HARRISHEALTH SYSTEM

POLICY AND REGULATIONS MANUAL

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TITLE: **HEALTH AND RELATED BENEFITS**

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

POLICY STATEMENT:

The Harris Health System (Harris Health) values the health and wellbeing of its employees 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 and Harris Health share the cost of providing medical, prescription, dental and vision plans. Harris Health System provides Basic Life, AD&D, Short Term Disability and Long Term Disability at no cost to employees. Benefit Eligible Employees are responsible for the premium on elected voluntary benefits; Employee, Spouse and Child Voluntary Life, Voluntary AD&D, Flexible Spending Accounts, Long Term Disability Buy-Up and all Supplemental Plans elected through AlliantChoice+.

POLICY ELABORATIONS:

I. ELIGIBILITY – EMPLOYEE

The Employee Benefits Department of Harris Health ("Benefits") is responsible for determining whether an employee or dependent is eligible for health and welfare benefits based on Harris Health's policies, programs, plans, and applicable law.

A. **BENEFIT ELIGIBLE EMPLOYEE:** Defined in Harris Health System Policy and Procedures 6.12 Employment; see Definitions of Full-Time Status and Part-Time with Benefits Status.

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B. **PPACA SUPPLEMENTAL EMPLOYEE:** A supplemental, registry or other employee of Harris Health who is not a Benefit Eligible Employee under Harris Health System Policy and Procedures 6.12 Employment, but who, during an applicable "measurement period," works an average of thirty (30) hours or more per week, an average of one hundred thirty (130) hours or more per month, or one thousand five hundred sixty (1,560) hours a year, as measured by Harris Health, and thus qualifies as a "full-time employee" under 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 will be offered enrollment in the Harris Health medical plan options beginning the March 1 immediately following the applicable measurement period. A twelve (12)-month "stability period" will typically apply to PPACA Supplemental Employees, which means that such employees will generally be eligible for coverage under the Harris Health medical plan options for a twelve (12)-month period, as required by the PPACA guidelines.

II. ELIGIBILITY – DEPENDENT:

A. Dependent Eligibility:

Except as provided in Section II.C below, a Benefit Eligible Employee enrolled in a Harris Health sponsored medical, dental, or vision plan (an "Enrollee") may also enroll his or her qualifying Benefit Eligible Dependent(s) in the same plans, as applicable, in which he or she is enrolled. A "Benefit Eligible Dependent" is:

1. The Enrollee's Spouse;
2. The Enrollee's Child 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; or

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, a similar declaration from another state, or a comparable document from a foreign country 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, permanent legal custody or permanent legal guardianship pursuant to a court order.

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

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C. Special Enrollment Provisions:

1. In cases in which both spouses are Benefit Eligible Employees and seek to enroll in a Harris Heath medical, dental, or vision plan, each spouse must choose to enroll either as an Enrollee or as the Spouse of an Enrollee. One individual cannot be enrolled as both an Enrollee and a Spouse at the same time.

2. In cases in which a Child or Grandchild seeking to enroll in a Harris Health medical, dental, or vision plan is the qualifying dependent of more than one Enrollee, that Child or Grandchild can only be enrolled as the dependent of one Enrollee. For example, in situations in which both parents of a qualifying Child work for Harris Health and both choose to enroll as Enrollees, only one of those Enrollees may enroll the Child as a Benefit Eligible Dependent.

3. In conflict of enrollment situations, additional documentation may be required to support evidence of eligibility for a Child or Grandchild. The final eligibility determination rests with Benefits.

D. 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.

E. 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

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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 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 is 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 PLAN OPTIONS AVAILABLE TO BENEFIT ELIGIBLE EMPLOYEES:

A. Medical Plan Options:

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Harris Health sponsors a group medical plan that offers several options to qualified Benefit Eligible Employees. These medical plan options are funded from contributions made by Harris Health and the covered benefit eligible employee. 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, 2021

1. Regular Full-Time and regular Part-Time new hires or rehires are offered the opportunity to participate in either the Consumer Driven Health Plan (CDHP) with a Health Reimbursement Account (HRA), the Value Plan , or the KelseyCare plan at date of hire.

2. If a regular Full-Time or regular Part-Time Employee and or Enrolled Spouse fails to timely and accurately complete the Wellness Premium Rewards Program (previously known as the Tiered Benefits Campaign), the regular Full-Time or regular Part-Time Employee will be charged a higher premium cost share in the medical plan options than participants who timely and accurately completed the Wellness Premium Rewards Program.

3. PPACA Supplemental Employees are eligible to enroll in any of the Harris Health medical plans. PPACA Supplemental Employees are not eligible to participate in the Harris Health Wellness Premium Rewards Program and will therefore have a higher premium cost share than other participants.

4. Supplemental employees who have not worked thirty (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 coverage under any Harris Health group medical plans.

B. Prescription Drugs:

Prescription drug benefits are included as a part of the medical plans provided by Harris Health.

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C. Dental Plans:

Harris Health sponsors two (2) group dental plans, to all regular Full-Time and regular Part-Time Benefit Eligible Employees. The insurance carrier for each Dental Plan 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 Plan.

D. Vision Plan Option:

Harris Health offers a vision plan to all regular Full-Time and regular Part-Time Benefit Eligible Employees. The insurance carrier for the Vision Plan 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 option.

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 the 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 Life 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 and Basic AD&D coverage.

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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. Health Reimbursement Plan (HRA)

Harris Health offers regular Full-Time and regular Part-Time Benefit Eligible Employees enrolled in the CDHP with an annual contribution amount of $500 for Employee Only enrollment and $1,000 for Employee + Dependent enrollment.

Newly-hired or newly-eligible employees electing the HRA after March 1st will receive a prorated contribution. Proration will occur quarterly beginning March 1st.

	Employee Only Election		Employee + Election	
	Monthly Proration	Quarterly Proration	Monthly Proration	Quarterly Proration
HRA Contribution	$500.00		$1,000.00	
Month				
March	$500.00		$1,000.00	
April	$458.33	$500.00	$916.67	$1,000.00
May	$416.66		$833.33	
June	$374.99		$750.00	
July	$333.32	$375.00	$666.67	$750.00
August	$291.65		$583.33	
September	$249.98		$500.00	
October	$208.31	$250.00	$416.67	$500.00
November	$166.64		$333.33	
December	$124.97		$250.00	
January	$83.30	$125.00	$166.67	$250.00
February	$41.63		$83.33	

I. Short-Term Disability Benefits:

Short-Term Disability (STD) benefits may be available to regular Full-Time Employees. Benefits may be available in the form of a self-funded STD benefit.

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For further details contact the Third-Party Administrator of the STD plan or refer to Harris Health System Policy and Procedures 6.32 Short-Term Disability.

J. Disability Benefits:

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.

K. Reduction in Force and Severance Benefits:

For details, refer to Harris Health System Policy and Procedures 6.01 Reorganizations, Restructuring, and Permanent Reduction in Work Force; Benefits for Positions Below Director-Level and Harris Health System Policy and Procedures 6.30 Severance Benefits for Positions at the Director Level and Above.

IV. BENEFIT ADMINISTRATION:

A. Ineligible Dependent:

A participant in a Harris Health plan is responsible for immediately contacting Benefits at (713)566-MyHR when a Dependent no longer meets eligibility guidelines so that coverage(s) can be timely terminated. If participant fails to

timely notify the Benefits Department within thirty-one (31) calendar days, participant will not receive a reimbursement of the premiums paid..

B. Plan Terms Control:

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

V. HARRIS HEALTH RIGHTS TO MODIFY BENEFITS:

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

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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 Senior Vice President of Human Resources / Benefits Director

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REVIEW/REVISION HISTORY:

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 01/09/2018	Structure and Operational Standards Committee
		Approved 1/24/2018	Board of Trustee
	8.0	Revised/Approved 1/14/2020	Structure and Operational Standards Committee
	9.0	Revised/Approved 9/14/2021	Structure and Operational Standards Committee

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APPENDIX A

PROCEDURES FOR ADMINISTRATION OF 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 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 option offered by Harris Health qualifies as his or her Spouse, Child, or Grandchild.

A. Proof of Qualifying Spouse Status:

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

1. 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

2. A certified copy of a Texas Declaration and Registration of Informal Marriage filed with the appropriate county clerk's office, a similar declaration from another state, or a comparable document from a foreign country 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 III 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 other documents 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 in which the Child attains age 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 option 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 15th 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.

C. A Retiree Can Continue Coverage:

A 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 retiree within the time limitations and other requirements set by the group term life insurance policy.

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III. 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 plan(s). 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, with the exception of Supplemental Life.

b. It is the new hire's responsibility to ensure that the benefit plan(s) he or she elects are accurate. If a new hire erroneously elects a benefit plan, this error must be corrected within the 31-day period mentioned above (commencing on the new hire's first day of employment, and ending thirty-one (31) days later). Corrections are made by notifying Benefits and requesting a change. Failure to notify Benefits within this 31-day period will result in the forfeiture of overpaid premiums. If the 31-day period has been exceeded, no changes can be made to the benefit plan options until the next Annual Enrollment Period or Qualifying Event.

c. 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.

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

i. A new hire who is a Benefit Eligible Employee can change his or her option selection under the medical, dental or

vision plan, or his or her Flexible Spending Account plan election, within thirty-one (31) days of his or her first day of employment. To make a change, the new hire must contact Benefits within the 31-day period. Benefits will open a benefits election window in PeopleSoft to allow for the election change. Changes made during the 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 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 elections under the medical, dental, or vision plan, his or her optional life insurance coverage or his or her flexible spending account plan election, during Annual Enrollment and in other situations described in the applicable plan documents.

B. **Premiums:**

1. Benefit Eligible Employee premiums are paid on a bi-weekly basis by payroll deduction.

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2. Benefit Eligible Employee premiums will be payroll-deducted during an approved FMLA leave (refer to Harris Health System Policy 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 to discuss the alternative payment arrangements available.

3. Benefit Eligible Employee self-pay premiums are due on a bi-weekly basis. Benefit Eligible Employee self-pay premiums are subject to a 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 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 documents.

D. **Changes in Benefit Elections Outside of Annual Enrollment:**

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

   a. If a change in election is allowed, Benefits will open a PeopleSoft window for the Benefit Eligible Employee 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. If a change in election is made and that change is effective retroactively, the individual's share of the premiums for the retroactive coverage period must be paid to Harris Health. The premiums for the retroactive coverage period will be deducted from the individual's paycheck after the retroactive election is made.

c. The eligible participant should contact Benefits about specific events to determine the appropriate benefit enrollment timeframe.

d. 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 31 calendar days from the date of the event.

a. If the Benefit Eligible Employee misses this 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 CHIP eligibility, that may extend the traditional 31-day enrollment window to 60 days. A Benefit Eligible Employee should contact Benefits 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 to 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 (CHIP), 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 option, 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. If the Benefit Eligible Employee is not enrolled in a Harris Health sponsored medical plan option, the agency issuing the order must select the Harris Health medical plan option in which the employee and the Child covered by the order will be enrolled. If the agency issuing the order fails to timely select an option, the Benefit Eligible Employee and his or her qualifying Child covered by the order will be enrolled in the Harris Health High Deductible medical plan option, which is the Harris Health medical plan default option.

6. It is the Benefit Eligible Employee's responsibility to ensure that the benefit plan options he or she elects are accurate. If a Benefit Eligible Employee erroneously elects a benefit plan option, this error must be corrected by notifying Benefits and requesting a change. If the mistaken election occurred during the Annual Enrollment Period, the correction must be made before the Annual Enrollment Period closes. If the mistaken election occurred due to a Qualifying Event, the correction must be made within thirty-one (31) days of the Qualifying Event. Failure to notify Benefits within these allotted periods will result in the forfeiture of overpaid premiums. If the allotted period has been exceeded, no changes can be made to the benefit plan options until the next Annual Enrollment Period or Qualifying Event.

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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 plan options 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.

F. **Plan Termination**

Upon termination of employment, retirement, or loss of eligibility, your enrollment in the medical, pharmacy, dental and vision plans will term on the last day of the month in which the termination occurs.

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