

**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) CALENDAR YEAR.** The 12-month consecutive period beginning on January 1st and ending on December 31st of each year.
- E) 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.
- F) COMPANY.** The Company is the County of El Paso, Texas.
- G) 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.
- H) 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.
- I) 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 spouse 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. 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 until enrolling 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.**

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. 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.

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.