

The County of El Paso Booklet is issued to describe, in general, the Medical Benefits.

The County of El Paso is Self Insured for its PPO medical plan.

These Medical Benefits are made available to you based upon your eligibility as defined by the Plan.

The County of El Paso expects you to use your Benefit Plan to its full extent, in a prudent manner, when you or one of your covered dependents is ill or injured.

The County of El Paso is the Trustee and Administrator of this Self-Funded Benefit Program and provides a major portion of the contributions necessary to properly fund these programs in order to make these benefits available to you.

This booklet's general information is not intended to be an exhaustive or all-inclusive description of services, which are covered, limited or excluded. It is only a simplified summary. It is not the legal document that actually governs the Plan. If this summary results in a misunderstanding or an inconsistency with the legal Plan Document, the legal document always governs.

We recommend that you contact the Plan Administrator to verify that your Plan will cover the Medical expenses necessary to treat your illness or injury **PRIOR** to starting any suggested plan of Medical treatment.

Your Plan Administrator is:

ACCESS ADMINISTRATORS, INC.
7430 Remcon Circle Bldg C
EL PASO, TEXAS 79912
(915) 581-8182
(800) 854-2339
www.accessadministrators.com
CUSTOMER SERVICE HOURS
7:00 a.m. - 6:00 p.m.
MONDAY--FRIDAY

Revised 7/23/07

By:

ATTEST:

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**Section 1
DEFINITIONS**

- A) ALLOWABLE EXPENSE.** An Allowable expense is an expense for a covered service or supply under this Plan and which, if made by a Network Provider, is a negotiated rate or charge; and which, if made by an Out-of-Network Provider, is either a Reasonable and Customary Charge in the case of a Physician or supplier, or a charge calculated by the Plan Administrator that approximates the standard or usual charge made by a Network Provider in the case of a Health Care Provider that is not a Physician or supplier.
- B) AMBULATORY SURGICAL CENTER.** An Ambulatory Surgical Center means a place approved or licensed as such by an agency of the governing jurisdiction.
- C) BENEFIT MAXIMUMS.** Total Plan payments for each participant are limited to certain maximum benefit amounts. A benefit maximum can apply to specific benefit categories or to all benefits. A benefit maximum amount also applies to a specific time period, such as annual or *lifetime*. Whenever the word *lifetime* appears in this Plan in reference to benefit maximums, it refers to the period of time you or your eligible dependents participate in this Plan or any other plan sponsored by the County of El Paso. The benefit maximums applicable to this Plan are shown in the Schedules of Medical Benefits.
- D) CANCER CLINICAL TRIALS.** Treatment provided in a phase I, Phase II, phase III, or phase IV cancer clinical trial that meets all of the following conditions:
- 1) The treatment must either: A) involve a drug that is exempt under federal regulations from a new drug application; or B) be approved by (i) one of the National Institutes of Health, (ii) the federal Food and Drug Administration in the form of an investigational new drug application; (iii) the United States Department of Defense, or (iv) the United States Veteran's Administration.
 - 2) The participant must have been diagnosed with cancer.
 - 3) Participation in the cancer clinical trial must be recommended by the Covered Person's physician based upon his or her medical determination that participation would have a meaningful potential to benefit the Covered Person.
 - 4) The cancer clinical trial must have a therapeutic intent. Clinical trials solely for the purpose of testing toxicity are not covered.
- Routine Patient Care Costs.** The costs associated with the provision of services for Cancer Clinical Trials, including drugs, items and services which would otherwise be covered under the Plan, including health services which are: A) typically provided absent a clinical trial; B) required solely for the provision of the investigational drug, item, device, or service; C) clinically appropriate monitoring of the investigational drug, item, device, or service; D) prevention of complications arising from the provision of the investigational drug, item, device, or service; and E) reasonable and necessary care arising from the provision of the investigational drug, item, device, or service, including the diagnosis or treatment of the complications.
- Routine Patient Care Costs do not include the following costs regarding Cancer Clinical Trials (in addition to the costs of non-covered services): 1) drugs or devices not approved by the federal Food and Drug Administration that are associated with the clinical trial; 2) services other than health care services such as travel, housing, companion expenses and other non-clinical expenses that the Covered Person may require as a result of the treatment provided for the purposes of the clinical trial; 3) any item or service provided solely to satisfy data collection and analysis needs for information that is not used in the clinical management; 4) health care services that, except for the fact that they are provided in a clinical trial, are otherwise specifically excluded from the Plan; and 5) health care services customarily provided by research sponsors free of charge to person enrolled in the clinical trial.
- E) CALENDAR YEAR.** The 12-month consecutive period beginning on January 1st and ending on December 31st of each year.
- F) CERTIFICATE OF CREDITABLE COVERAGE.** Under the Health Insurance Portability and Accountability Act (HIPAA), group health plans are required to automatically provide Certificates of Creditable Coverage to all individuals, both employees and dependents that lose group health coverage on or after June 1 1997. The Certificate of Creditable Coverage shows the type(s) of coverage and the length of time coverage was held.

One would establish creditable coverage by presenting this Certificate of Creditable Coverage describing previous coverage. The Act (HIPAA) permits a lapse of coverage of 63 days before prior coverage is no longer "creditable." Creditable Coverage will waive any Pre-existing medical Condition exclusion-day for day- by any period of Creditable Coverage.

The Plan Administrator automatically provides Certificates of Creditable Coverage to all individuals, both employees and dependents who lose coverage under the County of El Paso's group health plan, and subsequently if COBRA is elected, at the end of COBRA coverage.

A request for Certificates of Creditable Coverage by or on behalf of a former Employee or dependent must be honored as long as the request is received within 24 months of when that individual lost coverage.

- G) COMPANY.** The Company is the County of El Paso, Texas.
- H) COVERED PERSON.** Any Eligible Employee or Dependent, who has satisfied the Waiting Period, who has elected coverage and who has made any required contribution for coverage under the Plan, if any.
- I) COSMETIC PROCEDURES.** Cosmetic Procedures are the alteration of tissue (usually surgical) for the improvement of appearance, but which is not intended to effect a substantial improvement or restoration of bodily function. These procedures are:
 - 1) Due to neither injury nor sickness;
 - 2) Performed solely to improve the appearance rather than the function or usefulness of a structure of the body.
- J) CREDITABLE COVERAGE.** Coverage provided under:
 - 1) A self-funded or self-insured employee welfare benefit plan that provides health benefits and that is established in accordance with the Employee Retirement Income Security Act of 1974 (290 U.S.C. Section 1001 et seq.);
 - 2) A group Health Benefit Plan provided by a health insurance carrier or health maintenance organization;
 - 3) An individual health insurance policy or evidence of coverage;
 - 4) Part A or Part B of Title XVIII of the Social Security Act (42 U.S.C. Section 1395c et seq.);
 - 5) Part XIX of the Social Security Act (42 U.S.C. Section 1395c et seq.), other than coverage consisting solely of benefits under Section 1928 of that Act (42 U.S.C. Section 1396s et. seq.);
 - 6) Chapter 55, Title 10, United States Code (10 U.S.C. Section 1071 et seq.);
 - 7) A medical care program of the Indian Health Service or of a tribal organization;
 - 8) A state or political subdivision health benefits risk pool;
 - 9) A health plan offered under Chapter 89, Title 5, United States Code (5 U.S.C. Section 8901 et seq.)
 - 10) A public health plan as defined by federal regulations; or
 - 11) A Health Benefit Plan under Section 5(e), Peace Corps Act;
 - 12) Short term limited duration insurance.

Creditable Coverage does not include:

- 1) Accident only, disability income insurance, or a combination of accident only and disability income insurance;
- 2) Coverage issued as a supplement to liability insurance;
- 3) Liability insurance, including general liability insurance and automobile liability insurance;
- 4) Workers' compensation or similar insurance;

- 5) Automobile medical payment insurance;
- 6) Credit-only insurance;
- 7) Coverage for onsite medical clinics;
- 8) Other coverage that is:
 - a) Similar to the coverage described by this subsection under which benefits for medical care are secondary or incidental to other insurance benefits; and
 - b) Specified in federal regulations
 - (i) Coverage that provides limited-scope dental or vision benefits;
 - (ii) Long term care coverage or benefits, Nursing home care coverage or benefits, Home Health Care coverage or benefits, community-based care coverage or benefits, or any combination of those coverages or benefits
 - (iii) Coverage that provides other limited benefits specified by federal regulations;
 - (iv) Coverage for a specified disease or illness; or
 - (v) Hospital indemnity or other fixed indemnity insurance; or
 - (vi) Medical supplemental health insurance defined under Section 1882 (g)(1), Social Security Act ((42 U.S.C. Section 1395s), coverage supplemental to the coverage provided under Chapter 55, Title 10, United States Code (10 U.S.C. Section 1071 et seq.), and similar supplemental coverage provided under a group plan.

I) CUSTODIAL CARE. Care comprised of services and supplies provided primarily to assist in the activities of daily living.

J) DEDUCTIBLE. The amount of expenses a Covered Person must pay in each Calendar Year before benefits are payable under this Plan.

K) DRUGS. (Please See "Prescription Drug Expense Coverage" section for complete information.)

BRAND NAME. Brand Name Drugs shall mean prescription drugs, which are sold under a name, which is protected by a federally registered trademark.

GENERIC. Generic Drugs shall mean prescription drugs, which are sold under a name not protected by a federally registered trademark, and which are chemically equivalent to drugs sold under a name, which is protected by a federally registered trademark.

Drugs include insulin and prescription legend drugs. A legend drug is either:

- 1) A Federal Legend Drug which is any medicinal substance which bears the legend: "Caution: Federal Law prohibits dispensing without a prescription," or
- 2) A State Restricted Drug which is any medicinal substance which may be dispensed by prescription only, according to state law, and which is legally obtained from a licensed drug dispenser only upon a prescription of a currently licensed physician.

L) DURABLE MEDICAL EQUIPMENT. Durable Medical Equipment shall include equipment which:

- 1) Can withstand repeated use, and
- 2) Is primarily and customarily used to serve a medical purpose, and

- 3) Generally is not useful to a person in the absence of an illness or injury, and
- 4) Is appropriate for use in the home.

All requirements of the definition must be met before an item can be considered to be Durable Medical Equipment.

- M) **ELECTIVE SURGICAL PROCEDURE.** A non-emergency surgical procedure scheduled at the patient's convenience without jeopardizing the patient's life or causing serious impairment to the patient's bodily function.
- N) **ELIGIBLE DEPENDENT.** An Eligible Dependent shall mean the lawful spouse or common law spouse (with certificate of common law union) of an employee. It shall also mean the unmarried children of any employee whom:
 - 1) Under age 25, are the natural children, legally adopted children or children for whom the employee is a legal guardian; or
 - 2) Under age 25, are the step children who reside at the employee's home and are claimed as an eligible income tax deduction; or
 - 3) Upon reaching the age of 25 and having been covered under this Plan as an eligible dependent, are mentally or physically handicapped and are incapable of earning a living, may continue to be covered as an Eligible Dependent. The Plan Sponsor may require the employee to furnish periodic proof of this individual's continued incapacity or dependency, but not more often than annually. If such proof is not satisfactory, and further proof, which is satisfactory, is not provided upon request, coverage for the individual will end immediately.
- O) **ELIGIBLE EMPLOYEE.** An Eligible Employee is any full time employee who has satisfied the applicable waiting period. Full time shall mean a minimum of 30 hours per week. An Eligible Employee shall also include retired employees choosing to continue benefits under the Plan at the time of retirement. It shall also include all District Judges.
- P) **EMERGENCY CARE.** Emergency Care means health care services provided in a Hospital emergency facility or comparable facility to evaluate and stabilize medical conditions of a recent onset and severity, including but not limited to severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that the person's condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in:
 - 1) Placing the patient's health in serious jeopardy;
 - 2) Serious impairment to bodily functions;
 - 3) Serious dysfunction of any bodily organ or part;
 - 4) Serious disfigurement; or
 - 5) In the case of a pregnant woman, serious jeopardy to the health of the fetus.
- Q) **EMPLOYER.** The Employer is the County of El Paso.
- R) **ENROLLMENT.** Enrollment is the election by an Eligible Employee for coverage under the Plan.

New Employee. A new Eligible Employee may enroll in the Plan at any time before the end of the 90-day Waiting Period. *Failure to do so will make the Employee ineligible for health coverage during the remaining calendar year.* If Benefits are not elected within the 90 day Waiting Period, the Employee must wait to enroll during the open enrollment period of the Plan (which is the month of October) to obtain coverage. Elections made in October will become effective on the following January 1st.

New Dependents. When an Employee acquires eligible dependents, the Employee shall have 31 days to enroll these eligible dependents under the Plan.

If an Employee does not cover eligible dependents under the Health or Dental Programs within 31 days of their first becoming eligible, the Employee must wait until the open enrollment of the Plan during the month of October to obtain coverage for these dependents unless a change in family status or a loss of other coverage occurs. Examples of changes in family status are marriage, divorce, death, adoption, birth, and losing dependent status. Examples of loss of coverage are change in employee status, reduction in hours, exhaustion of COBRA coverage and losing coverage with another group benefit plan. Under such circumstances, the Employee will have 31 days to elect coverage for those eligible dependents. If Benefits are not elected at that time, the Employee must wait to enroll during the open enrollment period enrollment of the Plan (which is the month October) to obtain coverage. **Elections made in October will become effective on the following January 1st.**

An employee shall have the right, with respect to a child who is born while the employee is covered for benefits under the Plan and where the employee has previously waived coverage for other eligible dependent children, to obtain benefits for this child under the Plan. This child is a Covered Dependent under the Plan from the moment of birth.

However, any coverage that this child has solely by reason of this Newborn Child Provision, is hereby modified to provide that no benefits will be payable for any charge incurred for a service or supply which is necessary for the covered medical care of this child after the end of the 31 day period which immediately follows the child's birth, unless the employee notifies the Plan and completes any necessary enrollment forms during this same 31 day period. In the event that an employee has previously waived coverage for Eligible Dependents, this child who has become covered from the moment of birth by reason of Newborn Child Provisions will continue to be covered after the end of the 31 day period if the employee enrolls this newborn child during the 31 day period which immediately follows the child's date of birth. All other dependents for which coverage previously was waived will need to wait until an open enrollment period to be added as covered dependents.

Retired Employee. A retired employee shall have 31 days to elect to retain Health Coverage under the Plan from the date of retirement. Failure to do so will mean forfeiture of any further future coverage rights under the Plan. Employees retiring after April 1, 1983 shall not have the right to elect to continue Dental Coverage for themselves or their eligible dependents.

PLEASE NOTE: Upon retirement of a participating employee, only the eligible dependents covered under the employee at the time of retirement will be allowed to continue coverage as eligible dependents under the retired employee's benefits.

S) EXPERIMENTAL OR INVESTIGATIONAL DRUG, DEVICE, TREATMENT OR PROCEDURE:

- 1) A drug or device which cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and which has not been so approved for marketing at the time the drug or device is furnished; or
- 2) A drug, device, treatment or procedure which was reviewed and approved (or which is required by federal law to be reviewed and approved) by the treating facility's Institutional Review Board or other body serving a similar function, or a drug, device, treatment or procedure which is used with a patient informed consent document which was reviewed and approved (or which is required by federal law to be reviewed and approved) by the treating facility's Institutional Review Board or other body serving a similar function; or
- 3) A drug, device, treatment or procedure which Reliable Evidence shows is the subject of on-going phase I, II or III clinical trials or is under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or
- 4) A drug, device, treatment or procedure for which the prevailing opinion among experts, as shown by Reliable Evidence, is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy as compared with a standard means of treatment or diagnosis.

Reliable Evidence means only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, treatment or procedure.

- T) EXTENDED CARE FACILITY.** The term "Extended Care Facility" means an institution (or a distinct part of an institution) which:
- 1) Provides for inpatients 24 hours nursing care and related services for patients who require medical or nursing care, or service to the rehabilitation of injured or sick persons; and
 - 2) Has policies developed with the advice of (and subject to review by) professional personnel to cover nursing care and related services; and
 - 3) Has a physician, a registered professional nurse, or a medical staff responsible for the execution of such policies; and
 - 4) Requires that every patient be under the care of a physician, and makes a physician available to furnish medical care in case of emergency; and
 - 5) Maintains clinical records on all patients, and has appropriate methods for dispensing drugs and biologicals; and
 - 6) Has at least one registered professional nurse on duty at all times; and
 - 7) Provides for periodic review by a group of physicians to examine into the need for admissions, adequacy of care, duration of stay and medical necessity of continuing confinement of patients; and
 - 8) Is licensed pursuant to law, or is approved by appropriate authority as qualifying for licensing.

However, such term does not include a place, which is primarily for Custodial Care.

- U) FISCAL YEAR.** The 12-month consecutive period ending on the last day in the month of September.
- V) HEALTH CARE PROVIDER.** A health Care Provider is legally licensed in the USA and provides medical care or diagnostic treatment to individuals for a covered illness or injury. The requirement that the Health Care Provider be legally licensed in the USA will be waived when treatment is provided to a covered participant by a Health Care Provider licensed in the country where services are provided, in an emergency while traveling outside the United States. Examples, though not an exhaustive list, of Health Care Providers are as follows:
- 1) Ambulatory Surgical Center
 - 2) Extended Care Facility
 - 3) Home Health Agency
 - 4) Hospice
 - 5) Hospital
 - 6) Laboratory
 - 7) Nurse
 - 8) Nurse Practitioner
 - 9) Midwife
 - 10) Physician
 - 11) Psychologist
 - 12) Therapist
 - 13) Master of Social Work
 - 14) Licensed Clinical Social Worker
- W) HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA).** The Act establishes federal standards for the availability and portability of group and individual health insurance coverage. The provisions of the Act affect coverage whether the coverage is provided through self-insured plans, group health insurance, through individual policies or by HMO. The Act is designed to provide more options for maintaining health insurance for individuals that change jobs, lose jobs, become self employed, or move to a company that does not provide health insurance. The Act also limits the ability of employers or insurance issuers to impose preexisting condition exclusions or to use an individual's health status to deny coverage
- X) HOME HEALTH AGENCY.** A Home Health Agency means a public or private agency which

- 1) Is certified as a Home Health Agency under Medicare or is licensed as a Home Health Agency by the state; and
- 2) Is primarily engaged in providing skilled nursing and other therapeutic services; and
- 3) Has its policies set by a professional group which governs the services provided; and
- 4) Maintains records for each patient.

Y) HOSPICE. Hospice means a public or private entity, which is licensed or certified as a Hospice by Medicare and by the State. The care provided by a Hospice means the palliative, supportive and related care for the person diagnosed as terminally ill with a medical prognosis that life expectancy is six (6) months or less; but only where the Hospice:

- 1) Provides this care on a 24-hour basis to include providing control of symptoms associated with terminal illness; and
- 2) Has an interdisciplinary team consisting of at least one (1) Medical Doctor (M.D.) or Doctor of Osteopathy (D.O.); at least one (1) Registered Nurse (R.N.); at least one (1) volunteer and a volunteer program; and
- 3) Maintains central clinical records on all patients; and
- 4) Provides appropriate methods of dispensing and administering drugs and medicines; and
 - a) is not an organization or part thereof which is primarily engaged in providing custodial care; care for drug addicts and alcoholics; domestic services; or is a place for rest; a place for the aged; a hotel or similar institution.

Z) HOSPITAL. An institution for care of the sick or injured, which is properly licensed to operate as such, and which has licensed graduate registered nurses on duty 24 hours a day, a "physician" on call at all times, and facilities for diagnosis of illness and related equipment for performing surgery. The requirement of surgical facilities shall not apply to a treatment center, which is duly licensed for, and specialized in, the care and treatment of those who are mentally ill. In no event will the term Hospital include an institution which:

- 1) Furnishes primarily domiciliary or custodial care; or
- 2) Furnishes training in the routines of daily living; or
- 3) Is operated primarily as a school.

For the treatment of chemical dependency, the term Hospital shall also include a Chemical Dependency Treatment Center. The term Chemical Dependency Treatment Center means a facility which provides a program for the treatment of alcohol and other chemical dependence pursuant to a written treatment plan approved and monitored by a physician and which facility is also:

- 1) Affiliated with a hospital under the contractual agreement with an established system for patient referral, or
- 2) Accredited as such a facility by the Joint Commission on Accreditation of Hospitals, or
- 3) Licensed as an Chemical Treatment Program by the Texas Commission on Alcohol and Drug Abuse (TCADA), or
- 4) Licensed, Certified, or Approved as a Chemical Dependency Treatment Program or Center by any other State Agency having legal authority to so license, certify or approve.

AA) HOSPITAL CONFINEMENT. A stay in a Hospital is considered a Hospital Confinement when a Covered Person is admitted as an inpatient, and is charged room and board for at least one full day.

- BB) INCURRED EXPENSES.** An expense is deemed to be incurred on the date a service is rendered or a supply is furnished.
- CC) IMMUNIZATIONS.** Immunizations will be allowed in accordance of the Texas Administrative Code, Title 25(Health Services), Part 1(Texas Department of Health), Chapter 97 (Communicable Diseases), related to subchapters and rules.
- DD) INJURY.** Injury means an accidental bodily injury, which requires treatment by a physician. It must result in loss independently of sickness and other causes.
- EE) IN-NETWORK.** In-Network shall mean treatment or services provided by Network Providers.
- FF) LABORATORY.** A Laboratory means a public or private entity which is equipped for scientific experimentation, research, testing, or clinical studies of materials, fluids, or tissues obtained from patients and is properly approved or licensed as such by an agency of the governing jurisdiction.
- GG) LEAVE OF ABSENCE.** A period of time during which the employee does not work but which is of stated duration; after which time, the employee is expected to return to regular, active, full time employment.
- HH) MEDICAL CASE MANAGEMENT PROGRAM.** Medical Case Management Program shall mean a program, which provides for a nurse case manager to coordinate the medical services required by a Participant in the event such Participant suffers a serious Sickness or Injury which involves ongoing care or Hospital Confinement. The nurse case manager shall explore with the Participant; such Participant's Family and the treating Physician, the availability and feasibility of possible alternative treatment plans.
- II) MEDICALLY NECESSARY.** Medically Necessary shall mean services, treatment, supplies or drugs ordered or authorized by a Physician and which is determined by the designated Utilization Review Organization to be:
- 1) Provided for the diagnosis or direct treatment of an injury or sickness;
 - 2) Appropriate and consistent with the symptoms and findings or diagnosis and treatment of the Covered Person's injury or sickness;
 - 3) Provided in accordance with generally accepted medical practice on a national basis; and
 - 4) The most appropriate supply or level of service, which can be provided on a cost effective basis (including, but not limited to, inpatient versus outpatient care, electric versus manual wheelchair, surgical versus medical or other types of care).
- The fact that the Covered Person's physician prescribes services or supplies does not automatically mean such services or supplies is medically necessary and **covered by the Plan.**
- JJ) MEDICALLY APPROPRIATE.** Medically Appropriate shall mean:
- 1) Required for the symptoms and diagnosis associated with the medical or psychological Sickness, Injury or Surgical Procedure of the Participant;
 - 2) Provided in the facility, setting, or environment which can provide the most appropriate and cost effective level of care for the Participant's medical or psychological Sickness, Injury or Surgical Procedure; and
 - 3) Determined in the discretion of each of the applicable Administrators specified below to be within acceptable standards of medical or psychological practice for the specific Participant's medical or psychological Sickness, Injury or Surgical Procedure:
 - a) The Utilization Review Organization for the Out-of-Area Plan and for treatment or services provided by Out-of-Network Providers under the Managed Care Plan;
 - b) The designated Utilization Review Organization for treatment or services provided by Network Providers under the Plan.

- KK) MEDICARE.** Medicare means the Part A and Part B Plans described in Title XVIII of the United States Social Security Act, as amended.
- LL) MIDWIFE.** A registered nurse/Practitioner who has completed specialized theory and clinical courses in obstetrics and gynecology and is acting within the scope of applicable state licensure/certification requirements.
- MM) NAMED FIDUCIARY.** The person who has the authority to control and manage the operation and administration of the Plan. The Named Fiduciary for the Plan is the County of El Paso.
- NN) NATIONAL NETWORK:** Plan Participants will have access to a "National Network" of Health Care Providers, which have contracted with the Plan Administrator. These providers can be utilized when the Participants are outside of the El Paso area and require specified treatment, service or supplies. The Health Care Providers within the Network have agreed to a contracted/negotiated rate as payment in full.
- OO) NEGOTIATED RATE.** Negotiated Rate shall mean the amount, which a Network Provider has agreed to accept as payment in full for a specified treatment, service or supply provided to a Plan Participant, pursuant to a contract between the applicable Network Provider and the Network Administrator.
- PP) NETWORK.** Network shall mean the Health Care Providers, which have contracted with the Network Administrator to provide medical services to Plan Participants who have elected to participate in the Managed Care Plan.
- QQ) NETWORK ADMINISTRATOR.** Network Administrator shall mean the person or entity appointed Network Administrator. The Network Administrator is Advantage Care Network, Inc.
- RR) NETWORK PROVIDER.** Network Provider shall mean a Health Care Provider who has contracted with the Network Administrator to provide treatment or services to Participants under the Plan and to accept Negotiated Rates as payment in full for such treatment and services.
- SS) NON-OCCUPATIONAL.** A condition, which does not arise out of or in the course of employment for pay or profit and does not qualify under any Workers' Compensation law or similar legislation.
- TT) NURSE.** A Nurse is a properly licensed person holding the degree of Registered Nurse (R.N.), Licensed Vocational Nurse (L.V.N.), or Licensed Practical Nurse (L.P.N.).
- UU) NURSE PRACTITIONER.** A registered nurse with additional education, skills, and specialization in various fields of medicine. They must be licensed as an Advanced Nurse Practitioner.
- VV) OFFICE VISIT.** Office Visit shall mean the following services provided by a Physician in his office or in an Outpatient setting:
- 1) Time spent with or on behalf of the patient;
 - 2) Reviewing of patient history;
 - 3) Examination of the patient;
 - 4) Diagnosis;
 - 5) Medical decision-making;
 - 6) Counseling; and
 - 7) Coordination of medical care.
- WW) OUT-OF-AREA BENEFITS.** Out-of-Area Benefits shall mean the Benefits that are payable for treatment or services provided by Health Care Providers who are not in the Network Service Area. Members are encouraged to utilize the "National Network" in order for benefits to be paid at the In Network level.

- XX) OUT-OF-NETWORK BENEFITS.** Out-of-Network Benefits shall mean Benefits as defined in the Comprehensive Medical Benefits Section for treatment or services provided by Health Care Providers who are located within the El Paso and Las Cruces Service Area, but are not Network Providers.
- YY) OUTPATIENT.** A Covered Person shall be considered to be an Outpatient if he/she is treated at a hospital and is confined less than 24 consecutive hours.
- ZZ) OUTPATIENT HOSPITAL DEDUCTIBLE.** A separate deductible taken for services rendered in the outpatient department of the hospital. Examples are Outpatient Lab, Outpatient MRI, Outpatient CT Scan, Outpatient Physical Therapy, Outpatient X-rays, and Outpatient Surgeries.
- AAA) PHYSICIAN.** Shall be a properly licensed person holding the degree of Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Podiatry (D.P.M.), Doctor of Dental Surgery (D.D.S.), Doctor of Chiropractic (D.C.), and Doctor of Optometry (O.D.).
- BBB) PLAN.** The Plan is the benefits and the provisions for payment of these same described benefits herein and is called the County of El Paso Health and Life Benefits Fund.
- CCC) PLAN ADMINISTRATOR.** The person or firm providing technical services and advice to the Company in connection with the operation of the Plan and performing such other functions including processing any payment of claims as may be delegated to it. The Plan Administrator is Access Administrators, Inc.
- DDD) PLAN SPONSOR.** The Plan Sponsor is the County of El Paso, Texas. The Plan Sponsor, as used herein, shall be the person or firm responsible for the day to day function and management of the Plan and shall act as agent for service of legal process.
- EEE) PPO BENEFITS.** PPO Benefits shall mean the Benefit as defined in Comprehensive Medical Benefits Section for treatment or services provided by Health Care Providers who are in the Network.
- FFF) PRE-CERTIFICATION.** Pre-Certification is a procedure, completed in advance of obtaining services, which justifies the Medical Necessity of specific types of care and services covered under this Plan. When utilizing an In-Network Medical Care Provider, it is that Provider's responsibility to handle Pre-Certification. When utilizing Out-of-Network or Out-of-Area Health Care Providers, it is the responsibility of the Covered Person to handle Pre-Certification. In order to pre-certify or check on Pre-Certification, please contact the Plan Administrator, Access Administrators, Inc. at (915) 581-8182 or (800) 854-2339.
- GGG) PRE-EXISTING CONDITION.** A Pre-Existing Condition is any condition where medical care or treatment was received by a Covered Person or where medical care or treatment was recommended by a physician or surgeon for a Covered Person, within the 90-day period which immediately preceded the date such Covered Person became covered under this Plan. A Certificate of Creditable Coverage can eliminate or reduce the 12-month waiting period on Pre-existing conditions.
- HHH) PREFERRED HOSPITAL.** R.E. Thomason, Las Palmas and Del Sol Regional Healthcare Systems in El Paso, Texas are considered the preferred hospitals. The benefits described in the schedule of benefits are payable to the preferred hospitals in accordance with other plan provisions.
- III) PREFERRED LAB.** Designated laboratory entity that will offer the Plan maximum benefit in which contracted/negotiated fees are considered payment in full.
- JJJ) PREGNANCY.** Shall include resulting childbirth, except for complications arising there from, as defined herein as Pregnancy Complications. If, while covered under the Plan, a female employee or a covered dependent wife or dependent daughter becomes pregnant and on account of such pregnancy incurs hospital, surgical or other medical expense, the Plan shall pay such expense in the same manner as any other covered illness. Pre-Existing conditions and extension of benefits for pregnancy shall be covered in the same manner as any other covered illness. Pregnancy is considered to have commenced nine months before its termination, unless a doctor's written statement to the company states otherwise. Hospital charges for well baby care for a newborn child born to an *employee* or a *dependent wife* are considered to be eligible charges of the mother during the hospital stay. Charges for well baby care for a child born to a dependent daughter are not eligible for payment under the plan.

KKK) PREGNANCY COMPLICATIONS. Shall include the following:

- 1) Conditions requiring hospital confinement (when the pregnancy is not terminated) whose diagnosis are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity, but shall not include false labor, occasional spotting, physician prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, pre-eclampsia and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy, and
- 2) Non-elective Caesarean Section, ectopic pregnancy which is terminated and spontaneous termination of pregnancy, which occurs during a period of gestation in which a viable birth is not possible, a miscarriage or a non-elective abortion.

LLL) PSYCHOLOGIST. A Psychologist shall only include a practitioner who is duly licensed or certified in the state where the service is rendered and has a doctorate degree in psychology and has had at least two years clinical experience in a recognized health setting, or has met the standards of the National Register of Health Service Providers in Psychology.

MMM) REASONABLE AND CUSTOMARY. A Reasonable and Customary Charge shall be a charge which is less than the usual charges made by a Physician or supplier of services, medicines, or supplies and shall not exceed the general level of charges made by others rendering or furnishing such services, medicines, or supplies within the area* in which the charge is incurred for sickness or injuries comparable in severity and nature to the sickness or injury being treated.

*The term "Area" as it would apply to any particular service, medicine, or supplies means a county or such greater geographic area as is necessary to obtain a representative cross section of the level of charges. The Plan Administrator shall make the determination of Reasonable and Customary Charge based on established criteria in determining available benefits under the Plan.

NNN) RETIRED EMPLOYEE. Any individual who has been covered under the Plan, prior to September 19, 1988, as a Retired Employee. It shall also include any Employee who terminates employment on or after September 19, 1988 and who chooses to continue the Plan as a Retired Employee, within thirty days of the termination of employment, and meets one of the following criteria to be considered a Retired Employee:

- 1) The Employee has accumulated at least eight years of accredited service as a full time, permanent Employee of the County of El Paso and has attained the age of sixty, or
- 2) The Employee has accumulated total years of accredited service as a full time, permanent Employee of the County of El Paso and attained age whose total is equal to seventy-five or,
- 3) The Employee has accumulated a total of twenty years of accredited service as a full-time, permanent Employee of the County of El Paso regardless of age.

PLEASE NOTE: Upon retirement of a participating employee, only the eligible dependents covered under the employee at the time of retirement will be allowed to continue coverage as eligible dependents under the retired employee's benefits.

OOO) SERVICE AREA. Service Area shall mean the geographic area composed of United States Postal Service Zip Codes in which the Network Administrators have selected, established, and maintain a contracted network of Health Care Providers.

PPP) SURGICAL PROCEDURE. Surgical Procedure shall mean cutting, suturing, treating burns, correcting fractures, reducing a dislocation, manipulating a joint under general anesthesia, electrocauterizing, tapping (paracentesis), applying plaster casts, administering pneumothorax, endoscopy or injecting sclerosing solution.

QQQ) TERMINATION OF EMPLOYMENT. Termination of Employment shall mean an employee whom stops working due to resignation, with or without retirement benefits. It shall also mean an employee whom stops working at the request of the County of El Paso.

- RRR) THERAPIST.** A Therapist shall include a person who is duly licensed or certified in the state where the service is rendered to provide services for Physical, Speech or Occupational Therapy.
- SSS) TOTAL DISABILITY.** Total Disability, as applied to the Employee, means the complete inability of the employee to perform all of the substantial and material duties and functions of his/her occupation or any other gainful occupation in which the employee earns substantially the same compensation earned prior to disability and, as applied to Dependent, means confinement as a bed patient in a hospital.
- TTT) UTILIZATION REVIEW ORGANIZATION.** The Utilization Review Organization will be the entity awarded by the Third Party Administrator to administer the Utilization Review Program.
- UUU) WAITING PERIOD.** The Waiting Period is the period of time an Employee must be employed prior to becoming eligible to elect coverage under the Plan. The Waiting Period shall be 90-days of continuous full-time employment.

**Section 2
COMPREHENSIVE MEDICAL BENEFITS (CORE PLAN)**

OVERVIEW	In-Network/OOA	Out of network
<i>Please Note: Out of Network deductible must be met before benefits are paid</i>		
Individual Annual Deductible	\$1,000	\$2,000
Family Annual Deductible	\$2,000	\$4,000
Maximum Individual Out-of-Pocket <i>(for Hospital maximums see "Hospital Services")</i>	\$2,500	No Limit
Maximum Family Out-of-Pocket	\$5,000	No Limit
Stop Loss Protection **		
** Excludes co-payments, deductibles, any Out-of-Network mental health or any penalty(ies).		
Coinsurance	80%	65%
Maximum Lifetime Benefit	\$2,000,000 combined	

Hospital Services

RE THOMASON

PREFERRED HOSPITAL

Inpatient/Outpatient Coinsurance	95%
Hospital Deductible(per admission)	\$100
Outpatient Hospital Deductible (per year)	\$200
Maximum Individual Out-of-Pocket	\$2,500
Maximum Family Out-of-Pocket	\$5,000
Emergency Use of Emergency Room Co-pay	\$100 then 80%
Non-Emergency Use of Emergency Room Co-pay	\$100 then 80%

LAS PALMAS & DEL SOL

PREFERRED HOSPITAL

	80%
Hospital Deductible(per admission)	\$100
Outpatient Hospital Deductible (per year)	\$200
Maximum Individual Out-of-Pocket	\$2,500
Maximum Family Out-of-Pocket	\$5,000
Emergency Use of Emergency Room Co-pay	\$100 then 80%
Non Emergency Use of Emergency Room Co-pay	\$100 then 80%

OTHER PPO HOSPITAL FACILITIES*

	65%
Hospital Deductible(per admission)	\$100
Outpatient Hospital Deductible (per year)	\$200
Maximum Individual Out-of-Pocket	\$6,000
Maximum Family Out-of-Pocket	\$12,000
Emergency Use of Emergency Room Co-pay	\$100 then 80%
Non-Emergency Use of Emergency Room Co-pay	\$100 then 65%

NON NETWORK HOSPITAL FACILITES

	50%
Hospital Deductible(per admission)	\$100
Outpatient Hospital Deductible (per year)	\$200
Maximum Individual Out-of-Pocket	No Limit
Maximum Family Out-of-Pocket	No Limit
Emergency Use of Emergency Room Co-pay	\$100 then 80%
Non-Emergency Use of Emergency Room Co-pay	\$100 then 50% after deductible

***Refer to PPO directory**

If a procedure is not available at RE Thomason, Del Sol or Las Palmas then benefits will be paid at 80% coinsurance level when rendered at a PPO facility or Non-Network facility

Please Note: Emergency Room co-pay will be waived only in the case of a hospital admission

OVERVIEW	In-Network/OOA	Out of Network
Professional Services		
Office Visit *	100% after \$35 Co-payment/Visit	65%
Routine Annual Physical exams limit to:		
• Office visit (one per year)	100% after \$35 Co-payment/Visit	not covered
• Immunizations (all ages)	100%	not covered
• Pap smear (one per year)**	100%	not covered
• Mammography (one per year)**	100%	not covered
• Colorectal and Prostate exams (one per year)	100%	not covered
• Labs	100%	not covered
• EKG	100%	not covered
*Excludes any procedures such as labs, x-ray, etc.		
**These services are considered a part of the annual exam and do not require a co-payment		
Surgeon	80%	65%
Assistant Surgeon	80%	65%
Office Visits	80%	65%
All Other Office Services/Procedures	80%	65%
Hospital Visits	80%	65%
Allergy Tests and Treatments	80%	65%
Chiropractic Care		
Office Visit	\$35 co-pay then 100%	65%
Other Services	80%	65%
	\$2000 maximum combined	
Mental Health		
Inpatient Facility	80%	65%
Physician	80%	65%
Outpatient Physician	80%	65%
Other Services		
Skilled Nursing Facility	80%	65%
	60 days combined	
Preferred Lab	100%	N/A
Diagnostic X-ray & Lab	80%	65%
Chemo/Radiation Therapy	80%	65%
Home Health Care	80%	65%
	Prior approval required	
Registered Private Duty Nursing	No Benefit	No Benefit
Hospice Care	80%	65%
Ambulance		
Emergency Use	80%	80%
Transports/Non-Emergency Use	80%	65%
Physical and Speech Therapy	80%	65%
Prosthetic	80%	65%
Durable Medical Equipment	80%	65%

OVERVIEW	In Network/OOAN	Out of Network
Prescription Drugs * (30 day Retail supply)	\$10 co-pay/Generic Drugs	65% after deductible
	\$25 co-pay Preferred Brand Name Drugs	
	\$40 co-pay Non-Preferred Brand Name Drugs	
Mail Order Drugs * (90 day supply)	\$20 co-pay/Generic	no coverage
	\$50 co-pay Preferred Brand Name Drugs	
	\$80 co-pay Non-Preferred Brand Name Drugs	
<i>* Please see "Prescription Drug Expense Coverage" section for details on Drug Benefits</i>		
Pre-admission and Concurrent Review	Included	Required
Large Case Management	Included	Included

**Section 3
COMPREHENSIVE MEDICAL BENEFITS (BUY-UP PLAN)**

OVERVIEW	In-Network/OOA	Out of network
<i>Please Note: Out of Network deductible must be met before benefits are paid</i>		
Individual Annual Deductible	\$250	\$750
Family Annual Deductible	\$500	\$1,000
Maximum Individual Out-of-Pocket (for Hospital maximums see "Hospital Services")	\$2,000	No Limit
Maximum Family Out-of-Pocket	\$4,000	No Limit
Stop Loss Protection **		
** Excludes co-payments, deductibles, any Out-of-Network mental health or any penalty(ies).		
Coinsurance	80%	65%
Maximum Lifetime Benefit	\$2,000,000 combined	

Hospital Services

RE THOMASON

PREFERRED HOSPITAL

Inpatient/Outpatient Coinsurance	95%
Hospital Deductible(per admission)	\$100
Outpatient Hospital Deductible (per year)	\$200
Maximum Individual Out-of-Pocket	\$2,000
Maximum Family Out-of-Pocket	\$4,000
Emergency Use of Emergency Room Co-pay	\$100 then 80%
Non-Emergency Use of Emergency Room Co-pay	\$100 then 80%

LAS PALMAS & DEL SOL

PREFERRED HOSPITAL

	80%
Hospital Deductible(per admission)	\$100
Outpatient Hospital Deductible (per year)	\$200
Maximum Individual Out-of-Pocket	\$2,000
Maximum Family Out-of-Pocket	\$4,000
Emergency Use of Emergency Room Co-pay	\$100 then 80%
Non Emergency Use of Emergency Room Co-pay	\$100 then 80%

OTHER PPO HOSPITAL FACILITIES*

	65%
Hospital Deductible(per admission)	\$100
Outpatient Hospital Deductible (per year)	\$200
Maximum Individual Out-of-Pocket	\$5,000
Maximum Family Out-of-Pocket	\$10,000
Emergency Use of Emergency Room Co-pay	\$100 then 80%
Non-Emergency Use of Emergency Room Co-pay	\$100 then 65%

NON NETWORK HOSPITAL FACILITES

	50%
Hospital Deductible(per admission)	\$100
Outpatient Hospital Deductible (per year)	\$200
Maximum Individual Out-of-Pocket	No Limit
Maximum Family Out-of-Pocket	No Limit
Emergency Use of Emergency Room Co-pay	\$100 then 80%
Non-Emergency Use of Emergency Room Co-pay	\$100 then 50% after deductible

* Refer to PPO directory

If a procedure is not available at RE Thomason, Del Sol or Las Palmas then benefits will be paid at 80% coinsurance level when rendered at a PPO facility or Non-Network facility

Please Note: Emergency Room co-pay will be waived only in the case of a hospital admission

OVERVIEW	In-Network/OOA	Out of Network
Professional Services		
Office Visit *	100% after \$30 Co-payment/Visit	65%
Routine Annual Physical exams limit to:		
• Office visit (one per year)	100% after \$30 Co-payment/Visit	not covered
• Immunizations (all ages)	100%	not covered
• Pap smear (one per year)**	100%	not covered
• Mammography (one per year)**	100%	not covered
• Colorectal and Prostate exams (one per year)	100%	not covered
• Labs	100%	not covered
• EKG	100%	not covered
*Excludes any procedures such as labs, x-ray, etc.		
**These services are considered a part of the annual exam and do not require a co-payment		
Surgeon	80%	65%
Assistant Surgeon	80%	65%
Office Visits	80%	65%
All Other Office Services/Procedures	80%	65%
Hospital Visits	80%	65%
Allergy Tests and Treatments	80%	65%
Chiropractic Care		
Office Visit	\$30 co-pay then 100%	65%
Other Services	80%	65%
	\$2000 maximum combined	
Mental Health		
Inpatient Facility	80%	65%
Physician	80%	65%
Outpatient Physician	80%	65%
Other Services		
Skilled Nursing Facility	80%	65%
	60 days combined	
Preferred Lab	100%	N/A
Diagnostic X-ray & Lab	80%	65%
Chemo/Radiation Therapy	80%	65%
Home Health Care	80%	65%
	Prior approval required	
Registered Private Duty Nursing	No Benefit	No Benefit
Hospice Care	80%	65%
Ambulance		
Emergency Use	80%	80%
Transports/Non-Emergency Use	80%	65%
Physical and Speech Therapy	80%	65%
Prosthetic	80%	65%
Durable Medical Equipment	80%	65%

OVERVIEW	In Network/OOAN	Out of Network
Prescription Drugs * (30 day Retail supply)	\$5 co-pay/Generic Drugs	65% after deductible
	\$20 co-pay Preferred Brand Name Drugs	
	\$35 co-pay Non-Preferred Brand Name Drugs	
Mail Order Drugs * (90 day supply)	\$10 co-pay/Generic	no coverage
	\$40 co-pay Preferred Brand Name Drugs	
	\$70 co-pay Non-Preferred Brand Name Drugs	
<i>* Please see "Prescription Drug Expense Coverage" section for details on Drug Benefits</i>		
Pre-admission and Concurrent Review	Included	Required
Large Case Management	Included	Included

Section 4
PROCEDURES FOR CLAIMING BENEFITS UNDER THE PLAN

HOW DOES ONE FILE A CLAIM FOR BENEFITS FOR AN OUT-OF-NETWORK PROVIDER FOR BENEFITS UNDER THE PLAN?

In submitting claims for Out-of-Network Providers, an Employee Statement of Claim form must be completed by the employee in detail and signed. One form per Covered person per illness per calendar year will be required.

The Physician must complete the form or provide an itemized billing form, which includes a complete and accurate diagnosis of the medical problem. In addition, all original, itemized bills for covered services or supplies must include the following:

- 1) The Health Care Provider's name and tax identification number.
- 2) The patient's name.
- 3) The service or supply provided for the patient.
- 4) The date the service or supply was provided.
- 5) The charge for each services and or supply.
- 6) The explanation of benefits worksheet from the Primary carrier when filing for secondary claim benefits.
- 7) Accident details related to an injury, when relevant.

WHERE DOES ONE SEND A CLAIM FOR BENEFITS?

All claims are to be submitted to:

ACCESS ADMINISTRATORS, INC.
P. O. BOX 12609
EL PASO, TX 79913

HOW DOES ONE SUBMIT ADDITIONAL BILLS FOR THE SAME ILLNESS OR INJURY?

Any additional itemized bills, for a previously submitted illness or injury, should be submitted to the Plan Administrator at the address shown above. Bills need to clearly show the employee name, employee social security number and Employers' name. All claims for services and supplies received during a calendar year (January 1 through December 31) must be submitted to the Plan Administrator **NO LATER THAN ONE YEAR FROM THE DATE THE CLAIMED MEDICAL EXPENSES WERE INCURRED OR NOT LATER THAN MARCH 31ST OF THE FOLLOWING CALENDAR YEAR, WHICHEVER DATE FALLS FIRST.**

HOW IS A CLAIM FILED FOR BENEFITS FOR AN IN-NETWORK PROVIDER FOR BENEFITS UNDER THE PLAN?

The Network Provider, per a contract with the Network Administrator, must complete the applicable claim form, HCFA 1500, UB-92 or provide an itemized billing form, which includes a complete and accurate diagnosis of the medical problem.

Section 5
CONTRIBUTIONS

The Plan Sponsor shall determine the amount of contribution required for coverage for each covered person.

Such determination shall be made within a reasonable time preceding the end of any Fiscal Year and shall be reported to all employees as reasonably soon thereafter as possible.

Section 6 INDIVIDUAL EFFECTIVE DATE

An eligible enrolled employee's coverage will become effective on the first day following the satisfaction of the Waiting Period. An enrollment card must be completed by an employee to be enrolled for coverage or marked "waived" if this is the employee's choice.

If an eligible employee waives coverage for himself or herself, no coverage is available for their eligible dependents under the Plan. If an employee waives coverage for themselves and later wishes to be covered under the Plan, the employee must wait for the annual Open Enrollment.

The dependents of an eligible enrolled employee shall become covered on the later of-

- 1) The first day that they become eligible for coverage and enroll; or
- 2) Within the first 31 days of eligibility, the date on which they enroll. However if on the 31st day the County of El Paso is closed, then the time limit to enroll is extended to the next day when the County of El Paso is open.

If an employee elects coverage for eligible dependents and at a later time acquires additional eligible dependents, the employee must notify the Plan Administrator and properly complete and submit all necessary forms detailing the names and other information of these additional dependents within 31 days of the acquisition, (the qualifying event), in order for the newly acquired dependents to receive coverage.

The newborn child of a covered employee or spouse is automatically covered at birth for 31 days. For coverage to continue beyond 31 days, you must notify The County of El Paso Employee Benefits Office of the birth, complete and submit all necessary paperwork and pay any required premiums. (Premiums are required beginning the first of the calendar month following the birth month.) If notification and required premiums are not made, coverage will terminate at the end of 31 days following your child's birth. Your claim for maternity expenses is not considered enrollment of a newborn.

If an eligible employee does not elect coverage within the 31 days that the employee first acquires eligible dependents, the employee will be required to wait for the annual Open Enrollment.

Where an individual is covered as an eligible employee under this Plan, they may not be additionally covered under this Plan as the dependent of another eligible employee of this Plan.

A COBRA Qualified Beneficiary becomes covered effective the day that a Qualifying Event occurs if

- 1) They notify the Plan Administrator, for Qualifying Events listed as their responsibility for notification, within 60 days of the occurrence of that Qualifying Event;
 - a) Notification will need to be by written communication and
 - b) The notification should have the Beneficiary's name, address, telephone number, plan name, and the qualifying event. The qualifying event can be either a divorce or legal separation from his or her spouse or a dependent no longer eligible to be a dependant under the plan,
 - c) If the qualifying event is a divorce or legal separation, legal documentation must be furnished and
- 2) Return to the Plan Administrator, within 60 days of reception their signed election to continue coverage; and
- 3) Complete and return a new enrollment card to the Plan Administrator within 45 days of their election to continue this coverage; and
- 4) Pay the necessary contribution for these coverages within 45 days of their election to continue coverages to the Plan Administrator. The first payment shall be the necessary contribution to cover the Qualified Beneficiary from the date of the Qualifying Event through the end of the month in which this timely first payment is made.

Section 7
INDIVIDUAL TERMINATION OF COVERAGE

The coverage of any Covered Person covered under the Plan shall terminate on the earliest of the following dates:

- 1) The date of termination of the Plan; or
- 2) The date his/her membership ceases in an eligible class or with respect to a dependent the date such dependent no longer is an Eligible Dependent; or
- 3) The date all coverage or certain benefits are terminated on his/her particular class by modification of the Plan; or
- 4) The date he/she becomes a full-time member of the Armed Forces of any country; or
- 5) The date he/she fails to make a required contribution to the Plan, if any; or
- 6) After the 31st day following the birth of a child, with respect to such child, unless prior to the expiration of such 31 day period your Employer has been notified of the birth of such child and you have agreed to make any required contributions; or
- 7) If sick or injured, the date the County of El Paso notifies the Covered Person of termination of coverage; or
- 8) The date on which active full time employment terminates.

Section 8
MODEL GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS

CONTINUATION COVERAGE RIGHTS

The Plan Administrator is Access Administrators, Inc., 7430 Remcon Circle Bldg C, El Paso, TX 79912, 915-581-8182. The Plan Administrator is responsible for administering COBRA continuation coverage

COBRA Continuation Coverage

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a “qualifying event.” Specific qualifying events are listed later in this notice. COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because either one of the following qualifying events happens:

- 1) Your hours of employment are reduced, or
- 2) Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because any of the following qualifying events happens:

- 1) Your spouse dies;
- 2) Your spouse’s hours of employment are reduced;
- 3) Your spouse’s employment ends for any reason other than his or her gross misconduct;
- 4) Your spouse becomes enrolled in Medicare (Part A, Part B, or both); or
- 5) You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they will lose coverage under the Plan because any of the following qualifying events happens:

- 1) The parent-employee dies;
- 2) The parent-employee’s hours of employment are reduced;
- 3) The parent-employee’s employment ends for any reason other than his or her gross misconduct;
- 4) The parent-employee becomes enrolled in Medicare (Part A, Part B, or both);
- 5) The parents become divorced or legally separated; or
- 6) The child stops being eligible for coverage under the plan as a “dependent child.”

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the County of El Paso and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee is a qualified beneficiary with respect to the bankruptcy. The retired employee’s spouse, surviving spouse, and dependent children will also be qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee commencement of a proceeding in bankruptcy with respect to the employer, or enrollment of the employee in Medicare (Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event within 30 days of any of these events.

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator. The Plan requires you to notify the Plan Administrator within 60 days after the qualifying event occurs. You must send this notice to: Access Administrators, Inc., COBRA Department, 7430 Remcon Circle Bldg C, El Paso, TX 79912. The notice needs to include name, address, and telephone number, plan name and the qualifying event. If the qualifying event is a divorce or legal separation, legal documentation must be furnished. Failure to notify the Plan Administrator in the above stated time frames and prescribed manner will nullify your right to COBRA continuation of coverage.

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin this Plan on the date of the qualifying event

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, enrollment of the employee in Medicare (Part A, Part B, or both), your divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage lasts for up to 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled at any time during COBRA continuation coverage and you notify the Plan Administrator in a timely fashion, (within 60 days, in writing) you and your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. You must make sure that the Plan Administrator is notified of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage.] This notice should be sent to: Access Administrators, Inc., COBRA Department, 7430 Remcon Circle Bldg C, El Paso TX 79912. The notification should include name, address, telephone number, plan name, and a copy of the Social Security Administration's determination.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving COBRA continuation coverage, the spouse and dependent children in your family can get additional months of COBRA continuation coverage, up to a maximum of 36 months. This extension is available to the spouse and dependent children if the former employee dies, or gets divorced or legally separated. The extension is also available to a dependent child when that child stops being eligible under the Plan as a dependent child. **In all of these cases, you must make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event permitted under the terms This notice must be sent to: Access Administrators, Inc., COBRA Department, 7430 Remcon Circle Bldg C, El Paso, TX 79912. The notification should include name, address, telephone number, plan name, and qualifying event. Copies of documentation such as death certificate, Medicare card, divorce decree or legal separation papers must be included with the notification.**

If you have questions about your COBRA continuation coverage, you should contact Access Administrators, Inc.; COBRA Department.7430 Remcon Circle Bldg C, El Paso, TX 79912, telephone number 915-581-8182 or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's web site at www.dol.gov/ebsa.

Keep Your Plan Informed of Address Changes at all times

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator. **Please note that, as it is the sole responsibility of the Plan participants to notify the Plan Administrator in writing of any address changes for all family members, you and/or your family members may lose their rights for continuation of coverage in the event documentation is not received or sent due to your failure to notify of an address change.**

How can you elect continuation coverage?

Each qualified beneficiary listed on page one of this notice has an independent right to elect continuation coverage. For example, both the employee and the employee's spouse may elect continuation coverage, or only one of them. Parents may elect to continue coverage on behalf of their dependent children only. A qualified beneficiary must elect coverage by the date specified on the Election Form. Failure to do so will result in loss of the right to elect continuation coverage under the Plan. A qualified beneficiary may change a prior rejection of continuation coverage any time until that date.

In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of continuation coverage may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

How much does continuation coverage cost?

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage (or, in the case of an extension of continuation coverage due to a disability, 150 percent). The required payment for continuation coverage for the qualified beneficiaries

When and how must payment for continuation coverage be made?

First payment for continuation coverage

If you elect continuation coverage, you do not have to send any payment for continuation coverage with the Election Form. However, you must make your first payment for continuation coverage within 45 days after the date of your election. (This is the date the Election Notice is post-marked, if mailed.) If you do not make your first payment for continuation coverage within those 45 days, you will lose all continuation coverage rights under the Plan.

Your first payment must cover the cost of continuation coverage from the time your coverage under the Plan would have otherwise terminated up to the time you make the first payment. You are responsible for making sure that the amount of your first payment is enough to cover this entire period. You may contact Access Administrators, Inc., 7430 Remcon Circle Bldg C, El Paso, TX 79912, telephone number 915-581-8182 to confirm the correct amount of your first payment.

Your first payment for continuation coverage should be sent to:

**Access Administrators, Inc
COBRA Department.
7430 Remcon Circle Bldg C
El Paso, TX 79912**

Periodic payments for continuation coverage

After you make your first payment for continuation coverage, you will be required to pay for continuation coverage for each subsequent month of coverage. Under the Plan, these periodic payments for continuation coverage are due on the 1st of each month of coverage. If you make a periodic payment on or before its due date, your coverage under the Plan will continue for that coverage period without any break. The Plan will send periodic notices of payments due for these coverage periods.

Periodic payments for continuation coverage should be sent to:

**Access Administrators, Inc.
COBRA Department
7430 Remcon Circle Bldg C
El Paso, TX 79912**

Grace periods for periodic payments

Although periodic payments are due on the dates shown above, you will be given a grace period of 30 days to make each periodic payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if you pay a periodic payment later than its due date but during its grace period, your coverage under the Plan will be suspended as of the due date and then retroactively reinstated (going back to the due date) when the periodic payment is made. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you fail to make a periodic payment before the end of the grace period for that payment, you will lose all rights to continuation coverage under the Plan.

For more information

This notice does not fully describe continuation coverage or other rights under the Plan. More information about continuation coverage and your rights under the Plan is available in your summary plan description or from the Plan Administrator.

For more information about your rights, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA web site at www.dol.gov/ebsa.

Section 9
COVERED MEDICAL EXPENSES

A) COVERED EXPENSE. A Covered Expense shall mean a service or supply which is provided to a Covered Person, and which service or supply is:

- 1) Received while a person is covered under the Plan; and
- 2) Recommended by a physician; and
- 3) Medically necessary for the care and treatment of a covered illness or injury of a covered person; and
- 4) Provided by a Health Care Provider of these services or supplies.

These services and supplies which are furnished by, and fall within the scope of the authorized practice of, a Health Care Provider must be recognized throughout the Health Care Provider's profession to be the usual and customary treatment for the illness or injury, provided that:

- 1) For a hospital, Covered Expenses shall include the charges made by a hospital, on its own behalf, for room and board and other necessary services and supplies, except that for any day of hospital confinement, Covered Expenses shall not include any charges for room and board that are in excess of the hospital's average charge for a semi-private room. This limit shall not apply for a unit for intensive or specialized care. Covered Expenses shall not include charges, if any, for special nursing or physician's services;
- 2) For a Physician, Covered Expenses shall include the stand-by services for a Pediatrician for a Caesarean section.
- 3) Charges for services of a nurse shall include:
 - a) In a hospital, services of a registered professional nurse (R.N.), services of a licensed practical nurse (L.P.N.), or services of a licensed vocational nurse (L.V.N.), and
 - b) Other than in a hospital, services of a registered professional nurse (R.N.). Services of an L.V.N. or L.P.N. are covered if it can be shown that no R.N. was available.

The services of a nurse shall not be considered eligible if they are rendered by a member of the Covered Person's family as defined in the General Limitations Section.

- 4) For a Professional Licensed Ambulance Service, charges will include the services and supplies provided by the Professional Licensed Ambulance Service during:
 - a) Ground transportation by the Professional Licensed Ambulance Service to the nearest hospital qualified to render necessary medical treatment; or
 - b) Air ambulance transportation where it is medically necessary to air transport a Covered Person to the nearest facility qualified to render treatment, or where a life-threatening situation necessitates.
- 5) For the charges for services and supplies provided by a Licensed Extended Care Facility as listed below, the confinement begins by means of direct transfer from a hospital in which the individual was confined for at least three days. Coverage is limited to a total of 60 days of confinement in an Extended Care Facility in each calendar year. The following are covered Extended Care Facility services and supplies:
 - a) Board and room and nursing care (but no private duty nurse or attendant);
 - b) Physical therapy, occupational therapy and speech therapy;
 - c) Medical social service;
 - d) Biologicals, supplies, appliances, and equipment ordinarily provided by the facility for care of patients;
 - e) Medical care and other diagnostic and therapeutic services furnished to an Extended Care Facility patient by a hospital.

- 6) For the charges for a Home Health Agency, provided that the plan of care by the Home Health Agency:
- a) Is prescribed by a Physician; and
 - b) Is reviewed and approved by the Physician every two weeks; and
 - c) Contains a statement expressing the belief of the Physician and the Home Health Agency that:
 - (i) The number of days of home health care does not exceed the number of days of confinement in a Hospital which would have been required; and
 - (ii) The Home Health Care will probably cost less per day than the expected daily rate for confinement in a Hospital; and
 - (iii) Confinement in a Hospital would otherwise be required.
 - d) Is submitted for approval by the Plan prior to initiation of these services and supplies by the Home Health Agency.

Home Health Care shall include:

- (a) Skilled Nursing Care; and
 - (b) Any other services and supplies provided by the Home Health Agency in lieu of the services and supplies, which would have been covered, if the Covered Person was confined in a Hospital. Home Health Care does not include housekeeping or custodial care.
- 7) Covered Expense includes charges for Hospice care made by a Hospice only if:
- a) The expenses incurred by a Covered Person diagnosed by a Physician as terminally ill with a prognosis of six months or less to live; and
 - b) The Hospice provides a Plan of Care which:
 - (i) Is prescribed by the Physician; and
 - (ii) Is reviewed and approved by the Physician monthly; and
 - (iii) Is not for curative treatment; and
 - (iv) States the belief of the Physician and the Hospice that the Hospice Care will cost less in total than any comparable alternative to Hospice Care; and
 - (v) Is submitted for approval by the Plan prior to initiation of this Hospice Care.

Hospice Care may be provided in a Covered Person's home or in a Hospice In-patient facility. For such Hospice Care, the Plan will not apply the requirement that expenses will be covered only when incurred for the treatment of an illness or injury.

- 8) For Preventive medicine services provided by an In-Network Provider. Services allowed once per year are:
- a) Pap Smear
 - b) Hemocult
 - c) Mammogram
 - d) Physical Exam
 - e) Labs
 - f) EKG

- 9) For Well Baby Care Services provided by an In-Network Provider;
- 10) For Immunization services for all covered persons provided by an In-Network Provider.

COVERED EXPENSE shall also include:

- 11) Charges made for anesthesia and its administration; and
- 12) Charges made for diagnostic X-ray and laboratory examinations; and
- 13) Charges made for X-ray, radium and radioactive isotope treatment; and
- 14) Charges for blood transfusions; and
- 15) Charges made for oxygen and other gases and their administration; and
- 16) Charges made for prosthetic appliances; and
- 17) Charges made for drugs and medicines lawfully obtained only upon the written prescription of a physician and limited to 30 days for non-maintenance drugs; and

Charges made for drugs and medicines lawfully obtained only upon the written prescription of a physician for maintenance drugs are available through the designated mail order prescription system and limited to a 90-day supply; and

- 18) Charges made for the rental or purchase of Durable Medical Equipment. The Physician's prescription for the Durable Medical Equipment must be submitted to the Plan Administrator, by the Covered Person, to allow the Plan Administrator to determine whether to rent or purchase this necessary Durable Medical Equipment.
- 19) Covered Charges include Medical Expenses incurred by a *Qualified Participant* for the installation and use of an insulin infusion pump or other equipment or supplies used in the treatment of diabetes. Covered Charges also include expenses directly related to diabetic self-management education programs and those items associated with the treatment of diabetes. Such items, when obtained for an eligible participant, may include the following:
 - a) Diabetic Equipment - blood glucose monitors, insulin pumps and necessary accessories, insulin infusion devices (one per year) and podiatric appliances (one pair of diabetic-related shoes per year).
 - b) Diabetic Supplies - test strips for blood glucose monitors, visual reading and urine test strips, lancets and lancet devices, injection aids, and glucagon emergency kits

NOTE: *Qualified Participant* - an individual eligible for coverage under this Plan who has been diagnosed with: (i) insulin dependent or noninsulin dependent diabetes, (ii) elevated blood glucose levels induced by pregnancy, or (iii) another medical condition associated with elevated blood glucose levels

20) Routine Patient Care Costs for Cancer Clinical Trials

NOTE: Please refer to "Cancer Clinical Trials" in the "Definitions" section of this document.

- 21) For "Out-of-Network Providers, performing services in an In-network facility will only be covered at the higher level of benefits in an emergency situation. Member will be responsible for charges which are in excess of Regular and Customary Charges."
- 22) Medical expenses incurred as a result of intentionally self-inflicted injuries (or injuries resulting from attempted suicide) are covered to the same extent that medical expenses are otherwise covered by this plan.

Section 10
GENERAL LIMITATIONS

EXCLUDED EXPENSES. The term Excluded Expenses shall include any expense for a service or supply that is provided by someone other than a Health Care Provider or an expense (provided by a Health Care Provider) that does not meet the definition of Covered Expense. The term Excluded Expenses shall also include expenses for a service or supply which is provided by a Health Care Provider for any of the following items. No payment will be made under this Plan for expenses incurred by an employee or a dependent:

- A)** For or in connection with cosmetic surgery unless the Covered Person receives an injury as a result of an accident, which results in damage to this person requiring cosmetic surgery, or for correction of a birth defect of a child born while its parent is covered under the Plan and coverage for dependent children has not been previously waived;
- B)** For eyeglasses, hearing aids or examination for prescription or fitting of eyeglasses or hearing aids;
- C)** For the prevention or correction of teeth irregularities and malocclusion of jaws by wire appliances, braces, or other mechanical aids, or any other care, repair, removal, replacement or treatment of teeth, or surrounding tissues, except:
 - 1)** When necessitated by damage to sound natural teeth or surrounding tissues as a result of an injury which occurs while the employee or dependent, as the case may be, is covered under this Plan, or
 - 2)** For excision of impacted unerupted teeth or of a tumor or cyst, or incision and drainage of an abscess or cyst, or
 - 3)** For any other oral surgical procedure not involving any tooth structure, alveolar process, or gingival tissues, or
 - 4)** For correction of a birth defect of a child.
- D)** For which benefits are not payable under this Plan according to the Section of this Plan entitled General Limitations
- E)** For any services or supplies obtained from a Health Care Provider who is not legally licensed to provide these services or supplies in the United States. Additionally, a Health Care Provider must also be located within the United States in order for charges to be considered. This exclusion will be waived in a life-threatening emergency.
- F)** For or in connection with an injury arising out of, or in the course of, any employment for wage or profit, including self-employment, when the employee or dependent is entitled to benefits under any Workers' Compensation or similar law;
- G)** For or in connection with a sickness or accident for which the employee or dependent is entitled to benefits under any Worker's Compensation or similar law;
- H)** In a hospital owned or operated by the United States Government; unless for services and supplies obtained in accordance with the laws and regulations of the government and only to the extent that charges are made and the patient is legally required to pay;
- I)** To the extent that payment under this Plan is prohibited by any law of the jurisdiction in which the employee or dependent resides at the time the expenses are incurred;
- J)** For charges, which the Covered Person is not legally required to pay, or for charges which would not have been made if no coverage had existed;
- K)** For charges made which are in excess of Reasonable and customary charges, as established by the Plan Administrator, or for charges for unnecessary care or treatment;
- L)** To the extent that the employee or dependent is reimbursed, entitled to reimbursement, or in any way indemnified for those expenses by or through any public program. For the purpose of this paragraph, any

individual who, at any time, was entitled to enroll in the entire medical care program under Title XVIII of the Social Security Act of 1965 as amended (Medicare), but who did not enroll will be considered to have been entitled to reimbursement in an amount equal to the amount to which he would have been entitled, if any, if he/she were so enrolled;

- M)** For general health examinations except as shown in the Section titled Medical Expenses Covered/Excluded, or eye examinations;
- N)** For fitting or cost of eyeglasses, contact lenses or hearing aids;
- O)** For Dental expenses except as shown in the Section titled Medical Expenses Covered/Excluded;
- P)** For expenses relating to cosmetic repairs except as shown in the Section titled Medical Expenses Covered/Excluded;
- Q)** For transportation or travel other than as shown in the Section titled Medical Expenses Covered/Excluded;
- R)** For injury or sickness resulting from war;
- S)** For injury resulting from the commission or an attempt to commit a felony;
- T)** For preventive medicine except as shown in the Section titled Medical Expenses Covered/Excluded;
- U)** For treatment which is not Medically Necessary for the care and treatment of any injury or illness;
- V)** For Custodial Care while confined in a Hospital, extended care facility, or nursing home;
- W)** For charges for routine foot care;
- X)** For non-prescription drugs;
- Y)** For services rendered to any individual who requires them by reason of acting as a donor of any organ or element of their body unless the recipient of this organ or element is a covered participant under the Plan;
- Z)** For charges for acupuncture;
- AA)** For charges for refractive services/surgeries;
- BB)** For charges for the treatment of obesity, morbid obesity, weight reduction or dietetic control;
- CC)** For treatment by hypnosis, except as part of the physician's treatment of a mental illness or when hypnosis is used in lieu of an anesthetic;
- DD)** For services rendered on an experimental or research basis or not a recognized, generally accepted medical practice;
- EE)** For services rendered by a member of the Covered Person's family to include grandparents, parents, brothers and sisters, cousins, aunts and uncles, nieces and nephews or similar in-laws related by marriage to the Covered Person;
- FF)** For travel or accommodations, whether or not recommended by a physician;
- GG)** For immunizations, except when required as a result of accidental bodily injury and as shown in the Section titled Medical Expenses Covered/Excluded;
- HH)** For any charges for diagnosed or treatment of infertility, including, but not limited to:
 - a)** Fertility tests;
 - b)** Direct attempts to cause pregnancy by hormone therapy, artificial insemination, in vitro fertilization, and embryo transfer;

- II)** For reversal of sterilization procedures or surgery;
- JJ)** For charges for vocational therapy;
- KK)** For the services and supplies for:
 - 1)** Mandibular or maxillofacial surgery to correct growth defects, jaw disproportions or malocclusions, except for correction of congenital anomaly in a child who was covered under the Plan from birth, or
 - 2)** Appliances or restorations used solely to increase vertical dimension, reconstruct occlusion or correct or treat temporomandibular joint dysfunction or TMJ pain syndromes, or

Any charges due to temporomandibular joint disorder or dysfunction (TMJ);
- LL)** For expenses, which are submitted after one year from the date the claimed Medical Expenses were incurred or not later than March 31st of the following Calendar Year, whichever date falls first;
- MM)** For services and supplies not specifically listed as a covered expense;
- NN)** For private duty nursing services in a hospital setting;
- OO)** For massage therapy services;
- PP)** For remediation therapy services;
- QQ)** For Vitamin B-12 medication except when used for Pernicious Anemia or Crohn's Disease;
- RR)** For any sex change surgery;
- SS)** For any city or state taxes charged for services and supplies;
- TT)** For rolting services;
- UU)** For services and supplies not related to the diagnosed illness or injury, which is being treated;
- VV)** For chelation therapy services and/or supplies.
- WW)** For charges made in excess of the Reasonable and Customary allowable as determined by the Plan Administrator for Out-of-Network hospital services.
- XX)** Charges incurred for services and supplies for medical care under the Plan to the extent payment is made by an individual or individuals (or their insurers) considered responsible for the condition causing the charges.
- YY)** For elective nonemergency services and/or supplies provided outside the United States;
- ZZ)** For a Hospital admission for diagnostic or evaluation procedures unless the tests could not have been performed on an outpatient basis without adversely affecting the patient's physical condition or the quality of medical care rendered, provided that bed-patient Hospital expense, other than room accommodation charges, incurred during the Hospital admission shall be deemed to be other medical expense and benefits for such expense shall be provided accordingly;
- AAA)** For broken appointments or charges for completion of claim form by the Physician's office;
- BBB)** For assistant surgeon fees in excess of 25% of the Reasonable and Customary Charge for the surgeon;
- CCC)** For non-durable medical equipment;
- DDD)** For charges for funeral arrangements;
- EEE)** For charges for financial or legal counseling; including estate planning or drafting of will;

FFF) For charges for homemaker or caretaker services; or

GGG) For charges for respite care. This is care furnished during a period of time when the person's family or usual caretaker cannot, or will not, attend to the person's needs.

HHH) For services and/or supplies related to the treatment of alopecia;

III) For any charges that are for therapy, supplies, drugs or counseling for sexual dysfunctions or inadequacies, unless the dysfunctions or inadequacies are caused by an organic condition (examples are diabetes, prostate cancer, testicular cancer, and high blood pressure).

JJJ) For charges in situations when a claim is pended for information to assist in the adjudication process, such as coordination of benefits, accident details and subrogation, dependent status, additional medical information, etc., failure to respond to such requests within 60 days will cause any claim(s) submitted for consideration to be denied;

Section 11
EXTENSION OF MEDICAL BENEFITS

If a Covered Person is totally disabled as a result of a non-occupational illness or injury on the date coverage under this Plan is terminated, the incurred eligible charges for that illness or injury shall continue to be payable, as would have been payable had the coverage not been terminated, until the earliest of the following dates:

- 1) The date on which the injury or illness no longer causes the individual to be totally disabled, or
- 2) The County of El Paso stops providing funding towards the Covered person's contributions required for coverage as outlined in the County of El Paso's leave policy.

In either instance, upon termination of active coverage, continuation of coverage will be offered under COBRA.

SURVIVORSHIP BENEFIT. In the event of a covered retiree's death, the previously covered dependents of the deceased retiree shall have the right to continue benefits under the Plan, subject to further provisions hereof, until:

- 1) The date benefits for all individuals in this class are terminated;
- 2) If dependent children, the date that they do not meet the definition of an Eligible Dependent. In this case, continuation of coverage will be offered under COBRA.

Section 12
MEDICAL BENEFIT INFORMATION UNDER THE CORE PLAN

- A) GENERAL.** For Participants in this Plan, the obligations of the Plan and the Employer shall be fully satisfied by the payment of Benefits in accordance with the Schedule of Benefits of this Article. Benefits shall be paid for the reimbursement of Medical Expenses incurred by a Participant if:
- 1) The Medical Expenses are included in Covered Charges Section
 - 2) The Medical Expenses are not excluded under the Exclusions Section;
 - 3) This Plan's Benefits payable by this Plan are not reduced by the Coordination of Benefits and Order of Benefit Determination provisions;
 - 4) The Claims Procedures Section have been followed; and
 - 5) All other provisions of the Plan are satisfied.
- B) SERVICES NOT AVAILABLE IN-NETWORK.** Benefits for Medical Expenses incurred by a Participant shall be paid at 80% level if the type of services or supply for which the Medical Expense is incurred:
- 1) Is not available within the Service Area; or
 - 2) Is available within the Service Area, but is not available within the Network.

The Benefits paid in accordance with this Section shall not exceed the Reasonable and Customary Charges for the Service Area.

- C) UTILIZATION MANAGEMENT.** Utilization Management approval must be received for all services requiring pre-certification in order for charges to be paid at the highest level of benefit. The Plan requires that a member call and pre-certify any admission to an Out-of-Network Hospital facility. The Plan will perform Case management services through the Plan Administrator on an as needed basis.
- D) DEDUCTIBLE.** The Plan requires that a Participant pay Covered Charges each Plan Year in the amount of the deductible before the Plan will pay Benefits for the Plan Year. For purposes of this Article there shall be a \$1,000 per Participant per Plan Year for In-Network services and \$2,000 per participant per Plan Year for Out-of-Network services, except that in the case when two Participants in one Family have each satisfied the deductible during the same Plan Year, the deductible requirements shall be considered satisfied for all Participants in the Family for that Plan Year.

There will be a separate \$100 deductible for each Hospital Confinement and it will be in addition to the deductible specified above.

There will be a separate \$100 co-pay for each Hospital Emergency Room Visit, which will be waived in the case of hospital admission

There will be a separate \$200 deductible per calendar year for outpatient hospital based services.

The deductible provision will apply to all Covered Charges unless explicitly modified in this Section.

- E) IN-NETWORK CO-PAYMENTS.** The Plan requires that a Participant pay a Co-payment as follows:
- 1) A Co-payment of \$35 for any Office Visit to a Network Provider; and
 - 2) A Co-payment for retail, which shall be:
 - a) \$10 paid directly to the Network Provider for each initial or refill prescription when the Participant purchases Generic Drugs; and
 - b) \$25* paid directly to the Network Provider for each initial or refill prescription when the Participant purchases Preferred Brand Name Drugs; and
 - c) \$40* paid directly to the Network Provider for each initial or refill prescription when the Participant purchases Non-Preferred Brand Name Drugs.

- 3) A Co-payment for mail order, which shall be:
 - a) \$20 paid directly to the Network Provider for each initial or refill prescription when the Participant purchases Generic Drugs; and
 - b) \$50* paid directly to the Network Provider for each initial or refill prescription when the Participant purchases Preferred Brand Name Drugs; and
 - c) \$80* paid directly to the Network Provider for each initial or refill prescription when the Participant purchases Non-Preferred Brand Name Drugs.

These Co-payments will apply to Network Provider as well as the Mail Order Drug Company

* ***Please Note:*** In figuring the benefit amount, a Separate Brand Name Fee may apply to **brand name drugs** in addition to any applicable **co-pay**. The amount of the Separate Brand Name Fee will be equal to the difference between the cost of the **brand name drug** and the generic equivalent. *The Separate Brand Name Fee will apply to any brand name drug dispensed when the covered person requests a brand name drug and the prescription is written for a generic drug with instructions "Dispense as Written".*

- 4) Co-payments shall not be used to satisfy:
 - a) The deductible requirements;
 - b) The out-of-pocket maximums; or
 - c) The co-insurance limit of this Section.

F) CO-INSURANCE. The Plan will pay Benefits in the amount of

- 1) 100% of In-Network Covered Office Visit charges after the satisfaction of the Plan's In-Network Co-payment requirements specified herein;
- 2) 100% of In-Network Covered Prescription Drug Charges after the satisfaction of the Plan's In-Network Co-payment requirements specified herein;
- 3) 100% of Covered Required Immunizations specified herein;
- 4) 100% of In-Network covered Routine charges specified herein;
- 5) 80% of all other In-Network Covered Charges;
- 6) 65% of all other Out-of-Network Covered Charges after the satisfaction of the Plan's deductible requirement.
- 7) Except as indicated in the Comprehensive Medical Benefits Section:
 - a) 95% of In-Network covered Hospital charges for RE Thomason, for In-Patient and Out-Patient only.
 - b) 80% of In-Network covered Hospital charges for Las Palmas-Del Sol Healthcare Network, except for Emergency Room
 - c) 65% of Out-of-Network covered Hospital charges for other ACN Hospitals except for Emergency Room
 - d) 50% of Out-of-Network covered Hospital charges for Non-Network Hospitals, except for Emergency Room

The coinsurance provision will apply to all Covered Charges unless explicitly modified in this Section.

- G) IN-NETWORK OUT-OF-POCKET MAXIMUM.** The Plan will pay 100% of Covered Charges after the Participant has paid In-Network Covered Charges in the amount of the out-of-pocket maximum for the Plan Year. The out-of-pocket maximum shall consist of the Participant's In-Network out-of-pocket expenses arising out of the coinsurance provision of the Plan. The out-of-pocket maximum shall not include Co-payments. The out-of-pocket maximum shall be \$2,500 per Participant per Plan Year and \$5,000 per Family per Plan Year for services rendered at RE Thomason, Las Palmas or Del Sol Regional Healthcare Systems and providers in the ACN/PPO network. The out-of-pocket maximum shall be \$6,000 per Participant per Plan Year/\$12,000 per Family per Plan Year for services rendered at a PPO Hospital.

- H) **OUT-OF-NETWORK COINSURANCE LIMIT.** The Out-of-Network Out-of-Pocket is unlimited.
- I) **LIFETIME MAXIMUM BENEFIT.** In no event will the Plan pay Benefits to a Participant in excess of the lifetime maximum benefit. The lifetime maximum benefit shall be \$2,000,000 per Participant.
- J) **MEDICAL EMERGENCIES.** Out-of-Network Covered Charges for a Medical Emergency shall be paid in accordance with the Medical Schedule of Benefits.

In the event that a Covered Person is admitted as an inpatient into a non-preferred facility through an emergency room due to a covered emergency or accident, benefits will be paid at the 80% benefit level for post-stabilization services originating in a Hospital emergency facility or comparable facility.

The Covered Person will be reimbursed at the 80% benefit level for the cost for services rendered by a non-participating Provider located either within or outside the Network PPO Service Area, for those expenses, less any applicable deductibles, co-payments or cost sharing amounts described in the Plan, which are incurred up to the time the Covered Person is determined by the Plan Administrator or the Utilization Review/Utilization Management company to be medically able to travel or to be transported to a Network Provider.

In the event that the Covered Person elects to remain in the Hospital or non-preferred facility after the date that the Plan Administrator or the Utilization Review/Utilization Management company has determined and advised the Covered Person that the Covered Person no longer meets the criteria for continued inpatient confinement and is able to travel or be transported to a Network Provider, the Covered Person shall be fully responsible for the appropriate deductibles, co-payments or cost sharing provisions of the benefit level associated with the provider of the post emergency or accident services.

- K) **LIMITATIONS.** In addition to the maximum lifetime benefit, the following limitations apply to certain Benefits paid under this Plan. In no event will Benefits be paid in excess of these limitations:
 - 1) Benefits paid for home health care will be limited to the prior authorized visits;
 - 2) Benefits paid for Covered Charges incurred in a Skilled Nursing Facility will be limited to a maximum of 60 days In-Network and Out-of-Network and Out-of-Area combined per Plan Year;
 - 3) Benefits paid for chiropractic treatment will be limited to \$2000 plan year maximum combined
 - 4) No Benefits will be paid for Out-of-Network:
 - a) Routine adult physical examinations;
 - b) Routine pediatric physical examinations; and
 - c) Immunizations; and
 - 5) In-Network Outpatient prescription drugs shall be limited to:
 - a) A 90-day supply per Co-payment for prescription drugs which are classified as maintenance drugs by the Plan Administrator and filled through the Mail Order Pharmacy method; and
 - b) A 30-day supply per Co-payment for other prescription drugs.
- L) **GENERAL - OUT-OF-AREA.** For Participants in this Plan, the obligations of the Plan and the Employer shall be fully satisfied by the payment of Benefits in accordance with the Schedule of Benefits of this Article. Benefits shall be paid for the reimbursement of Medical Expenses incurred by a Participant if:
 - 1) The Medical Expenses are included in Covered Charges Section;
 - 2) The Medical Expenses are not excluded under the Exclusions Section;
 - 3) This Plan's Benefits payable by this Plan is not reduced by the Coordination of Benefits and Order of Benefit Determination provisions;

- 4) The Claims Procedures Section have been followed; and
- 5) Members will have access to the specified "National Network" of providers,
 - a) If they reside outside of the El Paso/Las Cruces area
 - b) If they require services not available within the local service area
 - c) If they require "Emergency Services" outside of the El Paso/Las Cruces area as a result of an injury or the sudden onset of illness
 - d) If a Health Care Provider is in the "National Network", the provider has agreed to the negotiated/contracted fee as payment in full.
 - e) Once repricing is received from this network, claims will be considered at the In-Network level of benefits
- 6) All other provisions of the Plan are satisfied.

Section 13
MEDICAL BENEFIT INFORMATION UNDER THE BUY-UP PLAN

- A) GENERAL.** For Participants in this Plan, the obligations of the Plan and the Employer shall be fully satisfied by the payment of Benefits in accordance with the Schedule of Benefits of this Article. Benefits shall be paid for the reimbursement of Medical Expenses incurred by a Participant if:
- 1) The Medical Expenses are included in Covered Charges Section
 - 2) The Medical Expenses are not excluded under the Exclusions Section;
 - 3) This Plan's Benefits payable by this Plan are not reduced by the Coordination of Benefits and Order of Benefit Determination provisions;
 - 4) The Claims Procedures Section have been followed; and
 - 5) All other provisions of the Plan are satisfied.

- B) SERVICES NOT AVAILABLE IN-NETWORK.** Benefits for Medical Expenses incurred by a Participant shall be paid at 80% level if the type of services or supply for which the Medical Expense is incurred:
- 1) Is not available within the Service Area; or
 - 2) Is available within the Service Area, but is not available within the Network.

The Benefits paid in accordance with this Section shall not exceed the Reasonable and Customary Charges for the Service Area.

- C) UTILIZATION MANAGEMENT.** Utilization Management approval must be received for all services requiring pre-certification in order for charges to be paid at the highest level of benefit. The Plan requires that a member call and pre-certify any admission to an Out-of-Network Hospital facility. The Plan will perform Case management services through the Plan Administrator on an as needed basis.
- D) DEDUCTIBLE.** The Plan requires that a Participant pay Covered Charges each Plan Year in the amount of the deductible before the Plan will pay Benefits for the Plan Year. For purposes of this Article there shall be a \$250 per participant per Plan Year deductible for In-Network services and \$750 per participant per Plan Year for Out-of-Network services, except that in the case when two Participants in one Family have each satisfied the deductible during the same Plan Year, the deductible requirements shall be considered satisfied for all Participants in the Family for that Plan Year.

There will be a separate \$100 deductible for each Hospital Confinement and it will be in addition to the deductible specified above.

There will be a separate \$100 co-pay for each Hospital Emergency Room Visit, which will be waived in the case of hospital admission

There will be a separate \$200 deductible per calendar year for outpatient hospital based services.

The deductible provision will apply to all Covered Charges unless explicitly modified in this Section.

- E) IN-NETWORK CO-PAYMENTS.** The Plan requires that a Participant pay a Co-payment as follows:
- 1) A Co-payment of \$30 for any Office Visit to a Network Provider; and
 - 2) A Co-payment for retail, which shall be:
 - a) \$5 paid directly to the Network Provider for each initial or refill prescription when the Participant purchases Generic Drugs; and
 - b) \$20* paid directly to the Network Provider for each initial or refill prescription when the Participant purchases Preferred Brand Name Drugs; and
 - c) \$35* paid directly to the Network Provider for each initial or refill prescription when the Participant purchases Non-Preferred Brand Name Drugs.
 - 3) A Co-payment for retail, which shall be:

- a) \$10 paid directly to the Network Provider for each initial or refill prescription when the Participant purchases Generic Drugs; and
- b) \$40* paid directly to the Network Provider for each initial or refill prescription when the Participant purchases Preferred Brand Name Drugs; and
- c) \$70* paid directly to the Network Provider for each initial or refill prescription when the Participant purchases Non-Preferred Brand Name Drugs.

These Co-payments will apply to Network Provider as well as the Mail Order Drug Company

* **Please Note:** In figuring the benefit amount, a Separate Brand Name Fee may apply to **brand name drugs** in addition to any applicable **co-pay**. The amount of the Separate Brand Name Fee will be equal to the difference between the cost of the **brand name drug** and the generic equivalent. *The Separate Brand Name Fee will apply to any brand name drug dispensed when the covered person requests a brand name drug and the prescription is written for a generic drug with instructions "Dispense as Written".*

- 4) Co-payments shall not be used to satisfy:
 - a) The deductible requirements;
 - b) The out-of-pocket maximums; or
 - c) The co-insurance limit of this Section.

F) CO-INSURANCE. The Plan will pay Benefits in the amount of

- 1) 100% of In-Network Covered Office Visit charges after the satisfaction of the Plan's In-Network Co-payment requirements specified herein;
- 2) 100% of In-Network Covered Prescription Drug Charges after the satisfaction of the Plan's In-Network Co-payment requirements specified herein;
- 3) 100% of Covered Required Immunizations specified herein;
- 4) 100% of In-Network covered Routine charges specified herein;
- 5) 80% of all other In-Network Covered Charges;
- 6) 65% of all other Out-of-Network Covered Charges after the satisfaction of the Plan's deductible requirement.
- 7) Except as indicated in the Comprehensive Medical Benefits Section:
 - a) 95% of In-Network covered Hospital charges for RE Thomason, for In-Patient and Out-Patient only.
 - b) 80% of In-Network covered Hospital charges for Las Palmas-Del Sol Healthcare Network, except for Emergency Room
 - c) 65% of Out-of-Network covered Hospital charges for other ACN Hospitals except for Emergency Room
 - d) 50% of Out-of Network covered Hospital charges for Non-Network Hospitals, except for Emergency Room

The coinsurance provision will apply to all Covered Charges unless explicitly modified in this Section.

- B) IN-NETWORK OUT-OF-POCKET MAXIMUM.** The Plan will pay 100% of Covered Charges after the Participant has paid In-Network Covered Charges in the amount of the out-of-pocket maximum for the Plan Year. The out-of-pocket maximum shall consist of the Participant's In-Network out-of-pocket expenses arising out of the coinsurance provision of the Plan. The out-of-pocket maximum shall not include Co-payments. The out-of-pocket maximum shall be \$2,000 per Participant per Plan Year. \$4,000 per Family per Plan Year for services rendered at RE Thomason, Las Palmas or Del Sol Regional Healthcare Systems and providers in the ACN/PPO network. The out-of-pocket maximum shall be \$5,000 per Participant per Plan Year/\$10,000 per Family per Plan Year for services rendered at a PPO Hospital.
- C) OUT-OF-NETWORK COINSURANCE LIMIT.** The Out-of-Network out-of-pocket maximum is unlimited.

- D) **LIFETIME MAXIMUM BENEFIT.** In no event will the Plan pay Benefits to a Participant in excess of the lifetime maximum benefit. The lifetime maximum benefit shall be \$2,000,000 per Participant.
- E) **MEDICAL EMERGENCIES.** Out-of-Network Covered Charges for a Medical Emergency shall be paid in accordance with the Medical Schedule of Benefits.

In the event that a Covered Person is admitted as an inpatient into a non-preferred facility through an emergency room due to a covered emergency or accident, benefits will be paid at the 80% benefit level for post-stabilization services originating in a Hospital emergency facility or comparable facility.

The Covered Person will be reimbursed at the 80% benefit level for the cost for services rendered by a non-participating Provider located either within or outside the Network PPO Service Area, for those expenses, less any applicable deductibles, co-payments or cost sharing amounts described in the Plan, which are incurred up to the time the Covered Person is determined by the Plan Administrator or the Utilization Review/Utilization Management company to be medically able to travel or to be transported to a Network Provider.

In the event that the Covered Person elects to remain in the Hospital or non-preferred facility after the date that the Plan Administrator or the Utilization Review/Utilization Management company has determined and advised the Covered Person that the Covered Person no longer meets the criteria for continued inpatient confinement and is able to travel or be transported to a Network Provider, the Covered Person shall be fully responsible for the appropriate deductibles, co-payments or cost sharing provisions of the benefit level associated with the provider of the post emergency or accident services.

- F) **LIMITATIONS.** In addition to the maximum lifetime benefit, the following limitations apply to certain Benefits paid under this Plan. In no event will Benefits be paid in excess of these limitations:

- 1) Benefits paid for home health care will be limited to the prior authorized visits;
- 2) Benefits paid for Covered Charges incurred in a Skilled Nursing Facility will be limited to a maximum of 60 days In-Network and Out-of-Network and Out-of-Area combined per Plan Year;
- 3) Benefits paid for chiropractic treatment will be limited to \$2000 plan year maximum combined
- 4) No Benefits will be paid for Out-of-Network:
 - b) Routine adult physical examinations;
 - c) Routine pediatric physical examinations; and
 - d) Immunizations; and
- 5) In-Network Outpatient prescription drugs shall be limited to:
 - b) A 90-day supply per Co-payment for prescription drugs which are classified as maintenance drugs by the Plan Administrator and filled through the Mail Order Pharmacy method; and
 - c) A 30-day supply per Co-payment for other prescription drugs.

- G) **GENERAL - OUT-OF-AREA.** For Participants in this Plan, the obligations of the Plan and the Employer shall be fully satisfied by the payment of Benefits in accordance with the Schedule of Benefits of this Article. Benefits shall be paid for the reimbursement of Medical Expenses incurred by a Participant if:

- 1) The Medical Expenses are included in Covered Charges Section;
- 2) The Medical Expenses are not excluded under the Exclusions Section;
- 3) This Plan's Benefits payable by this Plan is not reduced by the Coordination of Benefits and Order of Benefit Determination provisions;
- 4) The Claims Procedures Section have been followed; and

- 5) Members will have access to the specified "National Network" of providers,
- b) If they reside outside of the El Paso/Las Cruces area
 - c) If they require services not available within the local service area
 - d) If they require "Emergency Services" outside of the El Paso/Las Cruces area as a result of an injury or the sudden onset of illness
 - e) If a Health Care Provider is in the "National Network", the provider has agreed to the negotiated/contracted fee as payment in full.
 - f) Once repricing is received from this network, claims will be considered at the In-Network level of benefits
- 6) All other provisions of the Plan are satisfied.

Section 14
BENEFITS FOR ORGAN & TISSUE TRANSPLANTS

When a transplant procedure is needed, have your Physician contact our Utilization Review Department at (915) 581-8182 or (800) 854-2339.

Benefits for covered services and supplies by a Physician, Hospital or other provider will be determined as follows:

- 1) The transplant procedure is not experimental or investigational in nature;
- 2) Donated human organs or tissue are used;
- 3) The recipient is a participant under the Plan (benefits are also available if the donor is a participant under the Plan);
- 4) The transplant procedure is pre-certified.

When a transplant procedure is needed have your physician contact our Utilization Review Department. They may be able to arrange for benefits not otherwise provided under this Plan for transplants received in selected transplant hospitals. Selected transplant hospitals are noted for their success rate with particular transplant procedures.

Please be advised you can only access these selected transplant hospitals through our Utilization Review Department. Services provided before admission to and after discharge from a selected transplant hospital will be subject to the benefits described in this Plan.

No benefits are available for:

- 1) Living and/or travel expenses of the live donor or recipient;
- 2) Donor search and acceptability testing of potential living donors;
- 3) Expenses related to maintenance of life for purposes of organ or tissue donation;
- 4) Purchase of the organ or tissue; and
- 5) Any organ or tissue transplant procedure or any pre-preparation procedures considered experimental/investigational in nature.

Section 15
PRESCRIPTION DRUG EXPENSE COVERAGE

Effective January 1, 2005 the County of El Paso retained Aetna Life Insurance Company (Aetna) to manage its pharmacy benefits program.

Prescription Drug Expense Coverage is merely a name for the benefits in this section. It does not provide benefits covering expenses incurred for all **prescription drugs**. There are exclusions, co-payment features, and, if applicable to this Plan, deductible and maximum benefit features. They are described in the Booklet.

The Summary of Coverage outlines the Payment Percentages that apply to the Covered Prescription Drug Expenses described below.

- (1) **Covered Prescription**
- (2) **Drug Expenses**

This Plan pays the benefits shown in Section 2 of this document for certain **prescription drug** expenses incurred for the treatment of a disease or injury. These benefits apply separately to each covered person.

If a **prescription drug** is dispensed by a **preferred pharmacy** to a person for treatment of a disease or injury, a benefit will be paid, determined from the Benefit Amount subsection, but only if the **preferred pharmacy's** charge for the drug is more than the **co-pay** per **prescription** or refill.

Benefit amounts provided under this section will not be subject to any provision under this Plan for coordination of benefits with other plans, except the provision for coordinating benefits under this Plan with any Medicare benefits.

A. Benefit Amount

The benefit amount for each covered **prescription drug** or refill dispensed by a **preferred pharmacy** will be an amount equal to the Payment Percentage of the total charges. The total charge is determined by:

- the **preferred pharmacy**; and
- Aetna.

Any amount so determined will be paid to the **preferred pharmacy** on your behalf.

In figuring the benefit amount, a Separate Brand Name Fee may apply to **brand name drugs** in addition to any applicable **co-pay**. The amount of the Separate Brand Name Fee will be equal to the difference between the cost of the **brand name drug** and the generic equivalent. The Separate Brand Name Fee will apply to any **brand name drug** dispensed when the covered person requests a brand name drug and the prescription is written for a generic drug with instructions "Dispense as Written".

No benefit will be paid for a **prescription drug** dispensed by a **non-preferred pharmacy** under this benefit section except for an **emergency condition**, in which case the benefit will be payable at the preferred level of coverage.

B. Limitations

1. No benefits are paid under this section:

- For a device of any type unless specifically included as a **prescription drug**.
- For any drug entirely consumed at the time and place it is prescribed.
- For less than a 30 day supply of any drug dispensed by a **mail order pharmacy**.
- For more than a 30 day supply per **prescription** or refill. However, this limitation does not apply to a supply of up to 90 days per **prescription** or refill for drugs which are provided by a **mail order pharmacy**.
- For the administration or injection of any drug.
- For the following injectable drugs:
 - fertility drugs;
 - allergy sera or extracts; and
 - Imitrex, if it is more than the 48th such kit or 96th such vial dispensed to the person in any year.

- For any refill of a drug that is more than the number of refills specified by the **prescriber**. Before recognizing charges, Aetna may require a new **prescription** or evidence as to need:
 - If the **prescriber** has not specified the number of refills; or
 - If the frequency or number of **prescriptions** or refills appears excessive under accepted medical practice standards.
- For any refill of a drug dispensed more than one year after the latest **prescription** for it or as permitted by the law of the jurisdiction in which the drug is dispensed.
- For any drug provided by or while the person is an inpatient in any health care facility; or for any drug provided on an outpatient basis in any health care facility to the extent benefits are paid for it under any other part of this Plan or under any other medical or **prescription drug** expense benefit plan carried or sponsored by your Employer.
- For any drugs which do not, by federal or state law, require a prescription order (i.e. an over-the-counter (OTC) drug), even if a prescription is written.
- Any **Prescription Drug** for which there is an over-the-counter (OTC) product which has the same active ingredient and strength.
- For immunization agents.
- For biological sera and blood products.
- For nutritional supplements.
- For any fertility drugs.
- For more than 8 unit doses per 30 day supply for the following drugs used for the treatment of erectile dysfunction, impotence, or sexual dysfunction or inadequacy:
 - sildenafil citrate;
 - phentolamine;
 - apomorphine;
 - alprostadil; or
 - any other **prescription drug** that is in a similar or identical class has a similar or identical mode of action or exhibits similar or identical outcomes.

*This limitation applies whether or not the **prescription drug** is delivered in oral, injectable, or topical (including, but not limited to, gels, creams, ointments, and patches) forms. If the drug is not taken orally, the dosage covered will be determined by Aetna based on the comparable cost for a 30 day supply of pills.*

- For any drug dispensed by a **mail order pharmacy** for use for the treatment of erectile dysfunction, impotence, or sexual dysfunction or inadequacy.
- For any smoking cessation aids or drugs.
- For Appetite Suppressants
- For a **prescription drug** dispensed by a **mail order pharmacy** that is not a **preferred pharmacy**.
- For any **prescription** written for the drugs Caverjet, MUSE and Edex.

C. Certification For Certain Prescription Drugs

Certification of the necessity of certain **prescription drugs** is required before the drug is dispensed by a **pharmacy**.

2. When one of the **prescription drugs** shown on the Medication Formulary Guide is dispensed, expenses incurred will be payable as follows:

- If certification has been requested and the drug is **necessary**:
 - For the drugs listed on the Pre-certification List of the Medication Formulary Guide benefits will be payable at the applicable Payment Percentage;
 - If certification has not been requested and the drug is **necessary** no benefits will be payable.
 - If the drug is not **necessary** no benefits will be payable whether or not certification has been requested.

CERTIFICATION PROCEDURES

It is your responsibility to arrange for the **prescriber** of the drug to call the number shown on your ID card to request certification. This call must be made as soon as reasonably possible before the drug is to be dispensed. Copies of laboratory and/or medical records may be requested. If such information is requested, it must be provided in order to certify the necessity of the drug.

3. Written notice of the certification decision will be sent promptly to you. This notice will show:
- the approved period of certification, during which time any authorized refills of the drug may be dispensed; or
 - when certification is denied, the procedure to follow if you choose to appeal the decision.

If the drug is to be dispensed after the certification period ends, certification must again be requested, as described above.

LIST OF PRESCRIPTION DRUGS REQUIRING CERTIFICATION

Refer to the Medication Formulary Guide for the list of **prescription drugs** that require certification, or call the number shown on your ID Card.

The following prescription drugs **always** require pre-certification:

ACUTANE (ISOTRETINOIN).	HUMIRA
BLOOD CLOTTING DRUGS	LOTRONEX
EMEND	REBIF
ENDBREL	GROWTH HORMONES
ZELNORM	

Please note: List of Prescription Drugs requiring Certification may be modified by the Prescription Benefit Manager to add or delete drugs provided that the modifications are reported quarterly and reviewed by the County's Risk Pool Board.

QUANTITY LIMITS AND DOSAGE EFFICIENCY

Quantity limits are included as part of Aetna's pre-certification program and are designed to help promote appropriate and efficient medication use and enhance patient safety. Quantity limits are based on generally accepted pharmaceutical guidelines, efficient dosing regimens and dosing recommendations. Three types of quantity limits are in place. They are:

- Dose Efficiency Message – Limits prescriptions to one pill per dose or per day for drugs that are approved for once-daily dosing.
- Maximum Daily Dose – Informational message is sent to the pharmacy if prescription lies outside recommended minimum and maximum doses.
- Quantity Limits Over Time – Limits prescriptions to a specific number of units per a defined amount of time.

In order to receive coverage for amounts in excess of the quantity limits or recommended dosage, your physician must obtain pre-certification. Additional information may be obtained by contacting Aetna's Member Services by telephoning the number shown on your ID card.

D. General Exclusions Applicable to Prescription Drug Expense Coverage

4. Coverage is not provided for the following **prescription drug** charges:
- Those that are not prescribed by the person's **physician** or **dentist**.

- Those, as determined by Aetna, to be experimental or investigational. A drug will be determined to be experimental or investigational if:
 - there are insufficient outcomes data available from controlled clinical trials published in the peer reviewed literature to substantiate its safety and effectiveness for the disease or injury involved; or
 - if required by the FDA, approval has not been granted for marketing; or
 - a recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental, investigational or for research purposes; or
 - the written protocol or protocols used by the treating facility or the protocol or protocols of any other facility studying substantially the same drug or the written informed consent used by the treating facility or by another facility studying the same drug states that it is experimental, investigational or for research purposes.

However, this exclusion will not apply with respect to drugs that:

- *have been granted treatment investigational new drug (IND) or Group c/treatment IND status**
- *are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute**

*(*If Aetna determines that available scientific evidence demonstrates that the drug is effective or shows promise of being effective for the disease.)*

- Those that are made only because there is coverage.
- Those that a covered person is not legally obliged to pay.
- Those, as determined by Aetna, to be for **custodial care**.
- To the extent allowed by the law of the jurisdiction where the group contract is delivered, those
 - Furnished, paid for, or for which benefits are provided or required by reason of the past or present service of any person in the armed forces of a government.
 - Furnished, paid for, or for which benefits are provided or required under any law of a government. (This does not include a plan established by a government for its own employees or their dependents or Medicaid.) An example is benefits provided, to the extent required by law, under "no-fault" auto insurance law.
- Those for performance, athletic performance, or lifestyle enhancement drugs or supplies, except to the extent coverage for such drugs or supplies is specifically provided in your Booklet.
- Those for or related to artificial insemination, in vitro fertilization or embryo transfer procedures, except to the extent coverage for such procedures is specifically provided in your Booklet.

Any exclusion above will not apply to the extent that coverage of the charges is required under any law that applies to the coverage.

These excluded charges will not be used when figuring benefits.

The law of the jurisdiction where a person lives when a claim occurs may prohibit some benefits. If so, they will not be paid.

E. Pre-Certification Program

5. Coverage is not provided for those prescription drugs listed in the "Certification for Certain Drugs" section that are not **necessary**, as determined by Aetna, for the care or treatment of the physical or mental condition involved. This applies even if they are:

- Prescribed by a **physician** or **dentist** who is a preferred provider, as defined in the employer sponsored medical plan under which you are covered: and
- Dispensed by a **preferred pharmacy**, as defined in this Plan.

F. Drug Benefit Glossary

The following definitions of certain words and phrases will help you understand the benefits to which the definitions apply. Some definitions which apply only to a specific benefit appear in the benefit section. If a definition appears in a benefit section and also appears in the Glossary, the definition in the benefit section will apply in lieu of the definition in the Glossary.

(1) **Brand Name Drug**

A **prescription drug** which is protected by trademark registration

(2) **Co-pay**

This is a fee, charged to a person, which represents a portion of the applicable expense. It is specified in the Summary of Coverage.

As to a **prescription drug** dispensed by a **preferred pharmacy**, this is the fee charged to a person at the time the **prescription drug** is dispensed payable directly to the **pharmacy** for each **prescription** or refill at the time the **prescription** or refill is dispensed. For drugs dispensed as packaged kits, the fee applies to each kit at the time it is dispensed. In no event will the co-pay be greater than the **prescription** or refill.

(3) **Custodial Care**

6. This means services and supplies furnished to a person mainly to help him or her in the activities of daily life. This includes board and room and other institutional care. The person does not have to be disabled. Such services and supplies are custodial care without regard to:

- by whom they are prescribed; or
- by whom they are recommended; or
- by whom or by which they are performed.

(4) **Dentist**

This means a legally qualified dentist. Also, a **physician** who is licensed to do the dental work he or she performs.

(5) **Emergency Condition**

7. This means the sudden and, at that time, unexpected onset of a change in a person's physical or mental condition which, if the procedure or treatment was not performed right away could, as determined by Aetna, reasonably be expected to result in:

- loss of life or limb; or
- significant impairment to bodily function; or
- permanent dysfunction of a body part.

(6) **Generic Drug**

A **prescription drug** which is not protected by trademark registration, but is produced and sold under the chemical formulation name.

(7) **Mail Order Pharmacy**

An establishment where **prescription drugs** are legally dispensed by mail.

(8) **Medication Formulary**

A listing of **prescription drugs** which have been evaluated and selected by Aetna clinical pharmacists for their therapeutic equivalency and efficacy. This listing includes both **brand name drugs** and **generic drugs** and is subject to periodic review and modification by Aetna. See your Employer for a current listing.

(9) **Necessary**

A service or supply furnished by a particular provider is necessary if Aetna determines that it is appropriate for the diagnosis, the care or the treatment of the disease or injury involved.

8. To be appropriate, the service or supply must:

- be care or treatment, as likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or injury involved and the person's overall health condition;

- be a diagnostic procedure, indicated by the health status of the person and be as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or injury involved and the person's overall health condition; and
- as to diagnosis, care and treatment be no more costly (taking into account all health expenses incurred in connection with the service or supply) than any alternative service or supply to meet the above tests.

9. In determining if a service or supply is appropriate under the circumstances, Aetna will take into consideration:

- information provided on the affected person's health status;
- reports in peer reviewed medical literature;
- reports and guidelines published by nationally recognized healthcare organizations that include supporting scientific data;
- generally recognized professional standards of safety and effectiveness in the United States for diagnosis, care or treatment;
- the opinion of health professionals in the generally recognized health specialty involved; and
- any other relevant information brought to Aetna's attention.

10. *In no event will the following services or supplies be considered to be necessary:*

- those that do not require the technical skills of a medical, a mental health or a dental professional; or
- those furnished mainly for the personal comfort or convenience of the person, any person who cares for him or her, any person who is part of his or her family, any healthcare provider or healthcare facility; or
- those furnished solely because the person is an inpatient on any day on which the person's disease or injury could safely and adequately be diagnosed or treated while not confined; or
- those furnished solely because of the setting if the service or supply could safely and adequately be furnished in a physician's or a dentist's office or other less costly setting.

(10) Non-Occupational Disease

11. A non-occupational disease is a disease that does not:

- arise out of (or in the course of) any work for pay or profit; or
- result in any way from a disease that does.

12. A disease will be deemed to be non-occupational regardless of cause if proof is furnished that the person:

- is covered under any type of workers' compensation law; and
- is not covered for that disease under such law.

(11) Non-Occupational Injury

13. A non-occupational injury is an accidental bodily injury that does not:

- rise out of (or in the course of) any work for pay or profit; or
- result in any way from an injury which does.

(12) Non-Preferred Pharmacy

A **pharmacy** which is not party to a contract with Aetna, or a **pharmacy** which is party to such a contract but does not dispense **prescription drugs** in accordance with its terms.

(13) Pharmacy

An establishment where **prescription drugs** are legally dispensed.

(14) Physician

This means a legally qualified physician.

(15) Preferred Pharmacy

14. A **pharmacy**, including a **mail order pharmacy**, which is party to a contract with Aetna to dispense drugs to persons covered under this Plan, but only:

- while the contract remains in effect; and

- while such a **pharmacy** dispenses a **prescription drug** under the terms of its contract with Aetna.

(16) Prescriber

Any person, while acting within the scope of his or her license, who has the legal authority to write an order for a **prescription drug**.

(17) Prescription

An order of a **prescriber** for a **prescription drug**. If it is an oral order, it must promptly be put in writing by the **pharmacy**.

(18) Prescription Drugs

15. Any of the following:

- A drug, biological, compounded **prescription** or contraceptive device which, by Federal Law, may be dispensed only by **prescription** and which is required to be labeled "Caution: Federal Law prohibits dispensing without prescription".
- An injectable contraceptive drug prescribed to be administered by a paid healthcare professional.
- An injectable drug prescribed to be self-administered or administered by any other person except one who is acting within his or her capacity as a paid healthcare professional. Covered injectable drugs include insulin.
- Disposable needles and syringes which are purchased to administer a covered injectable **prescription drug**.
- Disposable diabetic supplies, other than alcohol swabs.

(19) Reasonable Charge

16. Only that part of a charge which is reasonable is covered. The reasonable charge for a **prescription drug** dispensed by a **non-preferred pharmacy** is the lowest of:

- the charge Aetna determines to be appropriate, based on factors such as the cost of providing the same or a similar drug and the manner in which charges for it are made; and
- the charge Aetna determines to be the prevailing charge level made for the drug in the geographic area where it is dispensed.

17. In determining the reasonable charge for a **prescription drug** that is:

- unusual; or
- not often provided in the area; or
- provided by only a small number of pharmacies in the area;

18. Aetna may take into account factors, such as:

- the compounding complexity of the drug;
- the prevailing charge in other areas.
- the availability of the product or its ingredients.

Section 16
SCHEDULE OF DENTAL BENEFITS

The Plan will pay as follows:

1. Preventive Dental Services	100% of Reasonable & Customary charges
2. Basic Dental Services	80% of Reasonable & Customary charges
3. Major Dental Services	50% of Reasonable & Customary charges
4. Orthodontic Services	50% of Reasonable & Customary charges

The Plan will pay for the services provided by a Dentist who is legally licensed in the USA to provide these services and supplies

Maximum Benefit Amounts:

- The maximum calendar year benefit payable under the plan for a covered participant for all dental benefits is \$1,500.
- The maximum lifetime benefit payable under the plan for a covered participant for Orthodontic benefits is \$1,000.

Section 17
DENTAL DEFINITIONS

- A) DENTIST.** A Doctor of Dental Surgery (D.D.S.) or a Doctor of Medical Dentistry (D.M.D.) who holds a lawful license authorizing the person to practice dentistry in the locale in which the service is rendered. A Dentist's practice must be located within the United States. Non-USA providers shall not be Eligible.
- B) ALTERNATIVE TREATMENT.** There is often more than one method of satisfactory treatment for a given dental condition. If this is the case, the Covered Dental Expenses will be limited to Reasonable and Customary charge which would be appropriate for these services and supplies which are customarily employed nationwide in the treatment of the disease or injury concerned and which are recognized by the dental profession to be appropriate methods of treatment in accordance with broadly accepted national standards of dental practice, taking into account the total current oral condition of the Covered Person.
- C) EMERGENCY PALLIATIVE TREATMENT.** Any dental procedures necessary to alleviate (but not cure) acute pain or temporarily alleviate (but not cure) conditions requiring the immediate attention of a Dentist to prevent irreparable harm to the Covered Person.
- D) BENEFITS PAYABLE.** If, because of a non-occupational condition, a Participant, while covered for benefits under this Section, incurs Covered Expenses, this Plan will pay the Benefit Percentage of Reasonable and Customary expenses in excess of the Deductible, if applicable. The Benefit Percentage, the Deductible, and the Maximum Benefits are shown in the Section titled "DENTAL BENEFITS".
- E) INCURRED DATE.** The date the service is received.
- F) DEDUCTIBLE.** The Deductible amount is the dollar amount of Covered Expenses, which must be paid by the Participant before reimbursement for any additional Covered Expenses can be paid. The deductible applies separately to each Participant in each calendar year, subject to the following:
- a)** When covered family members satisfy their Maximum Family Deductible limit, the family deductible will be considered satisfied for all covered family members for the remainder of that calendar year.
- G) BENEFITS PERCENTAGE.** The percentage of benefits payable during any one calendar year for Reasonable and Customary charges after the deductible amount is satisfied is shown in the Section titled "DENTAL BENEFITS".
- H) MAXIMUM BENEFITS.** Benefits paid to any Covered Person for dental expenses for Preventive, Basic and Major Services (combined) in any one calendar year shall not exceed the maximum as specified in Section titled "DENTAL BENEFITS".
- I) COVERED EXPENSES.** The term Covered Expense means an eligible charge actually incurred by or on behalf of a covered person for the charges listed below but only if the expenses are incurred while such Covered Person is covered for Dental Expense Benefits and only to the extent that the services or supplies are recommended by a physician (or dentist) and are essential for the necessary care and treatment of the dental problem suffered by the Covered Person.
- J) PRE-DETERMINATION OF BENEFITS.** A charge incurred by a Covered Person is eligible only when the dentist's proposed course of treatment ("Treatment Plan") has been submitted to and reviewed by the Plan Administrator, and returned to the dentist showing the estimated benefits. No "Treatment Plan" need be submitted if the total charges do not exceed \$300 or if emergency care is required. A "Treatment Plan" is the dentist's report that:
- 1)** Itemizes the dentist's recommended services,
 - 2)** Shows the dentist's charge for each service,
 - 3)** Is accompanied by supporting x-rays or other diagnostic records where required or requested by the Plan Administrator.

K) ELIGIBLE CHARGE. An Eligible Charge is one the dentist makes for a covered Preventive, Basic or Major dental service furnished, provided the service:

- 1) Is on the list of dental services,
- 2) Is part of a "Treatment Plan" as described above, and
- 3) Isn't listed in the "Exclusions Under Dental Expense Benefits".

*If a dental service is performed that is not on the list of dental services, but the list contains one or more other services that under customary dental practices are suitable for the condition being treated, for the purpose of coverage the listed services that the Plan Administrator determines would produce a satisfactory result will be considered to have been performed.

The amount of the eligible charge for a service is equal to the charge made by the dentist, not to exceed the maximum eligible charge applying to that service in the list of dental services.

L) INCURRED CHARGE. A charge will be considered to be incurred:

- 1) For an appliance or modification of an appliance - on the date the appliance is seated.
- 2) For a crown, bridge or gold restoration - on the date the appliance is seated.
- 3) For root canal therapy - on the date the pulp chamber is opened.
- 4) For all other services - on the date the service is received.
- 5) All other terms shall have the same meaning as specified in Section titled, "**DEFINITIONS**".

Section 18
COVERED DENTAL EXPENSES

A) PREVENTIVE SERVICES

- 1) Two dental examinations per calendar year;
- 2) Two prophylaxis (cleaning of teeth) treatments per calendar year;
- 3) Two bitewing x-rays per calendar year;
- 4) Topical application of fluoride solutions up to the age of nineteen (19) years;

B) BASIC SERVICES

- 1) Extractions;
- 2) Oral surgery - apicoectomies, impactions, and extractions (including alveolectomy, alveoplasty, and tori removal in connection with extractions);
- 3) Local anesthesia or I.V. sedation for covered oral surgery;
- 4) General anesthesia when medically indicated and administered by a Physician other than the operating dentist;
- 5) Restorative services (filling);
- 6) Periodontal scaling, treatment, diagnosis, and surgery;
- 7) Diagnostic x-ray and full mouth series of x-rays, but not more than one series per calendar year;
- 8) Repair or recementing of crowns, inlays, onlays, bridgework or dentures or relining of dentures;
- 9) Root canals;
- 10) Space maintainers for missing primary teeth;
- 11) Emergency palliative treatment;
- 12) Injection of antibiotic drugs by the attending dentist;
- 13) Consultation required by the attending dentist.

C) MAJOR SERVICES

- 1) Initial fixed bridgework and dentures replacing teeth extracted while covered under this Plan;
- 2) Replacement of bridgework or partial dentures when an additional tooth or teeth must be replaced;
- 3) Cast metal or ceramic material inlays, onlays, or crown restoration;
- 4) Replacement or modification of existing crowns, bridgework, or dentures that:
 - a) Are necessitated by the extraction of an additional natural tooth or teeth while covered under the Plan;
 - b) Cannot be made serviceable and were installed more than five years before replacement or modification; or
 - c) Are made necessary by the initial placement of an opposing denture while covered;

- 5) Initial fixed bridgework, dentures, or partial dentures replacing a tooth or teeth, all of which were extracted more than five (5) years before coverage. Twelve (12) months must have elapsed since the Effective Date of coverage under this Plan;
- 6) First installation (including adjustments during the six month period following installation of a removable denture (partial or full));
- 7) The existing denture is an immediate temporary denture and replacement by a permanent denture is required and done within twelve months from the date the immediate temporary denture was installed;

Crowns and initial installation of fixed bridgework (including inlays and crowns to form abutments).

D) ORTHODONTICS

- 1) Orthodontic Treatment is payable at 50%.
- 2) Orthodontic Treatment benefit is subject to a \$1000 lifetime maximum per eligible participant.

Section 19
DENTAL EXPENSE LIMITATIONS AND EXCLUSIONS:

LIMITATIONS

In the case of an individual (other than a dependent younger than age five) whose Dental Expense Benefits starts more than 31 days after that individual becomes eligible, the covered services received during the first year the benefits are in effect will be limited to those made necessary by an accident occurring while covered, and to preventive or basic dental services included in the list of dental services under the headings "Visits and X-rays", "Visits and Examinations", "X-ray and Pathology" and "Restorative Dentistry".

EXCLUSIONS UNDER DENTAL EXPENSE BENEFITS:

- 1) Anything not furnished by a dentist, except x-rays ordered by a dentist, and services by a licensed dental hygienist under the dentist's supervision; anything not necessary or not customarily provided for dental care;
- 2) Services, unless payment is legally required, for
 - a) furnished by or for the U.S. Government, or any other government, or
 - b) to the extent provided under any governmental program or law under which the individual is, or could be, covered;
- 3) An appliance, or modification of one, where an impression was made before the patient was covered; a crown, bridge or gold restoration for which the tooth was prepared before the patient was covered;
- 4) Root canal therapy if the pulp chamber was opened before the patient was covered;
- 5) A crown, gold restoration, or a denture or fixed bridge or addition of teeth to one, if the work involves a replacement or modification of a crown, gold restoration, denture or bridge installed less than five years before;
- 6) A denture or fixed bridge involving replacement of teeth missing before the individual was covered, unless it also replaces a tooth that is extracted while covered, and such tooth was not an abutment for a denture or fixed bridge installed during the preceding five years.
- 7) Services due to an accident or disease covered under worker's compensation or similar law.
- 8) Replacement of lost or stolen appliances; appliances or restorations or procedures for the purpose of splinting, or to alter vertical dimension or restore occlusion.
- 9) Treatment for temporomandibular joint problems; services for cosmetic purposes unless made necessary by an accident occurring while covered. Facings on molar crowns or pontics are always considered cosmetic.
- 10) Any portion of a charge for a service in excess of the reasonable and customary charge (the charge usually made by the provider when there is no coverage, not to exceed the prevailing charge in the area for dental care of a comparable nature, by a person of similar training and experience).
- 11) Expenses applied toward satisfaction of a deductible under the Dental Expense Benefits.
- 12) Services and Supplies provided by a Dentist located outside the United States.

If a particular charge is covered under the Dental Expense Benefits and also under another part of any other plans for which the County of El Paso shall have paid any part of the cost, the Dental Expense Benefit payment will be limited to the excess, if any, of the amount normally paid for that Benefit over the amount payable by all such other plans.

Section 20
EXTENSION OF BENEFITS

If the Dental Expense coverage for you or a dependent is terminated, the protection will be extended to cover charges incurred within the next 30 days for Basic Services, provided benefits would have been paid had the coverage remained in effect, and treatment was begun prior to the date of termination.

Section 21
COORDINATION BETWEEN THE PLAN AND AVAILABLE GROUP BENEFITS

The Plan has been designed to help meet the cost of sickness or injury. Since it is not intended that greater benefits be paid you than your actual medical expenses, the amount of benefits payable with the Plan will take into account any coverage a family member has with other "plans". The benefits under the Plan will be coordinated with the benefits of the other "plans".

The Plan will always pay either its regular benefits in full, or a reduced amount which, when added to the benefits payable by the other plan or plans, will equal 100 percent of "Allowable Expenses".

"Allowable Expenses" means any necessary, Reasonable and Customary expense, incurred while you are eligible for benefits under the Plan, part or all of which would be covered under any of the plans, but not any expenses contained in the list of Exclusions. "Plan" means any plan providing benefits or services for or by reason of medical or dental care or treatment, which benefits or services are provided by group insurance, self-insurance, or any similar plan or program.

Other Plan or Another Plan shall mean any plan, other than This Plan, providing benefits or services for or by reason of medical or dental care or treatment, which benefits or services are provided by any of the following:

- 1) Group, blanket or franchise insurance coverage;
- 2) Service plan contracts, group practice, individual practice or other prepayment coverage;
- 3) Any coverage under labor-management trustee plans, union welfare plans, employer organization plans, or employee benefit organization plans;
- 4) Any coverage under governmental programs and any coverage required or provided by any statute;
- 5) Group or individual no-fault automobile contracts or group traditional automobile medical expense contracts; and
- 6) Student coverage obtained through an educational institution above the high school level.

The benefits of Another Plan will be ignored for the purposes of determining Benefits under This Plan if:

- 1) The Other Plan which contains a provision coordinating its benefits with those of This Plan would, according to its rules, determine its benefits after the Benefits of This Plan have been determined; and
- 2) The rules set forth in this Section would require This Plan to determine its Benefits before the Other Plan.

Section 22
ORDER OF BENEFIT DETERMINATION

- A) ORDER OF BENEFIT DETERMINATION.** The following rules will be used to establish the order of benefit determination:
- 1)** The benefits of a plan which covers the Covered Person as a dependent with the earliest birth date, month and date will determine its benefits first, except that when a claim is made for a dependent child of divorced or separated parents, the following rules will apply:
 - a)** A plan which covers a child as a dependent of a parent who by court decree must provide health coverage will determine its benefits first;
 - b)** When there is no court decree, which requires a parent to provide health coverage to a dependent child, the following rules will apply:
 - (i)** When a parent who has custody of the child has not remarried, that parent's plan will determine its benefits first;
 - (ii)** When a parent who has custody of the child has remarried:
 - (1)** That parent's plan will determine its benefits first;
 - (2)** The stepparent's plan will determine its benefits next; and
 - (3)** The plan of the parent without custody will determine its benefits third.
 - 2)** When the rules explained in #1 (above) do not establish an order of benefit determination, the benefits of a plan which has covered the person on whose expenses claim is based for the longer period of time will be determined before the benefits of a plan which has covered the person the shorter period of time; and
 - 3)** When a plan does not contain a provision coordinating its benefits, that plan is always primary and always pays first.
- B) RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION.** For the purpose of determining the applicability of and implementing the terms of this provision of this Plan or any provision of similar purpose of any other plan, the County of El Paso may, without the consent of or notice to any person, release to or obtain from any Insurance Company or other organization or person any information, with respect to any person, which the County of El Paso deems to be necessary for such purposes. Any person, claiming benefits under this Plan shall furnish to the County of El Paso such information as may be necessary to implement this provision
- C) FACILITY OF BENEFIT PAYMENT.** Whenever payments which would have been made under this Plan in accordance with this provision have been made under any other plans, the County of El Paso shall have the right, exercisable alone and in its sole discretion, to pay over to any organization making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision, and amounts so paid shall be deemed to be benefits paid under this Plan and, to the extent of such payments, the County of El Paso shall be fully discharged from liability under this Plan.
- D) RIGHT OF RECOVERY.** Whenever **payments have been made by** the County of El Paso with respect to Allowable Expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at the time to satisfy the intent of this provision, the County of El Paso shall have the right to recover such payments, to the extent of such excess, from among one or more of the following, as the County of El Paso shall determine: any persons to or for or with respect to whom such payments were made, any insurance companies, and other organizations.
- E) SUBROGATION.** Your coverage is intended to afford protection to you against the cost of hospital and medical-surgical services required in case of illness or injury. It is not intended to serve any other purpose. If a participant is injured under circumstances, which impose on someone else a legal obligation to pay the expense of his/her treatments, as damages, the Plan will pay, but the Plan Sponsor reserves the right to be reimbursed from the payment made by the third party.

The Plan shall be subrogated, to the extent and in the amount of any payments made hereunder by the Plan to a Covered Person, to any cause of action said Covered Person may have against any tortfeasor for injury to the Covered Person which results in payment being made by the Plan. This means the Plan is not obligated to pay for services necessary on account of any injury or condition for which a third party is liable unless or until the Covered Person, or someone legally qualified and authorized to act for the Covered Person, promises in writing:

- 1) Include those amount in any claim the Covered Person makes against a third party for the injury or conditions; and
- 2) Repay the Plan those amounts to the extent that the proceeds of the Covered Person's recovery from a settlement with a third party by reason of such an injury or condition exceed his or her own portion of the total loss; repayment to the Plan to be made within thirty (30) days of the receipt of such proceeds; and
- 3) Cooperate fully with the Plan in asserting its rights, to supply the Plan with any and all information and execute any and all instruments the Plan reasonably needs for that purpose.

In the event claimant fails to, or refuses to execute whatever Assignment, Form or Document requested by the Plan Sponsor of the Plan, the Plan shall and is hereby relieved of any and all legal, equitable or contractual obligation contained in this the entire Plan for any benefits or covered expenses incurred by claimant.

Section 23
CLAIMS PROCEDURE

- A) QUESTIONS RELATING TO ELIGIBILITY, CLASSIFICATION, COVERAGE.** All questions relating to eligibility, classification, or coverage under the Plan shall be submitted to the Plan Administrator. The Plan Administrator may make a determination on whether or not a particular medical service is covered by the Plan or is medically necessary either before services are rendered or after services are rendered.
- B) WRITTEN PROOF OF LOSS.** All claims for Benefits under this Plan shall be submitted to the Plan Administrator on forms furnished by the Plan Administrator. Such Written Proof of Loss shall be submitted:
- 1) Within 90 days of the date the claimed Medical Expenses were incurred; or
 - 2) As soon as is reasonably possible, but not later than one year from the date the claimed Medical Expenses were incurred or not later than March 31st of the following Calendar Year, whichever date falls first.

In the case of incurred Medical Expenses, the billing statement or invoice of the medical service provider shall be attached as part of the Written Proof of Loss.

- C) PHYSICAL EXAMINATION.** The Plan Administrator, at the expense of the Plan, will have the right and opportunity to examine the person or any individual whose Injury or Sickness is the basis of a claim when and as often as it may reasonably require while the claim is pending.
- D) FREE CHOICE OF PHYSICIAN.** A claimant has free choice of any Physician, and the Physician-patient relationship will be maintained.
- E) PAYMENT OF BENEFITS.** All Medical Expense Benefits payable under this Plan for amounts billed by a Hospital shall be paid to the Hospital unless the claimant furnishes proof of payment of the Medical Expense at the time the claim is filed with the Plan Administrator in which case the Benefits shall be paid to the claimant.

All Medical Expense Benefits payable under this Plan for amounts billed by a Health Care Provider other than a Hospital shall be paid to the claimant unless the provider provides a statement which the claimant has signed indicating that the Benefits are assigned to the provider in which case the Benefits shall be paid to the provider.

- F) DENIALS OF COVERAGE/CLAIM.**
- 1) **Pre-Certification/Pre-Authorization.** Certain types of medical care and services require Pre-Certification that the medical care or service is Medically Necessary. If the Plan Administrator denies Pre-Certification, the Plan Administrator shall furnish the claimant with a written explanation of the denial of coverage. An Employee or Health Care Provider may request a review of the Plan Administrator's determination within 60 days by submitting a written request for Review to the Plan Administrator with supporting information from the Health Care Provider.
 - 2) **Pre-Determination of Coverage Prior to Services Rendered.** An Employee or Health Care Provider may request a Pre-Determination whether or not a particular medical service is covered by the Plan prior to (or during) the time that medical services are rendered. If the Plan Administrator determines that the service is not covered, the Plan Administrator shall furnish the claimant with a written explanation of the denial of Coverage. An Employee or Health Care Provider may request a review of the Plan Administrator's Pre-Determination within 60 days by submitting a written request for Review to the Plan Administrator with supporting information from the Health Care Provider.
 - 3) **Claim for Services After Medical Services Rendered.** After medical services have been provided, the Health Care Provider shall submit a Claim for Benefits (see Section 4). If a claim is wholly or partially denied, the Plan Administrator shall furnish the claimant with a written explanation of the denial.
- G) EXPLANATION OF DENIAL OF COVERAGE OR CLAIM.** The written explanation of a coverage or claim denial shall set forth, in a manner calculated to be understood by the claimant, the following information:

- 1) The specific reason or reasons for the denial;

- 2) Specific reference to pertinent Plan provisions, if any, on which the claim denial is based;
- 3) If the claim is denied because the Plan Administrator needs more information to make a decision, a description of any additional information necessary for the claimant to perfect the claim and explanation of why such information is necessary and must be received by the Plan Administrator within 60 days of the request for information;
- 4) A statement that the claim and its denial shall be reviewed upon submission of a written request to the Plan Administrator;
- 5) A statement that the claimant, the claimant's attorney, or other duly authorized representative shall have, as part of the review procedure, a reasonable opportunity:
 - a) To examine pertinent Plan Documents and records,
 - b) To submit written comments on the issues; and
- 6) A statement that the failure to submit a written request for review within 60 days after the receipt of the written explanation of the claim denial shall make the Plan Administrator's decision final.

H) REVIEW PROCEDURE. The Plan Administrator shall review a pre-certification, determination of coverage or claim and its denial if a written request for review is filed within 60 days after receipt of the written explanation of the denial by the claimant. Otherwise, the initial decision of the Plan Administrator shall be the final decision of the Plan. As part of the review procedure, the claimant or the claimant's duly authorized representative shall have a reasonable opportunity to examine pertinent Plan Documents and records and to submit written comments on the issues.

1) DECISION ON REVIEW. The Plan Administrator shall review the information and comments submitted by the claimant or the claimant's duly authorized representative.

- a) **Pre-Authorization.** If the medical care or service requested requires Pre-Authorization as defined in this Plan, the Plan Administrator shall refer the request to its Utilization Management Organization to seek a determination regarding the Medical Necessity of the service requested. If the medical procedure is not a covered benefit, a denial will be issued by the Plan Administrator to the Provider and Claimant. The fact that the Covered Person's physician prescribes services or supplies does not automatically mean such services or supplies is medically necessary and covered by the Plan.
- b) **Pre-Determination of Coverage.** If the medical care or service is not covered by the Plan, a denial of coverage shall be issued by the Plan Administrator to the Provider and Claimant.
- c) **Claim After Service Rendered.** If a Claim received by the Plan Administrator is not covered under the Plan, the Plan Administrator will deny the claim and issue a written denial to the Provider and Claimant.

2) EXPLANATION OF DECISION ON REVIEW. The written explanation of the decision on review shall set forth, in a manner calculated to be understood by the claimant, the following information:

- a) The specific reason or reasons for the decision, including a response to the information and comments, if any, submitted by the claimant and his duly authorized representative; and
- b) Specific reference to pertinent Plan provisions and records, if any, on which the decision is based.

3) LIMITATION.

- a) No action at law or in equity can be brought to recover on this Plan prior to the expiration of 90 days after Written Proof of Loss has been furnished to the Plan Administrator.
- b) No action at law or in equity can be brought to recover after the expiration of two years after the time Written Proof of Loss is required to be furnished to the Plan Administrator.

- l) APPEAL** If after utilizing all review process and the claimant is not satisfied with decision(s) rendered by the Plan Administrator regarding a Pre-Certification, a Pre-Determination of Coverage or Claim, the claimant can request a final appeal with the Board of Trustees of the Risk Pool for the El Paso County Health and Life Benefit Fund (also known as County of El Paso Risk Pool). The written appeal must be submitted within 60 days of the claimant's receipt of the Review Denial from the Plan Administrator.
- a)** The claimant will need to submit a written appeal to the Coordinator of Employee Benefits of the County of El Paso expressing his/her desire to appeal his/her claim denial and providing any additional supporting information from the Health Care Provider.
 - b)** After all pertinent information is received; the Coordinator will have the appeal placed on the agenda for the next County of El Paso Risk Pool meeting.
 - c)** The members of the County of El Paso Risk Pool will then hear the case and render the decision.
 - d)** Decisions by the County of El Paso Risk Pool will be considered as a final appeal decision.

Section 24
GENERAL PROVISIONS AND INFORMATION

- A) BOOKLETS.** The County of El Paso will issue herewith to each Covered Employee under this Plan an individual booklet which summarizes the benefits to which the person is entitled, to whom benefits are payable, and the provisions of this Plan principally affecting said person and his/her dependents.
- B) FUNDING.** Medical and Dental claims are paid directly by the County of El Paso Health and Life Benefits Fund. The County of El Paso has employed a Plan Administrator to assure accurate, impartial and timely payment of benefits to and in behalf of Covered Employees and Dependents. The contributions payable to the trust shall not exceed the Plan's qualified cost for the taxable year as provided by Internal Revenue Code Sections 419 and 419A; which limitations are hereby incorporated into this Plan by reference.
- C) CONFORMITY WITH STATUTES.** Any provision of the Plan, which on its Effective Date is in conflict with the statutes of the United States or of the jurisdiction of Texas, is hereby amended to conform to the minimum requirements of such statutes.
- D) CLAIMS PROCEDURE.** The County of El Paso, upon receipt of notice required by the Plan, will furnish to the Covered Person or to any other person notifying the County of El Paso of Claim such forms as usually furnished by it for filing proof of loss. Failure to furnish notice or proof of claim within the time provided in the Plan shall not invalidate or reduce any claims if it shall be shown not to have been reasonably possible to furnish such notice or proof and that such notice or proof was furnished as soon as possible.
- E) REVIEW PROCEDURE.** The County of El Paso or a person or persons authorized by County shall have the power to initiate a review of a claim made under this Plan. Such officer shall conduct the review in a manner in which he/she determines is in accordance with the best interests of the Plan and of the claimant and may utilize (but is not limited to) any or all of the following procedures:
- 1) Consulting with Plan Administrator with respect to such claim;
 - 2) Requesting Plan Administrator to review all matters relevant to such claim;
 - 3) Requesting Plan Administrator to furnish all records pertaining to such claim to County for County review;
 - 4) Appointing a committee to review the claim (size and content of committee to be determined by the County of El Paso).
- F) FACILITY OF PAYMENT.** If, in the opinion of the County of El Paso, a valid release cannot be rendered for the payment of any benefit payable under this Plan, the County of El Paso may, at its option, make such payment to the individuals as have, in the County of El Paso's opinion, assumed the care and principal support of the Covered Person and are therefore equitably entitled thereto. In the event of the death of the Covered Person prior to such time as all benefit payments due him/her have been made, the County of El Paso may, at its sole discretion and option, honor benefit assignments, if any, prior to the death of such Covered Person.
- Any payment made by the County of El Paso in accordance with the above provisions shall fully discharge the County of El Paso to the extent of such payment.
- G) FIDUCIARY OPERATION.** Each fiduciary shall discharge his/her duties with respect to the Plan solely in the interest of the participants and beneficiaries and
- 1) For the exclusive purposes of providing benefits to participants and their beneficiaries and defraying reasonable expenses of administering the Plan,
 - 2) With care, skill, prudence and diligence under the circumstances then prevailing that a prudent person acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of alike character and with like aims.
- H) PLAN ADMINISTRATION.** The Administrator shall have full charge of the operation and management of the Plan.

The Plan Administrator shall provide consulting services to the County of El Paso in connection with the operation of the Plan and shall perform such other functions and services including the processing and payment of claims, as may be delegated to it. The Plan Sponsor and Plan Administrator may designate any person or persons to carry out their respective responsibilities. Any person or group of persons may serve in more than one fiduciary capacity with respect to the Plan.

A Named Fiduciary, Employee, Agent, Representative or Other Person performing services to or for the Plan or County shall be entitled to reasonable compensation for services rendered, unless such person is the County of El Paso or already receives full-time pay from the County of El Paso, and for reimbursement of expenses properly and actually incurred.

- I) **NETWORK ADMINISTRATOR.** The Network Administrator shall have the authority and responsibility to:
 - 1) Carry out the responsibilities related to the program it administers in accordance with the provisions specified;
 - 2) Determine which Network Providers will be eligible for Network participation, which Network Providers are selected for Network participation and which Network Providers should be terminated from Network participation;
 - 3) Determine whether a treatment or service is (i) due to a Medical Emergency; or (ii) Medically Necessary and Appropriate; and interpret and construe the terms and provisions of the Plan related to such determinations for the Provider Network and program which it administers;
 - 4) Provide for the administration of the Utilization Review Program; and
 - 5) Perform all other responsibilities delegated to the Network Administrator in the instrument appointing the Network Administrator.

- J) **PLAN MODIFICATION AND AMENDMENTS OF PLAN.** The Plan and any provision thereof may be modified or amended at any time by the County of El Paso upon its due approval of such modification or amendment. The modification or amendment will be effective at the date of approval or at such later date as the County of El Paso may determine in connection therewith. Such modification or amendment shall be duly incorporated in writing into the master copy of the Plan on file with the County of El Paso or written copy thereof shall be deposited with such master copy of the Plan.

- K) **PLAN TERMINATION.** The Plan may be terminated at any time by the County of El Paso upon due authorization of such termination effective as of the date of such authorization or at such later date as the County of El Paso may provide. In the event of such termination, the County of El Paso shall have no obligation under the Plan beyond paying the difference between the claims incurred (even though later filed) and expenses of the Plan due up to the date of termination. Such claims and expenses shall be paid from the funds as normal expenses of the Plan.

- L) **PLAN IS NOT A CONTRACT.** The Plan shall not be deemed to constitute a contract between the County of El Paso and any Employee or to be a consideration for, or an inducement or condition of, the employment of any Employee. Nothing in the Plan shall be deemed to give any Employee the right to be retained in the service of the County of El Paso or to interfere with the right of the County of El Paso to discharge any Employee at any time.

Section 25
HIPAA PRIVACY AND SECURITY RULES (EFFECTIVE APRIL 14, 2003)

A) PARTICIPANT PRIVACY RIGHTS POLICY AND PROCEDURES

Policy

The County of El Paso ["Health Plan] has implemented policies and procedures to ensure participant privacy rights as required by and specified in the Privacy rule of the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996.

Procedure

Participant in the Health Plan have the right to:

Receive a paper copy of the Health Plan's Notice of Privacy Practices ["Notice"], even if participant has agreed previously to receive the Notice electronically;

Request restrictions on the uses and disclosures of Protected Health Information ["PHI"];

Request to receive confidential communication by an alternative means or at an alternative location if appropriate cause is shown;

Access documents in the designated record set for inspection and/or copying;

Request to amend documents in the designated record set that are inaccurate or incomplete; and

Obtain an accounting of disclosures of their PHI.

The Health Plan adheres to policies and procedures developed and implemented to ensure participant privacy rights. The Health Plan provides workforce members who perform plan administration functions with annual training regarding participant rights with respect to their PHI.

Security Regulations

The Plan and the Plan Sponsor will comply with the security regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996, 45 C.F.R. Parts 160, 162 and 164 (the "Security Regulations"). The following provisions apply to Electronic Protected Health Information ("ePHI") that is created, received, maintained or transmitted by the Plan Sponsor on behalf of the Plan, except for ePHI (1) it receives pursuant to an appropriate authorization (as directed in 45 C.F.R. section 164.504(f) (1) (ii) or (iii)), or (2) that qualifies as Summary health Information and that it receives for the purpose of either (a) obtaining premium bids for providing health insurance coverage under the Plan, or (b) modifying, amending or terminating the Plan (as authorized under 45 C.F.R. section 164.508). If other terms of the Plan conflict with the following provisions, the following provisions shall control. The Security Regulations are incorporated herein by reference. Unless defined otherwise in the Plan, all capitalized terms herein have the definition given to them by the Security Regulations. The Plan Sponsor shall, in accordance with the Security Regulations:

1. Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the ePHI that it creates, receives, maintains or transmits on behalf of the Plan.

2. Ensure that "adequate separation" is supported by reasonable and appropriate security measures. "Adequate separation" means the Plan Sponsor will use ePHI only for Plan administration activities and not for employment-related actions or for any purpose unrelated to Plan administration. Any employee or fiduciary of the Plan or Plan Sponsor who uses or disclosed ePHI in violation of the Plan's security or privacy policies and procedures or this Plan provision shall be subject to the Plan's disciplinary procedure.

3. Ensure that any agent or subcontractor to whom it provides ePHI agrees to implement reasonable and appropriate security measures to protect the information.

4. Report to the Plan any Security Incident of which it becomes aware.

B) NOTICE OF PRIVACY PRACTICES POLICY AND PROCEDURES

Policy

The privacy practices of the County of El Paso ["Health Plan"] designed to protect the privacy, use and disclosure of Protected Health Information (PHI), are clearly delineated in the [Health Plan's] Notice of Privacy Practices [Notice] which was developed and is used in accordance with the Privacy Rule.

Procedures

The privacy practices of the County of El Paso Health Plan are described in its Notice.

The Notice is distributed to all new participants at enrollment. All current participants received the Notice as of the compliance date. All participants receive a revised Notice within 60 days of any material revision to the Notice. The Notice is provided to the named participant or employee for the benefit of all dependents.

The Notice is available to anyone who requests it. Participants have the right to receive a paper copy of the Notice, even if they previously agreed to receive the Notice electronically.

All current participants are notified at least once every three years of the availability of the Notice and provided with instructions on how to obtain it.

The Notice is given to all Business Associates.

The Notice is reviewed with all current workforce members who perform Health Plan functions during their initial training and annually thereafter. The Notice is revised as needed to reflect any changes in the Health Plan's privacy practices. Revisions to the policies and procedures are not implemented prior to the effective date of the revised Notice.

When revisions to the Notice are necessary, all current participants, workforce members who perform Health Plan functions and Business Associates receive a revised copy of the Notice.

The Privacy Official retains copies of the original Notice and any subsequent revisions for a period of six (6) years from the date of its creation or when it was last in effect, whichever is later.

All workforce members who perform Health Plan functions and Business Associates are required to adhere to the privacy practices as detailed in the Notice, Privacy Policies and Procedures and Business Associate Contracts.

Violations of the Health Plan's privacy practices will result in disciplinary action up to and including termination of employment or contracts.

The Notice is prominently displayed and available electronically on the County of El Paso Health Plan's Web site at <http://www.co.el-paso.tx.us/>

C) NOTICE OF HEALTH PLAN'S 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.

USE AND DISCLOSURE OF HEALTH INFORMATION

The County of El Paso ("Health Plan") may use your health information, that is, information that constitutes protected health information as defined in the Privacy Rule of the Administrative Simplification provision of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), for purposes of making or obtaining payment for your care and conducting health care operations. Health Plan has established a policy to guard against unnecessary disclosure of your health information.

The following is a summary of the circumstances under which and purposes for which your health information may be used and disclosed:

To Make or Obtain Payment. Health Plan may use or disclose your health information to make payment to or collect payment from third parties, such as other health plans or providers, for the care you receive. For example, Health Plan may provide information regarding your coverage or health care treatment to other health plans to coordinate payment of benefits.

To Conduct Health Care Operations. Health Plan may use or disclose health information for its own operations to facilitate the administration of Health Plan and as necessary to provide coverage and services to all of Health Plan's participants. Health care operations includes such activities as:

- Quality assessment and improvement activities.
- Activities designed to improve health or reduce health care costs.
- Clinical guideline and protocol development, case management and care coordination.
- Contacting health care providers and participants with information about treatment alternatives and other related functions.
- Health care professional competence or qualifications review and performance evaluation.
- Accreditation, certification, licensing or credentialing activities. -Underwriting, premium rating or related functions to create, renew or replace health insurance or health benefits.
- Review and auditing, including compliance reviews, medical reviews, legal services and compliance programs.
- Business planning and development including cost management and planning related analyses and formulary development.
- Business management and general administrative activities of Health Plan, including customer service and resolution of internal grievances.

Certain marketing activities.

For example, Health Plan may use your health information to conduct case management, quality improvement and utilization review, and provider credentialing activities or to engage in customer service and grievance resolution activities.

For Treatment Alternatives. Health Plan may use and disclose your health information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

For Distribution of Health-Related Benefits and Services. Health Plan may use or disclose your health information to provide to you information on health-related benefits and services that may be of interest to you.

For Disclosure to the Plan Sponsor. Health Plan may disclose your health information to the plan sponsor for plan administration functions performed by the plan sponsor on behalf of Health Plan. Health Plan also may provide summary health information to the plan sponsor so that the plan sponsor may solicit premium bids from other health plans or modify, amend or terminate the plan.

When Legally Required. Health Plan will disclose your health information when it is required to do so by any federal, state or local law.

To Conduct Health Oversight Activities. Health Plan may disclose your health information to a health oversight agency for authorized activities including audits, civil administrative or criminal investigations, inspections, licensure or disciplinary action. Health Plan, however, may not disclose your health information if you are the subject of an investigation and the investigation does not arise out of or is not directly related to your receipt of health care or public benefits.

In Connection With Judicial and Administrative Proceedings. As permitted or required by state law, Health Plan may disclose your health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order or in response to a subpoena, discovery

request or other lawful process, but only when Health Plan makes reasonable efforts to either notify you about the request or to obtain an order protecting your health information.

For Law Enforcement Purposes. As permitted or required by state law, Health Plan may disclose your health information to a law enforcement official for certain law enforcement purposes, including, but not limited to, if Health Plan has a suspicion that your death was the result of criminal conduct or in an emergency to report a crime.

In the Event of a Serious Threat to Health or Safety. Health Plan may, consistent with applicable law and ethical standards of conduct, disclose your health information if Health Plan, in good faith, believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public.

For Specified Government Functions. In certain circumstances, federal regulations require Health Plan to use or disclose your health information to facilitate specified government functions related to the military and veterans, national security and intelligence activities, protective services for the president and others, and correctional institutions and inmates.

For Worker's Compensation. Health Plan may release your health information to the extent necessary to comply with laws related to worker's compensation or similar programs.

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Other than as stated above, Health Plan will not disclose your health information other than with your written authorization. If you authorize Health Plan to use or disclose your health information, you may revoke that authorization in writing at any time.

YOUR RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION

You have the following rights regarding your health information that Health Plan maintains:

Right to Request Restrictions. You may request restrictions on certain uses and disclosures of your health information. You have the right to request a limit on Health Plan's disclosure of your health information to someone involved in the payment of your care. However, Health Plan is not required to agree to your request. If you wish to make a request for restrictions, please contact the **County of El Paso**.

Right to Receive Confidential Communications. You have the right to request that Health Plan communicate with you in a certain way if you feel the disclosure of your health information could endanger you. For example, you may ask that Health Plan only communicate with you at a certain telephone number or by email. If you wish to receive confidential communications, please make your request in writing to County of El Paso, Health Plan will attempt to honor your reasonable requests for confidential communications.

Right to Inspect and Copy Your Health Information. You have the right to inspect and copy your health information. A request to inspect and copy records containing your health information must be made in writing to County of El Paso. If you request a copy of your health information, Health Plan may charge a reasonable fee for copying, assembling costs and postage, if applicable, associated with your request.

Right to Amend Your Health Information. If you believe that your health information records are inaccurate or incomplete, you may request that Health Plan amend the records. That request may be made as long as the information is maintained by Health Plan. A request for an amendment of records must be made in writing to County of El Paso. Health Plan may deny the request if it does not include a reason to support the amendment. The request also may be denied if your health information records were not created by Health Plan, if the health information you are requesting to amend is not part of Health Plan's records, if the health information you wish to amend falls within an exception to the health information you are permitted to inspect and copy, or if Health Plan determines the records containing your health information are accurate and complete.

Right to an Accounting. You have the right to request a list of disclosures of your health information made by Health Plan for any reason other than for treatment, payment or health operations. The request must be made in writing to County of El Paso. The request should specify the time period for which you are requesting the information, but may not start earlier than **April 14, 2003**. Accounting requests may not be made for periods of time going back more than six (6) years. Health Plan will provide the first accounting you request during any 12-month period without charge.

Subsequent accounting requests may be subject to a reasonable cost-based fee. Health Plan will inform you in advance of the fee, if applicable.

Right to a Paper Copy of this Notice. You have a right to request and receive a paper copy of this Notice at any time, even if you have received this Notice previously or agreed to receive the Notice electronically. To obtain a paper copy, please contact County of El Paso. ***(You also may obtain a copy of the current version of Health Plan's Notice at its Web site, <http://www.co.el-paso.tx.us/>***

DUTIES OF HEALTH PLAN

Health Plan is required by law to maintain the privacy of your health information as set forth in this Notice and to provide to you this Notice of its duties and privacy practices. Health Plan is required to abide by the terms of this Notice, which may be amended from time to time. Health Plan reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all health information that it maintains. If Health Plan changes its policies and procedures, Health Plan will revise the Notice and will provide a copy of the revised Notice to you within 60 days of the change. You have the right to express complaints to Health Plan and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. Any complaints to Health Plan should be made in writing to County of El Paso Health Plan encourages you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

CONTACT PERSON

Health Plan has designated the **County of El Paso, Director of Human Resources** as its contact person for all issues regarding patient privacy and your privacy rights. You may contact this person at (915) 546-2218.

EFFECTIVE DATE

This Notice is effective **April 14, 2003**.

IF YOU HAVE ANY QUESTIONS REGARDING THIS NOTICE, PLEASE CONTACT the COUNTY of EL PASO, at (915) 546-2218.