

Agenda Item Form

Agenda Date: 8/2/05

Districts Affected: All

Dept. Head/Contact Information: David Almonte, 541-4350

Type of Agenda Item:

- | | | |
|---|---|--|
| <input checked="" type="checkbox"/> Resolution | <input type="checkbox"/> Staffing Table Changes | <input type="checkbox"/> Board Appointments |
| <input type="checkbox"/> Tax Installment Agreements | <input type="checkbox"/> Tax Refunds | <input type="checkbox"/> Donations |
| <input type="checkbox"/> RFP/ BID/ Best Value Procurement | <input type="checkbox"/> Budget Transfer | <input type="checkbox"/> Item Placed by Citizen |
| <input type="checkbox"/> Application for Facility Use | <input type="checkbox"/> Bldg. Permits/Inspection | <input type="checkbox"/> Introduction of Ordinance |
| <input type="checkbox"/> Interlocal Agreements | <input type="checkbox"/> Contract/Lease Agreement | <input type="checkbox"/> Grant Application |
| <input type="checkbox"/> Other _____ | | |

Funding Source:

- General Fund
 Grant (duration of funds: _____ Months)
 Other Source: _____

Legal:

- Legal Review Required Attorney Assigned (please scroll down): JURGE VILLEGAS Approved Denied

Timeline Priority: High Medium Low # of days: _____

Why is this item necessary:

Council approval is necessary to change the single plan option for non-uniformed employees and retirees to a dual plan option plan design consisting of a basic plan and a buy-up plan. The resolution will also update definitions in the plan document to comply with state and federal rules and regulations. Plan design changes are necessary in order to offset increases in medical inflation. Updating in the wording is necessary in order to incorporate wording from previous amendments and to incorporate state and federal definitions into the document.

Explain Costs, including ongoing maintenance and operating expenditures, or Cost Savings:

Changes to the plan design and rates will assist the City in maintaining pace with local medical inflation. No changes to the plan design or adjustment of City contributions or employee/retiree deductions would result in a minimum \$5M shortfall in the health fund. Rates supporting the plan design changes have been included in the proposed FY06 budget.

Statutory or Citizen Concerns:

None

Departmental Concerns:

There have been no changes to the plan design or to the rates for non-uniformed employees and/or retirees since January 1, 2002. Twenty-six meetings were held in May 2005 for non-uniformed employees and retirees in order to explain the plan design changes and rate changes. Overall reception to the presentations was good.

05 JUL 28 AM 11:12
CITY CLERK DEPT.

RESOLUTION

WHEREAS, the City of El Paso (the "**City**") desires to restate the City of El Paso Employee Health Benefit Plan document (the "**Plan**") to: (i) add/change certain definitions in the Plan; (ii) amend certain headings in the Plan; (iii) clarify certain provisions in the Plan; (iv) include in the Plan the notice of privacy practices required under the Health Insurance Portability and Accountability Act ("HIPAA")/Department of Health and Human Services; and (v) make various "clean-up" changes to the Plan.

NOW THEREFORE, BE IT RESOLVED BY THE CITY COUNCIL OF THE CITY OF EL PASO:

THAT the City Council hereby adopts the Restated City of El Paso Employee Health Benefit Plan, effective as of September 1, 2005.

PASSED AND APPROVED this 2nd day of August 2005.

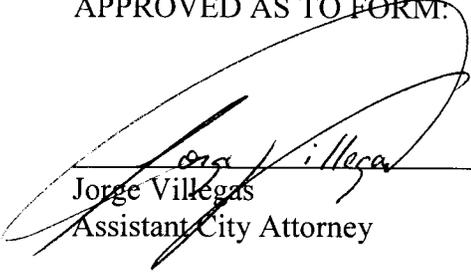
CITY OF EL PASO

John F. Cook
Mayor

ATTEST:

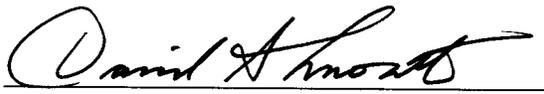
Richarda Duffy Momsen
City Clerk

APPROVED AS TO FORM:



Jorge Villegas
Assistant City Attorney

APPROVED AS TO CONTENT:



David Almonte, Director
Office of Management and Budget

THE CITY OF EL PASO EMPLOYEE HEALTH BENEFIT PROGRAM
RESTATED EFFECTIVE SEPTEMBER 1, 2005

The City of El Paso, Texas, Health Benefit Plan for the payment of certain expenses for the benefit of all Eligible Employees is hereby restated.

The Plan is subject to all the terms, provisions, and conditions recited on the following pages hereof.

This Plan is not in lieu of and does not affect any requirements for coverage by Worker's Compensation Insurance.

The City of El Paso has caused this Plan to take effect as of 12:01 a.m. on January 1, 2002 (Restated SEPTEMBER 1, 2005) pursuant to the City Council Resolution.

THE CITY OF EL PASO

By:

John Cook
Mayor

ATTEST:

Richarda Momsen
City Clerk

APPROVED AS TO FORM:

Jorge Villegas
Assistant City Attorney

APPROVED AS TO CONTENT:

David Almonte
Director, OMB

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Section 1. DEFINITIONS

- A) **ALLOWABLE EXPENSE.** An Allowable Expense is an expense for a covered service or supply under this Plan and which, if made by a Network Provider, is a negotiated rate or charge; and which, if made by an Out-of-Network Provider, is either a Reasonable and Customary Charge in the case of a Physician or supplier, or a charge calculated by the Plan Administrator that approximates the standard or usual charge made by a Network Provider in the case of a Health Care Provider that is not a Physician or supplier.
- B) **AMBULATORY SURGICAL CENTER.** An Ambulatory Surgical Center means a place approved or licensed as such by an agency of the governing jurisdiction.
- C) **BRAND NAME DRUGS.** Brand Name Drugs shall mean prescription drugs which are sold under a name which is protected by a federally registered trademark.
- D) **CITY.** The City is the City of El Paso, Texas.
- E) **COMPLICATIONS OF PREGNANCY.** Shall include the following:
- 1) Conditions requiring Hospital Confinement (when the pregnancy is not terminated) whose diagnosis are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity, but shall not include false labor, occasional spotting, physician prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, pre-eclampsia and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy, and
 - 2) Nonelective Caesarean Section, ectopic pregnancy which is terminated, spontaneous termination of pregnancy, which occurs during a period of gestation in which a viable birth is not possible, and a miscarriage or a nonelective abortion.
- F) **COSMETIC PROCEDURES.** Cosmetic Procedures are the alteration of tissue (usually surgical) for the improvement of appearance, but which is not intended to effect a substantial improvement or restoration of bodily function. These procedures are:
- 1) Due to neither injury nor sickness; and
 - 2) Performed solely to improve the appearance rather than the function or usefulness of a structure of the body.
- G) **COVERED PERSON.** Any Eligible Employee or Dependent, who has satisfied the Waiting Period, who has elected coverage and who has made any required contribution for coverage under the Plan, if any.
- H) **CUSTODIAL CARE.** Care comprised of services and supplies provided primarily to assist in the activities of daily living.
- I) **DEDUCTIBLE.** The amount of expenses a Covered Person must pay in each Plan Year before benefits are payable under this Plan.
- J) **DRUGS.**
- 1) **BRAND NAME.** Brand Name Drugs shall mean prescription drugs, which are sold under a name, which is protected by a federally registered trademark.
 - 2) **PREFERRED BRAND NAME.** Any drug listed on the Preferred Brand Name List distributed by the Pharmacy Benefit Manager.
 - 3) **GENERIC.** Generic Drugs shall mean prescription drugs, which are sold under a name not protected by a federally registered trademark and which are chemically equivalent to drugs sold under a name which is protected by a federally registered trademark.

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

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

K) DURABLE MEDICAL EQUIPMENT. Durable Medical Equipment shall include 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. All requirements of the definition must be met before an item can be considered to be Durable Medical Equipment.

L) ELECTIVE SURGICAL PROCEDURE. A nonemergency surgical procedure scheduled at the patient's convenience without jeopardizing the patient's life or causing serious impairment to the patient's bodily function.

M) ELIGIBLE DEPENDENT. An Eligible Dependent shall mean:

- 1) The spouse of an eligible employee (Formal documentation in the form of a marriage or common-law certificate is required).
- 2) It shall also mean the unmarried, unemancipated children of an eligible employee who:
 - a) Under the age of 25, are the natural children, legally adopted children or children for whom the Eligible Employee is a legal guardian;
 - b) Under the age of 25, are the step children who reside at the Eligible Employee's home;
 - c) A child of your child , if the child is under 25 and unmarried, and is financially dependent upon the Employee for support and claimed as dependents on the Employee's income tax. The Plan Sponsor will require the Eligible Employee to furnish proof of the Dependent's dependency at the time of enrollment by providing a copy of federal income tax return reflecting the dependency status; or
 - d) Upon reaching the age of 25 and having been covered under this Plan as an Eligible Dependent, are disabled and are incapable of earning a living, may continue to be covered as an Eligible Dependent. The Plan Sponsor may require the Eligible Employee to furnish periodic proof of this individual's continued incapacity or dependency, but not more often than annually. If such proof is not satisfactory and further proof which is satisfactory is not provided upon request, within the time period specified by the Plan Sponsor, coverage for the individual will end immediately.

N) ELIGIBLE EMPLOYEE. An Eligible Employee is any full-time employee who has satisfied the applicable waiting period. Full time shall mean a minimum of 40 hours per week. An Eligible Employee shall include:

- 1) Mayor and City Representatives.
- 2) Permanent full-time employees including Police Department, Fire Department and Water Department.
- 3) Any other employee of the City or related agency for whom health care coverage has been approved by the City Council.
- 4) Eligible retired employees choosing to retain available coverage for retired employees upon retirement. Failure to enroll for these coverages at retirement shall forfeit any further participation in the City Program.

An Eligible Employee under this Plan MAY NOT be additionally covered under this Plan as a dependent of another Eligible Employee.

- O) **EMERGENCY CARE.** Emergency care means health care services provided in a Hospital emergency facility or comparable facility to evaluate and stabilize medical conditions of a recent onset and severity, including but not limited to severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that the person's condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in:
- 1) Placing the patient's health in serious jeopardy;
 - 2) Serious impairment to bodily functions;
 - 3) Serious dysfunction of any bodily organ or part;
 - 4) Serious disfigurement; or
 - 5) In the case of a pregnant woman, serious jeopardy to the health of the fetus.
- P) **EMPLOYER.** The Employer is the City of El Paso.
- Q) **ENROLLMENT.** Enrollment is the election by an Eligible Employee for coverage under the Plan for themselves and/or Eligible Dependents.
- 1) Enrollment of Eligible Employee: When an employee first becomes eligible for coverage under the Plan, the Eligible Employee shall have 31 days to enroll for these benefits. Failure to complete the enrollment paperwork will constitute a waiver of coverage.
 - 2) Enrollment of Eligible Dependents: When an Eligible Employee, who has never previously had Eligible Dependents, acquires new Eligible Dependent(s), the Eligible Employee shall have 31 days to enroll these Eligible Dependent(s) under the Plan. Failure to complete the enrollment paperwork will constitute a waiver of coverage.

If an Eligible Employee who has previously waived coverage for himself/herself and/or any Eligible Dependents wishes to cover himself/herself and/or any Eligible Dependents, the Eligible Employee must furnish Evidence of Insurability satisfactory to the Plan Administrator in order to obtain coverage.

An active Eligible Employee who is eligible to retire under the City Employees Pension Fund or the Fire and Policemen Pension Fund of El Paso and who is covered under the Health Benefit Plan shall have 31 days to elect to retain Health Coverages under the Plan from the date of retirement. Failure to do so will mean forfeiture of any further future coverage rights under the Plan. Any active Eligible Employee who has waived coverage under the City Health Benefit Plan or chosen to be covered under another Plan available through the City is not eligible, at the time of retirement, to choose to be covered under the Retiree Health Benefit portion of this Plan, unless the Plan Sponsor so dictates. A retired Eligible Employee shall only have the right to continue coverage for current enrolled Eligible Dependents if the retiree had dependent coverage at the time of retirement.

An Eligible Employee, except for a retiree, shall have the right, with respect to a child who is born while the Eligible Employee is covered for benefits under the Plan and where the Eligible Employee had previously waived coverage for other Eligible Dependent children, to obtain benefits for this child under the Plan. This child is a Covered Dependent under the Plan from the moment of birth. However, any coverage that this child has solely by reason of this Newborn Child Provision, is hereby modified to provide that no benefits will be payable for any charge incurred for a service or supply which is necessary for the covered medical care of this child after the end of the 31 day period which immediately follows the child's birth, unless the Eligible Employee notifies the Plan and completes any necessary enrollment forms during this same 31 day period, to continue coverage for this child beyond the 31 day period.

In the event that an Eligible Employee has previously waived coverage for Eligible Dependents, this child who has become covered from the moment of birth by reason of Newborn Child Provisions will continue to be covered after the end of the 31 day period if the Eligible Employee enrolls this newborn child during the 31 day period which immediately follows the child's date of birth. All other dependents for whom coverage previously

was waived will not become eligible for coverage until the Eligible Employee furnishes Evidence of Insurability satisfactory to the Insurance Company providing Reinsurance to the Plan in order to obtain coverage for these dependents.

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

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

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

S) EXTENDED CARE FACILITY. The term "Extended Care Facility" means an institution (or a distinct part of an institution) which:

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

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

T) FISCAL YEAR. The Fiscal Year is from September 1 to August 31 as defined in the Charter of the City of El Paso.

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

V) HEALTH CARE PROVIDER. A Health Care Provider is any of the institutions or persons listed below, legally licensed in the USA, who provides medical care or diagnostic treatment to individuals for a covered illness or injury. The requirement that the Health Care Provider be legally licensed in the USA will be waived when treatment is provided to a covered participant by a Health Care Provider licensed in the country where services are provided, in a life threatening emergency:

- | | |
|-------------------------------|-------------------------------------|
| 1) Ambulatory Surgical Center | 2) Nurse / Nurse Practitioner |
| 3) Extended Care Facility | 4) Physician / Physician Assistant |
| 5) Home Health Agency | 6) Psychologist |
| 7) Hospice | 8) Therapist |
| 9) Hospital | 10) Master of Social Work |
| 11) Laboratory | 12) Licensed Clinical Social Worker |

W) HOME HEALTH AGENCY. A Home Health Agency means an agency which:

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

X) HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA). The Act establishes federal standards for the availability and portability of group and individual health insurance coverage. The provisions of the Act affect coverage whether the coverage is provided through self-insured plans, group health insurance, through individual policies or by HMO. The Act is designed to provide more options for maintaining health insurance for individuals that change jobs, lose jobs, become self employed, or move to a company that does not provide health insurance. The Act limits the ability of employers or insurance issuers to impose pre-existing condition exclusions or to use an individual's health status to deny coverage.

Y) HOSPICE. Hospice shall mean an entity, which is licensed or certified as a Hospice by Medicare and by the State. The care provided by a Hospice means the palliative, supportive and related care for the person diagnosed as terminally ill and:

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

Z) HOSPITAL. A Hospital shall mean:

- 1) An institution for care of the sick or injured, which is properly licensed to operate as such, and which has licensed graduate registered nurses on duty 24 hours a day, a physician on call at all times, and facilities for diagnosis of illness and related equipment for performing surgery. The requirement of surgical facilities

shall not apply to a treatment center which is duly licensed for, and specialized in, the care and treatment of those who are mentally ill. In no event will the term Hospital include an institution which:

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

2) An Alcohol Dependency Treatment Center. The term Alcohol Dependency Treatment Center means a facility which provides a program for the treatment of alcohol dependence pursuant to a written treatment plan approved and monitored by a physician and which facility is also:

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

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

BB) INCURRED EXPENSES. An expense is deemed to be incurred on the date a service is rendered or a supply is furnished.

CC) INJURY. Injury means an accidental bodily injury which requires treatment by a physician. It must result in loss independently of sickness and other causes.

DD) L.P.N. An L.P.N. is a Licensed Practical Nurse.

EE) L.V.N. An L.V.N. is a Licensed Vocational Nurse.

FF) LABORATORY. A Laboratory means a public or private entity which is equipped for scientific experimentation, research, testing, or clinical studies of materials, fluids, or tissues obtained from patients and is properly approved or licensed as such by an agency of the governing jurisdiction.

GG) LEAVE OF ABSENCE. A period of time during which the Eligible Employee does not work but which is of stated duration, after which time, the Eligible Employee is expected to return to regular, active, full time employment.

HH) LICENSED CLINICAL SOCIAL WORKER. A Licensed Clinical Social Worker shall only include a person who is duly certified by the appropriate State agency as a Clinical Social Worker with advanced clinical practice.

II) LIFETIME MAXIMUM BENEFIT. The maximum amount of total benefits that will be paid out by the plan to a covered member during their lifetime.

JJ) MEDICAL SOCIAL SERVICES. The following services under the direction of a Physician provided to a terminally ill individual:

- 1) Assessment of the social, psychological and family problems related to or arising out of a terminally ill individual's illness and treatment; and
- 2) Appropriate action and utilization of community resources to assist in resolving such problems.

- UU) OUT-OF-NETWORK PROVIDER.** Out-of-Network Provider shall mean treatment or services provided by Health Care Providers who are not Network Providers, although the service is available from Network Providers.
- VV) OUTPATIENT.** A Covered Person shall be considered to be an Outpatient if he/she is treated at a hospital and is confined less than 24 consecutive hours.
- WW) PHYSICIAN.** A Physician shall be a person holding an unrestricted license to practice in the state where services are rendered and who has the degree of Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Podiatry (D.P.M.), Doctor of Dental Surgery (D.D.S.), Doctor of Chiropractic (D.C.), or Doctor of Optometry (O.D.).
- XX) PLAN.** The Plan shall be the benefits and the provisions for payment of these benefits described herein and is called the City of El Paso Employee Health Benefit Program.
- YY) PLAN ADMINISTRATOR.** Plan Administrator shall mean the person or firm providing technical services and advice to the Plan Sponsor in connection with the operation of the Plan and performing such other functions including processing any payment of claims as may be delegated to it. The Plan Administrator is Access Administrators, Inc.
- ZZ) PLAN SPONSOR.** The Plan Sponsor is the City of El Paso, Texas.
- AAA) PLAN YEAR.** The Plan Year runs from September 1 through the following August 31.
- BBB) PPO BENEFIT.** The PPO Benefit shall mean the Benefit as defined in the Schedule of Benefits section for treatment of services provided by health care providers who are in the Advantage Care Network.
- CCC) PRE-EXISTING CONDITION.** A Pre-Existing Condition shall mean any condition where medical care or treatment was received by an Eligible Employee or Eligible Dependent or where medical care or treatment was recommended by a physician or surgeon for such person or for which any prudent person would have sought such care or treatment, within the 90-day period which immediately preceded the date such person became a Covered Person under this Plan.
- DDD) PREFERRED LAB.** Designated laboratory entity that will offer the Plan Maximum benefit in which contracted/negotiated fees are considered payment in full
- EEE) PREGNANCY.** Pregnancy shall include the birth of a child, except for Complications arising therefrom, as defined herein (Complications of Pregnancy). Pregnancy shall be a covered medical expense in the same manner as any other covered illness. Pre-Existing conditions and extension of benefits for pregnancy shall be covered in the same manner as any other covered illness. Pregnancy is considered to have commenced nine months before its termination, unless a physician's written statement to the Plan Administrator states otherwise. The eligible Hospital charges for well baby care for a newborn child are considered to be the newborn's charges with applicable deductibles during the hospital stay for employees and dependents.
- FFF) PRIMARY CARE PHYSICIAN.** Primary Care Physician is a physician who is available in one of the following fields:
- 1) Family Practice;
 - 2) Internal Medicine;
 - 3) General Practice;
 - 4) Obstetrical and Gynecology; or
 - 5) Pediatrics.

A female Covered Person who chose a Primary Care Physician in the field of Obstetrics and/or Gynecology is not limited to seeing that Primary Care Physician for Well-Woman exams and Pregnancy only.

KK) MEDICALLY NECESSARY. A Medically Necessary service or supply means one which is ordered or authorized by a Physician and which is determined by the Plan Administrator to be:

- 1) Provided for the diagnosis or direct treatment of an injury or sickness;
- 2) Appropriate and consistent with the symptoms and findings or diagnosis and treatment of the Covered Person's injury or sickness;
- 3) Provided in accordance with generally accepted medical practice on a national basis; and
- 4) The most appropriate supply or level of service, which can be provided on a cost effective basis (including, but not limited to, inpatient versus outpatient care, electric versus manual wheelchair, surgical versus medical or other types of care).

The fact that the Covered Person's physician prescribes services or supplies, does not automatically mean such services or supplies are medically necessary and covered by the Plan.

LL) MEDICARE. Medicare means the Part A and Part B health care coverages described in Title XVIII of the United States Social Security Act, as amended.

MM) MENTAL ILLNESS. Any physiological or psychological disorder or ailment of the mind which results from any cause and includes any condition that may result from the Mental Illness. It shall include Mental Illness ICD-9 diagnoses codes 290-319.

NN) NAMED FIDUCIARY. The person who has the authority to control and manage the operation and administration of the Plan. The Named Fiduciary for the Plan is the City.

OO) NETWORK. Network shall mean the Health Care Providers that have contracted with the Network Administrators to provide medical services under this Plan to Covered Persons who have elected to participate in the City of El Paso Employee Health Benefit Program.

PP) NETWORK ADMINISTRATORS. Network Administrators are Advantage Care Network, Inc. and Tri-State Physicians Healthcare Network, P.A.

QQ) NETWORK PROVIDER. Network Provider shall mean a Health Care Provider who has contracted with the Network Administrators to provide treatment or services to Covered Persons under this Plan and to accept negotiated rates as payment in full for such treatment and services.

RR) NONOCCUPATIONAL. A condition which does not arise out of or in the course of employment for pay or profit and does not qualify under any Workers' Compensation law or similar legislation.

SS) NURSE. A Nurse is a properly licensed person holding the degree of Registered Nurse (R.N.), Licensed Vocational Nurse (L.V.N.), or Licensed Practical Nurse (L.P.N.).

TT) OFFICE VISIT. Office Visit shall mean the following services provided by a Physician in his or her office or in an Outpatient setting:

- 1) Time spent with or on behalf of the patient;
- 2) Reviewing of patient history;
- 3) Examination of the patient;
- 4) Diagnosis;
- 5) Medical decision-making;
- 6) Counseling; and
- 7) Coordination of medical care.

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

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

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

III) R.N. An R.N. is a Registered Nurse licensed in the State where services are rendered.

JJJ) SELECT BENEFITS. Select Benefits shall mean the Benefit as defined in the Schedule of Benefits section for treatment or services provided by Health Care Providers who are in the the Select/EPO Directory.

KKK) SERIOUS MENTAL ILLNESS. Serious Mental Illness shall mean:

- 1) Schizophrenia;
- 2) Paranoid and other psychotic disorders;
- 3) Bipolar disorders (mixed, manic, and depressive);
- 4) Major depressive disorders (single episode or recurrent);
- 5) Schizo-affective disorders (bipolar or depressive);
- 6) Pervasive developmental disorders;
- 7) Obsessive-compulsive disorders; and
- 8) Depression in childhood and adolescence

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

MMM) SPECIALIST. Specialist shall mean any Physician other than a Primary Care Physician who participates under a contract with the Network Administrators as a Specialty Physician.

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

OOO) TERMINATION OF EMPLOYMENT. Termination of Employment shall mean an Eligible Employee who stops working due to resignation, with or without retirement benefits. It shall also mean an Eligible Employee who stops working due to an involuntary separation action.

PPP) THERAPIST. A Therapist shall include a person who is duly licensed or certified in the state where the service is rendered to provide services for Physical, Speech, Respiratory or Occupational Therapy.

QQQ) TOTAL DISABILITY. Total Disability shall mean that the Covered Person, if an employee, is prevented, solely because of a non-occupational injury or nonoccupational disease, from engaging in his/her regular or

customary occupation and is performing no work of any kind for compensation or profit; or if a dependent is prevented, solely because of a nonoccupational injury or disease, from engaging in all of the normal activities of a person of like age and sex who is in good health.

RRR) UTILIZATION REVIEW ORGANIZATION. The Utilization Review Organization will be the entity appointed by the Plan Administrator to administer the Utilization Review Program.

SSS) WAITING PERIOD. The Waiting Period before coverage hereunder becomes effective shall be 30 days of continuous permanent full-time employment unless otherwise specified.

Section 2. INDIVIDUAL EFFECTIVE DATE

- A) An Eligible Employee's coverage will become effective on the first day following the satisfaction of the Waiting Period and enrollment by the employee.**
- B) An enrollment card specified by the City must be completed by an Eligible Employee to effect coverage for the employee and any Eligible Dependents.**
- C) Failure to complete an enrollment card within 31 days from the date an employee becomes eligible will constitute waiver of coverage. If an Employee waives coverage for himself or herself, no coverage is available for any Eligible Dependents under the Plan. If an Eligible Employee waives coverage and later wishes to be covered under the Plan, the Eligible Employee must submit satisfactory Evidence of Insurability to the City of El Paso, unless making additions during the annual enrollment period.**
- D) The Eligible Dependents of an Eligible Employee shall become covered under the Plan on the date that they meet the definition of an Eligible Dependent and the Eligible Employee has completed, in a timely fashion, the necessary enrollment forms required for enrollment. If the enrollment is for dependents for whom the employee has previously waived coverage, the coverage shall be effective the date of enrollment of these Eligible Dependents, if the submitted Evidence of Insurability on these previously waived dependents is approved by the Plan Administrator or its designee.**
- E) An Eligible Employee who is not actively at work or an Eligible Dependent who is totally disabled on the effective date of their coverage will have their effective date of coverage delayed until the date the Eligible Employee becomes active at work or the date the Eligible Dependent is no longer totally disabled.**
- F) Employees who are on a Leave of Absence due to military service and who do not continue coverage as required by the Plan in Section 10 (Contributions) and employees who have a Termination of Employment due to military service and are reemployed by the City in accordance with the provisions of the Veterans' Reemployment Rights Act are entitled to certain health care protections upon return to City employment. Evidence of Insurability will not be required for reemployment when returning from military service. The effective date of coverage is immediate if the Eligible Employee pays the prorated contribution amount or concurrent with the month paid through the payroll deduction system.**

Please Note: These rights depend basically on the nature and length of the military service and may require certain notice to the City prior to the military service. Employees should consult with the Plan Administrator or the City's Health Benefits office.

- G) Where an individual is covered as an Eligible Employee under this Plan, they may not be additionally covered under this Plan as the dependent of another Eligible Employee of this Plan.**
- H) An employee who is on a Leave of Absence in accordance with the provisions of the Family and Medical Leave Act of 1993 remains eligible to participate in the Plan for the duration of such leave at the level and under the conditions of participation that would have been provided if the employee had continued in employment continuously for the duration of such leave.**
- I) The coverage of any person who elects Continuation of Coverage under the provisions of this Plan as a Qualified Beneficiary as defined by the Consolidated Omnibus Benefit Reconciliation Act of 1985 (COBRA) shall become effective the day that a Qualifying Event occurs if:**
 - 1) The City notifies the Plan Sponsor, for Qualifying events listed as its responsibility for notification, within 30 days of the occurrence of that Qualifying Event or the Qualified Beneficiary notifies the Plan Sponsor, for Qualifying events listed as their responsibility for notification, within 60 days of the occurrence of that Qualifying Event;**
 - 2) The Covered Person returns to the Plan Sponsor a signed Election to Continue Coverage Form within 60 days of their receipt of this form from the Plan Sponsor;**
 - 3) The Covered Person completes and returns a new enrollment card to the Plan Sponsor within 45 days of their election to continue this coverage; and**

- 4) The Covered Person pays the retroactive premium to the Plan Sponsor for these coverages within 45 days. The first payment will be the necessary contribution to cover the Qualified Beneficiary from the first of the month following the Qualifying Event through the end of the month in which the election is made.**

Section 3. INDIVIDUAL TERMINATION OF COVERAGE

- A)** The coverage of any Covered Person under the Plan shall terminate on the earliest of the following dates:
- 1)** The date of termination of the Plan;
 - 2)** The date his/her membership ceases in an eligible class;
 - 3)** The last day of the month in which a dependent child attains: 25 years of age;
 - 4)** The date all coverage or certain benefits are terminated on his/her particular class by modification of the Plan;
 - 5)** The date he/she becomes a full-time member of the Armed Forces of any country, or unless otherwise provided by City Council;
 - 6)** The last day of the month in which payment has been made if the Eligible Employee fails to make a required contribution to the Plan, if any;
 - 7)** The date following the end of the 31-day period of eligibility for a newborn child covered under the Mother's policy unless prior to the expiration of such 31 day period the employee has enrolled such dependent and has agreed to make any required contributions;
 - 8)** The date the City notifies the Covered Person, in accordance with the provisions of this Plan, of termination of coverage;
 - 9)** The last day of the month for which a full month's contribution has been made and:
 - a)** Active full-time employment terminates,
 - b)** A previously Covered Person becomes ineligible for coverage,
 - c)** A Covered Person elects to waive previously elected coverage; or
 - d)** A covered retiree waives coverage;
 - 10)** In the event a permanent full-time employee is terminated for any reason other than gross misconduct, coverage for the employee and for the dependents that are enrolled prior to the lay-off notification will be offered Continuation of Coverage under the provisions of COBRA.
- B)** The coverage of any person who elects Continuation of Coverage under the provisions of this Plan as a "Qualified Beneficiary" as defined by the Consolidated Omnibus Benefit Reconciliation Act of 1985 (COBRA) shall terminate on the earliest of the following dates:
- 1)** Thirty-six (36) months from the date a previously covered dependent continues coverage as a Qualified Beneficiary due to death of employee, Medicare entitlement, divorce or separation, dependent ceasing to be a dependent;
 - 2)** Twenty-nine (29) months if the Qualified Beneficiary, is disabled for Social Security purposes at the time of the termination or reduction in hours and who gives the Plan Sponsor notice of such determination within 60 days and before the end of the 18-month continuation period;
 - 3)** Eighteen (18) months from the date a previously covered employee continues coverage as a Qualified Beneficiary due to a Qualifying Event taking place;
 - 4)** For previously covered dependents, eighteen (18) months from the date an employee loses coverage due to voluntary or involuntary termination;
 - 5)** The date a Qualified Beneficiary becomes entitled to Medicare;

- 6) The date a required contribution is not made. The allowable grace period is 30 days from the due date; or
- 7) The Plan may terminate COBRA coverage on the date a COBRA participant becomes covered under another group health benefits plan.

Section 4. POINT OF SERVICE PLAN

The Point-of-Service Plan allows a Covered Person to receive Plan benefits by choosing any Physician or other Health Care Provider when health care is required for a covered medical illness or injury. The Point-of-Service Plan allows the patient to receive benefits for Covered Medical Expenses rendered by either the Physicians and Health Care Providers of the Select Program, or of the Preferred Provider Organization (PPO), or by any other licensed Physicians and Health Care Providers who are not included as Network Providers. Regardless of the Physician or Health Care Provider chosen, benefits will be subject to all other terms, conditions and limitations of the Plan. There are three levels of benefits under the Plan, each dependent on the choice of Health Care Provider made by the Covered Person.

All Copayments, Deductibles, Payable Percentages, Out-of-Pocket Expenses and any Maximums are shown in the Schedule of Benefits Section.

- A) SELECT Benefits:** If a Covered Person receives any covered services or supplies due to a covered illness or injury while covered under this Plan, the Plan will pay the benefits, in accordance with the section titled "Schedule of Benefits" for the Select Benefit, provided the service or supply is:
- 1) Deemed Medically Necessary (except for Emergency Care); and
 - 2) Provided by a Network Provider participating as a Select/EPO Provider.
- B) Preferred Provider Organization (PPO) Benefits:** If a Covered Person receives any covered services or supplies due to a covered illness or injury while covered under this Plan, the Plan will pay benefits in accordance with the Schedule of Benefits Section for the PPO, provided the service or supply is:
- 1) Deemed medically necessary; and
 - 2) Provided by a Network Provider participating in the Advantage Care Network.
- C) Out-of-Network Benefits:** If a Covered Person receives any covered services or supplies due to a covered illness or injury while covered under this Plan, the Plan will pay benefits in accordance with the Schedule of Benefits Section for the Out-of-Network benefit, provided the service or supply is deemed Medically Necessary and provided by a Physician or Health Care Provider who is not a Network Provider.

Section 5. SCHEDULE OF BENEFITS

A. BASIC PLAN (ACTIVE NON-UNIFORMED EMPLOYEES AND RETIREES)

FEATURES	SELECT	PPO	Out-of-Network
Individual annual deductible	\$1,000	\$2,000	\$3,000
	(Cross Application will apply at all levels of benefits)		
Family annual deductible	\$2,500	\$5,000	\$7,500
	(Cross Application will apply at all levels of benefits)		
Coinsurance paid by the patient	20%	40%	50%
Maximum individual out-of-pocket	\$2,000	\$4,000	\$6,000
Maximum lifetime benefit	Combined \$2,000,000		

(Serious Mental Illness and Pregnancy treated like any other illness under all benefit levels.)

All percentages applied to Allowable Expense

Hospital Services	Las Palmas/ Del Sol	All other ACN Facilities	Out of Network
Per admission Copayment	\$100	\$200	\$500
Room & board (semi-private)	80%	60%	50%
Ancillary hospital charges	80%	60%	50%
Outpatient	80%	60%	50%
Emergency room (ER) Copayment	\$75	\$150	\$250

(ER Copayment waived if inpatient admission occurs)

Professional Services

Pediatric or adult routine annual physical exams limited to:

Office Visits (one per year) PCP	\$20 Copayment	\$40 Copayment	50%
Specialist	\$30 Copayment	\$40 Copayment	50%
•Pap Smear (one per year)	100%	100%	50%
•Mammography (one per year)	100%	100%	50%
•Bone Density Testing (one per year)	100%	100%	50%
•Colorectal and Prostate Exams	100%	100%	50%
•Routine vision testing through age 5 (one per year)	100%	100%	50%
•Routine Basic Hearing exam (one per year)	100%	100%	50%
• <i>These services are allowed once every 12 months whether part of a routine physical exam OR any other visit and do not require an additional Copayment</i>			
Routine Newborn Services (through 2 years)	100%	100%	50%
Immunizations (no age limit)	100%	100%	50%
Pediatric or adult office visits (illness) PCP	\$20 Copayment	\$40 Copayment	50% after deductible
Specialist	\$30 Copayment	\$40 Copayment	50% after deductible
Other Physician services (lab, X-ray, etc.)	80%	60%	50%
Hospital Visits	80%	60%	50%
Allergy tests & treatments	80%	60%	50%
Surgeon	80%	60%	50%
Assistant Surgeon	80%	60%	50%
Anesthetist	80%	60%	50%

Deductibles and/or copayments do not apply towards out of pocket. Copayments do not apply to deductible.

FEATURES	SELECT	PPO	Out-of-Network
Chiropractic			
Office visit	\$20 Copayment	\$25 Copayment	50%
Other services	80%	60%	50%
Annual Maximum		\$1500 combined	
Mental Health (except Serious Mental Illness)			
Inpatient facility	80%	60%	50%
Physician for Inpatient Services	80%	60%	50%
Outpatient Physician	\$20 Copayment	\$25 Copayment	50%
Annual Maximum	N/A	N/A	\$10,000
All Other Services			
Ambulance	80%	60%	50%
Preferred Labs	100%	N/A	N/A
X-ray & Lab	80%	60%	50%
Chemo/radiation therapy	80%	60%	50%
Home health care (60 visits per year)	80%	60%	50%
Hospice care (100 home visits per year, and 180 days in a Hospice facility per lifetime)	80%	60%	50%
Physical & speech therapy (speech therapy under limited conditions)	80%	60%	50%
Durable medical equipment (Total billed charges greater than \$500 must have prior approval of Plan Administrator)	80%	60%	50%
Pre-authorization and Continued Care Review	Required.	Required.	Required.
Requirements and Penalties (please see Section 6, pg. 28 for list of services requiring Pre-authorization)	\$300 penalty if not obtained.	\$300 penalty if not obtained	\$300 penalty if not obtained
Second surgical opinion may be requested by Medical Case Manager	Applicable	Applicable	Applicable
Pre-existing Condition Limitation	\$1,000 combined for first year		

Deductibles and/or copayments do not apply towards out of pocket. Copayments do not apply to deductible.

Prescription Drug

Retail (30-day supply)

Generic Name	\$15 Copayment at Participating Pharmacies.
Preferred Brand Name	\$30 Copayment at Participating Pharmacies.
Non-Preferred Brand Name	\$45 Copayment at Participating Pharmacies.

Mail Order Maintenance and Retail Maintenance (90-day supply)

Generic Name	\$30 Copayment
Preferred Brand Name	\$60 Copayment
Non-Preferred Brand Name	\$90 Copayment

Please Note: No benefits will be paid for prescription drugs obtained at Non-Participating Pharmacies.

Note Regarding Collective Bargaining Employees: Prescription benefits may be different for uniformed Police and Fire Department employees. Please contact the City of El Paso, Insurance and Benefits Department for updates.

Emergency Out of Area Hospitalization

In all cases, members should coordinate services through the Access Utilization Management department to achieve the highest level of benefits.

B. BUY-UP PLAN (ACTIVE NON-UNIFORMED AND RETIREES)

FEATURES	SELECT	PPO	Out-of-Network
Individual annual deductible	\$300	\$600	\$1,000
Family annual deductible	\$750	\$1,500	\$2,500
Coinsurance paid by the patient	10%	40%	50%
Maximum individual out-of-pocket	\$1,500	\$3,000	\$4,500
Maximum lifetime benefit	Combined \$2,000,000		

(Serious Mental Illness and Pregnancy treated like any other illness under all benefit levels.)

All percentages applied to Allowable Expense

Hospital Services	Las Palmas/ Del Sol	All other ACN Facilities	Out of Network
Per admission Copayment	\$100	\$200	\$500
Room & board (semi-private)	90%	60%	50%
Ancillary hospital charges	90%	60%	50%
Outpatient	90%	60%	50%
Emergency room (ER) Copayment	\$75	\$150	\$250

(ER Copayment waived if inpatient admission occurs)

Professional Services

Pediatric or adult routine annual physical exams limited to:

Office Visits (one per year) PCP	\$20 Copayment	\$40 Copayment	50%
Specialist	\$30 Copayment	\$40 Copayment	50%
•Pap Smear (one per year)	100%	100%	50%
•Mammography (one per year)	100%	100%	50%
•Bone Density Testing (one per year)	100%	100%	50%
•Colorectal and Prostate Exams	100%	100%	50%
•Routine vision testing through age 5 (one per year)	100%	100%	50%
•Routine Basic Hearing exam (one per year)	100%	100%	50%
<i>• These services are allowed once every 12 months whether part of a routine physical exam OR any other visit and do not require an additional Copayment</i>			
Routine Newborn Services (through 2 years)	100%	100%	50%
Immunizations (no age limit)	100%	100%	50%
Pediatric or adult office visits (illness) PCP	\$20 Copayment	\$40 Copayment	50% after deductible
Specialist	\$30 Copayment	\$40 Copayment	50% after deductible
Other Physician services (lab, X-ray, etc.)	90%	60%	50%
Hospital Visits	90%	60%	50%
Allergy tests & treatments	90%	60%	50%
Surgeon	90%	60%	50%
Assistant Surgeon	90%	60%	50%
Anesthetist	90%	60%	50%

Deductibles and/or copayments do not apply towards out of pocket. Copayments do not apply to deductible.

FEATURES	SELECT	PPO	Out-of-Network
Chiropractic			
Office visit	\$20 Copayment	\$25 Copayment	50%
Other services	90%	60%	50%
Annual Maximum		\$1500 combined	
Mental Health (except Serious Mental Illness)			
Inpatient facility	90%	60%	50%
Physician for Inpatient Services	90%	60%	50%
Outpatient Physician	\$20 Copayment	\$25 Copayment	50%
Annual Maximum	N/A	N/A	\$10,000
All Other Services			
Ambulance	90%	60%	50%
Preferred Labs	100%	N/A	N/A
X-ray & Lab	90%	60%	50%
Chemo/radiation therapy	90%	60%	50%
Home health care (60 visits per year)	90%	60%	50%
Hospice care (100 home visits per year, and 180 days in a Hospice facility per lifetime)	90%	60%	50%
Physical & speech therapy (speech therapy under limited conditions)	90%	60%	50%
Durable medical equipment (Total billed charges greater than \$500 must have prior approval of Plan Administrator)	90%	60%	50%
Pre-authorization and Continued Care Review	Required.	Required.	Required.
Requirements and Penalties (please see Section 6, pg. 28 for list of services requiring Pre-authorization)	\$300 penalty if not obtained.	\$300 penalty if not obtained	\$300 penalty if not obtained
Second surgical opinion may be requested by Medical Case Manager	Applicable	Applicable	Applicable
Pre-existing Condition Limitation	\$1,000 combined for first year		

Deductibles and/or copayments do not apply towards out of pocket. Copayments do not apply to deductible.

Prescription Drug

Retail (30-day supply)

Generic Name	\$15 Copayment at Participating Pharmacies.
Preferred Brand Name	\$30 Copayment at Participating Pharmacies.
Non-Preferred Brand Name	\$45 Copayment at Participating Pharmacies.

Mail Order Maintenance and Retail Maintenance (90-day supply)

Generic Name	\$30 Copayment
Preferred Brand Name	\$60 Copayment
Non-Preferred Brand Name	\$90 Copayment

Please Note: No benefits will be paid for prescription drugs obtained at Non-Participating Pharmacies.

Note Regarding Collective Bargaining Employees: Prescription benefits may be different for uniformed Police and Fire Department employees. Please contact the City of El Paso, Insurance and Benefits Department for updates.

Emergency Out of Area Hospitalization

In all cases, members should coordinate services through the Access Utilization Management department to achieve the highest level of benefits.

C. UNIFORMED EMPLOYEES

FEATURES	SELECT	PPO	Out-of-Network*
Individual annual deductible	None	None	\$500
Family annual deductible	None	None	\$1,500
Coinsurance paid by the patient	None	15%	40%
Maximum individual out-of-pocket	None	\$1000	Unlimited
Maximum lifetime benefit		Unlimited	

Serious Mental Illness and Pregnancy treated like any other illness under all benefit levels.

All percentages applied to Allowable Expense

Hospital Services	Las Palmas/ Del Sol	All other ACN Facilities	Out of Network
Per admission Copayment	None	\$100	\$200
Room & board (semi-private)	100%	85%	60%
Ancillary hospital charges	100%	85%	60%
Outpatient	100%	85%	60%
Emergency room (ER) Copayment	\$50	\$100	\$100

(ER Copayment waived if inpatient admission occurs)

Professional Services

Pediatric or adult routine annual physical exams limited to:

Office Visits (one per year)	\$5 Copayment	\$20 Copayment	Not Covered
*Pap Smear (one per year)	100%	100%	Not Covered
*Routine Newborn Services (through 2 years)	100%	100%	Not Covered
*Mammography (one per year)	100%	100%	Not Covered
*Colorectal and Prostate Exams	100%	100%	Not Covered
*Immunizations (through age 6)	100%	100%	Not Covered

***These services are considered a part of an annual exam and do not require an additional Copayment.**

Pediatric or adult office visits (illness)	\$5 Copayment	\$20 Copayment	60%
Other Physician services (lab, X-ray, etc.)	100%	85%	60%
Hospital Visits	100%	85%	60%
Allergy tests & treatments	100%	85%	60%
Surgeon	100%	85%	60%
Assistant Surgeon	100%	85%	60%
Anesthetist	100%	85%	60%

FEATURES	SELECT	PPO	Out-of-Network
Chiropractic			
Office visit	\$5 Copayment	\$20 Copayment	60%
Other services	100%	85%	60%
Annual Maximum		\$2000 combined	
<hr/>			
Mental Health (except Serious Mental Illness)			
Inpatient facility	100%	85%	60%
Physician for Inpatient Services	100%	85%	60%
Outpatient Physician	\$5 Copayment	\$20 Copayment	60%
Annual Maximum	N/A	N/A	\$10,000
<hr/>			
All Other Services			
Ambulance	100%	85%	60%
X-ray & lab	100%	N/A	N/A
Chemo/radiation therapy	100%	85%	60%
Home health care (60 visits per year)	100%	85%	60%
Hospice care (100 home visits per year, and 180 days in a Hospice facility per lifetime)	100%	85%	60%
Physical & speech therapy (speech therapy under limited conditions)	100%	85%	60%
Durable medical equipment (Total billed charges greater than \$500 must have prior approval of Plan Administrator)	100%	85%	60%
Pre-Admission and Continued Care Review	Required.	Required.	Required.
Requirements and Penalties	Not Required by Employee.	\$300 penalty if not obtained	\$300 penalty if not obtained
Second surgical opinion may be requested by Medical Case Manager	Applicable	Applicable	Applicable

Prescription Drug

Retail (30-day supply)

Generic Name \$6 Copayment at Participating Pharmacies.

Brand Name \$15 Copayment at Participating Pharmacies.

Mail Order (90-day supply)

Generic Name \$10 Copayment

Brand Name \$20 Copayment

Please Note: No benefits will be paid for prescription drugs obtained at Non-Participating Pharmacies

Note Regarding Collective Bargaining Employees: Prescription benefits may be different for uniformed Police and Fire Department employees. Please contact the City of El Paso, Insurance and Benefits Department for updates.

Emergency Out of Area Hospitalization

In the event that a participant requires Emergency Hospitalization outside of the City of El Paso, the covered eligible expenses will be paid under the PPO portion of the program until the patient is medically stable and able to be transported.

In the event that the patient requires additional Hospitalization once medically stable and able to be transported, the patient may choose to remain at the Hospital outside of the City of El Paso or choose to be transported to a Select or PPO Hospital.

If the patient chooses to be transported to a Select Hospital, all covered eligible expenses will be paid under the Select option.

If the patient chooses to be transported to a PPO Hospital, all covered eligible expenses will be paid under the PPO option.

If the patient chooses to stay at the Hospital outside of the City of El Paso, all additional covered eligible expenses will be paid under the Out-of-Network option.

Section 6. PROCEDURES FOR OBTAINING BENEFITS UNDER THE PLAN

- A)** The Network Provider must complete the applicable claim form, HCFA 1500, UB-92 or provide an itemized billing form which includes a complete and accurate diagnosis of the medical problem. In submitting claims for Out-of-Network Providers, a claim form must be completed by the employee in detail and signed. The Physician must complete the form or provide an itemized billing form which includes a complete and accurate diagnosis of the medical problem.
- B)** All other bills for covered services or supplies provided must show:
- 1) Health Care Provider's name;
 - 2) Patient's name;
 - 3) Diagnosis;
 - 4) Service or supplies rendered and date rendered;
 - 5) Charge for services or supplies;
 - 6) The explanation of benefits worksheet from the Primary carrier when filing for secondary claim benefits; and
 - 7) Accident details when relevant.
- C)** All requests for benefit reimbursement are to be submitted to the Plan Administrator.
- D)** All further claims for this diagnosis, during the Plan Year, shall be sent to the Plan Administrator along with an identification of the group name and the employee's social security number..
- E)** A separate claim form is required to file an initial claim for a medical condition for each family member for each separate medical condition.
- F)** In the event that an employee has any questions regarding the manner in which either a claim has been paid or denied, in whole or in part, the employee should, immediately, contact the Plan Administrator for clarification of these questions.
- G)** In the event that the answer given to the employee by the Plan Administrator to any of these questions is not satisfactory, the employee may ask the Plan Administrator to review this claim with the Plan Sponsor for a final decision. The final determination for Plan payment will be the responsibility of the Plan Sponsor. The employee may also request the officer in charge of Employee Benefits to initiate a review as described in Section titled Review Procedure.
- H) UTILIZATION MANAGEMENT.** The Plan requires that a Participant or Provider call (915) 581-8740 or 1-(800)854-2339 and precertify any :
- Inpatient admissions;
 - Extended care expenses;
 - Home Infusion Therapy;
 - All treatment of chemical dependency; and
 - Transfer to another facility or to or from a specialty unit within the facility.

IN ADDITION, PLEASE CALL AND PRE-AUTHORIZE ANY:

- MRI scans, CT scans, PET scans and SPEC scans;
- Outpatient surgeries not performed in a physician's office, except for epidural injections;
- Sleep studies;
- Cardiac catheterizations;
- Therapies (speech, occupational, physical);
- DME billed charges greater than \$500;
- Home Health Care, Skilled Nursing and Hospice;
- Dialysis;

- Botox Injections;
- Sclerotherapy;
- Chemotherapy;
- Radiation; and
- Outpatient Wound Care.

The Plan will perform Case management services through the Plan Administrator on an “as needed” basis.

- I) All claims for services and supplies received during a Plan Year, must be received by the Plan Administrator no later than 90 days from the end of that Plan Year. Any bills submitted after that date are not eligible for payment by the Plan. Claims may be submitted to:

Access Administrators, Inc.
P.O. Box 12609
El Paso, TX 79913

Section 7. COVERED MEDICAL EXPENSES

- A) COVERED MEDICAL EXPENSE.** A Covered Medical Expense shall mean a service or supply which is provided to a Covered Person, and which service or supply is:
- 1) Received while a person is covered under the Plan;**
 - 2) Recommended by a Physician;**
 - 3) Medically Necessary for the care and treatment of a covered illness or injury of a Covered Person; and**
 - 4) Provided by a Health Care Provider of these services or supplies.**
- B) These services and supplies which are furnished by, and fall within the scope of the authorized practice of, a Health Care Provider must be recognized throughout the Health Care Provider's profession to be the usual and customary treatment for the illness or injury, provided that:**
- 1) For a Hospital, Covered Medical Expenses shall include the charges made by a Hospital, on its own behalf, for room and board and other necessary services and supplies, except that for any day of Hospital Confinement, Covered Medical Expenses shall not include any charges for room and board which are in excess of the Hospital's average charge for a semi-private room, unless a semi-private room is not available due to emergency admission. This limit shall not apply for a unit for intensive or specialized care. Covered Medical Expenses shall not include charges, if any, for special nursing or Physician's services;**
 - 2) Covered Charges include Medical Expenses incurred for a Surgical Procedure including:**
 - a) The performance of the Surgical Procedure by the Physician(s) and his assistant, who is a licensed Physician;**
 - b) The administration of anesthesia for the Surgical Procedure by an anesthesiologist or a registered anesthetist; and**
 - c) The postoperative care for the Surgical Procedure rendered by the Physician(s) who performed the procedure, including periodic follow-up visits.**
 - 3) Covered Charges include the Medical Expenses for Physician services delivered in the Hospital, the Physician's office or elsewhere provided that the Physician is providing these services within the scope of his license and experience.**
 - 4) Charges for services of a Nurse shall include:**
 - a) In a Hospital, services of a registered professional nurse (R.N.), services of a licensed practical nurse (L.P.N.), or services of a licensed vocational nurse (L.V.N.) when included as routine Hospital care, and**
 - b) Other than in a Hospital, services of an R.N. or of an L.V.N. or an L.P.N. are covered.**

The services of a nurse shall not be considered eligible if they are rendered by a member of the Covered Person's family as defined in the Section titled General Limitations/Exclusions.
 - 5) Covered Charges include Medical Expenses incurred for Outpatient care including:**
 - a) The charges made by the Hospital or duly licensed Outpatient clinic; and**
 - b) The charges made by the Physician for such Outpatient care.**
 - 6) Covered Charges include the Medical Expenses for services of a licensed physiotherapist.**

- 7) Covered Charges include the Medical Expenses associated with obtaining a second opinion from a Physician regarding the necessity of a surgery and treatment. Third opinions shall be covered as second opinions if the first two opinions differed.
- 8) Covered Charges include Medical Expenses incurred by a *Qualified Participant* for the installation and use of an insulin infusion pump or other equipment or supplies used in the treatment of diabetes. Covered Charges also include expenses directly related to diabetic self-management education programs and those items associated with the treatment of diabetes. Such items, when obtained for an eligible participant, may include the following:
 - a) Diabetic Equipment - blood glucose monitors, insulin pumps and necessary accessories, insulin infusion devices (one per year) and podiatric appliances (one pair of diabetic shoes per year).
 - b) Diabetic Supplies - test strips for blood glucose monitors, visual reading and urine test strips, lancets and lancet devices, injection aids, and glucagon emergency kits

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

- 9) For Preventive Care provided by eligible Network Providers for:
 - a) Immunizations,(check Plan's schedule of Benefits) and routine pediatric physical examinations;
 - b) Annual Pap Smear;
 - c) Annual routine adult physical examinations;
 - d) Annual low-dose mammography breast cancer screening; and
 - e) Annual Colorectal Prostate Exam.

In accordance with the schedule of services determined in the discretion of the Network Administrator to be appropriate for persons of the Participant's age and sex.

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

12) For the charges for a Home Health Agency, provided that the Plan of Care by the Home Health Agency:

- a) Begins within 7 days following a confinement in a Hospital or related convalescent facility;**
- b) Is prescribed by a Physician;**
- c) Is reviewed and approved by the Physician every two weeks;**
- d) Contains a statement expressing the belief of the Physician and the Home Health Agency that:**
 - (i) The number of days of home health care does not exceed the number of days of confinement in a Hospital which would have been required;**
 - (ii) The Home Health Care will probably cost less per day than the expected daily rate for confinement in a Hospital; and**
 - (iii) Confinement in a Hospital would otherwise be required;**
- e) Is submitted for approval by the Plan prior to initiation of these services and supplies by the Home Health Agency; and**
- f) Home Health Care shall include:**
 - (i) Skilled Nursing Care; and**
 - (ii) Any other services and supplies provided by the Home Health Agency in lieu of the services and supplies which would have been covered if the Covered Person was confined in a Hospital. Home Health Care does not include housekeeping or custodial care.**

13) Covered Medical Expense includes charges for Hospice care made by a Hospice only if:

- a) The expenses incurred by a Covered Person diagnosed by a Physician as terminally ill;**
- b) The Hospice provides a Plan of Care which:**
 - (i) Is prescribed by the Physician;**
 - (ii) Is reviewed and approved by the Physician monthly;**
 - (iii) Is not for curative treatment; and**
 - (iv) States the belief of the Physician and the Hospice that the Hospice Care will cost less in total than any comparable alternative to Hospice Care; and**
 - (v) Is submitted for approval by the Plan prior to initiation of this Hospice Care; and**
- c) Hospice Care may be provided in a Covered Person's home or in a Hospice Inpatient facility. For such Hospice Care, the Plan will not apply the requirement that expenses will be covered only when incurred for the treatment of an illness or injury.**

14) Charges made for diagnostic X-ray and laboratory examinations;

15) Charges made for X-ray, radium and radioactive isotope treatment;

16) Charges made for blood and blood plasma;

17) Charges made for oxygen and other gases and their administration;

18) Charges made for prosthetic appliances;

19) Covered Charges include the cost of prescription drugs if the following conditions are satisfied:

- a) The drugs are prohibited by federal law from being dispensed without a prescription;**
- b) The drugs are purchased from a licensed pharmacist;**
- c) The drugs are dispensed in accordance with the written prescription of the attending Physician; and**
- d) The drugs are prescribed for the Medically Necessary treatment of a Sickness or Injury.**
- e) In no event will Covered Charges include the following:**
 - (i) Drugs not approved for general use by the Food and Drug Administration;**
 - (ii) Vitamins, except for Vitamin B-12, when used for Pernicious Anemia or Krohn's Disease, or prenatal vitamins for pregnancy.**
 - (iii) Food supplements; or**
 - (iv) Drugs not used in accordance with the prescription.**

PLEASE NOTE: Prescription drugs (including self-injectables) received through a pharmacy will be paid through the Prescription Drug Benefit. They will NOT be eligible for benefit under the Medical Benefit portion of The Plan.

- f) Covered Charges will include birth control pills prescribed by a Network Provider only.**

20) Covered Charges include Durable Medical Equipment and Medical Supplies Expenses for:

- a) Artificial limbs and artificial eyes to replace natural limbs and eyes lost while the individual suffering such loss is a Participant in the Plan;**
- b) Initial placement of contact lenses required due to cataract surgery;**
- c) Casts, splints, braces, trusses, or crutches; or**
- d) The rental (up to the purchase price) of:**
 - (i) Respiration equipment;**
 - (ii) Hospital beds;**
 - (iii) Wheelchairs; or**
 - (iv) Other Durable Medical Equipment.**
- e) The purchase of replacement durable medical equipment will only be included in Covered Charges if the replacement is due to a physiological change to the Participant (e.g., replacement of an artificial leg due to stump revision or shrinkage would be included in Covered Charges).**
 - (i) Covered Charges for Durable Medical Equipment and Medical Supplies Expenses shall include Medical Expenses for the purchase of medical supplies such as:**
 - (a) Surgical dressings and colostomy bags;**
 - (b) Needles and syringes for the administration of prescription drugs;**
 - (c) Support stockings; and**

- (d) Oxygen.
- (ii) In any event, Covered Charges Durable Medical Equipment and Medical Supplies Expenses shall not include Medical Expenses incurred:
 - (a) For equipment rental in excess of the purchase price of the equipment;
 - (b) For the purchase of items of personal clothing, such as orthopedic shoes; personal hygiene items, or common household items;
 - (c) For items not prescribed by a Physician;
 - (d) For eyeglasses (other than the first pair of eyeglasses immediately following cataract surgery), contact lenses, or hearing aids; or
 - (e) For items which have value to the Participant in the absence of the Sickness or Injury being treated.
- 21) The services and supplies that are related to a sterilization procedure.
 - 22) Ambulance benefits will be covered at the level of benefits provided to the receiving hospital.
 - 23) Neonatology services will be covered at the Select benefit level at the Select facilities and at the PPO benefit level at PPO facilities.
 - 24) Emergency Room Physicians will be covered at the Select benefit level at the Select facilities and at the PPO benefit level at PPO facilities.
 - 25) All facility transplant centers (within the confinement) will be covered at the Select benefit level for Select facilities currently contracted on an individual basis.
 - 26) If a specialty is not contracted under any networks associated with Access Administrators, benefits will be covered at the Select benefit level.
 - 27) For Active Non-Uniformed Employees Plan, accepted surgical treatment of Morbid Obesity will be paid at the PPO level of coverage. Morbid obesity is a minimum of 100 pounds over a person's ideal weight or a Body Mass Index (BMI) greater than 40.0. Obesity, weight reduction and dietetic medications are not covered under any circumstances. Anyone seeking this treatment must have been covered under the City's Benefit Plan for at least 12 consecutive months and must first complete a medically monitored weight reduction program under the supervision of a physician, dietician/nutritionist, mental health provider and physiologist.
 - 28) For Active Non Uniformed Employees Plan, a one time treatment for Smoking Cessation in the form of one three-month prescription treatment per lifetime will be allowed.

Section 8. GENERAL LIMITATIONS/EXCLUSIONS

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

- 1) For cosmetic/reconstructive surgery, treatment or diagnostic services unless:**
 - a) The surgery, treatment or diagnostic service is necessary because of accidental injuries sustained while the Covered Person is covered under this Plan;**
 - b) The surgery, treatment or diagnostic service is related to or follows up surgery as a result of infection or other disease of the involved part (i.e., for breast reconstruction after mastectomy is performed while a Participant is covered under the Plan:**
 - (i) on the breast on which the mastectomy has been performed;**
 - (ii) on the breast on which the mastectomy was not performed to produce a symmetrical appearance; or**
 - (iii) prosthesis and treatment of physical complications of all stages of mastectomy, including lymphedemas.); or**
 - c) The surgery, treatment or diagnostic service is necessary because of an inborn disease or defect of a Covered Dependent child born while his/her parent is covered under this Plan.**

NOTE: Surgery, treatment or diagnostic service must be performed by the end of the next Plan Year following the year in which the illness or injury occurred which necessitates the cosmetic or reconstructive surgery.

- 2) 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;**
 - b) For excision of impacted unerupted teeth or of a tumor or cyst, or incision and drainage of an abscess or cyst,;**
 - 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.**
- 3) Charges incurred for services and supplies for medical care under the Plan to the extent payment is made by an individual or individuals (or their insurers) considered responsible for the condition causing the charges.**
- 4) For or in connection with a sickness or accident 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;**
- 5) To the extent that payment under this Plan is prohibited by any law of the jurisdiction in which the employee or dependent resides at the time the expenses are incurred;**
- 6) For services and/or supplies which the Covered Person is not legally required to pay or for services and/or supplies which would not have been made if no coverage had existed;**

- 7) For the purpose of this paragraph, any retired individual who, at any time, was entitled to enroll in the entire medical care program under Title XVIII of the Social Security Act of 1965 as amended (Medicare), but who did not enroll will be considered to have been entitled to reimbursement in an amount equal to the amount to which he would have been entitled, if any, if he/she were so enrolled;
- 8) For expenses which are submitted more than 90 days after the end of a Plan Year for services and/or supplies which were rendered in that Plan Year.
- 9) For any taxes charged for services and/or supplies;
- 10) For any services and/or supplies furnished for a Covered Person prior to his effective date or subsequent to his termination date of coverage under this Plan;
- 11) For elective non emergency services and/or supplies provided outside the United States;
- 12) In a Hospital owned or operated by the United States Government, unless for services and supplies obtained in accordance with the laws and regulations of the government and only to the extent that services and/or supplies are made and the patient is legally required to pay;
- 13) For a Hospital admission for diagnostic or evaluation procedures unless the tests could not have been performed on an outpatient basis without adversely affecting the patient's physical condition or the quality of medical care rendered, provided that bed-patient Hospital expense, other than room accommodation charges, incurred during the Hospital admission shall be deemed to be other medical expense and benefits for such expense shall be provided accordingly;
- 14) For transportation or travel other than as shown as Covered Medical Expenses;
- 15) For injury or sickness resulting from war;
- 16) For injury resulting from the commission or an attempt to commit a felony;
- 17) In connection with a Covered Person's participation in a riot or insurrection;
- 18) Expenses incurred as a result of an intentionally self-inflicted *illness or injury* or suicide or attempted suicide, unless the result of an underlying medical condition;
- 19) For private duty nursing services in a Hospital setting;
- 20) For custodial care while confined in a Hospital, extended care facility, nursing home, or at home;
- 21) For services rendered by a member of the Covered Person's family to include grandparents, parents, brothers and sisters, cousins, aunts and uncles, nieces and nephews or similar in-laws related by marriage to the Covered Person, unless prior approval is obtained from the Plan Administrator;
- 22) For assistant surgeon fees in excess of 25% of the Reasonable and Customary Charge for the surgeon;
- 23) For marriage counseling;
- 24) For charges for the treatment of a learning disability;
- 25) For broken appointments, incurred late fees or charges for completion of claim form by the Physician's office;
- 26) For services and/or supplies which are in excess of Regular and Customary Charges that are determined by the Plan Administrator;
- 27) For care and treatment of mental and/or nervous disorders in excess of the specified Covered Medical Expenses and in excess of the limitations shown;

- 28) For any Pre-existing Condition in excess of the amount payable, if any, specified in the Section titled Schedule of Benefits;**
- 29) Any Hospital expenses and Physician's charges relating to non-emergency Friday or Saturday Hospital admission if surgery or treatment is not performed on the day or the day after an individual is admitted to the Hospital. Treatment is defined as specialized treatment that necessitates Hospital Confinement;**
- 30) For charges for amniocentesis except when performed on women age 30 or older or when a history of genetic disorders has been present in the family;**
- 31) For midwife charges;**
- 32) For preventive medicine, except as specified in the Schedule of Benefits and provided by Network Providers;**
- 33) For treatment which is not medically necessary for the care and treatment of any injury or illness;**
- 34) For services and/or supplies not related to the diagnosed illness or injury which is being treated;**
- 35) For all charges for the treatment of obesity, weight reduction or dietetic control, except for the medical and surgical treatment of morbid obesity. Morbid obesity is a minimum of 100 pounds over a person's ideal weight or a Body Mass Index (BMI) greater than 40.0. Obesity, weight reduction and dietetic medications are not covered under any circumstances;**
- 36) For immunizations, except as specifically included;**
- 37) For B-12 medication except when used for Pernicious Anemia or Krohn's Disease;**
- 38) For services and/or supplies in connection with routine foot care;**
- 39) For services and/or supplies 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 Person under the Plan;**
- 40) For services and/or supplies related to acupuncture;**
- 41) For services and/or supplies for refractive services/surgeries;**
- 42) For fitting or cost of eyeglasses, contact lenses or hearing aids (other than the cost and fitting of eyeglasses immediately following cataract surgery);**
- 43) For treatment by hypnosis, except as part of the Physician's treatment of a mental illness or when hypnosis is used in lieu of an anesthetic;**
- 44) Charges in connection with treatments, procedures, devices, or drugs which are considered Experimental or Investigational;**
- 45) Charges in connection with the promotion of fertility including, but not limited to:
 - a) Fertility tests;**
 - b) Reversal of surgical sterilization; and**
 - c) Direct attempts to cause pregnancy by hormone therapy, artificial insemination, in vitro fertilization, and embryo transfer.****
- 46) For services and/or supplies not specifically listed as a Covered Medical Expense;**
- 47) For rolfing services and/or supplies;**

- 48) For any sex change surgery charges;**
- 49) For any charges that are for therapy, supplies or counseling for sexual dysfunctions or inadequacies, unless it is organic in nature.**
- 50) For non-prescription drugs;**
- 51) For non-durable medical equipment;**
- 52) Charges for orthopedic shoes or other supportive devices for the feet and orthotics unless prescribed by a Network Provider;**
- 53) For services and/or supplies for vocational therapy;**
- 54) For services and/or supplies for massage therapy;**
- 55) For services and/or supplies for remediation therapy;**
- 56) For services and/or supplies for chelation therapy;**
- 57) For any services and/or supplies rendered primarily for:
 - a) Environmental Sensitivity testing or treatment, or**
 - b) Clinical Ecology testing or treatment, or**
 - c) Inpatient allergy testing or treatment;****
- 58) For any charges for structural or nonstructural changes to a house or vehicle;**
- 59) For services and/or supplies related to the treatment of alopecia;**
- 60) For services and/or supplies provided by a Health Care Provider not included in this Plan;**
- 61) The term Home Health Care Expenses shall not include:
 - a) Custodial Care;**
 - b) Transportation services;**
 - c) Any period during which the Covered Person is not under the continuing care of a legally qualified Physician;**
 - d) Expenses for Home Health Care services which are incurred by a Covered Person during any Plan Year which exceed the Maximum Number of visits shown in the Plan Summary;****
- 62) The following charges are not included as Covered Medical Expenses:
 - a) Charges for bereavement counseling;**
 - b) Charges for funeral arrangements;**
 - c) Charges for pastoral counseling;**
 - d) Charges for financial or legal counseling, including estate planning or drafting of will;**
 - e) Charges for homemaker or caretaker services; and**
 - f) Charges for respite care. This is care furnished during a period of time when the person's family or usual caretaker cannot, or will not, attend to the person's needs;****

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

Section 9. EXTENSION OF MEDICAL BENEFITS

SURVIVORSHIP BENEFIT. In the event of the death of an Active or Retired Covered Employee, the previously Covered Dependents shall have the right to continue benefits under the Plan, subject to further provisions hereof, until:

- 1) If the employee who died was Active and at the time of death was not entitled to any pension benefits, the surviving eligible Covered Dependents shall have the option to elect Continuation of Coverage under the Health Benefit Program under the provisions of COBRA.**
- 2) If the employee who died was Active and at the time of death was entitled to any pension benefits but had continued as an active employee instead of choosing these pension benefits prior to the employee's death, the surviving eligible Covered Dependents shall have the option to continue the City Health Benefit Program under which they have previously been covered through the COBRA option or choose to take the retiree Health Benefit Program provided to eligible retirees and their dependents.**
- 3) If the employee who died was retired at the time of death and was receiving pension benefits prior to their death, the surviving eligible covered dependents shall have the option to continue the Health Benefit Program provided for retirees and their covered Eligible Dependents only if they were covered at the time of death.**
- 4) Those surviving Eligible Dependents who choose to continue coverage under the Retiree Health Benefit Plan shall have the right to continue Benefits under that Plan, subject to further provisions hereof, until:**
 - a) The date benefits for all individuals in this class are terminated;**
 - b) If a covered spouse, the date of remarriage of such spouse;**
 - c) If dependent children/grandchildren, the date that they do not meet the definition of a covered dependent child/grandchild; or**
 - d) The date the covered dependent becomes eligible for another group plan having similar benefits.**

Section 10. CONTRIBUTIONS

- A)** The amount of contribution required for coverage for each Covered Person shall be determined by the Plan Sponsor.
- B)** The Plan Sponsor may make a change in the amount of contributions required for coverage at any time during a Plan Year. Covered participants must be provided with a minimum of 30 days notice prior to the effective date of any change in contributions.
- C)** An Eligible Employee electing coverage under the Plan shall be required to contribute a pro rata portion of a full months contribution for the initial months coverage if coverage starts on any other day of the month except for the first of the month. The pro rata portion will be equal to one month's normal contributions divided by thirty-one (31) and multiplied by the actual number of days of coverage remaining in this initial month of coverage.
- D)** Contributions for coverages elected by an Eligible Employee will be paid through payroll deductions. The coverage for any month's benefits will be payroll deducted the month prior to the coverage provided by the Plan.

Section 11. COORDINATION OF BENEFITS AND SUBROGATION

A) COORDINATION OF BENEFITS

- 1) The Plan has been designed to help meet the cost of sickness or injury. Since it is not intended that greater benefits be paid you than your actual medical expenses, the amount of benefits payable with the Plan will take into account any coverage a family member has with other "plans". The benefits under the Plan will be coordinated with the benefits of the other group health coverage plans or programs.**
- 2) The Plan will always pay either its regular benefits in full, or a reduced amount which, when added to the benefits payable by the other plan or plans, will equal 100 percent of Allowable Expenses.**

B) SUBROGATION

- 1) Your coverage is intended to afford protection to you against the cost of Hospital and medical-surgical services required in case of illness or injury. It is not intended to serve any other purpose. If a participant is injured under circumstances which impose on someone else a legal obligation to pay the expense of his/her treatments, as damages, the Plan will pay, but the Administrator reserves the right to be reimbursed from the payment made by the third party.**
- 2) The Plan shall be subrogated, to the extent and in the amount of any payments made hereunder by the Plan to a Covered Person, to any cause of action said Covered Person may have against any tort feisor for injury to the Covered Person which results in payment being made by the Plan. This means the Plan is not obligated to pay for services necessary on account of any injury or condition for which a third party is liable unless or until the Covered Person, or someone legally qualified and authorized to act for the Covered Person, promises in writing to:
 - a) Include those amounts in any claim the Covered Person makes against a third party for the injury or conditions;**
 - b) Repay the Plan those amounts to the extent that the proceeds of the Covered Person's recovery from a settlement with a third party by reason of such an injury or condition exceed his or her own portion of the total loss; repayment to the Plan to be made within thirty (30) days of the receipt of such proceeds; and**
 - c) Cooperate fully with the Plan in asserting its rights, to supply the Plan with any and all information and execute any and all instruments the Plan reasonably needs for that purpose.****
- 3) In the event claimant fails to, or refuses to execute whatever Assignment, Form or Document requested by the Administrator of the Plan, the Plan shall and is hereby relieved of any and all legal, equitable or contractual obligation contained in this the entire Plan for any benefits or Covered Medical Expenses incurred by claimant**

Section 12. ORDER OF BENEFITS DETERMINATION

A) COORDINATION OF BENEFITS. The following rules will be used to establish the order of benefit determination:

- 1) Where an individual is covered as an employee under one Plan and a dependent under another Plan, the Plan under which the individual is covered as an employee shall be Primary and the Plan where the individual is covered as a dependent shall be Secondary.
- 2) Where a dependent child is covered as an Eligible Dependent of an employee under this Plan and is additionally covered as a dependent of an employee under another Plan, the benefit Plan which covers the dependent child of the employee with the earliest birth date (month/day) shall be Primary and the other Plan shall be Secondary, except that when a claim is made for a dependent child of divorced or separated parents, the following rules will apply:
 - a) A plan which covers a child as a dependent of a parent who by court decree must provide health coverage will determine its benefits first;
 - b) When there is no court decree which requires a parent to provide health coverage to a dependent child, the following rules will apply:
 - (i) When a parent who has custody of the child has not remarried, that parent's plan will determine its benefits first;
 - (ii) When a parent who has custody of the child has remarried:
 - (a) That parent's plan will determine its benefits first;
 - (b) The stepparent's plan will determine its benefits next; and
 - (c) The plan of the parent without custody will determine its benefits third.
- 3) When the rules in (a) do not establish an order of benefit determination, the benefits of a plan which has covered the person on whose expenses claim is based for the longer period of time will be determined before the benefits of a plan which has covered the person the shorter period of time; and
- 4) When a plan does not contain a provision coordinating its benefits, that plan is always primary and always pays first.

Where an individual is covered as an active employee or the dependent of an active employee and is additionally covered under Title XVIII of the Social Security Act of 1965 as amended, the Plan will pay Primary and Medicare will pay Secondary for eligible expenses.

If, however, an individual is covered as an active employee or the dependent of an active employee and is additionally covered under Title XVIII of the Social Security Act of 1965 as amended because of Renal Dialysis or Kidney Transplant, the Plan coverage will be Primary only during the first 30 months in which the individual is entitled to Medicare Benefits and the Plan will be Secondary to Medicare after this 30 month period.

Where an individual is covered as a retired employee or the dependent of a retired employee and is additionally covered under Title XVIII of the Social Security Act of 1965 as amended, the Plan will pay Secondary and Medicare will pay Primary for eligible expenses.

B) RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION. For the purpose of determining the applicability of and implementing the terms of this provision of this Plan or any provision of similar purpose of any other plan, the City may, without the consent of or notice to any person, release to or obtain from any Insurance Company or other organization or person any information, with respect to any person, which the City deems to be necessary for such purposes. Any person, claiming benefits under this Plan shall furnish to the City such information as may be necessary to implement this provision.

- C) FACILITY OF BENEFIT PAYMENT.** Whenever payments which would have been made under this Plan in accordance with this provision have been made under any other plans, the City shall have the right, exercisable alone and in its sole discretion, to pay over to any organization making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision, and amounts so paid shall be deemed to be benefits paid under this Plan and, to the extent of such payments, the City shall be fully discharged from liability under this Plan.
- D) RIGHT OF RECOVERY.** Whenever payments have been made by the City with respect to Allowable Expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at the time to satisfy the intent of this provision, the City shall have the right to recover such payments, to the extent of such excess, from among one or more of the following, as the City shall determine: any persons to or for or with respect to whom such payments were made, any insurance companies, and other organizations.

Section 13. COBRA

CONTINUATION COVERAGE RIGHTS

The Plan Administrator is Access Administrators, Inc., 7100 Westwind, El Paso, TX 79912, 915-581-8182. The Plan Administrator is responsible for administering COBRA continuation coverage

COBRA Continuation Coverage

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

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

- 1) Your hours of employment are reduced to a number below the number of hours required for eligibility under the Health Plan, or
- 2) Your employment ends for any reason other than your gross misconduct.

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

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

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

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

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

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of

hours of employment, death of the employee commencement of a proceeding in bankruptcy with respect to the employer, or enrollment of the employee in Medicare (Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event within 30 days of any of these events.

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator. The Plan requires you to notify the Plan Administrator within 60 days after the qualifying event occurs. You must send this notice to: Access Administrators, Inc., COBRA Department, 7100 Westwind, El Paso, TX 79912. The notice needs to include name, address, and telephone number, plan name and the qualifying event. If the qualifying event is a divorce or legal separation, legal documentation must be furnished. Failure to notify the Plan Administrator in the above stated time frames and prescribed manner will nullify your right to COBRA continuation of coverage.

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

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

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

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled at any time during COBRA continuation coverage and you notify the Plan Administrator in a timely fashion, (within 60 days, in writing) you and your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. You must make sure that the Plan Administrator is notified of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage.] This notice should be sent to: Access Administrators, Inc., COBRA Department, 7100 Westwind, El Paso TX 79912. The notification should include name, address, telephone number, plan name, and a copy of the Social Security Administration's determination.

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

If your family experiences another qualifying event while receiving COBRA continuation coverage, the spouse and dependent children in your family can get additional months of COBRA continuation coverage, up to a maximum of 36 months. This extension is available to the spouse and dependent children if the former employee dies, or gets divorced or legally separated. The extension is also available to a dependent child when that child stops being eligible under the Plan as a dependent child. **In all of these cases, you must make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event permitted under the terms This notice must be sent to: Access Administrators, Inc., COBRA Department, 7100 Westwind, El Paso, TX 79912. The notification should include name, address, telephone number, plan name, and qualifying event. Copies of documentation such as death certificate, Medicare card, divorce decree or legal separation papers must be included with the notification.**

If you have questions about your COBRA continuation coverage, you should contact Access Administrators, Inc., COBRA Department., 7100 Westwind, El Paso, TX 79912, telephone number 915-581-8182 or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's web site at www.dol.gov/ebsa.

Keep Your Plan Informed of Address Changes at all times

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator. **Please note that, as it is the sole responsibility of the Plan participants to notify the Plan**

Administrator in writing of any address changes for all family members, you and/or your family members may lose their rights for continuation of coverage in the event documentation is not received or sent due to your failure to notify of an address change.

How can you elect continuation coverage?

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

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

How much does continuation coverage cost?

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

When and how must payment for continuation coverage be made?

First payment for continuation coverage

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

Your first payment must cover the cost of continuation coverage from the time your coverage under the Plan would have otherwise terminated up to the time you make the first payment. You are responsible for making sure that the amount of your first payment is enough to cover this entire period. You may contact Access Administrators, Inc., 7100 Westwind, El Paso, TX 79912, telephone number 915-581-8182 to confirm the correct amount of your first payment.

Your first payment for continuation coverage should be sent to:

**Access Administrators, Inc
COBRA Department.
7100 Westwind
El Paso, TX 79912**

Periodic payments for continuation coverage

After you make your first payment for continuation coverage, you will be required to pay for continuation coverage for each subsequent month of coverage. Under the Plan, these periodic payments for continuation coverage are due on

the 1st of each month of coverage. If you make a periodic payment on or before its due date, your coverage under the Plan will continue for that coverage period without any break. The Plan will send periodic notices of payments due for these coverage periods.

Periodic payments for continuation coverage should be sent to:

**Access Administrators, Inc.
COBRA Department
7100 Westwind
El Paso, TX 79912**

Grace Periods for Periodic Payments

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

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

For more information

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

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

What is COBRA?

COBRA is the "Consolidated Omnibus Budget Reconciliation Act" of 1985 that requires continuation of Health and/or Dental care benefits for Qualified Beneficiaries.

Who is a Qualified Beneficiary?

A Qualified Beneficiary is an employee, spouse or dependent child who was covered under the Plan but loses coverage due to a Qualifying Event.

What is a Qualifying Event?

A qualifying Event for an Employee would be loss of coverage under the Plan due to:

- 1) Termination of employment (other than for gross misconduct); or
- 2) Reduction in hours of employment (i.e., approved leave of absence).

A qualifying Event for a spouse or dependent child would be loss of coverage under the Plan due to:

- 1) A covered employee's termination of employment (other than for gross misconduct) or reduction in hours of employment.

- 2) A covered employee's death.
- 3) Divorce or legal separation from a covered employee.
- 4) A covered employee's entitlement and enrollment in Medicare.
- 5) A dependent child losing dependent status as defined by the Plan.

When does a COBRA Qualified Beneficiary become covered?

A COBRA Qualified Beneficiary becomes covered effective the first day of the month following a Qualifying Event if:

- 1) They return to the Plan Sponsor, their signed Election to Continue Coverage Form within 60 days of their reception of this form from the Plan Sponsor; and
- 2) They complete and return a new enrollment card to the Plan Sponsor within 45 days of their election to continue this coverage; and
- 3) They pay the retroactive premium to the Plan Sponsor for the coverage within 45 days. The first payment will be the necessary contribution to cover the Qualified Beneficiary from the first of the month following the Qualifying Event through the end of the month in which the election is made.

How does a Qualified Beneficiary obtain the election form to continue coverage?

The Plan Administrator must forward the election form to a Qualified Beneficiary within 14 days of notification of a Qualifying Event.

Who must notify the employer of a Qualifying Event?

In the cases of termination of employment, reduction in hours of employment or death of the employee, the City of El Paso, Human Resource Department must notify the Plan Administrator within 30 days of the Qualifying Event.

In the cases of divorce, legal separation or loss of dependent child status, both the Qualified Beneficiary and the Employee must notify the Plan Administrator within 60 days of the Qualifying Event.

Timetable for submission of required forms to elect continuation of coverage under COBRA:

FROM THE DATE A QUALIFYING EVENT OCCURS:

The City of El Paso has 30 days or the Qualified Beneficiary has 60 days to notify the Plan Administrator of the Qualifying Event.

The Plan Administrator has 14 days from reception of this notification to forward the election form to the Qualified Beneficiary.

The Qualified Beneficiary has 60 days from reception of this form to return the election form to the Plan Administrator.

The Qualified Beneficiary has 45 days from the date of election to continue coverage to make the first payment to the Plan Administrator.

When does coverage end for a COBRA Qualified Beneficiary?

The coverage of any person who continues coverage under this Plan as a Qualified Beneficiary, as defined by the Consolidated Omnibus Budget Reconciliation Act (COBRA), will end on the earliest of the following dates:

- 1) Thirty-six (36) months from the date a previously covered dependent continues coverage as a Qualified Beneficiary due to death of employee, Medicare entitlement, divorce or separation, dependent ceasing to be a dependent; or
- 2) Twenty-nine (29) months if the Qualified Beneficiary, is disabled for Social Security purposes at the time of the termination or reduction in hours and who gives the Plan Sponsor notice of such determination within 60 days and before the end of the 18-month continuation period; or
- 3) Eighteen (18) months from the date a previously covered employee continues coverage as a Qualified Beneficiary due to a Qualifying Event taking place; or
- 4) For previously covered dependents, eighteen (18) months from the date an employee loses coverage due to voluntary or involuntary termination; or
- 5) The date a Qualified Beneficiary becomes entitled to Medicare; or
- 6) The date a required contribution is not made. The allowable grace period is 30 days from the due date.

Section 14. GENERAL PROVISIONS AND INFORMATION

- A) BOOKLETS.** The City will issue herewith to each Covered Employee under this Plan an individual booklet which summarizes the benefits to which the person is entitled, to whom benefits are payable, and the provisions of this Plan principally affecting said person and his/her dependents.
- B) FUNDING.** Medical and Dental claims are paid directly by the City of El Paso Health and Life Benefits Fund. The City has employed a Plan Administrator to assure accurate, impartial and timely payment of benefits to and in behalf of Covered Employees and Dependents.
- C) CONFORMITY WITH LAWS.** Any provision of the Plan which on its Effective Date is in conflict with the statutes of the United States or of the jurisdiction of Texas is hereby amended to conform to the minimum requirements of such laws.
- D) CLAIMS PROCEDURE.** The City, upon receipt of notice required by the Plan, will furnish to the Covered Person or to any other person notifying the City of Claim such forms as usually furnished by it for filing proof of loss. Failure to furnish notice or proof of claim within the time provided in the Plan shall not invalidate or reduce any claims if it shall be shown not to have been reasonably possible to furnish such notice or proof and that such notice or proof was furnished as soon as possible.
- E) REVIEW PROCEDURE.** The City or a person or persons authorized by the City shall have the power to initiate a review of a claim made under this Plan and may utilize any or all of the following procedures:
- 1) Appeal the claim in writing, within 60 days after receipt of the written explanation of benefits with the Plan Administrator with respect to such claim requesting that the Plan Administrator review all matters relevant to such claim;
 - 2) Requesting Plan Administrator to furnish all records pertaining to such claim to the City for City review;
 - 3) Last recourse available is to file a claim against the City of El Paso through the City's Legal Department.
- F) FACILITY OF PAYMENT.** If, in the opinion of the City, a valid release cannot be rendered for the payment of any benefit payable under this Plan, the City may, at its option, make such payment to the individuals as have, in the City's opinion, assumed the care and principal support of the Covered Person and are therefore equitably entitled thereto. In the event of the death of the Covered Person prior to such time as all benefit payments due him/her have been made, the City may, at its sole discretion and option, honor benefit assignments, if any, prior to the death of such Covered Person.
- Any payment made by the City in accordance with the above provisions shall fully discharge the City to the extent of such payment.
- G) FIDUCIARY OPERATION.** Each fiduciary shall discharge his/her duties with respect to the Plan solely in the interest of the participants and beneficiaries and
- 1) for the exclusive purposes of providing benefits to participants and their beneficiaries and defraying reasonable expenses of administering the Plan, and
 - 2) with care, skill, prudence and diligence under the circumstances then prevailing that a prudent person acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims.
- H) PLAN ADMINISTRATION.** The Plan Sponsor shall have full charge of the operation and management of the Plan.

The Plan Administrator shall provide consulting services to the Plan Sponsor in connection with the operation of the Plan and shall perform such other functions and services including the processing and payment of claims, as may be delegated to it.

The Plan Sponsor and Plan Administrator may designate any person or persons to carry out their respective responsibilities. Any person or group of persons may serve in more than one fiduciary capacity with respect to the Plan.

- I) **PLAN MODIFICATION AND AMENDMENTS OF PLAN.** The Plan and any provision thereof may be modified or amended at any time by the City upon its due approval of such modification or amendment. The modification or amendment will be effective at the date of approval or at such later date as the City may determine in connection therewith. Such modification or amendment shall be duly incorporated in writing into the master copy of the Plan on file with the City or written copy thereof shall be deposited with such master copy of the Plan.
- J) **PLAN TERMINATION.** The Plan may be terminated at any time by the City upon due authorization of such termination effective as of the date of such authorization or at such later date as the City may provide. In the event of such termination, the City shall have no obligation under the Plan, except as may otherwise be required by law, beyond paying the difference between the claims incurred (even though later filed) and expenses of the Plan due up to the date of termination. Such claims and expenses shall be paid from the funds as normal expenses of the Plan.
- K) **REFUND OF BENEFIT PAYMENTS.** If Access Administrators pays benefits for eligible expenses incurred by you or your covered dependents and it is found that the payment was more than it should have been, or was made in error, Access Administrators has the right to a refund from the person to or for whom such benefits were paid, any insurance company or carrier, or any other organization. If no refund is received, Access Administrators may deduct any refund due it from any future benefit payment.

On or after January 1, 1993, employees who are not participants in the City Health Benefit Plan program, at the time of retirement, will not be eligible to continue as participants in the City Health Plan as retirees.

Section 15. CLAIMS PROCEDURE

A) QUESTIONS RELATING TO ELIGIBILITY. All questions relating to eligibility, classification, or coverage under the Plan shall be submitted to the Plan Administrator.

B) WRITTEN PROOF OF LOSS. All claims for Benefits under this Plan shall be submitted to the Plan Administrator on forms furnished by the Plan Administrator.

Claims not submitted to and received by Access Administrators within 90 days from the end of a Plan Year for services rendered in that Plan Year will not be considered for payment.

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

C) PHYSICAL EXAMINATION. The Plan Administrator, at the expense of the Plan, will have the right and opportunity to examine the person or any individual whose Injury or Sickness is the basis of a claim when and as often as it may reasonably require while the claim is pending.

D) PAYMENT OF BENEFITS. All Medical Expense Benefits payable under this Plan for amounts billed by a Hospital shall be paid to the Hospital unless the claimant furnished proof of payment of the Medical Expense at the time the claim is filed with the Plan Administrator in which case the Benefits shall be paid to the claimant.

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

E) DENIAL OF CLAIM. If a claim is wholly or partially denied, the Plan Administrator shall furnish the claimant with a written explanation of the denial.

PLEASE NOTE: For situations when a claim is denied for information to assist in the adjudication process, such as coordination of benefits, accident details and subrogation, additional medical information, etc., failure to respond to such requests within 60 days may cause any claim(s) submitted for consideration to be denied.

F) EXPLANATION OF DENIAL. The written explanation of a claim denial shall set forth, in a manner calculated to be understood by the claimant, the following information:

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

G) REVIEW PROCEDURE. A claim and its denial shall be reviewed by the Plan Administrator if a written request for review is filed within 60 days after receipt of the written explanation of the claim denial by the claimant. As part of the review procedure, the claimant or the claimant's duly authorized representative shall have a

reasonable opportunity to examine pertinent Plan Documents and records and to submit written comments on the issues. Otherwise, the initial decision of the Plan Administrator shall be the final decision of the Plan.

H) **DECISION ON REVIEW.** The Plan Administrator shall review the information and comments submitted by the claimant or the claimant's duly authorized representative. The Plan Administrator shall furnish the claimant with a written explanation of his decision on review.

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

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

J) **FINAL APPEAL.** Upon completion of the above steps the final appeal may be submitted to the Plan Administrator for review with the City of El Paso.

K) **LIMITATION.**

- 1) No action at law or in equity can be brought to recover on this Plan prior to the expiration of 180 days after Written Proof of Loss has been furnished to the Plan Administrator.
- 2) No action at law or in equity can be brought to recover after the expiration of two years after the time Written Proof of Loss is required to be furnished to the Plan Administrator.
- 3) No lawsuit or action in law or equity may be brought by you or on your behalf unless:
 - a) You have fully complied with all the provisions of the Plan, including all of the procedures and requirements on the Claims Procedure and Review Procedure; and
 - b) Access Administrators, Inc. has either denied in writing your request for review of the claim determination or has not provided a written response to your request for review within sixty (60) days after receiving the request; and
 - c) Such lawsuit or action is brought within two years from the expiration of the time within which Written Proof of Loss is required to be furnished under the Plan.

Section 16. HIPAA PRIVACY AND SECURITY RULES (effective April 14, 2003)

A) PARTICIPANT PRIVACY RIGHTS POLICY AND PROCEDURES

Policy

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

Procedure

Participant in the Health Plan have the right to:

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

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

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

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

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

Obtain an accounting of disclosures of their PHI.

The Health Plan adheres to policies and procedures developed and implemented to ensure participant privacy rights.

The Health Plan provides workforce members who perform plan administration functions with annual training regarding participant rights with respect to their PHI.

B) NOTICE OF PRIVACY PRACTICES POLICY AND PROCEDURES

Policy

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

Procedures

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

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

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

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

The **Notice** is given to all Business Associates.

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

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

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

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

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

The **Notice** is prominently displayed and available electronically on the **City of El Paso Health Plan's** Web site.

C) **NOTICE OF HEALTH PLAN'S PRIVACY PRACTICES**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

USE AND DISCLOSURE OF HEALTH INFORMATION

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

THE FOLLOWING IS A SUMMARY OF THE CIRCUMSTANCES UNDER WHICH AND PURPOSES FOR WHICH YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED:

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

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

- Quality assessment and improvement activities.
- Activities designed to improve health or reduce health care costs.
- Clinical guideline and protocol development, case management and care coordination.
- Contacting health care providers and participants with information about treatment alternatives and other related functions.
- Health care professional competence or qualifications review and performance evaluation.
- Accreditation, certification, licensing or credentialing activities.

- Underwriting, premium rating or related functions to create, renew or replace health insurance or health benefits.
- Review and auditing, including compliance reviews, medical reviews, legal services and compliance programs.
- Business planning and development including cost management and planning related analyses and formulary development.
- Business management and general administrative activities of Health Plan, including customer service and resolution of internal grievances.
- Certain marketing activities.

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

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

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

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

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

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

In Connection With Judicial and Administrative Proceedings. As permitted or required by state law, Health Plan may disclose your health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order or in response to a subpoena, discovery request or other lawful process, but only when Health Plan makes reasonable efforts to either notify you about the request or to obtain an order protecting your health information.

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

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

For Specified Government Functions. In certain circumstances, federal regulations require Health Plan to use or disclose your health information to facilitate specified government functions related to the

military and veterans, national security and intelligence activities, protective services for the president and others, and correctional institutions and inmates.

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

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

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

YOUR RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION

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

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

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

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

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

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

Right to a Paper Copy of this Notice. You have a right to request and receive a paper copy of this Notice at any time, even if you have received this Notice previously or agreed to receive the Notice electronically. To obtain a paper copy, please contact The City of El Paso. ***[You also may obtain a copy of the current version of Health Plan's Notice at its Web site.]***

DUTIES OF HEALTH PLAN

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

CONTACT PERSON

The Health Plan has designated the **Assistant Director of Insurance and Benefits for the Office of Management and Budget, 915-541-4208**, as its contact person, (HIPAA Privacy Officer), for all issues regarding patient privacy and your privacy rights.

EFFECTIVE DATE

This Notice is effective April 14, 2003.

All other terms and conditions of this plan which are not affected by this amendment remains unchanged.

Date

John Cook, Mayor

David Almonte, Director of OMB