TITLE: HEALTH AND RELATED BENEFITS

PURPOSE: To provide an overview of the health and related benefits offered to Benefit Eligible Employees, Benefit Eligible Retirees, and their Benefit Eligible Dependents.

POLICY STATEMENT:

The Harris Health System **(Harris Health)** values the health and wellbeing of its employees and retirees and their dependents, and therefore provides a number of health and related benefits to those individuals.

Benefit eligibility is determined by employment category (i.e., full-time, part-time, supplemental/registry, etc.) and, for purposes of certain medical plan eligibility, by the requirements imposed under the Patient Protection and Affordable Care Act (PPACA) guidelines.

Both the Benefit Eligible Employee/Retiree and Harris Health share the cost of providing most of the benefits. At the time of retirement, a Benefit Eligible Retiree will be offered only the medical, dental, and vision coverage he or she was enrolled in as an active employee on the day before he or she retired.

POLICY ELABORATION:

I. ELIGIBILITY – EMPLOYEE AND RETIREE

The Employee Benefits Department of Harris Health **(Benefits)** is responsible for determining whether an employee, retiree, or dependent is eligible for health and welfare and retirement benefits based on Harris Health's policies, programs, and plans as summarized below, and applicable law. For purposes of this Policy, all references to **"termination," "terminated," "creditable service,"** and similar terms and phrases refer to employment with and termination of employment from Harris Health for purposes of benefits offered by Harris Health.

A. BENEFIT ELIGIBLE EMPLOYEE

A **"Benefit Eligible Employee"** is defined in Harris Health Policy and

Procedures 6.12 Employment; see Definitions of Full-Time Status and Part-Time with Benefits Status.

B. PPACA SUPPLEMENTAL EMPLOYEE

A **"PPACA Supplemental Employee"** is a supplemental, registry or other employee of Harris Health who is not a Benefit Eligible Employee under Harris Health Policy 6.12 Employment, but who has worked thirty (30) or more hours per week on average during a twelve (12) month "measurement period" and thus qualifies as a "full-time employee" for purposes of the PPACA guidelines.

The "measurement period" is a twelve (12) month period beginning either: (a) on the first day the employee is employed by Harris Health (if the employee is a new hire) or (b) the period from January 1 to December 31 of a calendar year.

As of March 1, 2015, for certain medical plan eligibility purposes only, a PPACA Supplemental Employee who, during an applicable measurement period, works an average of thirty (30) hours or more per week, an average of one hundred and thirty (130) hours or more per month or one thousand five hundred sixty (1,560) hours a year, as measured by Harris Health, will be offered enrollment in a Harris Health medical plan beginning the March 1 immediately following that measurement period. A twelve (12)-month "stability period" will typically apply to a PPACA Supplemental Employee, which means that employee will generally be eligible for certain Harris Health medical plan coverage for a twelve (12)-month period as required by the PPACA guidelines.

A PPACA Supplemental Employee will be considered a Benefit Eligible Employee only for purposes of Harris Health's High Deductible Plan.

C. BENEFIT ELIGIBLE RETIREE – GENERAL RULE

Generally, a **"Benefit Eligible Retiree"** is a regular Full-Time Employee who terminates employment and on the date employment terminates:

1. He or she is age fifty-five (55) or older;
2. His or her years of regular full-time creditable service with Harris Health plus his or her age equals or exceeds eighty (80) points **(Rule of 80)**; and

3. He or she was enrolled and participating in a medical, dental, or vision plan offered by Harris Health on the last day of active employment.

However, a Benefit Eligible Retiree may continue to carry into retirement only the medical, dental, or vision coverage that he or she was enrolled in on the day immediately preceding his or her date of termination, as provided in Section IV below.

The Rule of 80 applies to all current Benefit Eligible Employees, except as provided in Section I.D., below. The Rule of 80 also applies to all Benefit Eligible Employees hired or rehired on or after June 1, 2012.

D. BENEFIT ELIGIBLE RETIREE – SPECIAL RULES

There are exceptions to the general rule set out in Section I.C., above. An employee of Harris Health who terminates employment will qualify as a Benefit Eligible Retiree, and will be eligible to carry into retirement the healthcare coverage that he or she was enrolled in on the day immediately preceding his or her date of termination from Harris Health, if the regular Full-time Employee satisfies all of the requirements of one of the following numbered paragraphs:

1. Terminated employment before June 1, 2012, was at least age fifty-five (55) as of his or her date of termination with a minimum of ten (10) years of full-time creditable service and was not reemployed by Harris Health in a benefit-bearing employment position on or after June 1, 2012; or
2. Terminated employment before June 1, 2012, was at least age sixty-five (65) as of his or her date of termination with a minimum of 1 year of full-time creditable service and was not reemployed by Harris Health in a benefit-bearing employment position on or after June 1, 2012; or
3. Satisfied at least one of the following conditions:

    a. And is not re-employed in a benefit-bearing employment position by Harris Health after terminating employment with Harris Health:

        i. Age fifty (50) and at least twenty-five (25) years of regular full-time creditable service;

ii. Age fifty-five (55) and at least ten (10) years of regular full-time creditable service; or

iii. Age sixty-five (65) and at least one (1) year of regular full-time creditable service; or

b. Attains age fifty-five (55) in the month of March, April or May of 2017 and before June 1, 2012 attained age fifty (50) and at least twenty-five (25) years of regular full-time creditable service.

E. BENEFIT ELIGIBLE RETIREE – TERMINATION OF BENEFITS

1. A Benefit Eligible Retiree will lose coverage under a medical, dental, or vision plan offered by Harris Health on the date the Benefit Eligible Retiree drops coverage or otherwise ceases to participate in the plan, including for failure to timely pay required premiums.
2. An Enrollee will cease to qualify as a Benefit Eligible Retiree on the date he or she is reemployed as a Benefit Eligible Employee or reclassified as a Benefit Eligible Employee after being reemployed in a position not eligible for benefits. If a Benefit Eligible Retiree is rehired by Harris Health, his or her eligibility for active employee benefits will be determined based on his or her most recent date of hire into a benefits eligible position. A rehired Benefit Eligible Retiree who does not qualify for benefits as a Benefits Eligible Employee will be allowed to retain his or her retiree healthcare benefits.

II. ELIGIBILITY – DEPENDENT

A. Dependent Eligibility:

A Benefit Eligible Employee or Benefit Eligible Retiree enrolled in a Harris Health sponsored medical, dental, or vision plan (an **"Enrollee"**) may also enroll his or her qualifying Benefit Eligible Dependent in the same coverage, as applicable, in which he or she is enrolled. A **"Benefit Eligible Dependent"** is:

1. The Enrollee's Spouse.
2. The Enrollee's Child under up to the end of the month in which the Child attains age twenty-six (26).

3. The Enrollee's Child age twenty-six (26) or older who has a mental or physical disability of a permanent or of an indefinite but long duration.
4. The Enrollee's unmarried Grandchild:

    a. Up to the end of the month in which the Grandchild attains age twenty-six (26); and
    b. Who is a dependent of the Enrollee and/or the Enrollee's Spouse for federal income tax purposes at the time application for coverage is made.

The terms **"Spouse," "Child,"** and **"Grandchild"** are defined in the section below.

B. Spouse, Child and Grandchild

1. A Spouse is the person to whom the Enrollee is married. However, an informal marriage will be recognized by Harris Health only if the Enrollee has obtained from the appropriate county clerk's office a Texas Declaration and Registration of Informal Marriage for that marriage or a similar declaration from another state that is acceptable to Benefits.

2. A Child is:

    a. A natural child;
    b. A stepchild;
    c. A legally adopted child (including a child placed with the Enrollee and/or the Enrollee's Spouse pending finalization of adoption proceedings); or
    d. A child for whom the Enrollee and/or the Enrollee's Spouse has obtained sole, permanent legal custody or permanent legal guardianship pursuant to a court order (for which no other person including the biological parent has any custodial rights).

3. A Grandchild is a Child of your Child and/or a Child of your Spouse's Child.

C. Termination of Coverage:

Coverage provided to a Benefit Eligible Dependent will terminate upon the first of the following events to occur:

1. The date the dependent no longer satisfies the requirements for a Benefit Eligible Dependent; or
2. The date benefits coverage ends for the Enrollee.

D. Fraud or Intentional Misrepresentation of Material Fact

1. An Enrollee who enrolls an individual as a dependent in a Harris Health sponsored plan or program that is not funded by an insurer is liable to, and obligated to repay, Harris Health and such plan or program for all amounts paid to, for, or otherwise with respect to such individual for any period that the individual was not eligible for benefits. The Enrollee is also responsible for reimbursement of all reasonable costs and fees incurred by Harris Health to recover such amounts.
2. In the case of group health plan coverage as defined in the Public Health Services Act (PHSA), 42 U.S.C. §300gg-91, and/or section 5000(b)(1) of the Internal Revenue Code of 1986, as amended, that is subject to the provisions of Part A of Title XXVII of the PHSA (as amended by the Patient Protection and Affordable Care Act) (Affordable Care Act Medical Coverage), to the extent that such coverage is not funded by an insurer, an individual shall not be entitled to coverage under such Affordable Care Act Medical Coverage if the individual (or a person seeking coverage on behalf of the individual) performs an act, practice or omission that constitutes fraud or makes an intentional misrepresentation of material fact in connection with the enrollment of the individual in the plan.
3. An Enrollee who knowingly enrolls or attempts to enroll a dependent in coverage under a plan or program offered by Harris Health for which that individual is not eligible violates not only the terms of the applicable plan or program but the policies and ethics rules of Harris Health. Such an Enrollee who is an active employee of Harris Health is subject to disciplinary action up to and including possible termination of

employment and may face legal action for restitution to Harris Health or to the fully insured underwriter.

4. If an Enrollee or any other adult enrolled under a plan or program offered by Harris Health knowingly provides false, incomplete, or misleading information that constitutes fraud or intentional misrepresentation of a material fact, this may result in denial or loss of benefits. Coverage for such Enrollee or other adult person may be retroactively rescinded and the individual required to repay Harris Health or the policy underwriter all employer funded premiums and benefit payments made for which the person was not eligible.

III. HEALTH-RELATED PLANS AVAILABLE TO BENEFIT ELIGIBLE EMPLOYEES

A. Medical Plans

Harris Health offers the medical plans to qualifying Benefit Eligible Employees and PPACA Supplemental Employees. Harris Health's medical plans are funded from contributions made by Harris Health and the covered plan participants. Four (4) levels of coverage are offered: coverage for the qualifying Employee only, and coverage for the Qualifying Employee +Spouse, + Child(ren) and + Family.

Effective March 1, 2015:

1. Regular Full-Time and regular Part-Time new hires or rehires, are offered three medical plan options: a High Deductible Plan, a Low Deductible Plan, and a KelseyCare Plan at date of hire.
2. The option of any regular Full-Time or regular Part-Time Employee to voluntarily elect one of those three medical plans will end as of the beginning of the next plan year (March 1) if the regular Full-time or regular Part-Time Employee fails to timely and accurately complete an annual on-line Health Assessment with certain Biometric numbers as required by the Harris Health Tiered Benefits campaign. If the Health Assessment is not timely and accurately completed, the regular Full-Time or regular Part-Time Employee will be placed in the High Deductible Plan

for the following fiscal year of Harris Health with a higher premium cost share than certain other High Deductible Plan participants.

3. PPACA Supplemental Employees will be eligible to enroll in the High Deductible Plan. PPACA Supplemental Employees are not eligible to participate in the Harris Health Tiered Benefits campaign and will therefore have a higher premium cost share than certain other High Deductible Plan participants.
4. Supplemental employees who have not worked 30 or more hours per week on average during an applicable twelve (12) month "measurement period" (and thus do not qualify as "full-time employees" for purposes of the PPACA guidelines) will not be offered group medical plan coverage.

B. Prescription Drugs

Prescription drug benefits are included as part of the medical plans.

C. Dental Plans

Harris Health offers two fully insured dental plans to all regular Full-Time and regular Part-Time Benefit Eligible Employees. The Dental Plan insurance carrier has the full and exclusive authority to administer claims, interpret policy provisions, and resolve all questions arising out of the administration, interpretation, and application of the Harris Health sponsored fully insured Dental Plans.

D. Vision Plan

Harris Health offers a fully insured vision plan to all regular Full-time and regular Part-Time Benefit Eligible Employees. The Vision Plan insurance carrier has the full and exclusive authority to administer claims, interpret policy provisions and resolve all questions arising out of the administration, interpretation and application of the Harris Health sponsored fully insured Vision Plan.

E. Employee Assistance Program (EAP)

Harris Health offers an EAP to all employees. The EAP provides limited annual benefits to all active employees and their eligible dependents (as defined by carrier).

F. Life Insurance

Age graded Group Term Life insurance is offered to all regular Full-Time and regular Part-Time Benefit Eligible Employees who are actively at work.

1. Basic and Accidental Death & Dismemberment (AD&D) Insurance: Benefit Eligible Employees are automatically enrolled in Basic Life and Basic AD&D coverage, each at two (2) times base annual salary, subject to underwriter approval and Texas Department of Insurance regulations.
2. Additional coverage under Optional Life, Optional AD&D, Spouse and Child Dependent Life Insurance is also available. Benefit Eligible Employees must affirmatively elect any other coverage other than Basic Life.
3. Life Insurance Benefit Determinations: The Group Term Life Insurance carrier has the full and exclusive authority to control and manage the Group Term Life policies, administer claims, interpret the policies (including benefit eligibility and payment of benefits) and resolve all questions arising out of the administration, interpretation and application of the Group Term Life policies sponsored by Harris Health.

G. Flexible Spending Accounts (FSAs)

Harris Health offers regular Full-Time and regular Part-Time Benefit Eligible Employees both a Health Care and Dependent Care Flexible Spending Account (FSA) plan.

H. Short-Term Disability Benefits

Short-Term Disability (STD) benefits may be available to regular Full-Time Employees. For further details refer to Harris Health Policy and Procedures 6.32 Short-Term Disability.

I. Disability Benefits

Disability benefits may be available for a mental or physical disability of a permanent or an indefinite but long duration.

1. Disability Retirement – Harris County Hospital District Pension Plan

   If regular full-time active service stopped due to a disabling condition before March 1, 2007, benefits may be available in the form of a Disability Retirement benefit through the Harris County Hospital District sponsored Pension Plan. For further details contact Benefits.

2. Long-Term Disability (LTD) Fully Insured Plan:

   a. If regular full-time active service stopped due to a disabling condition on or after March 1, 2007, benefits may be available in the form of a fully insured LTD benefit. For further details contact the carrier.
   b. The disabled Enrollee should contact the Group Term Life Insurance carrier when deemed LTD disabled to discuss possible life insurance Waiver of Premium rights.

J. Reduction in Force and Severance Benefits

For details, refer to Harris Health System Policy and Procedures 6.01 Permanent Reduction In The Work Force and Harris Health System Policy and Procedures 6.30 Severance Benefits for Positions at the Director Level and Above.

IV. BENEFITS AVAILABLE TO BENEFIT ELIGIBLE RETIREES

A. A Benefit Eligible Retiree Can Continue Health Benefits:

A Benefit Eligible Retiree may continue to carry medical, dental, or vision coverage into retirement if he or she was enrolled in that type of coverage on the day immediately preceding his or her date of termination from Harris Health. Retiree coverage is effective as of the retirement date entered in PeopleSoft, but

coverage is contingent upon the Benefit Eligible Retiree's timely payment of applicable premiums.

1. A Benefit Eligible Retiree cannot add any new plan type of coverage at the time of or after his or her termination. The coverage in which the Benefit Eligible Employee is enrolled on the date immediately before his or her termination date is the only plan type of coverage in which the Benefit Eligible Employee may participate as a Benefit Eligible Retiree. If more than one plan type of coverage is offered, the Benefit Eligible Retiree may switch coverage types (e.g., Medical PPO to HMO or Dental PPO to HMO and vice versa) within thirty-one (31) days of the effective date of retirement.
2. A Benefit Eligible Retiree may continue to cover his or her Spouse and other dependents that he or she covered as a Benefit Eligible Employee on the day immediately preceding his or her termination.
3. A Benefit Eligible Retiree cannot add a Spouse to any coverage at the time of or following his or her termination.
4. A Benefit Eligible Retiree may enroll a qualifying Child in medical, dental, or vision coverage at the time of and following his or her termination, during Annual Enrollment, and in other situations described in the applicable group health plan.
5. A Benefit Eligible Retiree may drop coverage during Annual Enrollment and in other situations described in the applicable group health plan. Once coverage is dropped, coverage cannot be reinstated at a later date. COBRA rules will apply.
6. Failure to timely pay premiums for coverage provided to the Benefit Eligible Retiree will result in loss of the coverage. After coverage is lost for failure to timely pay premiums, the coverage cannot be reinstated.

B. A Benefit Eligible Retiree and Benefit Eligible Dependent Age Sixty-Five (65) or Older Must Enroll in Medicare

1. **Benefit Eligible Retirees and Benefit Eligible Dependents** who are age sixty-five (65) or older are required to enroll in both Part A and Part B of Medicare to obtain coverage under a medical plan offered by Harris Health.

2. **Benefit Eligible Retirees and Benefit Eligible Dependents** who are age sixty-five (65) or older are not required to enroll in Medicare Part D coverage.

C. A Disabled Benefit Eligible Retiree and Disabled Benefit Eligible Dependent Must Enroll in Medicare

1. A Benefit Eligible Retiree who is disabled and a Benefit Eligible Dependent who is disabled are required to enroll in Part A and Part B of Medicare to obtain coverage under a medical plan offered by Harris Health.
2. As an offset of the cost to carry Medicare coverage, Harris Health has waived the Benefit Eligible Retiree's cost share of the Harris Health medical plan premium based on the Retiree Only level of coverage. This rate reduction assumes continued Social Security Disabled status until age sixty-five (65) with continued coverage under both the Harris Health medical plan and Medicare. A limit of one (1) premium rate reduction per month per Benefit Eligible Retiree will apply.
3. An under-age sixty-five (65) disabled Benefit Eligible Retiree or under-age sixty-five (65) disabled Benefit Eligible Dependent who was awarded Medicare eligibility as a result of a Social Security approved disability prior to September 30, 2010 and who was not enrolled in both Part A and Part B of Medicare as of September 30, 2010 is exempt from the Harris Health medical plan Medicare enrollment requirement as of their awarded Medicare eligibility date. For these individuals, the Harris Health sponsored plan(s) will provide primary coverage with Medicare as secondary coverage until the grandfathered participant enrolls in both Part A and Part B of Medicare or attains age sixty-five (65), whichever occurs first.

V. BENEFIT ADMINISTRATION

A. Premiums – General Rules

Medical, dental and vision plan premium rate tables are approved by the Board of Managers for all benefit eligible plan participants.

B. Premiums – Grandfathered Premium Rate Retiree

A **"Grandfathered Premium Rate Retiree"** is a Benefit Eligible Retiree who satisfies the applicable requirements set forth herein in Section I.D. above at the time of termination from Harris Health.

1. A Benefit Eligible Retiree will cease to qualify as a Grandfathered Premium Rate Retiree with respect to coverage under a medical, dental, or vision plan sponsored by Harris Health on the date the retiree drops his or her coverage under, or otherwise ceases to participate in, a plan.
2. A retiree automatically ceases to qualify as a Grandfathered Premium Rate Retiree on the date he or she is reemployed as a Benefit Eligible Employee by Harris Health.

C. Ineligible Dependent

The plan participant is responsible for immediately contacting Benefits at 713-566-6451 when a Dependent no longer meets eligibility guidelines so that coverage(s) can be timely terminated. Failure to timely notify Benefits within thirty-one (31) calendar days will result in forfeiture of back premiums paid if the level of coverage is affected.

D. Plan Terms Control

If any information contained within this Harris Health Policy and Procedures 6.04 Health and Related Benefits conflicts with any official plan documents, the official plan documents will govern.

VI. HARRIS HEALTH RIGHTS TO MODIFY BENEFITS

Harris Health reserves the right to modify, amend, terminate, rescind or replace any and all benefit plans and programs, benefit offerings, premium rate tables, etc. with or without advance notice to any Benefit Eligible Employee, Benefit Eligible Retiree or Benefit Eligible Dependent, as Harris Health determines, at any time.

REFERENCES/BIBLIOGRAPHY:

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

Family Medical Leave Act of 1993 (FMLA).

Health Insurance Protection and Accountability Act of 1996.

Health Care and Education Reconciliation Act of 2010 signed into law on March 30, 2010.

Public Health Service Act provisions enacted/amended by the Patient Protection and Affordable Care Act signed into law on March 23, 2010.

Social Security Act of 1935.

Harris Health System Policy and Procedures 6.01 Permanent Reduction In The Work Force.

Harris Health System Policy and Procedures 6.30 Severance Benefits for Positions at the Director Level and Above.

Harris Health System Policy and Procedures 6.12 Employment.

Harris Health System Policy and Procedures 6.32 Short-Term Disability.

Harris Health System Policy and Procedures 6.29 Family and Medical Leave of Absence.

OFFICE OF PRIMARY RESPONSIBILITY:

Harris Health System Human Resources Department

REVIEW/REVISION HISTORY:

Record review and revisions below.

Effective Date	Version# (If Applicable)	Review or Revision Date (Indicate Reviewed or Revised)	Reviewed or Approved by: (If Board of Managers Approved, include Board Motion#)
07/26/2001	1.0		Board of Managers (No.01.7-314)
		Reviewed 09/06/2002	Administrator, Human Resources
		Reviewed 07/18/2003	Administrator, Human Resources
		Reviewed 11/15/2006	Administrator, Human Resources
	2.0	Revised 04/24/2007	Vice President of Human Resources
	3.0	Revised 04/30/2007	HCHD Policy Review Committee
05/31/2007			Board of Managers (No. 07.5-266)
	4.0	Approved 09/02/2008	HCHD Policy Review Committee
		Approved 01/08/2013	Operations Policy Committee
	5.0	Revised/Approved 01/13/2015	Operations Policy Committee
	6.0	Revised/Approved 04/14/2015	Operations Policy Committee
	7.0	Revised/Approved 10/13/2015	Operations Policy Committee

ATTACHMENT A
PROCEDURES FOR ADMINISTRATION OF HEALTH AND RELATED BENEFITS UNDER HARRIS HEALTH SYSTEM POLICY AND PROCEDURES 6.04 HEALTH AND RELATED BENEFITS

Harris Health System Policy and Procedures 6.04 Health And Related Benefits provides an overview of the health and related benefits offered by Harris Health to Benefit Eligible Employees, Benefit Eligible Retirees and their Benefit Eligible Dependents. Set forth below are certain procedures that the Employee Benefits Department of Harris Health (**Benefits**) has adopted to administer those benefits.

This document is a supplement to Harris Health System Policy and Procedures 6.04 Health And Related Benefits. Capitalized terms used herein but not expressly defined herein shall have the meaning set out in Harris Health System Policy and Procedures 6.04 Health and Related Benefits.

I. PROOF OF ELIGIBILITY:

This section sets out information that an Enrollee must provide to Benefits to demonstrate that an individual to be enrolled in a plan offered by Harris Health qualifies as his or her Spouse, Child or Grandchild.

A. Proof of Qualifying Spouse Status

1. The Enrollee must provide the following evidence of his or her marriage to a Spouse:

   a. A certified copy of a fully executed and valid Marriage License issued by a state, county or vital records office or a similar document from another country that is acceptable to Benefits; or

   b. A certified copy of a Texas Declaration and Registration of Informal Marriage filed with the appropriate county clerk's office or a similar declaration that has been filed in another state that is acceptable to Benefits.

B. Proof of Qualifying Child Status

1. Proof of Child eligibility must be provided to Benefits within the eligibility timeframes set forth in Section IV below. Proof of eligibility for a Child must be in the form of a copy of a certified Birth Certificate issued by a state, county or vital records office (or substantially equivalent documents issued outside the United States and approved by Benefits) that evidences that the Child is a qualifying dependent of the Enrollee and/or his or her Spouse. In the case of a newborn Child (from birth to thirty-one (31) days of age), a Birth Facts sheet issued by the facility where the newborn was born may also be used as evidence that the newborn is the qualifying Child of the Enrollee and/or his or her Spouse.
2. Proof of eligibility for an adopted Child must be in the form of a Certificate of Adoption, papers from the adoption agency showing a placement for adoption or other evidence of an intent to adopt, international adoption papers from the country of adoption or a Birth Certificate issued by the state, county or vital records office that names the Enrollee and/or his or her Spouse as the adoptive parent.
3. Proof that a Child has a mental or physical disability of a permanent or of an indefinite but long duration must be provided to Benefits (in the form of a Social Security disability award letter) within thirty-one (31) days of the end of the month which the Child attains age twenty-six (26) and at such other times as may be required by Harris Health or as allowed by applicable law.

C. Proof of Qualifying Grandchild Status

When an Enrollee first enrolls a Grandchild, the Enrollee must provide a copy of the certified Birth Certificate of the Grandchild or a Birth Facts sheet for the newborn Grandchild (from birth to thirty-one (31) days of age) and a copy of the birth certificate for the Enrollee's Child or his or her eligible Spouse's child who is the birth parent of the Grandchild. The Enrollee must also provide documents showing that the Grandchild resides with and is dependent on the Enrollee and/or his or her Spouse. Proof of Grandchild residency is required by Harris Health (such as medical or dental office statements or day care or school enrollment documents showing the Grandchild's name, date of birth and home address). In addition, a copy of the Enrollee's federal income tax return for the

prior calendar year and for the year the Grandchild is being enrolled in a Harris Health sponsored benefit plan or program is required. This documentation must be submitted to Benefits at the time of the Grandchild's initial enrollment or such later time, as it is first available, but no later than April 15 of the following year, to show that the Grandchild qualified as a dependent for the initial period of coverage. The Enrollee must complete an Affidavit to add the Grandchild at time of enrollment.

II. RULES REGARDING LIFE INSURANCE

A. Reductions in Life Insurance

Age-based benefit reductions may apply to the Group Term Life insurance policies offered to Benefit Eligible Employees and their Spouses age sixty-five (65) and over. Refer to the certificate of coverage for specific rate reduction tables.

B. Life Insurance Beneficiary

Benefit Eligible Employees should affirmatively elect one or more primary beneficiaries and contingent beneficiaries for all life insurance coverage.

1. Benefit Eligible Employees are not limited to who they can name as their primary or contingent beneficiaries.

2. Benefit Eligible Employees are automatically the beneficiaries of any Spouse Life or Dependent Life insurance purchased on behalf of their eligible dependents.

III. RULES REGARDING CONTINUATION OF COVERAGE:

A. A Benefit Eligible Retiree Can Continue Coverage

A Benefit Eligible Retiree may contact the insurance carrier to convert his or her active employee group term life insurance policy to a private policy, without a proof of insurability requirement. This conversion must be requested by the

Benefit Eligible Retiree within the time limitations and other requirements set by the group term life insurance policy.

B. A Benefit Eligible Retiree and Benefit Eligible Dependent Age sixty-five (65) or Older Must Enroll in Medicare

1. Failure to enroll in both Part A and Part B of Medicare will result in:

   a. medical expenses not being covered for the plan participant; and
   b. the Benefit Eligible Retiree paying the medical plan premiums even though the Benefit Eligible Retiree or Benefit Eligible Dependent of the retiree is not entitled to medical expense benefit coverage until the Benefit Eligible Retiree or Benefit Eligible Dependent successfully enrolls in Part A and Part B of Medicare, as necessary.

2. To obtain benefits from a Harris Health medical plan, the Benefit Eligible Retiree or Benefit Eligible Dependent age sixty-five (65) or older must use a physician who is a participating Medicare provider.

C. A Disabled Benefit Eligible Retiree and Disabled Benefit Eligible Dependent Must Enroll in Medicare:

1. Failure to enroll in both Part A and Part B of Medicare will result in:

   a. medical expenses not being covered for the plan participant, and
   b. the Enrollee paying Harris Health medical plan premiums even though the disabled Benefit Eligible Retiree or disabled Benefit Eligible Dependent of the retiree may not be entitled to medical expense benefit coverage until the Benefit Eligible Retiree or Benefit Eligible Dependent successfully enrolls in both Part A and Part B of Medicare, as necessary.

2. To obtain benefits from a Harris Health medical plan, the disabled Benefit Eligible Retiree or disabled Benefit Eligible Dependent must use a physician who is a participating Medicare provider.

IV. BENEFIT ADMINISTRATION

A. Benefit Elections

1. Benefit Eligible Employee - New Hire:

   a. A new hire has thirty-one (31) days, which includes the new hire's first day of employment, to enroll in Harris Health sponsored health and welfare benefit plans. If the new hire timely enrolls, coverage will generally be effective retroactively to the new hire's first day of employment (once his or her election is made). The new hire's share of the premiums for the retroactive coverage will be deducted from the new hire's paycheck after the retroactive election is made.

   b. A regular Full-Time or regular Part-Time new hire will automatically be enrolled in the Employee Assistance Program and Basic Life and Basic AD&D insurance effective as of the new hire's first day of employment, subject to requirements imposed by the insurance carrier and any Texas Department of Insurance regulations and exceptions.

   c. To enroll in employer-sponsored benefits, the new hire must complete the PeopleSoft enrollment process.

      (i) A new hire can change his or her medical (only available election for a PPACA Supplemental employee), dental, vision, or flexible spending account plan coverage elections within thirty-one 31 days of his or her first day of employment. To make a change, the new hire must contact Benefits at 713-566-6451 within the thirty-one (31) day period. Benefits will open a benefits election window in PeopleSoft to allow for the election change. Changes made during the thirty-one (31) day period will be effective retroactively to the new hire's first day of employment, subject to approval by Benefits and the insurance carrier. A regular Full-Time or regular Part-Time new hire may also change his or her optional life insurance coverage, but the change will take effect prospectively, not retroactively.

(ii) The new hire must provide within thirty-one (31) days of his or her first day of employment, all required Dependent documentation to show that each person the new hire elected to enroll qualifies for coverage. If required documentation is not timely submitted, that person's enrollment will not take effect.

(iii) If the regular Full-Time or regular Part-Time new hire enrolls in a benefit program that requires evidence of insurability, requested documentation must be timely provided as requested by the insurance carrier or the coverage requested will not take effect.

2. Benefit Eligible Employee – Current Employee:

A Benefit Eligible Employee (who has been employed for more than thirty-one (31) days) can change his or her medical (only available election for a PPACA Supplemental employee) dental, vision, optional life insurance and flexible spending account plan elections during Annual Enrollment and in other situations described in the applicable group health plan.

B. Premiums

1. Benefit Eligible Employee premiums are paid on a bi-weekly basis by payroll deduction.
2. Benefit Eligible Employee premiums will be payroll-deducted during an approved FMLA leave (refer to Harris Health System and Procedures 6.29 Family and Medical Leave of Absence). If there are, insufficient funds or no funds are available through a payroll deduction basis, the Benefit Eligible Employee remains responsible for timely payment of applicable premiums. Contact Benefits at 713-566-6451 to discuss the alternative payment arrangements available.
3. Benefit Eligible Retiree premiums may be deducted from the Benefit Eligible Retiree's monthly pension benefit payment or collected on a self-pay basis.

4. Benefit Eligible Employee self-pay premiums are due on a bi-weekly basis. Benefit Eligible Retiree premiums are due on a monthly basis. Both Benefit Eligible Employee/Retiree self-pay premiums are subject to a thirty (30) day grace period for timely payment of premiums. If coverage is terminated due to failure to timely pay applicable premiums, COBRA rules will apply.

C. Annual Enrollment

Each year, every Benefit Eligible Employee and every benefit-enrolled retiree will have a limited period of time to make changes in the coverage in which he or she is enrolled. The limited period during which the changes can be made is known as an "Annual Enrollment Period". If this window of opportunity is missed, new benefit elections cannot be made until the next Annual Enrollment Period or Qualifying Event, whichever occurs first. Changes in coverage elected during the Annual Enrollment Period become effective the following March 1st and remain in effect for one year unless the Enrollee's coverage terminates or the Enrollee changes his or her coverage election in other situations described in the applicable group health plan

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D. Changes in Benefit Elections Outside of Annual Enrollment

1. The benefit plans and programs of Harris Health include rules that, in certain circumstances, may allow a Benefit Eligible Employee or retiree plan participants to make benefit plan changes outside of the Annual Enrollment Period.

    a. If a change in coverage is allowed, Benefits will open a PeopleSoft window for the Benefit Eligible Employee or allow a paper election for a retiree plan participant within thirty-one (31) calendar days of the date of the event that gives rise to the right to make a change in election.
    b. The eligible plan participant should contact Benefits at 713-566-6451 about specific events to determine the appropriate benefit enrollment timeframe.

c. No benefit changes will be allowed in violation of any court order issued by a court of competent jurisdiction.

2. All Qualifying Event benefit enrollments (i.e., new hire, newly eligible, family status change, job status change, etc.) must satisfy the eligibility terms and conditions outlined in Sections I and II of Harris Health System Policy and Procedures 6.04 Health and Related Benefits and be made within thirty-one (31) calendar days from the date of the event.

   a. If the Benefit Eligible Employee or Benefit Eligible Retiree misses this thirty-one (31) day window, no benefit changes can be made until the next Qualifying Event or the next Annual Enrollment Period, whichever comes first.
   b. A Special Qualifying Event window may apply to make benefit changes in certain situations, such as for Medicaid and CHIPs eligibility, that may extend the traditional thirty-one (31) day enrollment window to sixty (60) days. A Benefit Eligible Employee/Retiree should contact Benefits at 713-566-6451 about the specific event to determine the appropriate benefit enrollment timeframe.

3. A family member or job status change may include a change in marital status, the number or eligibility of dependents, employment status (i.e., hourly to salary or salary to hourly part-time to full-time, Supplemental or PPACA Supplemental or vice versa, etc.) including retirement, geographic relocation (e.g., regional transfers), or an approved unpaid Leave of Absence including FMLA. Changes in benefit enrollments may also result from court orders, gaining or losing coverage under another employer's plan, enrolling under Part A or Part B of Medicare, enrolling under Medicaid (other than Medicaid coverage consisting solely of benefits under the program for distribution of pediatric vaccines), or losing coverage under a governmental program including the Texas Health Insurance Risk Pool, the Children's Health Insurance Program (CHIPs), or the Texas Healthy Kids Corporation (THKC).

4. Proof of Benefit Eligible Dependent status must be timely submitted to enroll and continue coverage. Dependent eligibility will be determined by Benefits.

5. If Harris Health receives a Qualified Medical Child Support Order that requires that a Benefit Eligible Employee's qualifying Child be enrolled in a Harris Health sponsored medical plan, the Child (and, if necessary, the Benefit Eligible Employee) will be enrolled as directed by the order and the Benefit Eligible Employee will be required to pay for the applicable coverage.

6. If Harris Health receives a Qualified Medical Child Support Order that requires a retiree medical plan participant to enroll a qualifying Child in a Harris Health sponsored medical plan, the Child will be enrolled as directed by the order and the retiree will be required to pay for the applicable coverage.

E. Ineligible Dependent

When Benefits determines that an **"Ineligible Dependent"** is enrolled in violation of Harris Health System Policy and Procedures 6.04 Health And Related Benefits, Benefits will terminate the Ineligible Dependent's enrollment to ensure that no further benefits can be paid under the employer sponsored plans or programs. If termination of coverage results in a level of coverage change for the Enrollee, Benefits will change applicable premium rates as allowed by the terms of the plan and by law. No refund of back premiums will be made. The termination of coverage of an Ineligible Dependent does not entitle an Enrollee to make any other benefit changes.