



COMMISSIONERS COURT COMMUNICATION

AGENDA DATE: 7/22/2013

CONSENT OR REGULAR: Public Hearing Regular

CONTRACT REFERENCE NO
(IF APPLICABLE): OP-13-243

PUBLIC HEARING:

Pursuant to Chapter 157, Subchapter F of the Texas Local Government Code, hold a public hearing to receive comments on the Amendment to the Summary Plan Description (SPD) for the County's Health and Dental Plan. The Amendment includes removal of the Domestic Partner language and the addition of Plus One Qualifying Adult language.

BACKGROUND/DISCUSSION OF TOPIC:

The County of El Paso sponsors a health care plan that is administered by a Third Party Administrator (TPA). 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 2013.

The Commissioners Court, on May 6, 2013, directed the Human Resources Department to amend the County's Summary Plan Description.

The attached Amendment represents the changes to the SPD as directed by the Commissioners Court and as discussed by the Risk Pool Board during their regular meeting on May 15, 2013.

FISCAL IMPACT:

The County is self-insured through the Risk Pool Fund for Medical, Prescription Drug, and Dental Benefits. While it is impossible to predict with certainty the future costs of the Risk Pool Fund for any individual or group, based on past experience and the experience of our health benefit consultant and TPA, we do not have any reason to believe that the additions to the Summary Plan Description would result in any increases or decreases to the fund that would be different from the addition of the same number of any other dependents.

PRIOR COMMISSIONERS COURT ACTION:

August 2012 - Commissioners Court approved the Health and Dental Summary Plan Description (OP-12-423) for the 2013 plan year.

May 6, 2013 - Commissioners Court directed the Human Resources Department to Amend the County's Summary Plan Description.

RECOMMENDATION:

Staff recommends for the Commissioners Court to approve the Amendment to the Health and Dental Summary Plan Description for 2013 plan year.

COUNTY ATTORNEY APPROVAL:

The Amendment to the Health and Dental Summary Plan Description has been reviewed and approved by the County Attorney's Office.

SUBMITTED BY:	Sam Trujillo, Risk Manager Human Resources Department		
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County of El Paso
HEALTH BENEFIT PLAN

Summary Plan Description

Effective: January 1, 2013

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ARTICLE 1

ESTABLISHMENT OF THE SUMMARY PLAN DESCRIPTION

THIS SUMMARY PLAN DESCRIPTION, made by County of El Paso effective as of January 1, 2013.

1.01 Effective Date

The Summary Plan Description is effective as of the date first set forth above, and each amendment is effective as of the date set forth therein.

1.02 Adoption of the Summary Plan Description

The Plan Sponsor, as the settlor of the Plan, hereby adopts this Summary Plan Description. This Summary Plan Description amends and replaces any prior statement of the health care coverage contained in the Plan or any predecessor to the Plan.

Note: It is important to make sure that Human Resources has your current and correct address. If Human Resources does not have your current information on record, that can delay or prevent you from receiving benefit coverage.

This Summary Plan Description describes your health plan benefits under the County health plan for medical, pharmacy and dental benefits. If you have trouble understanding it, or any part of the Summary Plan Description, you can get an explanation from the County Human Resources Department at:

Esta descripción resumida del plan describe el plan de beneficios de salud bajo el plan de salud del Condado para los beneficios médicos, de farmacia y dental. Si tiene problemas para entender, o cualquier parte de la descripción resumida del plan, usted puede obtener una explicación de el Departamento de Recursos Humanos en:

County of El Paso
800 E. Overland, Suite 223
El Paso, Texas 79901
(915) 546-2218

Or

HealthSCOPE Benefits
7430 Remcon Circle, Bldg C
El Paso, Texas 79912
(915) 581-8182 or (800) 854-2339
Customer Care Hours
7:00am – 6:00pm
Monday - Friday

ARTICLE 2

INTRODUCTION AND PURPOSE; GENERAL PLAN INFORMATION

2.01 Introduction and Purpose

Welcome to the County of El Paso Texas sponsored health care plan administered by HealthSCOPE Benefits. Your employer has provided you with this Summary Plan Description (SPD) which describes the Medical, Prescription Drug (Pharmacy) and Dental Benefits, as well as your rights and responsibilities under this SPD.

This SPD is your guide to the benefits, provisions, and programs offered by this plan. Services are subject to all provisions of the Plan, including the limitations and exclusions.

Please read this SPD carefully, paying special attention to the “Schedule of Benefits”, “Covered Medical Expenses”, and “General Limitations and Exclusions” sections to better understand how your benefits work.

The Plan benefits described in this SPD are being restated effective as of January 1, 2013. This SPD has been updated to comply with federal requirements including applicable provisions of the federal health care reform laws. As the Plan Administrator receives additional guidance and clarification on the new health reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, the Plan Administrator may be required to make additional changes to the Summary of Plan Description.

The County of El Paso offers three coverage choices for active employees, eligible retirees and COBRA participants: Core Plan Option, Buy Up Plan Option and Consumer Driven Health (CDH Plan) Option.

The benefits under the County of El Paso Benefit Plan are self-insured. These 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. Both County and plan participants contribute to the Plan Fund in order to make these benefits available to you.

The SPD is not a contract. The plan shall not be deemed to constitute a contract between the County of El Paso and any plan participant or to be a consideration for, or an inducement or condition of, the employment of any Employee. Nothing in the SPD 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.

The County of El Paso is a Grandfathered Health Plan for the Core Plan Option and Buy Up Plan Option. Being a Grandfathered Health Plan means that your Plan may not include certain consumer protections of the Affordable Care Act that apply to the CDH Plan option.

We recommend that you contact the Claims 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.

2.02 General Plan Information

Name of Plan:	County of El Paso Health Benefit Plan
Plan Sponsor and Plan Administrator (Named Fiduciary) :	County of El Paso 800 E. Overland, Suite 223 El Paso, Texas 79901 (915) 546-2218 Fax: (915) 546-8126 humanresources@epcounty.com
Source of Funding:	Self-Funded
Plan Year:	January 1 through December 31
Plan Type:	Medical Dental Prescription Drug
Third Party Administrator: (Claims and Cobra Administrator)	HealthSCOPE Benefits 7430 Remcon Circle, Bldg C El Paso, Texas 79912 (915) 581-8182 or (800) 854-2339 www.healthscopebenefits.com Customer Service Hours 7:00 a.m. – 6:00 p.m. Monday - Friday

2.03 Legal Entity; Service of Process

The Plan is a legal entity. Legal notice may be filed with, and legal process served upon, the Plan Administrator.

2.04 Not a Contract

This Summary Plan Description summarizes the terms and provisions of coverage under this Plan. The Summary Plan Description shall not be deemed to constitute a contract of any type between the County of El Paso and any Participant or to be consideration for, or an inducement or condition of, the employment of any Employee. Nothing in this Summary Plan Description 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; provided, however, that the foregoing shall not be deemed to modify the provisions of any collective bargaining agreements which may be entered into by the County of El Paso with the bargaining representatives of any Employees.

2.05 Mental Health Parity

Pursuant to the Mental Health Parity and Addiction Equity Act of 2008, this Plan applies its terms uniformly and enforces parity between covered health care benefits and covered mental health and substance disorder benefits relating to financial cost sharing restrictions and treatment duration limitations. For further details, please contact the Plan Administrator.

2.06 Discretionary Authority

The Plan Administrator shall have full and final discretionary authority to interpret all Plan provisions, including the right to remedy possible ambiguities, inconsistencies and/or omissions in the Plan and related documents; to make determinations in regards to issues relating to eligibility for benefits; to decide disputes that may arise relative to a Plan Participants' rights; and to determine all questions of fact and law arising under the Plan.

**ARTICLE 3
SCHEDULE OF BENEFITS**

	CORE PLAN OPTION		BUY UP PLAN OPTION		CDH PLAN OPTION	
	In-Network	Out-of-network	In-Network	Out-of-network	In-Network	Out-of-network
Annual Deductibles						
Employee	\$1000	\$2000	\$250	\$750	\$3,500	\$5,000
Employee/Dependent	\$2,000	\$4,000	\$500	\$1,000	\$7,000	\$10,000
Plan Year Out-of-Pocket Maximum	Excludes co-payments, deductibles and penalties		Excludes co-payments, deductibles and penalties		Includes co-payments and deductible	
Employee	\$2,500	No Limit	\$2,000	No Limit	\$3,500	\$8,000
Employee/Dependent	\$5,000	No Limit	\$4,000	No Limit	\$7,000	\$16,000
Hospital Co Pay (per admission)	\$100	N/A	\$100	N/A	Deductible applies	Deductible applies
Outpatient Hospital Deductible (per year)	\$200	N/A	\$200	N/A	Deductible applies	Deductible applies
	CORE PLAN OPTION HOSPITAL SERVICES (plan pays)		BUY UP PLAN OPTION HOSPITAL SERVICES (plan pays)		CDH PLAN OPTION HOSPITAL SERVICES (Deductible must be met before benefits are paid)	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
University Medical Center Preferred Hospital	95% after annual deductible	N/A	95% after annual deductible	N/A	100% after annual deductible	N/A
Other Hospital Facilities	80% after annual deductible	50% after annual deductible	80% after annual deductible	50% after annual deductible	100% after annual deductible	50% after annual deductible
Emergency Use of Emergency Room	80% after \$100 co-pay and annual deductible	80% after \$100 co-pay and annual deductible	80% after \$100 co-pay and annual deductible	80% after \$100 co-pay and annual deductible	100% after annual deductible	50% after annual deductible
Non-Emergency Use of Emergency Room	80% after \$100 co-pay and annual deductible	50% for Non-Emergency Use after \$100 co-pay and annual deductible	80% after \$100 co-pay and annual deductible	50% for Non-Emergency Use after \$100 co-pay and annual deductible	100% after annual deductible	50% after annual deductible

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

SCHEDULE OF BENEFITS

The Plan will pay the specified coinsurance once the Participant has satisfied the annual deductible.

	CORE PLAN OPTION		BUY UP PLAN OPTION		CDH PLAN OPTION (Deductible must be met before benefits are paid)	
	In-Network (Plan Pays)	Out-of-Network (Plan Pays)	In-Network (Plan Pays)	Out-of-Network (Plan Pays)	In-Network (Plan Pays)	Out-of-Network (Plan Pays)
Accidental Dental Care	80%	65%	80%	65%	100%	65%
Allergy Tests and Treatments	80%	65%	80%	65%	100%	65%
Ambulance Emergency Use	80%	80%	80%	80%	100%	65%
Ambulance Non-Emergency Use	80%	65%	80%	65%	100%	65%
Assistant Surgeon	80%	65%	80%	65%	100%	65%
Chiropractic Care	80%	65%	80%	65%	100%	65%
	\$2,000 maximum combined					
Durable Medical Equipment	80%	65%	80%	65%	100%	65%
Home Healthcare	80%	65%	80%	65%	100%	65%
	Prior Approval Required					
Home Infusion Therapy	80%	65%	80%	65%	100%	65%
Hospice Care	80%	65%	80%	65%	100%	65%
Inpatient Hospital Care	80%	65%	80%	65%	100%	65%
Inpatient Rehabilitations	80%	65%	80%	65%	100%	65%
Lab and X-Ray	80%	65%	80%	65%	100%	65%
Preferred Lab	100%	N/A	100%	N/A	100%	N/A
Medical Supplies	80%	65%	80%	65%	100%	65%
Mental Health Inpatient Stay	80%	65%	80%	65%	100%	65%
Mental Health Outpatient	80%	65%	80%	65%	100%	65%
Occupational Therapy	80%	65%	80%	65%	100%	65%
Office Visits	100% after \$35 co pay	65%	100% after \$30 co-pay	65%	100%	65%
Oral Surgery	80%	65%	80%	65%	100%	65%
	Limited to certain non-dental procedures for treatment due to accidental injury					
Outpatient Hospital Care	80%	65%	80%	65%	100%	65%
Physical Therapy	80%	65%	80%	65%	100%	65%

Physician Services	80%	65%	80%	65%	100%	65%
Preventive Care Services	100% after \$35 co pay	No coverage	100% after \$30 co pay	No Coverage	100%	No coverage
	100% of scheduled benefits under the Preventive Care Schedule. Routine annual exam subject to co-pay Preventive Care includes the following Routine annual physical exam (one per year) Colorectal and Prostate exams (one per year) Mammography (one per year) Immunizations (all ages) Labs DXA Bone Density Test (one per year) Colorectal and Prostate exams (one per year) EKG (one per year) Well woman exam to include pap smear (one per year) Colonoscopy (age 50 & older, not to exceed one per 10 years)					
Prescription Drugs		<i>Prescription Drugs are treated like any other medical expense, subject to HRA and Plan Participant Responsibility. If brand requested when a generic equivalent is available, Plan Participant will pay the difference in cost between brand and generic.</i>			<i>CDH-Preventive drugs as identified by the Pharmacy Benefit Manager and in accordance with IRS regulations may be purchased with a co-payment prior to the deductible being met.</i>	
Retail (30 day Retail Supply)	\$10 co-pay Generic Drugs \$25 co-pay Preferred Brand Name Drugs \$40 co-pay Non-Preferred Brand Name Drugs	65% after deductible	\$5 co-pay Generic Drugs \$20 co-pay Preferred Brand Name Drugs \$35 co-pay Non-Preferred Brand Name Drugs	65% after deductible	\$10 co-pay Generic Drugs \$25 co-pay Preferred Brand Name Drugs \$40 co-pay Non-Preferred Brand Name Drugs	No Coverage
Mail Order (90 day supply)	\$20 co-pay Generic Drugs \$50 co-pay Preferred Brand Name Drugs \$80 co-pay Non-Preferred Brand Name Drugs	No coverage	\$10 co-pay Generic Drugs \$40 co-pay Preferred Brand Name Drugs \$70 co-pay Non-Preferred Brand Name Drugs	No Coverage	\$20 co-pay Generic Drugs \$50 co-pay Preferred Brand Name Drugs \$70 co-pay Non-Preferred Brand Name Drugs	No Coverage
Prosthetics	80%	65%	80%	65%	100%	65%
Radiation Therapy Chemotherapy	80%	65%	80%	65%	100%	65%
Skilled Nursing Facility	80%	65%	80%	65%	100%	65%
	<i>Limited to 60 days per year; In-Network and Out-of-Network combined</i>					

Speech Therapy	80%	65%	80%	65%	100%	65%
Substance Abuse Inpatient	80%	65%	80%	65%	100%	65%
Substance Abuse Outpatient	80%	65%	80%	65%	100%	65%
Surgeon	80%	65%	80%	65%	100%	65%
Transplants	80%	65%	80%	65%	100%	65%
Urgent Care	80%	65%	80%	65%	100%	65%
All Other Covered Expenses	80%	65%	80%	65%	100%	65%

For limitations and exclusions please refer to Article 15

ARTICLE 4 DEFINITIONS

The following words and phrases shall have the following meanings when used in the Summary Plan Description. **The following definitions are not an indication that charges for particular care, supplies or services are eligible for payment under the Plan, however they may be used to identify ineligible expenses; please refer to the appropriate sections of the Summary Plan Description for that information.**

“Accident”

“Accident” shall mean a sudden and unforeseen event, or a deliberate act resulting in unforeseen consequences.

“Accidental Bodily Injury”

“Accidental Bodily Injury” shall mean an Injury sustained as the result of an Accident and independently of all other causes by an outside traumatic event or due to exposure to the elements.

“Actively At Work” or “Active Employment”

“Actively at Work” or “Active Employment” shall mean performance by the Employee of all the regular duties of his or her occupation at an established business location of the Participating Employer, or at another location to which he or she may be required to travel to perform the duties of his or her employment. An Employee shall be deemed actively at Work if the Employee is absent from work due to a health factor. In no event will an Employee be considered actively at Work if he or she has effectively terminated employment.

“ADA”

“ADA” shall mean the American Dental Association.

“AHA”

“AHA” shall mean the American Hospital Association.

“Allowable Expenses”

“Allowable Expenses” shall mean the Usual and Customary charge for any Medically Necessary, Reasonable eligible item of expense, at least a portion of which is covered under this Plan. When some Other Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered, in the amount that would be payable in accordance with the terms of the Plan, shall be deemed to be the benefit. Benefits payable under any Other Plan include the benefits that would have been payable had claim been duly made therefore.

“AMA”

“AMA” shall mean the American Medical Association.

“Ambulatory Surgical Center”

“Ambulatory Surgical Center” shall mean any public or private State licensed and approved (whenever required by law) establishment with an organized medical staff of Physicians, with permanent facilities that are equipped and operated primarily for the purpose of performing Surgical Procedures, with continuous Physician services and registered professional nursing service whenever a patient is in the facility, and which does not provide service or other accommodations for patients to stay overnight.

“Assignment of Benefits”

“Assignment of Benefits” shall mean an arrangement whereby the Plan Participant assigns their right to seek and receive payment of eligible Plan benefits, in strict accordance with the terms of the Plan, as summarized in this Summary Plan Description, to a Provider. If a provider accepts said arrangement, Providers’ rights to receive Plan benefits are equal to those of a Plan Participant, and are limited by the terms of this Summary Plan Description. A Provider that accepts this arrangement indicates acceptance of an “Assignment of Benefits” as consideration in full for services, supplies, and/or treatment rendered. For full information, consult the Claims Administrator.

“Assistance Eligible Individual”

“Assistance Eligible Individual” shall mean any Qualified Beneficiary who elects COBRA continuation coverage, and has satisfied all of the following conditions:

1. The qualifying event occurred at any time during the period that begins with September 1, 2008, and ends with May 31, 2010, and the Qualified Beneficiary was eligible for COBRA continuation coverage during this period;
2. The covered Employee or Qualified Beneficiary must elect COBRA or applicable state continuation coverage;
3. The qualifying event with respect to the COBRA continuation coverage consists of the involuntary termination of the covered Employee’s employment and occurred during such period*; and
4. The covered Employee must have had a modified adjusted gross income of less than \$145,000, if single, or \$290,000, if married filing jointly, for each tax year in which the subsidy is received. Note that the available COBRA subsidy will be reduced for years in which the covered Employee’s gross income exceeds \$125,000 (or \$250,000 for joint returns).

***Important Note:** If you experienced a reduction of hours during the period that begins with September 1, 2008 and ends with May 31, 2010, followed by an involuntary termination of employment on or after March 2, 2010 and by May 31, 2010, then your termination will constitute a qualifying event and you are entitled to a new election period for COBRA continuation coverage. Under the new election period, COBRA continuation coverage (but not the 18-month COBRA period) and the 15 months of subsidy would begin starting with the first period of coverage after the termination. See Plan Administrator to verify if the benefit is still available.

“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.

“Cardiac Care Unit”

“Cardiac Care Unit” shall mean a separate, clearly designated service area which is maintained within a Hospital and which meets all the following requirements:

1. It is solely for the treatment of patients who require special medical attention because of their critical condition;
2. It provides within such area special nursing care and observation of a continuous and constant nature not available in the regular rooms and wards of the Hospital;
3. It provides a concentration of special lifesaving equipment immediately available at all times for the treatment of patients confined within such area;
4. It contains at least two beds for the accommodation of critically ill patients; and
5. It provides at least one professional registered nurse, who continuously and constantly attends the patient confined in such area on a 24-hour-a-day basis.

“Centers of Excellence”

“Centers of Excellence” shall mean medical care facilities that have met stringent criteria for quality care in the specialized procedures of organ transplantation. These centers have the greatest experience in performing transplant procedures and the best survival rates. The Plan Administrator shall determine what Network Centers of Excellence are to be used.

Any Participant in need of an organ transplant may contact the Claims Administrator to initiate the pre-certification process resulting in a referral to a Center of Excellence. The Claims Administrator acts as the primary liaison with the Center of Excellence, patient and attending Physician for all transplant admission taking place at a Center of Excellence.

If a Participant chooses not to use a Center of Excellence, the payment for services will be limited to what would have been the cost at the nearest Center of Excellence.

Additional information about this option, as well as a list of Centers of Excellence, will be given to covered Employees and updated as requested.

“Certificate of Creditable Coverage”

“Certificate of Creditable Coverage” shall mean a written certification provided by any source that offers medical care coverage, including the Plan, for the purpose of confirming the duration and type of an individual’s previous coverage.

“Child”

“Child” shall mean, in addition to the Employee’s own blood descendant of the first degree or lawfully adopted Child, a Child placed with a covered Employee in anticipation of adoption, a covered Employee’s Child who is an alternate recipient under a Qualified Medical Child Support Order as required by the Federal Omnibus Budget Reconciliation Act of 1993, any stepchild, an “eligible foster child,” which is defined as an individual placed with the Employee by an authorized placement agency or by judgment, decree or other order of a court of competent jurisdiction, a Child of the Employee’s Spouse or Plus One Qualifying Adult, or any other Child for whom the Employee has obtained legal guardianship.

“CHIP” “CHIP” refers to the Children’s Health Insurance Program or any provision or section thereof, which is herein specifically referred to, as such act, provision or section may be amended from time to time.

“CHIPRA”

“CHIPRA” refers to the Children’s Health Insurance Program Reauthorization Act of 2009 or any provision or section thereof, which is herein specifically referred to, as such act.

“Chiropractic Care”

“Chiropractic Care” shall mean office visits, x-rays, manipulations, supplies, heat and cold treatment.

“Claim Determination Period”

“Claim Determination Period” shall mean each calendar year.

“Clean Claim”

A “Clean Claim” is one that can be processed in accordance with the terms of this document without obtaining additional information from the service Provider or a third party. It is a claim which has no defect or impropriety.

A defect or impropriety shall include a lack of required sustaining documentation as set forth and in accordance with this document, or a particular circumstance requiring special treatment which prevents timely payment as set forth in this document, and only as permitted by this document, from being made. A Clean Claim does not include claims under investigation for fraud and abuse or claims under review for Medical Necessity and Reasonableness, or fees under review for Usual and Customariness, or any other matter that may prevent the charge(s) from being covered expenses in accordance with the terms of this document.

Filing a Clean Claim. A Provider submits a Clean Claim by providing the required data elements on the standard claims forms, along with any attachments and additional elements or revisions to data elements, attachments and additional elements, of which the Provider has knowledge. The Plan Administrator may require attachments or other information in addition to these standard forms (as noted elsewhere in this document and at other times prior to claim submittal) to ensure charges constitute covered expenses as defined by and in accordance with the terms of this document. The paper claim form or electronic file record must include all required data elements and must be complete, legible, and accurate. A claim will not be considered to be a Clean Claim if the Plan Participant has failed to submit required forms or additional information to the Plan as well. For additional information refer to Article 9.

“COBRA”

“COBRA” shall mean the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

“Co-Payment”

“Co-Payment” shall mean the amount a participant will need to pay when you receive certain health care services

“Cosmetic Surgery”

“Cosmetic Surgery” shall mean any surgery, service, drug or supply designed to improve the appearance of an individual by changing, improving and/or alteration of a physical characteristic. Please see Article 15 for additional information.

“Covered Expense”

“Covered Expense” means a Usual and Customary fee for a Reasonable, Medically Necessary service, treatment or supply, meant to improve a condition or participant’s health, which is eligible for coverage in this Plan. Covered Expenses will be determined based upon all other Plan provisions. When more than one treatment option is available, and one option is no more effective than another, the Covered Expense is the least costly option that is no less effective than any other option.

All treatment is subject to benefit payment maximums shown in the Summary of Benefits and as determined elsewhere in this document.

“Covered Mental Health Service Providers”

“Covered Mental Health Service Providers” are physicians and associated visits which are limited and subject to the Summary of Benefits and terms of this document. Psychiatrists (M.D.), psychologists (Ph.D.) or counselors licensed to provide individual psychotherapy without supervision in the State they are practicing, may bill the Plan directly. Other licensed mental health practitioners must be under the direction of and must bill the Plan through these professionals.

“Creditable Coverage”

“Creditable Coverage” shall mean coverage of an individual under any of the following: a group health plan, health insurance coverage, Medicare, Medicaid (other than coverage consisting solely of benefits under the program for distribution of pediatric vaccines), medical and dental care for Plan Participants and certain former Plan Participants of the Uniformed Services and their dependents, a medical care program of the Indian Health Service or a tribal organization, a State health benefits risk pool, a health plan offered under the Federal Employees Health Benefits Program, a public health plan, or a health benefit plan under Section 5(e) of the Peace Corps Act, or Title XXI of the Social Security Act (State Children’s Health Insurance Program). To the extent that further clarification is needed with respect to the sources of Creditable Coverage listed in the prior sentence, please see the complete definition of Creditable Coverage that is set forth in 45 C.F.R. § 146.113(a). See sections 5.11A and 6.04.

“Custodial Care”

“Custodial Care” shall mean care or confinement provided primarily for the maintenance of the Participant, essentially designed to assist the Participant, whether or not Totally Disabled, in the activities of daily living, which could be rendered at home or by persons without professional skills or training. This care is not reasonably expected to improve the underlying medical condition, even though it may relieve symptoms or pain. Such care includes, but is not limited to, bathing, dressing, feeding, preparation of special diets, assistance in walking or getting in and out of bed, supervision over medication which can normally be self-administered and all domestic activities.

“Deductible”

“Deductible” shall mean an amount of money that is paid once a calendar year per Participant and Family Unit. Typically, there is one Deductible amount per Plan and it must be paid before any money is paid by the Plan for any covered services. Each calendar year, a new Deductible amount is required. **Deductibles do not accrue toward the 100% maximum out-of-pocket payment.**

“Dentist”

“Dentist” shall mean an individual holding a D.D.S. or D.M.D. degree, licensed to practice dentistry in the jurisdiction where such services are provided.

“Dependent”

“Dependent” shall mean:

Adult:

1. An Employee’s lawfully married spouse possessing a marriage license who is not divorced from the Employee; or
2. An Employee’s common law spouse, based upon a common law marriage which is legally recognized in the jurisdiction in which the Employee has his or her principal residence; or
3. An Employee’s Plus One Qualifying Adult who meet the requirements necessary for eligibility.

An Employee may not enroll more than one individual qualifying above.

Child:

4. A Child who is less than 26 years of age;
5. A Child, regardless of age, who is mentally or physically incapable of sustaining his or her own living. Written proof of such incapacity and dependency satisfactory to the Plan must be furnished and approved by the Plan within 31 days after the date the Child attains the limiting age under the bullets above. The Plan may require, at reasonable intervals, subsequent proof satisfactory to the Plan.

The Plan reserves the right to require documentation, satisfactory to the Plan Administrator, which establishes a Dependent relationship.

“Detoxification”

“Detoxification” shall mean the process whereby an alcohol-intoxicated person or person experiencing the symptoms of Substance Abuse is assisted, in a facility licensed by the Department of Health, through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol, alcohol dependency factors or

alcohol in combination with drugs as determined by a licensed Physician, while keeping the physiological risk to the patient at a minimum.

“Diagnostic Service”

“Diagnostic Service” shall mean a test or procedure performed for specified symptoms to detect or to monitor a Disease or condition. It must be ordered by a Physician or other professional Provider.

“Disease”

“Disease” shall mean any disorder which does not arise out of, which is not caused or contributed to by, and which is not a consequence of, any employment or occupation for compensation or profit; however, if evidence satisfactory to the Plan is furnished showing that the individual concerned is covered as an employee under any worker’s compensation law, occupational disease law or any other legislation of similar purpose, or under the maritime doctrine of maintenance, wages, and cure, but that the disorder involved is one not covered under the applicable law or doctrine, then such disorder shall, for the purposes of the Plan, be regarded as a Sickness, Illness or Disease.

“Drug”

“Drug” shall mean insulin and prescription legend drugs. A prescription legend drug is a Federal legend drug (any medicinal substance which bears the legend: “Caution: Federal law prohibits dispensing without a prescription”) or a State restricted drug (any medicinal substance which may be dispensed only by prescription, according to State law) and which, in either case, is legally obtained from a licensed drug dispenser only upon a prescription of a currently licensed Physician.

“Durable Medical Equipment”

“Durable Medical Equipment” shall mean equipment which:

1. Can withstand repeated use;
2. Is primarily and customarily used to serve a medical purpose;
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.

“Elective Surgical Procedure”

“Elective Surgical Procedure” shall mean 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.

“Emergency”

“Emergency” shall mean a situation where necessary treatment is required as the result of a sudden and severe medical event or acute condition. An Emergency includes poisoning, shock, and hemorrhage. Other Emergencies and acute conditions may be considered on receipt of proof, satisfactory to the Plan, that an Emergency did exist. The Plan may, at its own discretion, request satisfactory proof that an Emergency or acute condition did exist.

“Emergency Medical Condition”

“Emergency Medical Condition” shall mean a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act (42 U.S.C. 1395dd(e)(1)(A)). In that provision of the Social Security Act, clause (i) refers to placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; clause (ii) refers to serious impairment to bodily functions; and clause (iii) refers to serious dysfunction of any bodily organ or part.

“Emergency Care”

“Emergency Care” shall mean, with respect to an Emergency Medical Condition:

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 pregnant woman; serious jeopardy to the health of the fetus.

“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 157.101(a) of the Texas Local Government Code, as amended.

“Employer”

“Employer shall mean the County of El Paso Texas.

“Enrollment”

“Enrollment” information see Article 5.

“Essential Health Benefits”

“Essential Health Benefits” shall mean, under section 1302(b) of the Patient Protection and Affordable Care Act, those health benefits to include at least the following general categories and the items and services covered within the categories: ambulatory patient services; Emergency Services; hospitalization; maternity and newborn care; mental health and substance abuse disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

“Experimental” and/or “Investigational”

“Experimental” and/or “Investigational” (“Experimental”) shall mean services or treatments that are not widely used or accepted by most practitioners or lack credible evidence to support positive short or long-term outcomes from those services or treatments; these services are not included under or as Medicare reimbursable procedures, and include services, supplies, care, procedures, treatments or courses of treatment which:

1. Do not constitute accepted medical practice under the standards of the case and by the standards of a reasonable segment of the medical community or government oversight agencies at the time rendered; or
2. Are rendered on a research basis as determined by the United States Food and Drug Administration and the AMA's Council on Medical Specialty Societies.

All phases of clinical trials shall be considered Experimental.

A drug, device, or medical treatment or procedure is Experimental:

1. If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished;
2. If reliable evidence shows that the drug, device or medical treatment or procedure is the subject of ongoing Phase I, II, or III clinical trials or under study to determine its:
 - a) maximum tolerated dose;
 - b) toxicity;
 - c) safety;
 - d) efficacy; and
 - e) efficacy as compared with the standard means of treatment or diagnosis; or
3. if reliable evidence shows that the consensus among experts regarding the drug, device, or medical treatment or procedure is that further studies or clinical trials are necessary to determine its:
 - a) maximum tolerated dose;
 - b) toxicity;
 - c) safety;
 - d) efficacy; and

- e) efficacy as compared with the standard means of treatment or diagnosis.

Reliable evidence shall mean:

1. Only published reports and articles in the authoritative medical and scientific literature;
2. The written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, or medical treatment or procedure; or
3. The written informed consent used by the treating facility or by another facility studying substantially the same drug, device, or medical treatment or procedure.

The Plan Administrator retains maximum legal authority and discretion to determine what is Experimental.

“Family Unit”

“Family Unit” shall mean the Employee, his or her spouse and Children.

“FMLA”

“FMLA” shall mean the Family and Medical Leave Act of 1993, as amended.

“FMLA Leave”

“FMLA Leave” shall mean a leave of absence, which the County of El Paso is required to extend to an Employee under the provisions of the FMLA.

“GINA”

“GINA” shall mean the Genetic Information Nondiscrimination Act of 2008 (Public Law No. 110-233), which prohibits group health plans, issuers of individual health care policies, and employers from discriminating on the basis of genetic information.

“HIPAA”

“HIPAA” shall mean the Health Insurance Portability and Accountability Act of 1996, as amended.

“Home Health Care”

“Home Health Care” shall mean the continual care and treatment of an individual if:

1. The institutionalization of the individual would otherwise have been required if home health care was not provided;
2. The treatment plan covering the home health care service is established and approved in writing by the attending Physician; and
3. The home health care is the result of an Illness or Injury.

“Home Health Care Agency”

“Home Health Care Agency” shall mean an agency or organization which provides a program of home health care and which:

1. Is approved as a Home Health Agency under Medicare;
2. Is established and operated in accordance with the applicable laws in the jurisdiction in which it is located and, where licensing is required, has been licensed and approved by the regulatory authority having the responsibility for licensing; or
3. Meets all of the following requirements:
 - a. It is an agency which holds itself forth to the public as having the primary purpose of providing a home health care delivery system bringing supportive services to the home;
 - b. It has a full-time administrator;
 - c. It maintains written records of services provided to the patient;
 - d. Its staff includes at least one registered nurse (R.N.) or it has nursing care by a registered nurse (R.N.) available; and
 - e. Its employees are bonded and it provides malpractice insurance.

“Hospital”

“Hospital” shall mean an Institution that meets all of the following requirements:

1. It provides medical and Surgical facilities for the treatment and care of Injured or Sick persons on an Inpatient basis;
2. It is under the supervision of a staff of Physicians;
3. It provides 24-hour-a-day nursing service by registered nurses;
4. It is duly licensed as a hospital, except that this requirement will not apply in the case of a State tax-supported Institution;
5. It is not, other than incidentally, a place for rest, a place for the aged, a nursing home or a custodial or training-type Institution;
6. It is accredited by the Joint Commission on Accreditation of Hospitals sponsored by the AMA and the AHA.

The requirement of surgical facilities shall not apply to a Hospital specializing in the care and treatment of mentally ill patients, provided such Institution is accredited as such a facility by the Joint Commission on Accreditation of Hospitals sponsored by the AMA and the AHA.

Hospital shall also have the same meaning, where appropriate in context, set forth in the definition of “Ambulatory Surgical Center.”

“Illness”

“Illness” shall have the meaning set forth in the definition of “Disease.”

“Impregnation and Infertility Treatment”

“Impregnation and Infertility Treatment” shall mean artificial insemination, fertility drugs, G.I.F.T. (Gamete Intrafallopian Transfer), impotency drugs such as Viagra™, in-vitro fertilization, sterilization and/or reversal of a sterilization operation, surrogate mother, donor eggs, or any type of artificial impregnation procedure, whether or not such procedure is successful.

“Incurred”

“Incurred” shall mean that a covered expense is Incurred on the date the service is rendered or the supply is obtained. With respect to a course of treatment or procedure which includes several steps or phases of treatment, covered expenses are Incurred for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered. More specifically, covered expenses for the entire procedure or course of treatment are not Incurred upon commencement of the first stage of the procedure or course of treatment.

“Injury”

“Injury” shall mean an Accidental Bodily Injury, which requires treatment by a physician. It must result in loss independently of sickness and other causes.

“Inpatient”

“Inpatient” shall mean any person who, while confined to a Hospital, is assigned to a bed in any department of the Hospital other than its outpatient department and for whom a charge for Room and Board is made by the Hospital.

“Institution”

“Institution” shall mean a facility, operating within the scope of its license, whose purpose is to provide organized health care and treatment to individuals, such as a Hospital, Ambulatory Surgical Center, Psychiatric Hospital, community mental health center, residential treatment facility, psychiatric treatment facility, Substance Abuse Treatment Center, alternative birthing center, Home Health Care Center, or any other such facility that the Plan approves.

“Intensive Care Unit”

“Intensive Care Unit” shall have the same meaning set forth in the definition of “Cardiac Care Unit.”

“Leave of Absence”

“Leave of Absence” shall mean a leave of absence of an Employee that has been approved by his or her Participating Employer, as provided for in the Participating Employer’s rules, policies, procedures and practices.

“Mastectomy”

“Mastectomy” shall mean the surgical removal of all or part of a breast.

“Maximum Amount” or “Maximum Allowable Charge”

“Maximum Amount” and/or “Maximum Allowable Charge” shall mean the benefit payable for a specific coverage item or benefit under the Plan. Maximum Allowable Charge(s) will be the lesser of:

- The Usual and Customary amount;
- The allowable charge specified under the terms of the Plan;
- The negotiated rate established in a contractual arrangement with a Provider; or
- The actual billed charges for the covered services.

The Plan will reimburse the actual charge billed if it is less than the Usual and Customary amount. The Plan has the discretionary authority to decide if a charge is Usual and Customary and for a Medically Necessary and Reasonable service.

The **Maximum Allowable Charge** will not include any identifiable billing mistakes including, but not limited to, up-coding, duplicate charges, and charges for services not performed.

“Medical Child Support Order”

“Medical Child Support Order” See section 5.08.

“Medically Necessary”

“Medical Care Necessity”, “Medically Necessary”, “Medical Necessity” and similar language refers to health care services ordered by a Physician exercising prudent clinical judgment provided to a Plan Participant for the purposes of evaluation, diagnosis or treatment of that Plan Participant’s Sickness or Injury. Such services, to be considered Medically Necessary, must be clinically appropriate in terms of type, frequency, extent, site and duration for the diagnosis or treatment of the Plan Participant’s Sickness or Injury. The Medically Necessary setting and level of service is that setting and level of service which, considering the Plan Participant’s medical symptoms and conditions, cannot be provided in a less intensive medical setting. Such services, to be considered Medically Necessary must be no more costly than alternative interventions, including no intervention and are at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Plan Participant’s Sickness or Injury without adversely affecting the Plan Participant’s medical condition.

- a) It must not be maintenance therapy or maintenance treatment.
- b) Its purpose must be to restore health.
- c) It must not be primarily custodial in nature.
- d) It must not be a listed item or treatment not allowed for reimbursement by CMS (Medicare).
- e) The Plan reserves the right to incorporate CMS (Medicare) guidelines in effect on the date of treatment as additional criteria for determination of Medical Necessity and/or an Allowable Expense.

For Hospital stays, this means that acute care as an Inpatient is necessary due to the kind of services the Participant is receiving or the severity of the Participant’s condition and that safe and adequate care cannot be received as an outpatient or in a less intensified medical setting. The mere fact that the service is furnished, prescribed or approved by a Physician does not mean that it is “Medically Necessary.” In addition, the fact that certain services are excluded from coverage under this Plan because they are not “Medically Necessary” does not mean that any other services are deemed to be “Medically Necessary.”

To be Medically Necessary, all of these criteria must be met. Merely because a Physician or Dentist recommends, approves, or orders certain care does not mean that it is Medically Necessary. The determination of whether a service, supply, or treatment is or is not Medically Necessary may include findings of the American Medical Association and the Plan Administrator's own medical advisors. The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary.

“Medically Necessary Leave of Absence”

“Medically Necessary Leave of Absence” shall mean a Leave of Absence by a full-time student Dependent at a postsecondary educational institution that:

1. Commences while such Dependent is suffering from a serious Illness or Injury;
2. Is Medically Necessary; and
3. Causes such Dependent to lose student status for purposes of coverage under the terms of the Plan.

“Medical Record Review”

“Medical Record Review” is the process by which the Plan, based upon a medical record review and audit, determines that a different treatment or different quantity of a drug or supply was provided which is not supported in the billing, then the Plan Administrator may determine the **Maximum Allowable Charge** according to the medical record review and audit results.

“Medicare”

“Medicare” shall mean the program of health care for the aged established by Title XVIII of the Social Security Act of 1965, as amended.

“Mental Health Parity and Addiction Equity Act of 2008 (“MHPAEA”)”

“Mental Health Parity and Addiction Equity Act of 2008 (“MHPAEA”)” shall mean in the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health or substance use disorder benefits, such plan or coverage shall ensure that:

1. The financial requirements applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the Plan (or coverage) and that there are no separate cost sharing requirements that are applicable only with respect to mental health or substance use disorder benefits. If these benefits are covered by the group health plan (or health insurance coverage is offered in connection with such a plan); and
2. The treatment limitations applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the Plan (or coverage), and that there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits. If these benefits are covered by the group health plan (or health insurance coverage offered in connection with such a plan).

“Mental or Nervous Disorder”

“Mental or Nervous Disorder” shall mean any disease or condition, regardless of whether the cause is organic, that is classified as a Mental or Nervous Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services, is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association or other relevant State guideline or applicable sources.

“National Medical Support Notice” or “NMSN”

“National Medical Support Notice” See section 5.08

“Network”

“Network” shall mean the medical provider network of physicians, hospitals, and other health care providers. The Network is responsible for recruiting, credentialing, and communicating with the providers. Providers participating

in the Network agree to accept the allowable fees set by the Network and agree to file claims for Plan participants. The Network Provider will be identified on the Participants identification card.

“Non-Occupational Injury”

“Non-occupational Injury” shall have the meaning set forth in the definition of “Injury.”

“Open Enrollment Period”

“Open Enrollment Period” shall mean the month of October in each Plan Year, and as otherwise required by law.

“Other Plan”

“Other Plan” shall include, but is not limited to:

1. Any primary payer besides the Plan;
2. Any other group health plan;
3. Any other coverage or policy covering the Participant;
4. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
5. Any policy of insurance from any insurance company or guarantor of a responsible party;
6. Any policy of insurance from any insurance company or guarantor of a third party;
7. Worker’s compensation or other liability insurance company; or
8. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

“Out of Area”

“Out of Area” shall mean a geographic area. Services provided by Health Care Providers who are not in the Network Service Area (outside El Paso/Las Cruces). Participants have a “National Network” in order for benefits to be paid at the In Network level.

“Participant” / “Plan Participant”

“Participant” shall mean any Employee or Dependent who is eligible for benefits and enrolled under the Plan. See Article 5.

“Physician”

“Physician” shall mean a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Psychologist (Ph.D.), psychiatrist or midwife.

“Plan Year”

“Plan Year” shall mean January 1 through December 31.

“Plus One Qualifying Adult”

Plus One Qualifying Adult eligibility is extended to an individual who meets all of the following criteria:

1. The Employee and Plus One Qualifying Adult must have resided together in the same residence for at least twelve consecutive months and continue to do so for the Plus One Qualifying Adult to remain eligible. Copies of the Employee and Plus One Qualifying Adult’s Driver’s License or Government issued Identification Card listing a common address must be provided to the Plan Administrator;
2. The Plus One Qualifying Adult must be eighteen years of age or older; and
3. The Plus One Qualifying Adult must be financially interdependent with the Employee, sharing common financial obligations, as evidenced by three or more of the following documents (Financial Interdependence Documents), and continue to do so for the Plus One Qualifying Adult to remain eligible. Copies of the Financial Interdependence Documents must be provided to the Plan Administrator:
 - a. Joint deed or mortgage agreement to demonstrate common ownership or real property or a common leasehold interest in real property;
 - b. A Title or Vehicle Registration showing common ownership of a motor vehicle;
 - c. Proof of joint bank accounts or credit accounts;
 - d. Proof of designation as the primary beneficiary for life insurance or retirements benefits;

- e. Assignment of a durable property power of attorney or health care power of attorney.

Loss of Eligibility; Changes to Common Address or Financial Interdependence Documents. If the Employee and Plus One Qualifying Adult cease to reside together, or cease to share common financial obligations described in the Financial Interdependence Documents, the Plus One Qualifying Adult is no longer eligible to be a Dependent of the Employee. The Employee has an affirmative duty to inform the Plan Administrator of the change in status within 31 days. If the information on the Financial Interdependence Documents or Driver's license or Government issued Identification Card changes, the Employee must notify the Plan Administrator within 31 days and provide copies of the new documents, or risk loss of eligibility for the Plus One Qualifying Adult.

Note: Federal and/or State tax implications may arise when enrolling a Plus One Qualifying Adult as a Dependent under the Plan. Employees should contact his or her own tax consultant or attorney to address his or her specific situation.

Ineligible Individuals

The following individuals are not eligible for designation as a Plus One Qualifying Adult:

1. Parents;
2. Parents' other descendants (siblings, nieces, nephews);
3. Grandparents and descendants (aunts, uncles, cousins);
4. Step relatives; or
5. Renters, boarders, tenants, employees of the County Employee.

“Pre-admission Tests”

“Pre-admission Tests” shall mean those Diagnostic Services done prior to scheduled Surgery, provided that:

1. The tests are approved by both the Hospital and the Physician;
2. The tests are performed on an outpatient basis prior to Hospital admission; and
3. The tests are performed at the Hospital into which confinement is scheduled, or at a qualified facility designated by the Physician who will perform the Surgery.

“Pregnancy”

“Pregnancy” shall mean carrying a child, resulting childbirth, miscarriage and non-elective abortion. The Plan considers Pregnancy as a Sickness for the purpose of determining benefits.

“Pre-existing Condition”

“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 or practitioner duly licensed to provide such care under applicable State law and operating within the scope of practice authorized by such State law, during the 90 days prior to the date an Employee's Service Waiting Period commences.

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.

“Prior Plan”

“Prior Plan” shall mean the coverage provided on a group or group-type basis by the group insurance policy, benefit plan or service plan that was terminated on the day before the Effective Date of the Plan and replaced by the Plan.

“Prior to Effective Date” or “After Termination Date”

“Prior to Effective Date” or “After Termination Date” are dates occurring before a Participant gains eligibility from the Plan, or dates occurring after a Participant loses eligibility from the Plan, as well as charges incurred prior to the effective date of coverage under the Plan or after coverage is terminated.

“Privacy Standards”

“Privacy Standards” shall mean the standards of the privacy of individually identifiable health information, as pursuant to HIPAA.

“Provider”

“Provider” shall mean a Physician, a licensed speech or occupational therapist, licensed professional physical therapist, physiotherapist, audiologist, speech language pathologist, licensed professional counselor, certified nurse practitioner, certified psychiatric/mental health clinical nurse, or other practitioner or facility defined or listed herein, or approved by the Plan Administrator.

“Psychiatric Hospital”

“Psychiatric Hospital” shall mean an Institution constituted, licensed, and operated as set forth in the laws that apply to Hospitals, which meets all of the following requirements:

1. It is primarily engaged in providing psychiatric services for the diagnosis and treatment of mentally ill persons either by, or under the supervision of, a Physician;
2. It maintains clinical records on all patients and keeps records as needed to determine the degree and intensity of treatment provided;
3. It is licensed as a psychiatric hospital;
4. It requires that every patient be under the care of a Physician; and
5. It provides 24-hour-a-day nursing service.

The term Psychiatric Hospital does not include an Institution, or that part of an Institution, used mainly for nursing care, rest care, convalescent care, care of the aged, Custodial Care or educational care.

“Qualified Medical Child Support Order” or “QMCSO”

“Qualified Medical Child Support Order” or “QMCSO” See section 5.08.

“Qualifying Event”

“Qualifying Event” shall have the meaning described in section 7.06

“Reasonable”

“Reasonable” and/or “Reasonableness” shall mean in the administrator’s discretion, services or supplies, or fees for services or supplies which are necessary for the care and treatment of illness or injury not caused by the treating Provider. Determination that fee(s) or services are reasonable will be made by the Plan Administrator, taking into consideration unusual circumstances or complications requiring additional time, skill and experience in connection with a particular service or supply; industry standards and practices as they relate to similar scenarios; and the cause of injury or illness necessitating the service(s) and/or charge(s).

This determination will consider, but will not be limited to, the findings and assessments of the following entities: (a) The National Medical Associations, Societies, and organizations; and (b) The Food and Drug Administration. To be Reasonable, service(s) and/or fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures. Services, supplies, care and/or treatment that results from errors in medical care that are clearly identifiable, preventable, and serious in their consequence for patients, are not Reasonable. The Plan Administrator retains discretionary authority to determine whether service(s) and/or fee(s) are Reasonable based upon information presented to the Plan Administrator. A finding of Provider negligence and/or malpractice is not required for service(s) and/or fee(s) to be considered not Reasonable.

Charge(s) and/or services are not considered to be Reasonable, and as such are not eligible for payment (exceed the Maximum Allowable Charge), when they result from Provider error(s) and/or facility-acquired conditions deemed “reasonably preventable” through the use of evidence-based guidelines, taking into consideration but not limited to CMS guidelines.

The Plan reserves for itself and parties acting on its behalf the right to review charges processed and/or paid by the Plan, to identify charge(s) and/or service(s) that are not Reasonable and therefore not eligible for payment by the Plan.

“Rehabilitation Hospital”

“Rehabilitation Hospital” shall mean an Institution which mainly provides therapeutic and restorative services to Sick or Injured people. It is recognized as such if:

1. It carries out its stated purpose under all relevant Federal, State and local laws;
2. It is accredited for its stated purpose by either the Joint Commission on Accreditation of Hospitals or the Commission on Accreditation for Rehabilitation Facilities; or
3. It is approved for its stated purpose by Medicare.

“Reinstatement of Employment”

“Reinstatement of Employment” shall mean a Participant who has been reinstated under the Plan. A reinstated Participant and his/her dependents, if previously enrolled in the Plan, shall be reinstated with no loss of coverage. See section 5.01.

“Retiree”

“Retiree” as defined by the Plan Sponsor. See section 5.02.

“Room and Board”

“Room and Board” shall mean a Hospital’s charge for:

1. Room and linen service;
2. Dietary service, including meals, special diets and nourishment;
3. General nursing service; and
4. Other conditions of occupancy which are Medically Necessary.

“Scheduled benefit” or “Scheduled benefit amount”

“Scheduled Benefit” or “Scheduled benefit amount” means a specified dollar amount that will be considered for reimbursement under the Plan for a particular type of medical care, service or supply provided. Scheduled benefits are based upon covered expenses not otherwise limited or excluded under the terms of the Plan. A partial listing of scheduled benefit amounts may be found in Article 3, “Schedule of Benefits”. A listing of scheduled benefits may be obtained on the web site at <http://intranet/hr/health.htm>.

“Security Standards”

“Security Standards” shall mean the final rule implementing HIPAA’s Security Standards for the Protection of Electronic PHI, as amended.

“Service Waiting Period”

“Service Waiting Period” shall mean an interval of time an Employee must be employed prior to becoming eligible to enroll in the Plan. The waiting period shall be 90 days of continuous full-time employment.

“Sickness”

“Sickness” shall have the meaning set forth in the definition of “Disease.”

“Significant Break in Coverage”

“Significant Break in Coverage” shall mean a period of 63 consecutive days during each of which an individual does not have any Creditable Coverage.

“Special Enrollment”

“Special Enrollment” See section 5.06

“Substance Abuse”

“Substance Abuse” shall mean any use of alcohol, any Drug (whether obtained legally or illegally), any narcotic, or any hallucinogenic or other illegal substance, which produces a pattern of pathological use, causing impairment in social or occupational functioning, or which produces physiological dependency evidenced by physical tolerance or

withdrawal. It is the excessive use of a substance, especially alcohol or a drug. The DSM-IV definition is applied as follows:

- A. A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12-month period:
 - 1. Recurrent substance use resulting in a failure to fulfill major role obligations at work, school or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions or expulsions from school; neglect of children or household);
 - 2. Recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use);
 - 3. Recurrent substance-related legal problems (e.g., arrests for substance-related disorderly conduct); or
 - 4. Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights);
- B. The symptoms have never met the criteria for Substance Dependence for this class of substance.

“Substance Abuse Treatment Center”

“Substance Abuse Treatment Center” shall mean an Institution which provides a program for the treatment of Substance Abuse by means of a written treatment plan approved and monitored by a Physician. This Institution must be:

- 1. Affiliated with a Hospital under a contractual agreement with an established system for patient referral;
- 2. Accredited as such a facility by the Joint Commission on Accreditation of Hospitals; or
- 3. Licensed, certified or approved as an alcohol or Substance Abuse treatment program or center by a State agency having legal authority to do so.

Substance Dependence: Substance use history which includes the following: (1) substance abuse (see above); (2) continuation of use despite related problems; (3) development of tolerance (more of the drug is needed to achieve the same effect); and (4) withdrawal symptoms.

“Surgery”

“Surgery” shall mean any of the following:

- 1. The incision, excision, debridement or cauterization of any organ or part of the body, and the suturing of a wound;
- 2. The manipulative reduction of a fracture or dislocation or the manipulation of a joint including application of cast or traction;
- 3. The removal by endoscopic means of a stone or other foreign object from any part of the body or the diagnostic examination by endoscopic means of any part of the body;
- 4. The induction of artificial pneumothorax and the injection of sclerosing solutions;
- 5. Arthrodesis, paracentesis, arthrocentesis and all injections into the joints or bursa;
- 6. Obstetrical delivery and dilatation and curettage; or
- 7. Biopsy.

“Surgical Procedure”

“Surgical Procedure” shall have the same meaning set forth in the definition of “Surgery.”

“Total Disability”

“Total Disability” shall mean an individual is determined as being disabled for Social Security purposes and provides such evidence to the Plan of the determination as the Plan Administrator may, in its discretion, require.

“Totally Disabled”

“Totally Disabled” shall have the same meaning set forth in the definition of “Total Disability.”

“Uniformed Services”

“Uniformed Services” shall mean the Armed Forces, the Army National Guard and the Air National Guard, when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President of the United States in time of war or Emergency.

“USERRA”

“USERRA” shall mean the Uniformed Services Employment and Reemployment Rights Act of 1994 (“USERRA”) as amended.

“Usual and Customary”

“Usual and Customary” (U&C) shall mean covered expenses which are identified by the Plan Administrator, taking into consideration the fee(s) which the Provider most frequently charges the majority of patients for the service or supply, the cost to the Provider for providing the services, the prevailing range of fees charged in the same “area” by Providers of similar training and experience for the service or supply, and the Medicare reimbursement rates. The term(s) “same geographic locale” and/or “area” shall be defined as a metropolitan area, county, or such greater area as is necessary to obtain a representative cross-section of Providers, persons or organizations rendering such treatment, services, or supplies for which a specific charge is made. To be Usual and Customary, fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures.

The term “Usual” refers to the amount of a charge made for medical services, care, or supplies, to the extent that the charge does not exceed the common level of charges made by other medical professionals with similar credentials, or health care facilities, pharmacies, or equipment suppliers of similar standing, which are located in the same geographic locale in which the charge is incurred.

The term “Customary” refers to the form and substance of a service, supply, or treatment provided in accordance with generally accepted standards of medical practice to one individual, which is appropriate for the care or treatment of the same sex, comparable age and who receive such services or supplies within the same geographic locale.

The term “Usual and Customary” does not necessarily mean the actual charge made nor the specific service or supply furnished to a Plan Participant by a Provider of services or supplies, such as a physician, therapist, nurse, hospital, or pharmacist. The Plan Administrator will determine what the Usual and Customary charge is, for any procedure, service, or supply, and whether a specific procedure, service or supply is Usual and Customary.

Usual and Customary charges may, at the Plan Administrator’s discretion, alternatively be determined and established by the Plan using normative data such as, but not limited to, Medicare cost to charge ratios, average wholesale price (AWP) for prescriptions and/or manufacturer’s retail pricing (MRP) for supplies and devices.

All other defined terms in this Summary Plan Description shall have the meanings specified in the Summary Plan Description where they appear.

ARTICLE 5
ELIGIBILITY FOR COVERAGE
SPECIAL RESTRICTIONS FOR PRE-EXISTING CONDITIONS

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. The Employee effective date will be the first day following 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.

5.02 Eligibility for Retiree Coverage

A covered Employee is eligible for Retiree coverage under the same plan 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.

5.03 Eligibility Dates for Dependent Coverage

Each Employee will become eligible for coverage under this Plan for his or her Dependents on the latest of the following dates. The Employee will have 31 days from that date to enroll the Employee's Dependent under the Plan by contacting the Plan Administrator and providing copies of the required documentation to the Plan Administrator:

1. The Employee's date of eligibility for coverage for himself or herself under the Plan;
2. The date coverage for the Employee's Dependents first becomes available under any amendment to the Plan, if such coverage was not provided under the Plan on the Effective Date of the Plan;
3. The first date upon which the Employee acquires a Dependent under definitions 1, 2, 4 and 5 of Dependent;
4. As to definition 3 of Dependent, Plus One Qualifying Adult, the date of eligibility for coverage shall be the date the Employee and Plus One Qualifying Adult have resided together in the same residence for at least one year and continue to do so. Copies of the Employee and Plus One Qualifying Adult's Drivers License or Government issued Identification Card listing a common address and copies of Financial Interdependent Documents must be provided to the Plan Administrator.

In no event will any Dependent Child be covered as a Dependent of more than one Employee who is covered under the Plan.

Any reference in this Plan to an Employee's Dependent being covered means that such Employee and Dependent are enrolled in the Plan.

Note: Federal and/or State tax implications may arise when enrolling a Plus One Qualifying Adult as a Dependent under the Plan. Employees should contact his or her own tax consultant or attorney to address his or her specific situation.

5.04 Effective Dates of Coverage; Conditions

The coverage for which an individual is eligible under this Plan will become effective on the date specified below, subject to the conditions of this section.

1. Enrollment Form. Coverage for an Employee or his or her Dependents must be requested by the Employee on a form furnished by the Plan Administrator. This form must be completed and signed by the Employee and will become effective on the date such Employee or Dependents are eligible, provided the Employee has enrolled for such coverage on a form satisfactory to the Plan Administrator within the 31-day period immediately following the date of eligibility.
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.

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.

4. Requirement for Employee Coverage. No coverage for Dependents of an Employee will become effective unless the Employee is, or simultaneously becomes, eligible for coverage for himself or herself under the Plan.
5. Coverage as Both Employee and Dependent. No person may be simultaneously covered under this Plan as both an Employee and a Dependent.
6. Medicaid Coverage. An individual's eligibility for any State Medicaid benefits will not be taken into account by the Plan in determining that individual's eligibility under the Plan.
7. FMLA Leave. Regardless of any requirements set forth in the Plan, the Plan shall at all times comply with FMLA.

5.05 Benefits for the Survivors of Certain Public Servants

Eligible survivors of certain public servants who died as a result of personal injury sustained in the line of duty in the individual's position, as described, are entitled to purchase or continue to purchase health insurance benefits under Chapter 1551, Texas Insurance Code, as provided in this section.

A survivor is eligible if he or she is the surviving spouse of the individual or surviving dependent of the individual.

5.05A Certain Public Servants

This entitlement is available to eligible survivors of individuals who served in the following positions:

1. an individual elected, appointed, or employed as a peace officer by the state or a political subdivision of the state under Article 2.12, Code of Criminal Procedure, or other law;
2. a member of the class of employees of the correctional institutions division formally designated as custodial personnel under section 615.006 by the Texas Board of Criminal Justice or its predecessor in function;
3. a jailer or guard of a county jail who is appointed by the sheriff and who:
 - (a) performs a security, custodial, or supervisory function over the admittance, confinement, or discharge of prisoners; and

- (b) is certified by the Commission on Law Enforcement Officer Standards and Education
- 4. an individual who is employed by the state or a political or legal subdivision and is subject to certification by the Texas Commission on Fire Protection or an individual employed by the state or a political or legal subdivision whose principal duties are aircraft crash and rescue fire fighting who is employed by a political subdivision of the state; or
- 5. an individual who is employed by the state or a political subdivision of the state and who is considered by the governmental employer to be a trainee and is employed as a trainee for a position otherwise described in section 615.071 of the Texas Government Code.

5.05B Eligible Surviving Spouse

An eligible surviving spouse of a deceased individual who was employed by a political subdivision of the state is entitled to purchase or continue to purchase health insurance benefits from the political subdivision that employed the deceased individual, including health coverage:

- 1. provided by or through a political subdivision under:
 - a. a health insurance policy or health benefit plan written by a health insurer; or
 - b. a self-insured health benefits plan.
- 2. under Chapter 172, Local Government Code.

The surviving spouse is entitled to purchase or continue to purchase health insurance coverage until the date the surviving spouse becomes eligible for federal Medicare benefits.

5.05C Eligible Surviving Dependent

An eligible surviving dependent who is a minor child is entitled to purchase or continue to purchase health insurance coverage until the date the dependent reaches the age of 26 or a later date to the extent required by state or federal law.

An eligible surviving dependent who is not a minor child is entitled to purchase or continue to purchase health insurance coverage until the earlier or:

- 1. the date the dependent becomes eligible for group health insurance through another employer; or
- 2. the date the dependent becomes eligible for federal Medicare benefits.

5.06 Special Enrollment

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

5.06A 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.

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. 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
- 3. 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 on the date the other coverage was lost.

5.06B New Dependent

If a covered 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 Dependent 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.

The following conditions apply to any eligible Employee who has acquired a new Dependent:

An Employee may enroll his or her newly acquired Dependent during this special enrollment period if:

1. The covered Employee is eligible for coverage under the terms of this Plan; and
2. The covered 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

5.06C 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 becomes 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.

5.07 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.

5.08 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.

5.09 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.

5.09A 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.

5.09B 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 Claims 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 Claims Administrator later determines that an individual did not have the claimed Creditable Coverage, the Claims 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 Claims Administrator will act in accordance with its initial determination in favor of the Participant for the purpose of approving medical services.

5.10 "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.

ARTICLE 6

TERMINATION OF COVERAGE

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.
- 7.

6.02 Termination Dates of Retiree Coverage

The coverage of any Retiree who is covered under the Plan will terminate on the earliest to occur of the following dates:

1. The date of termination of the Plan;
2. The date of death of the covered Retiree; or
3. The date of the expiration of the last period for which the Retiree 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

6.03 Termination Dates of Dependent Coverage

The coverage for any Dependents of any Participant who are covered under the Plan will terminate on the earliest to occur of the following dates:

1. The date of termination of the Plan;
2. Upon the discontinuance of coverage for Dependents under the Plan;
3. The date of termination of the Participant's coverage for himself or herself under the Plan;
4. 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 Dependents to which he or she has agreed;
5. In the case of a Child age 26 or older for whom coverage is being continued due to mental or physical inability to earn his or her own living, the earliest to occur of:
 - a. Cessation of such inability;
 - b. Failure to furnish any required proof of the uninterrupted continuance of such inability or to submit to any required examination; or
 - c. Upon the Child's no longer being dependent on the Participant for his or her support;
6. The day immediately preceding the date such person ceases to be a Dependent, as defined herein, except as may be provided for in other areas of this section; or
7. 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.

6.04 Certificates of Creditable Coverage

The Plan generally will automatically provide a Certificate of Creditable Coverage to anyone who loses coverage in the Plan. In addition, a Certificate of Coverage will be provided upon request, at any time while the individual is covered under a plan and up to 24 months after the individual loses coverage under the Plan.

The Plan will make reasonable efforts to collect information applicable to any Dependents and to include that information on the Certificate of Coverage, but the Plan will not issue an automatic Certificate of Coverage for Dependents until the Plan has reason to know that a Dependent is or has been covered under the Plan.

ARTICLE 7 CONTINUATION OF COVERAGE

7.01 Continuation During FMLA Leave

The Plan shall at all times comply with FMLA. During any leave taken under FMLA, the Plan Participant will maintain coverage under this Plan on the same conditions as coverage would have been provided if the covered Plan Participant had been continuously employed during the entire leave period.

If provisions under the Plan change while the Plan Participant is on FMLA Leave, the changes will be effective for him or her on the same date as they would have been had he or she not taken leave.

An Employee must continue to pay his or her portion of the Plan contribution, if any, during the FMLA Leave. Payment must be made within 30 days of the due date established by the Plan Administrator. If payment is not received, coverage will terminate on the last date for which the contribution was received in a timely manner.

7.02 Recovery of Plan Contributions

The Participating Employer has the right to recover the portion of the Plan contributions it paid to maintain coverage under the Plan during an unpaid FMLA Leave if the Plan Participant does not return to work at the end of the leave. This right will not apply if failure to return is due to the continuation, recurrence or onset of a Serious Health Condition that entitles the Plan Participant to FMLA Leave (in which case the Participating Employer may require medical certification) or other circumstances beyond the Plan Participant's control at the discretion of the Plan Sponsor.

7.03 Reinstatement of Coverage

The law requires that coverage be reinstated upon the Plan Participant's return to work following an FMLA Leave whether or not the Employee maintained coverage under the Plan during the FMLA Leave.

On reinstatement, all provisions and limits of the Plan will apply as they would have applied if FMLA Leave had not been taken. The Service Waiting Period and the Pre-existing Condition limitation will be credited as if the Employee had been continually covered under the Plan.

NOTE: For complete information regarding FMLA rights, contact the County of El Paso Human Resources.
humanresources@epcounty.com

7.04 Continuation During COBRA - Introduction

The right to this form of continued coverage was created by a Federal law, under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"). COBRA Continuation Coverage can become available to Participants when they otherwise would lose their group health coverage. It also can become available to other members of the Participants family who are covered under the Plan when they otherwise would lose their group health coverage. The entire cost (plus a reasonable administration fee) must be paid by the person. Coverage will end in certain instances, including if the Participant or their covered dependents fail to make timely payment of contributions or premiums. Participants should check with their employer to see if COBRA applies to them and/or their covered dependents.

7.05 COBRA Continuation Coverage

"COBRA Continuation Coverage" is a continuation of Plan coverage when coverage otherwise would end because of a life event known as a "Qualifying Event." Life insurance, accidental death and dismemberment benefits and weekly income or long-term disability benefits (if a part of the employer's plan) are not considered for continuation under COBRA.

7.06 Qualifying Events

Specific Qualifying Events are listed below. After a Qualifying Event, COBRA Continuation Coverage must be offered to each person who is a "Qualified Plan Participant." The Employee, the Employee's spouse, and the Employee's dependent children could become Qualified Plan Participants if coverage under the Plan is lost because

of the Qualifying Event.

A covered Employee (meaning an employee covered under the Plan) will become a Qualified Plan Participant if he or she loses his or her coverage under the Plan because either one of the following Qualifying Events happens:

1. The hours of employment are reduced; or
2. The employment ends for any reason **other than gross misconduct**.

The spouse of a covered Employee will become a Qualified Plan Participant if he or she loses his or her coverage under the Plan because any of the following Qualifying Events happens:

1. The spouse dies;
2. The spouse's hours of employment are reduced;
3. The spouse's employment ends for any reason other than his or her gross misconduct;
4. The spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
5. The spouse becomes divorced or legally separated from his or her spouse.

Dependent children will become Qualified Plan Participants if they lose coverage under the Plan because any of the following Qualifying Events happens:

1. The parent-covered Employee dies;
2. The parent-covered Employee's hours of employment are reduced;
3. The parent-covered Employee's employment ends for any reason other than his or her gross misconduct;
4. The parent-covered Employee becomes entitled to Medicare benefits (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.

7.07 Employer Notice of Qualifying Events

When the Qualifying Event is the end of employment (for reasons other than gross misconduct), reduction of hours of employment, death of the covered Employee or the covered Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Employer must notify the COBRA Administrator of the Qualifying Event.

7.08 Employee Notice of Qualifying Events

Each covered Employee or Qualified Plan Participant is responsible for providing the Plan Administrator with the following notices, in writing, either by U.S. First Class Mail or hand delivery:

1. Notice of the occurrence of a Qualifying Event that is a divorce or legal separation of a covered Employee (or former employee) from his or her spouse;
2. Notice of the occurrence of a Qualifying Event that is an individual's ceasing to be eligible as a Dependent Child under the terms of the Plan;
3. Notice of the occurrence of a second Qualifying Event after a Qualified Plan Participant has become entitled to COBRA Continuation Coverage with a maximum duration of 18 (or 29) months;
4. Notice that a Qualified Plan Participant entitled to receive Continuation Coverage with a maximum duration of 18 months has been determined by the Social Security Administration ("SSA") to be disabled at any time during the first 60 days of Continuation Coverage; and
5. Notice that a Qualified Plan Participant, with respect to whom a notice described above has been provided, has subsequently been determined by the SSA to no longer be disabled.

The Plan Administrator is:

County of El Paso
Plan Administrator
800 E. Overland, Suite 223
El Paso, Texas 79901
(915) 546-2218

Notice forms are available from the Plan Administrator and must be used when providing the notice.

7.09 Deadline for providing the notice

For Qualifying Events described above, the notice must be furnished by the date that is 30 days after the latest of:

1. The date on which the relevant Qualifying Event occurs;
2. The date on which the Qualified Plan Participant loses (or would lose) coverage under the Plan as a result of the Qualifying Event; or
3. The date on which the Qualified Plan Participant is informed, through the furnishing of the Plan's SPD or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Administrator.

For the disability determination described above, the notice must be furnished by the date that is 30 days after the latest of:

1. The date of the disability determination by the Social Security Administration ("SSA");
2. The date on which a Qualifying Event occurs;
3. The date on which the Qualified Plan Participant loses (or would lose) coverage under the Plan as a result of the Qualifying Event; or
4. The date on which the Qualified Plan Participant is informed, through the furnishing of the Plan's SPD or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Administrator.

In any event, this notice must be furnished before the end of the first 18 months of Continuation Coverage.

For a change in disability status described above, the notice must be furnished by the date that is 30 days after the later of:

1. The date of the final determination by the SSA that the Qualified Plan Participant is no longer disabled; or
2. The date on which the Qualified Plan Participant is informed, through the furnishing of the Plan's SPD or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Administrator.

The notice must be postmarked (if mailed), or received by the County of El Paso (if hand delivered), by the deadline set forth above. If the notice is late, the opportunity to elect or extend COBRA Continuation Coverage is lost, and if the person is electing COBRA Continuation Coverage, his or her coverage under the Plan will terminate on the last date for which he or she is eligible under the terms of the Plan, or if the person is extending COBRA Continuation Coverage, such Coverage will end on the last day of the initial 18-month COBRA coverage period.

7.10 Who Can Provide the Notice

Any individual who is the covered Employee (or former employee), a Qualified Plan Participant with respect to the Qualifying Event, or any representative acting on behalf of the covered Employee (or former employee) or Qualified Plan Participant, may provide the notice, and the provision of notice by one individual shall satisfy any responsibility to provide notice on behalf of all related Qualified Plan Participants with respect to the Qualifying Event.

7.11 Required Contents of the Notice

The notice must contain the following information:

1. Name and address of the covered Employee or former employee;
2. Identification of the initial Qualifying Event and its date of occurrence, if the person is already receiving COBRA Continuation Coverage and wishes to extend the maximum coverage period;

3. A description of the Qualifying Event (for example, divorce, legal separation, cessation of dependent status, entitlement to Medicare by the covered Employee or former employee, death of the covered Employee or former employee, disability of a Qualified Plan Participant or loss of disability status);
4. In the case of a Qualifying Event that is divorce or legal separation, name(s) and address(es) of spouse and dependent child(ren) covered under the Plan, date of divorce or legal separation, and a copy of the decree of divorce or legal separation;
5. In the case of a Qualifying Event that is Medicare entitlement of the covered Employee or former employee, date of entitlement, and name(s) and address(es) of spouse and Dependent child(ren) covered under the Plan;
6. In the case of a Qualifying Event that is a Dependent Child's cessation of Dependent status under the Plan, name and address of the Child, reason the Child ceased to be an eligible Dependent (for example, attained limiting age, lost student status, married or other);
7. In the case of a Qualifying Event that is the death of the covered Employee or former employee, the date of death, and name(s) and address(es) of spouse and Dependent Child(ren) covered under the Plan;
8. In the case of a Qualifying Event that is disability of a Qualified Plan Participant, name and address of the disabled Qualified Plan Participant, name(s) and address(es) of other family members covered under the Plan, the date the disability began, the date of the SSA's determination, and a copy of the SSA's determination;
9. In the case of a Qualifying Event that is loss of disability status, name and address of the Qualified Plan Participant who is no longer disabled, name(s) and address(es) of other family members covered under the Plan, the date the disability ended and the date of the SSA's determination; and
10. A certification that the information is true and correct, a signature and date.

If a copy of the decree of divorce, legal separation or the SSA's determination cannot be provided by the deadline for providing the notice, complete and provide the notice, as instructed, by the deadline and submit the copy of the decree of divorce, legal separation or the SSA's determination within 30 days after the deadline. The notice will be timely if done so. However, no COBRA Continuation Coverage, or extension of such Coverage, will be available until the copy of the decree of divorce, legal separation or the SSA's determination is provided.

If the notice does not contain all of the required information, the Plan Administrator may request additional information. If the individual fails to provide such information within the time period specified by the Plan Administrator in the request, the Plan Administrator may reject the notice if it does not contain enough information for the Plan Administrator to identify the plan, the covered Employee (or former employee), the Qualified Plan Participants, the Qualifying Event or disability, and the date on which the Qualifying Event, if any, occurred.

7.12 Electing COBRA Continuation Coverage

Complete instructions on how to elect COBRA Continuation Coverage will be provided by the Plan Administrator within 14 days **of receiving the notice of the Qualifying Event**. The individual then has 60 days in which to elect COBRA Continuation Coverage. The 60-day period is measured from the later of the date coverage terminates and the date of the notice containing the instructions. If COBRA Continuation Coverage is not elected in that 60-day period, then the right to elect it ceases.

Each Qualified Plan Participant will have an independent right to elect COBRA Continuation Coverage. Covered Employees may elect COBRA Continuation Coverage on behalf of their spouses, and parents may elect COBRA Continuation Coverage on behalf of their children.

In the event that the Plan Administrator determines that the individual is not entitled to COBRA Continuation Coverage, the Plan Administrator will provide to the individual an explanation as to why he or she is not entitled to COBRA Continuation Coverage.

7.13 Duration of COBRA Continuation Coverage

COBRA Continuation Coverage will be available up to the maximum time period shown below. Generally, multiple Qualifying Events which may be combined under COBRA will not continue coverage for more than 36 months beyond the date of the original Qualifying Event. When the Qualifying Event is "entitlement to Medicare," the 36-month continuation period is measured from the date of the original Qualifying Event. For all other

Qualifying Events, the continuation period is measured from the date of the Qualifying Event, not the date of loss of coverage.

When the Qualifying Event is the death of the covered Employee (or former employee), the covered Employee's (or former employee's) becoming entitled to Medicare benefits (under Part A, Part B, or both), a divorce or legal separation, or a Dependent Child's losing eligibility as a Dependent Child, COBRA Continuation Coverage lasts for up to a total of 36 months.

When the Qualifying Event is the end of employment or reduction of the covered Employee's hours of employment, and the covered Employee became entitled to Medicare benefits less than 18 months before the Qualifying Event, COBRA Continuation Coverage for Qualified Plan Participants other than the covered Employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered Employee becomes entitled to Medicare eight months before the date on which his or her employment terminates, COBRA Continuation Coverage for his or her spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the Qualifying Event (36 months minus 8 months).

Otherwise, when the Qualifying Event is the end of employment (for reasons other than gross misconduct) or reduction of the covered Employee's hours of employment, COBRA Continuation Coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA Continuation Coverage can be extended.

7.14 Disability Extension of COBRA Continuation Coverage

If an Employee or anyone in an Employee's family covered under the Plan is determined by the SSA to be disabled and the Employee notifies the Plan Administrator as set forth above, the Employee and his or her entire family may be entitled to receive up to an additional 11 months of COBRA Continuation Coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA Continuation Coverage and must last at least until the end of the 18-month period of COBRA Continuation Coverage. An extra fee will be charged for this extended COBRA Continuation Coverage.

7.15 Second Qualifying Event Extension of COBRA Continuation Coverage

If an Employee's family experiences another Qualifying Event while receiving 18 months of COBRA Continuation Coverage, the spouse and Dependent Children in the family can get up to 18 additional months of COBRA Continuation Coverage, for a maximum of 36 months, if notice of the second Qualifying Event properly is given to the Plan as set forth above. This extension may be available to the spouse and any Dependent Children receiving COBRA Continuation Coverage if the covered Employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the Dependent Child stops being eligible under the Plan as a Dependent Child, but only if the event would have caused the spouse or Dependent Child to lose coverage under the Plan had the first Qualifying Event not occurred.

7.16 Shorter Duration of COBRA Continuation Coverage

COBRA Continuation Coverage also may end before the end of the maximum period on the earliest of the following dates:

1. The date the employer ceases to provide a group health plan to any employee;
2. The date on which coverage ceases by reason of the Qualified Plan Participant's failure to make timely payment of any required contributions or premium;
3. The date that the Qualified Plan Participant first becomes, after the date of election, covered under any other group health plan (as an employee or otherwise), or entitled to either Medicare Part A or Part B (whichever comes first). However, a Qualified Plan Participant who becomes covered under a group health plan which has a pre-existing condition limit must be allowed to continue COBRA Continuation Coverage for the length of a pre-existing condition or to the COBRA maximum time period, if less; or
4. The first day of the month that begins more than 30 days after the date of the SSA's determination that the Qualified Plan Participant is no longer disabled, but in no event before the end of the maximum coverage period that applied without taking into consideration the disability extension.

7.17 Contribution and/or Premium Requirements

Once COBRA Continuation Coverage is elected, the individual must pay for the cost of the initial period of coverage within 45 days. Payments then are due on the first day of each month to continue coverage for that month. If a payment is not received within 30 days of the due date, COBRA Continuation Coverage will be canceled and will not be reinstated.

7.18. Additional Information

Additional information about the Plan and COBRA Continuation Coverage is available from the Plan Administrator or COBRA Administrator, please see page 3 of this Summary Plan Description:

7.19 Current Addresses

In order to protect the rights of the Employee's family, the Plan Participant should keep the Plan Administrator (who is identified above) informed of any changes in the addresses of family members.

7.20 The Trade Act of 2002

Two provisions under the Trade Act of 2002 (the "Trade Act") affect the benefits received under COBRA. First, certain eligible individuals who lose their jobs due to international trade agreements may receive a 65% tax credit for premiums paid for certain types of health insurance, including COBRA contribution or premiums. Second, eligible individuals under the Trade Act who do not elect COBRA continuation within the election period will be allowed an additional 60-day period to elect COBRA continuation coverage. If the qualified Plan Participant elects continuation during this second election period, the coverage period will run from the beginning date of the second election period. You should consult the Plan Administrator if you believe the Trade Act applies to you.

ARTICLE 8 PLAN ADMINISTRATION

The Plan is administered by the Plan Administrator. The Plan Administrator has retained the services of the Third Party Administrator to provide certain claims processing and other technical services.

8.01. Plan Administrator

The Plan is administered by the Plan Administrator within the purview of applicable law and in accordance with these provisions. An individual or entity may be appointed by the Plan Sponsor to be Plan Administrator and serve at the convenience of the Plan Sponsor. If the Plan Administrator resigns, dies, is otherwise unable to perform, is dissolved, or is removed from the position, the Plan Sponsor shall appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits (including the determination of what services, supplies, care and treatments are Experimental), to decide disputes which may arise relative to a Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator as to the facts related to any claim for benefits and the meaning and intent of any provision of the Plan, or its application to any claim, shall receive the maximum deference provided by law and will be final and binding on all interested parties. Benefits under this Plan will be paid only if the Plan Administrator decides, in its discretion, that the Participant is entitled to them.

8.02. Duties of the Plan Administrator

The duties of the Plan Administrator include the following:

1. To administer the Plan in accordance with its terms;
2. To determine all questions of eligibility, status and coverage under the Plan;
3. To interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions and disputed terms;
4. To make factual findings;
5. To decide disputes which may arise relative to a Participant's rights and/or availability of benefits;
6. To prescribe procedures for filing a claim for benefits, to review claim denials and appeals relating to them and to uphold or reverse such denials;
7. To keep and maintain the Summary Plan Descriptions and all other records pertaining to the Plan;
8. To appoint and supervise a third party administrator to pay claims;
9. To establish and communicate procedures to determine whether a medical child support order is a QMCSO;
10. To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate; and
11. To perform each and every function necessary for or related to the Plan's administration.

8.03. Amending and Terminating the Plan

The Plan Sponsor expects to maintain this Plan indefinitely; however, as the settlor of the Plan, the Plan Sponsor, through its directors and officers, may, in its discretion, at any time, amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan.

Any such amendment, suspension or termination shall be enacted by order of the Plan Sponsor in accordance with applicable Federal and State law and any applicable governing documents.

If the Plan is terminated, the rights of the Participants are limited to expenses incurred before termination. All amendments to this Plan shall become effective as of a date established by the Plan Sponsor.

ARTICLE 9

CLAIM PROCEDURES; PAYMENT OF CLAIMS

The procedures outlined below must be followed by Participants to obtain payment of health benefits under this Plan.

9.01 Health Claims

All claims and questions regarding health claims should be directed to the Claims Administrator. The Plan Administrator shall be ultimately and finally responsible for adjudicating such claims and for providing full and fair review of the decision on such claims in accordance with the following provisions. Benefits under the Plan will be paid only if the Plan Administrator decides in its discretion that the Participant is entitled to them. The responsibility to process claims in accordance with the Summary Plan Description may be delegated to the Third Party Administrator; provided, however, that the Third Party Administrator is not a fiduciary of the Plan and does not have the authority to make decisions involving the use of discretion.

Each Participant claiming benefits under the Plan shall be responsible for supplying, at such times and in such manner as the Plan Administrator in its discretion may require, written proof that the expenses were incurred or that the benefit is covered under the Plan. If the Plan Administrator in its discretion determines that the Participant has not incurred a covered expense or that the benefit is not covered under the Plan, or if the Participant fails to furnish such proof as is requested, no benefits shall be payable under the Plan.

A call from a Provider who wants to know if an individual is covered under the Plan, or if a certain procedure is covered by the Plan, prior to providing treatment is not a “claim,” since an actual claim for benefits is not being filed with the Plan. These are simply requests for information, and **any response is not a guarantee of benefits, since payment of benefits is subject to all Plan provisions, limitations and exclusions.** Once treatment is rendered, a Clean Claim must be filed with the Plan (which will be a “Post-service Claim”). At that time, a determination will be made as to what benefits are payable under the Plan.

Benefits will be payable to a Plan Participant, or to a Provider that has accepted an assignment of benefits as consideration in full for services rendered.

According to Federal regulations which apply to the Plan, there are four types of claims: Pre-service (Urgent and Non-urgent), Concurrent Care and Post-service. However, as noted below, because of this Plan’s design, there are no Pre-service Urgent Care Claims which may be filed with the Plan.

1. Pre-service Claims. A “Pre-service Claim” is a claim for a benefit under the Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care. However, if the Plan does not require the Participant to obtain approval of a medical service prior to getting treatment, then there is no “Pre-service Claim.” The Participant simply follows the Plan’s procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a Post-service Claim.

A “Pre-service Urgent Care Claim” is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the Participant or the Participant’s ability to regain maximum function, or, in the opinion of a physician with knowledge of the Participant’s medical condition, would subject the Participant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

If a Participant needs medical care for a condition which could seriously jeopardize his or her life, obtain such care without delay, and communicate with the Plan as soon as reasonably possible.

The Plan does not require the Participant to obtain approval of any urgent care or emergency medical services or admissions prior to getting treatment for an urgent care or emergency situation, so there are no “Pre-service Urgent Care Claims” under the Plan. The Participant simply follows the Plan’s procedures

with respect to any notice which may be required after receipt of treatment, and files the claim as a Post-service Claim.

Pre-admission certification of a non-emergency Hospital admission is a “claim” only to the extent of the determination made – that the type of procedure or condition warrants Inpatient confinement for a certain number of days. The rules regarding Pre-service Claims will apply to that determination only. Once a Participant has the treatment in question, the claim for benefits relating to that treatment will be treated as a Post-service Claim.

2. Concurrent Claims. A “Concurrent Claim” arises when the Plan has approved an on-going course of treatment to be provided over a period of time or number of treatments, and either:
 - a. The Plan determines that the course of treatment should be reduced or terminated; or
 - b. The Participant requests extension of the course of treatment beyond that which the Plan has approved.

If the Plan does not require the Participant to obtain approval of a medical service prior to getting treatment, then there is no need to contact the Plan Administrator to request an extension of a course of treatment. The Participant simply follows the Plan’s procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a Post-service Claim.

3. Post-service Claims. A “Post-service Claim” is a claim for a benefit under the Plan after the services have been rendered.

9.02 When Claims Must Be Filed

Claims (which must be Clean Claims) must be filed with the Claims Administrator no later than March 31 of the following calendar year. Benefits are based upon the Plan’s provisions at the time the charges were incurred. Charges are considered incurred when treatment or care is given or supplies are provided. **Claims filed later than that date shall be denied.**

A Pre-service Claim (including a Concurrent Claim that also is a Pre-service Claim) is considered to be filed when the request for approval of treatment or services is made and received by the Claims Administrator in accordance with the Plan’s procedures. However, a Post-service Claim is considered to be filed when the following information is received by the Claims Administrator, together with a Form HCFA or Form UB92:

1. The date of service;
2. The name, address, telephone number and tax identification number of the Provider of the services or supplies;
3. The place where the services were rendered;
4. The diagnosis and procedure codes;
5. The amount of charges;
6. The name of the Plan;
7. The name of the covered Plan Participant; and
8. The name of the patient.

Upon receipt of this information, the claim will be deemed to be initiated with the Plan.

The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the claim (a Clean Claim). If not, more information may be requested as provided herein. This additional information must be received by the Claims Administrator within 45 days (48 hours in the case of Pre-service Urgent Care Claims) from receipt by the Participant of the request for additional information. **Failure to do so may result in claims being declined or reduced.**

9.03 Timing of Claim Decisions

Upon receiving a Clean Claim, the Claims Administrator shall notify the Participant, in accordance with the provisions set forth below, of any adverse benefit determination (and, in the case of Pre-service Claims and Concurrent Claims, of decisions that a claim is payable in full) within the following timeframes:

1. Pre-service Non-urgent Care Claims.

- a. If the Participant has provided all of the information needed to process the claim, in a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.
- b. If the Participant or a Provider has not provided all of the information needed to process the claim (a Clean Claim has not been submitted), then the Participant will be notified by Claims Administrator as to what specific information is needed as soon as possible, after receipt of the claim. The Participant will be notified of a determination of benefits within a reasonable period of time appropriate to the medical circumstances, either prior to the end of the extension period (if additional information was requested during the initial processing period), or by the date agreed to by the Claims Administrator and the Participant (if additional information was requested during the extension period).

2. Concurrent Claims:

- a. Plan Notice of Reduction or Termination. If the Claims Administrator is notifying the Participant of a reduction or termination of a course of treatment (other than by Plan amendment or termination), before the end of such period of time or number of treatments, the Participant will be notified sufficiently in advance of the reduction or termination to allow the Participant to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated.
- b. Request by Participant Involving Urgent Care. If the Claims Administrator receives a request from a Participant to extend the course of treatment beyond the period of time or number of treatments that is a claim involving Urgent Care, as soon as possible, taking into account the medical exigencies, but not later than 24 hours after receipt of the claim, as long as the Participant makes the request at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. If the Participant submits the request with less than 24 hours prior to the expiration of the prescribed period of time or number of treatments, the request will be treated as a claim involving Urgent Care and decided within the Urgent Care timeframe.
- c. Request by Participant Involving Non-urgent Care. If the Claims Administrator receives a request from the Participant to extend the course of treatment beyond the period of time or number of treatments that is a claim not involving Urgent Care, the request will be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim (either as a Pre-service Non-urgent Claim or a Post-service Claim).

3. Post-service Claims:

- a. If the Participant has provided a Clean Claim, in a reasonable period of time, but not later than 30 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.
- b. If the Participant has not provided all of the information needed to process the claim and additional information is requested during the initial processing period, then the Participant will be notified of a determination of benefits prior to the end of the extension period, unless additional information is

requested during the extension period, then the Participant will be notified of the determination by a date agreed to by the Plan Administrator and the Participant.

4. Extensions – Pre-service Non-urgent Care Claims. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Participant, prior to the expiration of the initial 15-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.
5. Extensions – Post-service Claims. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Participant, prior to the expiration of the initial 30-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.
6. Calculating Time Periods. The period of time within which a benefit determination is required to be made shall begin at the time a claim is deemed to be filed in accordance with the procedures of the Plan.

9.04 Notification of an Adverse Benefit Determination

The Claims Administrator shall provide a Plan Participant with a notice, either in writing or electronically (or, in the case of pre-service urgent care claims, by telephone, facsimile or similar method, with written or electronic notice following within 3 days), containing the following information:

1. A reference to the specific portion(s) of the Summary Plan Description upon which a denial is based;
2. Specific reason(s) for a denial;
3. A description of any additional information necessary for the Participant to perfect the claim and an explanation of why such information is necessary;
4. A description of the Plan's review procedures and the time limits applicable to the procedures, including a statement of the Participant's rights following an adverse benefit determination on final review;
5. A statement that the Participant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Participant's claim for benefits;
6. The identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request);
7. Any rule, guideline, protocol or similar criterion that was relied upon in making the determination (or a statement that it was relied upon and that a copy will be provided to the Participant, free of charge, upon request);
8. In the case of denials based upon a medical judgment (such as whether the treatment is Medically Necessary or Experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Participant's medical circumstances, or a statement that such explanation will be provided to the Participant, free of charge, upon request.
9. In a claim involving urgent care, a description of the Plan's expedited review process.

Appeal of Adverse Benefit Determinations

9.05 Full and Fair Review of All Claims

In cases where a claim for benefits is denied, in whole or in part, and the Participant believes the claim has been denied wrongly, the Participant may appeal the denial and review pertinent documents. The claims procedures of this Plan provide a Participant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination. More specifically, the Plan provides:

1. 180 days following receipt of a notification of an initial adverse benefit determination within which to appeal the determination;
2. The opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;

3. For a review that does not afford deference to the previous adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan, who shall be neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;
4. For a review that takes into account all comments, documents, records, and other information submitted by the Participant relating to the claim, without regard to whether such information was submitted or considered in the prior benefit determination;
5. That, in deciding an appeal of any adverse benefit determination that is based in whole or in part upon a medical judgment, the Plan fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual;
6. For the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claim, even if the Plan did not rely upon their advice; or
7. That a Participant will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Participant's claim for benefits in possession of the Plan Administrator or the Third Party Administrator; information regarding any voluntary appeals procedures offered by the Plan; any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse determination; and an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Participant's medical circumstances.

9.06 Requirements for Appeal

The Participant must file an appeal of a post-service claim in writing within 180 days following receipt of the notice of an adverse benefit determination.

For pre-service urgent care claims, if the Plan Participant chooses to initiate an appeal orally, the Plan Participant may telephone:

**HealthSCOPE Benefits
7430 Remcon Circle Bldg C
El Paso, Texas 79912
Phone: (915) 581-8182
Fax: (915) 581-7537**

Oral appeals should be submitted in writing as soon as possible after it has been initiated. To file any appeal in writing, the Participant's appeal must be addressed as follows:

1. For Pre-service Claims:

Participants should refer to their identification card for the name and address of the utilization review administrator. All pre-service claims must be sent to the utilization review administrator.

2. For Post-service Claims:

**HealthSCOPE Benefits
7430 Remcon Circle Bldg C
El Paso, Texas 79912
Phone: (915) 581-8182
Fax: (915) 581-7537**

It shall be the responsibility of the Participant to submit proof that the claim for benefits is covered and payable under the provisions of the Plan. Any appeal must include:

1. The name of the Plan Participant;
2. The Plan Participant's social security number;
3. The group name or identification number;

4. All facts and theories supporting the claim for benefits. **Failure to include any theories or facts in the appeal will result in their being deemed waived. In other words, the Participant will lose the right to raise factual arguments and theories which support this claim if the Participant fails to include them in the appeal;**
5. A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim; and
6. Any material or information that the Participant has which indicates that the Participant is entitled to benefits under the Plan.

If the Participant provides all of the required information, it may be that the expenses will be eligible for payment under the Plan.

9.07 Timing of Notification of Benefit Determination on Review

The Plan Administrator shall notify the Participant of the Plan's benefit determination on review within the following timeframes:

1. Pre-service Non-urgent Care Claims: Within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of the appeal.
2. Concurrent Claims: The response will be made in the appropriate time period based upon the type of claim – Pre-service Urgent, Pre-service Non-urgent or Post-service.
3. Post-service Claims: Within a reasonable period of time, but not later than 60 days after receipt of the appeal.
4. Calculating Time Periods. The period of time within which the Plan's determination is required to be made shall begin at the time an appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

9.08 Manner and Content of Notification of Adverse Benefit Determination on Review

The Plan Administrator shall provide a Participant with notification, with respect to pre-service urgent care claims, by telephone, facsimile or similar method, and with respect to all other types of claims, in writing or electronically, of a Plan's adverse benefit determination on review, setting forth:

1. The specific reason or reasons for the denial;
2. Reference to the specific portion(s) of the summary plan description on which the denial is based;
3. The identity of any medical or vocational experts consulted in connection with the claim, even if the Plan did not rely upon their advice;
4. A statement that the Plan Participant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Plan Participant's claim for benefits;
5. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the Plan Participant upon request;
6. If the adverse benefit determination is based upon a medical judgment, a statement that an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Plan Participant's medical circumstances, will be provided free of charge upon request;

7. A statement of the Plan Participant's rights, following an adverse benefit determination on final review; and
8. The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

9.09 Furnishing Documents in the Event of an Adverse Determination

In the case of an adverse benefit determination on review, the Plan Administrator shall provide such access to, and copies of, documents, records, and other information described in the section relating to "Manner and Content of Notification of Adverse Benefit Determination on Review" as appropriate.

9.10 Decision on Review to be Final

If, for any reason, the Participant does not receive a written response to the appeal within the appropriate time period set forth above, the Participant may assume that the appeal has been denied. The decision by the Plan Administrator or other appropriate named fiduciary of the Plan on review will be final, binding and conclusive and will be afforded the maximum deference permitted by law. **All claim review procedures provided for in the Plan must be exhausted before any legal action is brought.**

9.11 Appointment of Authorized Representative

A Participant is permitted to appoint an authorized representative to act on his or her behalf with respect to a benefit claim or appeal of a denial. An assignment of benefits by a Participant to a Provider will not constitute appointment of that Provider as an authorized representative. To appoint such a representative, the Participant must complete a form which can be obtained from the Plan Administrator or the Claims Administrator. However, in connection with a claim involving Urgent Care, the Plan will permit a health care professional with knowledge of the Participant's medical condition to act as the Participant's authorized representative without completion of this form. In the event a Participant designates an authorized representative, all future communications from the Plan will be with the representative, rather than the Participant, unless the Participant directs the Plan Administrator, in writing, to the contrary.

9.12 Physical Examinations

The Plan reserves the right to have a Physician of its own choosing examine any Participant whose condition, Sickness or Injury is the basis of a claim. All such examinations shall be at the expense of the Plan. This right may be exercised when and as often as the Plan may reasonably require during the pendency of a claim. The Participant must comply with this requirement as a necessary condition to coverage.

9.13 Autopsy

The Plan reserves the right to have an autopsy performed upon any deceased Participant whose condition, Sickness, or Injury is the basis of a claim. This right may be exercised only where not prohibited by law.

9.14 Payment of Benefits

All benefits under this Plan are payable, in U.S. Dollars, to the covered Plan Participant whose Sickness or Injury, or whose covered Dependent's Sickness or Injury, is the basis of a claim. In the event of the death or incapacity of a covered Plan Participant and in the absence of written evidence to this Plan of the qualification of a guardian for his or her estate, this Plan may, in its discretion, make any and all such payments to the individual or institution which, in the opinion of this Plan, is or was providing the care and support of such Employee.

9.15 Assignments

Benefits for medical expenses covered under this Plan may be assigned by a Participant to the Provider as consideration in full for services rendered; however, if those benefits are paid directly to the Plan Participant, the Plan shall be deemed to have fulfilled its obligations with respect to such benefits. The Plan will not be responsible for determining whether any such assignment is valid. Payment of benefits which have been assigned will be made directly to the assignee unless a written request not to honor the assignment, signed by the covered Plan Participant and the assignee, has been received before the proof of loss is submitted.

No Participant shall at any time, either during the time in which he or she is a Participant in the Plan, or following his or her termination as a Participant, in any manner, have any right to assign his or her right to sue to recover benefits under the Plan, to enforce rights due under the Plan or to any other causes of action which he or she may have against the Plan or its fiduciaries.

A Provider which accepts an assignment of benefits, in accordance with this Plan as consideration in full for services rendered, is bound by the rules and provisions set forth within the terms of this document.

9.16 Recovery of Payments

Occasionally, benefits are paid more than once, are paid based upon improper billing or a misstatement in a proof of loss or enrollment information, are not paid according to the Plan's terms, conditions, limitations or exclusions, or should otherwise not have been paid by the Plan. As such this Plan may pay benefits that are later found to be greater than the Maximum Allowable Charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid, primary payers, or from the party on whose behalf the charge(s) were paid. As such, whenever the Plan pays benefits exceeding the amount of benefits payable under the terms of the Plan, the Plan Administrator has the right to recover any such erroneous payment directly from the person or entity who received such payment and/or from other payers and/or the Plan Participant or dependent on whose behalf such payment was made.

A Plan Participant, Dependent, Provider, another benefit plan, insurer, or any other person or entity who receives a payment exceeding the amount of benefits payable under the terms of the Plan or on whose behalf such payment was made, shall return or refund the amount of such erroneous payment to the Plan within 30 days of discovery or demand. The Plan Administrator shall have no obligation to secure payment for the expense for which the erroneous payment was made or to which it was applied.

The person or entity receiving an erroneous payment may not apply such payment to another expense. The Plan Administrator shall have the discretion to choose who will repay the Plan for an erroneous payment and whether such payment shall be reimbursed in a lump sum. When a Plan Participant or other entity does not comply with the provisions of this section, the Plan Administrator shall have the authority, in its discretion, to deny payment of any claims for benefits by the Plan Participant and to deny or reduce future benefits payable (including payment of future benefits for other injuries or illnesses) under the Plan by the amount due as reimbursement to the Plan. The Plan Administrator may also, in its discretion, deny or reduce future benefits (including future benefits for other injuries or illnesses) under any other group benefits plan maintained by the Plan Sponsor. The reductions will equal the amount of the required reimbursement.

Providers and any other person or entity accepting payment from the Plan or to whom a right to benefits has been assigned, in consideration of services rendered, payments and/or rights, agrees to be bound by the terms of this Plan and agree to submit claims for reimbursement in strict accordance with their State's health care practice acts, ICD-9 or CPT standards, Medicare guidelines, HCPCS standards, or other standards approved by the Plan Administrator or insurer. Any payments made on claims for reimbursement not in accordance with the above provisions shall be repaid to the Plan within 30 days of discovery or demand or incur prejudgment interest of 1.5% per month. If the Plan must bring an action against a Plan Participant, Provider or other person or entity to enforce the provisions of this section, then that Plan Participant, Provider or other person or entity agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

Further, Plan Participants and/or their dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (Plan Participants) shall assign or be deemed to have assigned to the Plan their right to recover said payments made by the Plan, from any other party and/or recovery for which the Plan Participant(s) are entitled, for or in relation to facility-acquired condition(s), Provider error(s), or damages arising from another party's act or omission for which the Plan has not already been refunded.

The Plan reserves the right to deduct from any benefits properly payable under this Plan the amount of any payment which has been made:

1. In error;

2. Pursuant to a misstatement contained in a proof of loss or a fraudulent act;
3. Pursuant to a misstatement made to obtain coverage under this Plan within two years after the date such coverage commences;
4. With respect to an ineligible person;
5. In anticipation of obtaining a recovery if a Plan Participant fails to comply with the Plan's Third Party Recovery, Subrogation and Reimbursement provisions; or
6. Pursuant to a claim for which benefits are recoverable under any policy or act of law providing for coverage for occupational Injury or disease to the extent that such benefits are recovered. This provision (6) shall not be deemed to require the Plan to pay benefits under this Plan in any such instance.

The deduction may be made against any claim for benefits under this Plan by a Plan Participant or by any of his Covered Dependents if such payment is made with respect to the Plan Participant or any person covered or asserting coverage as a Dependent of the Plan Participant.

If the Plan seeks to recoup funds from a Provider, due to a claim being made in error, a claim being fraudulent on the part of the Provider, and/or the claim that is the result of the Provider's misstatement, said Provider shall, as part of its assignment to benefits from the Plan, abstain from billing the plan participant for any outstanding amount(s).

9.17 Medicaid Coverage

A Participant's eligibility for any State Medicaid benefits will not be taken into account in determining or making any payments for benefits to or on behalf of such Participant. Any such benefit payments will be subject to the State's right to reimbursement for benefits it has paid on behalf of the Participant, as required by the State Medicaid program; and the Plan will honor any Subrogation rights the State may have with respect to benefits which are payable under the Plan.

ARTICLE 10

COORDINATION OF BENEFITS

10.01 Benefits Subject to This Provision

This provision shall apply to all benefits provided under any section of this Plan.

10.02 Excess Insurance

If at the time of injury, sickness, disease or disability there is available, or potentially available any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage.

The Plan's benefits will be excess to, whenever possible:

- a) Any primary payer besides the Plan;
- b) Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
- c) Any policy of insurance from any insurance company or guarantor of a third party;
- d) Worker's compensation or other liability insurance company; or
- e) Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

10.03 Vehicle Limitation

When medical payments are available under any vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan and/or policy deductibles. This Plan shall always be considered secondary to such plans and/or policies. This applies to all forms of medical payments under vehicle plans and/or policies regardless of its name, title or classification.

10.04 Allowable Expenses.

"Allowable Expenses" shall mean the Usual and Customary charge for any Medically Necessary, Reasonable, eligible item of expense, at least a portion of which is covered under this Plan. When some Other Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered, in the amount that would be payable in accordance with the terms of the Plan, shall be deemed to be the benefit. Benefits payable under any Other Plan include the benefits that would have been payable had claim been duly made therefore.

10.05 "Claim Determination Period"

"Claim Determination Period" shall mean each calendar year.

10.06 "Application to Benefit Determinations"

The plan that pays first according to the rules in the section entitled "Order of Benefit Determination" will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance due up to 100% of the total Allowable Expenses. When there is a conflict in the rules, this Plan will never pay more than 50% of Allowable Expenses when paying secondary. Benefits will be coordinated on the basis of a Claim Determination Period.

When medical payments are available under automobile insurance, this Plan will pay excess benefits only, without reimbursement for automobile plan deductibles. This Plan will always be considered the secondary carrier regardless of the individual's election under personal injury protection (PIP) coverage with the automobile insurance carrier.

In certain instances, the benefits of the Other Plan will be ignored for the purposes of determining the benefits under this Plan. This is the case when:

1. The Other Plan would, according to its rules, determine its benefits after the benefits of this Plan have been determined; and

2. The rules in the section entitled “Order of Benefit Determination” would require this Plan to determine its benefits before the Other Plan.

10.07 “Order of Benefit Determination”

For the purposes of the section entitled “Application to Benefit Determinations,” the rules establishing the order of benefit determination are:

1. A plan without a coordinating provision will always be the primary plan;
2. The benefits of a plan which covers the person on whose expenses claim is based, other than as a dependent, shall be determined before the benefits of a plan which covers such person as a dependent;
3. If the person for whom claim is made is a dependent child covered under both parents’ plans, the plan covering the parent whose birthday (month and day of birth, not year) falls earlier in the year will be primary, except:
 - a. When the parents are separated or divorced, and the parent with the custody of the child has not remarried, the benefits of a plan which covers the child as a dependent of the parent with custody will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody; or
 - b. When the parents are divorced and the parent with custody of the child has remarried, the benefits of a plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a plan which covers that child as a dependent of the stepparent, and the benefits of a plan which covers that child as a dependent of the stepparent will be determined before the benefits of a plan which covers that child as a dependent of the parent without custody.

Notwithstanding the above, if there is a court decree which would otherwise establish financial responsibility for the child’s health care expenses, the benefits of the plan which covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any Other Plan which covers the child as a dependent child; and

4. When the rules 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 shall be determined before the benefits of a plan which has covered such person the shorter period of time.

10.08 Right to Receive and Release Necessary Information

For the purpose of determining the applicability of and implementing the terms of this provision or any provision of similar purpose of any Other Plan, this Plan may, without the consent of or notice to any person, release to or obtain from any insurance company, or other organization or individual, any information with respect to any person, which the Plan deems to be necessary for such purposes. Any person claiming benefits under this Plan shall furnish to the Plan such information as may be necessary to implement this provision.

10.09 Facility of Payment

Whenever payments which should have been made under this Plan in accordance with this provision have been made under any Other Plans, the Plan Administrator may, in its discretion, pay any organizations 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, this Plan shall be fully discharged from liability.

10.10 Right of Recovery

Whenever payments have been made by this Plan with respect to Allowable Expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this Article, the Plan shall have the right to recover such payments, to the extent of such excess, from any one or more of the following as this Plan shall determine: any person to or with respect to whom such payments were made, or such person’s legal representative, any insurance companies, or any other individuals or organizations which the Plan determines are responsible for payment of such Allowable Expenses, and any future benefits payable to the Participant or his or her Dependents.

ARTICLE 11 MEDICARE

11.01 Applicable to Active Employees and Their Spouses Ages 65 and Over

An active Employee and his or her spouse (ages 65 and over) may, at the option of such Employee, elect or reject coverage under this Plan. If such Employee elects coverage under this Plan, the benefits of this Plan shall be determined before any benefits provided by Medicare. If coverage under this Plan is rejected by such Employee, benefits listed herein will not be payable even as secondary coverage to Medicare.

11.02 Applicable to All Other Participants Eligible for Medicare Benefits

To the extent required by Federal regulations, this Plan will pay before any Medicare benefits. There are some circumstances under which Medicare would be required to pay its benefits first. In these cases, benefits under this Plan would be calculated as secondary payor (as described under the Article entitled “Coordination of Benefits”). The Participant will be assumed to have full Medicare coverage (that is, both Part A & B) whether or not the Participant has enrolled for the full coverage. If the Provider accepts assignment with Medicare, covered expenses will not exceed the Medicare-approved expenses.

11.03 Applicable to Medicare Services Furnished to End Stage Renal Disease (“ESRD”) Plan Participants Who Are Covered Under This Plan

If any Participant is eligible for Medicare benefits because of ESRD, the benefits of the Plan will be determined before Medicare benefits for the first 30 months of Medicare entitlement (with respect to charges incurred on or after August 5, 1997), unless applicable Federal law provides to the contrary, in which event the benefits of the Plan will be determined in accordance with such law.

ARTICLE 12

THIRD PARTY RECOVERY, SUBROGATION AND REIMBURSEMENT

12.01. Payment Condition

1. The Plan, in its discretion, may elect to conditionally advance payment of benefits in those situations where an injury, sickness, disease or disability is caused in whole or in part by, or results from the acts or omissions of Plan Participants, and/or their dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as “Plan Participant(s)”) or a third party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or grantor(s) of a third party (collectively “Coverage”).

2. Plan Participant(s), his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan’s conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain one hundred percent (100%) of the Plan’s conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan’s assignee. By accepting benefits the Plan Participant(s) agrees the Plan shall have an equitable lien on any funds received by the Plan Participant(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Plan Participant(s) agrees to include the Plan’s name as a co-payee on any and all settlement drafts.

3. In the event a Plan Participant(s) settles, recovers, or is reimbursed by any Coverage, the Plan Participant(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Plan Participant(s). If the Plan Participant(s) fails to reimburse the Plan out of any judgment or settlement received, the Plan Participant(s) will be responsible for any and all expenses (fees and costs) associated with the Plan’s attempt to recover such money.

4. If there is more than one party responsible for charges paid by the Plan, or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Plan Participant(s) is/are only one or a few, that unallocated settlement fund is considered designated as an “identifiable” fund from which the plan may seek reimbursement.

12.02 Subrogation

Subrogation applies to situations where the Covered Person is injured and another party is responsible for payment of health care expenses (s)he incurs because of the injury. The other party may be an individual, insurance company or some other public or private entity. Automobile accident injuries or personal injury on another’s property are examples of cases frequently subject to subrogation.

The Subrogation provision allows for the right of recovery for certain payments. Any payments made for the Covered Person’s injuries under the Plan may be recovered from the other party. Any payments made to the Covered Person for such injury may be recovered from the Covered Person from any judgment or settlement of his or her claims against the other party or parties.

By accepting Coverage under the Plan, the Covered Person automatically assigns to the Plan any rights the Covered Person may have to recover all or part of any payments made by the Plan from any other party, including an insurer or another group health program. The Covered Person has a duty to notify the Plan Administrator of any recovery or potential right of recovery from a third party whose action or inaction caused injury, and the Plan Administrator may act as the Covered Person’s substitute in the event any payment made by this Plan for health care benefits, including any payment for a Pre-existing Condition, is or

becomes the responsibility of another party. Such payments shall be referred to as Reimbursable Payments. This assignment allows the Plan to pursue any claim that the Covered Person may have, whether or not the Covered Person chooses to pursue that claim.

The Covered Person must cooperate fully and provide all information needed under the Plan to recover payments, execute any papers necessary for such recovery, and do whatever else is necessary to secure such rights to the Plan. The other party may be sued in order to recover the payments made for the Covered Person under the Plan.

12.03 Right of Reimbursement

Specifically, by accepting Coverage under the Plan the Covered Person agrees that if the Covered Person receives any recovery in the form of a judgment, settlement, payment or compensation (regardless of fault, negligence or wrongdoing) from (1) a tortfeasor, (2) a liability insurer for a tortfeasor, or (3) any other source, including but not limited to any form of insured or underinsured motorist coverage, any medical payments, no-fault or school insurance coverages, workers' compensation coverage, premises liability coverage, any medical malpractice recovery, or any other form of insurance coverage ("Recovery"), the Covered Person must notify the Plan Administrator of any recovery or potential right of recovery from a third party whose action or inaction caused injury, and repay the Plan in full for any medical, dental, vision, or disability benefits which have been paid or which will in the future be payable under the Plan for expenses already incurred or which are reasonably foreseeable at the time of such Recovery.

Pursuant to *Texas Local Government Code Chapter 172 and Section 172.015*, the Plan is subrogated to a covered person's right of recovery for personal injuries caused by the tortuous conduct of a third party. the Plan has an equitable lien against the Recovery rights of the Covered Person and has the right to be paid from any such Recovery any and all monies or properties: (1) paid; (2) payable to; or (3) for the benefit of, a Covered Person to the extent of benefits paid by the Plan ("Subrogated Amount"), whether or not the Covered Person has been "made whole" for the injuries received. This right applies on a first-dollar basis (i.e., has priority over other rights), applies whether the funds paid to (or for the benefit of) the Covered Person constitute a full or partial recovery, and applies to funds paid for non-health care charges or attorney fees, or other costs and expenses. This right for first priority in contravention of the "make whole" doctrine shall not be affected or limited in any way by the manner in which the Covered Person or any person or entity responsible for paying any Recovery attempts to designate or characterize the Recovery, regardless of whether the recovery itemizes or identifies an amount awarded for Plan benefits or medical expenses, or is specifically linked to certain kinds of damages or payments. Payment of the Subrogated Amount to the Plan shall be without reduction, set-off or abatement for attorney's fees or costs incurred by the Covered Person in the collection of damages. The Plan shall also be entitled to seek any other equitable remedy against any party possessing or controlling such monies or properties. At the discretion of the Plan Administrator, the Plan may reduce any future Eligible Expenses otherwise available to the Covered Person under the Plan by an amount up to the total amount of Subrogated Amount that is subject to the equitable lien. All rights of recovery will be limited to the amount of payments made under this Plan.

The equitable lien shall also attach to the first right of Recovery to any money or property that is obtained by anybody, including but not limited to the Covered Person, the Covered Person's attorney, and/or a trust for the direct or indirect benefit of the Insured or for his/her "special needs," as a result of an exercise of the Covered Person's rights of Recovery.

The Plan may, in its sole discretion, require the Covered Person, as a pre-condition to receiving benefit payments, to sign a subrogation agreement and to agree in writing to assist the Plan to secure the Plan's right to payment of the Subrogation Amount from the third party. In the event that the Plan does not receive payment of the Subrogated Amount, the Plan may, in its sole discretion, bring legal action against the Covered Person or reduce or set-off the unpaid Subrogated Amount against any future benefit payments to the Covered Person. If the Plan takes legal action to enforce its subrogation rights, the Plan shall be entitled to recover its attorneys' fees and costs from the Covered Person.

The following provisions apply to the Plan's right of subrogation, reimbursement, and creation of an equitable lien:

1. **"Pursue and Pay."** The Plan Administrator has elected a "pursue and pay" in connection with the subrogation, reimbursement and equitable lien rights. At its sole discretion, the Plan Administrator may elect to "pursue and pay" in connection with the subrogation, reimbursement and equitable lien rights for all claims involving Eligible Expenses of \$500 or more. Pursuant to the election of "pursue and pay", the Plan Administrator has the right to apply the subrogation, reimbursement and equitable lien rights prior to making any benefit payments under the Plan, and such payment shall be reduced by any amounts that were paid by any other party as described in this section.

2. **Scope of Subrogation, Reimbursement and Equitable Lien Rights.** The subrogation, reimbursement and equitable lien rights apply to any benefits paid by the Plan on behalf of the Covered Person as a result of the Injuries sustained, including, but not limited to:

- a. Any no-fault insurance;
- b. Medical benefits coverage under any automobile liability plan. This includes the Covered Person's Plan or any third party's policy under which the Covered Person is entitled to benefits;
- c. Under-insured and uninsured motorist coverage;
- d. Any automobile medical payments and personal injury protection benefits;
- e. Any third party's liability insurance
- f. Any premises/guest medical payments coverage;
- g. Any medical malpractice recovery;
- h. Workers' compensation benefits. The right of subrogation, reimbursement and equitable lien attach to any right to payment for workers' compensation, whether by judgment or settlement, where the Plan has paid expenses otherwise eligible as Covered Services prior to a determination that the Covered Services arose out of and in the course of employment. Payment by Workers' Compensation insurers or the employer will be deemed to mean that such a determination has been made;
- i. Any other governmental agency reimbursement (i.e., state medical malpractice compensation funds).

12.04 Separation of Funds

1. Benefits paid by the Plan, funds recovered by the Plan Participant(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Plan Participant(s), such that the death of the Plan Participant(s), or filing of bankruptcy by the Plan Participant(s), will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement.

12.05 Wrongful Death

1. In the event that the Plan Participant(s) dies as a result of his or her injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply.

12.06 Obligations

1. It is the Plan Participant(s)' obligation at all times, both prior to and after payment of medical benefits by the Plan:
 - a) To cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights;

- b) To provide the Plan with pertinent information regarding the sickness, disease, disability, or injury, including accident reports, settlement information and any other requested additional information;
 - c) To take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;
 - d) To do nothing to prejudice the Plan's rights of subrogation and reimbursement;
 - e) To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received; and
 - f) To not settle or release, without the prior consent of the Plan, any claim to the extent that the Plan Participant may have against any responsible party or Coverage.
2. If the Plan Participant(s) and/or his or her attorney fails to reimburse the Plan for all benefits paid or to be paid, as a result of said injury or condition, out of any proceeds, judgment or settlement received, the Plan Participant(s) will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Plan Participant(s).
 3. The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Plan Participant(s)' cooperation or adherence to these terms.

12.07 Offset

1. Failure by the Plan Participant(s) and/or his or her attorney to comply with any of these requirements may, at the Plan's discretion, result in a forfeiture of payment by the Plan of medical benefits and any funds or payments due under this Plan on behalf of the Plan Participant(s) may be withheld until the Plan Participant(s) satisfies his or her obligation.

12.08 Minor Status

1. In the event the Plan Participant(s) is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.
2. If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

12.09 Language Interpretation

1. The Plan Administrator retains full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan's subrogation and reimbursement rights. The Plan Administrator may amend the Plan at any time without notice.

12.10 Severability

1. In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

ARTICLE 13

MISCELLANEOUS PROVISIONS

13.01 Clerical Error/Delay

Clerical errors made on the records of the Plan and delays in making entries on such records shall not invalidate coverage nor cause coverage to be in force or to continue in force. Rather, the Effective Dates of coverage shall be determined solely in accordance with the provisions of this Plan regardless of whether any contributions with respect to Participants have been made or have failed to be made because of such errors or delays. Upon discovery of any such error or delay, an equitable adjustment of any such contributions will be made.

13.02 Conformity With Applicable Laws

This Plan shall be deemed to automatically be amended to conform as required by any applicable law, regulation or the order or judgment of a court of competent jurisdiction governing provisions of this Plan, including, but not limited to, stated maximums, exclusions or limitations. In the event that any law, regulation or the order or judgment of a court of competent jurisdiction causes the Plan Administrator to pay claims which are otherwise limited or excluded under this Plan, such payments will be considered as being in accordance with the terms of this Summary Plan Description.

13.03 Fraud

The following actions by any Participant, or a Participant's knowledge of such actions being taken by another, constitute fraud and will result in immediate termination of all coverage under this Plan for the entire Family Unit of which the Participant is a member:

1. Attempting to submit a claim for benefits (which includes attempting to fill a prescription) for a person who is not a Participant of the Plan;
2. Attempting to file a claim for a Participant for services which were not rendered or Drugs or other items which were not provided;
3. Providing false or misleading information in connection with enrollment in the Plan; or
4. Providing any false or misleading information to the Plan.

13.04 Headings

The headings used in this Summary Plan Description are used for convenience of reference only. Participants are advised not to rely on any provision because of the heading.

13.05 No Waiver or Estoppel

No term, condition or provision of this Plan shall be deemed to have been waived, and there shall be no estoppel against the enforcement of any provision of this Plan, except by written instrument of the party charged with such waiver or estoppel. No such written waiver shall be deemed a continuing waiver unless specifically stated therein, and each such waiver shall operate only as to the specific term or condition waived and shall not constitute a waiver of such term or condition for the future or as to any act other than the one specifically waived.

13.06 Plan Contributions

The Plan Administrator shall, from time to time, evaluate the funding method of the Plan and determine the amount to be contributed by the Plan Sponsor and the amount to be contributed (if any) by each Participant.

The Plan Sponsor shall fund the Plan in a manner consistent with the provisions of the Internal Revenue Code, and such other laws and regulations as shall be applicable to the end that the Plan shall be funded on a lawful and sound basis; but, to the extent permitted by governing law, the Plan Administrator shall be free to determine the manner and means of funding the Plan. The amount of the Participant's contribution (if any) will be determined from time to time by the Plan Sponsor. Current plan year contributions are available through the Human Resources Department.

13.07 Right to Receive and Release Information

For the purpose of determining the applicability of and implementing the terms of these benefits, the Plan Administrator may, without the consent of or notice to any person, release or obtain any information necessary to determine the acceptability of any applicant or Participant for benefits from this Plan. In so acting, the Plan Administrator shall be free from any liability that may arise with regard to such action. Any Participant claiming benefits under this Plan shall furnish to the Plan Administrator such information as may be necessary to implement this provision.

13.08 Written Notice

Any written notice required under this Plan which, as of the Effective Date, is in conflict with the law of any governmental body or agency which has jurisdiction over this Plan shall be interpreted to conform to the minimum requirements of such law.

13.09 Right of Recovery

Whenever payments have been made by this Plan in a total amount, at any time, in excess of the maximum amount of benefits payable under this Plan, the Plan shall have the right to recover such payments, to the extent of such excess, from any one or more of the following as this Plan shall determine: any person to or with respect to whom such payments were made, or such person's legal representative, any insurance companies, or any other individuals or organizations which the Plan determines are responsible for payment of such amount, and any future benefits payable to the Participant or his or her Dependents..

13.10 Statements

All statements made by the Plan Sponsor or by a Plan Participant will, in the absence of fraud, be considered representations and not warranties, and no statements made for the purpose of obtaining benefits under this document will be used in any contest to avoid or reduce the benefits provided by the document unless contained in a written application for benefits and a copy of the instrument containing such representation is or has been furnished to the Plan Participant.

Any Plan Participant who knowingly and with intent to defraud the Plan, files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any material fact, commits a fraudulent act. The Plan Participant may be subject to civil action or criminal prosecution. Fraudulently claiming benefits may be punishable by a substantial fine, imprisonment, or both.

13.11 Claims Review Procedures

In addition to the Plan's Medical Record Review process, the Claims Administrator may use its discretionary authority to utilize an independent bill review and/or claim audit program or service for a complete claim. While every claim may not be subject to a bill review or audit, the Claims Administrator has the discretionary authority for selection of claims subject to review or audit.

The analysis will be employed to identify charges billed in error and/or charges that are not Usual and Customary and/or Medically Necessary and Reasonable, if any, and may include a patient medical billing records review and/or audit of the patient's medical charts and records.

Upon completion of an analysis, a report will be submitted to the Claims Administrator or its agent to identify the charges deemed in excess of the Usual and Customary and Reasonable amounts or other applicable provisions, as outlined in this Summary Plan Description.

Despite the existence of any agreement to the contrary, the Claims Administrator has the discretionary authority to reduce any charge to a Usual and Customary and Reasonable charge, in accord with the terms of this Summary Plan Description.

13.12 Language Interpretation

The Plan Administrator retains full and final discretionary authority to construe and interpret the language of this Summary Plan Description, to determine all questions of fact and law arising under this Summary Plan Description, and to administer the Plan's subrogation and reimbursement rights. The Plan Administrator may amend the Plan at any time without notice.

13.13 Severability

In the event that any section of this Summary Plan Description is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

ARTICLE 14

COVERED MEDICAL EXPENSES

14.01 Medical Benefits

Subject to the Plan's provisions, limitations and exclusions, the following are covered major medical benefits:

1. **Allergy Services.** Charges related to the Treatment of allergies;
2. **Ambulance.** Transportation by professional licensed ambulance, including approved available air transportation to a local Hospital or transfer to the nearest facility having the capability to treat the condition.
3. **Ambulatory Surgical Center.** Services of an Ambulatory Surgical Center for Medically Necessary care provided;
4. **Anesthesia.** Anesthesia, anesthesia supplies, and administration of anesthesia by facility staff;
5. **Birthing Center.** Services of a Birthing Center for Medically Necessary care provided within the scope of its license;
6. **Blood and Plasma.** Blood transfusions, plasma and blood derivatives and charges for whole blood not donated or replaced by a blood bank;
7. **Chemotherapy.** Charges for chemotherapy/radiation;
8. **Chiropractic Care.** Spinal adjustment and manipulation, x-rays for manipulation and adjustment and other modalities performed by a Physician or other licensed practitioner, as limited in the Summary of Benefits;
9. **Dental.** Emergency repair due to Injury to sound natural teeth.
 - a. Result of an injury which occurs while the Plan Participant or dependent is covered under this plan;
 - b. Excision of impacted unerupted teeth or of a tumor or cyst, or incision and drainage of an abscess or cyst;
 - c. Oral surgery not involving any tooth structure;
 - d. Correction of a birth defect of a child
10. **Diabetic Equipment.** 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 a Covered Person, 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.
11. **Diagnostic Tests; Examinations.** Charges for x-rays, microscopic tests, laboratory tests, esophagoscopy, gastroscopy, proctosigmoidoscopy, colonoscopy and other diagnostic tests and procedures;

12. **Durable Medical Equipment.** Charges for rental, up to the purchase price, of Durable Medical Equipment, including glucose home monitors for insulin-Dependent diabetics. At its option, and with its advance written approval, the Plan may cover the purchase of such items when it is less costly and more practical than rental. The Plan does not pay for:
- a. Any purchases without its advance written approval;
 - b. Replacements or repairs; or
 - c. The rental or purchase of items which do not fully meet the definition of “Durable Medical Equipment”;
13. **Foot Disorders.** Surgical treatment of foot disorders, including associated services, performed by a licensed podiatrist (excluding routine foot care);
14. **General Limits.** Payment for any of the expenses listed herein are subject to all plan exclusions, limitations and provisions. Benefits for Pregnancy expenses are paid the same as any other illness.
15. **Glaucoma.** Treatment of glaucoma, cataract Surgery and one set of lenses (contacts or frame-type);
16. **Home Health Care.** Charges by a Home Health Care Agency:
- a. Registered Nurses or Licensed Practical Nurses;
 - b. Certified home health aides under the direct supervision of a Registered Nurse;
 - c. Registered therapist performing physical, occupational or Speech Therapy;
 - d. Physician calls in the office, home, clinic or Outpatient department;
 - e. Services, drugs and medical supplies which are Medically Necessary for the treatment of the Plan Participant that would have been provided in the Hospital, but not including Custodial Care; and
 - f. Rental of Durable Medical Equipment or the purchase of this equipment if economically justified, whichever is less.

NOTE: Transportation services are not covered under this benefit;

17. **Hospice Care.** Charges relating to Hospice Care, provided the Plan Participant has a life expectancy of 6 months or less, subject to the maximums, if any, stated in the Summary of Benefits. Covered Hospice expenses are limited to:
- a. Room and Board for Confinement in a Hospice;
 - b. Ancillary charges furnished by the Hospice while the patient is confined therein, including rental of Durable Medical Equipment which is used solely for treating an Injury or Sickness;
 - c. Medical supplies, drugs and medicines prescribed by the attending Physician, but only to the extent such items are necessary for pain control and management of the terminal condition;
 - d. Physician services and nursing care by a Registered Nurse, Licensed Practical Nurse or a Licensed Vocational Nurse (L.V.N.);
 - e. Home health aide services;
 - f. Home care furnished by a Hospital or Home Health Care Agency, under the direction of a Hospice, including Custodial Care if it is provided during a regular visit by a Registered Nurse, a Licensed Practical Nurse or a home health aide;
 - g. Medical social services by licensed or trained social workers, Psychologists or counselors;
 - h. Nutrition services provided by a licensed dietitian;
 - i. Respite care; and
 - j. Bereavement counseling, which is a supportive service provided by the Hospice team to Plan Participants in the deceased’s Family after the death of the Terminally Ill person, to assist the Plan Participants in adjusting to the death. Benefits will be payable if the following requirements are met:

- (1) On the date immediately before his or her death, the Terminally Ill person was in a Hospice Care Program and a Plan Participant under the Plan; and

- (2) Charges for such services are Incurred by the Plan Participants within 6 months of the Terminally Ill person's death.

The Hospice Care Program must be renewed in writing by the attending Physician every 30 days. Hospice Care ceases if the terminal illness enters remission;

18. **Hospital.** Charges made by a Hospital for:

a. Inpatient Treatment

- (1) Daily Semi-Private Room and Board charges;
- (2) Intensive Care Unit (ICU) and Cardiac Care Unit (CCU) Room and Board charges;
- (3) General nursing services; and
- (4) Medically Necessary services and supplies furnished by the Hospital, other than Room and Board

b. Outpatient Treatment

- (1) Emergency room;
- (2) Treatment for chronic conditions;
- (3) Physical Therapy treatments;
- (4) Hemodialysis; and
- (5) X-ray, laboratory and linear therapy;

19. **Mastectomy.** The Federal Women's Health and Cancer Rights Act, signed into law on October 21, 1998, contains coverage requirements for breast cancer patients who elect reconstruction in connection with a Mastectomy. The Federal law requires group health plans that provide Mastectomy coverage to also cover breast reconstruction Surgery and prostheses following Mastectomy.

As required by law, you are being provided this notice to inform you about these provisions. The law mandates that individuals receiving benefits for a Medically Necessary Mastectomy will also receive coverage for:

- a. Reconstruction of the breast on which the Mastectomy has been performed;
 - b. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
 - c. Prostheses and physical complications from all stages of Mastectomy, including lymphedemas;
- in a manner determined in consultation with the attending Physician and the patient.

This coverage will be subject to the same annual Deductible and coinsurance provisions that currently apply to Mastectomy coverage, and will be provided in consultation with you and your attending Physician;

20. **Medical Supplies.** Dressings, casts, splints, trusses, braces and other Medically Necessary medical supplies, with the exception of dental braces or corrective shoes, but including syringes for diabetic and allergy diagnosis, and lancets and chemstrips for diabetics;

21. **Newborn Care.** Hospital and Physician nursery care for Newborns who are natural children of the Employee or spouse and properly enrolled in the Plan, as set forth below. Hospital charges for well baby care for a newborn are considered to be eligible charges of the mother during the Hospital stay.

- a. Hospital routine care for a Newborn during the child's initial Hospital Confinement at birth; and
- b. The following Physician services for well-baby care during the Newborn's initial Hospital Confinement at birth:
 - (1) The initial Newborn examination and a second examination performed prior to discharge from the Hospital; and
 - (2) Circumcision.

NOTE: The Plan will cover Hospital and Physician nursery care for an ill Newborn as any other medical condition, provided the Newborn is properly enrolled in the Plan. These benefits are provided under the baby's coverage;

22. **Nursing Services.** Services of a Registered Nurse or Licensed Practical Nurse;
23. **Occupational Therapy.** Treatment or services rendered by a registered occupational therapist, under the direct supervision of a Physician, in a home setting or at a facility or institution whose primary purpose is to provide medical care for an Illness or Injury, or at a free-standing Outpatient facility;
24. **Oral Surgery.** Oral Surgery in relation to the bone, including tumors, cysts and growths, not related to the teeth and extraction of soft tissue impacted teeth by a Physician or Dentist, correction of congenital anomaly in a child who was covered under the Plan from birth;
25. **Osseous Surgery.** Charges for osseous Surgery;
26. **Pathology Services.** Charges for Pathology Services;
27. **Physical Therapy.** Treatment or services rendered by a physical therapist, under direct supervision of a Physician, in a home setting or a facility or institution whose primary purpose is to provide medical care for an Illness or Injury, or at a free-standing duly licensed Outpatient therapy facility;
28. **Physician Services.** Services of a Physician for Medically Necessary care, including office visits, Hospital Inpatient care, Hospital Outpatient visits and exams, clinic care, surgical opinion consultations and stand-by services for a Pediatrician for Caesarean section;
29. **Preferred Provider Organization.** A current list of PPO Providers is available on the Network website: www.advantagecarenetwork.com. Each participant has a free choice of any physician and surgeon and the physician/patient relationship shall be maintained. The participant, together with his or her physician, is ultimately responsible for determining the appropriate course of medical treatment, regardless of whether the plan will pay for all or a portion of the cost of such care. The network does not participate in the patient/provider relationship. The participating providers listed in this directory are independent contractors and are not employees of the network. This list of PPO Providers is subject to change;
30. **Pregnancy Expenses.** Dependent wife or dependent daughter are eligible for coverage for any expenses in connection with Pregnancy;

Under the Newborns' and Mothers' Health Protection Act of 1996, group health plans and health insurance issuers generally may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn Child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a Provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). In no event will an "attending provider" include a plan, hospital, managed care organization, or other issuer.

Benefits are payable in the same manner as for medical or Surgical care of an Illness, shown in the "Summary of Benefits" and this section, and subject to the same maximums;

31. **Preventive Care.** Charges for preventive care services;
32. **Private Duty Nursing.** Private duty nursing (outpatient only);

33. **Prosthetics, Orthotics, Supplies and Surgical Dressings.** Prosthetic devices (other than dental) to replace all or part of an absent body organ or part, including replacement due to natural growth or pathological change, but not including charges for repair or maintenance. Orthotic devices, but excluding orthopedic shoes and other supportive devices for the feet;
34. **Radiation Therapy.** Charges for radiation and dialysis therapy and treatment;
35. **Respiration Therapy.** Respiration therapy services, when rendered in accordance with a Physician's written treatment plan;
36. **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.
37. **Second Surgical Opinions.** Charges for second surgical opinions;
38. **Self-Inflicted Injuries.** 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.
39. **Skilled Nursing Facility.** Charges made by a Skilled Nursing Facility or a Convalescent Care Facility, up to the limits set forth in the Summary of Benefits, in connection with convalescence from an Illness or Injury (excluding drug addiction, chronic brain syndrome, alcoholism, senility, mental retardation or other Mental or Nervous Disorders) for which the Plan Participant is confined;
40. **Speech Therapy.** Speech therapy by a Physician or qualified speech therapist, when needed due to a Sickness or Injury (other than a functional nervous disorder) or due to surgery performed as the result of a Sickness or Injury, excluding Speech Therapy services that are educational in any part or due to articulation disorders, tongue thrust, stuttering, lisping, abnormal speech development, changing an accent, dyslexia, hearing loss which is not medically documented or similar disorders;
41. **Sterilization.** Charges related to sterilization procedures;
42. **Surgery.** Surgical operations and procedures, unless otherwise specifically excluded under the Plan, and limited as follows:
 - a. Multiple procedures adding significant time or complexity will be allowed at:
 - (1) 100% of the full Usual and Customary Fee value for the first or major procedure;
 - (2) 50% of the Usual and Customary Fee value for the secondary and subsequent procedures;
 - b. Bilateral procedures which add significant time or complexity, which are provided at the same operative session, will be allowed at 100% of Usual and Customary Fee value for the major procedure, and 50% of the Usual and Customary Fee value for the secondary or lesser procedure;
 - c. Charges made for services rendered by an assistant surgeon will be allowed at 20% of the Usual, and Customary Fee value for the type of surgery performed;
 - d. No benefit will be payable for incidental procedures, such as appendectomy during an abdominal Surgery, performed during a single operative session;
43. **Surgical Treatment of Jaw.** Surgical treatment of Diseases, Injuries, fractures and dislocations of the jaw by a Physician or Dentist, correction of congenital anomaly in a child who was covered under the Plan from birth;

44. **Transplants.** Organ or tissue transplants are covered for the following human to human organ or tissue transplant procedures:

- a. Bone marrow;
- b. Heart;
- c. Lung;
- d. Heart and lung;
- e. Liver;
- f. Pancreas;
- g. Kidney; and
- h. Cornea.

In accordance with Health Care Reform, Transplants must comply with the Essential Health Benefits under section 1302(b) of the Patient Protection and Affordable Care Act.

Covered expenses will be considered the same as any other Sickness for Plan Participant's or Dependents as a recipient of an organ or tissue transplant. Covered expenses include:

- a. Organ or tissue procurement from a cadaver consisting of removing, preserving and transporting the donated part;
- b. Services and supplies furnished by a Provider; and
- c. Drug therapy treatment to prevent rejection of the transplanted organ or tissue.

44. **Utilization Management.** Failure to comply with Utilization Management will result in a higher cost to Participants. **"Utilization Management"** includes hospital pre-admission certification, continued stay review, length-of-stay determination and discharge planning. These programs are designed to ensure that Medically Necessary, high-quality patient care is provided and enables maximum benefits under the Plan. See pre-certification requirements in the section entitled "Cost Containment."

The following services will require pre-certification

- Inpatient Hospitalization;
- Transplant evaluations and procedures (organ and/or tissue);
- Home Health Services;
- Durable Medical Equipment in excess of \$1,000 billed per date of service;
- Emergency admissions within 24 hours after the services are provided;
- Transfers to a NICU within 24 hours of the infant's transfer;
- Physical Therapy, Occupational Therapy, Speech Therapy or Cognitive Therapy;
- Inpatient Mental/Nervous facility based programs;
- Inpatient Substance Abuse facility based programs;
- Hospice Care;
- Endovascular procedures;
- Chemotherapy;
- PET Scan;
- Sclerotherapy

14.02 Mental Health and Substance Abuse Benefits

The Plan shall conform to the Mental Health Parity and Addiction Equity act of 2008, as amended. For further details, contact the Claims Administrator.

14.03 Inpatient Benefits

Subject to the limitations contained in the Summary of Benefits, the Plan will pay covered expenses for:

1. Semi-private hospital Room and Board;
2. Miscellaneous facility charges on days a Room and Board charge is covered;
3. Individual psychotherapy;
4. Group psychotherapy;
5. Psychological testing;
6. Family counseling; and
7. Convulsive therapy treatment.

The benefits above are also available when receiving treatment during the day only or during the night only at a day/night Psychiatric Hospital or at a Substance Abuse Treatment Center and/or Rehabilitation Hospital.

14.04 Outpatient Benefits

Subject to the limitations contained in the Summary of Benefits, the Plan will pay covered expenses for:

1. Individual psychotherapy;
2. Group psychotherapy;
3. Psychological testing;
4. Family counseling;
5. Convulsive therapy treatment; and
6. Prescription drugs or medicines for the treatment of mental illness or chemical dependency.

ARTICLE 15

GENERAL LIMITATIONS AND EXCLUSIONS

Exclusions 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 Expenses. This is not an exhaustive list of limitations or exclusions.

1. **Abortion.** Expenses incurred directly or indirectly as the result of an abortion except when the life of the mother would be threatened if the fetus were carried to term, or when complications arise;
2. **Acupuncture.** Charges relating directly or indirectly to acupuncture;
3. **Alopecia.** For the services and/or supplies related to the treatment of alopecia;
4. **Assistant Surgeon.** For assistant surgeon fees in excess of 20% of the reasonable and customary charge for the surgeon;
5. **Biofeedback.** Biofeedback;
6. **Broken Appointments.** For broken appointments;
7. **Caretaker.** For homemaker or caretaker services;
8. **Chelation Therapy.** Services and supplies;
9. **Completion of Claim Form.** Charges for completion of a claim form or charges for failure to keep a scheduled visit,;
10. **Cosmetic Surgery.** Charges for Cosmetic Surgery with the following exceptions:
 - a) Treatment provided for the correction of defects incurred in an accidental injury sustained by the participant; or
 - b) Treatment provided for reconstructive surgery following cancer surgery; or
 - c) Surgery performed on a newborn child for the treatment or correction of a congenital defect; or
 - d) Surgery performed on a covered dependent child (other than a newborn child) under the age of 19 for the treatment or correction of congenital defect other than conditions of the breast; or
 - e) Reconstruction of the breast on which a mastectomy has been performed; surgery and reconstruction of the other breast to achieve a symmetrical appearance; and prosthesis and treatment of physical complications, including lymphedemas, at all stages of the mastectomy; or
 - f) Reconstructive surgery performed on a covered dependent child under the age of 19 due to craniofacial abnormalities to improve the function of, or attempt to create a normal appearance of an abnormal structure caused by a congenital defect, developmental deformities, trauma, tumors, infections, or disease.
11. **Custodial Care.** Custodial Care, domiciliary care or rest cures, or home health care except as specifically provided herein;

12. **Donor.** 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;
13. **Dental Expenses.** For dental expenses except as shown in this section titled Teeth Irregularities;
14. **Education or Training Program.** Services performed by a Physician or other Provider enrolled in an education or training program when such services are related to the education or training program, except as specifically provided herein;
15. **Estate Planning.** Charges for financial or legal counseling, drafting a will or estate planning;
16. **Eyeglasses, Contacts, and Refractions.** Charges for eyeglasses, contacts, or examination for prescription or fitting of eyeglasses or contact lenses. Eye refractions (except for aphakic patients, and soft lenses or sclera shells intended for use in the treatment of Disease or Injury);
17. **Family.** Services rendered by a member of the Covered Person's family to include grandparents, parents, brothers, sisters, cousins, aunts, uncles, nieces, nephews or similar in-laws related by marriage to the Covered Person;
18. **Felony.** Injury resulting from the commission or an attempt to commit a felony;
19. **Foot.** Charges for routine foot care;
20. **Funeral.** Charges for funeral arrangements;
21. **Government.** That are expenses to the extent paid, or which the Participant is entitled to have paid or obtain without cost, in accordance with the laws or regulations of any government;
22. **Hair Pieces.** Wigs, artificial hair pieces, human or artificial hair transplants, or any drug, prescription or otherwise, used to eliminate baldness, services and supplies related to the treatment of alopecia; except as related to loss of hair due to chemotherapy.
23. **Health Care Provider.** Provider who is not legally licensed to provide these services or supplies in the United States. Health Care Provider must be located within the United States in order for charges to be considered. This exclusion may be waived in an accident or life-threatening emergency;
24. **Hearing Devices.** Hearing aids or examinations for the prescription or fitting of hearing aids;
25. **Hypnosis.** For treatment by hypnosis, except as part of the physicians treatment of a mental illness or when hypnosis is used in lieu of an anesthetic;
26. **Impregnation and Infertility Treatment.** Following charges related to Impregnation and Infertility Treatment or any reversal of sterilization procedures or surgery;
27. **Incurred by Other Persons.** For expenses actually incurred by other persons;
28. **Massage Therapy.** Charges for massage therapy services;
29. **Medicare.** For benefits that are provided, or which would have been provided had the Participant enrolled, applied for, or maintained eligibility for such care and service benefits, under Title XVIII of the Federal Social Security Act of 1965 (Medicare), including any amendments thereto, or under any Federal law or regulation, except as provided in the sections entitled "Coordination of Benefits" and "Medicare"

30. **Negligence.** For injuries resulting from negligence, misfeasance, malfeasance, nonfeasance or malpractice on the part of any licensed Physician;
31. **No Legal Obligation.** That are provided to a Participant for which the Provider of a service customarily makes no direct charge, or for which the Participant is not legally obligated to pay, or for which no charges would be made in the absence of this coverage, including but not limited to fees, care, supplies, or services for which a person, company or any other entity except the Participant or this benefit plan, may be liable for necessitating the fees, care, supplies, or services;
32. **Non-Medically Necessary.** Treatment which is not medically necessary for the care and treatment of any injury or illness;
33. **Non-Prescription Drugs.** Charges for non-prescription drugs;
34. **Not Acceptable.** That are not accepted as standard practice by the AMA, ADA, or the Food and Drug Administration;
35. **Not Actually Rendered.** That are not actually rendered;
36. **Not Specifically Covered.** That are not specifically covered under this Plan;
37. **Obesity.** Expenses related to obesity, morbid obesity, weight reduction or dietetic control;
38. **Oral Surgery.** Oral Surgery or dental treatment, except as specifically provided in the Plan;
39. **Organ Transplants.** Expenses related to donation of a human organ or tissue, except as specifically provided;
40. **Orthopedic Shoes.** Orthopedic shoes, unless they are an integral part of a leg brace and the cost is included in the orthotist's charge, and other supportive devices for the feet;
41. **Personal Convenience Items.** Equipment that does not meet the definition of Durable Medical Equipment, including air conditioners, humidifiers and exercise equipment, whether or not recommended by a Physician;
42. **Prior to Coverage.** That are rendered or received prior to any period of coverage;
43. **Private Duty Nursing.** For private duty nursing services in a hospital setting;
44. **Prohibited by Law.** To the extent that payment under this plan is prohibited by any law of the jurisdiction in which the Plan Participant or dependent resides at the time the expenses or incurred;
45. **Provider Error.** Required as a result of unreasonable provider error;
46. **Radial Keratotomy.** Radial keratotomy or other plastic surgeries on the cornea in lieu of eyeglasses;
47. **Reasonable and Customary.** For charges which are in excess of reasonable and customary charges, as established by the Claims Administrator, or for charges for unnecessary care or treatment;
48. **Remediation Therapy.** For remediation therapy services;
49. **Respite Care.** Charges for respite care;
50. **Rolfing Services.** Charges for Rolfing services;

51. **Sex Change Operation.** Expenses related to a sex change operation or treatment of sexual dysfunction not related to organic disease;
52. **Taxes.** For any city or state taxes charged for services and supplies.
53. **Teeth Irregularities.** 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:
- (a) 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
 - (b) For excision of impacted unerupted teeth or of a tumor or cyst, or incision and drainage of an abscess or cyst, or
 - (c) For any other oral surgical procedure not involving any tooth structure, alveolar process, or gingival tissues, or
 - (d) For correction of a birth defect of a child.
54. **Temporomandibular Joint Disorder.** Charges for the diagnosis and treatment of, or in connection with, temporomandibular joint disorders, myofascial pain dysfunction or orthognathic treatment;
55. **Timely Filing.** For expenses which are submitted after March 31st of the given calendar year for services or supplies, which were incurred in the prior calendar year;
56. **Travel.** Travel, whether or not recommended by a Physician, except as specifically provided herein;
57. **Unrelated Services.** For services and supplies not related to the diagnosed illness or injury, which is being treated;
58. **Vitamins.** Vitamins, vitamin B-12 except when used for Pernicious Anemia or Crohn's Disease;
59. **Vocational Therapy.** For charges for vocational therapy;
60. **War.** Injury or sickness resulting from declared war;
61. **Worker's Compensation.** Injury or sickness 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;

ARTICLE 16

PRESCRIPTION DRUG BENEFITS

The County of El Paso contracts with a Pharmacy Benefit Manager (PBM) to manage its pharmacy benefits program. In 2013, the County's PBM is Medco Health Solutions (Medco). Check with the Plan Administrator or Claims Administrator to confirm the current PBM.

Prescription Drug Benefits 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.

The Schedules of Benefits outline the Co-payments, Coinsurance amounts and any applicable Deductibles that apply to the covered Prescription Drug Expenses described below.

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-payment** 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. Selecting a Pharmacy

Preferred Retail Pharmacy

When you go to a Participating Preferred Pharmacy:

- present your Identification Card to the pharmacist along with your Prescription Order,
- provide the pharmacist with the birth date and relationship of the patient,
- sign the insurance claim log.

Participating Preferred Pharmacies have agreed to accept as payment in full the least of:

- the billed charges, or
- the Allowable Amount as determined by Medco, or
- other contractually determined payment amounts.

You are responsible for paying any Deductibles, Copayment Amounts and any pricing differences, when applicable. You may be required to pay for limited or non-covered services. No claim forms are required.

If you are unsure whether a Pharmacy is a Participating Preferred Pharmacy, you may access the Medco website at www.medco.com or contact the Medco Customer Service team at 1-800-711-0917 or toll-free number shown on your Identification Card.

Mail-Order Pharmacy

The mail-order program provides delivery of Covered Drugs directly to your home address. If you and your covered Dependents elect to use the mail-order service, refer to your Schedule of Benefits for applicable payment levels.

Some drugs may not be available through the mail-order program. If you have any questions about this mail-order program, need assistance in determining the amount of your payment, or need to obtain the mail-order prescription form, you may access the website at www.medco.com or contact Medco Customer Service team at 1-800-711-0917 or the toll-free number on your Identification Card. Mail the completed form, your Prescription Order(s) and payment to the address indicated on the form.

B. 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
- the PBM.

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-Payment. 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.

C. Limitations

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, the PBM 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.

Note: 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 the PBM 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.

D. Prior Authorization or Pre-Certification for Certain Prescription Drugs

Prior Authorization or Pre-Certification of the necessity of certain **prescription drugs** is required before the drug is dispensed by a **pharmacy**. Coverage for certain designated prescription drugs is subject to prior authorization criteria. This means that in order to ensure that a drug is safe, effective, and part of a specific treatment plan, certain medications may require prior authorization and the evaluation of additional clinical information before dispensing.

When you submit a Prescription Order to a Preferred Pharmacy for one of these designated medications, the Pharmacist will be alerted online if your Prescription Order is on the list of medication which requires Prior Authorization or Pre-certification before it can be filled. If this occurs, your Health Care Practitioner will be required to submit an authorization form. This form may also be submitted by your Health Care Practitioner in advance of the request to the Pharmacy. The Health Care Practitioner can obtain the authorization form by accessing the Medco website at www.medco.com or contacting Medco's Provider Line at 1-800-753-2851. The requested medication may be approved or denied for coverage under the Plan based upon its accordance with established clinical criteria.

It is your responsibility to arrange for the **prescriber** of the drug to contact the PBM 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.

E. Preferred Drug Step Therapy

Coverage for certain designated prescription drugs may be subject to a step therapy program. Step therapy programs favor the use of clinically acceptable alternative medications or preferred drugs that may be less costly for you prior to those medications on the step therapy list of drugs being covered under the Plan. When you submit a Prescription Order to a Participating Pharmacy for one of these designated medications, the Pharmacist will be alerted if the online review of your prescription claims history indicates an acceptable alternative medication has not been

previously tried. A toll free number is provided for your Health Care Practitioner to call and obtain additional program and criteria information. A list of step therapy medications and possible alternatives are available to you and your Health Care Practitioner on the Medco website at www.medco.com.

F. Quantity Duration or Quantity Limits

The maximum quantity of a given prescription drug indicates the number of units to be dispensed and is determined based on pertinent medical information and clinical efficacy and safety. Quantities of some drugs are restricted regardless of the quantity ordered by the Health Care Practitioner. To determine if a specific drug is subject to this limitation, you may access the Medco website at www.medco.com or contact Medco's Customer Service team at 1-800-711-0917 or the toll-free number on your Identification Card.

If a Prescription Order is written for a certain quantity of medication to be taken in a time period directed by a Health Care Practitioner, the Prescription Order will only be covered for a clinically appropriate pre-determined quantity of medication for the specified amount of time. Dispensing limits are based upon FDA dosing recommendations and nationally recognized clinical guidelines.

If you require a Prescription Order in excess of the established dispensing, ask your Health Care Practitioner to submit a request for clinical review on your behalf. The Health Care Practitioner can obtain an override request form by accessing the Medco website at www.medco.com or by contacting Medco's Provider Line at 1-800-753-2851. The request will be approved or denied after evaluation of the submitted clinical information.

The following list of prescription drugs is subject to change but describes certain prescription drugs subject to Quantity Duration or Quantity Limits at either a retail or the mail order pharmacy:

Hypnotic Agents:

- Ambien (zolpidem)
- Ambien CR (zolpidem)
- Edluar (zolpidem sublingual)
- Lunesta (eszopiclone)
- Rozerem(ramelteon)
- Sonata (zaleplon)
- Silenor (doxepin)
- Zolpimist (zolpidem oral spray)

G. General Exclusions Applicable to Prescription Drug Expense Coverage

Coverage is not provided for the following **prescription drug** charges:

- Those that are not prescribed by the Covered Person's **physician** or **dentist**.
- Those, as determined by the PBM, 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 the PBM 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 the PBM, 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.

H. 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) Compound Drugs

Drugs that have been measured and mixed with U. S. Food and Drug Administration (FDA)–approved pharmaceutical ingredients by a pharmacist to produce a unique formulation that is Medically Necessary because commercial products either do not exist or do not exist in the correct dosage, size, or form. The drugs used must meet the following requirements:

1. The drugs in the compounded product are Food and Drug Administration (FDA) approved;
2. The approved product has an assigned National Drug Code (NDC); and
3. The primary active ingredient is a Covered Drug under the Plan.

(3) 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.

(4) Custodial Care

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.

(5) Dentist

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

(6) Emergency Condition

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 the PBM, reasonably be expected to result in:

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

(7) Generic Drug

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

(8) Mail Order Pharmacy

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

(9) Medication Formulary

A listing of **prescription drugs** which have been evaluated and selected by the PBM 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 the PBM. .

(10) Necessary

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

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.

In determining if a service or supply is appropriate under the circumstances, the PBM 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 the PBM's attention.

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 Health Care 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.

(11) Non-Occupational Disease

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.

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.

(12) Non-Occupational Injury

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.

(13) Non-Preferred Pharmacy

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

(14) Pharmacy

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

(15) Physician

This means a legally qualified physician.

(16) Preferred Pharmacy

A **pharmacy**, including a **mail order pharmacy**, which is party to a contract with the PBM 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 the PBM.

(17) 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**.

(18) 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**.

(19) Prescription Drugs

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.

(20) Reasonable Charge

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 the PBM 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 the PBM determines to be the prevailing charge level made for the drug in the geographic area where it is dispensed.

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;

the PBM 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.

I. Preventive Care Drugs (for the CDHP or CDH Plan)

Prescription drugs that can help keep you from developing a health condition are called preventive prescription drugs. They can help you maintain your quality of life and avoid expensive treatment, healing to reduce your overall healthcare costs.

If your doctor prescribes a preventive prescription drug on this list, it will be covered at 0% coinsurance, with a copay before you have met your deductible.

The following is a list of the most commonly prescribed preventive drug types. The list is not all-inclusive and does not guarantee coverage.

- Ace Inhibitors (hypertension, diabetes)
- Antihyperlipidemics (high cholesterol)
- Beta-Blockers (hypertension)
- Angiotensin II Receptor Antagonists (hypertension)
- Diuretics (hypertension)
- Miscellaneous Antihypertensives (hypertension)
- Direct Renin Inhibitor (hypertension)
- Antiadrenergic Antihypertensives (hypertension)
- Calcium Channel Blockers (heart disease, hypertension)
- Blood Thinning Agents (stroke prevention)
- Antiasthmatics (asthma)
- Asthma Supplies (asthma)
- Antidiabetic Drugs (diabetes)
- Diabetic Supplies (diabetes)
- Osteoporosis Drugs (osteoporosis)
- Pediatric Vitamins with Fluoride
- Prenatal Multivitamins with Iron and Folic Acid
- Contraceptives

ARTICLE 17

COST CONTAINMENT

17.01 Pre-Certification Procedures. The Covered Person must obtain Pre-certification from the Claims Administrator for the following covered services, procedures or supplies in order to receive Coverage Failure to receive the required pre-certification will result in loss of coverage for the service, procedure or supply:

Urgent Care or Emergency Admissions:

If a Participant needs medical care for a condition which could seriously jeopardize his or her life, obtain such care without delay, and communicate with the Plan as soon as reasonably possible.

If a Participant must be admitted on an Emergency basis, the Participant should follow the Physician's instructions carefully and contact the pre-certification department as follows:

1. For Emergency admissions after business hours on Friday, on a weekend or over a holiday weekend, a call to the pre-certification department must be made within 72 hours after the admission date, but no later than the first business day following the Emergency admission, by or on behalf of the covered patient; and
2. For Emergency admissions on a weekday, a call to the pre-certification department must be made within 24 hours after the admission date.

The Plan does not require the Participant to obtain approval of a medical service prior to getting treatment for an urgent care or emergency situation, so there are no "Pre-service Urgent Care Claims" under the Plan. The Participant simply follows the Plan's procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a Post-service Claim.

Non-emergency Admissions:

For Inpatient Hospital stays that are scheduled in advance, a call to the pre-certification department should be completed as soon as possible before actual services are rendered. Once the pre-certification call is received, it will be routed to an appropriate review specialist who will create an on-line patient file. The review specialist will contact the Participant's attending Physician to obtain information and to discuss the specifics of the admission request. An on-line expert system that features state-of-the-art, widely accepted clinical review criteria is used to effectively guide the review process. If appropriate, alternative care will be explored with the Physician.

If, after assessing procedure necessity, the need for an Inpatient confinement is confirmed, the review specialist will determine the intensity of management required and will remain in contact with the Physician or Hospital during the confinement.

If, at any time during the review process, Medical Necessity cannot be validated, the review specialist will refer the episode to a board-certified Physician advisor who will immediately contact the attending Physician to negotiate an appropriate treatment plan. At the end of the Hospital confinement, the review specialist is also available to assist with discharge planning and will work closely with the attending Physician and Hospital to ensure that medically appropriate arrangements are made.

17.02 Alternate Course of Treatment

Certain types of conditions, such as spinal cord Injuries, cancer, AIDS or premature births, may require long-term, or perhaps lifetime, care.

If the Plan Administrator should determine that an alternate course of treatment is appropriate, and if the attending Physician agrees to the alternate course of treatment, all Medically Necessary expenses stated in the treatment plan will be eligible for payment under the Plan, even if these expenses normally would not be eligible for payment under the Plan. In the event the Participant and the attending Physician select an alternative course of treatment, coverage under the Plan will be based upon the charge allowed for the alternate course of treatment.

ARTICLE 18

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 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.

18.01 Dental Definitions

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 Health Care Providers shall not be Eligible.

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.

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.

Benefits Payable.

If, because of a non-occupational condition, a Covered Person, 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 "Schedule of Dental Benefits".

Incurred Date

The date the service is received.

Deductible.

The Deductible amount is the dollar amount of Covered Expenses, which must be paid by the Covered Person before reimbursement for any additional Covered Expenses can be paid. The deductible applies separately to each Covered Person in each calendar year, subject to the following:

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.

Dental Implant.

An artificial tooth that is anchored in the gums or jawbone to replace a missing tooth.

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 "Schedule of Dental Benefits".

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 "Covered Dental Expenses".

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.

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:

- a) Itemizes the dentist's recommended services,
- b) Shows the dentist's charge for each service,
- c) Is accompanied by supporting x-rays or other diagnostic records where required or requested by the Plan Administrator.

Eligible Charge

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

- a) Is on the list of dental services,
- b) Is part of a "Treatment Plan" as described above, and
- c) Isn't listed in the "Dental Limitations, Extensions and Exclusions".

*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.

Incurred Charge.

A charge will be considered to be incurred:

- a) For an appliance or modification of an appliance - on the date the appliance is seated.
- b) For a crown, bridge or gold restoration - on the date the appliance is seated.
- c) For root canal therapy - on the date the pulp chamber is opened.
- d) For all other services - on the date the service is received.
- e) All other terms shall have the same meaning as specified in Section titled, "**Dental Definitions**".

18.02 Covered Expenses

The following is a brief description of the types of expenses that will be considered for coverage under the Plan, subject to the limitations contained in the Summary of Benefits. Charges must be for services and supplies customarily employed for treatment of the dental condition, and rendered in accordance with ADA accepted standards of practice. Coverage will be limited to Usual and Customary Fees.

Preventive Dental Service

- 1. Routine oral examinations and prophylaxis (cleaning, scaling and polishing teeth), two per calendar year;
- 2. Bitewing x-rays, two per calendar year;
- 3. Topical application of fluoride for Dependent Children under age 19, two per calendar year;

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);

Major Dental Services

All Major Dental Services require 12 months of continuous coverage in order for services to be covered.

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;
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. 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;
6. Implants

Orthodontic Services

1. Preliminary study, including cephalometric radiographs, diagnostic casts and treatment plan;
2. Interceptive, interventive or preventive orthodontic services;
3. Fixed and removable appliance placement, and active treatment per month after the first month; and
4. Extractions in connection with orthodontic services.

18.03 Dental Exclusions, Limitations and Extension

Extension of Dental 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.

The following exclusions and limitations are in addition to those set forth in the Articles entitled “General Limitations and Exclusions,” and “Schedule of Benefits.”

1. **Adjustments.** Charges for services to alter vertical dimension (work done or appliance used to increase the distance between nose and chin); to restore or maintain occlusion (work done or appliance used to change the way the top and bottom teeth meet or mesh); to replace tooth structure lost as a result of abrasion or attrition; for splinting; or for treatment of disturbances of the temporomandibular joint;
2. **Administrative Costs.** For administrative costs of completing claim forms or reports or for providing dental records;
3. **After the Termination Date.** The Plan will not pay for services or supplies furnished after the date coverage terminates, even if payments have been predetermined for a course of treatment submitted before the termination date. However, benefits for covered dental expenses incurred for the following procedures will be payable as though the coverage had continued in force:
 - a. A prosthetic device, such as full or partial dentures, if the Dentist took the impression and prepared the abutment teeth while the patient was a Participant in the Plan, and delivers and installs the device within two months following termination of coverage;
 - b. A crown, if the Dentist prepared the tooth for the crown while the patient was a Participant in the Plan, and installs the crown within two months following termination of coverage; and
 - c. Root canal therapy if the Dentist opened the tooth while the patient was a Participant in the Plan, and completes the treatment within two months following termination of coverage;

4. **Broken Appointments.** For charges for broken or missed dental appointments;
5. **Cosmetic.** Charges for cosmetic dental work. This includes, but is not limited to, characterization of dentures and services to correct congenital or developmental malformations. This exclusion will not apply to cosmetic work needed as a result of Accidental Injuries, but damage resulting from biting or chewing is not considered an Accidental Injury. This exclusion also does not apply to covered Orthodontic Treatment;
6. **Crowns.** For crowns for teeth that are restorable by other means or for the purpose of Periodontal Splinting;
7. **Education.** Charges for instruction in oral hygiene, plaque control or diet;
8. **Excess Charges.** Charges in excess of the Reasonable Charge for the service or supply received or charges in excess of any maximum payable under this Plan;
9. **Experimental.** Charges for Experimental dental care, implantology or dental care which is not customarily used or which does not meet the standards set by the American Dental Association;
10. **Government Provided.** Charges for dental care paid for or provided by the laws of any government or treatment given in a government-owned facility, unless the Employee or Dependent is legally required to pay;
11. **Immediate Relative.** Services rendered by a person who is an immediate relative of, or who ordinarily resides with, the Plan Participant requiring treatment. "Immediate relative" means spouse, child, brother, sister or parent of the Plan Participant, whether by birth, adoption or marriage;
12. **Miscellaneous.** The Plan does not cover any charge, service or supply which is:
 - a. For treatment other than by a Dentist or Physician, except:
 - (1) Cleaning, scaling and application of fluoride performed by a licensed dental hygienist under the supervision of a Dentist; and
 - (2) Non-experimental services performed at a dental school under the supervision of a Dentist, if the school customarily charges patients for its services;
 - b. For local infiltration anesthetic when billed for separately by a Dentist;
 - c. For personalization or characterization of dentures or veneers or any cosmetic procedures or supplies;
 - d. For oral hygiene or dietary instruction;
 - e. For a plaque control program (a series of instructions on the care of the teeth);
 - f. For implants, including any appliances and/or crowns and the surgical insertion or removal of implants;
 - g. For periodontal splinting;
 - h. For consultations, charges for failure to keep a scheduled visit, or charges for completion of a claim form;
 - i. For substances or agents which are administered to minimize fear, or charges for analgesia, unless the patient is handicapped by cerebral palsy, mental retardation or spastic disorder;
 - j. For replacement of a lost, missing or stolen prosthetic device;
 - k. Not equal to accepted standards of dental practice, including charges for services or supplies which are Experimental;
 - l. Paid, payable or required to be provided under any no-fault or equivalent automobile insurance law. Any uninsured motorist will be considered to be self-insured;
 - m. Charges for missed appointments or completion of claim forms;
 - n. Covered under the "Covered Medical Expenses" Article of the Plan; and

- o. Services performed by a Physician or other Provider enrolled in an education or training program when such services are related to the education or training program, except as specifically provided herein;
- 13. **Missing Appliances.** Charges for replacement of lost, missing or stolen appliances or prosthetic devices;
- 14. **No Coverage.** Services or supplies for which charges are incurred at a time when no coverage is in force for that person, or for which charges are incurred while coverage is in force, but final delivery is made more than 3 months after the date coverage for that person terminated;
- 15. **No Legal Obligation.** Charges for which the person has no legal obligation to pay, or for which no charge would be made in the absence of a Treatment Plan;
- 16. **No Listing.** For services which are not included in the list of covered dental services;
- 17. **Not Necessary.** Charges for unnecessary care, treatment, services or supplies, including replacement at any time of a bridge or denture which meets or can be made to meet commonly held dental standards of functional acceptability;
- 18. **Not Recommended.** Charges for services or supplies which are not recommended and approved by a Dentist or Physician;
- 19. **Occupational.** Charges for dental care which results from any employment or where the employee or dependent is entitled to benefits under any Workers' Compensation or similar law;
- 20. **Orthognathic Surgery.** For surgery to correct malpositions in the bones of the jaw;
- 21. **Personalization.** For expenses for services or supplies that are cosmetic in nature, including charges for personalization or characterization of dentures;
- 22. **Prior to Coverage.** An appliance, or modification where an impression for a crown, bridge or gold restoration was made or where root canal therapy began prior to coverage under this Plan.
- 23. **Replacements.** Charges for replacement made within five years after the last placement of any prosthetic appliance, crown, inlay or onlay restoration, or fixed bridge. This exclusion is waived if replacement is needed because the appliance, crown, inlay, onlay or bridge, while in the oral cavity, is damaged beyond repair due to Injury sustained by the Plan Participant. (Damage resulting from biting or chewing is not considered an Accidental Injury;)
- 24. **Single Provider Care.** In the event a Participant transfers from the care of one Provider to that of another during a course of treatment, or if more than one Provider performs services for one or more dental procedures, the Plan shall consider only such expense as would be appropriate had a single Provider performed the service. An appropriate expense in this case will be the Usual and Customary Fee;
- 25. **Space Maintainers.** Charges for duplicate space maintainers;
- 26. **Splinting.** For crowns, fillings or appliances that are used to connect (splint) teeth, or change or alter the way the teeth meet, including altering the vertical dimension, restoring the bite (occlusion) or are cosmetic; and
- 27. **War/Riot.** Charges for services or supplies needed as a result of war, declared or undeclared, or any act of war or act of aggression by any Country; or voluntary participation in a riot.

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.

18.03 Pre-determination of Dental Benefits

If a Participant's proposed course of treatment reasonably can be expected to involve dental charges of \$300 or more, a description of the procedures to be performed and an estimate of the charges therefore may be filed with the Claims Administrator prior to the commencement of the course of treatment. **However, approval is not required prior to treatment.** Any pre-determination of dental benefits is provided only as a convenience to the Participant.

If requested, the Claims Administrator will notify the Employee, and the Dentist or Physician, of the pre-determination based upon such proposed course of treatment. In determining the amount of benefits available, consideration will be given to alternate procedures, services, supplies and courses of treatment which may be performed to accomplish the required result. **The pre-determination is not a guarantee of payment or approval of a benefit. After treatment is received, a claim must be filed as a post-service claim, which will be subject to all applicable Plan provisions.**

ARTICLE 19

BENEFIT DETERMINATION

19.01 Timing of Claim Decisions

The Claims Administrator shall notify the claimant, in accordance with the provisions set forth below, of any adverse benefit determination within a reasonable period of time, but not later than 45 days after receipt of the claim by the Plan.

1. Extensions. This period may be extended by the Plan for up to 30 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial 45-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If, prior to the end of the first 30-day extension period, the Plan Administrator determines that, due to matters beyond the control of the Plan a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days, provided that the Plan Administrator notifies the claimant, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the Plan expects to render a decision. In the case of any extension, the notice of extension shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues.
2. Calculating Time Periods. The period of time within which a benefit determination is required to be made shall begin at the time a claim is deemed to be filed in accordance with the procedures of the Plan.
3. Requests for Additional Information. In the event the circumstances requiring an extension include the need for more information, the claimant must be allowed at least 45 days after receipt of the notice to provide this information. If the additional information is requested during the initial 45-day processing period, then the remainder of time left in the initial processing period is lost, and, upon receipt of the information, the first 30-day extension period begins to run. Similarly, if the additional information is requested during the first extension period, then the remainder of time left in the first extension period is lost, and, upon receipt of the information, the second 30-day extension period begins to run. If the additional information is requested during the second extension period, then the remainder of time left in the second extension period is lost, and the Plan must obtain the claimant's consent to additional time for processing the information provided.

19.02 Notification of an Adverse Benefit Determination

The Claims Administrator shall provide a claimant with written or electronic explanation of benefits stating that a claim is denied, in whole or in part, and advising the claimant of the right to appeal.

19.03 Appeals of Adverse Benefit Determinations

In accordance with the terms set forth in Article 9 , the following shall apply:

19.04 Full and Fair Review of All Claims

In cases where a claim for benefits is denied, in whole or in part, and the claimant believes the claim has been denied wrongly, the claimant may appeal the denial and review pertinent documents. The claims procedures of this Plan provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination, including the right, if necessary, to file two separate appeals. More specifically, the Plan provides:

1. Claimants at least 180 days following receipt of a notification of an adverse benefit determination within which to appeal the determination;
2. Claimants at least 45 days following receipt of a request for additional information to provide such information to the Plan;

3. Claimants the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;
4. For a review that affords no particular deference to the initial adverse benefit determination and that is conducted by the Plan Administrator or another appropriate named fiduciary of the Plan, who shall be neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;
5. For a review that takes into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.
6. That, in deciding an appeal of any adverse benefit determination that is based in whole or in part upon a medical judgment, the Plan Administrator or another appropriate named fiduciary of the Plan shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual;
7. For the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and
8. That a claimant will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits; information regarding any voluntary appeals procedures offered by the Plan; any rule, guideline, protocol or other similar criterion relied upon in making the adverse determination; and an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances.

19.05 First Appeal Level

Requirements for First Appeal

The claimant must file the first appeal in writing within 180 days following receipt of the notice of an adverse benefit determination. The claimant's appeal must be addressed as follows:

HealthSCOPE Benefits
ATTENTION: Appeals Department
P.O. Box 12609
El Paso, Texas 79913

Upon receipt, an appeal shall be deemed to be filed with the Plan provided all of the information listed below is included.

It shall be the responsibility of the claimant to submit proof that the claim for benefits is covered and payable under the provisions of the Plan. Any appeal must include:

1. The name of the employee/claimant;
2. The employee/claimant's social security number;
3. The group name or identification number;
4. All facts and theories supporting the claim for benefits. **Failure to include any theories or facts in the written appeal will result in their being deemed waived. In other words, the claimant will lose the right to raise factual arguments and theories which support his or her claim if he or she fails to include them in the written appeal;**
5. The reason or reasons for disagreement with the handling of the claim; and
6. Any material or information that the claimant has which indicates that the claimant is entitled to benefits under the Plan.

If the claimant provides all of the required information, it may be that the claimant will be eligible for disability benefits under the Plan.

Timing of Notification of Benefit Determination on First Appeal

The Claims Administrator shall notify the claimant of the Plan's benefit determination on review within a reasonable period of time, but no later than 23 days after receipt by the Plan of the claimant's request for review, unless the Claims Administrator determines that special circumstances require an extension of time for processing the claim.

1. Extensions. If the Claims Administrator determines that an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 23-day period. In no event shall such extension exceed a period of 23 days from the end of the initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the Plan expects to render the determination on review.
2. Calculating Time Periods. The period of time within which the Plan's determination is required to be made shall begin at the time an appeal is filed in accordance with the procedures of this Plan.
3. Requests for Additional Information. In the event the circumstances requiring an extension include the need for more information, the claimant must be allowed at least 45 days after receipt of the notice to provide this information. If the additional information is requested during the initial 23-day period, then the remainder of time left in that initial period is lost, and, upon receipt of the information, the 23-day extension period begins to run. If the additional information is requested during the 23-day extension period, then the remainder of time left in the extension period is lost, and the Plan must obtain the claimant's consent for an extension of time to process the additional information once it is received by the Plan.

Manner and Content of Notification of Adverse Benefit Determination on First Appeal

The Claims Administrator shall provide a claimant with written or electronic notification of a Plan's adverse benefit determination on review, setting forth:

1. The specific reason or reasons for the denial;
2. Reference to the specific portion(s) of the Summary Plan on which the denial is based;
3. A description of any additional information necessary for the claimant to perfect the claim and an explanation of why such information is necessary;
4. A description of the Plan's review procedures and the time limits applicable to the procedures;
5. The identity of any medical or vocational experts consulted in connection with the claim, even if the Plan did not rely upon their advice;
6. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits;
7. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request;
8. If the adverse benefit determination is based upon a medical judgment, a statement that an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be provided free of charge upon request;
9. A statement that the Plan does not offer any voluntary appeal procedures;
10. A statement of the claimant's right to bring an action in the event of an adverse benefit determination following a second appeal; and
11. The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

Furnishing Documents in the Event of an Adverse Determination

In the case of an adverse benefit determination on review, the Claims Administrator shall provide such access to, and copies of, documents, records, and other information described in the section entitled “Manner and Content of Notification of Adverse Benefit Determination on First Appeal” as appropriate.

19.06 Second Appeal Level

Adverse Decision on First Appeal; Requirements for Second Appeal

If, for any reason, the claimant does not receive a written response within the appropriate time period set forth above, the claimant may assume that the first appeal has been denied. Upon expiration of that time period without receipt of a written decision or upon receipt of notice of the Plan’s adverse decision regarding the first appeal, the claimant has 60 days to file a second appeal of the denial of benefits. The claimant again is entitled to a “full and fair review” of any denial made at the first appeal, which means the claimant has the same rights during the second appeal as he or she had during the first appeal. As with the first appeal, the claimant’s second appeal must include all of the items set forth in the section entitled “Requirements for First Appeal.”

The Plan Administrator shall notify the claimant of the Plan’s benefit determination on review within a reasonable period of time, but no later than 22 days after receipt by the Plan of the claimant’s request for review, unless the Plan Administrator determines that special circumstances require an extension of time for processing the claim.

1. Extensions. If the Plan Administrator determines that an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 22-day period. In no event shall such extension exceed a period of 22 days from the end of the initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the Plan expects to render the determination on review.
2. Calculating Time Periods. The period of time within which the Plan’s determination is required to be made shall begin at the time the second appeal is filed in accordance with the procedures of this Plan.
3. Requests for Additional Information. In the event the circumstances requiring an extension include the need for more information, the claimant must be allowed at least 45 days after receipt of the notice to provide this information. If the additional information is requested during the initial 22-day period, then the remainder of time left in that initial period is lost, and, upon receipt of the information, the 22-day extension period begins to run. If the additional information is requested during the 22-day extension period, then the remainder of time left in the extension period is lost, and the Plan must obtain the claimant’s consent for an extension of time to process the additional information once it is received by the Plan.

Manner and Content of Notification of Adverse Benefit Determination on Second Appeal

The same information must be included in the Plan’s response to a second appeal as a first appeal, except for:

1. A description of any additional information necessary for the claimant to perfect the claim and an explanation of why such information is needed; and
2. A description of the Plan’s review procedures and the time limits applicable to the procedures.

See the section entitled “Manner and Content of Notification of Adverse Benefit Determination on First Appeal.”

Furnishing Documents in the Event of an Adverse Determination

In the case of an adverse benefit determination on the second appeal, the Plan Administrator shall provide such access to, and copies of, documents, records, and other information described in the section entitled “Manner and Content of Notification of Adverse Benefit Determination on First Appeal,” as is appropriate.

Decision on Second Appeal to be Final

If, for any reason, the claimant does not receive a written response to the second appeal within the appropriate time period set forth above, the claimant may assume that the second appeal has been denied. The decision by the Plan Administrator or other appropriate named fiduciary of the Plan on review will be final, binding and conclusive and will be afforded the maximum deference permitted by law. **All claim review procedures provided for in the Plan must be exhausted before any legal action is brought. Any legal action for the recovery of any benefits must be commenced within one year after the Plan's claim review procedures have been exhausted.**

19.07 Standard External Review

A. Standard external review

Standard external review is external review that is not considered expedited (as described in paragraph B of this section).

1. Request for external review. The Plan will allow a claimant to file a request for an external review with the Plan if the request is filed within four (4) months after the date of receipt of a notice of an adverse benefit determination or final internal adverse benefit determination. If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.
2. Preliminary review. Within five (5) business days following the date of receipt of the external review request, the Plan will complete a preliminary review of the request to determine whether:
 - (a) The claimant is or was covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided;
 - (b) The adverse benefit determination or the final adverse benefit determination does not relate to the claimant's failure to meet the requirements for eligibility under the terms of the Plan (e.g., worker classification or similar determination);
 - (c) The claimant has exhausted the Plan's internal appeal process unless the claimant is not required to exhaust the internal appeals process under the interim final regulations; and
 - (d) The claimant has provided all the information and forms required to process an external review.Within one (1) business day after completion of the preliminary review, the Plan will issue a notification in writing to the claimant. If the request is complete but not eligible for external review, such notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, such notification will describe the information or materials needed to make the request complete and the Plan will allow a claimant to perfect the request for external review with the four-month filing period or within the 48 hour period following the receipt of the notification, whichever is later.
3. Referral to Independent Review Organization. The Plan will assign an independent review organization (IRO) that is accredited by URAC or by a similar nationally-recognized accrediting organization to conduct the external review. Moreover, the Plan will take action against bias and to ensure independence. Accordingly, the Plan will contract with (or direct the Claims Processor to contract with, on its behalf) at least three (3) IROs for assignments under the Plan and rotate claims assignments among them (or incorporate other independent unbiased method for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.
4. Reversal of Plan's decision. Upon receipt of a notice of a final external review decision reversing the adverse benefit determination or final internal adverse benefit determination, the Plan immediately will

provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

B. Expedited external review

1. Request for expedited external review. The Plan will allow a claimant to make a request for an expedited external review with the Plan at the time the claimant receives:
 - (a) An adverse benefit determination if the adverse benefit determination involves a medical condition of the claimant for which the timeframe for completion of a standard internal appeal under the interim final regulations would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function and the claimant has filed a request for an expedited internal appeal; or
 - (b) A final internal adverse benefit determination, if the claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services, but has not been discharged from a facility.
2. Preliminary review. Immediately upon receipt of the request for expedited external review, the Plan will determine whether the request meets the reviewability requirements set forth in paragraph A.2 above for standard external review. The Plan will immediately send a notice that meets the requirements set forth in paragraph A.2 above for standard external review to the claimant of its eligibility determination.
3. Referral to independent review organization. Upon a determination that a request is eligible for external review following the preliminary review, the Plan will assign an IRO pursuant to the requirements set forth in paragraph A.3 above for standard review. The Plan will provide or transmit all necessary documents and information considered in making the adverse benefit determination or final internal adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO will review the claim de novo and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.
4. Notice of final external review decision. The Plan's (or Claim Processor's) contract with the assigned IRO will require the IRO to provide notice of the final external review decision, in accordance with the requirements set forth in paragraph A.3 above, as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO will provide written confirmation of the decision to the claimant and the Plan.

19.08 Payment of Benefits

All benefits under this Plan are payable, in U.S. Dollars, to the claimant. In the event of the death or incapacity of a claimant and in the absence of written evidence to this Plan of the qualification of a guardian for his or her estate, this Plan may, in its discretion, make any and all such payments to the individual or institution which, in the opinion of this Plan, is or was providing the care and support of such claimant.

19.09 Recovery of Payments

The Plan reserves the right to deduct from any benefits properly payable under this Plan the amount of any payment which has been made:

1. In error;
2. Pursuant to a misstatement contained in a proof of loss or a fraudulent act;

3. Pursuant to a misstatement made to obtain coverage under this Plan within two years after the date such coverage commences; or
4. With respect to an ineligible person.

The deduction may be made against any claim for benefits under this Plan by a claimant or his or her covered Dependents.

ARTICLE 20

HIPAA PRIVACY

20.01 Commitment to Protecting Health Information

The Plan will comply with the Standards for Privacy of Individually Identifiable Health Information (i.e., the “Privacy Rule”) set forth by the U.S. Department of Health and Human Services (“HHS”) pursuant to the Health Insurance Portability and Accountability Act (“HIPAA”). Such standards control the dissemination of “protected health information” (“PHI”) of Plan Participants. Privacy standards will be implemented and enforced in the offices of the Employer and Plan Sponsor and any other entity that may assist in the operation of the Plan.

The Plan is required by law to take reasonable steps to ensure the privacy of the Plan Participant’s PHI, and inform him/her about:

1. The Plan’s disclosures and uses of PHI;
2. The Plan Participant’s privacy rights with respect to his/her PHI;
3. The Plan’s duties with respect to his/her PHI;
4. The Plan Participant’s right to file a complaint with the Plan and with the Secretary of HHS; and
5. The person or office to contact for further information about the Plan’s privacy practices.

Within this provision capitalized terms may be used, but not otherwise defined. These terms shall have the same meaning as those terms set forth in 45 CFR Sections 160.103 and 164.501. Any HIPAA regulation modifications altering a defined HIPAA term or regulatory citation shall be deemed incorporated into this provision.

20.02 How Health Information May be Used and Disclosed

In general, the Privacy Rules permit the Plan to use and disclose an individual’s PHI, without obtaining authorization, only if the use or disclosure is:

1. To carry out Payment of benefits;
2. For Health Care Operations;
3. For Treatment purposes; or
4. If the use or disclosure falls within one of the limited circumstances described in the rules (e.g., the disclosure is required by law or for public health activities).

20.03 Disclosure of PHI to the Plan Sponsor for Plan Administration Purposes

In order that the Plan Sponsor may receive and use PHI for plan administration purposes, the Claims Administrator agrees to:

1. Not use or further disclose PHI other than as permitted or required by the Summary Plan Descriptions or as required by law (as defined in the privacy standards);
2. Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;
3. Establish safeguards for information, including security systems for data processing and storage;
4. Maintain the confidentiality of all PHI, unless an individual gives specific consent or authorization to disclose such data or unless the data is used for health care payment or Plan operations;
5. Receive PHI, in the absence of an individual’s express authorization, only to carry out Plan administration functions;

6. Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the privacy standards;
7. Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;
8. Make available PHI in accordance with section 164.524 of the privacy standards (45 CFR 164.524);
9. Make available PHI for amendment and incorporate any amendments to PHI in accordance with section 164.526 of the privacy standards (45 CFR 164.526);
10. Make available the information required to provide an accounting of disclosures in accordance with section 164.528 of the privacy standards (45 CFR 164.528);
11. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services (“HHS”), or any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with part 164, subpart E, of the privacy standards (45 CFR 164.500 et seq);
12. Report to the Plan any inconsistent uses or disclosures of PHI of which the Plan Sponsor becomes aware;
13. Train employees in privacy protection requirements and appoint a privacy compliance coordinator responsible for such protections;
14. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and
15. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in section 164.504(f)(2)(iii) of the privacy standards (45 CFR 164.504(f)(2)(iii)), is established as follows:
 - (a) The following employees, or classes of employees, or other persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed:
 - (i) Privacy Officer: The access to and use of PHI by the individuals described above shall be restricted to the plan administration functions that the Plan Sponsor performs for the Plan.

HR Director
Risk Manager
HR Generalist/Benefits Specialist
 - (b) In the event any of the individuals described in above do not comply with the provisions of the Summary Plan Descriptions relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. The Plan Administrator will promptly report such violation or non-compliance to the Plan, and will cooperate with the Plan to correct violation or non-compliance to impose appropriate disciplinary action or sanctions. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

20.04 Disclosure of Summary Health Information to the Plan Sponsor

The Plan may disclose PHI to the Plan Sponsor of the group health plan for purposes of plan administration or pursuant to an authorization request signed by the Plan Participant. The Plan may use or disclose “summary health information” to the Plan Sponsor for obtaining premium bids or modifying, amending, or terminating the group health plan.

20.05 Disclosure of Certain Enrollment Information to the Plan Sponsor

Pursuant to section 164.504(f)(1)(iii) of the privacy standards (45 CFR 164.504(f)(1)(iii)), the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has un-enrolled from a health insurance issuer or health maintenance organization offered by the Plan to the Plan Sponsor.

20.06 Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage

The Plan Sponsor may hereby authorize and direct the Plan, through the Plan Administrator or the third party administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters (“MGUs”) for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the privacy standards.

20.07 Other Disclosures and Uses of PHI:

20.07A Primary Uses and Disclosures of PHI

1. Treatment, Payment and Health Care Operations: The Plan has the right to use and disclose a Plan Participant’s PHI for all activities as included within the definitions of Treatment, Payment, and Health Care Operations and pursuant to the HIPAA Privacy Rule.
2. Business Associates: The Plan contracts with individuals and entities (Business Associates) to perform various functions on its behalf. In performance of these functions or to provide services, Business Associates will receive, create, maintain, use, or disclose PHI, but only after the Plan and the Business Associate agree in writing to contract terms requiring the Business Associate to appropriately safeguard the Plan Participant’s information.
3. Other Covered Entities: The Plan may disclose PHI to assist health care Providers in connection with their treatment or payment activities or to assist other covered entities in connection with payment activities and certain health care operations. For example, the Plan may disclose PHI to a health care Provider when needed by the Provider to render treatment to a Plan Participant, and the Plan may disclose PHI to another covered entity to conduct health care operations. The Plan may also disclose or share PHI with other insurance carriers (such as Medicare, etc.) in order to coordinate benefits, if a Plan Participant has coverage through another carrier.

20.07B Other Possible Uses and Disclosures of PHI

1. Required by Law: The Plan may use or disclose PHI when required by law, provided the use or disclosure complies with and is limited to the relevant requirements of such law.
2. Public Health and Safety: The Plan may use or disclose PHI when permitted for purposes of public health activities, including disclosures to:
 - (a) a public health authority or other appropriate government authority authorized by law to receive reports of child abuse or neglect;

- (b) report reactions to medications or problems with products or devices regulated by the Federal Food and Drug Administration or other activities related to quality, safety, or effectiveness of FDA-regulated products or activities;
 - (c) locate and notify persons of recalls of products they may be using; and
 - (d) a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition, if authorized by law.
- 3. The Plan may disclose PHI to a government authority, except for reports of child abuse or neglect permitted by (1) above, when required or authorized by law, or with the Plan Participant's agreement, if the Plan reasonably believes he/she to be a victim of abuse, neglect, or domestic violence. In such case, the Plan will promptly inform the Plan Participant that such a disclosure has been or will be made unless the Plan believes that informing him/her would place him/her at risk of serious harm (but only to someone in a position to help prevent the threat). Disclosure generally may be made to a minor's parents or other representatives although there may be circumstances under Federal or State law when the parents or other representatives may not be given access to the minor's PHI.
- 4. Health Oversight Activities: The Plan may disclose PHI to a health oversight agency for oversight activities authorized by law. This includes civil, administrative or criminal investigations; inspections; claim audits; licensure or disciplinary actions; and other activities necessary for appropriate oversight of a health care system, government health care program, and compliance with certain laws.
- 5. Lawsuits and Disputes: The Plan may disclose PHI when required for judicial or administrative proceedings. For example, the Plan Participant's PHI may be disclosed in response to a subpoena, discovery requests, or other required legal processes when the Plan is given satisfactory assurances that the requesting party has made a good faith attempt to advise the Plan Participant of the request or to obtain an order protecting such information, and done in accordance with specified procedural safeguards.
- 6. Law Enforcement: The Plan may disclose PHI to a law enforcement official when required for law enforcement purposes concerning identifying or locating a suspect, fugitive, material witness or missing person. Under certain circumstances, the Plan may disclose the Plan Participant's PHI in response to a law enforcement official's request if he/she is, or are suspected to be, a victim of a crime and if it believes in good faith that the PHI constitutes evidence of criminal conduct that occurred on the Sponsor's or Plan's premises.
- 7. Decedents: The Plan may disclose PHI to a coroner, funeral director or medical examiner for the purpose of identifying a deceased person, determining a cause of death or as necessary to carry out their duties as authorized by law.
- 8. Research: The Plan may use or disclose PHI for research, subject to certain limited conditions.
- 9. To Avert a Serious Threat to Health or Safety: The Plan may disclose PHI in accordance with applicable law and standards of ethical conduct, if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a threat to health or safety of a person or to the public.
- 10. Workers' Compensation: The Plan may disclose PHI when authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.
- 11. Military and National Security: The Plan may disclose PHI to military authorities of armed forces personnel under certain circumstances. As authorized by law, the Plan may disclose PHI required for intelligence, counter-intelligence, and other national security activities to authorized Federal officials.

20.08 Required Disclosures of PHI

1. Disclosures to Plan Participants: The Plan is required to disclose to a Plan Participant most of the PHI in a Designated Record Set when the Plan Participant requests access to this information. The Plan will disclose a Plan Participant's PHI to an individual who has been assigned as his/her representative and who has qualified for such designation in accordance with the relevant State law. Before disclosure to an individual qualified as a personal representative, the Plan must be given written supporting documentation establishing the basis of the personal representation.

The Plan may elect not to treat the person as the Plan Participant's personal representative if it has a reasonable belief that the Plan Participant has been, or may be, subjected to domestic violence, abuse, or neglect by such person, it is not in the Plan Participant's best interest to treat the person as his/her personal representative, or treating such person as his/her personal representative could endanger the Plan Participant.

2. Disclosures to the Secretary of the U.S. Dept of Health and Human Services: The Plan is required to disclose the Plan Participant's PHI to the Secretary of the U.S. Department of Health and Human Resources when the Secretary is investigating or determining the Plan's compliance with the HIPAA Privacy Rule.

20.09 Rights to Individuals

The Plan Participant has the following rights regarding PHI about him/her:

1. Request Restrictions: The Plan Participant has the right to request additional restrictions on the use or disclosure of PHI for treatment, payment, or health care operations. The Plan Participant may request the Plan restrict disclosures to family members, relatives, friends or other persons identified by him/her who are involved in his/her care or payment for his/her care. The Plan is not required to agree to these requested restrictions.
2. Right to Receive Confidential Communication: The Plan Participant has the right to request that he/she receive communications regarding PHI in a certain manner or at a certain location. The request must be made in writing and how the Plan Participant would like to be contacted. The Plan will accommodate all reasonable requests.
3. Copy of this Notice: The Plan Participant is entitled to receive a paper copy of this notice at any time. To obtain a paper copy, contact the Privacy Compliance Coordinator.
4. Accounting of Disclosures: The Plan Participant has the right to request an accounting of disclosures the Plan has made of his/her PHI. The request must be made in writing and does not apply to disclosures for treatment, payment, health care operations, and certain other purposes. The Plan Participant is entitled to such an accounting for the six (6) years prior to his/her request, though not earlier than April 14, 2003. Except as provided below, for each disclosure, the accounting will include: (a) the date of the disclosure, (b) the name of the entity or person who received the PHI and, if known, the address of such entity or person; (c) a description of the PHI disclosed, (d) a statement of the purpose of the disclosure that reasonably informs the Plan Participant of the basis of the disclosure, and certain other information. If the Plan Participant wishes to make a request, please contact the Privacy Compliance Coordinator.
5. Access: The Plan Participant has the right to request the opportunity to look at or get copies of PHI maintained by the Plan about him/her in certain records maintained by the Plan. If the Plan Participant requests copies, he/she may be charged a fee to cover the costs of copying, mailing, and other supplies. To inspect or copy PHI contact the Privacy Compliance Coordinator. In very limited circumstances, the Plan may deny the Plan Participant's request. If the Plan denies the request, the Plan Participant may be entitled to a review of that denial.

6. Amendment: The Plan Participant has the right to request that the Plan change or amend his/her PHI. The Plan reserves the right to require this request be in writing. Submit the request to the Privacy Compliance Coordinator. The Plan may deny the Plan Participant's request in certain cases, including if it is not in writing or if he/she does not provide a reason for the request.

20.10 Questions or Complaints

If the Plan Participant wants more information about the Plan's privacy practices, has questions or concerns, or believes that the Plan may have violated his/her privacy rights, please contact the Plan using the following information. The Plan Participant may submit a written complaint to the U.S. Department of Health and Human Services or with the Plan. The Plan will provide the Plan Participant with the address to file his/her complaint with the U.S. Department of Health and Human Services upon request.

The Plan will not retaliate against the Plan Participant for filing a complaint with the Plan or the U.S. Department of Health and Human Services.

Contact Information:

Privacy Compliance Coordinator Contact Information:

Betsy C. Keller, SPHR
Director of Human Resources
County of El Paso
800 E. Overland, Ste. 223
El Paso, Texas 79901
(p) (915) 546-2218
(f) (915) 546-8126

Additional Contact Information for HIPAA Questions:

Sam Trujillo
Risk Manager
County of El Paso
800 E. Overland, Ste. 223
El Paso, Texas 79901
(p) (915) 546-2218
(f) (915) 546-8126

ARTICLE 21 HIPAA SECURITY

Disclosure of Electronic Protected Health Information (“Electronic PHI”) to the Plan Sponsor for Plan Administration Functions

STANDARDS FOR SECURITY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (“SECURITY RULE”)

The Security Rule imposes regulations for maintaining the integrity, confidentiality and availability of protected health information that it creates, receives, maintains, or maintains electronically that is kept in electronic format (ePHI) as required under the Health Insurance Portability and Accountability Act (HIPAA).

Definitions:

“*Electronic Protected Health Information*” (ePHI) is defined in Section 160.103 of the Security Standards (45 C.F.R. 160.103) and means individually identifiable health information transmitted or maintained in any electronic media.

“*Security Incidents*” is defined within Section 164.304 of the Security Standards (45 C.F.R. 164.304) and means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operation in an information system.

Plan Sponsor Obligations

To enable the Plan Sponsor to receive and use Electronic PHI for Plan Administration Functions (as defined in 45 CFR §164.504(a)), the Plan Sponsor agrees to:

1. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan.
2. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate Security Measures.
3. Ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides Electronic PHI created, received, maintained, or transmitted on behalf of the Plan, agrees to implement reasonable and appropriate report to the Plan any security incident of which it becomes aware.
4. Report to the Plan any security incident of which it becomes aware.

Notification Requirements in the Event of a Breach of Unsecured PHI

The required breach notifications are triggered upon the discovery of a breach of unsecured PHI. A breach is discovered as of the first day the breach is known, or reasonably should have been known.

When a breach of unsecured PHI is discovered, the Plan will:

1. Notify the individual whose PHI has been, or is reasonably believed to have been, assessed, acquired, used, or disclosed as a result of the breach, in writing, without unreasonable delay and in no case later than 60 calendar days after discovery of the breach.

2. Notify the media if the breach affected more than 500 residents of a State or jurisdiction. Notice must be provided to prominent media outlets serving the State or jurisdiction without unreasonable delay and in no case later than 60 calendar days after the date the breach was discovered.
3. Notify the HHS Secretary if the breach involves 500 or more individuals, contemporaneously with the notice to the affected individual and in the manner specified by HHS. If the breach involves less than 500 individuals, an internal log or other documentation of such breaches must be maintained and annually submitted to HHS within 60 days after the end of each calendar year.
4. When a Business Associate, which provides services for the Plan and comes in contact with PHI in connection with those services discovers a breach has occurred, that Business Associate will notify the Plan without unreasonable delay and in no case later than 60 calendar days after discovery of a breach so that the affected individuals may be notified. To the extent possible, the Business Associate should identify each individual whose unsecured PHI has been, or is reasonably believed to have been, breached.

Any terms not otherwise defined in this section shall have the meanings set forth in the Security Standards.

County of El Paso
HEALTH BENEFIT PLAN

Summary Plan Description
Effective: January 1, 2013

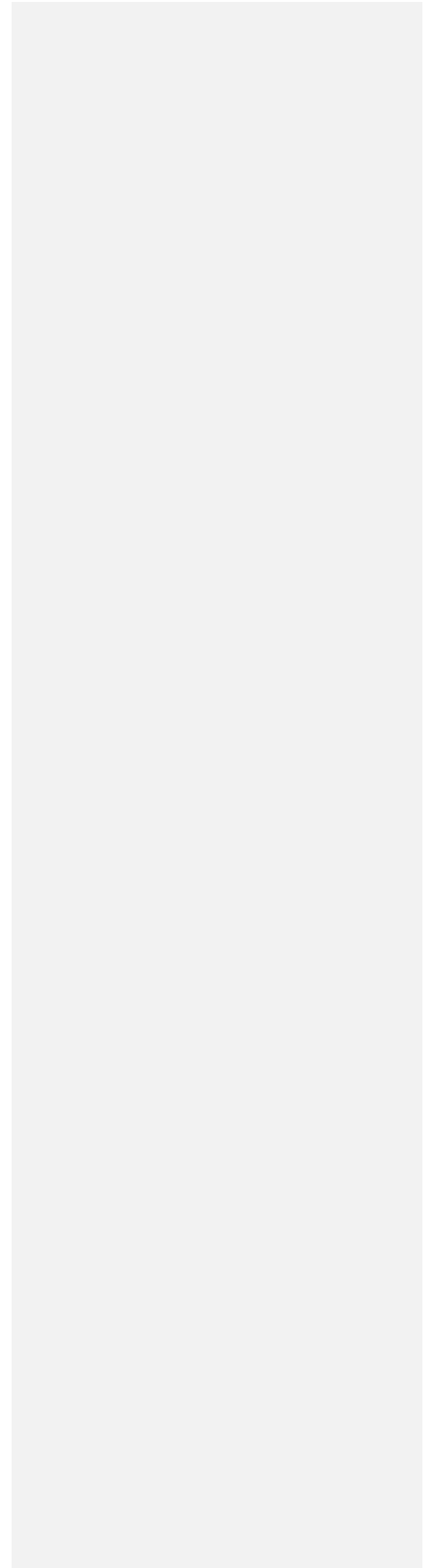


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ARTICLE 1
ESTABLISHMENT OF THE SUMMARY PLAN DESCRIPTION

THIS SUMMARY PLAN DESCRIPTION, made by County of El Paso effective as of January 1, 2013.

1.01 Effective Date

The Summary Plan Description is effective as of the date first set forth above, and each amendment is effective as of the date set forth therein.

1.02 Adoption of the Summary Plan Description

The Plan Sponsor, as the settlor of the Plan, hereby adopts this Summary Plan Description. This Summary Plan Description amends and replaces any prior statement of the health care coverage contained in the Plan or any predecessor to the Plan.

Note: It is important to make sure that Human Resources has your current and correct address. If Human Resources does not have your current information on record, that can delay or prevent you from receiving benefit coverage.

This Summary Plan Description describes your health plan benefits under the County health plan for medical, pharmacy and dental benefits. If you have trouble understanding it, or any part of the Summary Plan Description, you can get an explanation from the County Human Resources Department at:

Esta descripción resumida del plan describe el plan de beneficios de salud bajo el plan de salud del Condado para los beneficios médicos, de farmacia y dental. Si tiene problemas para entender, o cualquier parte de la descripción resumida del plan, usted puede obtener una explicación de el Departamento de Recursos Humanos en:

County of El Paso
800 E. Overland, Suite 223
El Paso, Texas 79901
(915) 546-2218

Or

HealthSCOPE Benefits
7430 Remcon Circle, Bldg C
El Paso, Texas 79912
(915) 581-8182 or (800) 854-2339
Customer Care Hours
7:00am – 6:00pm
Monday - Friday

ARTICLE 2 INTRODUCTION AND PURPOSE; GENERAL PLAN INFORMATION

2.01 Introduction and Purpose

Welcome to the County of El Paso Texas sponsored health care plan administered by HealthSCOPE Benefits. Your employer has provided you with this Summary Plan Description (SPD) which describes the Medical, Prescription Drug (Pharmacy) and Dental Benefits, as well as your rights and responsibilities under this SPD.

This SPD is your guide to the benefits, provisions, and programs offered by this plan. Services are subject to all provisions of the Plan, including the limitations and exclusions.

Please read this SPD carefully, paying special attention to the “Schedule of Benefits”, “Covered Medical Expenses”, and “General Limitations and Exclusions” sections to better understand how your benefits work.

The Plan benefits described in this SPD are being restated effective as of January 1, 2013. This SPD has been updated to comply with federal requirements including applicable provisions of the federal health care reform laws. As the Plan Administrator receives additional guidance and clarification on the new health reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, the Plan Administrator may be required to make additional changes to the Summary of Plan Description.

The County of El Paso offers three coverage choices for active employees, eligible retirees and COBRA participants: Core Plan Option, Buy Up Plan Option and Consumer Driven Health (CDH Plan) Option.

The benefits under the County of El Paso Benefit Plan are self-insured. These 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. Both County and plan participants contribute to the Plan Fund in order to make these benefits available to you.

The SPD is not a contract. The plan shall not be deemed to constitute a contract between the County of El Paso and any plan participant or to be a consideration for, or an inducement or condition of, the employment of any Employee. Nothing in the SPD 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.

The County of El Paso is a Grandfathered Health Plan for the Core Plan Option and Buy Up Plan Option. Being a Grandfathered Health Plan means that your Plan may not include certain consumer protections of the Affordable Care Act that apply to the CDH Plan option.

We recommend that you contact the Claims 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.

2.02 General Plan Information

Name of Plan: County of El Paso Health Benefit Plan

**Plan Sponsor and Plan Administrator
(Named Fiduciary) :** County of El Paso
800 E. Overland, Suite 223
El Paso, Texas 79901
(915) 546-2218
Fax: (915) 546-8126
humanresources@epcountv.com

Source of Funding: Self-Funded

Plan Year: January 1 through December 31

Plan Type: Medical
Dental
Prescription Drug

**Third Party Administrator:
(Claims and Cobra Administrator)** HealthSCOPE Benefits
7430 Remcon Circle, Bldg C
El Paso, Texas 79912
(915) 581-8182 or (800) 854-2339
www.healthscopebenefits.com
Customer Service Hours
7:00 a.m. – 6:00 p.m.
Monday - Friday

2.03 Legal Entity; Service of Process

The Plan is a legal entity. Legal notice may be filed with, and legal process served upon, the Plan Administrator.

2.04 Not a Contract

This Summary Plan Description summarizes the terms and provisions of coverage under this Plan. The Summary Plan Description shall not be deemed to constitute a contract of any type between the County of El Paso and any Participant or to be consideration for, or an inducement or condition of, the employment of any Employee. Nothing in this Summary Plan Description 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; provided, however, that the foregoing shall not be deemed to modify the provisions of any collective bargaining agreements which may be entered into by the County of El Paso with the bargaining representatives of any Employees.

2.05 Mental Health Parity

Pursuant to the Mental Health Parity and Addiction Equity Act of 2008, this Plan applies its terms uniformly and enforces parity between covered health care benefits and covered mental health and substance disorder benefits relating to financial cost sharing restrictions and treatment duration limitations. For further details, please contact the Plan Administrator.

2.06 Discretionary Authority

The Plan Administrator shall have full and final discretionary authority to interpret all Plan provisions, including the right to remedy possible ambiguities, inconsistencies and/or omissions in the Plan and related documents; to make determinations in regards to issues relating to eligibility for benefits; to decide disputes that may arise relative to a Plan Participants' rights; and to determine all questions of fact and law arising under the Plan.

**ARTICLE 3
SCHEDULE OF BENEFITS**

	CORE PLAN OPTION		BUY UP PLAN OPTION		CDH PLAN OPTION	
	In-Network	Out-of-network	In-Network	Out-of-network	In-Network	Out-of-network
Annual Deductibles						
Employee	\$1000	\$2000	\$250	\$750	\$3,500	\$5,000
Employee/Dependent	\$2,000	\$4,000	\$500	\$1,000	\$7,000	\$10,000
Plan Year Out-of-Pocket Maximum	Excludes co-payments, deductibles and penalties		Excludes co-payments, deductibles and penalties		Includes co-payments and deductible	
Employee	\$2,500	No Limit	\$2,000	No Limit	\$3,500	\$8,000
Employee/Dependent	\$5,000	No Limit	\$4,000	No Limit	\$7,000	\$16,000
Hospital Co Pay (per admission)	\$100	N/A	\$100	N/A	Deductible applies	Deductible applies
Outpatient Hospital Deductible (per year)	\$200	N/A	\$200	N/A	Deductible applies	Deductible applies
	CORE PLAN OPTION HOSPITAL SERVICES (plan pays)		BUY UP PLAN OPTION HOSPITAL SERVICES (plan pays)		CDH PLAN OPTION HOSPITAL SERVICES (Deductible must be met before benefits are paid)	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
University Medical Center Preferred Hospital	95% after annual deductible	N/A	95% after annual deductible	N/A	100% after annual deductible	N/A
Other Hospital Facilities	80% after annual deductible	50% after annual deductible	80% after annual deductible	50% after annual deductible	100% after annual deductible	50% after annual deductible
Emergency Use of Emergency Room	80% after \$100 co-pay and annual deductible	80% after \$100 co-pay and annual deductible	80% after \$100 co-pay and annual deductible	80% after \$100 co-pay and annual deductible	100% after annual deductible	50% after annual deductible
Non-Emergency Use of Emergency Room	80% after \$100 co-pay and annual deductible	50% for Non-Emergency Use after \$100 co-pay and annual deductible	80% after \$100 co-pay and annual deductible	50% for Non-Emergency Use after \$100 co-pay and annual deductible	100% after annual deductible	50% after annual deductible

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

SCHEDULE OF BENEFITS

The Plan will pay the specified coinsurance once the Participant has satisfied the annual deductible.

	CORE PLAN OPTION		BUY UP PLAN OPTION		CDH PLAN OPTION (Deductible must be met before benefits are paid)	
	In-Network (Plan Pays)	Out-of-Network (Plan Pays)	In-Network (Plan Pays)	Out-of-Network (Plan Pays)	In-Network (Plan Pays)	Out-of-Network (Plan Pays)
Accidental Dental Care	80%	65%	80%	65%	100%	65%
Allergy Tests and Treatments	80%	65%	80%	65%	100%	65%
Ambulance Emergency Use	80%	80%	80%	80%	100%	65%
Ambulance Non-Emergency Use	80%	65%	80%	65%	100%	65%
Assistant Surgeon	80%	65%	80%	65%	100%	65%
Chiropractic Care	80%	65%	80%	65%	100%	65%
	\$2,000 maximum combined					
Durable Medical Equipment	80%	65%	80%	65%	100%	65%
Home Healthcare	80%	65%	80%	65%	100%	65%
	Prior Approval Required					
Home Infusion Therapy	80%	65%	80%	65%	100%	65%
Hospice Care	80%	65%	80%	65%	100%	65%
Inpatient Hospital Care	80%	65%	80%	65%	100%	65%
Inpatient Rehabilitations	80%	65%	80%	65%	100%	65%
Lab and X-Ray	80%	65%	80%	65%	100%	65%
Preferred Lab	100%	N/A	100%	N/A	100%	N/A
Medical Supplies	80%	65%	80%	65%	100%	65%
Mental Health Inpatient Stay	80%	65%	80%	65%	100%	65%
Mental Health Outpatient	80%	65%	80%	65%	100%	65%
Occupational Therapy	80%	65%	80%	65%	100%	65%
Office Visits	100% after \$35 co pay	65%	100% after \$30 co-pay	65%	100%	65%
Oral Surgery	80%	65%	80%	65%	100%	65%
	Limited to certain non-dental procedures for treatment due to accidental injury					
Outpatient Hospital Care	80%	65%	80%	65%	100%	65%
Physical Therapy	80%	65%	80%	65%	100%	65%

Physician Services	80%	65%	80%	65%	100%	65%
Preventive Care Services	100% after \$35 co pay	No coverage	100% after \$30 co pay	No Coverage	100%	No coverage
	100% of scheduled benefits under the Preventive Care Schedule. Routine annual exam subject to co-pay Preventive Care includes the following Routine annual physical exam (one per year) Colorectal and Prostate exams (one per year) Mammography (one per year) Immunizations (all ages) Labs DXA Bone Density Test (one per year) Colorectal and Prostate exams (one per year) EKG (one per year) Well woman exam to include pap smear (one per year) Colonoscopy (age 50 & older, not to exceed one per 10 years)					
Prescription Drugs	<i>Prescription Drugs are treated like any other medical expense, subject to HRA and Plan Participant Responsibility. If brand requested when a generic equivalent is available, Plan Participant will pay the difference in cost between brand and generic.</i>			<i>CDH-Preventive drugs as identified by the Pharmacy Benefit Manager and in accordance with IRS regulations may be purchased with a co-payment prior to the deductible being met.</i>		
Retail (30 day Retail Supply)	\$10 co-pay Generic Drugs \$25 co-pay Preferred Brand Name Drugs \$40 co-pay Non-Preferred Brand Name Drugs	65% after deductible	\$5 co-pay Generic Drugs \$20 co-pay Preferred Brand Name Drugs \$35 co-pay Non-Preferred Brand Name Drugs	65% after deductible	\$10 co-pay Generic Drugs \$25 co-pay Preferred Brand Name Drugs \$40 co-pay Non-Preferred Brand Name Drugs	No Coverage
Mail Order (90 day supply)	\$20 co-pay Generic Drugs \$50 co-pay Preferred Brand Name Drugs \$80 co-pay Non-Preferred Brand Name Drugs	No coverage	\$10 co-pay Generic Drugs \$40 co-pay Preferred Brand Name Drugs \$70 co-pay Non-Preferred Brand Name Drugs	No Coverage	\$20 co-pay Generic Drugs \$50 co-pay Preferred Brand Name Drugs \$70 co-pay Non-Preferred Brand Name Drugs	No Coverage
Prosthetics	80%	65%	80%	65%	100%	65%
Radiation Therapy	80%	65%	80%	65%	100%	65%
Chemotherapy	80%	65%	80%	65%	100%	65%
Skilled Nursing Facility	Limited to 60 days per year; In-Network and Out-of-Network combined					

Speech Therapy	80%	65%	80%	65%	100%	65%
Substance Abuse Inpatient	80%	65%	80%	65%	100%	65%
Substance Abuse Outpatient	80%	65%	80%	65%	100%	65%
Surgeon	80%	65%	80%	65%	100%	65%
Transplants	80%	65%	80%	65%	100%	65%
Urgent Care	80%	65%	80%	65%	100%	65%
All Other Covered Expenses	80%	65%	80%	65%	100%	65%

For limitations and exclusions please refer to Article 15

ARTICLE 4 DEFINITIONS

The following words and phrases shall have the following meanings when used in the Summary Plan Description. **The following definitions are not an indication that charges for particular care, supplies or services are eligible for payment under the Plan, however they may be used to identify ineligible expenses; please refer to the appropriate sections of the Summary Plan Description for that information.**

“Accident”

“Accident” shall mean a sudden and unforeseen event, or a deliberate act resulting in unforeseen consequences.

“Accidental Bodily Injury”

“Accidental Bodily Injury” shall mean an Injury sustained as the result of an Accident and independently of all other causes by an outside traumatic event or due to exposure to the elements.

“Actively At Work” or “Active Employment”

“Actively at Work” or “Active Employment” shall mean performance by the Employee of all the regular duties of his or her occupation at an established business location of the Participating Employer, or at another location to which he or she may be required to travel to perform the duties of his or her employment. An Employee shall be deemed actively at Work if the Employee is absent from work due to a health factor. In no event will an Employee be considered actively at Work if he or she has effectively terminated employment.

“ADA”

“ADA” shall mean the American Dental Association.

“AHA”

“AHA” shall mean the American Hospital Association.

“Allowable Expenses”

“Allowable Expenses” shall mean the Usual and Customary charge for any Medically Necessary, Reasonable eligible item of expense, at least a portion of which is covered under this Plan. When some Other Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered, in the amount that would be payable in accordance with the terms of the Plan, shall be deemed to be the benefit. Benefits payable under any Other Plan include the benefits that would have been payable had claim been duly made therefore.

“AMA”

“AMA” shall mean the American Medical Association.

“Ambulatory Surgical Center”

“Ambulatory Surgical Center” shall mean any public or private State licensed and approved (whenever required by law) establishment with an organized medical staff of Physicians, with permanent facilities that are equipped and operated primarily for the purpose of performing Surgical Procedures, with continuous Physician services and registered professional nursing service whenever a patient is in the facility, and which does not provide service or other accommodations for patients to stay overnight.

“Assignment of Benefits”

“Assignment of Benefits” shall mean an arrangement whereby the Plan Participant assigns their right to seek and receive payment of eligible Plan benefits, in strict accordance with the terms of the Plan, as summarized in this Summary Plan Description, to a Provider. If a provider accepts said arrangement, Providers’ rights to receive Plan benefits are equal to those of a Plan Participant, and are limited by the terms of this Summary Plan Description. A Provider that accepts this arrangement indicates acceptance of an “Assignment of Benefits” as consideration in full for services, supplies, and/or treatment rendered. For full information, consult the Claims Administrator.

“Assistance Eligible Individual”

“Assistance Eligible Individual” shall mean any Qualified Beneficiary who elects COBRA continuation coverage, and has satisfied all of the following conditions:

1. The qualifying event occurred at any time during the period that begins with September 1, 2008, and ends with May 31, 2010, and the Qualified Beneficiary was eligible for COBRA continuation coverage during this period;
2. The covered Employee or Qualified Beneficiary must elect COBRA or applicable state continuation coverage;
3. The qualifying event with respect to the COBRA continuation coverage consists of the involuntary termination of the covered Employee’s employment and occurred during such period*; and
4. The covered Employee must have had a modified adjusted gross income of less than \$145,000, if single, or \$290,000, if married filing jointly, for each tax year in which the subsidy is received. Note that the available COBRA subsidy will be reduced for years in which the covered Employee’s gross income exceeds \$125,000 (or \$250,000 for joint returns).

***Important Note:** If you experienced a reduction of hours during the period that begins with September 1, 2008 and ends with May 31, 2010, followed by an involuntary termination of employment on or after March 2, 2010 and by May 31, 2010, then your termination will constitute a qualifying event and you are entitled to a new election period for COBRA continuation coverage. Under the new election period, COBRA continuation coverage (but not the 18-month COBRA period) and the 15 months of subsidy would begin starting with the first period of coverage after the termination. See Plan Administrator to verify if the benefit is still available.

“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.

“Cardiac Care Unit”

“Cardiac Care Unit” shall mean a separate, clearly designated service area which is maintained within a Hospital and which meets all the following requirements:

1. It is solely for the treatment of patients who require special medical attention because of their critical condition;
2. It provides within such area special nursing care and observation of a continuous and constant nature not available in the regular rooms and wards of the Hospital;
3. It provides a concentration of special lifesaving equipment immediately available at all times for the treatment of patients confined within such area;
4. It contains at least two beds for the accommodation of critically ill patients; and
5. It provides at least one professional registered nurse, who continuously and constantly attends the patient confined in such area on a 24-hour-a-day basis.

“Centers of Excellence”

“Centers of Excellence” shall mean medical care facilities that have met stringent criteria for quality care in the specialized procedures of organ transplantation. These centers have the greatest experience in performing transplant procedures and the best survival rates. The Plan Administrator shall determine what Network Centers of Excellence are to be used.

Any Participant in need of an organ transplant may contact the Claims Administrator to initiate the pre-certification process resulting in a referral to a Center of Excellence. The Claims Administrator acts as the primary liaison with the Center of Excellence, patient and attending Physician for all transplant admission taking place at a Center of Excellence.

If a Participant chooses not to use a Center of Excellence, the payment for services will be limited to what would have been the cost at the nearest Center of Excellence.

Additional information about this option, as well as a list of Centers of Excellence, will be given to covered Employees and updated as requested.

“Certificate of Creditable Coverage”

“Certificate of Creditable Coverage” shall mean a written certification provided by any source that offers medical care coverage, including the Plan, for the purpose of confirming the duration and type of an individual’s previous coverage.

“Child”

“Child” shall mean, in addition to the Employee’s own blood descendant of the first degree or lawfully adopted Child, a Child placed with a covered Employee in anticipation of adoption, a covered Employee’s Child who is an alternate recipient under a Qualified Medical Child Support Order as required by the Federal Omnibus Budget Reconciliation Act of 1993, any stepchild, an “eligible foster child,” which is defined as an individual placed with the Employee by an authorized placement agency or by judgment, decree or other order of a court of competent jurisdiction, a Child of the Employee’s Domestic Partner, a Child of the Employee’s Spouse or Plus One Qualifying Adult, or any other Child for whom the Employee has obtained legal guardianship.

“CHIP” “CHIP” refers to the Children’s Health Insurance Program or any provision or section thereof, which is herein specifically referred to, as such act, provision or section may be amended from time to time.

“CHIPRA”

“CHIPRA” refers to the Children’s Health Insurance Program Reauthorization Act of 2009 or any provision or section thereof, which is herein specifically referred to, as such act.

“Chiropractic Care”

“Chiropractic Care” shall mean office visits, x-rays, manipulations, supplies, heat and cold treatment.

“Claim Determination Period”

“Claim Determination Period” shall mean each calendar year.

“Clean Claim”

A “Clean Claim” is one that can be processed in accordance with the terms of this document without obtaining additional information from the service Provider or a third party. It is a claim which has no defect or impropriety.

A defect or impropriety shall include a lack of required sustaining documentation as set forth and in accordance with this document, or a particular circumstance requiring special treatment which prevents timely payment as set forth in this document, and only as permitted by this document, from being made. A Clean Claim does not include claims under investigation for fraud and abuse or claims under review for Medical Necessity and Reasonableness, or fees under review for Usual and Customariness, or any other matter that may prevent the charge(s) from being covered expenses in accordance with the terms of this document.

Filing a Clean Claim. A Provider submits a Clean Claim by providing the required data elements on the standard claims forms, along with any attachments and additional elements or revisions to data elements, attachments and additional elements, of which the Provider has knowledge. The Plan Administrator may require attachments or other information in addition to these standard forms (as noted elsewhere in this document and at other times prior to claim submittal) to ensure charges constitute covered expenses as defined by and in accordance with the terms of this document. The paper claim form or electronic file record must include all required data elements and must be complete, legible, and accurate. A claim will not be considered to be a Clean Claim if the Plan Participant has failed to submit required forms or additional information to the Plan as well. For additional information refer to Article 9.

“COBRA”

“COBRA” shall mean the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

“Co-Payment”

“Co-Payment” shall mean the amount a participant will need to pay when you receive certain health care services

“Cosmetic Surgery”

“Cosmetic Surgery” shall mean any surgery, service, drug or supply designed to improve the appearance of an individual by changing, improving and/or alteration of a physical characteristic. Please see Article 15 for additional information.

“Covered Expense”

“Covered Expense” means a Usual and Customary fee for a Reasonable, Medically Necessary service, treatment or supply, meant to improve a condition or participant’s health, which is eligible for coverage in this Plan. Covered Expenses will be determined based upon all other Plan provisions. When more than one treatment option is available, and one option is no more effective than another, the Covered Expense is the least costly option that is no less effective than any other option.

All treatment is subject to benefit payment maximums shown in the Summary of Benefits and as determined elsewhere in this document.

“Covered Mental Health Service Providers”

“Covered Mental Health Service Providers” are physicians and associated visits which are limited and subject to the Summary of Benefits and terms of this document. Psychiatrists (M.D.), psychologists (Ph.D.) or counselors licensed to provide individual psychotherapy without supervision in the State they are practicing, may bill the Plan directly. Other licensed mental health practitioners must be under the direction of and must bill the Plan through these professionals.

“Creditable Coverage”

“Creditable Coverage” shall mean coverage of an individual under any of the following: a group health plan, health insurance coverage, Medicare, Medicaid (other than coverage consisting solely of benefits under the program for distribution of pediatric vaccines), medical and dental care for Plan Participants and certain former Plan Participants of the Uniformed Services and their dependents, a medical care program of the Indian Health Service or a tribal organization, a State health benefits risk pool, a health plan offered under the Federal Employees Health Benefits Program, a public health plan, or a health benefit plan under Section 5(e) of the Peace Corps Act, or Title XXI of the Social Security Act (State Children’s Health Insurance Program). To the extent that further clarification is needed with respect to the sources of Creditable Coverage listed in the prior sentence, please see the complete definition of Creditable Coverage that is set forth in 45 C.F.R. § 146.113(a). See sections 5.11A and 6.04.

“Custodial Care”

“Custodial Care” shall mean care or confinement provided primarily for the maintenance of the Participant, essentially designed to assist the Participant, whether or not Totally Disabled, in the activities of daily living, which could be rendered at home or by persons without professional skills or training. This care is not reasonably expected to improve the underlying medical condition, even though it may relieve symptoms or pain. Such care includes, but is not limited to, bathing, dressing, feeding, preparation of special diets, assistance in walking or getting in and out of bed, supervision over medication which can normally be self-administered and all domestic activities.

“Deductible”

“Deductible” shall mean an amount of money that is paid once a calendar year per Participant and Family Unit. Typically, there is one Deductible amount per Plan and it must be paid before any money is paid by the Plan for any covered services. Each calendar year, a new Deductible amount is required. **Deductibles do not accrue toward the 100% maximum out-of-pocket payment.**

“Dentist”

“Dentist” shall mean an individual holding a D.D.S. or D.M.D. degree, licensed to practice dentistry in the jurisdiction where such services are provided.

“Dependent”

“Dependent” shall mean ~~one or more of the following person(s):~~

Adult:

1. An Employee’s lawfully married spouse possessing a marriage license who is not divorced from the Employee; ~~or~~
2. An Employee’s common law spouse, based upon a common law marriage which is legally recognized in the jurisdiction in which the Employee has his or her principal residence; ~~or~~
3. ~~An Employee’s Domestic Partner~~ Plus One Qualifying Adult who meet the requirements necessary for eligibility.

An Employee may not enroll more than one individual qualifying above.

Child:

- ~~3.4.~~ A Child who is less than 26 years of age;
- ~~4.5.~~ A Child, regardless of age, who is mentally or physically incapable of sustaining his or her own living. Written proof of such incapacity and dependency satisfactory to the Plan must be furnished and approved by the Plan within 31 days after the date the Child attains the limiting age under the bullets above. The Plan may require, at reasonable intervals, subsequent proof satisfactory to the Plan.

The Plan reserves the right to require documentation, satisfactory to the Plan Administrator, which establishes a Dependent relationship.

“Detoxification”

“Detoxification” shall mean the process whereby an alcohol-intoxicated person or person experiencing the symptoms of Substance Abuse is assisted, in a facility licensed by the Department of Health, through the period of

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time necessary to eliminate, by metabolic or other means, the intoxicating alcohol, alcohol dependency factors or alcohol in combination with drugs as determined by a licensed Physician, while keeping the physiological risk to the patient at a minimum.

“Diagnostic Service”

“Diagnostic Service” shall mean a test or procedure performed for specified symptoms to detect or to monitor a Disease or condition. It must be ordered by a Physician or other professional Provider.

“Disease”

“Disease” shall mean any disorder which does not arise out of, which is not caused or contributed to by, and which is not a consequence of, any employment or occupation for compensation or profit; however, if evidence satisfactory to the Plan is furnished showing that the individual concerned is covered as an employee under any worker’s compensation law, occupational disease law or any other legislation of similar purpose, or under the maritime doctrine of maintenance, wages, and cure, but that the disorder involved is one not covered under the applicable law or doctrine, then such disorder shall, for the purposes of the Plan, be regarded as a Sickness, Illness or Disease.

“Domestic Partner”

~~“An individual who lives in the same household and shares the common resources of life in a close, personal, intimate relationship with a County Employee if, under Texas law, the individual would not be prevented from marrying the Employee on account of age, consanguinity or prior undissolved marriage to another. A domestic partner may be of the same or opposite gender as the Employee; and must be eighteen years of age or older; r. m. Must not be married; to or related to the Employee by blood. The Employee and Domestic Partner must, who have resided together in the same residence for at least **one year** and intend to do so indefinitely. Three of the following documents will be required to demonstrate interdependence:~~

~~Joint deed or mortgage agreement to demonstrate common ownership or real property or a common leasehold interest in property;
Common ownership of a motor vehicle;
Driver’s licenses listing a common address
Proof of joint bank accounts or credit accounts;
Proof of designation as the primary beneficiary for life insurance or retirements benefits;
Assignment of a durable property power of attorney or health care power of attorney.~~

~~The Employee and Domestic Partner must sign a Declaration of Domestic Partnership. Upon termination of the relationship, a declaration of Termination of Domestic Partnership must be signed.~~

~~Note: Federal and/or State tax implications may arise when enrolling a Domestic Partner as a Dependent under the Plan. Employees should contact his or her own tax consultant or attorney to address his or her specific situation.~~

“Drug”

“Drug” shall mean insulin and prescription legend drugs. A prescription legend drug is a Federal legend drug (any medicinal substance which bears the legend: “Caution: Federal law prohibits dispensing without a prescription”) or a State restricted drug (any medicinal substance which may be dispensed only by prescription, according to State law) and which, in either case, is legally obtained from a licensed drug dispenser only upon a prescription of a currently licensed Physician.

“Durable Medical Equipment”

“Durable Medical Equipment” shall mean equipment which:

1. Can withstand repeated use;
2. Is primarily and customarily used to serve a medical purpose;
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.

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“Elective Surgical Procedure”

“Elective Surgical Procedure” shall mean 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.

“Emergency”

“Emergency” shall mean a situation where necessary treatment is required as the result of a sudden and severe medical event or acute condition. An Emergency includes poisoning, shock, and hemorrhage. Other Emergencies and acute conditions may be considered on receipt of proof, satisfactory to the Plan, that an Emergency did exist. The Plan may, at its own discretion, request satisfactory proof that an Emergency or acute condition did exist.

“Emergency Medical Condition”

“Emergency Medical Condition” shall mean a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act (42 U.S.C. 1395dd(e)(1)(A)). In that provision of the Social Security Act, clause (i) refers to placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; clause (ii) refers to serious impairment to bodily functions; and clause (iii) refers to serious dysfunction of any bodily organ or part.

“Emergency Care”

“Emergency Care” shall mean, with respect to an Emergency Medical Condition:

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 pregnant woman; serious jeopardy to the health of the fetus.

“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 157.101(a) of the Texas Local Government Code, as amended.

“Employer”

“Employer” shall mean the County of El Paso Texas.

“Enrollment”

“Enrollment” information see Article 5.

“Essential Health Benefits”

“Essential Health Benefits” shall mean, under section 1302(b) of the Patient Protection and Affordable Care Act, those health benefits to include at least the following general categories and the items and services covered within the categories: ambulatory patient services; Emergency Services; hospitalization; maternity and newborn care; mental health and substance abuse disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

“Experimental” and/or “Investigational”

“Experimental” and/or “Investigational” (“Experimental”) shall mean services or treatments that are not widely used or accepted by most practitioners or lack credible evidence to support positive short or long-term outcomes from

those services or treatments; these services are not included under or as Medicare reimbursable procedures, and include services, supplies, care, procedures, treatments or courses of treatment which:

1. Do not constitute accepted medical practice under the standards of the case and by the standards of a reasonable segment of the medical community or government oversight agencies at the time rendered; or
2. Are rendered on a research basis as determined by the United States Food and Drug Administration and the AMA's Council on Medical Specialty Societies.

All phases of clinical trials shall be considered Experimental.

A drug, device, or medical treatment or procedure is Experimental:

1. If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished;
2. If reliable evidence shows that the drug, device or medical treatment or procedure is the subject of ongoing Phase I, II, or III clinical trials or under study to determine its:
 - a) maximum tolerated dose;
 - b) toxicity;
 - c) safety;
 - d) efficacy; and
 - e) efficacy as compared with the standard means of treatment or diagnosis; or
3. if reliable evidence shows that the consensus among experts regarding the drug, device, or medical treatment or procedure is that further studies or clinical trials are necessary to determine its:
 - a) maximum tolerated dose;
 - b) toxicity;
 - c) safety;
 - d) efficacy; and
 - e) efficacy as compared with the standard means of treatment or diagnosis.

Reliable evidence shall mean:

1. Only published reports and articles in the authoritative medical and scientific literature;
2. The written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, or medical treatment or procedure; or
3. The written informed consent used by the treating facility or by another facility studying substantially the same drug, device, or medical treatment or procedure.

The Plan Administrator retains maximum legal authority and discretion to determine what is Experimental.

“Family Unit”

“Family Unit” shall mean the Employee, his or her spouse and Children.

“FMLA”

“FMLA” shall mean the Family and Medical Leave Act of 1993, as amended.

“FMLA Leave”

“FMLA Leave” shall mean a leave of absence, which the County of El Paso is required to extend to an Employee under the provisions of the FMLA.

“GINA”

“GINA” shall mean the Genetic Information Nondiscrimination Act of 2008 (Public Law No. 110-233), which prohibits group health plans, issuers of individual health care policies, and employers from discriminating on the basis of genetic information.

“HIPAA”

“HIPAA” shall mean the Health Insurance Portability and Accountability Act of 1996, as amended.

“Home Health Care”

“Home Health Care” shall mean the continual care and treatment of an individual if:

1. The institutionalization of the individual would otherwise have been required if home health care was not provided;
2. The treatment plan covering the home health care service is established and approved in writing by the attending Physician; and
3. The home health care is the result of an Illness or Injury.

“Home Health Care Agency”

“Home Health Care Agency” shall mean an agency or organization which provides a program of home health care and which:

1. Is approved as a Home Health Agency under Medicare;
2. Is established and operated in accordance with the applicable laws in the jurisdiction in which it is located and, where licensing is required, has been licensed and approved by the regulatory authority having the responsibility for licensing; or
3. Meets all of the following requirements:
 - a. It is an agency which holds itself forth to the public as having the primary purpose of providing a home health care delivery system bringing supportive services to the home;
 - b. It has a full-time administrator;
 - c. It maintains written records of services provided to the patient;
 - d. Its staff includes at least one registered nurse (R.N.) or it has nursing care by a registered nurse (R.N.) available; and
 - e. Its employees are bonded and it provides malpractice insurance.

“Hospital”

“Hospital” shall mean an Institution that meets all of the following requirements:

1. It provides medical and Surgical facilities for the treatment and care of Injured or Sick persons on an Inpatient basis;
2. It is under the supervision of a staff of Physicians;
3. It provides 24-hour-a-day nursing service by registered nurses;
4. It is duly licensed as a hospital, except that this requirement will not apply in the case of a State tax-supported Institution;
5. It is not, other than incidentally, a place for rest, a place for the aged, a nursing home or a custodial or training-type Institution;
6. It is accredited by the Joint Commission on Accreditation of Hospitals sponsored by the AMA and the AHA.

The requirement of surgical facilities shall not apply to a Hospital specializing in the care and treatment of mentally ill patients, provided such Institution is accredited as such a facility by the Joint Commission on Accreditation of Hospitals sponsored by the AMA and the AHA.

Hospital shall also have the same meaning, where appropriate in context, set forth in the definition of “Ambulatory Surgical Center.”

“Illness”

“Illness” shall have the meaning set forth in the definition of “Disease.”

“Impregnation and Infertility Treatment”

“Impregnation and Infertility Treatment” shall mean artificial insemination, fertility drugs, G.I.F.T. (Gamete Intrafallopian Transfer), impotency drugs such as Viagra™, in-vitro fertilization, sterilization and/or reversal of a

sterilization operation, surrogate mother, donor eggs, or any type of artificial impregnation procedure, whether or not such procedure is successful.

“Incurred”

“Incurred” shall mean that a covered expense is Incurred on the date the service is rendered or the supply is obtained. With respect to a course of treatment or procedure which includes several steps or phases of treatment, covered expenses are Incurred for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered. More specifically, covered expenses for the entire procedure or course of treatment are not Incurred upon commencement of the first stage of the procedure or course of treatment.

“Injury”

“Injury” shall mean an Accidental Bodily Injury, which requires treatment by a physician. It must result in loss independently of sickness and other causes.

“Inpatient”

“Inpatient” shall mean any person who, while confined to a Hospital, is assigned to a bed in any department of the Hospital other than its outpatient department and for whom a charge for Room and Board is made by the Hospital.

“Institution”

“Institution” shall mean a facility, operating within the scope of its license, whose purpose is to provide organized health care and treatment to individuals, such as a Hospital, Ambulatory Surgical Center, Psychiatric Hospital, community mental health center, residential treatment facility, psychiatric treatment facility, Substance Abuse Treatment Center, alternative birthing center, Home Health Care Center, or any other such facility that the Plan approves.

“Intensive Care Unit”

“Intensive Care Unit” shall have the same meaning set forth in the definition of “Cardiac Care Unit.”

“Leave of Absence”

“Leave of Absence” shall mean a leave of absence of an Employee that has been approved by his or her Participating Employer, as provided for in the Participating Employer’s rules, policies, procedures and practices.

“Mastectomy”

“Mastectomy” shall mean the surgical removal of all or part of a breast.

“Maximum Amount” or “Maximum Allowable Charge”

“Maximum Amount” and/or “Maximum Allowable Charge” shall mean the benefit payable for a specific coverage item or benefit under the Plan. Maximum Allowable Charge(s) will be the lesser of:

- The Usual and Customary amount;
- The allowable charge specified under the terms of the Plan;
- The negotiated rate established in a contractual arrangement with a Provider; or
- The actual billed charges for the covered services.

The Plan will reimburse the actual charge billed if it is less than the Usual and Customary amount. The Plan has the discretionary authority to decide if a charge is Usual and Customary and for a Medically Necessary and Reasonable service.

The **Maximum Allowable Charge** will not include any identifiable billing mistakes including, but not limited to,

up-coding, duplicate charges, and charges for services not performed.

“Medical Child Support Order”

“Medical Child Support Order” See section 5.08.

“Medically Necessary”

“Medical Care Necessity”, “Medically Necessary”, “Medical Necessity” and similar language refers to health care services ordered by a Physician exercising prudent clinical judgment provided to a Plan Participant for the purposes of evaluation, diagnosis or treatment of that Plan Participant’s Sickness or Injury. Such services, to be considered Medically Necessary, must be clinically appropriate in terms of type, frequency, extent, site and duration for the diagnosis or treatment of the Plan Participant’s Sickness or Injury. The Medically Necessary setting and level of service is that setting and level of service which, considering the Plan Participant’s medical symptoms and conditions, cannot be provided in a less intensive medical setting. Such services, to be considered Medically Necessary must be no more costly than alternative interventions, including no intervention and are at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Plan Participant’s Sickness or Injury without adversely affecting the Plan Participant’s medical condition.

- a) It must not be maintenance therapy or maintenance treatment.
- b) Its purpose must be to restore health.
- c) It must not be primarily custodial in nature.
- d) It must not be a listed item or treatment not allowed for reimbursement by CMS (Medicare).
- e) The Plan reserves the right to incorporate CMS (Medicare) guidelines in effect on the date of treatment as additional criteria for determination of Medical Necessity and/or an Allowable Expense.

For Hospital stays, this means that acute care as an Inpatient is necessary due to the kind of services the Participant is receiving or the severity of the Participant’s condition and that safe and adequate care cannot be received as an outpatient or in a less intensified medical setting. The mere fact that the service is furnished, prescribed or approved by a Physician does not mean that it is “Medically Necessary.” In addition, the fact that certain services are excluded from coverage under this Plan because they are not “Medically Necessary” does not mean that any other services are deemed to be “Medically Necessary.”

To be Medically Necessary, all of these criteria must be met. Merely because a Physician or Dentist recommends, approves, or orders certain care does not mean that it is Medically Necessary. The determination of whether a service, supply, or treatment is or is not Medically Necessary may include findings of the American Medical Association and the Plan Administrator’s own medical advisors. The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary.

“Medically Necessary Leave of Absence”

“Medically Necessary Leave of Absence” shall mean a Leave of Absence by a full-time student Dependent at a postsecondary educational institution that:

1. Commences while such Dependent is suffering from a serious Illness or Injury;
2. Is Medically Necessary; and
3. Causes such Dependent to lose student status for purposes of coverage under the terms of the Plan.

“Medical Record Review”

“Medical Record Review” is the process by which the Plan, based upon a medical record review and audit, determines that a different treatment or different quantity of a drug or supply was provided which is not supported in the billing, then the Plan Administrator may determine the **Maximum Allowable Charge** according to the medical record review and audit results.

“Medicare”

“Medicare” shall mean the program of health care for the aged established by Title XVIII of the Social Security Act of 1965, as amended.

“Mental Health Parity and Addiction Equity Act of 2008 (“MHPAEA”)

“Mental Health Parity and Addiction Equity Act of 2008 (“MHPAEA”)” shall mean in the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health or substance use disorder benefits, such plan or coverage shall ensure that:

1. The financial requirements applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the Plan (or coverage) and that there are no separate cost sharing requirements that are applicable only with respect to mental health or substance use disorder benefits. If these benefits are covered by the group health plan (or health insurance coverage is offered in connection with such a plan); and
2. The treatment limitations applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the Plan (or coverage), and that there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits. If these benefits are covered by the group health plan (or health insurance coverage offered in connection with such a plan).

“Mental or Nervous Disorder”

“Mental or Nervous Disorder” shall mean any disease or condition, regardless of whether the cause is organic, that is classified as a Mental or Nervous Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services, is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association or other relevant State guideline or applicable sources.

“National Medical Support Notice” or “NMSN”

“National Medical Support Notice” See section 5.08

“Network”

“Network” shall mean the medical provider network of physicians, hospitals, and other health care providers. The Network is responsible for recruiting, credentialing, and communicating with the providers. Providers participating in the Network agree to accept the allowable fees set by the Network and agree to file claims for Plan participants. The Network Provider will be identified on the Participants identification card.

“Non-Occupational Injury”

“Non-occupational Injury” shall have the meaning set forth in the definition of “Injury.”

“Open Enrollment Period”

“Open Enrollment Period” shall mean the month of October in each Plan Year, and as otherwise required by law.

“Other Plan”

“Other Plan” shall include, but is not limited to:

1. Any primary payer besides the Plan;
2. Any other group health plan;
3. Any other coverage or policy covering the Participant;
4. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
5. Any policy of insurance from any insurance company or guarantor of a responsible party;
6. Any policy of insurance from any insurance company or guarantor of a third party;
7. Worker’s compensation or other liability insurance company; or
8. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

“Out of Area”

“Out of Area” shall mean a geographic area. Services provided by Health Care Providers who are not in the Network Service Area (outside El Paso/Las Cruces). Participants have a “National Network” in order for benefits to be paid at the In Network level.

“Participant” / “Plan Participant”

“Participant” shall mean any Employee or Dependent who is eligible for benefits and enrolled under the Plan. See Article 5.

“Physician”

“Physician” shall mean a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Psychologist (Ph.D.), psychiatrist or midwife.

“Plan Year”

“Plan Year” shall mean January 1 through December 31.

“Plus One Qualifying Adult”

Plus One Qualifying Adult eligibility is extended to an individual who meets all of the following criteria:

1. The Employee and Plus One Qualifying Adult must have resided together in the same residence for at least twelve consecutive months and continue to do so for the Plus One Qualifying Adult to remain eligible. Copies of the Employee and Plus One Qualifying Adult’s Driver’s License or Government issued Identification Card listing a common address must be provided to the Plan Administrator;
2. The Plus One Qualifying Adult must be eighteen years of age or older; and
3. The Plus One Qualifying Adult must be financially interdependent with the Employee, sharing common financial obligations, as evidenced by three or more of the following documents (Financial Interdependence Documents), and continue to do so for the Plus One Qualifying Adult to remain eligible. Copies of the Financial Interdependence Documents must be provided to the Plan Administrator;
 - a. Joint deed or mortgage agreement to demonstrate common ownership or real property or a common leasehold interest in real property;
 - b. A Title or Vehicle Registration showing common ownership of a motor vehicle;
 - c. Proof of joint bank accounts or credit accounts;
 - d. Proof of designation as the primary beneficiary for life insurance or retirements benefits;
 - e. Assignment of a durable property power of attorney or health care power of attorney.

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Loss of Eligibility; Changes to Common Address or Financial Interdependence Documents. If the Employee and Plus One Qualifying Adult cease to reside together, or cease to share common financial obligations described in the Financial Interdependence Documents, the Plus One Qualifying Adult is no longer eligible to be a Dependent of the Employee. The Employee has an affirmative duty to inform the Plan Administrator of the change in status within 31 days. If the information on the Financial Interdependence Documents or Driver’s license or Government issued Identification Card changes, the Employee must notify the Plan Administrator within 31 days and provide copies of the new documents, or risk loss of eligibility for the Plus One Qualifying Adult.

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Note: Federal and/or State tax implications may arise when enrolling a Plus One Qualifying Adult as a Dependent under the Plan. Employees should contact his or her own tax consultant or attorney to address his or her specific situation.

Ineligible Individuals

The following individuals are not eligible for designation as a Plus One Qualifying Adult:

1. Parents;
2. Parents’ other descendants (siblings, nieces, nephews);
3. Grandparents and descendants (aunts, uncles, cousins);
4. Step relatives; or
5. Renters, boarders, tenants, employees of the County Employee.

“Pre-admission Tests”

“Pre-admission Tests” shall mean those Diagnostic Services done prior to scheduled Surgery, provided that:

1. The tests are approved by both the Hospital and the Physician;
2. The tests are performed on an outpatient basis prior to Hospital admission; and
3. The tests are performed at the Hospital into which confinement is scheduled, or at a qualified facility designated by the Physician who will perform the Surgery.

“Pregnancy”

“Pregnancy” shall mean carrying a child, resulting childbirth, miscarriage and non-elective abortion. The Plan considers Pregnancy as a Sickness for the purpose of determining benefits.

“Pre-existing Condition”

“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 or practitioner duly licensed to provide such care under applicable State law and operating within the scope of practice authorized by such State law, during the 90 days prior to the date an Employee’s Service Waiting Period commences.

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.

“Prior Plan”

“Prior Plan” shall mean the coverage provided on a group or group-type basis by the group insurance policy, benefit plan or service plan that was terminated on the day before the Effective Date of the Plan and replaced by the Plan.

“Prior to Effective Date” or “After Termination Date”

“Prior to Effective Date” or “After Termination Date” are dates occurring before a Participant gains eligibility from the Plan, or dates occurring after a Participant loses eligibility from the Plan, as well as charges incurred prior to the effective date of coverage under the Plan or after coverage is terminated.

“Privacy Standards”

“Privacy Standards” shall mean the standards of the privacy of individually identifiable health information, as pursuant to HIPAA.

“Provider”

“Provider” shall mean a Physician, a licensed speech or occupational therapist, licensed professional physical therapist, physiotherapist, audiologist, speech language pathologist, licensed professional counselor, certified nurse practitioner, certified psychiatric/mental health clinical nurse, or other practitioner or facility defined or listed herein, or approved by the Plan Administrator.

“Psychiatric Hospital”

“Psychiatric Hospital” shall mean an Institution constituted, licensed, and operated as set forth in the laws that apply to Hospitals, which meets all of the following requirements:

1. It is primarily engaged in providing psychiatric services for the diagnosis and treatment of mentally ill persons either by, or under the supervision of, a Physician;
2. It maintains clinical records on all patients and keeps records as needed to determine the degree and intensity of treatment provided;
3. It is licensed as a psychiatric hospital;
4. It requires that every patient be under the care of a Physician; and
5. It provides 24-hour-a-day nursing service.

The term Psychiatric Hospital does not include an Institution, or that part of an Institution, used mainly for nursing care, rest care, convalescent care, care of the aged, Custodial Care or educational care.

“Qualified Medical Child Support Order” or “QMCSO”

“Qualified Medical Child Support Order” or “QMCSO” See section 5.08.

“Qualifying Event”

“Qualifying Event” shall have the meaning described in section 7.06

“Reasonable”

“Reasonable” and/or “Reasonableness” shall mean in the administrator’s discretion, services or supplies, or fees for services or supplies which are necessary for the care and treatment of illness or injury not caused by the treating Provider. Determination that fee(s) or services are reasonable will be made by the Plan Administrator, taking into consideration unusual circumstances or complications requiring additional time, skill and experience in connection with a particular service or supply; industry standards and practices as they relate to similar scenarios; and the cause of injury or illness necessitating the service(s) and/or charge(s).

This determination will consider, but will not be limited to, the findings and assessments of the following entities: (a) The National Medical Associations, Societies, and organizations; and (b) The Food and Drug Administration. To be Reasonable, service(s) and/or fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures. Services, supplies, care and/or treatment that results from errors in medical care that are clearly identifiable, preventable, and serious in their consequence for patients, are not Reasonable. The Plan Administrator retains discretionary authority to determine whether service(s) and/or fee(s) are Reasonable based upon information presented to the Plan Administrator. A finding of Provider negligence and/or malpractice is not required for service(s) and/or fee(s) to be considered not Reasonable.

Charge(s) and/or services are not considered to be Reasonable, and as such are not eligible for payment (exceed the Maximum Allowable Charge), when they result from Provider error(s) and/or facility-acquired conditions deemed “reasonably preventable” through the use of evidence-based guidelines, taking into consideration but not limited to CMS guidelines.

The Plan reserves for itself and parties acting on its behalf the right to review charges processed and/or paid by the Plan, to identify charge(s) and/or service(s) that are not Reasonable and therefore not eligible for payment by the Plan.

“Rehabilitation Hospital”

“Rehabilitation Hospital” shall mean an Institution which mainly provides therapeutic and restorative services to Sick or Injured people. It is recognized as such if:

1. It carries out its stated purpose under all relevant Federal, State and local laws;
2. It is accredited for its stated purpose by either the Joint Commission on Accreditation of Hospitals or the Commission on Accreditation for Rehabilitation Facilities; or
3. It is approved for its stated purpose by Medicare.

“Reinstatement of Employment”

“Reinstatement of Employment” shall mean a Participant who has been reinstated under the Plan. A reinstated Participant and his/her dependents, if previously enrolled in the Plan, shall be reinstated with no loss of coverage. See section 5.01.

“Retiree”

“Retiree” as defined by the Plan Sponsor. See section 5.02.

“Room and Board”

“Room and Board” shall mean a Hospital’s charge for:

1. Room and linen service;
2. Dietary service, including meals, special diets and nourishment;
3. General nursing service; and

4. Other conditions of occupancy which are Medically Necessary.

“Scheduled benefit” or “Scheduled benefit amount”

“Scheduled Benefit” or “Scheduled benefit amount” means a specified dollar amount that will be considered for reimbursement under the Plan for a particular type of medical care, service or supply provided. Scheduled benefits are based upon covered expenses not otherwise limited or excluded under the terms of the Plan. A partial listing of scheduled benefit amounts may be found in Article 3, “Schedule of Benefits”. A listing of scheduled benefits may be obtained on the web site at <http://intranet/hr/health.htm>.

“Security Standards”

“Security Standards” shall mean the final rule implementing HIPAA’s Security Standards for the Protection of Electronic PHI, as amended.

“Service Waiting Period”

“Service Waiting Period” shall mean an interval of time an Employee must be employed prior to becoming eligible to enroll in the Plan. The waiting period shall be 90 days of continuous full-time employment.

“Sickness”

“Sickness” shall have the meaning set forth in the definition of “Disease.”

“Significant Break in Coverage”

“Significant Break in Coverage” shall mean a period of 63 consecutive days during each of which an individual does not have any Creditable Coverage.

“Special Enrollment”

“Special Enrollment” See section 5.06

“Substance Abuse”

“Substance Abuse” shall mean any use of alcohol, any Drug (whether obtained legally or illegally), any narcotic, or any hallucinogenic or other illegal substance, which produces a pattern of pathological use, causing impairment in social or occupational functioning, or which produces physiological dependency evidenced by physical tolerance or withdrawal. It is the excessive use of a substance, especially alcohol or a drug. The DSM-IV definition is applied as follows:

- A. A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12-month period:
 1. Recurrent substance use resulting in a failure to fulfill major role obligations at work, school or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions or expulsions from school; neglect of children or household);
 2. Recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use);
 3. Recurrent substance-related legal problems (e.g., arrests for substance-related disorderly conduct); or
 4. Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights);
- B. The symptoms have never met the criteria for Substance Dependence for this class of substance.

“Substance Abuse Treatment Center”

“Substance Abuse Treatment Center” shall mean an Institution which provides a program for the treatment of Substance Abuse by means of a written treatment plan approved and monitored by a Physician. This Institution must be:

1. Affiliated with a Hospital under a contractual agreement with an established system for patient referral;

2. Accredited as such a facility by the Joint Commission on Accreditation of Hospitals; or
3. Licensed, certified or approved as an alcohol or Substance Abuse treatment program or center by a State agency having legal authority to do so.

Substance Dependence: Substance use history which includes the following: (1) substance abuse (see above); (2) continuation of use despite related problems; (3) development of tolerance (more of the drug is needed to achieve the same effect); and (4) withdrawal symptoms.

“Surgery”

“Surgery” shall mean any of the following:

1. The incision, excision, debridement or cauterization of any organ or part of the body, and the suturing of a wound;
2. The manipulative reduction of a fracture or dislocation or the manipulation of a joint including application of cast or traction;
3. The removal by endoscopic means of a stone or other foreign object from any part of the body or the diagnostic examination by endoscopic means of any part of the body;
4. The induction of artificial pneumothorax and the injection of sclerosing solutions;
5. Arthrodesis, paracentesis, arthrocentesis and all injections into the joints or bursa;
6. Obstetrical delivery and dilatation and curettage; or
7. Biopsy.

“Surgical Procedure”

“Surgical Procedure” shall have the same meaning set forth in the definition of “Surgery.”

“Total Disability”

“Total Disability” shall mean an individual is determined as being disabled for Social Security purposes and provides such evidence to the Plan of the determination as the Plan Administrator may, in its discretion, require.

“Totally Disabled”

“Totally Disabled” shall have the same meaning set forth in the definition of “Total Disability.”

“Uniformed Services”

“Uniformed Services” shall mean the Armed Forces, the Army National Guard and the Air National Guard, when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President of the United States in time of war or Emergency.

“USERRA”

“USERRA” shall mean the Uniformed Services Employment and Reemployment Rights Act of 1994 (“USERRA”) as amended.

“Usual and Customary”

“Usual and Customary” (U&C) shall mean covered expenses which are identified by the Plan Administrator, taking into consideration the fee(s) which the Provider most frequently charges the majority of patients for the service or supply, the cost to the Provider for providing the services, the prevailing range of fees charged in the same “area” by Providers of similar training and experience for the service or supply, and the Medicare reimbursement rates. The term(s) “same geographic locale” and/or “area” shall be defined as a metropolitan area, county, or such greater area as is necessary to obtain a representative cross-section of Providers, persons or organizations rendering such treatment, services, or supplies for which a specific charge is made. To be Usual and Customary, fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures.

The term “Usual” refers to the amount of a charge made for medical services, care, or supplies, to the extent that the charge does not exceed the common level of charges made by other medical professionals with similar credentials,

or health care facilities, pharmacies, or equipment suppliers of similar standing, which are located in the same geographic locale in which the charge is incurred.

The term “Customary” refers to the form and substance of a service, supply, or treatment provided in accordance with generally accepted standards of medical practice to one individual, which is appropriate for the care or treatment of the same sex, comparable age and who receive such services or supplies within the same geographic locale.

The term “Usual and Customary” does not necessarily mean the actual charge made nor the specific service or supply furnished to a Plan Participant by a Provider of services or supplies, such as a physician, therapist, nurse, hospital, or pharmacist. The Plan Administrator will determine what the Usual and Customary charge is, for any procedure, service, or supply, and whether a specific procedure, service or supply is Usual and Customary.

Usual and Customary charges may, at the Plan Administrator’s discretion, alternatively be determined and established by the Plan using normative data such as, but not limited to, Medicare cost to charge ratios, average wholesale price (AWP) for prescriptions and/or manufacturer’s retail pricing (MRP) for supplies and devices.

All other defined terms in this Summary Plan Description shall have the meanings specified in the Summary Plan Description where they appear.

ARTICLE 5 ELIGIBILITY FOR COVERAGE SPECIAL RESTRICTIONS FOR PRE-EXISTING CONDITIONS

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. The Employee effective date will be the first day following 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.

5.02 Eligibility for Retiree Coverage

A covered Employee is eligible for Retiree coverage under the same plan 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.

5.03 Eligibility Dates for Dependent Coverage

Each Employee will become eligible for coverage under this Plan for his or her Dependents on the latest of the following dates. The Employee will have 31 days from that date to enroll the Employee's Dependent under the Plan by contacting the Plan Administrator and providing copies of the required documentation to the Plan Administrator:

1. ~~His or her~~ The Employee's date of eligibility for coverage for himself or herself under the Plan;
2. The date coverage for ~~his or her~~ the Employee's Dependents first becomes available under any amendment to the Plan, if such coverage was not provided under the Plan on the Effective Date of the Plan; ~~and~~
3. The first date upon which ~~he or she~~ the Employee acquires a Dependent under definitions 1, 2, 4 and 5 of Dependent;
- ~~3.4. As to definition 3 of Dependent, Plus One Qualifying Adult, the date of eligibility for coverage shall be the date the Employee and Plus One Qualifying Adult have resided together in the same residence for at least one year and continue to do so. Copies of the Employee and Plus One Qualifying Adult's Drivers License or Government issued Identification Card listing a common address and copies of Financial Interdependent Documents must be provided to the Plan Administrator.~~

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In no event will any Dependent Child be covered as a Dependent of more than one Employee who is covered under the Plan.

Any reference in this Plan to an Employee's Dependent being covered means that such Employee and Dependent is covered for Dependent Coverage are enrolled in the Plan.

Note: Federal and/or State tax implications may arise when enrolling a ~~Domestic Partner~~ Plus One Qualifying Adult as a Dependent under the Plan. Employees should contact his or her own tax consultant or attorney to address his or her specific situation.

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5.04 Effective Dates of Coverage; Conditions

The coverage for which an individual is eligible under this Plan will become effective on the date specified below, subject to the conditions of this section.

1. Enrollment Form. Coverage for an Employee or his or her Dependents must be requested by the Employee on a form furnished by the Plan Administrator. This form must be completed and signed by the Employee and will become effective on the date such Employee or Dependents are eligible, provided the Employee has enrolled for such coverage on a form satisfactory to the Plan Administrator within the 31-day period immediately following the date of eligibility.
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.

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.

4. Requirement for Employee Coverage. No coverage for Dependents of an Employee will become effective unless the Employee is, or simultaneously becomes, eligible for coverage for himself or herself under the Plan.
5. Coverage as Both Employee and Dependent. No person may be simultaneously covered under this Plan as both an Employee and a Dependent.
6. Medicaid Coverage. An individual's eligibility for any State Medicaid benefits will not be taken into account by the Plan in determining that individual's eligibility under the Plan.
7. FMLA Leave. Regardless of any requirements set forth in the Plan, the Plan shall at all times comply with FMLA.

5.05 Benefits for the Survivors of Certain Public Servants

Eligible survivors of certain public servants who died as a result of personal injury sustained in the line of duty in the individual's position, as described, are entitled to purchase or continue to purchase health insurance benefits under Chapter 1551, Texas Insurance Code, as provided in this section.

A survivor is eligible if he or she is the surviving spouse of the individual or surviving dependent of the individual.

5.05A Certain Public Servants

This entitlement is available to eligible survivors of individuals who served in the following positions:

1. an individual elected, appointed, or employed as a peace officer by the state or a political subdivision of the state under Article 2.12, Code of Criminal Procedure, or other law;
2. a member of the class of employees of the correctional institutions division formally designated as custodial personnel under section 615.006 by the Texas Board of Criminal Justice or its predecessor in function;
3. a jailer or guard of a county jail who is appointed by the sheriff and who:

- (a) performs a security, custodial, or supervisory function over the admittance, confinement, or discharge of prisoners; and
 - (b) is certified by the Commission on Law Enforcement Officer Standards and Education
- 4. an individual who is employed by the state or a political or legal subdivision and is subject to certification by the Texas Commission on Fire Protection or an individual employed by the state or a political or legal subdivision whose principal duties are aircraft crash and rescue fire fighting who is employed by a political subdivision of the state; or
- 5. an individual who is employed by the state or a political subdivision of the state and who is considered by the governmental employer to be a trainee and is employed as a trainee for a position otherwise described in section 615.071 of the Texas Government Code.

5.05B Eligible Surviving Spouse

An eligible surviving spouse of a deceased individual who was employed by a political subdivision of the state is entitled to purchase or continue to purchase health insurance benefits from the political subdivision that employed the deceased individual, including health coverage:

- 1. provided by or through a political subdivision under:
 - a. a health insurance policy or health benefit plan written by a health insurer; or
 - b. a self-insured health benefits plan.
- 2. under Chapter 172, Local Government Code.

The surviving spouse is entitled to purchase or continue to purchase health insurance coverage until the date the surviving spouse becomes eligible for federal Medicare benefits.

5.05C Eligible Surviving Dependent

An eligible surviving dependent who is a minor child is entitled to purchase or continue to purchase health insurance coverage until the date the dependent reaches the age of 26 or a later date to the extent required by state or federal law.

An eligible surviving dependent who is not a minor child is entitled to purchase or continue to purchase health insurance coverage until the earlier or:

- 1. the date the dependent becomes eligible for group health insurance through another employer; or
- 2. the date the dependent becomes eligible for federal Medicare benefits.

5.06 Special Enrollment

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

5.06A 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.

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. 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
- 3. 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 on the date the other coverage was lost.

5.06B New Dependent

If a covered 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 Dependent 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.

The following conditions apply to any eligible Employee who has acquired a new Dependent:

An Employee may enroll his or her newly acquired Dependent during this special enrollment period if:

1. The covered Employee is eligible for coverage under the terms of this Plan; and
2. The covered 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

5.06C 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 becomes 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.

5.07 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.

5.08 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 Recipient(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.

5.09 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.

5.09A 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.

5.09B 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 Claims 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 Claims Administrator later determines that an individual did not have the claimed Creditable Coverage, the Claims 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 Claims Administrator will act in accordance with its initial determination in favor of the Participant for the purpose of approving medical services.

5.10 "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.

ARTICLE 6

TERMINATION OF COVERAGE

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.
- 7.

6.02 Termination Dates of Retiree Coverage

The coverage of any Retiree who is covered under the Plan will terminate on the earliest to occur of the following dates:

1. The date of termination of the Plan;
2. The date of death of the covered Retiree; or
3. The date of the expiration of the last period for which the Retiree 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

6.03 Termination Dates of Dependent Coverage

The coverage for any Dependents of any Participant who are covered under the Plan will terminate on the earliest to occur of the following dates:

1. The date of termination of the Plan;
2. Upon the discontinuance of coverage for Dependents under the Plan;
3. The date of termination of the Participant's coverage for himself or herself under the Plan;
4. 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 Dependents to which he or she has agreed;
5. In the case of a Child age 26 or older for whom coverage is being continued due to mental or physical inability to earn his or her own living, the earliest to occur of:
 - a. Cessation of such inability;
 - b. Failure to furnish any required proof of the uninterrupted continuance of such inability or to submit to any required examination; or
 - c. Upon the Child's no longer being dependent on the Participant for his or her support;
6. The day immediately preceding the date such person ceases to be a Dependent, as defined herein, except as may be provided for in other areas of this section; or
7. 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.

6.04 Certificates of Creditable Coverage

The Plan generally will automatically provide a Certificate of Creditable Coverage to anyone who loses coverage in the Plan. In addition, a Certificate of Coverage will be provided upon request, at any time while the individual is covered under a plan and up to 24 months after the individual loses coverage under the Plan.

The Plan will make reasonable efforts to collect information applicable to any Dependents and to include that information on the Certificate of Coverage, but the Plan will not issue an automatic Certificate of Coverage for Dependents until the Plan has reason to know that a Dependent is or has been covered under the Plan.

ARTICLE 7 CONTINUATION OF COVERAGE

7.01 Continuation During FMLA Leave

The Plan shall at all times comply with FMLA. During any leave taken under FMLA, the Plan Participant will maintain coverage under this Plan on the same conditions as coverage would have been provided if the covered Plan Participant had been continuously employed during the entire leave period.

If provisions under the Plan change while the Plan Participant is on FMLA Leave, the changes will be effective for him or her on the same date as they would have been had he or she not taken leave.

An Employee must continue to pay his or her portion of the Plan contribution, if any, during the FMLA Leave. Payment must be made within 30 days of the due date established by the Plan Administrator. If payment is not received, coverage will terminate on the last date for which the contribution was received in a timely manner.

7.02 Recovery of Plan Contributions

The Participating Employer has the right to recover the portion of the Plan contributions it paid to maintain coverage under the Plan during an unpaid FMLA Leave if the Plan Participant does not return to work at the end of the leave. This right will not apply if failure to return is due to the continuation, recurrence or onset of a Serious Health Condition that entitles the Plan Participant to FMLA Leave (in which case the Participating Employer may require medical certification) or other circumstances beyond the Plan Participant's control at the discretion of the Plan Sponsor.

7.03 Reinstatement of Coverage

The law requires that coverage be reinstated upon the Plan Participant's return to work following an FMLA Leave whether or not the Employee maintained coverage under the Plan during the FMLA Leave.

On reinstatement, all provisions and limits of the Plan will apply as they would have applied if FMLA Leave had not been taken. The Service Waiting Period and the Pre-existing Condition limitation will be credited as if the Employee had been continually covered under the Plan.

NOTE: For complete information regarding FMLA rights, contact the County of El Paso Human Resources.
humanresources@epcounty.com

7.04 Continuation During COBRA - Introduction

The right to this form of continued coverage was created by a Federal law, under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"). COBRA Continuation Coverage can become available to Participants when they otherwise would lose their group health coverage. It also can become available to other members of the Participants family who are covered under the Plan when they otherwise would lose their group health coverage. The entire cost (plus a reasonable administration fee) must be paid by the person. Coverage will end in certain instances, including if the Participant or their covered dependents fail to make timely payment of contributions or premiums. Participants should check with their employer to see if COBRA applies to them and/or their covered dependents.

7.05 COBRA Continuation Coverage

"COBRA Continuation Coverage" is a continuation of Plan coverage when coverage otherwise would end because of a life event known as a "Qualifying Event." Life insurance, accidental death and dismemberment benefits and weekly income or long-term disability benefits (if a part of the employer's plan) are not considered for continuation under COBRA.

7.06 Qualifying Events

Specific Qualifying Events are listed below. After a Qualifying Event, COBRA Continuation Coverage must be offered to each person who is a "Qualified Plan Participant." The Employee, the Employee's spouse, and the Employee's dependent children could become Qualified Plan Participants if coverage under the Plan is lost because

of the Qualifying Event.

A covered Employee (meaning an employee covered under the Plan) will become a Qualified Plan Participant if he or she loses his or her coverage under the Plan because either one of the following Qualifying Events happens:

1. The hours of employment are reduced; or
2. The employment ends for any reason **other than gross misconduct**.

The spouse of a covered Employee will become a Qualified Plan Participant if he or she loses his or her coverage under the Plan because any of the following Qualifying Events happens:

1. The spouse dies;
2. The spouse's hours of employment are reduced;
3. The spouse's employment ends for any reason other than his or her gross misconduct;
4. The spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
5. The spouse becomes divorced or legally separated from his or her spouse.

Dependent children will become Qualified Plan Participants if they lose coverage under the Plan because any of the following Qualifying Events happens:

1. The parent-covered Employee dies;
2. The parent-covered Employee's hours of employment are reduced;
3. The parent-covered Employee's employment ends for any reason other than his or her gross misconduct;
4. The parent-covered Employee becomes entitled to Medicare benefits (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.

7.07 Employer Notice of Qualifying Events

When the Qualifying Event is the end of employment (for reasons other than gross misconduct), reduction of hours of employment, death of the covered Employee or the covered Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Employer must notify the COBRA Administrator of the Qualifying Event.

7.08 Employee Notice of Qualifying Events

Each covered Employee or Qualified Plan Participant is responsible for providing the Plan Administrator with the following notices, in writing, either by U.S. First Class Mail or hand delivery:

1. Notice of the occurrence of a Qualifying Event that is a divorce or legal separation of a covered Employee (or former employee) from his or her spouse;
2. Notice of the occurrence of a Qualifying Event that is an individual's ceasing to be eligible as a Dependent Child under the terms of the Plan;
3. Notice of the occurrence of a second Qualifying Event after a Qualified Plan Participant has become entitled to COBRA Continuation Coverage with a maximum duration of 18 (or 29) months;
4. Notice that a Qualified Plan Participant entitled to receive Continuation Coverage with a maximum duration of 18 months has been determined by the Social Security Administration ("SSA") to be disabled at any time during the first 60 days of Continuation Coverage; and
5. Notice that a Qualified Plan Participant, with respect to whom a notice described above has been provided, has subsequently been determined by the SSA to no longer be disabled.

The Plan Administrator is:
County of El Paso
Plan Administrator
800 E. Overland, Suite 223
El Paso, Texas 79901
(915) 546-2218

Notice forms are available from the Plan Administrator and must be used when providing the notice.

7.09 Deadline for providing the notice

For Qualifying Events described above, the notice must be furnished by the date that is 30 days after the latest of:

1. The date on which the relevant Qualifying Event occurs;
2. The date on which the Qualified Plan Participant loses (or would lose) coverage under the Plan as a result of the Qualifying Event; or
3. The date on which the Qualified Plan Participant is informed, through the furnishing of the Plan's SPD or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Administrator.

For the disability determination described above, the notice must be furnished by the date that is 30 days after the latest of:

1. The date of the disability determination by the Social Security Administration ("SSA");
2. The date on which a Qualifying Event occurs;
3. The date on which the Qualified Plan Participant loses (or would lose) coverage under the Plan as a result of the Qualifying Event; or
4. The date on which the Qualified Plan Participant is informed, through the furnishing of the Plan's SPD or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Administrator.

In any event, this notice must be furnished before the end of the first 18 months of Continuation Coverage.

For a change in disability status described above, the notice must be furnished by the date that is 30 days after the later of:

1. The date of the final determination by the SSA that the Qualified Plan Participant is no longer disabled; or
2. The date on which the Qualified Plan Participant is informed, through the furnishing of the Plan's SPD or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Administrator.

The notice must be postmarked (if mailed), or received by the County of El Paso (if hand delivered), by the deadline set forth above. If the notice is late, the opportunity to elect or extend COBRA Continuation Coverage is lost, and if the person is electing COBRA Continuation Coverage, his or her coverage under the Plan will terminate on the last date for which he or she is eligible under the terms of the Plan, or if the person is extending COBRA Continuation Coverage, such Coverage will end on the last day of the initial 18-month COBRA coverage period.

7.10 Who Can Provide the Notice

Any individual who is the covered Employee (or former employee), a Qualified Plan Participant with respect to the Qualifying Event, or any representative acting on behalf of the covered Employee (or former employee) or Qualified Plan Participant, may provide the notice, and the provision of notice by one individual shall satisfy any responsibility to provide notice on behalf of all related Qualified Plan Participants with respect to the Qualifying Event.

7.11 Required Contents of the Notice

The notice must contain the following information:

1. Name and address of the covered Employee or former employee;
2. Identification of the initial Qualifying Event and its date of occurrence, if the person is already receiving COBRA Continuation Coverage and wishes to extend the maximum coverage period;

3. A description of the Qualifying Event (for example, divorce, legal separation, cessation of dependent status, entitlement to Medicare by the covered Employee or former employee, death of the covered Employee or former employee, disability of a Qualified Plan Participant or loss of disability status);
4. In the case of a Qualifying Event that is divorce or legal separation, name(s) and address(es) of spouse and dependent child(ren) covered under the Plan, date of divorce or legal separation, and a copy of the decree of divorce or legal separation;
5. In the case of a Qualifying Event that is Medicare entitlement of the covered Employee or former employee, date of entitlement, and name(s) and address(es) of spouse and Dependent child(ren) covered under the Plan;
6. In the case of a Qualifying Event that is a Dependent Child's cessation of Dependent status under the Plan, name and address of the Child, reason the Child ceased to be an eligible Dependent (for example, attained limiting age, lost student status, married or other);
7. In the case of a Qualifying Event that is the death of the covered Employee or former employee, the date of death, and name(s) and address(es) of spouse and Dependent Child(ren) covered under the Plan;
8. In the case of a Qualifying Event that is disability of a Qualified Plan Participant, name and address of the disabled Qualified Plan Participant, name(s) and address(es) of other family members covered under the Plan, the date the disability began, the date of the SSA's determination, and a copy of the SSA's determination;
9. In the case of a Qualifying Event that is loss of disability status, name and address of the Qualified Plan Participant who is no longer disabled, name(s) and address(es) of other family members covered under the Plan, the date the disability ended and the date of the SSA's determination; and
10. A certification that the information is true and correct, a signature and date.

If a copy of the decree of divorce, legal separation or the SSA's determination cannot be provided by the deadline for providing the notice, complete and provide the notice, as instructed, by the deadline and submit the copy of the decree of divorce, legal separation or the SSA's determination within 30 days after the deadline. The notice will be timely if done so. However, no COBRA Continuation Coverage, or extension of such Coverage, will be available until the copy of the decree of divorce, legal separation or the SSA's determination is provided.

If the notice does not contain all of the required information, the Plan Administrator may request additional information. If the individual fails to provide such information within the time period specified by the Plan Administrator in the request, the Plan Administrator may reject the notice if it does not contain enough information for the Plan Administrator to identify the plan, the covered Employee (or former employee), the Qualified Plan Participants, the Qualifying Event or disability, and the date on which the Qualifying Event, if any, occurred.

7.12 Electing COBRA Continuation Coverage

Complete instructions on how to elect COBRA Continuation Coverage will be provided by the Plan Administrator within 14 days of **receiving the notice of the Qualifying Event**. The individual then has 60 days in which to elect COBRA Continuation Coverage. The 60-day period is measured from the later of the date coverage terminates and the date of the notice containing the instructions. If COBRA Continuation Coverage is not elected in that 60-day period, then the right to elect it ceases.

Each Qualified Plan Participant will have an independent right to elect COBRA Continuation Coverage. Covered Employees may elect COBRA Continuation Coverage on behalf of their spouses, and parents may elect COBRA Continuation Coverage on behalf of their children.

In the event that the Plan Administrator determines that the individual is not entitled to COBRA Continuation Coverage, the Plan Administrator will provide to the individual an explanation as to why he or she is not entitled to COBRA Continuation Coverage.

7.13 Duration of COBRA Continuation Coverage

COBRA Continuation Coverage will be available up to the maximum time period shown below. Generally, multiple Qualifying Events which may be combined under COBRA will not continue coverage for more than 36 months beyond the date of the original Qualifying Event. When the Qualifying Event is "entitlement to Medicare," the 36-month continuation period is measured from the date of the original Qualifying Event. For all other

Qualifying Events, the continuation period is measured from the date of the Qualifying Event, not the date of loss of coverage.

When the Qualifying Event is the death of the covered Employee (or former employee), the covered Employee's (or former employee's) becoming entitled to Medicare benefits (under Part A, Part B, or both), a divorce or legal separation, or a Dependent Child's losing eligibility as a Dependent Child, COBRA Continuation Coverage lasts for up to a total of 36 months.

When the Qualifying Event is the end of employment or reduction of the covered Employee's hours of employment, and the covered Employee became entitled to Medicare benefits less than 18 months before the Qualifying Event, COBRA Continuation Coverage for Qualified Plan Participants other than the covered Employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered Employee becomes entitled to Medicare eight months before the date on which his or her employment terminates, COBRA Continuation Coverage for his or her spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the Qualifying Event (36 months minus 8 months).

Otherwise, when the Qualifying Event is the end of employment (for reasons other than gross misconduct) or reduction of the covered Employee's hours of employment, COBRA Continuation Coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA Continuation Coverage can be extended.

7.14 Disability Extension of COBRA Continuation Coverage

If an Employee or anyone in an Employee's family covered under the Plan is determined by the SSA to be disabled and the Employee notifies the Plan Administrator as set forth above, the Employee and his or her entire family may be entitled to receive up to an additional 11 months of COBRA Continuation Coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA Continuation Coverage and must last at least until the end of the 18-month period of COBRA Continuation Coverage. An extra fee will be charged for this extended COBRA Continuation Coverage.

7.15 Second Qualifying Event Extension of COBRA Continuation Coverage

If an Employee's family experiences another Qualifying Event while receiving 18 months of COBRA Continuation Coverage, the spouse and Dependent Children in the family can get up to 18 additional months of COBRA Continuation Coverage, for a maximum of 36 months, if notice of the second Qualifying Event properly is given to the Plan as set forth above. This extension may be available to the spouse and any Dependent Children receiving COBRA Continuation Coverage if the covered Employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the Dependent Child stops being eligible under the Plan as a Dependent Child, but only if the event would have caused the spouse or Dependent Child to lose coverage under the Plan had the first Qualifying Event not occurred.

7.16 Shorter Duration of COBRA Continuation Coverage

COBRA Continuation Coverage also may end before the end of the maximum period on the earliest of the following dates:

1. The date the employer ceases to provide a group health plan to any employee;
2. The date on which coverage ceases by reason of the Qualified Plan Participant's failure to make timely payment of any required contributions or premium;
3. The date that the Qualified Plan Participant first becomes, after the date of election, covered under any other group health plan (as an employee or otherwise), or entitled to either Medicare Part A or Part B (whichever comes first). However, a Qualified Plan Participant who becomes covered under a group health plan which has a pre-existing condition limit must be allowed to continue COBRA Continuation Coverage for the length of a pre-existing condition or to the COBRA maximum time period, if less; or
4. The first day of the month that begins more than 30 days after the date of the SSA's determination that the Qualified Plan Participant is no longer disabled, but in no event before the end of the maximum coverage period that applied without taking into consideration the disability extension.

7.17 Contribution and/or Premium Requirements

Once COBRA Continuation Coverage is elected, the individual must pay for the cost of the initial period of coverage within 45 days. Payments then are due on the first day of each month to continue coverage for that month. If a payment is not received within 30 days of the due date, COBRA Continuation Coverage will be canceled and will not be reinstated.

7.18. Additional Information

Additional information about the Plan and COBRA Continuation Coverage is available from the Plan Administrator or COBRA Administrator, please see page 3 of this Summary Plan Description:

7.19 Current Addresses

In order to protect the rights of the Employee's family, the Plan Participant should keep the Plan Administrator (who is identified above) informed of any changes in the addresses of family members.

7.20 The Trade Act of 2002

Two provisions under the Trade Act of 2002 (the "Trade Act") affect the benefits received under COBRA. First, certain eligible individuals who lose their jobs due to international trade agreements may receive a 65% tax credit for premiums paid for certain types of health insurance, including COBRA contribution or premiums. Second, eligible individuals under the Trade Act who do not elect COBRA continuation within the election period will be allowed an additional 60-day period to elect COBRA continuation coverage. If the qualified Plan Participant elects continuation during this second election period, the coverage period will run from the beginning date of the second election period. You should consult the Plan Administrator if you believe the Trade Act applies to you.

ARTICLE 8

PLAN ADMINISTRATION

The Plan is administered by the Plan Administrator. The Plan Administrator has retained the services of the Third Party Administrator to provide certain claims processing and other technical services.

8.01. Plan Administrator

The Plan is administered by the Plan Administrator within the purview of applicable law and in accordance with these provisions. An individual or entity may be appointed by the Plan Sponsor to be Plan Administrator and serve at the convenience of the Plan Sponsor. If the Plan Administrator resigns, dies, is otherwise unable to perform, is dissolved, or is removed from the position, the Plan Sponsor shall appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits (including the determination of what services, supplies, care and treatments are Experimental), to decide disputes which may arise relative to a Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator as to the facts related to any claim for benefits and the meaning and intent of any provision of the Plan, or its application to any claim, shall receive the maximum deference provided by law and will be final and binding on all interested parties. Benefits under this Plan will be paid only if the Plan Administrator decides, in its discretion, that the Participant is entitled to them.

8.02. Duties of the Plan Administrator

The duties of the Plan Administrator include the following:

1. To administer the Plan in accordance with its terms;
2. To determine all questions of eligibility, status and coverage under the Plan;
3. To interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions and disputed terms;
4. To make factual findings;
5. To decide disputes which may arise relative to a Participant's rights and/or availability of benefits;
6. To prescribe procedures for filing a claim for benefits, to review claim denials and appeals relating to them and to uphold or reverse such denials;
7. To keep and maintain the Summary Plan Descriptions and all other records pertaining to the Plan;
8. To appoint and supervise a third party administrator to pay claims;
9. To establish and communicate procedures to determine whether a medical child support order is a QMCSO;
10. To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate; and
11. To perform each and every function necessary for or related to the Plan's administration.

8.03. Amending and Terminating the Plan

The Plan Sponsor expects to maintain this Plan indefinitely; however, as the settlor of the Plan, the Plan Sponsor, through its directors and officers, may, in its discretion, at any time, amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan.

Any such amendment, suspension or termination shall be enacted by order of the Plan Sponsor in accordance with applicable Federal and State law and any applicable governing documents.

If the Plan is terminated, the rights of the Participants are limited to expenses incurred before termination. All amendments to this Plan shall become effective as of a date established by the Plan Sponsor.

ARTICLE 9 CLAIM PROCEDURES; PAYMENT OF CLAIMS

The procedures outlined below must be followed by Participants to obtain payment of health benefits under this Plan.

9.01 Health Claims

All claims and questions regarding health claims should be directed to the Claims Administrator. The Plan Administrator shall be ultimately and finally responsible for adjudicating such claims and for providing full and fair review of the decision on such claims in accordance with the following provisions. Benefits under the Plan will be paid only if the Plan Administrator decides in its discretion that the Participant is entitled to them. The responsibility to process claims in accordance with the Summary Plan Description may be delegated to the Third Party Administrator; provided, however, that the Third Party Administrator is not a fiduciary of the Plan and does not have the authority to make decisions involving the use of discretion.

Each Participant claiming benefits under the Plan shall be responsible for supplying, at such times and in such manner as the Plan Administrator in its discretion may require, written proof that the expenses were incurred or that the benefit is covered under the Plan. If the Plan Administrator in its discretion determines that the Participant has not incurred a covered expense or that the benefit is not covered under the Plan, or if the Participant fails to furnish such proof as is requested, no benefits shall be payable under the Plan.

A call from a Provider who wants to know if an individual is covered under the Plan, or if a certain procedure is covered by the Plan, prior to providing treatment is not a “claim,” since an actual claim for benefits is not being filed with the Plan. These are simply requests for information, and **any response is not a guarantee of benefits, since payment of benefits is subject to all Plan provisions, limitations and exclusions.** Once treatment is rendered, a Clean Claim must be filed with the Plan (which will be a “Post-service Claim”). At that time, a determination will be made as to what benefits are payable under the Plan.

Benefits will be payable to a Plan Participant, or to a Provider that has accepted an assignment of benefits as consideration in full for services rendered.

According to Federal regulations which apply to the Plan, there are four types of claims: Pre-service (Urgent and Non-urgent), Concurrent Care and Post-service. However, as noted below, because of this Plan’s design, there are no Pre-service Urgent Care Claims which may be filed with the Plan.

1. Pre-service Claims. A “Pre-service Claim” is a claim for a benefit under the Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care. However, if the Plan does not require the Participant to obtain approval of a medical service prior to getting treatment, then there is no “Pre-service Claim.” The Participant simply follows the Plan’s procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a Post-service Claim.

A “Pre-service Urgent Care Claim” is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the Participant or the Participant’s ability to regain maximum function, or, in the opinion of a physician with knowledge of the Participant’s medical condition, would subject the Participant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

If a Participant needs medical care for a condition which could seriously jeopardize his or her life, obtain such care without delay, and communicate with the Plan as soon as reasonably possible.

The Plan does not require the Participant to obtain approval of any urgent care or emergency medical services or admissions prior to getting treatment for an urgent care or emergency situation, so there are no “Pre-service Urgent Care Claims” under the Plan. The Participant simply follows the Plan’s procedures

with respect to any notice which may be required after receipt of treatment, and files the claim as a Post-service Claim.

Pre-admission certification of a non-emergency Hospital admission is a “claim” only to the extent of the determination made – that the type of procedure or condition warrants Inpatient confinement for a certain number of days. The rules regarding Pre-service Claims will apply to that determination only. Once a Participant has the treatment in question, the claim for benefits relating to that treatment will be treated as a Post-service Claim.

2. Concurrent Claims. A “Concurrent Claim” arises when the Plan has approved an on-going course of treatment to be provided over a period of time or number of treatments, and either:
 - a. The Plan determines that the course of treatment should be reduced or terminated; or
 - b. The Participant requests extension of the course of treatment beyond that which the Plan has approved.

If the Plan does not require the Participant to obtain approval of a medical service prior to getting treatment, then there is no need to contact the Plan Administrator to request an extension of a course of treatment. The Participant simply follows the Plan’s procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a Post-service Claim.

3. Post-service Claims. A “Post-service Claim” is a claim for a benefit under the Plan after the services have been rendered.

9.02 When Claims Must Be Filed

Claims (which must be Clean Claims) must be filed with the Claims Administrator no later than March 31 of the following calendar year. Benefits are based upon the Plan’s provisions at the time the charges were incurred. Charges are considered incurred when treatment or care is given or supplies are provided. **Claims filed later than that date shall be denied.**

A Pre-service Claim (including a Concurrent Claim that also is a Pre-service Claim) is considered to be filed when the request for approval of treatment or services is made and received by the Claims Administrator in accordance with the Plan’s procedures. However, a Post-service Claim is considered to be filed when the following information is received by the Claims Administrator, together with a Form HCFA or Form UB92:

1. The date of service;
2. The name, address, telephone number and tax identification number of the Provider of the services or supplies;
3. The place where the services were rendered;
4. The diagnosis and procedure codes;
5. The amount of charges;
6. The name of the Plan;
7. The name of the covered Plan Participant; and
8. The name of the patient.

Upon receipt of this information, the claim will be deemed to be initiated with the Plan.

The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the claim (a Clean Claim). If not, more information may be requested as provided herein. This additional information must be received by the Claims Administrator within 45 days (48 hours in the case of Pre-service Urgent Care Claims) from receipt by the Participant of the request for additional information. **Failure to do so may result in claims being declined or reduced.**

9.03 Timing of Claim Decisions

Upon receiving a Clean Claim, the Claims Administrator shall notify the Participant, in accordance with the provisions set forth below, of any adverse benefit determination (and, in the case of Pre-service Claims and Concurrent Claims, of decisions that a claim is payable in full) within the following timeframes:

1. Pre-service Non-urgent Care Claims.

- a. If the Participant has provided all of the information needed to process the claim, in a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.
- b. If the Participant or a Provider has not provided all of the information needed to process the claim (a Clean Claim has not been submitted), then the Participant will be notified by Claims Administrator as to what specific information is needed as soon as possible, after receipt of the claim. The Participant will be notified of a determination of benefits within a reasonable period of time appropriate to the medical circumstances, either prior to the end of the extension period (if additional information was requested during the initial processing period), or by the date agreed to by the Claims Administrator and the Participant (if additional information was requested during the extension period).

2. Concurrent Claims:

- a. Plan Notice of Reduction or Termination. If the Claims Administrator is notifying the Participant of a reduction or termination of a course of treatment (other than by Plan amendment or termination), before the end of such period of time or number of treatments, the Participant will be notified sufficiently in advance of the reduction or termination to allow the Participant to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated.
- b. Request by Participant Involving Urgent Care. If the Claims Administrator receives a request from a Participant to extend the course of treatment beyond the period of time or number of treatments that is a claim involving Urgent Care, as soon as possible, taking into account the medical exigencies, but not later than 24 hours after receipt of the claim, as long as the Participant makes the request at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. If the Participant submits the request with less than 24 hours prior to the expiration of the prescribed period of time or number of treatments, the request will be treated as a claim involving Urgent Care and decided within the Urgent Care timeframe.
- c. Request by Participant Involving Non-urgent Care. If the Claims Administrator receives a request from the Participant to extend the course of treatment beyond the period of time or number of treatments that is a claim not involving Urgent Care, the request will be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim (either as a Pre-service Non-urgent Claim or a Post-service Claim).

3. Post-service Claims:

- a. If the Participant has provided a Clean Claim, in a reasonable period of time, but not later than 30 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.
- b. If the Participant has not provided all of the information needed to process the claim and additional information is requested during the initial processing period, then the Participant will be notified of a determination of benefits prior to the end of the extension period, unless additional information is

requested during the extension period, then the Participant will be notified of the determination by a date agreed to by the Plan Administrator and the Participant.

4. Extensions – Pre-service Non-urgent Care Claims. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Participant, prior to the expiration of the initial 15-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.
5. Extensions – Post-service Claims. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Participant, prior to the expiration of the initial 30-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.
6. Calculating Time Periods. The period of time within which a benefit determination is required to be made shall begin at the time a claim is deemed to be filed in accordance with the procedures of the Plan.

9.04 Notification of an Adverse Benefit Determination

The Claims Administrator shall provide a Plan Participant with a notice, either in writing or electronically (or, in the case of pre-service urgent care claims, by telephone, facsimile or similar method, with written or electronic notice following within 3 days), containing the following information:

1. A reference to the specific portion(s) of the Summary Plan Description upon which a denial is based;
2. Specific reason(s) for a denial;
3. A description of any additional information necessary for the Participant to perfect the claim and an explanation of why such information is necessary;
4. A description of the Plan's review procedures and the time limits applicable to the procedures, including a statement of the Participant's rights following an adverse benefit determination on final review;
5. A statement that the Participant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Participant's claim for benefits;
6. The identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request);
7. Any rule, guideline, protocol or similar criterion that was relied upon in making the determination (or a statement that it was relied upon and that a copy will be provided to the Participant, free of charge, upon request);
8. In the case of denials based upon a medical judgment (such as whether the treatment is Medically Necessary or Experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Participant's medical circumstances, or a statement that such explanation will be provided to the Participant, free of charge, upon request.
9. In a claim involving urgent care, a description of the Plan's expedited review process.

Appeal of Adverse Benefit Determinations

9.05 Full and Fair Review of All Claims

In cases where a claim for benefits is denied, in whole or in part, and the Participant believes the claim has been denied wrongly, the Participant may appeal the denial and review pertinent documents. The claims procedures of this Plan provide a Participant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination. More specifically, the Plan provides:

1. 180 days following receipt of a notification of an initial adverse benefit determination within which to appeal the determination;
2. The opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;

3. For a review that does not afford deference to the previous adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan, who shall be neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;
4. For a review that takes into account all comments, documents, records, and other information submitted by the Participant relating to the claim, without regard to whether such information was submitted or considered in the prior benefit determination;
5. That, in deciding an appeal of any adverse benefit determination that is based in whole or in part upon a medical judgment, the Plan fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual;
6. For the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claim, even if the Plan did not rely upon their advice; or
7. That a Participant will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Participant's claim for benefits in possession of the Plan Administrator or the Third Party Administrator; information regarding any voluntary appeals procedures offered by the Plan; any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse determination; and an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Participant's medical circumstances.

9.06 Requirements for Appeal

The Participant must file an appeal of a post-service claim in writing within 180 days following receipt of the notice of an adverse benefit determination.

For pre-service urgent care claims, if the Plan Participant chooses to initiate an appeal orally, the Plan Participant may telephone:

**HealthSCOPE Benefits
7430 Remcon Circle Bldg C
El Paso, Texas 79912
Phone: (915) 581-8182
Fax: (915) 581-7537**

Oral appeals should be submitted in writing as soon as possible after it has been initiated. To file any appeal in writing, the Participant's appeal must be addressed as follows:

1. For Pre-service Claims:

Participants should refer to their identification card for the name and address of the utilization review administrator. All pre-service claims must be sent to the utilization review administrator.

2. For Post-service Claims:

**HealthSCOPE Benefits
7430 Remcon Circle Bldg C
El Paso, Texas 79912
Phone: (915) 581-8182
Fax: (915) 581-7537**

It shall be the responsibility of the Participant to submit proof that the claim for benefits is covered and payable under the provisions of the Plan. Any appeal must include:

1. The name of the Plan Participant;
2. The Plan Participant's social security number;
3. The group name or identification number;

4. All facts and theories supporting the claim for benefits. **Failure to include any theories or facts in the appeal will result in their being deemed waived. In other words, the Participant will lose the right to raise factual arguments and theories which support this claim if the Participant fails to include them in the appeal;**
5. A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim; and
6. Any material or information that the Participant has which indicates that the Participant is entitled to benefits under the Plan.

If the Participant provides all of the required information, it may be that the expenses will be eligible for payment under the Plan.

9.07 Timing of Notification of Benefit Determination on Review

The Plan Administrator shall notify the Participant of the Plan's benefit determination on review within the following timeframes:

1. Pre-service Non-urgent Care Claims: Within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of the appeal.
2. Concurrent Claims: The response will be made in the appropriate time period based upon the type of claim – Pre-service Urgent, Pre-service Non-urgent or Post-service.
3. Post-service Claims: Within a reasonable period of time, but not later than 60 days after receipt of the appeal.
4. Calculating Time Periods: The period of time within which the Plan's determination is required to be made shall begin at the time an appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

9.08 Manner and Content of Notification of Adverse Benefit Determination on Review

The Plan Administrator shall provide a Participant with notification, with respect to pre-service urgent care claims, by telephone, facsimile or similar method, and with respect to all other types of claims, in writing or electronically, of a Plan's adverse benefit determination on review, setting forth:

1. The specific reason or reasons for the denial;
2. Reference to the specific portion(s) of the summary plan description on which the denial is based;
3. The identity of any medical or vocational experts consulted in connection with the claim, even if the Plan did not rely upon their advice;
4. A statement that the Plan Participant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Plan Participant's claim for benefits;
5. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the Plan Participant upon request;
6. If the adverse benefit determination is based upon a medical judgment, a statement that an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Plan Participant's medical circumstances, will be provided free of charge upon request;

7. A statement of the Plan Participant's rights, following an adverse benefit determination on final review; and
8. The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

9.09 Furnishing Documents in the Event of an Adverse Determination

In the case of an adverse benefit determination on review, the Plan Administrator shall provide such access to, and copies of, documents, records, and other information described in the section relating to "Manner and Content of Notification of Adverse Benefit Determination on Review" as appropriate.

9.10 Decision on Review to be Final

If, for any reason, the Participant does not receive a written response to the appeal within the appropriate time period set forth above, the Participant may assume that the appeal has been denied. The decision by the Plan Administrator or other appropriate named fiduciary of the Plan on review will be final, binding and conclusive and will be afforded the maximum deference permitted by law. **All claim review procedures provided for in the Plan must be exhausted before any legal action is brought.**

9.11 Appointment of Authorized Representative

A Participant is permitted to appoint an authorized representative to act on his or her behalf with respect to a benefit claim or appeal of a denial. An assignment of benefits by a Participant to a Provider will not constitute appointment of that Provider as an authorized representative. To appoint such a representative, the Participant must complete a form which can be obtained from the Plan Administrator or the Claims Administrator. However, in connection with a claim involving Urgent Care, the Plan will permit a health care professional with knowledge of the Participant's medical condition to act as the Participant's authorized representative without completion of this form. In the event a Participant designates an authorized representative, all future communications from the Plan will be with the representative, rather than the Participant, unless the Participant directs the Plan Administrator, in writing, to the contrary.

9.12 Physical Examinations

The Plan reserves the right to have a Physician of its own choosing examine any Participant whose condition, Sickness or Injury is the basis of a claim. All such examinations shall be at the expense of the Plan. This right may be exercised when and as often as the Plan may reasonably require during the pendency of a claim. The Participant must comply with this requirement as a necessary condition to coverage.

9.13 Autopsy

The Plan reserves the right to have an autopsy performed upon any deceased Participant whose condition, Sickness, or Injury is the basis of a claim. This right may be exercised only where not prohibited by law.

9.14 Payment of Benefits

All benefits under this Plan are payable, in U.S. Dollars, to the covered Plan Participant whose Sickness or Injury, or whose covered Dependent's Sickness or Injury, is the basis of a claim. In the event of the death or incapacity of a covered Plan Participant and in the absence of written evidence to this Plan of the qualification of a guardian for his or her estate, this Plan may, in its discretion, make any and all such payments to the individual or institution which, in the opinion of this Plan, is or was providing the care and support of such Employee.

9.15 Assignments

Benefits for medical expenses covered under this Plan may be assigned by a Participant to the Provider as consideration in full for services rendered; however, if those benefits are paid directly to the Plan Participant, the Plan shall be deemed to have fulfilled its obligations with respect to such benefits. The Plan will not be responsible for determining whether any such assignment is valid. Payment of benefits which have been assigned will be made directly to the assignee unless a written request not to honor the assignment, signed by the covered Plan Participant and the assignee, has been received before the proof of loss is submitted.

No Participant shall at any time, either during the time in which he or she is a Participant in the Plan, or following his or her termination as a Participant, in any manner, have any right to assign his or her right to sue to recover benefits under the Plan, to enforce rights due under the Plan or to any other causes of action which he or she may have against the Plan or its fiduciaries.

A Provider which accepts an assignment of benefits, in accordance with this Plan as consideration in full for services rendered, is bound by the rules and provisions set forth within the terms of this document.

9.16 Recovery of Payments

Occasionally, benefits are paid more than once, are paid based upon improper billing or a misstatement in a proof of loss or enrollment information, are not paid according to the Plan's terms, conditions, limitations or exclusions, or should otherwise not have been paid by the Plan. As such this Plan may pay benefits that are later found to be greater than the Maximum Allowable Charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid, primary payers, or from the party on whose behalf the charge(s) were paid. As such, whenever the Plan pays benefits exceeding the amount of benefits payable under the terms of the Plan, the Plan Administrator has the right to recover any such erroneous payment directly from the person or entity who received such payment and/or from other payers and/or the Plan Participant or dependent on whose behalf such payment was made.

A Plan Participant, Dependent, Provider, another benefit plan, insurer, or any other person or entity who receives a payment exceeding the amount of benefits payable under the terms of the Plan or on whose behalf such payment was made, shall return or refund the amount of such erroneous payment to the Plan within 30 days of discovery or demand. The Plan Administrator shall have no obligation to secure payment for the expense for which the erroneous payment was made or to which it was applied.

The person or entity receiving an erroneous payment may not apply such payment to another expense. The Plan Administrator shall have the discretion to choose who will repay the Plan for an erroneous payment and whether such payment shall be reimbursed in a lump sum. When a Plan Participant or other entity does not comply with the provisions of this section, the Plan Administrator shall have the authority, in its discretion, to deny payment of any claims for benefits by the Plan Participant and to deny or reduce future benefits payable (including payment of future benefits for other injuries or illnesses) under the Plan by the amount due as reimbursement to the Plan. The Plan Administrator may also, in its discretion, deny or reduce future benefits (including future benefits for other injuries or illnesses) under any other group benefits plan maintained by the Plan Sponsor. The reductions will equal the amount of the required reimbursement.

Providers and any other person or entity accepting payment from the Plan or to whom a right to benefits has been assigned, in consideration of services rendered, payments and/or rights, agrees to be bound by the terms of this Plan and agree to submit claims for reimbursement in strict accordance with their State's health care practice acts, ICD-9 or CPT standards, Medicare guidelines, HCPCS standards, or other standards approved by the Plan Administrator or insurer. Any payments made on claims for reimbursement not in accordance with the above provisions shall be repaid to the Plan within 30 days of discovery or demand or incur prejudgment interest of 1.5% per month. If the Plan must bring an action against a Plan Participant, Provider or other person or entity to enforce the provisions of this section, then that Plan Participant, Provider or other person or entity agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

Further, Plan Participants and/or their dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (Plan Participants) shall assign or be deemed to have assigned to the Plan their right to recover said payments made by the Plan, from any other party and/or recovery for which the Plan Participant(s) are entitled, for or in relation to facility-acquired condition(s), Provider error(s), or damages arising from another party's act or omission for which the Plan has not already been refunded.

The Plan reserves the right to deduct from any benefits properly payable under this Plan the amount of any payment which has been made:

1. In error;

2. Pursuant to a misstatement contained in a proof of loss or a fraudulent act;
3. Pursuant to a misstatement made to obtain coverage under this Plan within two years after the date such coverage commences;
4. With respect to an ineligible person;
5. In anticipation of obtaining a recovery if a Plan Participant fails to comply with the Plan's Third Party Recovery, Subrogation and Reimbursement provisions; or
6. Pursuant to a claim for which benefits are recoverable under any policy or act of law providing for coverage for occupational Injury or disease to the extent that such benefits are recovered. This provision (6) shall not be deemed to require the Plan to pay benefits under this Plan in any such instance.

The deduction may be made against any claim for benefits under this Plan by a Plan Participant or by any of his Covered Dependents if such payment is made with respect to the Plan Participant or any person covered or asserting coverage as a Dependent of the Plan Participant.

If the Plan seeks to recoup funds from a Provider, due to a claim being made in error, a claim being fraudulent on the part of the Provider, and/or the claim that is the result of the Provider's misstatement, said Provider shall, as part of its assignment to benefits from the Plan, abstain from billing the plan participant for any outstanding amount(s).

9.17 Medicaid Coverage

A Participant's eligibility for any State Medicaid benefits will not be taken into account in determining or making any payments for benefits to or on behalf of such Participant. Any such benefit payments will be subject to the State's right to reimbursement for benefits it has paid on behalf of the Participant, as required by the State Medicaid program; and the Plan will honor any Subrogation rights the State may have with respect to benefits which are payable under the Plan.

ARTICLE 10 COORDINATION OF BENEFITS

10.01 Benefits Subject to This Provision

This provision shall apply to all benefits provided under any section of this Plan.

10.02 Excess Insurance

If at the time of injury, sickness, disease or disability there is available, or potentially available any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage.

The Plan's benefits will be excess to, whenever possible:

- a) Any primary payer besides the Plan;
- b) Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
- c) Any policy of insurance from any insurance company or guarantor of a third party;
- d) Worker's compensation or other liability insurance company; or
- e) Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

10.03 Vehicle Limitation

When medical payments are available under any vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan and/or policy deductibles. This Plan shall always be considered secondary to such plans and/or policies. This applies to all forms of medical payments under vehicle plans and/or policies regardless of its name, title or classification.

10.04 Allowable Expenses.

"Allowable Expenses" shall mean the Usual and Customary charge for any Medically Necessary, Reasonable, eligible item of expense, at least a portion of which is covered under this Plan. When some Other Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered, in the amount that would be payable in accordance with the terms of the Plan, shall be deemed to be the benefit. Benefits payable under any Other Plan include the benefits that would have been payable had claim been duly made therefore.

10.05 "Claim Determination Period"

"Claim Determination Period" shall mean each calendar year.

10.06 "Application to Benefit Determinations"

The plan that pays first according to the rules in the section entitled "Order of Benefit Determination" will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance due up to 100% of the total Allowable Expenses. When there is a conflict in the rules, this Plan will never pay more than 50% of Allowable Expenses when paying secondary. Benefits will be coordinated on the basis of a Claim Determination Period.

When medical payments are available under automobile insurance, this Plan will pay excess benefits only, without reimbursement for automobile plan deductibles. This Plan will always be considered the secondary carrier regardless of the individual's election under personal injury protection (PIP) coverage with the automobile insurance carrier.

In certain instances, the benefits of the Other Plan will be ignored for the purposes of determining the benefits under this Plan. This is the case when:

1. The Other Plan would, according to its rules, determine its benefits after the benefits of this Plan have been determined; and

2. The rules in the section entitled “Order of Benefit Determination” would require this Plan to determine its benefits before the Other Plan.

10.07 “Order of Benefit Determination”

For the purposes of the section entitled “Application to Benefit Determinations,” the rules establishing the order of benefit determination are:

1. A plan without a coordinating provision will always be the primary plan;
2. The benefits of a plan which covers the person on whose expenses claim is based, other than as a dependent, shall be determined before the benefits of a plan which covers such person as a dependent;
3. If the person for whom claim is made is a dependent child covered under both parents’ plans, the plan covering the parent whose birthday (month and day of birth, not year) falls earlier in the year will be primary, except:
 - a. When the parents are separated or divorced, and the parent with the custody of the child has not remarried, the benefits of a plan which covers the child as a dependent of the parent with custody will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody; or
 - b. When the parents are divorced and the parent with custody of the child has remarried, the benefits of a plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a plan which covers that child as a dependent of the stepparent, and the benefits of a plan which covers that child as a dependent of the stepparent will be determined before the benefits of a plan which covers that child as a dependent of the parent without custody.

Notwithstanding the above, if there is a court decree which would otherwise establish financial responsibility for the child’s health care expenses, the benefits of the plan which covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any Other Plan which covers the child as a dependent child; and

4. When the rules 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 shall be determined before the benefits of a plan which has covered such person the shorter period of time.

10.08 Right to Receive and Release Necessary Information

For the purpose of determining the applicability of and implementing the terms of this provision or any provision of similar purpose of any Other Plan, this Plan may, without the consent of or notice to any person, release to or obtain from any insurance company, or other organization or individual, any information with respect to any person, which the Plan deems to be necessary for such purposes. Any person claiming benefits under this Plan shall furnish to the Plan such information as may be necessary to implement this provision.

10.09 Facility of Payment

Whenever payments which should have been made under this Plan in accordance with this provision have been made under any Other Plans, the Plan Administrator may, in its discretion, pay any organizations 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, this Plan shall be fully discharged from liability.

10.10 Right of Recovery

Whenever payments have been made by this Plan with respect to Allowable Expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this Article, the Plan shall have the right to recover such payments, to the extent of such excess, from any one or more of the following as this Plan shall determine: any person to or with respect to whom such payments were made, or such person’s legal representative, any insurance companies, or any other individuals or organizations which the Plan determines are responsible for payment of such Allowable Expenses, and any future benefits payable to the Participant or his or her Dependents.

ARTICLE 11 MEDICARE

11.01 Applicable to Active Employees and Their Spouses Ages 65 and Over

An active Employee and his or her spouse (ages 65 and over) may, at the option of such Employee, elect or reject coverage under this Plan. If such Employee elects coverage under this Plan, the benefits of this Plan shall be determined before any benefits provided by Medicare. If coverage under this Plan is rejected by such Employee, benefits listed herein will not be payable even as secondary coverage to Medicare.

11.02 Applicable to All Other Participants Eligible for Medicare Benefits

To the extent required by Federal regulations, this Plan will pay before any Medicare benefits. There are some circumstances under which Medicare would be required to pay its benefits first. In these cases, benefits under this Plan would be calculated as secondary payor (as described under the Article entitled "Coordination of Benefits"). The Participant will be assumed to have full Medicare coverage (that is, both Part A & B) whether or not the Participant has enrolled for the full coverage. If the Provider accepts assignment with Medicare, covered expenses will not exceed the Medicare-approved expenses.

11.03 Applicable to Medicare Services Furnished to End Stage Renal Disease ("ESRD") Plan Participants Who Are Covered Under This Plan

If any Participant is eligible for Medicare benefits because of ESRD, the benefits of the Plan will be determined before Medicare benefits for the first 30 months of Medicare entitlement (with respect to charges incurred on or after August 5, 1997), unless applicable Federal law provides to the contrary, in which event the benefits of the Plan will be determined in accordance with such law.

ARTICLE 12

THIRD PARTY RECOVERY, SUBROGATION AND REIMBURSEMENT

12.01. Payment Condition

1. The Plan, in its discretion, may elect to conditionally advance payment of benefits in those situations where an injury, sickness, disease or disability is caused in whole or in part by, or results from the acts or omissions of Plan Participants, and/or their dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as “Plan Participant(s)”) or a third party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or grantor(s) of a third party (collectively “Coverage”).

2. Plan Participant(s), his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan’s conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain one hundred percent (100%) of the Plan’s conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan’s assignee. By accepting benefits the Plan Participant(s) agrees the Plan shall have an equitable lien on any funds received by the Plan Participant(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Plan Participant(s) agrees to include the Plan’s name as a co-payee on any and all settlement drafts.

3. In the event a Plan Participant(s) settles, recovers, or is reimbursed by any Coverage, the Plan Participant(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Plan Participant(s). If the Plan Participant(s) fails to reimburse the Plan out of any judgment or settlement received, the Plan Participant(s) will be responsible for any and all expenses (fees and costs) associated with the Plan’s attempt to recover such money.

4. If there is more than one party responsible for charges paid by the Plan, or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Plan Participant(s) is/are only one or a few, that unallocated settlement fund is considered designated as an “identifiable” fund from which the plan may seek reimbursement.

12.02 Subrogation

Subrogation applies to situations where the Covered Person is injured and another party is responsible for payment of health care expenses (s)he incurs because of the injury. The other party may be an individual, insurance company or some other public or private entity. Automobile accident injuries or personal injury on another’s property are examples of cases frequently subject to subrogation.

The Subrogation provision allows for the right of recovery for certain payments. Any payments made for the Covered Person’s injuries under the Plan may be recovered from the other party. Any payments made to the Covered Person for such injury may be recovered from the Covered Person from any judgment or settlement of his or her claims against the other party or parties.

By accepting Coverage under the Plan, the Covered Person automatically assigns to the Plan any rights the Covered Person may have to recover all or part of any payments made by the Plan from any other party, including an insurer or another group health program. The Covered Person has a duty to notify the Plan Administrator of any recovery or potential right of recovery from a third party whose action or inaction caused injury, and the Plan Administrator may act as the Covered Person’s substitute in the event any payment made by this Plan for health care benefits, including any payment for a Pre-existing Condition, is or

becomes the responsibility of another party. Such payments shall be referred to as Reimbursable Payments. This assignment allows the Plan to pursue any claim that the Covered Person may have, whether or not the Covered Person chooses to pursue that claim.

The Covered Person must cooperate fully and provide all information needed under the Plan to recover payments, execute any papers necessary for such recovery, and do whatever else is necessary to secure such rights to the Plan. The other party may be sued in order to recover the payments made for the Covered Person under the Plan.

12.03 Right of Reimbursement

Specifically, by accepting Coverage under the Plan the Covered Person agrees that if the Covered Person receives any recovery in the form of a judgment, settlement, payment or compensation (regardless of fault, negligence or wrongdoing) from (1) a tortfeasor, (2) a liability insurer for a tortfeasor, or (3) any other source, including but not limited to any form of insured or underinsured motorist coverage, any medical payments, no-fault or school insurance coverages, workers' compensation coverage, premises liability coverage, any medical malpractice recovery, or any other form of insurance coverage ("Recovery"), the Covered Person must notify the Plan Administrator of any recovery or potential right of recovery from a third party whose action or inaction caused injury, and repay the Plan in full for any medical, dental, vision, or disability benefits which have been paid or which will in the future be payable under the Plan for expenses already incurred or which are reasonably foreseeable at the time of such Recovery.

Pursuant to *Texas Local Government Code Chapter 172 and Section 172.015*, the Plan is subrogated to a covered person's right of recovery for personal injuries caused by the tortious conduct of a third party. the Plan has an equitable lien against the Recovery rights of the Covered Person and has the right to be paid from any such Recovery any and all monies or properties: (1) paid; (2) payable to; or (3) for the benefit of, a Covered Person to the extent of benefits paid by the Plan ("Subrogated Amount"), whether or not the Covered Person has been "made whole" for the injuries received. This right applies on a first-dollar basis (i.e., has priority over other rights), applies whether the funds paid to (or for the benefit of) the Covered Person constitute a full or partial recovery, and applies to funds paid for non-health care charges or attorney fees, or other costs and expenses. This right for first priority in contravention of the "make whole" doctrine shall not be affected or limited in any way by the manner in which the Covered Person or any person or entity responsible for paying any Recovery attempts to designate or characterize the Recovery, regardless of whether the recovery itemizes or identifies an amount awarded for Plan benefits or medical expenses, or is specifically linked to certain kinds of damages or payments. Payment of the Subrogated Amount to the Plan shall be without reduction, set-off or abatement for attorney's fees or costs incurred by the Covered Person in the collection of damages. The Plan shall also be entitled to seek any other equitable remedy against any party possessing or controlling such monies or properties. At the discretion of the Plan Administrator, the Plan may reduce any future Eligible Expenses otherwise available to the Covered Person under the Plan by an amount up to the total amount of Subrogated Amount that is subject to the equitable lien. All rights of recovery will be limited to the amount of payments made under this Plan.

The equitable lien shall also attach to the first right of Recovery to any money or property that is obtained by anybody, including but not limited to the Covered Person, the Covered Person's attorney, and/or a trust for the direct or indirect benefit of the Insured or for his/her "special needs," as a result of an exercise of the Covered Person's rights of Recovery.

The Plan may, in its sole discretion, require the Covered Person, as a pre-condition to receiving benefit payments, to sign a subrogation agreement and to agree in writing to assist the Plan to secure the Plan's right to payment of the Subrogation Amount from the third party. In the event that the Plan does not receive payment of the Subrogated Amount, the Plan may, in its sole discretion, bring legal action against the Covered Person or reduce or set-off the unpaid Subrogated Amount against any future benefit payments to the Covered Person. If the Plan takes legal action to enforce its subrogation rights, the Plan shall be entitled to recover its attorneys' fees and costs from the Covered Person.

The following provisions apply to the Plan's right of subrogation, reimbursement, and creation of an equitable lien:

1. **"Pursue and Pay."** The Plan Administrator has elected a "pursue and pay" in connection with the subrogation, reimbursement and equitable lien rights. At its sole discretion, the Plan Administrator may elect to "pursue and pay" in connection with the subrogation, reimbursement and equitable lien rights for all claims involving Eligible Expenses of \$500 or more. Pursuant to the election of "pursue and pay", the Plan Administrator has the right to apply the subrogation, reimbursement and equitable lien rights prior to making any benefit payments under the Plan, and such payment shall be reduced by any amounts that were paid by any other party as described in this section.

2. **Scope of Subrogation, Reimbursement and Equitable Lien Rights.** The subrogation, reimbursement and equitable lien rights apply to any benefits paid by the Plan on behalf of the Covered Person as a result of the Injuries sustained, including, but not limited to:

- a. Any no-fault insurance;
- b. Medical benefits coverage under any automobile liability plan. This includes the Covered Person's Plan or any third party's policy under which the Covered Person is entitled to benefits;
- c. Under-insured and uninsured motorist coverage;
- d. Any automobile medical payments and personal injury protection benefits;
- e. Any third party's liability insurance
- f. Any premises/guest medical payments coverage;
- g. Any medical malpractice recovery;
- h. Workers' compensation benefits. The right of subrogation, reimbursement and equitable lien attach to any right to payment for workers' compensation, whether by judgment or settlement, where the Plan has paid expenses otherwise eligible as Covered Services prior to a determination that the Covered Services arose out of and in the course of employment. Payment by Workers' Compensation insurers or the employer will be deemed to mean that such a determination has been made;
- i. Any other governmental agency reimbursement (i.e., state medical malpractice compensation funds).

12.04 Separation of Funds

1. Benefits paid by the Plan, funds recovered by the Plan Participant(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Plan Participant(s), such that the death of the Plan Participant(s), or filing of bankruptcy by the Plan Participant(s), will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement.

12.05 Wrongful Death

1. In the event that the Plan Participant(s) dies as a result of his or her injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply.

12.06 Obligations

1. It is the Plan Participant(s)' obligation at all times, both prior to and after payment of medical benefits by the Plan:
 - a) To cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights;

- b) To provide the Plan with pertinent information regarding the sickness, disease, disability, or injury, including accident reports, settlement information and any other requested additional information;
 - c) To take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;
 - d) To do nothing to prejudice the Plan's rights of subrogation and reimbursement;
 - e) To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received; and
 - f) To not settle or release, without the prior consent of the Plan, any claim to the extent that the Plan Participant may have against any responsible party or Coverage.
2. If the Plan Participant(s) and/or his or her attorney fails to reimburse the Plan for all benefits paid or to be paid, as a result of said injury or condition, out of any proceeds, judgment or settlement received, the Plan Participant(s) will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Plan Participant(s).
3. The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Plan Participant(s)' cooperation or adherence to these terms.

12.07 Offset

1. Failure by the Plan Participant(s) and/or his or her attorney to comply with any of these requirements may, at the Plan's discretion, result in a forfeiture of payment by the Plan of medical benefits and any funds or payments due under this Plan on behalf of the Plan Participant(s) may be withheld until the Plan Participant(s) satisfies his or her obligation.

12.08 Minor Status

1. In the event the Plan Participant(s) is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.
2. If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

12.09 Language Interpretation

1. The Plan Administrator retains full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan's subrogation and reimbursement rights. The Plan Administrator may amend the Plan at any time without notice.

12.10 Severability

1. In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

ARTICLE 13 MISCELLANEOUS PROVISIONS

13.01 Clerical Error/Delay

Clerical errors made on the records of the Plan and delays in making entries on such records shall not invalidate coverage nor cause coverage to be in force or to continue in force. Rather, the Effective Dates of coverage shall be determined solely in accordance with the provisions of this Plan regardless of whether any contributions with respect to Participants have been made or have failed to be made because of such errors or delays. Upon discovery of any such error or delay, an equitable adjustment of any such contributions will be made.

13.02 Conformity With Applicable Laws

This Plan shall be deemed to automatically be amended to conform as required by any applicable law, regulation or the order or judgment of a court of competent jurisdiction governing provisions of this Plan, including, but not limited to, stated maximums, exclusions or limitations. In the event that any law, regulation or the order or judgment of a court of competent jurisdiction causes the Plan Administrator to pay claims which are otherwise limited or excluded under this Plan, such payments will be considered as being in accordance with the terms of this Summary Plan Description.

13.03 Fraud

The following actions by any Participant, or a Participant's knowledge of such actions being taken by another, constitute fraud and will result in immediate termination of all coverage under this Plan for the entire Family Unit of which the Participant is a member:

1. Attempting to submit a claim for benefits (which includes attempting to fill a prescription) for a person who is not a Participant of the Plan;
2. Attempting to file a claim for a Participant for services which were not rendered or Drugs or other items which were not provided;
3. Providing false or misleading information in connection with enrollment in the Plan; or
4. Providing any false or misleading information to the Plan.

13.04 Headings

The headings used in this Summary Plan Description are used for convenience of reference only. Participants are advised not to rely on any provision because of the heading.

13.05 No Waiver or Estoppel

No term, condition or provision of this Plan shall be deemed to have been waived, and there shall be no estoppel against the enforcement of any provision of this Plan, except by written instrument of the party charged with such waiver or estoppel. No such written waiver shall be deemed a continuing waiver unless specifically stated therein, and each such waiver shall operate only as to the specific term or condition waived and shall not constitute a waiver of such term or condition for the future or as to any act other than the one specifically waived.

13.06 Plan Contributions

The Plan Administrator shall, from time to time, evaluate the funding method of the Plan and determine the amount to be contributed by the Plan Sponsor and the amount to be contributed (if any) by each Participant.

The Plan Sponsor shall fund the Plan in a manner consistent with the provisions of the Internal Revenue Code, and such other laws and regulations as shall be applicable to the end that the Plan shall be funded on a lawful and sound basis; but, to the extent permitted by governing law, the Plan Administrator shall be free to determine the manner and means of funding the Plan. The amount of the Participant's contribution (if any) will be determined from time to time by the Plan Sponsor. Current plan year contributions are available through the Human Resources Department.

13.07 Right to Receive and Release Information

For the purpose of determining the applicability of and implementing the terms of these benefits, the Plan Administrator may, without the consent of or notice to any person, release or obtain any information necessary to determine the acceptability of any applicant or Participant for benefits from this Plan. In so acting, the Plan Administrator shall be free from any liability that may arise with regard to such action. Any Participant claiming benefits under this Plan shall furnish to the Plan Administrator such information as may be necessary to implement this provision.

13.08 Written Notice

Any written notice required under this Plan which, as of the Effective Date, is in conflict with the law of any governmental body or agency which has jurisdiction over this Plan shall be interpreted to conform to the minimum requirements of such law.

13.09 Right of Recovery

Whenever payments have been made by this Plan in a total amount, at any time, in excess of the maximum amount of benefits payable under this Plan, the Plan shall have the right to recover such payments, to the extent of such excess, from any one or more of the following as this Plan shall determine: any person to or with respect to whom such payments were made, or such person's legal representative, any insurance companies, or any other individuals or organizations which the Plan determines are responsible for payment of such amount, and any future benefits payable to the Participant or his or her Dependents..

13.10 Statements

All statements made by the Plan Sponsor or by a Plan Participant will, in the absence of fraud, be considered representations and not warranties, and no statements made for the purpose of obtaining benefits under this document will be used in any contest to avoid or reduce the benefits provided by the document unless contained in a written application for benefits and a copy of the instrument containing such representation is or has been furnished to the Plan Participant.

Any Plan Participant who knowingly and with intent to defraud the Plan, files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any material fact, commits a fraudulent act. The Plan Participant may be subject to civil action or criminal prosecution. Fraudulently claiming benefits may be punishable by a substantial fine, imprisonment, or both.

13.11 Claims Review Procedures

In addition to the Plan's Medical Record Review process, the Claims Administrator may use its discretionary authority to utilize an independent bill review and/or claim audit program or service for a complete claim. While every claim may not be subject to a bill review or audit, the Claims Administrator has the discretionary authority for selection of claims subject to review or audit.

The analysis will be employed to identify charges billed in error and/or charges that are not Usual and Customary and/or Medically Necessary and Reasonable, if any, and may include a patient medical billing records review and/or audit of the patient's medical charts and records.

Upon completion of an analysis, a report will be submitted to the Claims Administrator or its agent to identify the charges deemed in excess of the Usual and Customary and Reasonable amounts or other applicable provisions, as outlined in this Summary Plan Description.

Despite the existence of any agreement to the contrary, the Claims Administrator has the discretionary authority to reduce any charge to a Usual and Customary and Reasonable charge, in accord with the terms of this Summary Plan Description.

13.12 Language Interpretation

The Plan Administrator retains full and final discretionary authority to construe and interpret the language of this Summary Plan Description, to determine all questions of fact and law arising under this Summary Plan Description, and to administer the Plan's subrogation and reimbursement rights. The Plan Administrator may amend the Plan at any time without notice.

13.13 Severability

In the event that any section of this Summary Plan Description is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

ARTICLE 14 COVERED MEDICAL EXPENSES

14.01 Medical Benefits

Subject to the Plan's provisions, limitations and exclusions, the following are covered major medical benefits:

1. **Allergy Services.** Charges related to the Treatment of allergies;
2. **Ambulance.** Transportation by professional licensed ambulance, including approved available air transportation to a local Hospital or transfer to the nearest facility having the capability to treat the condition.
3. **Ambulatory Surgical Center.** Services of an Ambulatory Surgical Center for Medically Necessary care provided;
4. **Anesthesia.** Anesthesia, anesthesia supplies, and administration of anesthesia by facility staff;
5. **Birthing Center.** Services of a Birthing Center for Medically Necessary care provided within the scope of its license;
6. **Blood and Plasma.** Blood transfusions, plasma and blood derivatives and charges for whole blood not donated or replaced by a blood bank;
7. **Chemotherapy.** Charges for chemotherapy/radiation;
8. **Chiropractic Care.** Spinal adjustment and manipulation, x-rays for manipulation and adjustment and other modalities performed by a Physician or other licensed practitioner, as limited in the Summary of Benefits;
9. **Dental.** Emergency repair due to Injury to sound natural teeth.
 - a. Result of an injury which occurs while the Plan Participant or dependent is covered under this plan;
 - b. Excision of impacted unerupted teeth or of a tumor or cyst, or incision and drainage of an abscess or cyst;
 - c. Oral surgery not involving any tooth structure;
 - d. Correction of a birth defect of a child
10. **Diabetic Equipment.** 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 a Covered Person, 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.
11. **Diagnostic Tests; Examinations.** Charges for x-rays, microscopic tests, laboratory tests, esophagoscopy, gastroscopy, proctosigmoidoscopy, colonoscopy and other diagnostic tests and procedures;

12. **Durable Medical Equipment.** Charges for rental, up to the purchase price, of Durable Medical Equipment, including glucose home monitors for insulin-Dependent diabetics. At its option, and with its advance written approval, the Plan may cover the purchase of such items when it is less costly and more practical than rental. The Plan does not pay for:
- a. Any purchases without its advance written approval;
 - b. Replacements or repairs; or
 - c. The rental or purchase of items which do not fully meet the definition of “Durable Medical Equipment”;
13. **Foot Disorders.** Surgical treatment of foot disorders, including associated services, performed by a licensed podiatrist (excluding routine foot care);
14. **General Limits.** Payment for any of the expenses listed herein are subject to all plan exclusions, limitations and provisions. Benefits for Pregnancy expenses are paid the same as any other illness.
15. **Glaucoma.** Treatment of glaucoma, cataract Surgery and one set of lenses (contacts or frame-type);
16. **Home Health Care.** Charges by a Home Health Care Agency:
- a. Registered Nurses or Licensed Practical Nurses;
 - b. Certified home health aides under the direct supervision of a Registered Nurse;
 - c. Registered therapist performing physical, occupational or Speech Therapy;
 - d. Physician calls in the office, home, clinic or Outpatient department;
 - e. Services, drugs and medical supplies which are Medically Necessary for the treatment of the Plan Participant that would have been provided in the Hospital, but not including Custodial Care; and
 - f. Rental of Durable Medical Equipment or the purchase of this equipment if economically justified, whichever is less.

NOTE: Transportation services are not covered under this benefit;

17. **Hospice Care.** Charges relating to Hospice Care, provided the Plan Participant has a life expectancy of 6 months or less, subject to the maximums, if any, stated in the Summary of Benefits. Covered Hospice expenses are limited to:
- a. Room and Board for Confinement in a Hospice;
 - b. Ancillary charges furnished by the Hospice while the patient is confined therein, including rental of Durable Medical Equipment which is used solely for treating an Injury or Sickness;
 - c. Medical supplies, drugs and medicines prescribed by the attending Physician, but only to the extent such items are necessary for pain control and management of the terminal condition;
 - d. Physician services and nursing care by a Registered Nurse, Licensed Practical Nurse or a Licensed Vocational Nurse (L.V.N.);
 - e. Home health aide services;
 - f. Home care furnished by a Hospital or Home Health Care Agency, under the direction of a Hospice, including Custodial Care if it is provided during a regular visit by a Registered Nurse, a Licensed Practical Nurse or a home health aide;
 - g. Medical social services by licensed or trained social workers, Psychologists or counselors;
 - h. Nutrition services provided by a licensed dietitian;
 - i. Respite care; and
 - j. Bereavement counseling, which is a supportive service provided by the Hospice team to Plan Participants in the deceased’s Family after the death of the Terminally Ill person, to assist the Plan Participants in adjusting to the death. Benefits will be payable if the following requirements are met:
 - (1) On the date immediately before his or her death, the Terminally Ill person was in a Hospice Care Program and a Plan Participant under the Plan; and

- (2) Charges for such services are Incurred by the Plan Participants within 6 months of the Terminally Ill person's death.

The Hospice Care Program must be renewed in writing by the attending Physician every 30 days. Hospice Care ceases if the terminal Illness enters remission;

18. **Hospital.** Charges made by a Hospital for:

a. Inpatient Treatment

- (1) Daily Semi-Private Room and Board charges;
- (2) Intensive Care Unit (ICU) and Cardiac Care Unit (CCU) Room and Board charges;
- (3) General nursing services; and
- (4) Medically Necessary services and supplies furnished by the Hospital, other than Room and Board

b. Outpatient Treatment

- (1) Emergency room;
- (2) Treatment for chronic conditions;
- (3) Physical Therapy treatments;
- (4) Hemodialysis; and
- (5) X-ray, laboratory and linear therapy;

19. **Mastectomy.** The Federal Women's Health and Cancer Rights Act, signed into law on October 21, 1998, contains coverage requirements for breast cancer patients who elect reconstruction in connection with a Mastectomy. The Federal law requires group health plans that provide Mastectomy coverage to also cover breast reconstruction Surgery and prostheses following Mastectomy.

As required by law, you are being provided this notice to inform you about these provisions. The law mandates that individuals receiving benefits for a Medically Necessary Mastectomy will also receive coverage for:

- a. Reconstruction of the breast on which the Mastectomy has been performed;
 - b. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
 - c. Prostheses and physical complications from all stages of Mastectomy, including lymphedemas;
- in a manner determined in consultation with the attending Physician and the patient.

This coverage will be subject to the same annual Deductible and coinsurance provisions that currently apply to Mastectomy coverage, and will be provided in consultation with you and your attending Physician;

20. **Medical Supplies.** Dressings, casts, splints, trusses, braces and other Medically Necessary medical supplies, with the exception of dental braces or corrective shoes, but including syringes for diabetic and allergy diagnosis, and lancets and chemstrips for diabetics;

21. **Newborn Care.** Hospital and Physician nursery care for Newborns who are natural children of the Employee or spouse and properly enrolled in the Plan, as set forth below. Hospital charges for well baby care for a newborn are considered to be eligible charges of the mother during the Hospital stay.

- a. Hospital routine care for a Newborn during the child's initial Hospital Confinement at birth; and
- b. The following Physician services for well-baby care during the Newborn's initial Hospital Confinement at birth:
 - (1) The initial Newborn examination and a second examination performed prior to discharge from the Hospital; and
 - (2) Circumcision.

NOTE: The Plan will cover Hospital and Physician nursery care for an ill Newborn as any other medical condition, provided the Newborn is properly enrolled in the Plan. These benefits are provided under the baby's coverage;

22. **Nursing Services.** Services of a Registered Nurse or Licensed Practical Nurse;
23. **Occupational Therapy.** Treatment or services rendered by a registered occupational therapist, under the direct supervision of a Physician, in a home setting or at a facility or institution whose primary purpose is to provide medical care for an Illness or Injury, or at a free-standing Outpatient facility;
24. **Oral Surgery.** Oral Surgery in relation to the bone, including tumors, cysts and growths, not related to the teeth and extraction of soft tissue impacted teeth by a Physician or Dentist, correction of congenital anomaly in a child who was covered under the Plan from birth;
25. **Osseous Surgery.** Charges for osseous Surgery;
26. **Pathology Services.** Charges for Pathology Services;
27. **Physical Therapy.** Treatment or services rendered by a physical therapist, under direct supervision of a Physician, in a home setting or a facility or institution whose primary purpose is to provide medical care for an Illness or Injury, or at a free-standing duly licensed Outpatient therapy facility;
28. **Physician Services.** Services of a Physician for Medically Necessary care, including office visits, Hospital Inpatient care, Hospital Outpatient visits and exams, clinic care, surgical opinion consultations and stand-by services for a Pediatrician for Caesarean section;
29. **Preferred Provider Organization.** A current list of PPO Providers is available on the Network website: www.advantagecarenetwork.com. Each participant has a free choice of any physician and surgeon and the physician/patient relationship shall be maintained. The participant, together with his or her physician, is ultimately responsible for determining the appropriate course of medical treatment, regardless of whether the plan will pay for all or a portion of the cost of such care. The network does not participate in the patient/provider relationship. The participating providers listed in this directory are independent contractors and are not employees of the network. This list of PPO Providers is subject to change;
30. **Pregnancy Expenses.** Dependent wife or dependent daughter are eligible for coverage for any expenses in connection with Pregnancy;

Under the Newborns' and Mothers' Health Protection Act of 1996, group health plans and health insurance issuers generally may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn Child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a Provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). In no event will an "attending provider" include a plan, hospital, managed care organization, or other issuer.

Benefits are payable in the same manner as for medical or Surgical care of an Illness, shown in the "Summary of Benefits" and this section, and subject to the same maximums;

31. **Preventive Care.** Charges for preventive care services;
32. **Private Duty Nursing.** Private duty nursing (outpatient only);

33. **Prosthetics, Orthotics, Supplies and Surgical Dressings.** Prosthetic devices (other than dental) to replace all or part of an absent body organ or part, including replacement due to natural growth or pathological change, but not including charges for repair or maintenance. Orthotic devices, but excluding orthopedic shoes and other supportive devices for the feet;
34. **Radiation Therapy.** Charges for radiation and dialysis therapy and treatment;
35. **Respiration Therapy.** Respiration therapy services, when rendered in accordance with a Physician's written treatment plan;
36. **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.
37. **Second Surgical Opinions.** Charges for second surgical opinions;
38. **Self-Inflicted Injuries.** 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.
39. **Skilled Nursing Facility.** Charges made by a Skilled Nursing Facility or a Convalescent Care Facility, up to the limits set forth in the Summary of Benefits, in connection with convalescence from an Illness or Injury (excluding drug addiction, chronic brain syndrome, alcoholism, senility, mental retardation or other Mental or Nervous Disorders) for which the Plan Participant is confined;
40. **Speech Therapy.** Speech therapy by a Physician or qualified speech therapist, when needed due to a Sickness or Injury (other than a functional nervous disorder) or due to surgery performed as the result of a Sickness or Injury, excluding Speech Therapy services that are educational in any part or due to articulation disorders, tongue thrust, stuttering, lisping, abnormal speech development, changing an accent, dyslexia, hearing loss which is not medically documented or similar disorders;
41. **Sterilization.** Charges related to sterilization procedures;
42. **Surgery.** Surgical operations and procedures, unless otherwise specifically excluded under the Plan, and limited as follows:
- a. Multiple procedures adding significant time or complexity will be allowed at:
 - (1) 100% of the full Usual and Customary Fee value for the first or major procedure;
 - (2) 50% of the Usual and Customary Fee value for the secondary and subsequent procedures;
 - b. Bilateral procedures which add significant time or complexity, which are provided at the same operative session, will be allowed at 100% of Usual and Customary Fee value for the major procedure, and 50% of the Usual and Customary Fee value for the secondary or lesser procedure;
 - c. Charges made for services rendered by an assistant surgeon will be allowed at 20% of the Usual, and Customary Fee value for the type of surgery performed;
 - d. No benefit will be payable for incidental procedures, such as appendectomy during an abdominal Surgery, performed during a single operative session;
43. **Surgical Treatment of Jaw.** Surgical treatment of Diseases, Injuries, fractures and dislocations of the jaw by a Physician or Dentist, correction of congenital anomaly in a child who was covered under the Plan from birth;

44. **Transplants.** Organ or tissue transplants are covered for the following human to human organ or tissue transplant procedures:

- a. Bone marrow;
- b. Heart;
- c. Lung;
- d. Heart and lung;
- e. Liver;
- f. Pancreas;
- g. Kidney; and
- h. Cornea.

In accordance with Health Care Reform, Transplants must comply with the Essential Health Benefits under section 1302(b) of the Patient Protection and Affordable Care Act.

Covered expenses will be considered the same as any other Sickness for Plan Participant's or Dependents as a recipient of an organ or tissue transplant. Covered expenses include:

- a. Organ or tissue procurement from a cadaver consisting of removing, preserving and transporting the donated part;
- b. Services and supplies furnished by a Provider; and
- c. Drug therapy treatment to prevent rejection of the transplanted organ or tissue.

44. **Utilization Management.** Failure to comply with Utilization Management will result in a higher cost to Participants. **"Utilization Management"** includes hospital pre-admission certification, continued stay review, length-of-stay determination and discharge planning. These programs are designed to ensure that Medically Necessary, high-quality patient care is provided and enables maximum benefits under the Plan. See pre-certification requirements in the section entitled "Cost Containment."

The following services will require pre-certification

- Inpatient Hospitalization;
- Transplant evaluations and procedures (organ and/or tissue);
- Home Health Services;
- Durable Medical Equipment in excess of \$1,000 billed per date of service;
- Emergency admissions within 24 hours after the services are provided;
- Transfers to a NICU within 24 hours of the infant's transfer;
- Physical Therapy, Occupational Therapy, Speech Therapy or Cognitive Therapy;
- Inpatient Mental/Nervous facility based programs;
- Inpatient Substance Abuse facility based programs;
- Hospice Care;
- Endovascular procedures;
- Chemotherapy;
- PET Scan;
- Sclerotherapy

14.02 Mental Health and Substance Abuse Benefits

The Plan shall conform to the Mental Health Parity and Addiction Equity act of 2008, as amended. For further details, contact the Claims Administrator.

14.03 Inpatient Benefits

Subject to the limitations contained in the Summary of Benefits, the Plan will pay covered expenses for:

1. Semi-private hospital Room and Board;
2. Miscellaneous facility charges on days a Room and Board charge is covered;
3. Individual psychotherapy;
4. Group psychotherapy;
5. Psychological testing;
6. Family counseling; and
7. Convulsive therapy treatment.

The benefits above are also available when receiving treatment during the day only or during the night only at a day/night Psychiatric Hospital or at a Substance Abuse Treatment Center and/or Rehabilitation Hospital.

14.04 Outpatient Benefits

Subject to the limitations contained in the Summary of Benefits, the Plan will pay covered expenses for:

1. Individual psychotherapy;
2. Group psychotherapy;
3. Psychological testing;
4. Family counseling;
5. Convulsive therapy treatment; and
6. Prescription drugs or medicines for the treatment of mental illness or chemical dependency.

ARTICLE 15

GENERAL LIMITATIONS AND EXCLUSIONS

Exclusions 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 Expenses. This is not an exhaustive list of limitations or exclusions.

1. **Abortion.** Expenses incurred directly or indirectly as the result of an abortion except when the life of the mother would be threatened if the fetus were carried to term, or when complications arise;
2. **Acupuncture.** Charges relating directly or indirectly to acupuncture;
3. **Alopecia.** For the services and/or supplies related to the treatment of alopecia;
4. **Assistant Surgeon.** For assistant surgeon fees in excess of 20% of the reasonable and customary charge for the surgeon;
5. **Biofeedback.** Biofeedback;
6. **Broken Appointments.** For broken appointments;
7. **Caretaker.** For homemaker or caretaker services;
8. **Chelation Therapy.** Services and supplies;
9. **Completion of Claim Form.** Charges for completion of a claim form or charges for failure to keep a scheduled visit,;
10. **Cosmetic Surgery.** Charges for Cosmetic Surgery with the following exceptions:
 - a) Treatment provided for the correction of defects incurred in an accidental injury sustained by the participant; or
 - b) Treatment provided for reconstructive surgery following cancer surgery; or
 - c) Surgery performed on a newborn child for the treatment or correction of a congenital defect; or
 - d) Surgery performed on a covered dependent child (other than a newborn child) under the age of 19 for the treatment or correction of congenital defect other than conditions of the breast; or
 - e) Reconstruction of the breast on which a mastectomy has been performed; surgery and reconstruction of the other breast to achieve a symmetrical appearance; and prosthesis and treatment of physical complications, including lymphedemas, at all stages of the mastectomy; or
 - f) Reconstructive surgery performed on a covered dependent child under the age of 19 due to craniofacial abnormalities to improve the function of, or attempt to create a normal appearance of an abnormal structure caused by a congenital defect, developmental deformities, trauma, tumors, infections, or disease.
11. **Custodial Care.** Custodial Care, domiciliary care or rest cures, or home health care except as specifically provided herein;

12. **Donor.** 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;
13. **Dental Expenses.** For dental expenses except as shown in this section titled Teeth Irregularities;
14. **Education or Training Program.** Services performed by a Physician or other Provider enrolled in an education or training program when such services are related to the education or training program, except as specifically provided herein;
15. **Estate Planning.** Charges for financial or legal counseling, drafting a will or estate planning;
16. **Eyeglasses, Contacts, and Refractions.** Charges for eyeglasses, contacts, or examination for prescription or fitting of eyeglasses or contact lenses. Eye refractions (except for aphakic patients, and soft lenses or sclera shells intended for use in the treatment of Disease or Injury);
17. **Family.** Services rendered by a member of the Covered Person's family to include grandparents, parents, brothers, sisters, cousins, aunts, uncles, nieces, nephews or similar in-laws related by marriage to the Covered Person;
18. **Felony.** Injury resulting from the commission or an attempt to commit a felony;
19. **Foot.** Charges for routine foot care;
20. **Funeral.** Charges for funeral arrangements;
21. **Government.** That are expenses to the extent paid, or which the Participant is entitled to have paid or obtain without cost, in accordance with the laws or regulations of any government;
22. **Hair Pieces.** Wigs, artificial hair pieces, human or artificial hair transplants, or any drug, prescription or otherwise, used to eliminate baldness, services and supplies related to the treatment of alopecia; except as related to loss of hair due to chemotherapy.
23. **Health Care Provider.** Provider who is not legally licensed to provide these services or supplies in the United States. Health Care Provider must be located within the United States in order for charges to be considered. This exclusion may be waived in an accident or life-threatening emergency;
24. **Hearing Devices.** Hearing aids or examinations for the prescription or fitting of hearing aids;
25. **Hypnosis.** For treatment by hypnosis, except as part of the physicians treatment of a mental illness or when hypnosis is used in lieu of an anesthetic;
26. **Impregnation and Infertility Treatment.** Following charges related to Impregnation and Infertility Treatment or any reversal of sterilization procedures or surgery;
27. **Incurred by Other Persons.** For expenses actually incurred by other persons;
28. **Massage Therapy.** Charges for massage therapy services;
29. **Medicare.** For benefits that are provided, or which would have been provided had the Participant enrolled, applied for, or maintained eligibility for such care and service benefits, under Title XVIII of the Federal Social Security Act of 1965 (Medicare), including any amendments thereto, or under any Federal law or regulation, except as provided in the sections entitled "Coordination of Benefits" and "Medicare"

30. **Negligence.** For injuries resulting from negligence, misfeasance, malfeasance, nonfeasance or malpractice on the part of any licensed Physician;
31. **No Legal Obligation.** That are provided to a Participant for which the Provider of a service customarily makes no direct charge, or for which the Participant is not legally obligated to pay, or for which no charges would be made in the absence of this coverage, including but not limited to fees, care, supplies, or services for which a person, company or any other entity except the Participant or this benefit plan, may be liable for necessitating the fees, care, supplies, or services;
32. **Non-Medically Necessary.** Treatment which is not medically necessary for the care and treatment of any injury or illness;
33. **Non-Prescription Drugs.** Charges for non-prescription drugs;
34. **Not Acceptable.** That are not accepted as standard practice by the AMA, ADA, or the Food and Drug Administration;
35. **Not Actually Rendered.** That are not actually rendered;
36. **Not Specifically Covered.** That are not specifically covered under this Plan;
37. **Obesity.** Expenses related to obesity, morbid obesity, weight reduction or dietetic control;
38. **Oral Surgery.** Oral Surgery or dental treatment, except as specifically provided in the Plan;
39. **Organ Transplants.** Expenses related to donation of a human organ or tissue, except as specifically provided;
40. **Orthopedic Shoes.** Orthopedic shoes, unless they are an integral part of a leg brace and the cost is included in the orthotist's charge, and other supportive devices for the feet;
41. **Personal Convenience Items.** Equipment that does not meet the definition of Durable Medical Equipment, including air conditioners, humidifiers and exercise equipment, whether or not recommended by a Physician;
42. **Prior to Coverage.** That are rendered or received prior to any period of coverage;
43. **Private Duty Nursing.** For private duty nursing services in a hospital setting;
44. **Prohibited by Law.** To the extent that payment under this plan is prohibited by any law of the jurisdiction in which the Plan Participant or dependent resides at the time the expenses or incurred;
45. **Provider Error.** Required as a result of unreasonable provider error;
46. **Radial Keratotomy.** Radial keratotomy or other plastic surgeries on the cornea in lieu of eyeglasses;
47. **Reasonable and Customary.** For charges which are in excess of reasonable and customary charges, as established by the Claims Administrator, or for charges for unnecessary care or treatment;
48. **Remediation Therapy.** For remediation therapy services;
49. **Respite Care.** Charges for respite care;
50. **Rolfing Services.** Charges for Rolfing services;

51. **Sex Change Operation.** Expenses related to a sex change operation or treatment of sexual dysfunction not related to organic disease;
52. **Taxes.** For any city or state taxes charged for services and supplies.
53. **Teeth Irregularities.** 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:
- (a) 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
 - (b) For excision of impacted unerupted teeth or of a tumor or cyst, or incision and drainage of an abscess or cyst, or
 - (c) For any other oral surgical procedure not involving any tooth structure, alveolar process, or gingival tissues, or
 - (d) For correction of a birth defect of a child.
54. **Temporomandibular Joint Disorder.** Charges for the diagnosis and treatment of, or in connection with, temporomandibular joint disorders, myofascial pain dysfunction or orthognathic treatment;
55. **Timely Filing.** For expenses which are submitted after March 31st of the given calendar year for services or supplies, which were incurred in the prior calendar year;
56. **Travel.** Travel, whether or not recommended by a Physician, except as specifically provided herein;
57. **Unrelated Services.** For services and supplies not related to the diagnosed illness or injury, which is being treated;
58. **Vitamins.** Vitamins, vitamin B-12 except when used for Pernicious Anemia or Crohn's Disease;
59. **Vocational Therapy.** For charges for vocational therapy;
60. **War.** Injury or sickness resulting from declared war;
61. **Worker's Compensation.** Injury or sickness 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;

ARTICLE 16

PRESCRIPTION DRUG BENEFITS

The County of El Paso contracts with a Pharmacy Benefit Manager (PBM) to manage its pharmacy benefits program. In 2013, the County's PBM is Medco Health Solutions (Medco). Check with the Plan Administrator or Claims Administrator to confirm the current PBM.

Prescription Drug Benefits 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.

The Schedules of Benefits outline the Co-payments, Coinsurance amounts and any applicable Deductibles that apply to the covered Prescription Drug Expenses described below.

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-payment 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. Selecting a Pharmacy

Preferred Retail Pharmacy

When you go to a Participating Preferred Pharmacy:

- present your Identification Card to the pharmacist along with your Prescription Order,
- provide the pharmacist with the birth date and relationship of the patient,
- sign the insurance claim log.

Participating Preferred Pharmacies have agreed to accept as payment in full the least of:

- the billed charges, or
- the Allowable Amount as determined by Medco, or
- other contractually determined payment amounts.

You are responsible for paying any Deductibles, Copayment Amounts and any pricing differences, when applicable. You may be required to pay for limited or non-covered services. No claim forms are required.

If you are unsure whether a Pharmacy is a Participating Preferred Pharmacy, you may access the Medco website at www.medco.com or contact the Medco Customer Service team at 1-800-711-0917 or toll-free number shown on your Identification Card.

Mail-Order Pharmacy

The mail-order program provides delivery of Covered Drugs directly to your home address. If you and your covered Dependents elect to use the mail-order service, refer to your Schedule of Benefits for applicable payment levels.

Some drugs may not be available through the mail-order program. If you have any questions about this mail-order program, need assistance in determining the amount of your payment, or need to obtain the mail-order prescription form, you may access the website at www.medco.com or contact Medco Customer Service team at 1-800-711-0917 or the toll-free number on your Identification Card. Mail the completed form, your Prescription Order(s) and payment to the address indicated on the form.

B. 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
- the PBM.

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-Payment. 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.

C. Limitations

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, the PBM 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.

Note: 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 the PBM 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.

D. Prior Authorization or Pre-Certification for Certain Prescription Drugs

Prior Authorization or Pre-Certification of the necessity of certain **prescription drugs** is required before the drug is dispensed by a **pharmacy**. Coverage for certain designated prescription drugs is subject to prior authorization criteria. This means that in order to ensure that a drug is safe, effective, and part of a specific treatment plan, certain medications may require prior authorization and the evaluation of additional clinical information before dispensing.

When you submit a Prescription Order to a Preferred Pharmacy for one of these designated medications, the Pharmacist will be alerted online if your Prescription Order is on the list of medication which requires Prior Authorization or Pre-certification before it can be filled. If this occurs, your Health Care Practitioner will be required to submit an authorization form. This form may also be submitted by your Health Care Practitioner in advance of the request to the Pharmacy. The Health Care Practitioner can obtain the authorization form by accessing the Medco website at www.medco.com or contacting Medco's Provider Line at 1-800-753-2851. The requested medication may be approved or denied for coverage under the Plan based upon its accordance with established clinical criteria.

It is your responsibility to arrange for the **prescriber** of the drug to contact the PBM 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.

E. Preferred Drug Step Therapy

Coverage for certain designated prescription drugs may be subject to a step therapy program. Step therapy programs favor the use of clinically acceptable alternative medications or preferred drugs that may be less costly for you prior to those medications on the step therapy list of drugs being covered under the Plan. When you submit a Prescription Order to a Participating Pharmacy for one of these designated medications, the Pharmacist will be alerted if the online review of your prescription claims history indicates an acceptable alternative medication has not been

previously tried. A toll free number is provided for your Health Care Practitioner to call and obtain additional program and criteria information. A list of step therapy medications and possible alternatives are available to you and your Health Care Practitioner on the Medco website at www.medco.com.

F. Quantity Duration or Quantity Limits

The maximum quantity of a given prescription drug indicates the number of units to be dispensed and is determined based on pertinent medical information and clinical efficacy and safety. Quantities of some drugs are restricted regardless of the quantity ordered by the Health Care Practitioner. To determine if a specific drug is subject to this limitation, you may access the Medco website at www.medco.com or contact Medco's Customer Service team at 1-800-711-0917 or the toll-free number on your Identification Card.

If a Prescription Order is written for a certain quantity of medication to be taken in a time period directed by a Health Care Practitioner, the Prescription Order will only be covered for a clinically appropriate pre-determined quantity of medication for the specified amount of time. Dispensing limits are based upon FDA dosing recommendations and nationally recognized clinical guidelines.

If you require a Prescription Order in excess of the established dispensing, ask your Health Care Practitioner to submit a request for clinical review on your behalf. The Health Care Practitioner can obtain an override request form by accessing the Medco website at www.medco.com or by contacting Medco's Provider Line at 1-800-753-2851. The request will be approved or denied after evaluation of the submitted clinical information.

The following list of prescription drugs is subject to change but describes certain prescription drugs subject to Quantity Duration or Quantity Limits at either a retail or the mail order pharmacy:

Hypnotic Agents:

Ambien (zolpidem)
Ambien CR (zolpidem)
Edluar (zolpidem sublingual)
Lunesta (eszopiclone)
Rozerem(ramelteon)
Sonata (zaleplon)
Silenor (doxepin)
Zolpimist (zolpidem oral spray)

G. General Exclusions Applicable to Prescription Drug Expense Coverage

Coverage is not provided for the following **prescription drug** charges:

- Those that are not prescribed by the Covered Person's **physician or dentist**.
- Those, as determined by the PBM, 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 the PBM 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 the PBM, 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.

H. 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) Compound Drugs

Drugs that have been measured and mixed with U. S. Food and Drug Administration (FDA)—approved pharmaceutical ingredients by a pharmacist to produce a unique formulation that is Medically Necessary because commercial products either do not exist or do not exist in the correct dosage, size, or form. The drugs used must meet the following requirements:

1. The drugs in the compounded product are Food and Drug Administration (FDA) approved;
2. The approved product has an assigned National Drug Code (NDC); and
3. The primary active ingredient is a Covered Drug under the Plan.

(3) **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.

(4) **Custodial Care**

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.

(5) **Dentist**

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

(6) **Emergency Condition**

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 the PBM, reasonably be expected to result in:

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

(7) **Generic Drug**

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

(8) **Mail Order Pharmacy**

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

(9) **Medication Formulary**

A listing of **prescription drugs** which have been evaluated and selected by the PBM 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 the PBM. .

(10) **Necessary**

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

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.

In determining if a service or supply is appropriate under the circumstances, the PBM 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 the PBM's attention.

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 Health Care 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.

(11) Non-Occupational Disease

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.

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.

(12) Non-Occupational Injury

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

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

(13) Non-Preferred Pharmacy

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

(14) Pharmacy

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

(15) Physician

This means a legally qualified physician.

(16) Preferred Pharmacy

A **pharmacy**, including a **mail order pharmacy**, which is party to a contract with the PBM 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 the PBM.

(17) 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**.

(18) 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**.

(19) Prescription Drugs

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.

(20) Reasonable Charge

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 the PBM 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 the PBM determines to be the prevailing charge level made for the drug in the geographic area where it is dispensed.

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;

the PBM 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.

I. Preventive Care Drugs (for the CDHP or CDH Plan)

Prescription drugs that can help keep you from developing a health condition are called preventive prescription drugs. They can help you maintain your quality of life and avoid expensive treatment, healing to reduce your overall healthcare costs.

If your doctor prescribes a preventive prescription drug on this list, it will be covered at 0% coinsurance, with a copay before you have met your deductible.

The following is a list of the most commonly prescribed preventive drug types. The list is not all-inclusive and does not guarantee coverage.

- ACE Inhibitors (hypertension, diabetes)
- Antihyperlipidemics (high cholesterol)
- Beta-Blockers (hypertension)
- Angiotensin II Receptor Antagonists (hypertension)
- Diuretics (hypertension)
- Miscellaneous Antihypertensives (hypertension)
- Direct Renin Inhibitor (hypertension)
- Antiadrenergic Antihypertensives (hypertension)
- Calcium Channel Blockers (heart disease, hypertension)
- Blood Thinning Agents (stroke prevention)
- Antiasthmatics (asthma)
- Asthma Supplies (asthma)
- Antidiabetic Drugs (diabetes)
- Diabetic Supplies (diabetes)
- Osteoporosis Drugs (osteoporosis)
- Pediatric Vitamins with Fluoride
- Prenatal Multivitamins with Iron and Folic Acid
- Contraceptives

ARTICLE 17 COST CONTAINMENT

17.01 Pre-Certification Procedures. The Covered Person must obtain Pre-certification from the Claims Administrator for the following covered services, procedures or supplies in order to receive Coverage. Failure to receive the required pre-certification will result in loss of coverage for the service, procedure or supply:

Urgent Care or Emergency Admissions:

If a Participant needs medical care for a condition which could seriously jeopardize his or her life, obtain such care without delay, and communicate with the Plan as soon as reasonably possible.

If a Participant must be admitted on an Emergency basis, the Participant should follow the Physician's instructions carefully and contact the pre-certification department as follows:

1. For Emergency admissions after business hours on Friday, on a weekend or over a holiday weekend, a call to the pre-certification department must be made within 72 hours after the admission date, but no later than the first business day following the Emergency admission, by or on behalf of the covered patient; and
2. For Emergency admissions on a weekday, a call to the pre-certification department must be made within 24 hours after the admission date.

The Plan does not require the Participant to obtain approval of a medical service prior to getting treatment for an urgent care or emergency situation, so there are no "Pre-service Urgent Care Claims" under the Plan. The Participant simply follows the Plan's procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a Post-service Claim.

Non-emergency Admissions:

For Inpatient Hospital stays that are scheduled in advance, a call to the pre-certification department should be completed as soon as possible before actual services are rendered. Once the pre-certification call is received, it will be routed to an appropriate review specialist who will create an on-line patient file. The review specialist will contact the Participant's attending Physician to obtain information and to discuss the specifics of the admission request. An on-line expert system that features state-of-the-art, widely accepted clinical review criteria is used to effectively guide the review process. If appropriate, alternative care will be explored with the Physician.

If, after assessing procedure necessity, the need for an Inpatient confinement is confirmed, the review specialist will determine the intensity of management required and will remain in contact with the Physician or Hospital during the confinement.

If, at any time during the review process, Medical Necessity cannot be validated, the review specialist will refer the episode to a board-certified Physician advisor who will immediately contact the attending Physician to negotiate an appropriate treatment plan. At the end of the Hospital confinement, the review specialist is also available to assist with discharge planning and will work closely with the attending Physician and Hospital to ensure that medically appropriate arrangements are made.

17.02 Alternate Course of Treatment

Certain types of conditions, such as spinal cord Injuries, cancer, AIDS or premature births, may require long-term, or perhaps lifetime, care.

If the Plan Administrator should determine that an alternate course of treatment is appropriate, and if the attending Physician agrees to the alternate course of treatment, all Medically Necessary expenses stated in the treatment plan will be eligible for payment under the Plan, even if these expenses normally would not be eligible for payment under the Plan. In the event the Participant and the attending Physician select an alternative course of treatment, coverage under the Plan will be based upon the charge allowed for the alternate course of treatment.

ARTICLE 18 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 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.

18.01 Dental Definitions

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 Health Care Providers shall not be Eligible.

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.

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.

Benefits Payable.

If, because of a non-occupational condition, a Covered Person, 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 "Schedule of Dental Benefits".

Incurred Date

The date the service is received.

Deductible.

The Deductible amount is the dollar amount of Covered Expenses, which must be paid by the Covered Person before reimbursement for any additional Covered Expenses can be paid. The deductible applies separately to each Covered Person in each calendar year, subject to the following:

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.

Dental Implant.

An artificial tooth that is anchored in the gums or jawbone to replace a missing tooth.

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 "Schedule of Dental Benefits".

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 "Covered Dental Expenses".

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.

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:

- a) Itemizes the dentist's recommended services,
- b) Shows the dentist's charge for each service,
- c) Is accompanied by supporting x-rays or other diagnostic records where required or requested by the Plan Administrator.

Eligible Charge

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

- a) Is on the list of dental services,
- b) Is part of a "Treatment Plan" as described above, and
- c) Isn't listed in the "Dental Limitations, Extensions and Exclusions".

*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.

Incurred Charge.

A charge will be considered to be incurred:

- a) For an appliance or modification of an appliance - on the date the appliance is seated.
- b) For a crown, bridge or gold restoration - on the date the appliance is seated.
- c) For root canal therapy - on the date the pulp chamber is opened.
- d) For all other services - on the date the service is received.
- e) All other terms shall have the same meaning as specified in Section titled, "**Dental Definitions**".

18.02 Covered Expenses

The following is a brief description of the types of expenses that will be considered for coverage under the Plan, subject to the limitations contained in the Summary of Benefits. Charges must be for services and supplies customarily employed for treatment of the dental condition, and rendered in accordance with ADA accepted standards of practice. Coverage will be limited to Usual and Customary Fees.

Preventive Dental Service

- 1. Routine oral examinations and prophylaxis (cleaning, scaling and polishing teeth), two per calendar year;
- 2. Bitewing x-rays, two per calendar year;
- 3. Topical application of fluoride for Dependent Children under age 19, two per calendar year;

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);

Major Dental Services

All Major Dental Services require 12 months of continuous coverage in order for services to be covered.

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;
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. 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;
6. Implants

Orthodontic Services

1. Preliminary study, including cephalometric radiographs, diagnostic casts and treatment plan;
2. Interceptive, interventive or preventive orthodontic services;
3. Fixed and removable appliance placement, and active treatment per month after the first month; and
4. Extractions in connection with orthodontic services.

18.03 Dental Exclusions, Limitations and Extension

Extension of Dental 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.

The following exclusions and limitations are in addition to those set forth in the Articles entitled "General Limitations and Exclusions," and "Schedule of Benefits."

1. **Adjustments.** Charges for services to alter vertical dimension (work done or appliance used to increase the distance between nose and chin); to restore or maintain occlusion (work done or appliance used to change the way the top and bottom teeth meet or mesh); to replace tooth structure lost as a result of abrasion or attrition; for splinting; or for treatment of disturbances of the temporomandibular joint;
2. **Administrative Costs.** For administrative costs of completing claim forms or reports or for providing dental records;
3. **After the Termination Date.** The Plan will not pay for services or supplies furnished after the date coverage terminates, even if payments have been predetermined for a course of treatment submitted before the termination date. However, benefits for covered dental expenses incurred for the following procedures will be payable as though the coverage had continued in force:
 - a. A prosthetic device, such as full or partial dentures, if the Dentist took the impression and prepared the abutment teeth while the patient was a Participant in the Plan, and delivers and installs the device within two months following termination of coverage;
 - b. A crown, if the Dentist prepared the tooth for the crown while the patient was a Participant in the Plan, and installs the crown within two months following termination of coverage; and
 - c. Root canal therapy if the Dentist opened the tooth while the patient was a Participant in the Plan, and completes the treatment within two months following termination of coverage;

4. **Broken Appointments.** For charges for broken or missed dental appointments;
5. **Cosmetic.** Charges for cosmetic dental work. This includes, but is not limited to, characterization of dentures and services to correct congenital or developmental malformations. This exclusion will not apply to cosmetic work needed as a result of Accidental Injuries, but damage resulting from biting or chewing is not considered an Accidental Injury. This exclusion also does not apply to covered Orthodontic Treatment;
6. **Crowns.** For crowns for teeth that are restorable by other means or for the purpose of Periodontal Splinting;
7. **Education.** Charges for instruction in oral hygiene, plaque control or diet;
8. **Excess Charges.** Charges in excess of the Reasonable Charge for the service or supply received or charges in excess of any maximum payable under this Plan;
9. **Experimental.** Charges for Experimental dental care, implantology or dental care which is not customarily used or which does not meet the standards set by the American Dental Association;
10. **Government Provided.** Charges for dental care paid for or provided by the laws of any government or treatment given in a government-owned facility, unless the Employee or Dependent is legally required to pay;
11. **Immediate Relative.** Services rendered by a person who is an immediate relative of, or who ordinarily resides with, the Plan Participant requiring treatment. "Immediate relative" means spouse, child, brother, sister or parent of the Plan Participant, whether by birth, adoption or marriage;
12. **Miscellaneous.** The Plan does not cover any charge, service or supply which is:
 - a. For treatment other than by a Dentist or Physician, except:
 - (1) Cleaning, scaling and application of fluoride performed by a licensed dental hygienist under the supervision of a Dentist; and
 - (2) Non-experimental services performed at a dental school under the supervision of a Dentist, if the school customarily charges patients for its services;
 - b. For local infiltration anesthetic when billed for separately by a Dentist;
 - c. For personalization or characterization of dentures or veneers or any cosmetic procedures or supplies;
 - d. For oral hygiene or dietary instruction;
 - e. For a plaque control program (a series of instructions on the care of the teeth);
 - f. For implants, including any appliances and/or crowns and the surgical insertion or removal of implants;
 - g. For periodontal splinting;
 - h. For consultations, charges for failure to keep a scheduled visit, or charges for completion of a claim form;
 - i. For substances or agents which are administered to minimize fear, or charges for analgesia, unless the patient is handicapped by cerebral palsy, mental retardation or spastic disorder;
 - j. For replacement of a lost, missing or stolen prosthetic device;
 - k. Not equal to accepted standards of dental practice, including charges for services or supplies which are Experimental;
 - l. Paid, payable or required to be provided under any no-fault or equivalent automobile insurance law. Any uninsured motorist will be considered to be self-insured;
 - m. Charges for missed appointments or completion of claim forms;
 - n. Covered under the "Covered Medical Expenses" Article of the Plan; and

- o. Services performed by a Physician or other Provider enrolled in an education or training program when such services are related to the education or training program, except as specifically provided herein;
- 13. **Missing Appliances.** Charges for replacement of lost, missing or stolen appliances or prosthetic devices;
- 14. **No Coverage.** Services or supplies for which charges are incurred at a time when no coverage is in force for that person, or for which charges are incurred while coverage is in force, but final delivery is made more than 3 months after the date coverage for that person terminated;
- 15. **No Legal Obligation.** Charges for which the person has no legal obligation to pay, or for which no charge would be made in the absence of a Treatment Plan;
- 16. **No Listing.** For services which are not included in the list of covered dental services;
- 17. **Not Necessary.** Charges for unnecessary care, treatment, services or supplies, including replacement at any time of a bridge or denture which meets or can be made to meet commonly held dental standards of functional acceptability;
- 18. **Not Recommended.** Charges for services or supplies which are not recommended and approved by a Dentist or Physician;
- 19. **Occupational.** Charges for dental care which results from any employment or where the employee or dependent is entitled to benefits under any Workers' Compensation or similar law;
- 20. **Orthognathic Surgery.** For surgery to correct malpositions in the bones of the jaw;
- 21. **Personalization.** For expenses for services or supplies that are cosmetic in nature, including charges for personalization or characterization of dentures;
- 22. **Prior to Coverage.** An appliance, or modification where an impression for a crown, bridge or gold restoration was made or where root canal therapy began prior to coverage under this Plan.
- 23. **Replacements.** Charges for replacement made within five years after the last placement of any prosthetic appliance, crown, inlay or onlay restoration, or fixed bridge. This exclusion is waived if replacement is needed because the appliance, crown, inlay, onlay or bridge, while in the oral cavity, is damaged beyond repair due to Injury sustained by the Plan Participant. (Damage resulting from biting or chewing is not considered an Accidental Injury;)
- 24. **Single Provider Care.** In the event a Participant transfers from the care of one Provider to that of another during a course of treatment, or if more than one Provider performs services for one or more dental procedures, the Plan shall consider only such expense as would be appropriate had a single Provider performed the service. An appropriate expense in this case will be the Usual and Customary Fee;
- 25. **Space Maintainers.** Charges for duplicate space maintainers;
- 26. **Splinting.** For crowns, fillings or appliances that are used to connect (splint) teeth, or change or alter the way the teeth meet, including altering the vertical dimension, restoring the bite (occlusion) or are cosmetic; and
- 27. **War/Riot.** Charges for services or supplies needed as a result of war, declared or undeclared, or any act of war or act of aggression by any Country; or voluntary participation in a riot.

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.

18.03 Pre-determination of Dental Benefits

If a Participant's proposed course of treatment reasonably can be expected to involve dental charges of \$300 or more, a description of the procedures to be performed and an estimate of the charges therefore may be filed with the Claims Administrator prior to the commencement of the course of treatment. **However, approval is not required prior to treatment.** Any pre-determination of dental benefits is provided only as a convenience to the Participant.

If requested, the Claims Administrator will notify the Employee, and the Dentist or Physician, of the pre-determination based upon such proposed course of treatment. In determining the amount of benefits available, consideration will be given to alternate procedures, services, supplies and courses of treatment which may be performed to accomplish the required result. **The pre-determination is not a guarantee of payment or approval of a benefit. After treatment is received, a claim must be filed as a post-service claim, which will be subject to all applicable Plan provisions.**

ARTICLE 19

BENEFIT DETERMINATION

19.01 Timing of Claim Decisions

The Claims Administrator shall notify the claimant, in accordance with the provisions set forth below, of any adverse benefit determination within a reasonable period of time, but not later than 45 days after receipt of the claim by the Plan.

1. Extensions. This period may be extended by the Plan for up to 30 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial 45-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If, prior to the end of the first 30-day extension period, the Plan Administrator determines that, due to matters beyond the control of the Plan a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days, provided that the Plan Administrator notifies the claimant, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the Plan expects to render a decision. In the case of any extension, the notice of extension shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues.
2. Calculating Time Periods. The period of time within which a benefit determination is required to be made shall begin at the time a claim is deemed to be filed in accordance with the procedures of the Plan.
3. Requests for Additional Information. In the event the circumstances requiring an extension include the need for more information, the claimant must be allowed at least 45 days after receipt of the notice to provide this information. If the additional information is requested during the initial 45-day processing period, then the remainder of time left in the initial processing period is lost, and, upon receipt of the information, the first 30-day extension period begins to run. Similarly, if the additional information is requested during the first extension period, then the remainder of time left in the first extension period is lost, and, upon receipt of the information, the second 30-day extension period begins to run. If the additional information is requested during the second extension period, then the remainder of time left in the second extension period is lost, and the Plan must obtain the claimant's consent to additional time for processing the information provided.

19.02 Notification of an Adverse Benefit Determination

The Claims Administrator shall provide a claimant with written or electronic explanation of benefits stating that a claim is denied, in whole or in part, and advising the claimant of the right to appeal.

19.03 Appeals of Adverse Benefit Determinations

In accordance with the terms set forth in Article 9, the following shall apply:

19.04 Full and Fair Review of All Claims

In cases where a claim for benefits is denied, in whole or in part, and the claimant believes the claim has been denied wrongly, the claimant may appeal the denial and review pertinent documents. The claims procedures of this Plan provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination, including the right, if necessary, to file two separate appeals. More specifically, the Plan provides:

1. Claimants at least 180 days following receipt of a notification of an adverse benefit determination within which to appeal the determination;
2. Claimants at least 45 days following receipt of a request for additional information to provide such information to the Plan;

3. Claimants the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;
4. For a review that affords no particular deference to the initial adverse benefit determination and that is conducted by the Plan Administrator or another appropriate named fiduciary of the Plan, who shall be neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;
5. For a review that takes into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.
6. That, in deciding an appeal of any adverse benefit determination that is based in whole or in part upon a medical judgment, the Plan Administrator or another appropriate named fiduciary of the Plan shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual;
7. For the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and
8. That a claimant will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits; information regarding any voluntary appeals procedures offered by the Plan; any rule, guideline, protocol or other similar criterion relied upon in making the adverse determination; and an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances.

19.05 First Appeal Level

Requirements for First Appeal

The claimant must file the first appeal in writing within 180 days following receipt of the notice of an adverse benefit determination. The claimant's appeal must be addressed as follows:

HealthSCOPE Benefits
ATTENTION: Appeals Department
P.O. Box 12609
El Paso, Texas 79913

Upon receipt, an appeal shall be deemed to be filed with the Plan provided all of the information listed below is included.

It shall be the responsibility of the claimant to submit proof that the claim for benefits is covered and payable under the provisions of the Plan. Any appeal must include:

1. The name of the employee/claimant;
2. The employee/claimant's social security number;
3. The group name or identification number;
4. All facts and theories supporting the claim for benefits. **Failure to include any theories or facts in the written appeal will result in their being deemed waived. In other words, the claimant will lose the right to raise factual arguments and theories which support his or her claim if he or she fails to include them in the written appeal;**
5. The reason or reasons for disagreement with the handling of the claim; and
6. Any material or information that the claimant has which indicates that the claimant is entitled to benefits under the Plan.

If the claimant provides all of the required information, it may be that the claimant will be eligible for disability benefits under the Plan.

Timing of Notification of Benefit Determination on First Appeal

The Claims Administrator shall notify the claimant of the Plan's benefit determination on review within a reasonable period of time, but no later than 23 days after receipt by the Plan of the claimant's request for review, unless the Claims Administrator determines that special circumstances require an extension of time for processing the claim.

1. Extensions. If the Claims Administrator determines that an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 23-day period. In no event shall such extension exceed a period of 23 days from the end of the initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the Plan expects to render the determination on review.
2. Calculating Time Periods. The period of time within which the Plan's determination is required to be made shall begin at the time an appeal is filed in accordance with the procedures of this Plan.
3. Requests for Additional Information. In the event the circumstances requiring an extension include the need for more information, the claimant must be allowed at least 45 days after receipt of the notice to provide this information. If the additional information is requested during the initial 23-day period, then the remainder of time left in that initial period is lost, and, upon receipt of the information, the 23-day extension period begins to run. If the additional information is requested during the 23-day extension period, then the remainder of time left in the extension period is lost, and the Plan must obtain the claimant's consent for an extension of time to process the additional information once it is received by the Plan.

Manner and Content of Notification of Adverse Benefit Determination on First Appeal

The Claims Administrator shall provide a claimant with written or electronic notification of a Plan's adverse benefit determination on review, setting forth:

1. The specific reason or reasons for the denial;
2. Reference to the specific portion(s) of the Summary Plan on which the denial is based;
3. A description of any additional information necessary for the claimant to perfect the claim and an explanation of why such information is necessary;
4. A description of the Plan's review procedures and the time limits applicable to the procedures;
5. The identity of any medical or vocational experts consulted in connection with the claim, even if the Plan did not rely upon their advice;
6. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits;
7. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request;
8. If the adverse benefit determination is based upon a medical judgment, a statement that an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be provided free of charge upon request;
9. A statement that the Plan does not offer any voluntary appeal procedures;
10. A statement of the claimant's right to bring an action in the event of an adverse benefit determination following a second appeal; and
11. The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact you local U.S. Department of Labor Office and your State insurance regulatory agency."

Furnishing Documents in the Event of an Adverse Determination

In the case of an adverse benefit determination on review, the Claims Administrator shall provide such access to, and copies of, documents, records, and other information described in the section entitled “Manner and Content of Notification of Adverse Benefit Determination on First Appeal” as appropriate.

19.06 Second Appeal Level

Adverse Decision on First Appeal; Requirements for Second Appeal

If, for any reason, the claimant does not receive a written response within the appropriate time period set forth above, the claimant may assume that the first appeal has been denied. Upon expiration of that time period without receipt of a written decision or upon receipt of notice of the Plan’s adverse decision regarding the first appeal, the claimant has 60 days to file a second appeal of the denial of benefits. The claimant again is entitled to a “full and fair review” of any denial made at the first appeal, which means the claimant has the same rights during the second appeal as he or she had during the first appeal. As with the first appeal, the claimant’s second appeal must include all of the items set forth in the section entitled “Requirements for First Appeal.”

The Plan Administrator shall notify the claimant of the Plan’s benefit determination on review within a reasonable period of time, but no later than 22 days after receipt by the Plan of the claimant’s request for review, unless the Plan Administrator determines that special circumstances require an extension of time for processing the claim.

1. Extensions. If the Plan Administrator determines that an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 22-day period. In no event shall such extension exceed a period of 22 days from the end of the initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the Plan expects to render the determination on review.
2. Calculating Time Periods. The period of time within which the Plan’s determination is required to be made shall begin at the time the second appeal is filed in accordance with the procedures of this Plan.
3. Requests for Additional Information. In the event the circumstances requiring an extension include the need for more information, the claimant must be allowed at least 45 days after receipt of the notice to provide this information. If the additional information is requested during the initial 22-day period, then the remainder of time left in that initial period is lost, and, upon receipt of the information, the 22-day extension period begins to run. If the additional information is requested during the 22-day extension period, then the remainder of time left in the extension period is lost, and the Plan must obtain the claimant’s consent for an extension of time to process the additional information once it is received by the Plan.

Manner and Content of Notification of Adverse Benefit Determination on Second Appeal

The same information must be included in the Plan’s response to a second appeal as a first appeal, except for:

1. A description of any additional information necessary for the claimant to perfect the claim and an explanation of why such information is needed; and
2. A description of the Plan’s review procedures and the time limits applicable to the procedures.

See the section entitled “Manner and Content of Notification of Adverse Benefit Determination on First Appeal.”

Furnishing Documents in the Event of an Adverse Determination

In the case of an adverse benefit determination on the second appeal, the Plan Administrator shall provide such access to, and copies of, documents, records, and other information described in the section entitled “Manner and Content of Notification of Adverse Benefit Determination on First Appeal,” as is appropriate.

Decision on Second Appeal to be Final

If, for any reason, the claimant does not receive a written response to the second appeal within the appropriate time period set forth above, the claimant may assume that the second appeal has been denied. The decision by the Plan Administrator or other appropriate named fiduciary of the Plan on review will be final, binding and conclusive and will be afforded the maximum deference permitted by law. **All claim review procedures provided for in the Plan must be exhausted before any legal action is brought. Any legal action for the recovery of any benefits must be commenced within one year after the Plan's claim review procedures have been exhausted.**

19.07 Standard External Review

A. Standard external review

Standard external review is external review that is not considered expedited (as described in paragraph B of this section).

1. Request for external review. The Plan will allow a claimant to file a request for an external review with the Plan if the request is filed within four (4) months after the date of receipt of a notice of an adverse benefit determination or final internal adverse benefit determination. If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.
2. Preliminary review. Within five (5) business days following the date of receipt of the external review request, the Plan will complete a preliminary review of the request to determine whether:
 - (a) The claimant is or was covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided;
 - (b) The adverse benefit determination or the final adverse benefit determination does not relate to the claimant's failure to meet the requirements for eligibility under the terms of the Plan (e.g., worker classification or similar determination);
 - (c) The claimant has exhausted the Plan's internal appeal process unless the claimant is not required to exhaust the internal appeals process under the interim final regulations; and
 - (d) The claimant has provided all the information and forms required to process an external review.Within one (1) business day after completion of the preliminary review, the Plan will issue a notification in writing to the claimant. If the request is complete but not eligible for external review, such notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, such notification will describe the information or materials needed to make the request complete and the Plan will allow a claimant to perfect the request for external review with the four-month filing period or within the 48 hour period following the receipt of the notification, whichever is later.
3. Referral to Independent Review Organization. The Plan will assign an independent review organization (IRO) that is accredited by URAC or by a similar nationally-recognized accrediting organization to conduct the external review. Moreover, the Plan will take action against bias and to ensure independence. Accordingly, the Plan will contract with (or direct the Claims Processor to contract with, on its behalf) at least three (3) IROs for assignments under the Plan and rotate claims assignments among them (or incorporate other independent unbiased method for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.
4. Reversal of Plan's decision. Upon receipt of a notice of a final external review decision reversing the adverse benefit determination or final internal adverse benefit determination, the Plan immediately will

provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

B. Expedited external review

1. Request for expedited external review. The Plan will allow a claimant to make a request for an expedited external review with the Plan at the time the claimant receives:
 - (a) An adverse benefit determination if the adverse benefit determination involves a medical condition of the claimant for which the timeframe for completion of a standard internal appeal under the interim final regulations would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function and the claimant has filed a request for an expedited internal appeal; or
 - (b) A final internal adverse benefit determination, if the claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services, but has not been discharged from a facility.
2. Preliminary review. Immediately upon receipt of the request for expedited external review, the Plan will determine whether the request meets the reviewability requirements set forth in paragraph A.2 above for standard external review. The Plan will immediately send a notice that meets the requirements set forth in paragraph A.2 above for standard external review to the claimant of its eligibility determination.
3. Referral to independent review organization. Upon a determination that a request is eligible for external review following the preliminary review, the Plan will assign an IRO pursuant to the requirements set forth in paragraph A.3 above for standard review. The Plan will provide or transmit all necessary documents and information considered in making the adverse benefit determination or final internal adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO will review the claim de novo and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.
4. Notice of final external review decision. The Plan's (or Claim Processor's) contract with the assigned IRO will require the IRO to provide notice of the final external review decision, in accordance with the requirements set forth in paragraph A.3 above, as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO will provide written confirmation of the decision to the claimant and the Plan.

19.08 Payment of Benefits

All benefits under this Plan are payable, in U.S. Dollars, to the claimant. In the event of the death or incapacity of a claimant and in the absence of written evidence to this Plan of the qualification of a guardian for his or her estate, this Plan may, in its discretion, make any and all such payments to the individual or institution which, in the opinion of this Plan, is or was providing the care and support of such claimant.

19.09 Recovery of Payments

The Plan reserves the right to deduct from any benefits properly payable under this Plan the amount of any payment which has been made:

1. In error;
2. Pursuant to a misstatement contained in a proof of loss or a fraudulent act;

3. Pursuant to a misstatement made to obtain coverage under this Plan within two years after the date such coverage commences; or
4. With respect to an ineligible person.

The deduction may be made against any claim for benefits under this Plan by a claimant or his or her covered Dependents.

ARTICLE 20 HIPAA PRIVACY

20.01 Commitment to Protecting Health Information

The Plan will comply with the Standards for Privacy of Individually Identifiable Health Information (i.e., the “Privacy Rule”) set forth by the U.S. Department of Health and Human Services (“HHS”) pursuant to the Health Insurance Portability and Accountability Act (“HIPAA”). Such standards control the dissemination of “protected health information” (“PHI”) of Plan Participants. Privacy standards will be implemented and enforced in the offices of the Employer and Plan Sponsor and any other entity that may assist in the operation of the Plan.

The Plan is required by law to take reasonable steps to ensure the privacy of the Plan Participant’s PHI, and inform him/her about:

1. The Plan’s disclosures and uses of PHI;
2. The Plan Participant’s privacy rights with respect to his/her PHI;
3. The Plan’s duties with respect to his/her PHI;
4. The Plan Participant’s right to file a complaint with the Plan and with the Secretary of HHS; and
5. The person or office to contact for further information about the Plan’s privacy practices.

Within this provision capitalized terms may be used, but not otherwise defined. These terms shall have the same meaning as those terms set forth in 45 CFR Sections 160.103 and 164.501. Any HIPAA regulation modifications altering a defined HIPAA term or regulatory citation shall be deemed incorporated into this provision.

20.02 How Health Information May be Used and Disclosed

In general, the Privacy Rules permit the Plan to use and disclose an individual’s PHI, without obtaining authorization, only if the use or disclosure is:

1. To carry out Payment of benefits;
2. For Health Care Operations;
3. For Treatment purposes; or
4. If the use or disclosure falls within one of the limited circumstances described in the rules (e.g., the disclosure is required by law or for public health activities).

20.03 Disclosure of PHI to the Plan Sponsor for Plan Administration Purposes

In order that the Plan Sponsor may receive and use PHI for plan administration purposes, the Claims Administrator agrees to:

1. Not use or further disclose PHI other than as permitted or required by the Summary Plan Descriptions or as required by law (as defined in the privacy standards);
2. Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;
3. Establish safeguards for information, including security systems for data processing and storage;
4. Maintain the confidentiality of all PHI, unless an individual gives specific consent or authorization to disclose such data or unless the data is used for health care payment or Plan operations;
5. Receive PHI, in the absence of an individual’s express authorization, only to carry out Plan administration functions;

6. Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the privacy standards;
7. Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;
8. Make available PHI in accordance with section 164.524 of the privacy standards (45 CFR 164.524);
9. Make available PHI for amendment and incorporate any amendments to PHI in accordance with section 164.526 of the privacy standards (45 CFR 164.526);
10. Make available the information required to provide an accounting of disclosures in accordance with section 164.528 of the privacy standards (45 CFR 164.528);
11. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services (“HHS”), or any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with part 164, subpart E, of the privacy standards (45 CFR 164.500 et seq);
12. Report to the Plan any inconsistent uses or disclosures of PHI of which the Plan Sponsor becomes aware;
13. Train employees in privacy protection requirements and appoint a privacy compliance coordinator responsible for such protections;
14. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and
15. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in section 164.504(f)(2)(iii) of the privacy standards (45 CFR 164.504(f)(2)(iii)), is established as follows:
 - (a) The following employees, or classes of employees, or other persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed:
 - (i) Privacy Officer: The access to and use of PHI by the individuals described above shall be restricted to the plan administration functions that the Plan Sponsor performs for the Plan.

HR Director
Risk Manager
HR Generalist/Benefits Specialist
 - (b) In the event any of the individuals described in above do not comply with the provisions of the Summary Plan Descriptions relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. The Plan Administrator will promptly report such violation or non-compliance to the Plan, and will cooperate with the Plan to correct violation or non-compliance to impose appropriate disciplinary action or sanctions. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

20.04 Disclosure of Summary Health Information to the Plan Sponsor

The Plan may disclose PHI to the Plan Sponsor of the group health plan for purposes of plan administration or pursuant to an authorization request signed by the Plan Participant. The Plan may use or disclose “summary health information” to the Plan Sponsor for obtaining premium bids or modifying, amending, or terminating the group health plan.

20.05 Disclosure of Certain Enrollment Information to the Plan Sponsor

Pursuant to section 164.504(f)(1)(iii) of the privacy standards (45 CFR 164.504(f)(1)(iii)), the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has un-enrolled from a health insurance issuer or health maintenance organization offered by the Plan to the Plan Sponsor.

20.06 Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage

The Plan Sponsor may hereby authorize and direct the Plan, through the Plan Administrator or the third party administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters (“MGUs”) for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the privacy standards.

20.07 Other Disclosures and Uses of PHI:

20.07A Primary Uses and Disclosures of PHI

1. Treatment, Payment and Health Care Operations: The Plan has the right to use and disclose a Plan Participant’s PHI for all activities as included within the definitions of Treatment, Payment, and Health Care Operations and pursuant to the HIPAA Privacy Rule.
2. Business Associates: The Plan contracts with individuals and entities (Business Associates) to perform various functions on its behalf. In performance of these functions or to provide services, Business Associates will receive, create, maintain, use, or disclose PHI, but only after the Plan and the Business Associate agree in writing to contract terms requiring the Business Associate to appropriately safeguard the Plan Participant’s information.
3. Other Covered Entities: The Plan may disclose PHI to assist health care Providers in connection with their treatment or payment activities or to assist other covered entities in connection with payment activities and certain health care operations. For example, the Plan may disclose PHI to a health care Provider when needed by the Provider to render treatment to a Plan Participant, and the Plan may disclose PHI to another covered entity to conduct health care operations. The Plan may also disclose or share PHI with other insurance carriers (such as Medicare, etc.) in order to coordinate benefits, if a Plan Participant has coverage through another carrier.

20.07B Other Possible Uses and Disclosures of PHI

1. Required by Law: The Plan may use or disclose PHI when required by law, provided the use or disclosure complies with and is limited to the relevant requirements of such law.
2. Public Health and Safety: The Plan may use or disclose PHI when permitted for purposes of public health activities, including disclosures to:
 - (a) a public health authority or other appropriate government authority authorized by law to receive reports of child abuse or neglect;

- (b) report reactions to medications or problems with products or devices regulated by the Federal Food and Drug Administration or other activities related to quality, safety, or effectiveness of FDA-regulated products or activities;
 - (c) locate and notify persons of recalls of products they may be using; and
 - (d) a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition, if authorized by law.
- 3. The Plan may disclose PHI to a government authority, except for reports of child abuse or neglect permitted by (1) above, when required or authorized by law, or with the Plan Participant's agreement, if the Plan reasonably believes he/she to be a victim of abuse, neglect, or domestic violence. In such case, the Plan will promptly inform the Plan Participant that such a disclosure has been or will be made unless the Plan believes that informing him/her would place him/her at risk of serious harm (but only to someone in a position to help prevent the threat). Disclosure generally may be made to a minor's parents or other representatives although there may be circumstances under Federal or State law when the parents or other representatives may not be given access to the minor's PHI.
- 4. **Health Oversight Activities:** The Plan may disclose PHI to a health oversight agency for oversight activities authorized by law. This includes civil, administrative or criminal investigations; inspections; claim audits; licensure or disciplinary actions; and other activities necessary for appropriate oversight of a health care system, government health care program, and compliance with certain laws.
- 5. **Lawsuits and Disputes:** The Plan may disclose PHI when required for judicial or administrative proceedings. For example, the Plan Participant's PHI may be disclosed in response to a subpoena, discovery requests, or other required legal processes when the Plan is given satisfactory assurances that the requesting party has made a good faith attempt to advise the Plan Participant of the request or to obtain an order protecting such information, and done in accordance with specified procedural safeguards.
- 6. **Law Enforcement:** The Plan may disclose PHI to a law enforcement official when required for law enforcement purposes concerning identifying or locating a suspect, fugitive, material witness or missing person. Under certain circumstances, the Plan may disclose the Plan Participant's PHI in response to a law enforcement official's request if he/she is, or are suspected to be, a victim of a crime and if it believes in good faith that the PHI constitutes evidence of criminal conduct that occurred on the Sponsor's or Plan's premises.
- 7. **Decedents:** The Plan may disclose PHI to a coroner, funeral director or medical examiner for the purpose of identifying a deceased person, determining a cause of death or as necessary to carry out their duties as authorized by law.
- 8. **Research:** The Plan may use or disclose PHI for research, subject to certain limited conditions.
- 9. **To Avert a Serious Threat to Health or Safety:** The Plan may disclose PHI in accordance with applicable law and standards of ethical conduct, if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a threat to health or safety of a person or to the public.
- 10. **Workers' Compensation:** The Plan may disclose PHI when authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.
- 11. **Military and National Security:** The Plan may disclose PHI to military authorities of armed forces personnel under certain circumstances. As authorized by law, the Plan may disclose PHI required for intelligence, counter-intelligence, and other national security activities to authorized Federal officials.

20.08 Required Disclosures of PHI

1. Disclosures to Plan Participants: The Plan is required to disclose to a Plan Participant most of the PHI in a Designated Record Set when the Plan Participant requests access to this information. The Plan will disclose a Plan Participant's PHI to an individual who has been assigned as his/her representative and who has qualified for such designation in accordance with the relevant State law. Before disclosure to an individual qualified as a personal representative, the Plan must be given written supporting documentation establishing the basis of the personal representation.

The Plan may elect not to treat the person as the Plan Participant's personal representative if it has a reasonable belief that the Plan Participant has been, or may be, subjected to domestic violence, abuse, or neglect by such person, it is not in the Plan Participant's best interest to treat the person as his/her personal representative, or treating such person as his/her personal representative could endanger the Plan Participant.

2. Disclosures to the Secretary of the U.S. Dept of Health and Human Services: The Plan is required to disclose the Plan Participant's PHI to the Secretary of the U.S. Department of Health and Human Resources when the Secretary is investigating or determining the Plan's compliance with the HIPAA Privacy Rule.

20.09 Rights to Individuals

The Plan Participant has the following rights regarding PHI about him/her:

1. Request Restrictions: The Plan Participant has the right to request additional restrictions on the use or disclosure of PHI for treatment, payment, or health care operations. The Plan Participant may request the Plan restrict disclosures to family members, relatives, friends or other persons identified by him/her who are involved in his/her care or payment for his/her care. The Plan is not required to agree to these requested restrictions.
2. Right to Receive Confidential Communication: The Plan Participant has the right to request that he/she receive communications regarding PHI in a certain manner or at a certain location. The request must be made in writing and how the Plan Participant would like to be contacted. The Plan will accommodate all reasonable requests.
3. Copy of this Notice: The Plan Participant is entitled to receive a paper copy of this notice at any time. To obtain a paper copy, contact the Privacy Compliance Coordinator.
4. Accounting of Disclosures: The Plan Participant has the right to request an accounting of disclosures the Plan has made of his/her PHI. The request must be made in writing and does not apply to disclosures for treatment, payment, health care operations, and certain other purposes. The Plan Participant is entitled to such an accounting for the six (6) years prior to his/her request, though not earlier than April 14, 2003. Except as provided below, for each disclosure, the accounting will include: (a) the date of the disclosure, (b) the name of the entity or person who received the PHI and, if known, the address of such entity or person; (c) a description of the PHI disclosed, (d) a statement of the purpose of the disclosure that reasonably informs the Plan Participant of the basis of the disclosure, and certain other information. If the Plan Participant wishes to make a request, please contact the Privacy Compliance Coordinator.
5. Access: The Plan Participant has the right to request the opportunity to look at or get copies of PHI maintained by the Plan about him/her in certain records maintained by the Plan. If the Plan Participant requests copies, he/she may be charged a fee to cover the costs of copying, mailing, and other supplies. To inspect or copy PHI contact the Privacy Compliance Coordinator. In very limited circumstances, the Plan may deny the Plan Participant's request. If the Plan denies the request, the Plan Participant may be entitled to a review of that denial.

6. Amendment: The Plan Participant has the right to request that the Plan change or amend his/her PHI. The Plan reserves the right to require this request be in writing. Submit the request to the Privacy Compliance Coordinator. The Plan may deny the Plan Participant's request in certain cases, including if it is not in writing or if he/she does not provide a reason for the request.

20.10 Questions or Complaints

If the Plan Participant wants more information about the Plan's privacy practices, has questions or concerns, or believes that the Plan may have violated his/her privacy rights, please contact the Plan using the following information. The Plan Participant may submit a written complaint to the U.S. Department of Health and Human Services or with the Plan. The Plan will provide the Plan Participant with the address to file his/her complaint with the U.S. Department of Health and Human Services upon request.

The Plan will not retaliate against the Plan Participant for filing a complaint with the Plan or the U.S. Department of Health and Human Services.

Contact Information:

Privacy Compliance Coordinator Contact Information:

Betsy C. Keller, SPHR
Director of Human Resources
County of El Paso
800 E. Overland, Ste. 223
El Paso, Texas 79901
(p) (915) 546-2218
(f) (915) 546-8126

Additional Contact Information for HIPAA Questions:

Sam Trujillo
Risk Manager
County of El Paso
800 E. Overland, Ste. 223
El Paso, Texas 79901
(p) (915) 546-2218
(f) (915) 546-8126

ARTICLE 21 HIPAA SECURITY

Disclosure of Electronic Protected Health Information (“Electronic PHI”) to the Plan Sponsor for Plan Administration Functions

STANDARDS FOR SECURITY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (“SECURITY RULE”)

The Security Rule imposes regulations for maintaining the integrity, confidentiality and availability of protected health information that it creates, receives, maintains, or maintains electronically that is kept in electronic format (ePHI) as required under the Health Insurance Portability and Accountability Act (HIPAA).

Definitions:

“*Electronic Protected Health Information*” (ePHI) is defined in Section 160.103 of the Security Standards (45 C.F.R. 160.103) and means individually identifiable health information transmitted or maintained in any electronic media.

“*Security Incidents*” is defined within Section 164.304 of the Security Standards (45 C.F.R. 164.304) and means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operation in an information system.

Plan Sponsor Obligations

To enable the Plan Sponsor to receive and use Electronic PHI for Plan Administration Functions (as defined in 45 CFR §164.504(a)), the Plan Sponsor agrees to:

1. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan.
2. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate Security Measures.
3. Ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides Electronic PHI created, received, maintained, or transmitted on behalf of the Plan, agrees to implement reasonable and appropriate report to the Plan any security incident of which it becomes aware.
4. Report to the Plan any security incident of which it becomes aware.

Notification Requirements in the Event of a Breach of Unsecured PHI

The required breach notifications are triggered upon the discovery of a breach of unsecured PHI. A breach is discovered as of the first day the breach is known, or reasonably should have been known.

When a breach of unsecured PHI is discovered, the Plan will:

1. Notify the individual whose PHI has been, or is reasonably believed to have been, assessed, acquired, used, or disclosed as a result of the breach, in writing, without unreasonable delay and in no case later than 60 calendar days after discovery of the breach.

2. Notify the media if the breach affected more than 500 residents of a State or jurisdiction. Notice must be provided to prominent media outlets serving the State or jurisdiction without unreasonable delay and in no case later than 60 calendar days after the date the breach was discovered.
3. Notify the HHS Secretary if the breach involves 500 or more individuals, contemporaneously with the notice to the affected individual and in the manner specified by HHS. If the breach involves less than 500 individuals, an internal log or other documentation of such breaches must be maintained and annually submitted to HHS within 60 days after the end of each calendar year.
4. When a Business Associate, which provides services for the Plan and comes in contact with PHI in connection with those services discovers a breach has occurred, that Business Associate will notify the Plan without unreasonable delay and in no case later than 60 calendar days after discovery of a breach so that the affected individuals may be notified. To the extent possible, the Business Associate should identify each individual whose unsecured PHI has been, or is reasonably believed to have been, breached.

Any terms not otherwise defined in this section shall have the meanings set forth in the Security Standards.