60 days following the end of the declared national emergency caused by COVID-19 or one year from the date of your qualifying event, whichever is earlier. 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.

Notice to Human Resources includes creating a life event on **MyTHR.org**.

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 HealthEquity 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 on **MyTHR.org**) of your right to continue coverage. You should receive the paperwork to elect continuation coverage within 44 days of your qualifying event. Normally, 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.

Generally, COBRA enrollees have 45 days from their COBRA election to make the first premium payment, and subsequent monthly payments must be made within a 30-day grace period that starts at the beginning of each coverage month. The time period for paying premiums has been extended until 60 days following the end of the declared national emergency or one year following your qualifying event, whichever is earlier.

If you do not elect to continue coverage, 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.

HCFSA CONTINUATION

If you have the Health Care Flexible Spending Account (HCFSA) 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 HCFSA during Open Enrollment. If you elect to continue the Health Care Flexible 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 December 31 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)
- You 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 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, enrollment materials are mailed to the home of a COBRA participant explaining the plan changes beginning January 1 of the next year. Also included 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 the Texas Health Benefits Dept. by the deadline for open enrollment. Your new election will take effect on January 1. You may not re-enroll in a Health Care Flexible Spending Account.

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 30 days of the marriage, birth, or adoption.

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 (HealthEquity). 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 **DOL.gov/ebsa**. (The address and phone number of Regional and District EBSA Offices are available on the website.)

Separation Pay Plan (THR Employees excluding THPG and Urgent Care Staff)

OVERVIEW

The Texas Health Separation Pay Plan is designed to provide benefits to eligible employees who are involuntarily terminated due to job elimination as a result of outsourcing all or part of a department, division, operating unit, or function; closing all or part of an entity, department, division operating unit or function; restructuring all or part of an entity, department or division, operating unit or function; so other changes as Texas Health may designate from time to time. This is a summary of the Plan. If there is a conflict between this summary and the actual Plan document, the Plan document will govern.

WHO IS ELIGIBLE

The Separation Pay Plan applies to full and part-time benefits-eligible employees (as defined in the Employee Handbook) of Texas Health Resources wholly-owned entities whose positions are eliminated. The plan for THPG Clinic Practice Staff and Urgent Care Staff can be found on pages 206 – 208. PRN and part-time benefits-ineligible employees, administrative residents/interns/fellows, medical directors, medical residents/interns/fellows, THPG/THBC physicians, employees hired as a direct result of a research or educational grant, and employees under contract are not eligible for the Plan. Employee status, base pay, standard hours 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. Employees who are terminated for cause (such as poor performance or policy violation) are not 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, if you are not a director or officer, you will be given a minimum of 30 calendar days' notice before your position is eliminated. During this period, 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. However, you may be given a notice period in which case you must actively search for other positions within Texas Health during the notice period to be eligible for separation pay.

In certain situations, with the approval of the Chief People Officer, 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 notice period, you will not be entitled to separation pay or pay for the remainder of the notice period.

REASONABLE OFFER

If, during the notice period, you fail to actively apply for full-time or part-time positions for which you are qualified and that could result in a reasonable offer or refuse or decline one reasonable offer from a wholly-owned Texas Health facility or an acquiring employer, you will be treated as having voluntarily separated and will not be eligible for separation pay.

A reasonable offer means an offer from a Texas Health wholly owned entity which the employee meets minimum qualifications of the position (some additional training may be necessary) and the base pay (as defined below) for the new position is 95% or more of the base pay 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 the employee's benefits status. A reasonable offer may also include a shift change, schedule change, change in benefits status, or reassignment to a different department or operating unit if that operating unit is located no more than 35 miles from the employee's current work location. An employee's current work location for purposes of the Plan is defined as the location where 60% of their time is recorded.

An "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.

If you accept a position from Texas Health that is not a reasonable offer as defined in the Plan, you will not be eligible for separation pay but may be eligible for transition pay. Transition pay is a percentage of the separation pay you would have received if you had not accepted a position. The percentage is determined by a fraction:

- The numerator is the difference between:
  - The eliminated position hourly rate times the eliminated position standard hours
  - The new position hourly rate times new position standard hours.
- The denominator is the eliminated position hourly rate times the eliminated position standard hours.

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 will begin with the payroll period in which you begin in the new position. 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 you change to a position that would have been a reasonable offer at the time of your position elimination during the six month period, you will stop receiving transition pay effective as of the first day of the payroll period that includes the change in position.

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.

Employees are expected to actively pursue reasonable opportunities for which they are qualified. If, during the notice period, an employee fails to, does not or refuses to interview for open positions with Texas Health or an acquiring employer, he or she will not be eligible for separation pay.

Employees who continue working through their 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. The Career Center can assist employees in identifying job opportunities for which they may be qualified.

If requested, the Chief People Officer may, in her discretion, elect to pay separation pay in lieu of providing an employee with notice or requiring the employee to actively pursue a job.

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 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, including a protected leave of absence, your position may be eliminated or terminated for business reasons.

A "protected leave of absence" is an approved military leave, ADA or Family Medical Leave Act (FMLA) 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 from a Texas Health wholly owned entity or an acquiring employer. 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 range, Texas Health's compensation guidelines concerning lateral or promotional transfers will apply.
- If an employee accepts a position that is in a lower salary range, 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 notice period or
- Receive one reasonable offer from Texas Health or
- Receive a reasonable offer from an acquiring employer.

If you meet all the requirements of the Separation Pay Plan, you will be entitled to separation pay according to the table below.

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 (standard hours). Base Pay does not include differentials, bonuses, overtime, or commissions. Title is based on EEO category in the HR/payroll system.

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 Texas Health. 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 Texas Health's "Bridging of Service Policy" and the employee has not previously received separation pay from Texas Health for that service. The EVP, Chief People Officer must approve all exceptions to the years of service calculation. This determination will be at the discretion of the EVP, Chief People Officer.

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.

The employee will have seven (7) days to revoke the release once signed. 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.

Separation Pay

Position Defined by Title	Weeks of Base Pay Earned Per Year of Service	Minimum Number of Weeks of Base Pay per Year of Service	Maximum Number of Weeks of Base Pay per Year of Service
Staff	1	2	12
Managers	2	2	26
Directors	6	13	39
Executives	8	26	52

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 Chief People Officer 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 Chief People Officer.

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.

Separation Pay Plan (THPG Clinic Practice and Urgent Care Staff)

OVERVIEW

The Texas Health Separation Pay Plan is designed to provide benefits to eligible employees who are involuntarily terminated due to job elimination as a result of outsourcing all or part of a department, division, operating unit, or function; closing all or part of an entity, department, division operating unit or function; restructuring all or part of an entity, department or division, operating unit or function; so other changes as Texas Health may designate from time to time. This is a summary of the Plan. If there is a conflict between this summary and the actual Plan document, the Plan document will govern.

WHO IS ELIGIBLE

The Separation Pay Plan applies to full and part-time benefits-eligible employees (as defined in the Employee Handbook) of Texas Health Resources wholly-owned entities whose positions are eliminated. This section applies to THPG Clinic Practice Staff and Urgent Care Staff. The plan for non-THPG employees can be found on pages 202 – 205. PRN and part-time benefits-ineligible employees, administrative residents/interns/fellows, medical directors, medical residents/interns/fellows, THPG physicians, employees hired as a direct result of a research or educational grant, and employees under contract are not eligible for the Plan. Employee status, base pay, standard hours 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. Employees who are terminated for cause (such as poor performance or policy violation) are not 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, if you are not a director or officer, you will be given a minimum of 30 calendar days' notice before your position is eliminated. During this period, 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. However, you may be given a notice period in which case you must actively search for other positions within Texas Health during the notice period to be eligible for separation pay.

In certain situations, with the approval of the Chief People Officer, 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 notice period, you will not be entitled to separation pay or pay for the remainder of the notice period.

REASONABLE OFFER

If, during the notice period, you fail to actively apply for full-time or part-time positions for which you are qualified and that could result in a reasonable offer or refuse or decline one reasonable offer from a wholly-owned Texas Health facility or an acquiring employer, you will be treated as having voluntarily separated and will not be eligible for separation pay.

A reasonable offer means an offer from a Texas Health wholly owned entity which the employee meets minimum qualifications of the position (some additional training may be necessary) and the base pay (as defined below) for the new position is 95% or more of the base pay 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 the employee's benefits status. A reasonable offer may also include a shift change, schedule change, change in benefits status, or reassignment to a different department or operating unit if that operating unit is located no more than 35 miles from the employee's current work location. An employee's current work location for purposes of the Plan is defined as the location where 60% of their time is recorded.

An "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.

If you accept a position from Texas Health that is not a reasonable offer as defined in the Plan, you will not be eligible for separation pay but may be eligible for transition pay. Transition pay is a percentage of the separation pay you would have received if you had not accepted a position. The percentage is determined by a fraction:

- The numerator is the difference between:
  - The eliminated position hourly rate times the eliminated position standard hours
  - The new position hourly rate times new position standard hours.
- The denominator is the eliminated position hourly rate times the eliminated position standard hours.

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 will begin with the payroll period in which you begin in the new position. 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 you change to a position that would have been a reasonable offer at the time of your position elimination during the six month period, you will stop receiving transition pay effective as of the first day of the payroll period that includes the change in position.

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.

Employees are expected to actively pursue reasonable opportunities for which they are qualified. If, during the notice period, an employee fails to, does not or refuses to interview for open positions with Texas Health or an acquiring employer, he or she will not be eligible for separation pay.

Employees who continue working through their 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. The Career Center can assist employees in identifying job opportunities for which they may be qualified.

If requested, the Chief People Officer may, in her discretion, elect to pay separation pay in lieu of providing an employee with notice or requiring the employee to actively pursue a job.

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 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, including a protected leave of absence, your position may be eliminated or terminated for business reasons.

A "protected leave of absence" is an approved military leave, ADA or Family Medical Leave Act (FMLA) 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 from a Texas Health wholly owned entity or an acquiring employer. 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 range, Texas Health's compensation guidelines concerning lateral or promotional transfers will apply.
- If an employee accepts a position that is in a lower salary range, 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 notice period or
- Receive one reasonable offer from Texas Health or
- Receive a reasonable offer from an acquiring employer.

THPG Clinic Practice Staff who meet all the requirements of the Separation Pay Plan will be entitled to two (2) weeks of separation pay.

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 (standard hours). Base Pay does not include differentials, bonuses, overtime, or commissions. Title is based on EEO category in the HR/payroll system.

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 Texas Health. 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 Texas Health'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.

The employee will have seven (7) days to revoke the release once signed. 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 Chief People Officer 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 Chief People Officer.

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.

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 149) 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 Governance 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 214) 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 be written in a way that is calculated to be understood by you and in a culturally and linguistically appropriate manner. The decision will include:

- the specific reason or reasons for the denial of benefits;
- a specific reference to the pertinent provisions of the Plan upon which the denial is based;
- a description of any additional material or information that is necessary for you to perfect the claim and an explanation of why such material or information is necessary;
- a discussion of the decision, including an explanation of the basis for disagreeing with or not following:
  - the views you presented to the Plan of health care professionals treating you and vocational professionals who evaluated you;

  - the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and
  - a disability determination regarding you presented by you to the Plan made by the Social Security Administration;
- if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request;
- an explanation of the Plan's review procedures and the time limits applicable to such procedures, as provided below, including a statement of your right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974, as amended, following an adverse benefit determination on review;
- if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion, or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the plan do not exist;
- a statement that you is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.

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.

The review shall not afford deference to the initial adverse benefit determination and shall be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of that individual.

If the adverse benefit determination is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional will be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual. Any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination will be identified upon written request by you or your authorized representative, without regard to whether the advice was relied upon in making the benefit determination.

The decision shall be in writing and shall set forth, in a manner calculated to be understood by you and in a culturally and linguistically appropriate manner:

- the specific reason or reasons for the denial of benefits;
- a specific reference to the pertinent provisions of the Plan upon which the denial is based;
- a statement that you is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits;
- a statement describing any voluntary appeal procedures offered by the plan and your right to obtain the information about such procedures described in paragraph (c)(3)(iv) of this section, and a statement of your right to bring an action under section 502(a) of the Act, including any applicable contractual limitations period that applies to your right to bring such an action and the calendar date on which the contractual limitations period expires for the claim;

- a discussion of the decision, including an explanation of the basis for disagreeing with or not following:
  - the views presented by you to the Plan of health care professionals treating you and vocational professionals who evaluated you;
  - the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and
  - a disability determination regarding you presented by you to the Plan made by the Social Security Administration;
- if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request;
- an explanation of your right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974, as amended, following an adverse benefit determination on review.

Before the Plan can issue an adverse benefit determination on review on a claim based on disability, the Plan Administrator will:

1. provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the plan, insurer, or other person making the benefit determination (or at the direction of the plan, insurer or such other person) in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided hereunder to give you a reasonable opportunity to respond prior to that date; and
2. provide you, free of charge, with the rationale as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give you a reasonable opportunity to respond prior to that date.

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 216 – 217.

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 63 – 72, 98 – 100, 103 – 104 and 211 – 213, 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.

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 these 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 Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory
- The Division of Technical Assistance and Inquiries, Employee Benefits Security 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 Governance Committee, under the authority granted to it by the Board of Trustees, has the sole authority to adopt and/or amend benefit plans. The Governance 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 Governance Committee acts on behalf of Texas Health in its capacity as plan administrator. The Governance Committee can be reached at:

Governance Committee
Attn: Chief People Officer
Texas Health
612 E. Lamar Blvd., Suite 900
Arlington, Texas 76011
682-236-7900

Members of the Governance Committee are appointed by the Board of Trustees of Texas Health. The current members of the Governance Committee are:

- Charles John Wilder, Jr.

  200 Crescent Court, Suite 1900
  Dallas, TX 75201

- W. Dennis Stripling, M.D.

  612 E. Lamar Blvd., Suite 400
  Arlington, TX 76011

- Lynn Montgomery

  3707 Camp Bowie Blvd.
  Fort Worth, TX 76107

- Hunter L. Hunt

  1900 North Akard Street
  Dallas, TX 75201

- Richard M. Vigness, M.D.

  1307 8th Ave. #601
  Fort Worth, TX 76104

- James Wynne

  612 E. Lamar Blvd., Suite 400
  Arlington, TX 76011

- Michael Guyton

  612 E. Lamar Blvd., Suite 400
  Arlington, TX 76011

The Governance 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 Governance 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.

Committee are:

- Charles John Wilder, Jr.

  200 Crescent Court, Suite 1900
  Dallas, TX 75201

- W. Dennis Stripling, M.D.

  612 E. Lamar Blvd., Suite 400
  Arlington, TX 76011

- Lynn Montgomery

  3707 Camp Bowie Blvd.
  Fort Worth, TX 76107

- Hunter L. Hunt

  1900 North Akard Street
  Dallas, TX 75201

- Richard M. Vigness, M.D.

  1307 8th Ave. #601
  Fort Worth, TX 76104

- James Wynne

  612 E. Lamar Blvd., Suite 400
  Arlington, TX 76011

- Michael Guyton

  612 E. Lamar Blvd., Suite 400
  Arlington, TX 76011

Agent for Service of Legal Process

Texas Health Resources
Ken Kramer, 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				
• Texas Health Aetna	501	Self-funded medical plans[1]	Self-funded	Texas Health Aetna[2]
• UHC Choice and Choice Plus	501	Self-funded medical plans[1]	Self-funded	UnitedHealthcare[2]
• CVS Caremark	501	Self-funded[1]	Self-funded	CVS Caremark[2]
Be Healthy	501	Wellness	Funded by company	UnitedHealthcare
Employee Assistance Program (EAP)	501	Employee Assistance Program	Funded by company	Texas Health Resources
Texas Health Dental Plan • Aetna® Managed Dental Plan (DMO®) • Aetna PDN (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]
Texas Health Vision Plan	514	Fully insured vision plan through National Guardian Life Insurance Company	Premiums are paid by employee contributions	Superior Vision
Texas Health Short Term Disability Plan	503	Fully insured disability plan	Premiums are paid by employee contributions	Prudential

[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 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	Prudential
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	Prudential[3] Life Insurance Company of North America (BTA)[3]
Texas Health Flexible Benefits Plan	506	Self-funded cafeteria plan, Health Care Flexible Spending Account, and Day Care Flexible Spending Account	Funded by employee contributions	HealthEquity
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
Texas Health Supplemental Plans	509	Supplemental Plans	Funded by employee contributions	MetLife

[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. Fidelity Investments 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 Fidelity Investments. 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 pages 61 – 63 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:	10/13/2020
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, health care flexible spending account plans, and the Health Savings Account. In 2021, the medical TPAs are Texas Health Aetna and UnitedHealthcare. The dental TPA is Aetna, the vision TPA is Superior Vision, the health care flexible spending account TPA is HealthEquity, and the Health Savings Account TPA is also HealthEquity.

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 flexible 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. The GHP will not use or disclosure your health information without written authorization, except as described in this Notice. Use or disclosure pursuant to this Notice may include electronic transfer of your health information.

Your Health Information Rights

If you are a participant in Texas Health's medical, dental, vision, or health care flexible 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, such as when it is determined that compliance with the restriction cannot be guaranteed
- Request, by written authorization, to inspect or obtain a copy of your health information as provided by the law
- Request, in writing, that your health information be amended, as provided by the law, 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.
- Request, in writing, to obtain an accounting of disclosures or a report of who has accessed of your health information, as provided by the law
- 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 (**BeHealthyTHR.org**) 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

Unless you give notice of an objection, and in accordance with your agreement, your health information about your location or condition may be used or disclosed to a family member or other person who is responsible for your care or who helps you pay for your care. 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. You will be given an opportunity to agree or object to these disclosures, except as due to your incapacity or in emergency circumstances.

Disclosures Required by Law or Otherwise Allowed Without Authorization or Notification

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.

Breach Notification

In certain instances, you have the right to be notified in the event that the GHP, or one of its business associates, discloses an inappropriate use or disclosure of your health information. Notice of any such use or disclosure will be made as required by state and federal law.

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. Specific examples of uses or disclosures requiring authorization include: use of psychotherapy notes, marketing activities, and some types of sale of your health information.

Your genetic information cannot be used or disclosed for underwriting purposes except for the long term care policy.

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 1-866-35-HIPAA (1-866-354-4722).

Effective Date

April 14, 2003
Updated January 2014

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, the state of Texas may have a premium assistance program that can help pay for coverage using funds from their Medicaid or CHIP programs.

If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

You may be eligible for assistance paying your employer health plan premiums. Contact your State for more information on eligibility.

Website: http://chipmedicaid.org
Phone: 1-877-541-7905

For more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

NOTICE REGARDING WELLNESS PROGRAM

Be Healthy is a voluntary wellness program available to benefits-eligible employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the *Be Healthy* program, you will be asked to complete a voluntary health check survey that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete a biometric screening, which will include a blood test in regard to blood glucose and LDL cholesterol. You are not required to complete the health check survey or to participate in the blood test or other medical examinations.

However, employees who choose to participate in the *Be Healthy* program will receive an incentive of $75 for completion of the health check survey and up to $520 in premiums credits for completion of the biometric screening (or completion of a reasonable alternative). Although you are not required to complete the health check or participate in the biometric screening, only employees who do so will receive the incentive.

If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting the Texas Health Benefits department at 1-877-MyTHRLink (877-698-4754), prompt 9.

The information from your health check and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and Texas Health may use aggregate information it collects to design a program based on identified health risks in the workplace, *Be Healthy* will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information include doctors, nurses, Employee Health, applicable and need-to-know third-party vendors, and health coaches in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact the Texas Health Benefits department at 1-877-MyTHRLink (877-698-4754), prompt 9.

DISCRIMINATION IS AGAINST THE LAW

Texas Health Resources complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Texas Health does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Texas Health:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Jeanette Oliveros.

If you believe that Texas Health has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Jeanette Oliveros
Civil Rights Coordinator
612 E. Lamar Blvd. Suite 400
Arlington TX 76011
682-236-7555
JeanetteOliveros@texashealth.org

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Jeanette Oliveros, Civil Rights Coordinator, is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue
SW Room 509F, HHH Building
Washington, D.C. 20201

1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at **hhs.gov/ocr/office/file/index.html**.

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.

Autism Spectrum Disorder: A condition marked by enduring problems communicating and interacting with others, along with restricted and repetitive behaviors, interests or activities.

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.

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.

Cellular Therapy: Administration of living whole cells into a patient for the treatment of disease.

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. The claims administrator 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 $30 for an office visit to your primary physician or family doctor. Medical 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 use disorder, 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 **TexasHealthAetna.com** or **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 **TexasHealthAetna.com** and **UnitedHealthcareOnline.com**. 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.

Definitive Drug Test: Test to identify specific medications, illicit substances and metabolites and is qualitative or quantitative to identify possible use or non-use of a drug.

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.

Eligible Expenses: For covered health services incurred while the plan is in effect. Eligible expenses are determined in accordance with the claim's administrator's reimbursement policy guidelines. The claims administrator develops the reimbursement policy guidelines, in the claims administrator's discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association, and/or the Centers for Medicare and Medicaid Services (CMS);
- As reported by generally recognized professionals or publications;
- As used for Medicare; or
- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that the claims administrator accepts.

Emergency: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:

- Placing the health of the covered person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

EOB: See Explanation of benefits.

Experimental or investigational services: Medical, surgical, diagnostic, psychiatric, mental health, substance-related and addictive disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time the claims administrator makes a determination regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use (Devices which are FDA approved under the Humanitarian Use Device exemption are not considered to be experimental or investigational.)
- The subject of an ongoing clinical trial that meets the definition of a Phase I, II, or III Clinical Trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

Exceptions:

- Clinical trials for which benefits are available.
- If you are not a participant in a qualifying clinical trial and have a sickness or condition that is likely to cause death within one year of the request for treatment, the claims administrator and Texas Health Resources may, at their discretion, consider an otherwise experimental or investigational service to be a covered health service for that sickness or condition. Prior to such consideration, the claims administrator and Texas Health Resources must determine that, although unproven, the service has significant potential as an effective treatment for that sickness or condition.

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.

Gene Therapy: Therapeutic delivery of nucleic acid (DNA or RNA) into a patient's cells as a drug to treat a disease.

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 tables on pages 23 – 31. 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: Physical illness, disease or pregnancy. Includes mental illness, or substance-related and addictive disorders, regardless of the cause or origin of the mental illness, or substance-related and addictive disorder.

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 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.

Intensive Behavioral Therapy (IBT): Outpatient behavioral/educational services that aim to reinforce adaptive behaviors, reduce maladaptive behaviors, and improve the mastery of functional age-appropriate skills in people with Autism Spectrum Disorders. Examples include Applied Behavior Analysis (ABA), The Denver Model, and Relationship Development Intervention (RDI).

Intensive outpatient treatment: A structured outpatient mental health or substance-related and addictive disorders treatment program that may be free-standing or hospital-based and provides services for at least three hours per day, two or more days per week.

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.

Medically necessary: health care services that are all of the following as determined by the claims administrator or its designee, within the claims administrator's sole discretion.

- in accordance with Generally Accepted Standards of Medical Practice;

- clinically appropriate, in terms of type, frequency, extent, service site and duration, and considered effective for your sickness, injury, mental illness, substance-related and addictive disorders disease or its symptoms;
- not mainly for your convenience or that of your doctor or other health care provider; and
- not more costly than an alternative drug, service(s), service site, or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your sickness, injury, disease or symptoms.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on physician specialty society recommendations or professional standards of care may be considered. The claims administrator reserves the right to consult expert opinion in determining whether health care services are medically necessary. The decision to apply physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within the claims administrator's sole discretion.

The claims administrator develops and maintains clinical policies that describe the *Generally Accepted Standards of Medical Practice* scientific evidence, prevailing medical standards and clinical guidelines supporting its determinations regarding specific services. These clinical policies (as developed by the claims administrator and revised from time to time), are available to covered persons on **TexasHealthAetna.com**, **MyUHC.com** or by calling the number on your ID card, and to physicians and other health care professionals on **Unitedhealthcareonline.com**.

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 use disorder dependency or addiction.

Mental health/substance use disorder administrator: a representative from the claims administrator that provides coordination of care and referrals to providers for mental health services benefits and substance use disorder services.

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.

National Advantage Program (NAP): A program in which providers can choose to participate. Texas Health Aetna contracts with third-party vendor networks of health care professionals and facilities. When members visit providers in these vendor networks, they can get negotiated rates for certain out-of-network services.

Not all non-participating providers have a NAP agreement. Texas Health Aetna's goal is to help a member become whole when possible. There are other ways that Texas Health Aetna attempts to negotiate with out of network providers when a contracted rate is not available i.e. Facility Claim Review(FCR).

Network: A group of physicians, hospitals, pharmacies, and other medical service providers who have agreed to provide discounted fees for their services.

Non-Medical 24-Hour Withdrawal Management: An organized residential service, including those defined in American Society of Addiction Medicine (ASAM), providing 24-hour supervision, observation, and support for patients who are intoxicated or experiencing withdrawal, using peer and social support rather than medical and nursing care.

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 226) 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 network.

Out-of-pocket maximum: The highest or total amount of costs in a year that you will pay towards covered healthcare services.

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 24 hours per week.

Pharmaceutical product: U.S. Food and Drug Administration (FDA)-approved prescription medications or products administered in connection with a Covered Health Service by a Physician.

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.

Presumptive Drug Test: Test to determine the presence or absence of drugs or a drug class in which the results are indicated as negative or positive result.

Primary physician: A network physician who specializes in general practice, obstetrics/gynecology, 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.

PRN employee: An employee of Texas Health Resources who is classified in the HR/Payroll system as benefits-ineligible and does not have a set number of hours per week.

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.

Shared Savings Program: a program in which UnitedHealthcare may obtain a discount to a non-Network provider's billed charges. This discount is usually based on a schedule previously agreed to by the non-network provider. When this happens, you may experience lower out-of-pocket amounts. Plan coinsurance and deductibles would still apply to the reduced charge. Sometimes plan provisions or administrative practices conflict with the scheduled rate, and a different rate is determined by UnitedHealthcare. In this case the non-Network provider may bill you for the difference between the billed amount and the rate determined by UnitedHealthcare. If this happens you should call the number on your ID Card. Shared Savings Program providers are not network providers and are not credentialed by UnitedHealthcare.

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 use disorder services: Covered health services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded. The fact that a disorder is listed in the *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a covered health service.

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: Care that requires prompt attention to avoid adverse consequences, but does not pose an immediate threat to a person's life. Urgent care is usually delivered in a walk-in setting and without an appointment. Urgent care facilities are a location, distinct from a hospital emergency department, an office or a clinic. The purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.

Urgent care clinic or center: A facility that provides covered health services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen sickness, injury, or the onset of acute or severe symptoms.

Virtual visit: For the purposes of this Handbook, a virtual visit is a visit to provide medical information in real-time between a patient and a provider through use of interactive audio with video communications or audio-only equipment outside of a medical facility (for example, from home or from work).

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.

UTSW entity: William P. Clements Jr. University Hospital and Zale Lipshy University Hospital

2021 Cost of Coverage

The tables below and on the following page show your benefit costs **per pay period.** Premiums will be deducted from 26 pay periods. Following is your cost per pay period for medical coverage. Remember to deduct your wellness credits from the medical costs shown below (see page 77 for more information).

Medical Coverage with Low Rx and High Rx (Paid Before Tax)[1]

PLAN NAME	Employee Only		Employee + Spouse		Employee + Child(ren)		Employee + Family	
	YOU PAY	Texas Health Pays	YOU PAY	Texas Health Pays	YOU PAY	Texas Health Pays	YOU PAY	Texas Health Pays
Full-Time Employees Who Earn Less Than $25,000								
Texas Health Aetna Select 1000/Low Rx	**$24.08**	$320.63	**$73.85**	$650.04	**$50.42**	$594.20	**$95.61**	$928.18
Texas Health Aetna Select 1000/High Rx	**$24.85**	$327.13	**$79.97**	$659.19	**$53.11**	$605.10	**$107.31**	$938.07
Texas Health Aetna Select 3000/Low Rx	**$31.28**	$290.43	**$82.74**	$606.12	**$63.69**	$553.99	**$96.60**	$840.42
Texas Health Aetna Select 3000/High Rx	**$32.05**	$296.93	**$88.86**	$615.27	**$66.38**	$564.89	**$108.30**	$850.31
UHC Choice 500/Low Rx	**$30.10**	$342.12	**$129.71**	$651.94	**$80.12**	$615.92	**$172.28**	$933.19
UHC Choice 500/High Rx	**$30.87**	$348.62	**$135.83**	$661.09	**$82.81**	$626.82	**$183.98**	$943.08
UHC Choice 1000/Low Rx	**$27.31**	$323.83	**$83.77**	$659.18	**$57.19**	$604.38	**$108.45**	$942.27
UHC Choice 1000/High Rx	**$28.08**	$330.33	**$89.89**	$668.33	**$59.88**	$615.28	**$120.15**	$952.16
UHC Choice Plus 1500/Low Rx	**$67.34**	$294.49	**$299.91**	$458.04	**$220.11**	$458.99	**$383.31**	$672.85
UHC Choice Plus 1500/High Rx	**$68.11**	$300.99	**$306.03**	$467.19	**$222.80**	$469.89	**$395.01**	$682.74
Full-Time Employees Who Earn $25,000 - $49,999								
Texas Health Aetna Select 1000/Low Rx	**$29.90**	$314.81	**$95.76**	$628.13	**$85.69**	$558.93	**$149.59**	$874.20
Texas Health Aetna Select 1000/High Rx	**$32.22**	$319.76	**$104.70**	$634.46	**$89.61**	$568.60	**$166.93**	$878.45
Texas Health Aetna Select 3000/Low Rx	**$34.29**	$287.42	**$86.69**	$602.17	**$81.62**	$536.06	**$113.79**	$823.23
Texas Health Aetna Select 3000/High Rx	**$36.61**	$292.37	**$95.63**	$608.50	**$85.54**	$545.73	**$131.13**	$827.48
UHC Choice 500/Low Rx	**$47.97**	$324.25	**$198.43**	$583.22	**$172.52**	$523.52	**$322.13**	$783.34
UHC Choice 500/High Rx	**$50.29**	$329.20	**$207.37**	$589.55	**$176.44**	$533.19	**$339.47**	$787.59
UHC Choice 1000/Low Rx	**$33.92**	$317.22	**$108.62**	$634.33	**$97.20**	$564.37	**$169.68**	$881.04
UHC Choice 1000/High Rx	**$36.24**	$322.17	**$117.56**	$640.66	**$101.12**	$574.04	**$187.02**	$885.29
UHC Choice Plus 1500/Low Rx	**$114.79**	$247.04	**$420.22**	$337.73	**$353.34**	$325.76	**$637.54**	$418.62
UHC Choice Plus 1500/High Rx	**$117.11**	$251.99	**$429.16**	$344.06	**$357.26**	$335.43	**$654.88**	$422.87

1 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.

PLAN NAME	Employee Only		Employee + Spouse		Employee + Child(ren)		Employee + Family	
	YOU PAY	Texas Health Pays	YOU PAY	Texas Health Pays	YOU PAY	Texas Health Pays	YOU PAY	Texas Health Pays
Full-Time Employees Who Earn $50,000 - $74,999								
Texas Health Aetna Select 1000/Low Rx	**$31.00**	$313.71	**$98.91**	$624.98	**$90.13**	$554.49	**$153.24**	$870.55
Texas Health Aetna Select 1000/High Rx	**$34.11**	$317.87	**$109.25**	$629.91	**$94.87**	$563.34	**$173.38**	$872.00
Texas Health Aetna Select 3000/Low Rx	**$36.10**	$285.61	**$92.25**	$596.61	**$87.48**	$530.20	**$121.80**	$815.22
Texas Health Aetna Select 3000/High Rx	**$39.21**	$289.77	**$102.59**	$601.54	**$92.22**	$539.05	**$141.94**	$816.67
UHC Choice 500/Low Rx	**$49.11**	$323.11	**$209.08**	$572.57	**$186.69**	$509.35	**$340.68**	$764.79
UHC Choice 500/High Rx	**$52.22**	$327.27	**$219.42**	$577.50	**$191.43**	$518.20	**$360.82**	$766.24
UHC Choice 1000/Low Rx	**$35.16**	$315.98	**$112.19**	$630.76	**$102.23**	$559.34	**$173.82**	$876.90
UHC Choice 1000/High Rx	**$38.27**	$320.14	**$122.53**	$635.69	**$106.97**	$568.19	**$193.96**	$878.35
UHC Choice Plus 1500/Low Rx	**$118.91**	$242.92	**$442.64**	$315.31	**$376.90**	$302.20	**$673.76**	$382.40
UHC Choice Plus 1500/High Rx	**$122.02**	$247.08	**$452.98**	$320.24	**$381.64**	$311.05	**$693.90**	$383.85
Full-Time Employees Who Earn $75,000 - $99,999								
Texas Health Aetna Select 1000/Low Rx	**$34.86**	$309.85	**$132.91**	$590.98	**$121.02**	$523.60	**$218.01**	$805.78
Texas Health Aetna Select 1000/High Rx	**$38.73**	$313.25	**$147.81**	$591.35	**$127.62**	$530.59	**$239.60**	$805.78
Texas Health Aetna Select 3000/Low Rx	**$36.86**	$284.85	**$115.73**	$573.13	**$107.27**	$510.41	**$197.84**	$739.18
Texas Health Aetna Select 3000/High Rx	**$40.73**	$288.25	**$130.63**	$573.50	**$113.87**	$517.40	**$219.43**	$739.18
UHC Choice 500/Low Rx	**$62.97**	$309.25	**$310.24**	$471.41	**$256.47**	$439.57	**$494.25**	$611.22
UHC Choice 500/High Rx	**$66.84**	$312.65	**$325.14**	$471.78	**$263.07**	$446.56	**$515.84**	$611.22
UHC Choice 1000/Low Rx	**$39.54**	$311.60	**$150.76**	$592.19	**$137.27**	$524.30	**$247.29**	$803.43
UHC Choice 1000/High Rx	**$43.41**	$315.00	**$165.66**	$592.56	**$143.87**	$531.29	**$268.88**	$803.43
UHC Choice Plus 1500/Low Rx	**$162.34**	$199.49	**$650.29**	$107.66	**$546.38**	$132.72	**$1,008.92**	$47.24
UHC Choice Plus 1500/High Rx	**$166.21**	$202.89	**$665.19**	$108.03	**$552.98**	$139.71	**$1,030.51**	$47.24

1 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.

PLAN NAME	Employee Only		Employee + Spouse		Employee + Child(ren)		Employee + Family	
	YOU PAY	Texas Health Pays	YOU PAY	Texas Health Pays	YOU PAY	Texas Health Pays	YOU PAY	Texas Health Pays
Full-Time Employees Who Earn $100,000 and above								
Texas Health Aetna Select 1000/Low Rx	**$45.91**	$298.80	**$182.02**	$541.87	**$163.77**	$480.85	**$296.59**	$727.20
Texas Health Aetna Select 1000/High Rx	**$50.64**	$301.34	**$197.29**	$541.87	**$171.62**	$486.59	**$318.18**	$727.20
Texas Health Aetna Select 3000/Low Rx	**$47.11**	$274.60	**$163.90**	$524.96	**$150.16**	$467.52	**$245.43**	$691.59
Texas Health Aetna Select 3000/High Rx	**$51.84**	$277.14	**$179.17**	$524.96	**$158.01**	$473.26	**$267.02**	$691.59
UHC Choice 500/Low Rx	**$84.06**	$288.16	**$418.27**	$363.38	**$346.78**	$349.26	**$673.24**	$432.23
UHC Choice 500/High Rx	**$88.79**	$290.70	**$433.54**	$363.38	**$354.63**	$355.00	**$694.83**	$432.23
UHC Choice 1000/Low Rx	**$52.07**	$299.07	**$206.47**	$536.48	**$185.76**	$475.81	**$336.42**	$714.30
UHC Choice 1000/High Rx	**$56.80**	$301.61	**$221.74**	$536.48	**$193.61**	$481.55	**$358.01**	$714.30
UHC Choice Plus 1500/Low Rx	**$212.87**	$148.96	**$757.95**	$0.00	**$679.10**	$0.00	**$1,056.16**	$0.00
UHC Choice Plus 1500/High Rx	**$217.60**	$151.50	**$773.22**	$0.00	**$686.95**	$5.74	**$1,077.75**	$0.00
Part-Time Employees[1]								
Texas Health Aetna Select 1000/Low Rx	**$77.99**	$266.72	**$180.31**	$543.58	**$164.28**	$480.34	**$264.24**	$759.55
Texas Health Aetna Select 1000/High Rx	**$85.26**	$266.72	**$195.58**	$543.58	**$175.76**	$482.45	**$285.83**	$759.55
Texas Health Aetna Select 3000/Low Rx	**$80.56**	$241.15	**$180.27**	$508.59	**$167.66**	$450.02	**$246.27**	$690.75
Texas Health Aetna Select 3000/High Rx	**$87.83**	$241.15	**$195.54**	$508.59	**$179.14**	$452.13	**$267.86**	$690.75
UHC Choice 500/Low Rx	**$182.35**	$189.87	**$440.37**	$341.28	**$378.05**	$317.99	**$620.62**	$484.85
UHC Choice 500/High Rx	**$189.62**	$189.87	**$455.64**	$341.28	**$389.53**	$320.10	**$642.21**	$484.85
UHC Choice 1000/Low Rx	**$88.46**	$262.68	**$204.53**	$538.42	**$186.34**	$475.23	**$299.73**	$750.99
UHC Choice 1000/High Rx	**$95.73**	$262.68	**$219.80**	$538.42	**$197.82**	$477.34	**$321.32**	$750.99
UHC Choice Plus 1500/Low Rx	**$283.64**	$78.19	**$683.49**	$74.46	**$580.65**	$98.45	**$1,056.16**	$0.00
UHC Choice Plus 1500/High Rx	**$290.91**	$78.19	**$698.76**	$74.46	**$592.13**	$100.56	**$1,077.75**	$0.00

1 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 Max (Low Option)	Aetna PDN (High Option)
Employee Only	$6.88	$9.17	$21.53
Employee + Spouse	$13.74	$18.33	$43.02
Employee + Child(ren)	$18.39	$24.52	$57.57
Employee + Family	$23.33	$31.12	$73.07

Vision (Paid Before-Tax)

Coverage Level	Superior Vision
Employee Only	$3.50
Employee + Spouse	$7.53
Employee + Child(ren)	$5.67
Employee + Family	$10.33

Additional Life* (Paid After-Tax)

Your Age*	Cost per pay period per $1,000 of coverage
Under 30	$0.016
30 - 34	$0.020
35 - 39	$0.028
40 - 44	$0.036
45 - 49	$0.056
50 - 54	$0.087
55 - 59	$0.131
60 - 64	$0.171
65 - 69	$0.254
70 - 74	$0.345
75 - 79	$0.496

Spouse Life* (Paid After-Tax)

Your Age*	Cost per pay period per $1,000 of coverage
Under 30	$0.026
30 - 34	$0.035
35 - 39	$0.040
40 - 44	$0.044
45 - 49	$0.066
50 - 54	$0.102
55 - 59	$0.190
60 - 64	$0.291
65 - 69	$0.560
70 - 74	$0.908
75 - 79	$0.908

Child Life (Paid After-Tax)

Coverage	Cost per pay period
All your children	$0.270 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

* Additional and Spouse Life rates are based on the employee's age as of Jan. 1, 2021.

Cost of Disability Coverage

To calculate your premiums for disability, multiply your hourly base rate by the cost of coverage listed in the tables below. For example, if you earn $11 per hour and you are electing STD with a 14-day waiting period, multiply $11 x $0.7643 = $8.41 per paycheck.

If you are regularly scheduled to work less than 80 hours per pay period, multiply $11 x $0.7643 x (hours you are regularly scheduled to work ÷ 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)	$0.3008

Hospital Indemnity (Paid After-Tax)

Coverage	Low Option	High Option
Employee Only	$5.83	$10.54
Employee + Spouse	$11.46	$20.74
Employee + Child(ren)	$8.30	$15.02
Employee + Family	$13.92	$25.22

Accident Insurance (Paid After-Tax)

Coverage	Low Option	High Option
Employee Only	$3.15	$4.74
Employee + Spouse	$5.01	$7.54
Employee + Child(ren)	$6.29	$9.46
Employee + Family	$8.15	$12.25

Critical Illness Insurance (Paid After-Tax)

Your Age	Employee Only	Employee + Spouse	Employee + Children	Employee + Family
$15,000 OF COVERAGE				
29 and Under	$2.35	$4.78	$2.42	$4.85
30-34	$3.18	$6.44	$3.25	$6.51
35-39	$3.60	$7.27	$3.67	$7.34
40-44	$4.36	$8.79	$4.43	$8.86
45-49	$6.23	$12.53	$6.30	$12.60
50-54	$8.72	$17.52	$8.79	$17.58
55-59	$12.88	$25.82	$12.95	$25.89
60-64	$21.67	$43.41	$21.74	$43.48
65 and Over	$47.70	$95.47	$47.77	$95.54
$30,000 OF COVERAGE				
29 and Under	$3.88	$7.89	$4.02	$8.03
30-34	$5.54	$11.22	$5.68	$11.35
35-39	$6.37	$12.88	$6.51	$13.02
40-44	$7.89	$15.92	$8.03	$16.06
45-49	$11.63	$23.40	$11.77	$23.54
50-54	$16.62	$33.37	$16.75	$33.51
55-59	$24.92	$49.98	$25.06	$50.12
60-64	$42.51	$85.15	$42.65	$85.29
65 and Over	$94.71	$189.55	$94.85	$189.69

*Employee and spouse rates are based on employee's age as of Jan. 1.

Important Contacts

For Information About:	Contact:	At:
Flexible Benefits **General questions** and to request forms	THR Benefits Support	1-877-MyTHRLink, prompt 9 or email THRBenefitsSupport@texashealth.org
Medical Plan	Texas Health Aetna P.O. Box 981106 El Paso, TX 79998-1106	1-877-MyTHRLink, prompt 1 TexasHealthAetna.com
	UnitedHealthcare Services Inc. 185 Asylum St. Hartford, CT 06103-3408	1-877-MyTHRLink, prompt 2 MyUHC.com
Pharmacy Benefits	CVS Caremark P.O. Box 659529 San Antonio, TX 78265-9529	1-877-MyTHRLink, prompt 3 Caremark.com
Be Healthy	Virgin Pulse	1-877-MyTHRLink, prompt 4, press 3 support@virginpulse.com
Dental Plan	Aetna P.O. Box 14094 Lexington, KY 40512-4094	1-877-MyTHRLink, prompt 6, press 3 Aetna.com
Vision Plan	Superior Vision Services 11101 White Rock Road, Suite 150 Rancho Cordova, CA 95670	1-877-MyTHRLink, prompt 6, press 4 Superiorvision.com
Life and Accident Insurance Life Insurance and Accidental Death & Dismemberment	Prudential Insurance Company of America 80 Livingston Avenue Roseland, NJ 07068	1-877-MyTHRLink, prompt 6, press 8
Business Travel Accident	Life Insurance Company of North America	1-877-MyTHRLink, press 9
Disability Short Term Disability Long Term Disability	The Prudential Insurance Company of America 751 Broad Street Newark, New Jersey 07102	1-844-223-4398
Accounts Health Care Flexible Spending Account, Day Care Flexible Spending Account, and Health Savings Account	HealthEquity P.O. Box 14053 Lexington, KY 40512	1-877-MyTHRLink, prompt 6, press 6 Fax: 877-353-9236 WageWorks.com to track expenses
Paid Time Off	THR Benefits Support	1-877-MyTHRLink, prompt 9 www.MyTHR.org
Texas Health Retirement Program	Fidelity	1-877-MyTHRLink, prompt 5 NetBenefits.com/thr
Tuition Reimbursement	Texas Health Tuition Reimbursement 612 E. Lamar Blvd., Suite 400 Arlington, TX 76011	1-877-MyTHRLink, prompt 6, press 2 or e-mail at THRTuitionReimbursement@texashealth.org

Flexible Benefits (continued)

For Information About:	Contact:	At:
COBRA Continuation of Coverage	HealthEquity, Inc. P.O. Box 14055 Lexington, KY 40512-4055	1-888-678-4881
Governance Committee	Texas Health 612 E. Lamar Blvd, Suite 900 Arlington, TX 76011	682-236-7900
Employee Assistance Program (EAP)	Texas Health Resources Behavioral Health	1-877-MyTHRLink, prompt 4, press 4 www2.texashealth.org/eap
Tobacco Cessation	Consumer Wellness Solutions Inc.	1-877-MyTHRLink, prompt 4, press 2 Quitnow.net/texashealthresources
Leave of Absence (LOA)	Your IDM representative	1-877-MyTHRLink, prompt 6, press 1 or e-mail at THRIDM@texashealth.org
Discount Program	Beneplace	1-877-MyTHRLink, prompt 6, press 5 texashealth.savings.beneplace.com
Real Appeal	Real Appeal	1-877-MyTHRLink, prompt 4, press 1 THR.realappeal.com
Supplemental Benefits (MetLife) Accident Insurance Hospital Indemnity Insurance Critical Illness Insurance	Metropolitan Life Insurance Company P.O. Box 80826 Lincoln, NE 68501-0826	1-866-626-3705 mybenefits.metlife.com
Student Loan Repayment	SoFi	(833) 277-7634 customerservice@sofi.com

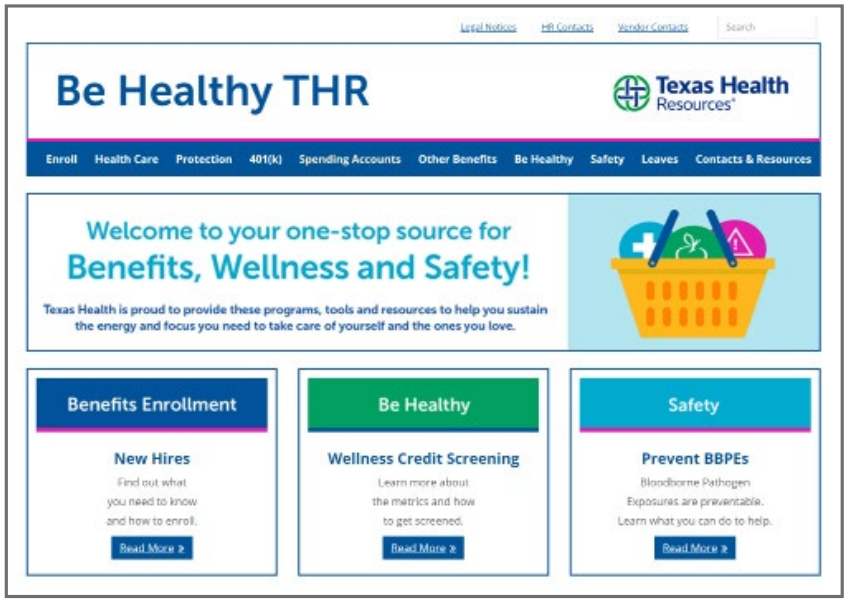
Don't forget,

www.BeHealthyTHR.org

is your one-stop source for additional information about your benefits.

Visit **www.BeHealthyTHR.org** for:

- An electronic copy of your benefits handbook
- Enrollment information and instructions
- Claim forms
- Wellness program information
- Safety information and more!



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