COMMISSIONERS COURT COMMUNICATION

AGENDA DATE: 7/23/2012

CONSENT OR REGULAR: Regular

CONTRACT REFERENCE NO (IF APPLICABLE): 2012-0319

SUBJECT: Approve the Summary Plan Description Amendment for the County's Health and Dental Plan for 2012. The Summary Plan Description Amendment was approved by the Risk Pool Board during their meeting on June 25, 2012 and reviewed by the County Attorney's Office.

BACKGROUND/DISCUSSION OF TOPIC:

The County of El Paso sponsors a health care plan that is administered by our Third Party Administrator. As part of the plan, the County develops a Summary Plan Description (SPD) which describes the Medical, Prescription Drug (Pharmacy) and Dental Benefits, as well as employee rights and responsibilities. The SPD is a guide to the benefits, provisions, and programs offered by the health care plan for 2012.

The Human Resources Department, the County Attorney's Office, Consultants, and our Third Party Administrator continuously review the Summary Plan Description to ensure compliance with federal requirements including applicable provisions of the federal health care reform laws.

After the most recent review, staff is recommending approval of the changes noted in the SPD amendment which include clarification of language to more accurately describe the plan and the addition of definitions and procedures to address cancer clinical trials and cancer routine patient care costs.

FISCAL IMPACT:

The County is self-insured through the Risk Pool Fund for Medical, Prescription Drug, and Dental Benefits. The proposed amendment clarifies language within the SPD and should not result in any significant increases or decreases to the fund.

PRIOR COMMISSIONERS COURT ACTION:

October 2011, the Commissioners Court approved the Health and Dental Summary Plan Description (KK-11-429) for the 2012 plan year.

RECOMMENDATION:

Staff recommends for the Commissioners Court to approve the amendment to the Health and Dental Summary Plan Description.

COUNTY ATTORNEY APPROVAL:

The Health and Dental Summary Plan Description has been reviewed and approved by the County Attorney's Office. (2012-0319)

SUBMITTED BY:	Sam Trujillo, Risk Manager Human Resources Department		

COUNTY OF EL PASO
Health Benefit Plan

Amendment No. 1

Effective July 23, 2012

The County of El Paso Health Benefit Plan is hereby amended as follows:

1. *To remove the definition for Employee under Article 4 and replace it with the following:*

"Employee"
"Employee" shall mean (1) a person who is a regular full-time Employee of the Participating Employer; or (2) county and district officers and as otherwise permitted by the Plan Administrator pursuant to Section 157.01(a) of the Texas Local Government Code, as amended.

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2. *To remove the definition of "Late Enrollee" from Article 4.*

3. *To remove all references to a Late Enrollee or to Late Enrollees throughout.*

4. *To add the following definitions to Article 4:*

"Cancer Clinical Trials"
"Cancer Clinical Trials" shall mean 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 Participant's physician based upon his or her medical determination that participation would have a meaningful potential to benefit the Participant; and
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"
"Routine Patient Care Costs" shall mean 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 item 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 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 Participant 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 persons enrolled in the clinical trial.

5. *To remove section 5.01 under Article 5 and replace it with the following:*

5.01 Eligibility for Individual Coverage

Each Employee will become eligible for coverage under this Plan with respect to himself or herself on the initial date of full time employment, following completion of the Service Waiting Period of 90 days. Each Employee who was covered under the prior Plan, if any, will be eligible on the Effective Date of this Plan. Any Service Waiting Period or portion thereof satisfied under the Prior Plan, if any, will be applied toward satisfaction of the Service Waiting Period of the Plan. If a Participant separates from employment and the Participant is Reinstated pursuant to the timeframes outlined in the County of El Paso policies the service waiting period will be waived.

6. *To remove section 5.02 under Article 5 and replace it with the following:*

5.02 Eligibility for Retiree Coverage

A person is eligible for Retiree coverage from the first day that he or she is a Retired Employee of the Employer through Texas County and District Retirement System, but must enroll and pay the first month's premium to the Plan Administrator within 31 days of being eligible for enrollment or lose their eligibility.

To enroll in Retiree coverage, an Employee must complete and sign an enrollment application and an Authorization for Direct Payment. The enrollment will be "timely" if the completed form and the first month's premium is received by the Plan Administrator no later than 31 days after the person becomes eligible for Retiree coverage which is on the termination date as an Active Employee. If the Plan Administrator does not receive the first month's premium within 31 days after the Employee becomes eligible for Retiree coverage, the Employee will lose their eligibility for Retiree coverage.

7. *To remove section 5.04(2) under Article 5 and replace it with the following:*

2. Birth of Dependent Child. In the event of the birth of a child, the child will automatically be covered for the first 31 days following the birth. For the coverage to continue beyond the 31 days, the Employee must notify the Employer of the birth and complete all necessary paperwork before the 31 days has lapsed, as well as pay the required premiums. If notification and required premiums are not made, coverage will terminate at the end of the 31 days following the birth.

Please note, the claim for maternity care is not considered an enrollment application for enrollment of the newborn infant.

8. To remove section 5.04(3) under Article 5 and replace it with the following:

3. Newly Acquired Dependents. If an Employee acquires a Dependent while covered under the Plan, coverage for the newly acquired Dependent shall be effective on the date the Dependent becomes eligible, provided application is made to the Plan within 31 days of the date of eligibility and any required contributions are made.

The Pre-existing Condition limitation does not apply to a Participant or Dependent that has not yet reached age 19.

9. To amend Article 5 starting with section 5.09 as follows:

5.09 Special Enrollment
The Plan provides the following special enrollment periods that allow Employee's to enroll in the Plan.

5.09A Loss of Other Coverage
If an Employee declined enrollment for himself or herself or his or her Dependents (including his or her spouse) because of other health coverage, he or she may enroll for coverage for himself or herself and/or his or her Dependents if the other health coverage is lost. The Employee must make written application for special enrollment within 31 days of the date the other health coverage was lost. For example, if the Employee loses his or her other health coverage on January 15, he or she must notify the Plan Administrator and apply for coverage by close of business on February 15.

The following conditions apply to any eligible Employee and Dependents:
An Employee may enroll during this special enrollment period due to Loss of Other Coverage:

1. If the Employee is eligible for coverage under the terms of this Plan*;*
2. The Employee is not currently enrolled under the Plan;
3. When enrollment was previously offered, the Employee declined because of coverage under another group health plan or health insurance coverage. The Employee must have provided a written statement that other health coverage was the reason for declining enrollment under this Plan*;* and
4. If the other coverage was terminated due to loss of eligibility for the coverage (including due to legal separation, divorce, death, termination of employment, or reduction in the number of hours), or because employer contributions for the coverage were terminated.

The Employee is not eligible for this special enrollment due to Loss of Other Coverage if:

1. The other coverage was COBRA continuation coverage and the Employee did not exhaust the maximum time available to him or her for that COBRA coverage; or
2. The other coverage was lost due to non-payment of requisite contribution / premium or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the other plan).

If the conditions for special enrollment due to Loss of Other Coverage are satisfied, and the Employee submits the written application in time, coverage for the Employee and/or his or her

Dependent(s) will be effective at 12:01 A.M. on the first day of the first calendar month beginning after the date the satisfactory application is received by the Plan Administrator.

5.09B New Dependent

If an Employee acquires a new Dependent as a result of marriage, birth, adoption, or placement for adoption, he or she may be able to enroll his or her new Dependents during a special enrollment period. The Employee must make written application for special enrollment no later than 31 days after he or she acquires the new Dependent. For example, if the Employee is married on January 15, he or she must notify the Plan Administrator and apply for coverage by close of business on February 15.

The following conditions apply to any eligible Employee who has acquired a new Dependent*:*
An Employee may enroll his or her newly acquired Dependents during this special enrollment period if:

1. The Employee is eligible for coverage under the terms of this Plan; and
2. The Employee has acquired a new Dependent through marriage, birth, adoption, or placement for adoption

Coverage shall begin on the following:

a. On the date of the marriage
b. On the date of birth
c. On the date of the adoption or placement for adoption

5.09C Additional Special Enrollment Rights

Employees and Dependents who are eligible but not enrolled are entitled to enroll under the following circumstances:

1. The Employee's or Dependent's Medicaid or State Child Health Insurance Plan (i.e. CHIP) coverage has terminated as a result of loss of eligibility and the Employee requests coverage under the Plan within 60 days after the termination; or
2. The Employee or Dependent become eligible for a contribution / premium assistance subsidy under Medicaid or a State Child Health Insurance Plan (i.e. CHIP), and the Employee requests coverage under the Plan within 60 days after eligibility is determined.

5.10 Open Enrollment

Participants may enroll for coverage during Open Enrollment Periods. Coverage for Participants enrolling during this period will become effective on January 1, of the following Plan year, unless the Employee has not satisfied the Service Waiting Period. In the event that the Service Waiting Period has not been satisfied, coverage for the Employee and his or her Dependents will become effective on the day following completion of the Service Waiting Period.

"Open Enrollment Period" shall mean the month of October in each Plan Year.

5.11 Effective Date of Coverage; Conditions

All conditions for effectiveness of coverage under the Plan, which are set forth in the section entitled "Effective Dates of Coverage; Conditions," will apply to Participants enrolling during a Special or Open Enrollment Period. Coverage for Participants enrolling during a Special Enrollment Period will become effective on the first day following the enrollment due to loss of coverage or marriage, and on the date of birth, adoption or placement for adoption in the case of such events.

5.12 Qualified Medical Child Support Orders

The Plan Administrator shall enroll for immediate coverage under this Plan any Alternate Recipient who is the subject of a Medical Child Support Order that is a "Qualified Medical Child Support Order" ("QMCSO") if such an individual is not already covered by the Plan as an Eligible Dependent, once the Plan Administrator has determined that such order meets the standards for qualification set forth below.

"Alternate Recipient" shall mean any Child of a Participant who is recognized under a Medical Child Support Order as having a right to enrollment under this Plan as the Participant's Eligible Dependent. For purposes of the benefits provided under this Plan, an Alternate Recipient shall be treated as an Eligible Dependent.

"Medical Child Support Order" shall mean any judgment, decree or order (including approval of a domestic relations settlement agreement) issued by a court of competent jurisdiction that:

1. Provides for child support with respect to a Participant's Child or directs the Participant to provide coverage under a health benefits plan pursuant to a State domestic relations law (including a community property law); or
2. Enforces a law relating to medical child support described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822) with respect to a group health plan.

"National Medical Support Notice" or "NMSN" shall mean a notice that contains the following information:

1. Name of an issuing State agency;
2. Name and mailing address (if any) of an employee who is a Participant under the Plan;
3. Name and mailing address of one or more Alternate Recipients (i.e., the child or children of the Participant or the name and address of a substituted official or agency that has been substituted for the mailing address of the Alternate Recipients(s)); and
4. Identity of an underlying child support order.

"Qualified Medical Child Support Order" or "QMCSO" is a Medical Child Support Order that creates or recognizes the existence of an Alternate Recipient's right to, or assigns to an Alternate Recipient the right to, receive benefits for which a Participant or Eligible Dependent is entitled under this Plan. In order for such order to be a QMCSO, it must clearly specify the following:

1. The name and last known mailing address (if any) of the Participant and the name and mailing address of each such Alternate Recipient covered by the order;
2. A reasonable description of the type of coverage to be provided by the Plan to each Alternate Recipient, or the manner in which such type of coverage is to be determined;
3. The period of coverage to which the order pertains; and
4. The name of this Plan.

In addition, a National Medical Support Notice shall be deemed a QMCSO if it:

1. Contains the information set forth above in the definition of "National Medical Support Notice";

2. a. Identifies either the specific type of coverage or all available group health coverage. If the Employer receives an NMSN that does not designate either specific type(s) of coverage or all available coverage, the Employer and the Plan Administrator will assume that all are designated;

   b. Informs the Plan Administrator that, if a group health plan has multiple options and the participant is not enrolled, the issuing agency will make a selection after the NMSN is qualified, and, if the agency does not respond within 20 days, the child will be enrolled under the Core Plan); and

3. Specifies that the period of coverage may end for the Alternate Recipient(s) only when similarly situated dependents are no longer eligible for coverage under the terms of the Plan, or upon the occurrence of certain specified events.

However, such an order need not be recognized as "qualified" if it requires the Plan to provide any type or form of benefit, or any option, not otherwise provided to the Participants and Eligible Plan Participants without regard to this section, except to the extent necessary to meet the requirements of a State law relating to medical child support orders, as described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822).

Upon receiving a Medical Child Support Order, the Plan Administrator shall, as soon as administratively possible:

1. Notify the Participant and each Alternate Recipient covered by the Order (at the address included in the Order) in writing of the receipt of such Order and the Plan's procedures for determining whether the Order qualifies as a QMCSO; and

2. Make an administrative determination if the order is a QMCSO and notify the Participant and each affected Alternate Recipient of such determination.

Upon receiving a National Medical Support Notice, the Plan Administrator shall:

1. Notify the State agency issuing the notice with respect to the child whether coverage of the child is available under the terms of the Plan and, if so:

    a. Whether the child is covered under the Plan; and
    b. Either the effective date of the coverage or, if necessary, any steps to be taken by the custodial parent or by the official of a State or political subdivision to effectuate the coverage; and
2. Provide to the custodial parent (or any State official serving in a substitute capacity) a description of the coverage available and any forms or documents necessary to effectuate such coverage.

To give effect to this requirement, the Plan Administrator shall:

1. Establish reasonable, written procedures for determining the qualified status of a Medical Child Support Order or National Medical Support Notice; and

2. Permit any Alternate Recipient to designate a representative for receipt of copies of the notices that are sent to the Alternate Recipient with respect to the Order.

5.13 Special Restrictions for Pre-Existing Conditions

A Pre-existing Condition limitation will apply for all Employees and Dependents entering or reentering the Plan after the Effective Date, except as set forth in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). No coverage is provided for expenses in connection with a Pre-existing Condition.

A "**Pre-existing Condition**" is any Sickness, Illness, Disease or Injury (other than Pregnancy), regardless of cause, for which medical advice, diagnosis, care or treatment was recommended or received, by or from a Provider, during the 90 days immediately prior to the Enrollment date on the Plan.

Coverage will be available for such condition on the day immediately following the expiration of 12 months. A Participant has the right to demonstrate any Creditable Coverage, and the applicable

period shall be reduced by any Creditable Coverage unless that Creditable Coverage occurred before a Significant Break in Coverage.

The Pre-existing Condition limitation does not apply to any Participant or Dependent that has not yet reached age 19.

5.13A Proof of Creditable Coverage
A Participant may prove Creditable Coverage by either of two methods:

1. For Creditable Coverage the Participant may present a written Certificate of Coverage from the source or entity that provided the coverage showing:

    a. The date the Certificate was issued;
    b. The name of the group health plan that provided the coverage;
    c. The name of the Participant or Dependent to whom the Certificate applies;
    d. The name, address, and telephone number of the plan administrator or issuer providing the Certificate;
    e. A telephone number for further information (if different);
    f. Either:
        (1) A statement that the Participant or Dependent has at least 18 months (546 days) of Creditable Coverage, not counting days of coverage before a Significant Break in Coverage; or
        (2) The date any waiting period (and affiliation period, if applicable) began and the date Creditable Coverage began; and
    g. The date Creditable Coverage ended, unless the Certificate indicates that coverage is continuing as of the date of the Certificate; or

2. If the Participant for any reason is unable to obtain a Certificate from another plan (including because the Creditable Coverage was effective prior to July 1, 1996), he or she may demonstrate Creditable Coverage by other evidence, including but not limited to documents, records, third-party statements, or telephone calls by this Plan to a third-party Provider. This Plan will treat a Participant as having provided a Certificate if that individual:

    a. Attests to the period of Creditable Coverage;
    b. Presents relevant corroborating evidence of some Creditable Coverage during the period; and
    c. Cooperates with the Plan Administrator's efforts to verify his or her status. A Participant has the right to request a Certificate from his or her prior health plan, and the Plan Administrator will help the Participant in obtaining the Certificate.

    A Participant has the right to request a Certificate from his or her prior health plan, and the Plan Administrator will help the Participant in obtaining the Certificate.

5.13B Notice of Pre-Existing Condition Exclusion
If, within a reasonable time after receiving the information about Creditable Coverage described in the section entitled "Proof of Creditable Coverage," the Plan Administrator determines that an exclusion for Pre-existing Conditions applies, it will notify the Participant of that conclusion and will specify the source of any information on which it relied in reaching the determination. Such notification will also explain the Plan's appeals procedures and give the Participant a reasonable opportunity to present additional evidence.

If the Plan Administrator later determines that an individual did not have the claimed Creditable Coverage, the Plan Administrator may modify its initial determination to the contrary. In that case, the individual will be notified of the reconsideration; however, until a final determination is

reached, the Plan Administrator will act in accordance with its initial determination in favor of the Participant for the purpose of approving medical services.

5.14 "GINA"
"GINA" prohibits group health plans, issuers of individual health care policies, and employers from discriminating on the basis of genetic information.

The term "genetic information" means, with respect to any individual, information about:

1. Such individual's genetic tests;
2. The genetic tests of family members of such individual; and
3. The manifestation of a disease or disorder in family members of such individual.

The term "genetic information" includes participating in clinical research involving genetic services. Genetic tests would include analysis of human DNA, RNA, chromosomes, proteins, or metabolite that detect genotypes, mutations, or chromosomal changes. Genetic information is a form of Protected Health Information (PHI) as defined by and in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and is subject to applicable Privacy and Security Standards.

Family members as it relates to GINA include dependents, plus all relatives to the fourth degree, without regard to whether they are related by blood, marriage, or adoption. Underwriting as it relates to GINA includes any rules for determining eligibility, computing premiums or contributions, and applying preexisting conditions. Offering reduced premiums or other rewards for providing genetic information would be impermissible underwriting.
GINA will not prohibit a health care Provider who is treating an individual from requesting that the patient undergo genetic testing. The rules permit the Plan to obtain genetic test results and use them to make claims payment determinations when it is necessary to do so to determine whether the treatment provided to the patient was medically advisable and/or necessary.

The Plan may request, but not require, genetic testing in certain very limited circumstances involving research, so long as the results are not used for underwriting, and then only with written notice to the individual that participation is voluntary and will not affect eligibility for benefits, premiums or contributions. In addition, the Plan will notify and describe its activity to the Health and Human Services secretary of its activities falling within this exception.

While the Plan may collect genetic information after initial enrollment as authorized by law, it may not do so in connection with any annual renewal process where the collection of information affects subsequent enrollment. The Plan will not adjust premiums or increase group contributions based upon genetic information, request or require genetic testing or collect genetic information either prior to or in connection with enrollment or for underwriting purposes.

10. To remove section 6.01 under Article 6 and replace it with the following:

6.01 Termination Dates of Individual Coverage
The coverage of any Participant for himself or herself under this Plan will terminate on the earliest to occur of the following dates:

1. The date of termination of the Plan;
2. The day of the month in, or with respect to which, he or she requests that such coverage be terminated, provided such request is made on or before such date and is permitted in accordance with Internal Revenue Code §125;

3. The date of the expiration of the last period for which the Participant has made a contribution, in the event of his or her failure to make, when due, any contribution for coverage for himself or herself to which he or she has agreed;
4. The date of the month in which he or she ceases to be eligible for such coverage under the Plan;
5. The date in which the termination of employment occurs; or
6. Immediately after a Participant or his or her Dependent submits, or has knowledge of the submission of, a fraudulent claim or any fraudulent information to the Plan, including enrollment information.

11. To add the following to Article 14:

Routine Patient Care Costs. Charges for Routine Patient Care Costs as defined by the Plan associated with a Cancer Clinical Trial within the Plan's definition.

12. To remove the section "Maximum Benefit Amounts:" under Article 18 and replace it with the following:

Maximum Benefit Amounts:

- The maximum calendar year benefit payable under the plan for a Covered Person for all dental benefits is $1,500. This includes Preventive, Basic and Major Dental Service.
- The maximum lifetime benefit payable under the plan for a Covered Person for Orthodontic benefits is $1,000.

13. To remove section 18.02 "Basic Dental Services" under Article 18 and replace it with the following:

Basic Dental Services

1. All Medically Necessary x-rays;
2. Full mouth x-rays, but not more than one series per calendar year;
3. Panoramic x-rays, but not more than one per calendar year;
4. Amalgam, silicate, acrylic, synthetic porcelain and composite filling restorations to restore diseased or accidentally broken teeth. Gold foil restorations are not eligible;
5. Simple extractions;
6. Repair or recementing of crowns, inlays, onlays, bridgework or dentures or relining of dentures;
7. Endodontics, including pulpotomy, direct pulp capping, root canal treatment and placement of a temporary crown in connection with a root canal;
8. Anesthetic services, except local infiltration or block anesthetics, performed by, or under the direct personal supervision of, and billed for by a Dentist, other than the operating Dentist or his or her assistant;
9. Periodontal examinations, treatment and surgery;
10. Consultations;
11. Space maintainers (not made of precious metals) that replace prematurely lost teeth for Dependent children under age 19. No payment will be made for duplicate space maintainers;
12. Emergency palliative treatment of an acute condition requiring immediate care;
13. Injection of antibiotic drugs by the attending dentist.
14. Periapical x-rays

15. Oral Surgery- apicoectomies, impactions, and extractions (including alveolectomy, alveoplasty, and tori removal in connection with extractions);

14. To remove section 18.02 "Major Dental Services" under Article 18 and replace it with the following:

Major Dental Services
All Major Dental Services require a 12 month waiting period.

1. Prosthodontic services (initial installation or replacement of bridgework or dentures) will be covered only when a Participant has been covered continuously for 12 months, unless otherwise required by applicable law;
2. Initial fixed bridgework and dentures replacing teeth extracted while covered under this Plan;
3. Replacement of bridgework or partial dentures when an additional tooth or teeth must be replaced;
4. Cast metal, or ceramic material inlays, onlays, or crown restoration;
5. Unless otherwise required by applicable law, replacement of an existing crowns, denture or fixed bridgework, or the addition of teeth to an existing partial removable denture or bridgework, to replace one or more natural teeth:
    a. Where the existing denture or bridgework was installed at least five years prior to its replacement and it cannot be made serviceable; or
    b. First installation (including adjustments during the six month period following installation of a removable denture (partial or full);
    c. Where the existing denture is an immediate temporary denture, and necessary replacement by the permanent denture takes place within 12 months;

The Plan Document and Summary Plan Description is hereby amended to reflect these changes. All other terms and conditions of the Plan which are not affected by this amendment remain unchanged.

Accepted by:

County of El Paso

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Signed

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Dated