



**PLAN DOCUMENT AND
SUMMARY PLAN DESCRIPTION
FOR**

EL PASO COUNTY

REACH YOUR PEAK MEDICAL EPO

RESTATED: JANUARY 1, 2017

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INTRODUCTION

This document is a description of El Paso County (the Plan). No oral interpretations can change this Plan. The Plan described is designed to protect Plan Participants against certain catastrophic health expenses.

Coverage under the Plan will take effect for an eligible Employee and designated Dependents when the Employee and such Dependents satisfy the Waiting Period and all the eligibility requirements of the Plan.

The Employer fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue or amend the Plan at any time and for any reason.

Changes in the Plan may occur in any or all parts of the Plan including benefit coverage, deductibles, maximums, copayments, exclusions, limitations, definitions, eligibility and the like.

Failure to follow the eligibility or enrollment requirements of this Plan may result in delay of coverage or no coverage at all. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, such as coordination of benefits, subrogation, exclusions, timeliness of COBRA elections, utilization review or other cost management requirements, lack of Medical Necessity, lack of timely filing of claims or lack of coverage.

No action at law or in equity shall be brought to recover under any section of this Plan until the appeal rights provided have been exercised and the Plan benefits requested in such appeals have been denied in whole or in part.

EBMS (the Claims Administrator) utilizes Aetna's Clinical Policy Bulletins (CPBs) to determine whether services and procedures are considered Medically Necessary and Experimental and/or Investigational under the Plan. The CPBs are based on peer-reviewed, published medical journals, a review of available studies on a particular topic, evidence-based consensus statements, expert opinions of health care professionals and guidelines from nationally recognized health care organizations. These CPBs are reviewed on a regular basis based upon a review of currently available clinical information.

The Plan will pay benefits only for the expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage terminated. An expense for a service or supply is incurred on the date the service or supply is furnished.

If the Plan is terminated, amended, or benefits are eliminated, the rights of Covered Persons are limited to Covered Charges incurred before termination, amendment or elimination.

Grandfathered Plan. This Plan believes it is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that the Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status, can be directed to the Plan Administrator. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1 (866) 444-3272 or the U.S. Department of Health and Human Services at www.HealthCare.gov. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

This document summarizes the Plan rights and benefits for covered Employees and their Dependents and is divided into the following parts:

Eligibility, Funding, Effective Date and Termination. Explains eligibility for coverage under the Plan, funding of the Plan and when the coverage takes effect and terminates.

Schedule of Benefits. Provides an outline of the Plan reimbursement formulas as well as payment limits on certain services.

Benefit Descriptions. Explains when the benefit applies and the types of charges covered.

Care Management Services. Explains the methods used to curb unnecessary and excessive charges.

Defined Terms. Defines those Plan terms that have a specific meaning.

Plan Exclusions. Shows what charges are **not** covered.

How To Submit A Claim. Explains the rules for filing claims.

Coordination of Benefits. Shows the Plan payment order when a person is covered under more than one plan.

Third Party Recovery Provision. Explains the Plan's rights to recover payment of charges when a Covered Person has a claim against another person because of injuries sustained.

COBRA Continuation Coverage. Explains when a person's coverage under the Plan ceases and the continuation options which are available.

SCHEDULE OF BENEFITS

MEDICAL BENEFITS

All benefits described in this Schedule are subject to the exclusions and limitations described more fully herein including, but not limited to, the Plan Administrator or its designee's determination that: care and treatment is Medically Necessary; that charges are reasonable and customary (as defined as an Allowable Charge); that services, supplies and care are not Experimental and/or Investigational. The meanings of these capitalized terms are in the Defined Terms section of this document.

Pre-notification of certain services is strongly recommended, but not required by the Plan. Pre-notification provides information regarding coverage before the Covered Person receives treatment, services or supplies. *A benefit determination on a Claim will be made only after the Claim has been submitted. A pre-notification of services by CareLink is not a determination by the Plan that a Claim will be paid. All Claims are subject to the terms and conditions, limitations and exclusions of the Plan in effect at the time services are provided. A pre-notification is not required as a condition precedent to paying benefits and can only be appealed under the procedures in the Care Management Services section. A pre-notification cannot be appealed under the Plan's Claims Review Procedures section.*

This Plan has entered into an agreement with certain Hospitals, Physicians and other health care providers, which are called **Participating Providers**. Because these Participating Providers have agreed to charge reduced fees to persons covered under the Plan, the Plan can afford to reimburse a higher percentage of their fees.

This Plan will utilize the **El Paso County Employee Health Center ("Clinic")** and the Aetna Signature Administrators PPO Network.

In order to receive benefits, all medical care must be provided by a Participating Provider. The use of non-Participating Providers will not be eligible under this Plan, except when otherwise noted.

If the Covered Person's Participating Provider Primary Care Physician or other Participating Provider determines the Covered Person requires hospitalization, arrangements will need to be made for the Covered Person's admission into a Participating Provider Network Hospital.

To access a list of Participating Providers, please refer to the **Aetna Signature Administrators PPO Network website**, <http://www.aetna.com/asa>, the miBenefits website via www.ebms.com or contact the Claims Administrator (EBMS) toll-free @ 1 (866) 887-4115.

***Note:** Sutter Health Systems is not a Participating Provider under this Plan. Services rendered by Sutter Health Systems will be payable subject to the Non-Participating Provider benefit level as stated in the Schedule of Benefits.*

REACH YOUR PEAK BENEFIT OPTION - REFERRAL REQUIREMENT

Upon a completed referral by the Clinic, *the initial office visit associated with and following the completed Clinic referral, recommended testing services, and procedures rendered to determine or establish a diagnosis, will be payable at 100% and will not be subject to either deductible or copayment.* Once a diagnosis has been established, any additional recommended medical treatments / services will be payable per normal Plan provisions.

NON-PARTICIPATING PROVIDER AUTHORIZATION

If the Covered Person is unable to locate a Participating Provider in the specialty and/or for Medically Necessary treatment/services that he/she is seeking, please contact EBMS at (866) 887-4115 in order to obtain a prior authorization to use a Non-Participating Provider.

Note: *Documentation from the referring Physician, as to the medical necessity to utilize a Non-Participating*

Provider specialist or other Non-Participating Provider or facility, must be provided to EBMS before a Non-Participating Provider Authorization can be approved.

Failure to obtain authorization to utilize a Non-Participating Provider or facility will result in no reimbursement from the Plan for services rendered.

Under the following circumstances, the Participating Provider payment benefit level will be made for certain Non-Participating Provider services. (Note: Balance billing may apply.) :

Prior to receiving medical care services, the Covered Person should confirm with the provider and the Participating Provider Organization that the provider is a participant in this organization.

- For services rendered by a non-Participating Provider when ordered by a Participating Provider or delivered at a Participating Provider facility (including but not limited to, DME, anesthesiologist, laboratory, radiologist, pathologist, and assistant surgeon), *and the Covered Person has no choice of the provider*, Covered Charges will be payable at the Participating Provider benefit level;
- The Covered Person is in mid-treatment for a medical condition or a behavioral health condition and such treatment is being rendered by a Non-Participating Provider at the time of the individual's ***initial enrollment*** under this Plan, such care by the Non-Participating Provider may continue until treatment for the medical condition or behavioral condition has either been completed or is safe for the Covered Person to transition to a new Participating Provider, ***whichever comes first***. (Refer to the separate Transitional Care or Continuous Care provision below for more information regarding this "exception".);
- The Covered Person is in mid-treatment for a medical condition or a behavioral health condition and the Covered Person's attending Physician or provider has terminated his/her participation within the Participating Provider Organization and transitioning to a new Participating Provider is neither recommended nor safe to the Covered Person. Continuous treatment by the attending Physician/provider will be covered until the current treatment has either been completed or it is safe for the Covered Person to transition to a new Participating Provider, ***whichever comes first***. (Refer to the separate Transitional Care or Continuous Care provision below for more information regarding this "exception".)

TRANSITIONAL CARE OR CONTINUOUS CARE:

Transitional Care. In the event a Covered Person is in mid-treatment for a medical condition or a behavioral health condition and such treatment is being rendered by a Non-Participating Provider at the time of enrollment under this Plan, such care by the Non-Participating Provider may continue until treatment for the medical condition or behavioral condition has either been completed or is safe for the Covered Person to transition to a new Participating Provider, ***whichever comes first***.

In the event a Covered Person is in mid-treatment for a medical condition or a behavioral health condition and such treatment was being rendered by a Participating Provider and such provider is not contracted in this Plan's current Participating Provider Organization (PPO) network, such care by the now Non-Participating Provider may continue until such treatment for the medical condition or behavioral condition has either been completed or is safe for the Covered Person to transition to a new Participating Provider, ***whichever comes first***.

Continuous Care. In the event the Covered Person is in mid-treatment for a medical condition or a behavioral health condition and the Covered Person's attending Physician or provider has terminated his/her participation within the Participating Provider Organization and transitioning to a new Participating Provider is neither recommended nor safe to the Covered Person, continuous treatment by the attending Physician/provider will be covered until the current treatment has either been completed or it is safe for the Covered Person to transition to a new Participating Provider, ***whichever comes first***.

The following provisions will apply to either Transitional Care or Continuous Care:

Further treatment for the medical condition or behavioral health condition or related conditions must follow the

Participating Provider network requirements under this Plan. Additional treatment by a Non-Participating Provider will be payable subject to the Non-Participating Provider benefit levels under this Plan. (**Note: Balance billing may apply.**)

Examples of a medical condition that may be permitted for Transitional Care or Continuous Care include, but are not limited to, the following:

- Pregnancy in the second or third trimester (as of the date of the Covered Person's initial enrollment under this Plan or as of the date of the attending Physician/provider's termination in the Participating Provider Organization);
- "High risk" Pregnancy if the Pregnant mother is 35 years or older and has / had:
 - Early delivery (three weeks) in previous Pregnancies;
 - Gestational diabetes;
 - Pregnancy induced hypertension;
 - Multiple inpatient admissions during the current Pregnancy;
- Cancer treatment, either newly diagnosed cancer or a relapse of cancer, and in the middle of chemotherapy, radiation therapy or reconstructive surgery;
- Trauma conditions;
- Transplant recipients in need of ongoing care due to complications associated with a transplant;
- Major surgery (while still in a post-surgical follow-up period of six to eight weeks);
- Acute conditions undergoing Active Treatment including heart attacks, strokes or unstable chronic conditions.
- Hospital confinement as of the date of the Covered Person's initial eligibility under this Plan;
- Behavioral health conditions during Active Treatment.

Note: "Active Treatment" for purposes of these benefits shall include a Physician's visit or Hospital stay with documentation reflecting any changes in a therapeutic regimen. Such changes must have occurred within 21 days prior to either the Covered Person's initial eligibility under this Plan or to the termination of the Covered Person's attending Physician / provider from the Participating Provider Organization.

Examples of conditions which will not be eligible for coverage under the Transitioning Care or Continuous Care benefits:

- Routine exams, immunizations / vaccinations and other such preventive care;
- Chronic conditions including, but not limited to, diabetes, arthritis, allergies, asthma, hypertension and glaucoma, which are stabilized and not requiring Active Treatment (as defined under this benefit);
- Acute minor Illnesses including, but not limited to, colds, flu, sore throats, or ear infections;
- Elective surgeries including, but not limited to, a lesion removal, bunionectomy, hernia repair or hysterectomies.

Deductibles/Copayments/Coinsurance payable by Plan Participants

Deductibles/Copayments are dollar amounts that the Covered Person must pay before the Plan pays.

A **deductible** is an amount of money that is paid once a Calendar Year per Covered Person. Typically, there is one deductible amount per Plan and it must be paid before any money is paid by the Plan for any Covered Charges. Each **January 1st**, a new deductible amount is required.

*Deductibles **do not** apply toward the maximum out-of-pocket amount.*

A **copayment** is the amount of money that is paid each time a particular service is used. Typically, there may be copayments on some services and other services will not have any copayments.

*Copayments **do not** apply toward the deductible.*

*Copayments **do not** apply toward the maximum out-of-pocket amount.*

Coinsurance is the percentage amount remaining after the Plan pays the reimbursement rate as shown in the Schedule of Benefits and is the Covered Person's responsibility. Coinsurance *does not* apply to the deductible and *does not* include copayment amounts.

Coinsurance is payable by the Covered Person until the maximum out-of-pocket amount, as shown in the Schedule of Benefits is reached. Then, Covered Charges incurred by a Covered Person will be payable at 100% (except for any charges which do not apply to the maximum out-of-pocket amount) for the remainder of the Calendar Year.

REACH YOUR PEAK MEDICAL EPO BENEFITS SCHEDULE

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
CALENDAR YEAR ANNUAL BENEFIT AMOUNT	Unlimited	
DEDUCTIBLE, PER CALENDAR YEAR		
Per Covered Person	\$2,000	Not Covered
Per Family Unit	\$6,000	Not Covered
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR		
Per Covered Person	\$3,000	Not Covered
Per Family Unit	\$7,000	Not Covered
The Plan will pay the designated percentage of Covered Charges until the maximum out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise.		
The following charges do not apply toward the maximum out-of-pocket amount and are never paid at 100%. <ul style="list-style-type: none"> • Deductibles • Copayments • Amounts over the Allowable Charge 		
COVERED CHARGES		
Hospital Services		
Inpatient Room and Board	75% after deductible and \$500 copayment per admission based on the semiprivate room rate	Not Covered
Intensive Care Unit	75% after deductible and \$500 copayment per admission based on the Hospital's ICU Charge	Not Covered
Inpatient room and board will include, but is not limited to, the following services when provided on an inpatient basis: Diagnostic/therapeutic lab and x-ray, drugs, medication, operating and recovery room, radiation therapy, chemotherapy, anesthesia, inhalation therapy, MRIs, MRAs, CAT Scans, and PET Scans Note: The copayment will apply as long as services billed include inpatient room or observation room charges.		
Outpatient Facility Services	75% after \$250 copayment per visit No deductible applies	Not Covered
Outpatient Physician services	75%, no deductible or copayment applies	Not Covered
Outpatient Facility Services will include the following services when provided on an outpatient basis: Operating room, recovery room, procedure room, and treatment room, and will also include the following diagnostic/therapeutic lab and x-rays, anesthesia and inhalation therapy. Note: The copayment will apply as long as services billed include one or more of the facility room charges: Operating room, recovery room, procedures room, treatment room, and observation room.		
Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities	75% after deductible the facility's semiprivate room rate 60 days maximum per Calendar Year	Not Covered

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Emergency Room Services (including ER Physician services)		
Medical Emergency Care	100% after \$200 copayment per visit; No deductible applies	
Medical Non-Emergency Care	Not Covered*	
<i>Note: The ER copayment will be waived if admitted to the Hospital directly from the ER.</i>		
*Medical Non-Emergency Care will be payable subject to the Medical Emergency Care benefit if the Covered Person calls the Nurse Line and is referred to the Emergency Room.		
Urgent Care Services (including Urgent Care Physician services)	100% after \$100 copayment per visit; No deductible applies	100% after \$100 copayment per visit; No deductible applies
Note: The Urgent Care copayment will be waived if admitted to the Hospital or to the emergency room directly from Urgent Care.		
Physician Services		
Inpatient Services	75% after deductible	Not Covered
El Paso County Employee Health Center (Clinic) Office Visit	100% after \$10 copayment per visit No deductible applies	Not Covered
Primary Care Physician (PCP) Office Visit	100% after \$50 copayment per visit No deductible applies	Not Covered
Note: A Primary Care Physician (PCP) is defined as a general practitioner, family practitioner, general internist (internist whose practice is 70% general medicine), Nurse Practitioner, Physician's Assistant, or pediatrician.		
<i>An OB/GYN will be considered a specialist.</i>		
Specialist office visits	100% after \$50 copayment per visit No deductible applies	Not Covered
Surgery performed in the office (including any medical supplies and injections rendered during the surgery)	100% after \$10 Clinic, \$50 PCP or \$50 Specialist copayment per visit No deductible applies	Not Covered
Injections (other than allergy)	100% after applicable Clinic, PCP or Specialist office visit copayment No deductible applies	Not Covered
Note: Injections billed outside of the office visit, the office visit copayment will be waived.		
Allergy serum and injections (including related office visit)	100%, No deductible or copayment will apply	Not Covered
Preventive Care		
Routine Well Care (ages birth through adult)	100%, No deductible or copayment applies	Not Covered
Includes: Routine office visits, routine physical examinations, PSA, routine lab and x-rays, routine colonoscopy, flexible sigmoidoscopy, immunizations, and additional services in compliance with following Women's Preventive Services (as recommended by the Patient Protection and Affordable Care Act (PPACA)) as listed below:		
Women's Preventive Services, will include, but will not be limited to, the following routine services:		
Office visits, well-women visits, mammogram, gynecological exam, Pap smear, counseling for sexually transmitted infections, human papillomavirus (HPV) testing, counseling and screening for human immune-deficiency virus (HIV), interpersonal and domestic violence, contraceptive methods and counseling as prescribed, sterilization procedures, patient education and counseling for all women with reproductive capacity (<i>and does not include birthing classes</i>), screening for gestational diabetes in pregnant women, breastfeeding support, supplies, and counseling in conjunction with each birth.		

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Ambulance Service	75% after deductible	
Note: Pre-authorization with the Claims Administrator will be required for non-emergent transport.		
Advanced Radiological Imaging (i.e., MRIs, MRAs, CAT Scans, PET Scans and Nuclear Medicine)	75%, No deductible or copayment will apply	Not Covered
Chiropractic Services	100% after \$20 copay per visit No deductible applies 24 visit maximum per Calendar Year	Not Covered
Diagnostic X-ray & Lab Testing	100%, No deductible or copayment will apply	Not Covered
Durable Medical Equipment	100%, No deductible or copayment will apply	Not Covered
Home Health Care	75% after deductible 60 days maximum per Calendar Year	Not Covered
Home Infusion Therapy	75% after deductible	Not Covered
Hospice Care	75% after deductible	Not Covered
Bereavement Counseling	75% after deductible	Not Covered
Mental Disorders and Substance Abuse Treatment		
Inpatient Services	Payable per normal Plan provisions	Not Covered
Outpatient Services	Payable per normal Plan provisions	Not Covered
Physician Office Visits	100% after \$10 copayment No deductible applies	Not Covered
Morbid Obesity Benefit	Payable per normal Plan provisions	Not Covered
Note: A pre-authorization is required prior to services being rendered. Please see the Covered Charges section for more information regarding this benefit.		
Nutritional Evaluation	Payable per normal Plan provisions 3 visits per Calendar Year maximum	Not Covered
Note: Please see the Covered Charges section for more information regarding this benefit.		
Outpatient Short-Term Rehabilitation Therapy	100% after \$20 copay per visit No deductible applies 60 days combined maximum for all therapies per Calendar Year	Not Covered
Includes: Cardiac Rehab, Physical Therapy, Speech Therapy, Occupational Therapy, Pulmonary Rehab, and Cognitive Therapy. Multiple services provided on the same day constitute one day, but a separate copayment will apply to the services provided by each Physician. The Outpatient Short Term Rehab copay does not apply to services provided as part of a Home Health Care visit. Therapy sessions provided in the home will accumulate to the benefit maximum.		
Orthotics	100%, No deductible or copayment will apply	Not Covered
Note: See Covered Charges section for details.		
Ostomy Supplies	100%, no deductible applies	
Prosthetics	100%, No deductible or copayment will apply	Not Covered

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Pregnancy *		
Initial visit (to confirm Pregnancy)	100% after \$50 Specialist office visit copayment	Not Covered
All subsequent prenatal visits, postnatal visits, and Physician's delivery charges (i.e., global maternity fee)	75% after deductible	Not Covered
Physician's office visits in addition to the global maternity fee (when performed by an OB/GYN or specialist)	100% after \$50 office visit copayment No deductible applies	Not Covered
Delivery – Facility charges (Inpatient Hospital, Birthing Center)	Payable per Inpatient Hospitalization benefit	Not Covered
<p>*Note: If a Clinic referral is received either to confirm a Pregnancy or after the initial diagnosis has been made and the Covered Person also enrolls in the Maternity Management Program during the second trimester of the Pregnancy, the Covered Person will not be subject to the inpatient Hospital copay, inpatient Hospital deductible or inpatient Physician deductible for the delivery charges or other Pregnancy related treatment (billed with a primary diagnosis of "Pregnancy").</p> <p>Any Emergency Room visit that is Pregnancy related (billed with a primary diagnosis of "Pregnancy") shall be covered in full. Neither Emergency Room copayments or Outpatient Facility/Physician deductible or coinsurance will apply if billed related to the Emergency Room Visit. If the Covered Person is admitted, the Emergency Room copayment will be waived; however any applicable deductible and coinsurance will apply to the inpatient stay.</p>		
Organ Transplants	Payable per normal Plan provisions	Not Covered
Travel / Lodging Expenses: (Available only when using a COE facility)	\$10,000 Lifetime Maximum	Not Covered
Note: See the Covered Charges section for more information regarding the Organ Transplant benefit.		
Renal Dialysis Services (will be payable subject to 200% of the Medicare equivalent rate)	75% after deductible	
<i>Note: Please see the COVERED CHARGES section for additional information regarding this benefit.</i>		
Wigs	75% after deductible \$1,000 Lifetime Maximum	
Note: Limited to the initial purchase of a wig when deemed Medically Necessary due to temporary or permanent hair loss. See the Covered Charges section for more information regarding this benefit.		
All Other Covered Charges	75% after deductible	Not Covered

ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS

A Plan Participant should contact the Claims Administrator to obtain additional information, free of charge, about Plan coverage of a specific benefit, particular drug, treatment, test or any other aspect of Plan benefits or requirements.

ELIGIBILITY

Eligible Classes of Employees

- All Full-Time, Active Employees of the Employer
- Pre-Medicare Eligible Retirees

Eligibility Requirements for Employee Coverage. A person is eligible for Employee coverage from the first day that he or she:

- (1) is a Full-Time, Active Employee of the Employer. An Employee is considered to be Full-Time if he or she normally works at least 30 hours per week and is on the regular payroll of the Employer for that work.

The Employer uses a 12-month look-back measurement period to determine the Full-Time status of an Employee. The Employee must average or be expected to average the required minimum hours of service established by the Employer each month in the Employee's initial 12-month measurement period to be eligible for coverage.

An Employee's initial measurement period begins the first day of the month following the date of hire, with an initial stability period commencing the first day of the first full calendar month following the initial measurement period. The Employer's standard 12-month measurement period begins each October 15th, with a standard stability period commencing each January 1st. Coverage is effective the first day of the stability period following the applicable measurement period. To remain eligible for coverage, the Employee must average the required minimum hours of service each week during each subsequent standard measurement period.

For more information on benefit measurement periods, contact the Employer's Human Resources Department.

- (2) is a pre-Medicare eligible Retiree;

In order to be eligible for continued coverage under this Plan as a pre-Medicare eligible Retiree; the covered Employee must meet the following requirements at the time of retirement from the Employer:

- Meets all requirements as set forth by El Paso County Benefits and Retirement office;
- Be actively enrolled under the Plan at the time of retirement; and
- Must complete and sign an enrollment form electing to continue coverage under the Plan as a Pre-Medicare eligible Retiree.

- (3) is in a class eligible for coverage;

- (4) has met all requirements to **qualify for the Reach Your Peak (RYP) wellness program** by established deadlines;

- (5) completes the employment Waiting Period as follows:
- a) If the Employee is hired full-time from the 1st through the 15th of the month, coverage will become effective on the first day of the next calendar month; or
 - b) If the Employee is hired full-time starting the 16th through the last day of the month, coverage will become effective the first day of the second following month as an Active Employee.

A "Waiting Period" is the time between the first day of employment as an eligible Employee and the first day of coverage under the Plan; and

- (6) per Federal guidelines, all Employees and their covered Dependents must provide his/her social security number at the time of enrollment under this Plan.

Upon retirement, an Employee can choose between COBRA Continuation Coverage or continuing under the terms of the Plan as a pre-Medicare eligible Retiree if he/she satisfies the criteria as set forth above.

If the Employee is eligible and chooses to continue coverage under the terms of the Plan as a pre-Medicare eligible Retiree, he or she will forfeit his or her right to elect COBRA Continuation Coverage at a later date.

In the event the Employee chooses to continue under the terms of the Plan as a pre-Medicare eligible Retiree, the Employee and his or her Spouse and Dependent children, who are active Plan Participants at the time of the Employee's retirement with the Employer, may remain eligible for coverage up to the limitations as stated under the Plan, providing enrollment is made on a timely basis as defined in the section "Timely Enrollments" in the Enrollment section under this Plan.

Eligible Classes of Dependents. A Dependent is any one of the following persons:

- (1) A covered **Employee's Spouse**, a **covered Retiree's Spouse**, or a **deceased Retiree's Spouse**, and **children** from birth to the limiting age of 26 years. When a child reaches the limiting age, coverage will end on the last day of the child's birthday month.

The term "Spouse" shall mean a covered Employee's wife or husband (including a common law wife or husband) and shall include same-sex Spouses that are required to be recognized as Spouses under applicable federal or state law. The term "Spouse" shall also mean a covered Employee's partner in a Civil Union under Colorado state law. The Plan Administrator may require documentation proving a legal marital or civil union relationship.

The term "**children**" shall include natural children, adopted children, children placed with a covered Employee in anticipation of adoption, or step-children.

The phrase "**child placed with a covered Employee in anticipation of adoption**" refers to a child whom the Employee intends to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such placement for adoption. The term "placed" means the assumption and retention by such Employee of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

Any child of a Plan Participant who is an alternate recipient under a **Qualified Medical Child Support Order (QMCSO)** shall be considered as having a right to Dependent coverage under this Plan. A participant of this Plan may obtain, without charge, a copy of the procedures governing QMCSO determinations from the US Department of Labor website at <https://www.dol.gov/ebsa/publications/qmcsos.html>

The Plan Administrator may require documentation proving dependency, including birth certificates, tax records or initiation of legal proceedings severing parental rights.

Premium payments for Dependent health insurance are usually exempt from federal income tax. Generally, if the covered Employee can claim an individual as a Dependent for purposes of federal income tax, then the premium for that Dependent's health insurance coverage will not be taxable to the covered Employee as income. However, in the rare instance that the covered Employee does cover an individual under his/her health insurance who does not meet the federal definition of a Dependent, the premium may be taxable to the covered Employee as income. For further questions and information, please consult a tax consultant or attorney.

- (2) A covered Dependent child who reaches the **limiting age and is Totally Disabled** and is incapable of self-sustaining employment by reason of mental or physical handicap. The Plan Administrator may require, at reasonable intervals during the two years following the Dependent's reaching the limiting age, subsequent proof of the child's Total Disability and dependency.

After such two-year period, the Plan Administrator may require subsequent proof not more than once each year. The Plan Administrator reserves the right to have such Dependent examined by a Physician of the Plan Administrator's choice, at the Plan's expense, to determine the existence of such incapacity.

These persons are excluded as Dependents: other individuals living in the covered Employee's home, but who are not eligible as defined; the divorced former Spouse of the Employee; foster children; or any person who is covered under the Plan as an Employee.

If a person covered under this Plan changes status from Employee to Dependent or Dependent to Employee, and the person is covered continuously under this Plan before, during and after the change in status, credit will be given for deductibles and all amounts applied to maximums.

If both mother and father are Employees, their children may be covered as Dependents of the mother or father, but not of both.

Eligibility Requirements for Dependent Coverage. A family member of an Employee will become eligible for Dependent coverage on the first day that the Employee is eligible for Employee coverage and the family member satisfies the requirements for Dependent coverage.

At any time, the Plan may require proof that a Spouse or a child qualifies or continues to qualify as a Dependent as defined by this Plan.

FUNDING

Cost of the Plan. El Paso County shares the cost of Employee and Dependent coverage under this Plan with the covered Employees.

The level of any Employee contributions is set by the Plan Administrator. The Plan Administrator reserves the right to change the level of Employee contributions.

Please refer to the El Paso County Employee Benefits Brochure for information regarding the cost of Employee and Dependent coverage under this Plan.

Please refer to the El Paso County Retiree Benefits Brochure for information regarding the cost of Retiree and Dependent coverage under this Plan.

ENROLLMENT

Enrollment Requirements

An Employee must enroll for coverage by filling out and signing an enrollment application along with or applying online providing an appropriate payroll deduction authorization. If Dependent coverage is desired, the Employee will be required to enroll his/her Dependents.

Enrollment Requirements for Newborn Children

A newborn child of a covered Employee will become insured for Medical Insurance on the date of his birth for only the initial thirty-one (31) day period. In order to continue coverage beyond this thirty-one (31) day period, the newborn child must be enrolled in this Plan on a timely basis, as defined in the section "Timely Enrollment" below or the enrollment will be considered a Late Enrollment, there will be no further payment from the Plan and the parents will be responsible for all expenses incurred beyond this initial thirty-one (31) day period.

TIMELY, LATE OR OPEN ENROLLMENT

- (1) **Timely Enrollment** - The enrollment will be "timely" if the completed form is received by the Plan Administrator no later than thirty-one (31) days after the person becomes eligible for the coverage, either initially or under a Special Enrollment Period.

If two Employees (husband and wife) are covered under the Plan and the Employee who is covering the Dependent children terminates coverage, the Dependent coverage may be continued by the other covered Employee with no Waiting Period as long as coverage has been continuous.

- (2) **Late Enrollment** - An enrollment is "late" if it is not made on a "timely basis" or during a Special Enrollment Period. Late Enrollees and their Dependents who are not eligible to join the Plan during a Special Enrollment Period may join only during open enrollment.

If an individual loses eligibility for coverage as a result of terminating employment, a reduction of hours or a general suspension of coverage under the Plan, then upon becoming eligible again due to resumption of employment or due to resumption of Plan coverage, only the most recent period of eligibility will be considered for purposes of determining whether the individual is a Late Enrollee.

The time between the date a Late Enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period. *Coverage begins as stated in the Open Enrollment section.*

- (i) **Open Enrollment** - Each year there is an annual open enrollment period designated by the Employer during which covered Employees may change their benefit elections under the Plan, and a covered Employee may add or drop coverage for their Dependents.

Benefit choices made during the open enrollment period will take effect January 1st following the open enrollment period.

Benefit choices made during the open enrollment period will remain in effect until the next open enrollment period unless there is a Special Enrollment event or a change in family status during the year (birth, death, marriage, divorce, adoption) or loss of coverage due to loss of a Spouse's employment. To the extent previously satisfied coverage Waiting Periods will be considered satisfied when changing from one benefit option under the Plan to another benefit option under the Plan.

A Plan Participant may automatically retain his or her present coverages. ***Plan Participants will receive detailed information regarding open enrollment from their Employer.***

- (3) **Enrollment Following Benefit Measurement Period** - Employees who qualified as Full-Time Active Employees during the applicable measurement period (and their eligible Dependents) may enroll in the Plan the first day of the first full calendar month of the following stability period. Employees will be credited for time previously satisfied toward the employment Waiting Period.

SPECIAL ENROLLMENT RIGHTS

Federal law provides Special Enrollment provisions under some circumstances. If an Employee is declining enrollment for himself or his dependents (including their spouse) because of other health insurance or group health plan coverage, there may be a right to enroll in this Plan if there is a loss of eligibility for that other coverage (or if the employer stops contributing towards the other coverage or coinciding with an open enrollment period specific to the other coverage). However, a request for enrollment must be made within thirty-one (31) days after the coverage ends (or after the employer stops contributing towards the other coverage).

Note: A pre-Medicare eligible Retiree who declines continued coverage at retirement and later loses other coverage will not be entitled to a Special Enrollment right, nor will their Dependent children.

In addition, in the case of a birth, marriage, adoption or placement for adoption, there may be a right to enroll in this Plan. However, a request for enrollment must be made within thirty-one (31) days after the birth, marriage, adoption or placement for adoption.

The Special Enrollment rules are described in more detail below. To request Special Enrollment or obtain more detailed information of these portability provisions, contact the Plan Administrator or its designee.

SPECIAL ENROLLMENT PERIODS

The Enrollment Date for anyone who enrolls under a Special Enrollment Period is the first date of coverage. Thus, the time between the date a special enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period. *(Note: A pre-Medicare eligible Retiree who declines continued coverage at retirement and later loses other coverage will not be entitled to a Special Enrollment right, nor will their Dependent children.)*

- (1) Individuals losing other coverage creating a Special Enrollment right.** An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if loss of eligibility for coverage meets all of the following conditions:

(Note: The following provisions may not be applicable to pre-Medicare eligible Retirees or their Spouses and Dependent children. If an enrolled pre-Medicare Retiree's Spouse loses other group coverage, he or she may be eligible to enroll.)

- (a)** The Employee or Dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual.
- (b)** If the Employee provided proof of other coverage at the time that coverage was offered and that the other health coverage was the reason for declining enrollment.
- (c)** The coverage of the Employee or Dependent who had lost the coverage was under COBRA and the COBRA coverage was exhausted, or was not under COBRA and either the coverage was terminated as a result of loss of eligibility for the coverage or because employer contributions towards the coverage were terminated.
- (d)** The Employee or Dependent requests enrollment in this Plan not later than 31 days after the date of exhaustion of COBRA coverage or the termination of non-COBRA coverage due to loss of eligibility or termination of employer contributions, described above.

For purposes of these rules, a loss of eligibility occurs if one of the following occurs:

- (i)** The Employee or Dependent has a loss of eligibility due to the plan no longer offering any benefits to a class of similarly situated individuals (i.e., part-time employees).

- (ii) The Employee or Dependent has a loss of eligibility as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death, termination of employment, or reduction in the number of hours of employment or contributions towards the coverage were terminated.
- (iii) The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual).
- (iv) The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual), and no other benefit package is available to the individual.

(2) Dependent beneficiaries. If:

- (a) The Employee is a participant under this Plan (or has met the Waiting Period applicable to becoming a participant under this Plan and is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period), or
- (b) The pre-Medicare eligible Retiree is a participant under this Plan; and
- (c) A person becomes a Dependent of the Employee or pre-Medicare eligible Retiree through marriage, birth, adoption or placement for adoption,

then the Dependent (and if not otherwise enrolled, the Employee) may be enrolled under this Plan. In the case of the birth or adoption of a child, the Spouse of the covered Employee may be enrolled as a Dependent of the covered Employee if the Spouse is otherwise eligible for coverage.

In the case of marriage, birth, adoption or placement for adoption, the Spouse or Dependent of a covered pre-Medicare eligible Retiree may be enrolled as a Spouse or Dependent of the covered pre-Medicare eligible Retiree if the Spouse or Dependent is otherwise eligible for coverage under the Plan.

If the Employee is not enrolled at the time of the event, the Employee must enroll under this Special Enrollment Period in order for his eligible Dependents to enroll. *If the pre-Medicare eligible Retiree is not enrolled at the time of the event, this Special Enrollment right will not be applicable.*

The Dependent Special Enrollment Period is a period of 31 days and begins on the date of the marriage, birth, adoption or placement for adoption. To be eligible for this Special Enrollment, the Dependent and/or Employee must request enrollment during this 31-day period.

The coverage of the Dependent and/or Employee or pre-Medicare eligible Retiree enrolled in the Special Enrollment Period will be effective:

- (a) in the case of marriage, as of the date of marriage or beginning the first day of the calendar month following the date of marriage;
- (b) in the case of a Dependent's birth, as of the date of birth; or
- (c) in the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA)

Employees and their Dependents who are otherwise eligible for coverage under the Plan but who are not enrolled can enroll in the Plan provided that they request enrollment in writing within sixty (60) days from the date of the following loss of coverage or gain in eligibility:

- (a) The eligible person ceases to be eligible for Medicaid or Children's Health Insurance Program (CHIP) coverage; or
- (b) The eligible person becomes newly eligible for a premium subsidy under Medicaid or CHIP.

If eligible, the Dependent (and, if not otherwise enrolled, the Employee) may be enrolled under this Plan.

This Dependent Special Enrollment Period is a period of 60 days and begins on the date of the loss of coverage under the Medicaid or CHIP plan OR on the date of the determination of eligibility for a premium subsidy under Medicaid or CHIP. To be eligible for this Special Enrollment, the Employee must request enrollment in writing during this 60-day period. *The effective date of coverage will begin the first day of the first calendar month following the date of loss of coverage or gain in eligibility.*

If a State in which the Employee lives offers any type of subsidy, this Plan shall also comply with any other State laws as set forth in statutes enacted by State legislature and amended from time to time, to the extent that the State law is applicable to the Plan, the Employer and its Employees.

For more information regarding special enrollment rights, contact the Plan Administrator.

EFFECTIVE DATE

Effective Date of Employee Coverage. An Employee will be covered under this Plan as outlined under the separate *Eligibility Requirements for Employee Coverage* provision (refer to the "Eligibility" section under this Plan), when the Employee satisfies all of the following:

- (1) The Eligibility Requirements.
- (2) The Enrollment Requirements of the Plan.

Effective Date of Dependent Coverage. A Dependent's coverage will take effect on the day that the Eligibility Requirements are met; the Employee is covered under the Plan; and all Enrollment Requirements are met.

TERMINATION OF COVERAGE

The Employer or Plan has the right to rescind any coverage of the Employee, pre-Medicare eligible Retiree and/or Dependents for cause, making a fraudulent claim or an intentional material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan. The Employer or Plan may either void coverage for the Employee, pre-Medicare eligible Retiree and/or covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days' advance written notice of such action. The employer will refund all contributions paid for any coverage rescinded; however, claims paid will be offset from this amount. The employer reserves the right to collect additional monies if claims are paid in excess of the Employee's or pre-Medicare eligible Retiree and/or Dependent's paid contributions.

An Employee or pre-Medicare eligible Retiree may voluntarily terminate coverage only during a designated Open Enrollment period or due to a qualifying Special Enrollment event and only if the request is submitted in writing within 31 days.

When Employee Coverage Terminates. Employee coverage will terminate on the earliest of these dates:

- (1) The date the Plan is terminated;
- (2) The date the covered Employee's Eligible Class is eliminated;
- (3) The last day of the calendar month in which the covered Employee ceases to be in one of the Eligible Classes, or if applicable, the last day of the stability period for which the covered Employee met the required minimum hours of service established by the Employer. This includes death or termination of Active Employment of the covered Employee. (See the section entitled COBRA Continuation Coverage.) It also includes an Employee on disability leave of absence or other leave of absence, unless the Plan specifically provides for continuation during these periods;
- (4) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due. *In the event of late or non-payment of health premiums, coverage will be terminated retroactively to the last day coverage was paid in full. Health benefits will not be reinstated if payment has not been received in full by the end of the 30-day grace period;*
- (5) If an Employee commits fraud or makes an intentional material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan, then the Employer or Plan may either void coverage for the Employee and covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days' advance written notice of such action; or
- (6) As otherwise stated in the Eligibility section.

Note: Except in certain circumstances, a covered Employee may be eligible for COBRA Continuation Coverage. For a complete explanation of when COBRA Continuation Coverage is available, what conditions apply and how to select it, see the section entitled COBRA Continuation Coverage.

Continuation During Periods of Employer-Certified Disability or Leave of Absence. A person may remain eligible for a limited time if Active, full-time work ceases due to disability, leave of absence or layoff. This continuance will end as follows:

For disability leave only: If a covered Employee's Active service ends and he/she is approved for coverage under the Employer's Short-Term Disability (STD) policy the Employee will remain eligible while he/she is continuously covered under the Employer's STD policy. However, the Employee's coverage will not continue past the date coverage under the Employer's STD policy ends.

For approved leave of absence: the end of the sixty (60) day period that next follows the date on which the person last worked as an Active Employee.

While continued, coverage will be that which was in force on the last day worked as an Active Employee. However, if benefits reduce for others in the class, they will also reduce for the continued person.

Continuation During Family and Medical Leave. Regardless of the established leave policies mentioned above, this Plan shall at all times comply with the Family and Medical Leave Act of 1993 (FMLA) as promulgated in regulations issued by the Department of Labor, if, in fact, FMLA is applicable to the Employer and all of its Employees and locations. This Plan shall also comply with any other State leave laws as set forth in statutes enacted by State legislature and amended from time to time, to the extent that the State leave law is applicable to the Employer and all of its Employees. Leave taken pursuant to any other State leave law shall run concurrently with leave taken under FMLA, to the extent consistent with applicable law.

If applicable, during any leave taken under the FMLA and/or other State leave law, the Employer will maintain

coverage under this Plan on the same conditions as coverage would have been provided if the covered Employee had been continuously employed during the entire leave period.

If Plan coverage terminates during the FMLA, coverage will be reinstated for the Employee and his or her covered Dependents if the Employee returns to work in accordance with the terms of the FMLA and/or other State leave law. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA leave started, and will be reinstated to the same extent that it was in force when that coverage terminated.

Rehiring a Terminated Employee. A terminated Employee who is rehired prior to the end of a thirteen (13) week period after the date of termination will be credited with time met towards the employment Waiting Period as of the date of termination. Coverage will begin the first day of the first calendar month following the date of rehire or the first day of the first calendar month following completion of the Waiting Period.

Otherwise, a terminated Employee who is rehired will be treated as a new hire and be required to satisfy all Eligibility and Enrollment requirements.

However, if the Employee is returning to work directly from COBRA Continuation Coverage, this Employee will be credited with time met towards the employment Waiting Period as of the date the Employee elected COBRA Continuation Coverage.

Employees on Military Leave. Employees going into or returning from military service may elect to continue Plan coverage as specified by the El Paso County Policies and Procedures Manual. These rights apply only to Employees and their Dependents covered under the Plan immediately before leaving for military service.

This Plan shall at all times comply with the Uniformed Services Employment and Reemployment Rights Act (USERRA), as amended from time to time. If the Employee has continuation rights under USERRA, the Employee must meet the same requirements for electing USERRA coverage as are required for electing COBRA Continuation Coverage. An Employee covered by the Plan immediately before leaving for military service has election rights under USERRA. Dependents do not have independent election rights under USERRA. An Employee performing military duty of more than 30 days may elect to continue coverage for up to 24 months; however, the Employee may be required to pay up to 102 percent of the full premium. For military service of less than 31 days, coverage is provided as if the Employee had remained employed. The Employee may be eligible for continuation coverage under both COBRA and USERRA, coverage elected under these circumstances is concurrent, not cumulative. Please contact the Employee Benefits Department for additional information.

If a pre-Medicare Eligible Retiree Coverage Terminates. Pre-Medicare eligible Retiree coverage will terminate on the earliest of these dates:

- (1) The date the Plan is terminated;
- (2) The date the pre-Medicare eligible Retiree's Eligible Class is eliminated;
- (3) The last day of the calendar month in which the covered pre-Medicare eligible Retiree becomes eligible for Medicare benefits whether or not he or she has enrolled in Medicare under Part A, Part B or both;
- (4) The date of the pre-Medicare eligible Retiree's death;
- (5) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due. *In the event of late or non-payment of health premiums, coverage will be terminated retroactively to the last day coverage was paid in full. Health benefits will not be reinstated if payment has not been received in full by the end of the 30-day grace period;*
- (6) If an pre-Medicare eligible Retiree commits fraud or makes an intentional material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan, then the Employer or Plan may either void coverage for the pre-Medicare eligible Retiree and covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days' advance written notice of such action; or

- (7) As otherwise stated in the Eligibility section.

When Dependent Coverage Terminates. A Dependent's coverage will terminate on the earliest of these dates:

- (1) The date the Plan or Dependent coverage under the Plan is terminated;
- (2) The date that the Employee's coverage under the Plan terminates for any reason including death. (See the section entitled COBRA Continuation Coverage.);
- (3) The last day of the calendar month in which the covered pre-Medicare eligible Retiree's Spouse becomes eligible for Medicare benefits whether or not he or she has enrolled in Medicare under Part A, Part B or both.
- (4) The last day of the calendar month in which a covered Spouse or pre-Medicare eligible Retiree's Spouse loses coverage due to loss of dependency status. (See the section entitled COBRA Continuation Coverage.);
- (5) The last day of the calendar month in which a covered Spouse or pre-Medicare eligible Retiree's Spouse drops coverage under this Plan during the Spouse's employer-sponsored open enrollment period;
- (6) The last day of the birthday month in which a Dependent child reaches the limiting age as defined by the Plan;
- (7) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due. *In the event of late or non-payment of health premiums, coverage will be terminated retroactively to the last day coverage was paid in full. Health benefits will not be reinstated if payment has not been received in full by the end of the 30-day grace period;*
- (8) If a Dependent commits fraud or makes an intentional material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan, then the Employer or Plan may either void coverage for the Dependent for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days' advance written notice of such action; or
- (9) As otherwise stated in the Eligibility section.

Note: Except in certain circumstances, a covered Dependent may be eligible for COBRA Continuation Coverage. For a complete explanation of when COBRA Continuation Coverage is available, what conditions apply and how to select it, see the section entitled COBRA Continuation Coverage.

MEDICAL BENEFITS

Medical Benefits apply when Covered Charges are incurred by a Covered Person for care of an Injury or Sickness and while the person is covered for these benefits under the Plan.

DEDUCTIBLE

Deductible Amount. This is an amount of Covered Charges for which no benefits will be paid. Before benefits can be paid in a Calendar Year a Covered Person must meet the deductible shown in the Schedule of Benefits.

The deductible amount *will not* apply toward the maximum out-of-pocket amount.

Note: In the event a Covered Person is hospitalized continuously on an inpatient basis as of December 31st of the current Calendar Year and through January 1st of the subsequent Calendar Year, the Covered Person will not be required to satisfy two individual deductible amounts for both Calendar Year periods for the same continuous inpatient hospitalization. Only the initial deductible amount (individual and/or family) in effect as of the first day of the inpatient hospitalization must be satisfied by the Covered Person for the duration of the continuous inpatient hospitalization.

Family Unit Limit. When the maximum amount shown in the Schedule of Benefits has been incurred by members of a Family Unit toward their Calendar Year deductibles, the deductibles of all members of that Family Unit will be considered satisfied for that year.

BENEFIT PAYMENT AND COINSURANCE

Each Calendar Year, benefits will be paid for the Covered Charges of a Covered Person after the Covered Person has met his or her Calendar Year deductible and any applicable copayment(s).

Benefit payment made by the Plan will be at the percentage rate shown in the Schedule of Benefits. No benefits will be paid in excess of any listed limit of the Plan.

Once the Plan has made the applicable benefit payment, the remaining percentage owed is the Covered Person's "Coinsurance" responsibility. For example, if the Plan's reimbursement rate is 75%, the Covered Person's responsibility (or coinsurance) is 25%.

Coinsurance *does not* include any deductible or copayment amounts. Coinsurance will apply to the maximum out-of-pocket amount.

MAXIMUM OUT-OF-POCKET AMOUNT

Covered Charges are payable by the Plan at the percentages shown each Calendar Year until the maximum out-of-pocket amount shown in the Schedule of Benefits is reached. Then, Covered Charges incurred by a Covered Person will be payable at 100% (except for any charges which do not apply to the maximum out-of-pocket amount) for the rest of the Calendar Year.

When a Family Unit reaches the maximum out-of-pocket amount, Covered Charges for that Family Unit will be payable at 100% (except for any charges which do not apply to the maximum out-of-pocket amount) for the rest of the Calendar Year.

COVERED CHARGES

Covered Charges are the Allowable Charges that are incurred for the following items of service and supply. These charges are subject to the benefit limits, exclusions and other provisions of this Plan. A charge is incurred on the date that the service or supply is performed or furnished.

- (1) **Hospital Care.** The medical services and supplies furnished by a Hospital or Ambulatory Surgical Center or a Birthing Center. Covered Charges for room and board will be payable as shown in the

Schedule of Benefits. After 23 observation hours, a confinement will be considered an inpatient confinement.

Room charges made by a Hospital having only private rooms will be payable at the average private room rate of that facility.

Charges for an Intensive Care Unit stay are payable as described in the Schedule of Benefits.

- (2) **Coverage of Pregnancy.** The Allowable Charges for the care and treatment of Pregnancy are covered the same as any other Sickness.

Color / 3-D Ultrasounds will not be a Covered Charge under this benefit.

Group health plans generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

- (3) **Skilled Nursing Facility Care.** The room and board and nursing care furnished by a Skilled Nursing Facility will be payable up to the limits as stated in the Schedule of Benefits if and when:

- (a) the patient is confined as a bed patient in the facility; and
- (b) the attending Physician certifies that the confinement is Medically Necessary; and
- (c) the attending Physician completes a treatment plan which includes a diagnosis, the proposed course of treatment and the projected date of discharge from the Skilled Nursing Facility.

- (4) **Physician Care.** The professional services of a Physician for surgical or medical services.

Charges for **multiple surgical procedures** will be a Covered Charge subject to the following provisions:

- (a) If bilateral or multiple surgical procedures are performed by one (1) surgeon, benefits will be determined based on the Allowable Charge for the primary procedures; 50% of the Allowable Charge will be allowed for each additional procedure performed through the same incision or during the same operative session. Any procedure that would not be an integral part of the primary procedure or is unrelated to the diagnosis will be considered "incidental" and no benefits will be provided for such procedures;
- (b) If multiple unrelated surgical procedures are performed by two (2) or more surgeons on separate operative fields, benefits will be based on the Allowable Charge for each surgeon's primary procedure. If two (2) or more surgeons perform a procedure that is normally performed by one (1) surgeon, benefits for all surgeons will not exceed the Allowable Charge allowed for that procedure; and
- (c) If an assistant surgeon is required, the assistant surgeon's Covered Charge will not exceed 20% of the surgeon's Allowable Charge.

- (5) **Private Duty Nursing Care.** The private duty nursing care by a licensed nurse (R.N., L.P.N. or L.V.N.). Covered Charges for this service will be included to this extent:

- (a) **Inpatient Nursing Care.** Charges are covered only when care is Medically Necessary or not Custodial in nature and the Hospital's Intensive Care Unit is filled or the Hospital has no Intensive Care Unit.

(b) **Outpatient Nursing Care.** Charges are covered only when care is Medically Necessary and not Custodial in nature. The only charges covered for Outpatient nursing care are those shown below, under Home Health Care Services and Supplies. Outpatient private duty nursing care on a 24-hour-shift basis is not covered.

(6) **Home Health Care Services and Supplies.** Charges for home health care services and supplies are covered only for care and treatment of an Injury or Illness, and will be payable up to the limits as stated in the Schedule of Benefits. The diagnosis, care and treatment must be certified by the attending Physician and be contained in a Home Health Care Plan.

A home health care visit will be considered a periodic visit by either a nurse or therapist, as the case may be, or four hours of home health aide services. *Outpatient private duty nursing will be a Covered Charge when deemed Medically Necessary.*

(7) **Hospice Care Services and Supplies.** Charges for hospice care services and supplies are covered only when the attending Physician has diagnosed the Covered Person's condition as being terminal, determined that the person is not expected to live more than six months and placed the person under a Hospice Care Plan.

Covered Charges for Hospice Care Services and Supplies are payable as described in the Schedule of Benefits.

The following charges for Hospice Care will not be covered under the Plan:

- The services of a person who is a member of the Covered Person's family or who normally resides in the Covered Person's house;
- For any period when the Covered Person is not under the care of a Physician;
- For services or supplies not listed or defined under Hospice Care Services and Supplies;
- For any curative or life-prolonging procedures;
- To the extent that any other benefits are payable for those expenses under the Plan; or
- For services or supplies that are primarily to aid the Covered Person in daily living.

Bereavement counseling services by a licensed social worker or a licensed pastoral counselor for the patient's immediate family (covered Spouse and/or covered Dependent Children). Bereavement services must be furnished within six (6) months after the patient's death.

(8) **Other Medical Services and Supplies.** These services and supplies not otherwise included in the items above are covered as follows:

(a) **Allergy** testing, serum and injections.

(b) **Ambulance.** Local Medically Necessary professional land or air ambulance service. A charge for this item will be a Covered Charge only if the service is to the nearest Hospital or Skilled Nursing Facility where necessary treatment can be provided unless the Plan Administrator or its designee finds a longer trip was Medically Necessary.

(c) **Anesthetic;** oxygen; blood and blood derivatives that are not donated or replaced; intravenous injections and solutions. Administration of these items is included.

The following will not be a Covered Charge under this Plan:

Fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the attending Physician's

opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.

(d) Breast pump, breast pump supplies, lactation support and counseling.

Breast pump, breast pump supplies

A standard electric breast pump or a manual breast pump for initiation or continuation of breastfeeding may be bought rather than rented, with the cost to rent not to exceed the actual purchase price.

- Rental of a heavy duty/hospital grade breast pump may be considered Medically Necessary only for the period of time that a newborn remains inpatient in the Hospital. Purchase of a heavy duty/hospital grade breast pump is not considered Medically Necessary or a Covered Charge under this Plan.
- For female Covered Persons using a breast pump from a prior Pregnancy, a new set of breast pump supplies will be covered with each subsequent Pregnancy.
- Replacement of either a standard electric breast pump or a manual breast pump, but not both, will be covered every (3) three Calendar Years following a subsequent Pregnancy.

Covered Charges for the purchase or rental of a breast pump and supplies will be payable subject to the Preventive Care benefits as shown in the Schedule of Benefits section.

Note: *Breast pumps and breast pump supplies when purchased through a retail store (for example, through Target, Wal-Mart, Walgreens) will be considered payable at the Participating Provider benefit level only for the purposes of this benefit.*

The Claims Administrator will require the following documentation: claim form with proof of purchase to include purchase price and item description.

Lactation support and counseling

Covered Charges include inpatient and outpatient comprehensive prenatal and postnatal lactation support and counseling for female Covered Persons for the duration of the breastfeeding. Services must be rendered by a Physician acting within the scope of their license or certification under applicable State law.

Note: *Payment will be made for Covered Charges for lactation support and counseling under the Preventive Care benefits in the Schedule of Benefits section at the Participating Provider payment, including Non-Participating Provider services for the purposes of this benefit.*

(e) Chemotherapy or radiation treatment with radioactive substances. The materials and services of technicians are included.

Pre-notification of services, by the Plan Participant, for cancer treatment services is strongly recommended. The pre-notification request to **CareLink** should include the Covered Person's plan of care and treatment protocol. Pre-notification of services should occur at least seven (7) days prior to the initiation of treatment.

For pre-notification of services, call **CareLink** at the following numbers:

Toll Free in the United States: (866) 894-1505
Local Call in Billings, Montana: (406) 245-3575

A pre-notification of services by CareLink is not a determination by the Plan that claims will be paid. All claims are subject to the provisions of the Plan, including but not limited to medical necessity, exclusions and limitations in effect at the time services are provided. A pre-

notification is not required as a condition precedent to paying benefits, and can only be appealed under the procedures in the Care Management Services section. A pre-notification cannot be appealed under the Plan's Claims Review Procedures section.

- (f) **Chiropractic services.** Covered Charges for Spinal Manipulation / Chiropractic services provided by a licensed M.D., D.O., or D.C. will be payable up to the limits as stated in the Schedule of Benefits.

Services will include the management of neuromusculoskeletal conditions through manipulation and ancillary physiological treatment that is rendered to restore motion, reduce pain and improve function.

The following will not be a Covered Charge under this Plan: Treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic, or recreational performance, including but not limited to routine, long term, or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.

- (g) **Circumcision.** Care, treatment, services and supplies in connection with circumcision when performed for a newborn child after Hospital discharge after birth.
- (h) **Clinical Trials.** Covered Charges will include charges made for routine patient services associated with cancer clinical trials approved and sponsored by the federal government. In addition the following criteria must be met:

- The cancer clinical trial is listed on the National Institute of Health (NIH) web site www.clinicaltrials.gov as being sponsored by the federal government;
- The trial investigates a treatment for terminal cancer and:
 - (i) the person has failed standard therapies for the disease;
 - (ii) cannot tolerate standard therapies for the disease; or
 - (iii) no effective non-experimental treatment for the disease exists;
- The Covered Person meets all inclusion criteria for the clinical trial and is not treated “off-protocol”;
- The trial is approved by the Institutional Review Board of the institution administering the treatment.

Routine patient services will include costs for services received during the course of a clinical trial, which are the usual costs for medical care, such as Physician visits, Hospital stays, clinical laboratory tests and x-rays that a Covered Person would receive whether or not he or she were participating in a clinical trial, will not be considered Experimental or Investigational.

Routine patient services do not include, and reimbursement will not be provided for:

- The investigational service or supply itself;
- Services or supplies listed herein as Plan Exclusions;
- Services or supplies related to data collection for the clinical trial (i.e., protocol-induced costs);
- Services or supplies which, in the absence of private health care coverage, are provided by a clinical trial sponsor or other party (e.g. device, drug, item or service supplied by a manufacturer and not yet FDA approved) without charge to the trial participant.

- (i) Initial **contact lenses** or glasses required following cataract surgery.
- (j) **Dental Injuries.** Charges for Injury to the mouth and teeth will be Covered Charges under Medical Benefits only if that care is for the following oral surgical procedures:
- Emergency repair and treatment made within six (6) months of an Injury to sound natural teeth.
 - Surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth.

No charge will be covered under Medical Benefits for dental and oral surgical procedures involving orthodontic care of the teeth, periodontal disease and preparing the mouth for the fitting of or continued use of dentures.

Covered Charges will include those Medically Necessary charges made by a Hospital for Inpatient Room and Board and supplies and services or charges made by a Free-Standing Surgical facility or the outpatient department of a Hospital in connection with a surgery.

- (k) **Durable Medical Equipment (DME).** Charges for Durable Medical Equipment and supplies necessary for the maintenance and operation of the Durable Medical Equipment that meet all of the following criteria:
- Medically Necessary;
 - Prescribed by a Physician for outpatient use;
 - Is NOT primarily for the comfort and convenience of the Covered Person;
 - Does NOT have significant non-medical uses (i.e. air conditioners, air filters, humidifiers, environmental control devices).

If more than one item of Durable Medical Equipment can meet a Covered Person's needs, Plan benefits are only available for the least cost alternative as determined by the Plan Administrator or its designee. Benefits are not available for certain convenience or luxury features that are considered non-standard.

DME will be provided on a rental basis; however, such equipment may be purchased at the Plan's option. Any amount paid to rent the equipment will be applied towards the purchase price. In no case will the rental cost of DME exceed the acquisition cost of the item.

The acquisition cost of the item may be prorated over a 6 month period, subject to prior approval by the Plan Administrator or its designee. Items deemed "not purchasable" by the Plan's Preferred Provider Network will not be subject to the Plan's limitation on rental up to the acquisition cost. *Non-purchasable DME items will be subject to a medical necessity review both initially and annually following twelve (12) months of rental. For more information, refer to the Concurrent Care provision listed under the Claims Review Procedures section.*

Replacement of a purchased Durable Medical Equipment item will be a Covered Charge limited to once every 4 Calendar Years. Subject to prior approval of the Plan Administrator or its designee, replacement for a *purchased* Durable Medical Equipment item may be available sooner than the 4 Calendar Year period for damage beyond repair with normal wear and tear, when repair costs exceed the acquisition cost, or when a change in the Covered Person's medical condition occurs.

Repair of a Durable Medical Equipment item including the replacement of essential accessories

such as hoses, tubing, mouth pieces, etc., are Covered Charges. Total estimated repair and replacement costs are limited to the acquisition cost of the item. Requests to repair a Durable Medical Equipment item are not subject to the 4 Calendar Year limit.

The Plan Administrator may require documentation, including but not limited to the make and model number of the Durable Medical Equipment item, the acquisition cost to the provider, and documentation to support Medical Necessity.

- (l) **Erectile Dysfunction.** Charges made for medical diagnostic services to determine the causes of erectile dysfunction. Penile implants are covered for an established medical condition that clearly is the cause of erectile dysfunction, such as postoperative prostatectomy and diabetes. *Penile implants are not covered as treatment of psychogenic erectile dysfunction.*
- (m) **Family Planning.** Covered Charges made for Family Planning, including counseling for family planning, medical history, physical exam, related laboratory tests, medical supervision in accordance with generally accepted medical practices, and other medical services, information and counseling on contraception, and FDA-approved contraceptives including, but not limited to, implantable contraceptives, injectable contraceptives and contraceptive devices (e.g. intra-uterine devices (IUDs)) and associated Physician and facility charges (including complications). These charges will be payable under the Women's Preventive Services benefit as shown under the Preventive Care benefit in the Schedule of Benefits.
- (n) **Gender Reassignment services .** Medically Necessary surgical and non-surgical services, treatment, care, and supplies that can align a Covered Person's physical body with their gender identity. *Benefits for outpatient Prescription Drugs will be covered under the Prescription Drug Benefits section of this Plan.*

Before undertaking Gender Reassignment services, the Covered Person will need to undergo important medical and psychological evaluations, and begin medical therapies and behavioral trials to confirm that surgery is the most appropriate treatment choice. The Plan will require a documented treatment plan.

- (o) **Genetic testing.** Care, services and supplies in connection with genetic testing and genetic counseling if:
 - the Covered Person has symptoms or signs of a genetically-linked inheritable disease; or
 - it has been determined that a Covered Person is at risk for carrier status as supported by existing peer-reviewed, evidence-based, scientific literature for the development of a genetically-linked inheritable disease when the results will impact clinical outcome; or
 - the therapeutic purpose is to identify specific genetic mutation that has been demonstrated in the existing peer-reviewed, evidence-based, scientific literature to directly impact treatment options.

Pre-implantation genetic testing, genetic diagnosis prior to embryo transfer, is covered when either parent has an inherited disease or is a documented carrier of a genetically-linked inheritable disease.

Genetic counseling is covered if a Covered Person is undergoing approved genetic testing, or if a Covered Person has an inherited disease and is a potential candidate for genetic testing. *Genetic counseling is limited to 3 visits per Calendar Year for both pre- and post-genetic testing.*

- (p) **Home Infusion Therapy.** The Plan will cover home infusion therapy services and supplies when provided by an accredited home infusion therapy agency, which is not a licensed Home Health Agency. These services must be Medically Necessary and are required for the administration of a home infusion therapy regimen when ordered by and are part of a formal written plan prescribed by a Physician.

The benefit will include all Medically Necessary services and supplies including the nursing services associated with patient and/or alternative caregiver training, visits to monitor intravenous therapy regimen, emergency care, Prescription Drugs, administration of therapy and the collection, analysis and reporting of the results of laboratory testing services required to monitor a response to therapy.

- (q) **Jaw joint conditions.** Medically Necessary services for care and treatment of jaw joint conditions, including surgical and non-surgical treatment of Temporomandibular Joint syndrome (TMJ).

- (r) **Laboratory studies.** Covered Charges for diagnostic lab testing and services.

- (s) **Mental Disorders and Substance Abuse.** Covered Charges will be payable for care, supplies and treatment of Mental Disorders and Substance Abuse.

- Bereavement counseling, when provided by a Mental Health provider, will be payable under the Mental Disorders benefit under this Plan.
- Life Threatening Injuries. Medical treatment required as a result of an emergency, such as a suicide attempt, will be considered a medical expense until the medical condition is stabilized.

The following are specifically excluded from Mental Disorders and Substance Abuse services:

Developmental disorders, including but not limited to, developmental reading disorders, developmental arithmetic disorders, developmental language or articulation disorders.

- (t) **Morbid Obesity benefit.** Charges for diagnostic testing, surgical and non-surgical procedures for the treatment of Morbid Obesity, when deemed Medically Necessary for Covered Persons ages 18 years and older or has reached full expected skeletal growth, including any associated complications resulting from the direct or indirect surgery related to treatment under this benefit.

A **pre-notification** of services, by the Plan Participant is **required prior to receiving** either inpatient or outpatient surgical procedures and **will require the following documentation** including, but not limited to, a written treatment plan by the attending Physician and documentation that all required medical criteria in advance of any surgical treatment has been met.

Documentation that the Plan Participant has attempted weight loss in the past without successful long term weight reduction will be required. **The Plan Participant must have also participated in the following criterion:**

A Physician-supervised nutrition and exercise program (unless contraindicated). The Physician-supervised nutrition and exercise program **must meet ALL of the following criteria and must be supervised and monitored by a Physician working in cooperation with a registered dietician and/or nutritionist:**

- The program must be twelve (12) months or longer in duration;
- The program must occur within two (2) years prior to the surgery;

- The program must be documented in the medical record by an attending Physician who does not perform bariatric surgery.

Covered Charges under this Morbid Obesity Benefit will also include Physician's office visits, related laboratory testing, surgical and non-surgical treatment.

The measurement of Body Mass Index (BMI) as defined under this Plan or a BMI of 35 or greater with any co morbid conditions that are expected to improve, reverse or be limited by this surgical treatment and which must be documented in a record or letter of medical necessity must demonstrate the diagnosis of Morbid Obesity.

Dietary counseling will be covered under the separate Nutritional Evaluation benefit under this Plan.

Weight loss medications prescribed by a Physician will not be payable under this Plan.

Programs such as Weight Watchers, Jenny Craig, and Optifast are acceptable alternatives if done in conjunction with the supervision of a Physician or registered dietician and detailed documentation of participation is available for review by the Claims Administrator. For individuals with long-standing Morbid Obesity, participation in a program within the last five (5) years is sufficient if reasonable attendance in the weight management program over an extended period of time of at least six (6) months can be demonstrated. However, Physician-supervised programs consisting exclusively of pharmacological management are not sufficient to meet this requirement.

- (u) **Nutritional Evaluation.** Covered Charges for nutritional evaluation and counseling when diet is a part of the medical management of a documented organic disease as well as for the treatment of Morbid Obesity, and will be payable up to the limits as stated in the Schedule of Benefits.
- (v) **Organ transplant** benefits. Medically Necessary charges incurred for the care and treatment due to an organ or tissue transplant, which are not considered Experimental or Investigational, and which will also include the recipient's medical, surgical, and Hospital services, including the recipient's inpatient immunosuppressive medications, and are subject to the following criteria:
 - The transplant must be performed to replace an organ or tissue.
 - **Organ transplant benefit period:** A period of 365 continuous days beginning five (5) days immediately prior to an approved organ transplant procedure. In the case of a bone marrow transplant, the date the transplant begins will be defined as either the earlier of the date of the beginning of the preparatory regimen (marrow ablation therapy) or the date the marrow/stem cells is/are infused.
 - **Organ procurement limits.** Charges for obtaining donor organs or tissues (from a cadaver or live donor) are Covered Charges under the Plan only when the recipient is a Covered Person.

When the donor has medical coverage, his or her plan will pay first. The donor benefits under this Plan will be reduced by those payable under the donor's plan. Donor charges include those for:

- (i) Evaluating the organ or tissue;
- (ii) Removing the organ or tissue from a donor;
- (iii) Transportation of the organ or tissue from within the United States or Canada to the facility where the transplant is to be performed; and
- (iv) The transportation, hospitalization and surgery of a live donor.

Compatibility testing undertaken prior to procurement is covered if deemed Medically Necessary. Costs related to the search for, and identification of a bone marrow or stem cell donor for an allogeneic transplant are also covered.

Note: Expenses related to the purchase of any organ will not be covered.

As soon as reasonably possible, but in no event more than ten (10) days after a Covered Person's attending Physician has indicated that the Covered Person is a potential candidate for a transplant, the Covered Person or his or her Physician must contact CareLink at (866) 894-1505.

- In the event a Participating Provider transplant facility is utilized, benefits will be payable at the Participating Provider benefit level.
- In the event a Participating Provider transplant facility is unavailable and the providing transplant facility is a Center of Excellence facility, benefits will be payable at the Participating Provider benefit level.
- ***In the event a Non-Participating Provider transplant facility is utilized and the providing transplant facility is not a Center of Excellence facility, there will not be any coverage under this Plan.***

There is no obligation to the Covered Person to use either a Participating Provider or a Center of Excellence facility; however, benefits for the transplant and related expenses will vary depending upon whether services are provided by a Participating Provider or a Non-Participating Provider and whether or not a Center of Excellence facility is utilized.

A **Center of Excellence** is a licensed healthcare facility that has entered into a participation agreement with a national transplant network to provide approved transplant services, at a negotiated rate, to which the Plan has access. A Covered Person may contact CareLink to determine whether or not a facility is considered a Center of Excellence.

Travel and Lodging Expenses

If the Covered Person resides **60 miles** or more from a Center of Excellence transplant facility, the Plan will pay for the following services incurred during the transplant benefit period (subject to the maximum benefit as specifically stated in the Schedule of Benefits):

- A. Transportation expenses to and from the Center of Excellence facility for the following individuals:
- The Covered Person; and
 - One or both parents of the Covered Person (only if the Covered Person is a Dependent minor child); or
 - One adult to accompany the Covered Person.

Transportation expenses include commercial transportation (coach class only).

- B. Reasonable lodging and meal expenses incurred for the Covered Person, and one or both parents of the Covered Person (only if the Covered Person is a Dependent minor child), or one adult companion who is accompanying the Covered Person, only while the Covered Person is receiving transplant-related services at a Center of Excellence facility.

The following are specifically excluded travel expenses:

- Lodging will not include private residences.
- Travel **within** 60 miles from a Covered Person's residence.
- Laundry bills, telephone bills, alcohol or tobacco products.

Special Transplant Benefits

Under certain circumstances, there may be special transplant benefits available when the group health plan and/or a Covered Person participates in a special transplant program and/or contracts with a specific transplant network. Therefore, it is very important to contact CareLink at (866) 894-1505 as soon as reasonably possible so that the Plan can advise the Covered Person or his or her Physician of the transplant benefits that may be available.

- (w) **Orthognathic surgery.** Orthognathic surgery to repair or correct a severe facial deformity or disfigurement that orthodontics alone cannot correct provided:
- The deformity or disfigurement is accompanied by a documented clinically significant functional impairment, and there is a reasonable expectation that the procedure will result in meaningful functional improvement; or
 - The orthognathic surgery is Medically Necessary as a result of tumor, trauma, disease; or
 - The orthognathic surgery is performed prior to age 19 years and is required as a result of severe congenital facial deformity or congenital condition.

Repeat or subsequent orthognathic surgeries for the same condition are covered only when the previous orthognathic surgery met the above requirements, and there is high probability of significant additional improvement when determined by the Claims Administrator.

- (x) **Orthotic appliances.** The initial purchase, fitting and repair of orthotic appliances such as braces, splints or other appliances which are required for support for an injured or deformed part of the body as a result of a disabling congenital condition or an Injury or Sickness.

*Corrective orthopedic shoes, arch supports or foot orthotics **are not** a Covered Charge under this Plan.*

- (y) **Ostomy supplies.** Medical ostomy supplies, when prescribed by a Physician, will be a Covered Charge.
- (z) **Prescription Drugs** (as defined). Outpatient Prescription Drugs **will not** be a Covered Charge under this Plan.
- (a1) Routine **Preventive Care.** Covered Charges under Medical Benefits are payable for routine Preventive Care as described in the Schedule of Benefits.

Charges for Routine Well Care. Routine well care is care by a Physician that is not for an Injury or Sickness.

- (a2) **Prosthetic devices.** The initial purchase, fitting and repair of fitted prosthetic devices which replace missing body parts and are necessary to alleviate or correct Sickness, Injury or congenital defect; including only artificial arms and legs, terminal devices such as hands or hooks. Replacement of such prostheses is covered only if needed due to normal anatomical growth.

- (a3) **Reconstructive Surgery.** Correction of abnormal congenital conditions and reconstructive mammoplasties will be considered Covered Charges.

This mammoplasty coverage will include reimbursement for:

- (i) reconstruction of the breast on which a mastectomy has been performed,
- (ii) surgery and reconstruction of the other breast to produce a symmetrical appearance, and
- (iii) coverage of prostheses and physical complications during all stages of mastectomy, including lymphedemas,

in a manner determined in consultation with the attending Physician and the patient.

- (a4) Charges for **Rehabilitation therapy.** Services must be Medically Necessary to restore and improve a bodily or cognitive function that was previously normal but was lost as a result of an accidental Injury, Illness, or surgery.

Inpatient Care. Services must be furnished in a specialized rehabilitative unit of a Hospital and billed by the Hospital or be furnished and billed by a rehabilitation facility approved by the Plan. This benefit only covers care the Covered Person received within 24 months from the onset of the Injury or Illness or from the date of the surgery that made rehabilitation necessary. The care must also be part of a written plan of multidisciplinary treatment prescribed and periodically reviewed by a physiatrist (a Physician specializing in rehabilitative medicine).

- (a5) **Renal Dialysis Services.** Renal dialysis visits, are paid at 200% of the Medicare equivalent rate, up to the out-of-pocket limitation after the satisfaction of deductible, if any. For renal dialysis treatments associated with an in-patient hospitalization, the Plan Administrator or its designee has the discretionary authority to negotiate a contract rate or other discounting arrangement on the entire inpatient claim.

Renal dialysis visits shall include dialysis, facility services, supplies and medications provided during treatment. Laboratory testing and Physician visits will be payable per normal Plan provisions.

Medicare Part B Reimbursement

If the Covered Person has End-Stage Renal Disease (“ESRD”), the Plan’s primary status applies during the first thirty (30) months of dialysis, the first thirty (30) months of treatment in connection with a transplant, or as otherwise directed by Centers of Medicare and Medicaid Services (“CMS”) /Medicare coordination rules for ESRD. Thereafter, Medicare generally becomes the primary payer of benefits.

The Medicare Secondary Payer statute requires the Plan to identify members in the Plan, including eligible Dependents, who are eligible for Medicare, including those eligible based on ESRD. To ensure the correct coordination of claims payments, members are required to provide the Plan the basis for their eligibility to Medicare (age, ESRD, or disability) and the effective date of Medicare Part A and Part B.

If the Covered Person becomes entitled, including dually entitled, to Medicare based on ESRD, the Plan will reimburse the Covered Person up to a lifetime maximum amount of \$5,000 for Medicare Part B monthly premiums made during the period where the Plan has primary status.

Reimbursement for monies withheld by Medicare from Social Security, Railroad Retirement, or Office of Personnel Management payments will be made at the end of each calendar quarter. The Plan Administrator may require documentation of the payment of Part B premiums. For additional information on how to submit a new request for reimbursement of Part B premiums, please contact the Plan Administrator or its designee.

For more information on benefits available under the Medicare program, visit www.medicare.gov or call toll-free 1 (800)-MEDICARE (1 (800) 633-4227). For more information on Medicare Part B premiums, visit www.socialsecurity.gov, the local Social Security office or call Social Security at 1 (800) 772-1213.

- (a6) **Short-term Rehabilitative Therapy.** Charges made for Short-Term Rehabilitative Therapy which is a part of a rehabilitation program, including physical, speech, occupational, cardiac rehabilitation, and pulmonary rehabilitation therapy, when provided in the most medically appropriate setting. Covered Charges will be payable up to the limits as stated in the Schedule of Benefits.

The following limitations will apply to Short-Term Rehabilitative Therapy:

- Occupational therapy is provided only for purposes of training members to perform the activities of daily living.
- Speech therapy is not covered when (a) used to improve speech skills that have not fully developed; (b) considered custodial or educational; (c) intended to maintain speech communication; or (d) not restorative in nature.

The following will not be a Covered Charge under this Plan: Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic, or recreational performance, including but not limited to routine, long term, or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.

- (a7) **Sterilization** procedures. Sterilization procedures for female Covered Persons will be payable as shown under the Preventive Care benefit as shown in the Schedule of Benefits section.

The following charges will be payable per normal Plan provisions:

- Hysterectomies; and
- Sterilization procedures for male Covered Persons.

- (a8) **Stereotactic Radiosurgery (SRS).** Covered Charges for Stereotactic Radiosurgery (SRS) and Stereotactic Body Radiation Therapy (SBRT) including fractionated stereotactic radiotherapy and/or stereotactic body radiation therapy when deemed Medically Necessary for ANY of the following indications:

- Arteriovenous malformation of the brain or spine;
- Primary brain tumor (e.g. glioma, meningioma, pituitary tumor, hemangioblastoma, acoustic neuroma (i.e., vestibular schwannoma), hypothalamic hamartoma);
- Metastatic tumor to the brain;
- Symptomatic primary or metastatic spinal tumor(e.g. neurological impairment, pain);
- Trigeminal neuralgia refractory to medical management;
- Nasopharyngeal cancer;
- Parkinsonian or essential tremor that is refractory to medical management;
- Uveal melanoma (melanoma of the uveal tract (iris, ciliary body and choroid));
- Any of the following neoplasms if unresectable or the Covered Person is a poor surgical candidate or declines surgery:
 - Liver malignancy
 - Non small-cell lung cancer (NSCLC) or pulmonary metastasis
 - Renal cell carcinoma (RCC) tumor
- Extracranial malignancy which is either in or adjacent to a previously irradiated volume, or located near a critical structure, where the risk of toxicity precludes use of another local modality.

This Plan **will not** cover stereotactic radiosurgery including fractionated stereotactic radiotherapy and/or stereotactic body radiation therapy for any other indication, including but not limited to the following, as it is either considered Experimental / Investigational or unproven:

- Behavioral health disorders (e.g. obsessive-compulsive disorder)
- Breast Cancer
- Epilepsy
- Pancreatic Cancer
- Prostate Cancer

(a9) Surgical dressings, splints, casts and other devices used in the reduction of fractures and dislocations.

(a10) Well Newborn Routine Nursery/Physician Care.

Charges for Routine Nursery Care. Routine well newborn nursery care is care while the newborn, **who is neither injured nor ill**, is Hospital-confined after birth and includes room, board and other normal care, including circumcision, for which a Hospital makes a charge.

Coverage for a newborn who is either injured or ill at birth will be payable under the Plan of the newborn child and will be payable per normal Plan provisions.

This coverage is only provided if the healthy newborn child is an **eligible and enrolled Dependent**, as stated under the separate *Enrollment Requirements For Newborn Children section under this Plan*, and a parent (1) is a Covered Person who was covered under the Plan at the time of the birth, or (2) enrolls himself or herself (as well as the newborn child if required) in accordance with the Special Enrollment provisions with coverage effective as of the date of birth.

The benefit is limited to Allowable Charges for nursery care for the newborn child while Hospital confined as a result of the child's birth.

Charges for covered routine nursery care will be applied toward the Plan of the covered parent.

Group health plans generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Charges for Routine Physician Care. The benefit is limited to the Allowable Charges made by a Physician, including circumcision, for the healthy newborn child while Hospital confined as a result of the child's birth.

Charges for covered routine Physician care will be applied toward the Plan of the covered parent.

(a11) Wigs. Charges associated with the **initial purchase** of a wig when deemed Medically Necessary for Covered Persons suffering from either **temporary or permanent hair loss** as a result of an Injury, Illness or medical treatment of another condition, such as chemotherapy, alopecia areata, alopecia totalis, trichotillomania or any other clinical disease, must be prescribed by a Physician.

The Plan Administrator will require written confirmation and/or medical documentation from the prescribing Physician confirming the Covered Person's temporary or permanent hair loss and that such purchase would improve the Covered Person's mental well-being.

NOTE: Naturally occurring hair loss is not considered a form of a disease and **is not** a Covered Charge under this Plan.

(a12) X-rays. Covered Charges for diagnostic x-ray services.

THE WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 (WHCRA)

The Women's Health and Cancer Rights Act of 1998 (WHCRA) was signed into law on October 21, 1998.

In the case of an Employee or Dependent who receives benefits under the plan in connection with a mastectomy and who elects breast reconstruction (in a manner determined in consultation with the attending *physician* and the patient), coverage will be provided for:

- Reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

Benefits will be subject to the same cost-sharing (deductible, co-payment, co-insurance) provisions as apply to the mastectomy.

CARE MANAGEMENT SERVICES

UTILIZATION MANAGEMENT

Utilization Management is a program designed to assist Covered Persons in understanding and becoming involved with their diagnosis and medical plan of care, and advocates patient involvement in choosing a medical plan of care. Utilization Management begins with the pre-notification process.

Pre-notification of certain services is strongly recommended, but not required by the Plan. Pre-notification provides information regarding coverage before the Covered Person receives treatment, services and/or supplies. *A benefit determination on a Claim will be made only after the Claim has been submitted. A pre-notification of services by CareLink is not a determination by the Plan that a Claim will be paid. All Claims are subject to the terms and conditions, limitations and exclusions of the Plan in effect at the time services are provided. A pre-notification is not required as a condition precedent to paying benefits and can only be appealed under the procedures in the Care Management Services section. A pre-notification cannot be appealed under the Plan's Claims Review Procedures section.*

Examples of when the Physician and Covered Person should contact CareLink prior to treatment include:

- Inpatient admissions to a Hospital
- Inpatient admissions to free-standing chemical dependency, mental health, and rehabilitation facilities
- Cancer treatment plan of care, administered on an inpatient or outpatient basis
- Inpatient or outpatient surgeries relating to, but not limited to, hysterectomies, back surgery, or bariatric surgery (if applicable under this Plan); and
- Outpatient services as follows:
 - Dialysis
 - Genetic testing
 - Injectables
 - Home Health Care
 - Hospice
 - Durable Medical Equipment (DME) over \$2,000

All Claims are subject to the terms and conditions, limitations and exclusions of the Plan at the time charges are incurred.

The Physician or Covered Person should notify CareLink at least seven (7) days before services are scheduled to be rendered with the following information:

- The name of the patient and relationship to the covered Employee
- The name, Employee identification number and address of the Covered Person
- The name of the Employer
- The name and telephone number of the attending Physician
- The name of the Hospital, proposed date of admission, and proposed length of stay
- The diagnosis and/or type of surgery
- The plan of care, treatment protocol and/or informed consent, if applicable

If there is an emergency admission to the Hospital, the Covered Person, Covered Person's family member, Hospital or attending Physician should notify CareLink within two (2) business days after the admission.

Hospital Observation Room stays in excess of 23 hours are considered an admission for purposes of this program, therefore CareLink should be notified.

Contact the Care Management administrator at:

**CareLink (406) 245-3575 or (866) 894-1505
Monday through Friday, 6:00 a.m. to 7:00 p.m. (Mountain Time)**

PRE-ADMISSION AND POST DISCHARGE CARE CALLS

A CareLink nurse will contact the Covered Person to provide health education, pre-surgical counseling, inpatient care coordination, facilitation of discharge plan and post-discharge follow-up.

PRE-NOTIFICATION DETERMINATION AND REVIEW PROCESS

The Claims Administrator or its designee, on the Plan's behalf, will review the submitted information and make a determination on a pre-notification request within fifteen (15) days of receipt of the pre-notification request and all supporting documentation. If additional records are necessary to process the pre-notification request, the Claims Administrator or its designee will notify the Covered Person or the Physician. The time for making a determination on the request will be deferred from the date that the additional information is requested until the date that the information is received.

The Physician and Covered Person will be provided notice of the Plan's determination. . If the pre-notification request is denied, written notice will provide the reason for the adverse pre-notification determination.

The Plan offers a one-level review procedure for adverse pre-notification determinations. The request for reconsideration must be submitted in writing within thirty (30) days of the receipt of the adverse pre-notification determination and include a statement as to why the Covered Person disagrees with the adverse pre-notification determination. The Covered Person may include any additional documentation, medical records, and/or letters from the Covered Person's treating Physician(s). The request for reconsideration should be addressed to:

CareLink
Attn: Appeals
7400 West Campus Rd.
New Albany, OH 43054

The Claims Administrator or its designee will perform the reconsideration review. The Claims Administrator or its designee will review the information initially received and any additional information provided by the Covered Person, and determine if the pre-notification determination was appropriate. If the adverse pre-notification determination was based upon the medical necessity, the Experimental/ Investigational nature of the treatment, service or supply or an equivalent exclusion, the Plan may consult with a health care professional who has the appropriate training and experience in the applicable field of medicine. Written or electronic notice of the determination upon reconsideration will be provided within thirty (30) days of the receipt of the request for reconsideration.

CASE MANAGEMENT

If a Covered Person has an ongoing medical condition or catastrophic illness, a Case Manager may be assigned to monitor this Covered Person, and to work with the attending Physician and Covered Person to design a treatment plan and coordinate appropriate Medically Necessary care. The Case Manager will consult with the Covered Person, the family, and the attending Physician in order to assist in coordinating the plan of care approved by the Covered Person's attending Physician and the Covered Person.

This plan of care may include some or all of the following:

- Individualized support to the patient;
- Contacting the family to offer assistance for coordination of medical care needs;
- Monitoring response to treatment;
- Evaluating outcomes; and
- Assisting in obtaining any necessary equipment and services.

Case Management is not a requirement of the Plan. There are no reductions of benefits or penalties if the Covered Person and family choose not to participate.

Each treatment plan is individualized to a specific Covered Person and is not appropriate or recommended for any other patient, even one with the same diagnosis. All treatment and care decisions will be the sole determination of the Covered Person and the attending Physician.

MATERNITY MANAGEMENT PROGRAM

Maternity Management Program is an educational and empowerment program for eligible female Employees, Dependent Spouses and Dependent daughters.

This program provides a means to positively affect a Pregnancy and the health of the baby.

A CareLink nurse will set up a confidential, personal telephone interview to identify medical history and lifestyles that could have an impact on the outcome of the Pregnancy.

A CareLink nurse is available to assist and coordinate high risk aspects of maternity care. This includes providing information such as access to educational programs and community resources designed to meet the needs identified by the patient or Physician.

Notification Requirements: The Covered Person needs to notify CareLink by the end of the second trimester of her Pregnancy.

CARELINK ADVANCED PROGRAM

CareLink Advanced is a health service provided by a team of health care professionals who will help a Covered Person *with significant healthcare needs* “navigate” the health care system in order to provide health education and guidance in accomplishing the Covered Person’s individual health goals.

Eligibility for CareLink Advanced is determined through risk analysis and members eligible for the program are notified by the CareLink Advanced healthcare team.

For Covered Persons with significant healthcare needs who are invited to enroll and participate in the CareLink Advanced Service, any applicable Office Visit co-payment when rendered through a Participating Provider will be waived during the time period the Covered Person is enrolled and participating in this program.

A CareLink Advanced nurse will contact those Covered Persons with significant healthcare needs in order to explain the benefits and services of this program.

DEFINED TERMS

The following terms have special meanings and when used in this Plan will be capitalized.

Active Employee is an Employee who is on the regular payroll of the Employer and who has begun to perform the duties of his or her job with the Employer on a full-time basis.

Allowable Charge means the charge for a treatment, service, or supply that is the lesser of: 1) the charge made by the provider that furnished the care, service, or supply; 2) the negotiated amount established by a discounting or negotiated arrangement other than the Aetna network; 3) the reasonable and customary charge for the same treatment, service, or supply furnished in the same geographic area by a provider of like service as further described below; or 4) an amount equivalent to the following:

- For specialty drugs, 130% of the average sales price;
- For inpatient or outpatient facility claims, an amount equivalent to 200% of the Medicare equivalent allowable.

The reasonable and customary charge shall mean an amount equivalent to the 90th percentile of a commercially available database, or such other cost or quality-based reimbursement methodologies as may be available and adopted by the Plan. If there are insufficient charges submitted for a given procedure, the Plan will determine an Allowable Charge based upon charges made for similar services. Determination of the reasonable and customary charge will consider the nature and severity of the condition being treated, medical complications or unusual circumstances that require more time, skill or experience, and the cost and quality data for that provider.

For Covered Charges rendered by a Physician, Hospital or Ancillary Provider in a geographic area where applicable law dictates the maximum amount that can be billed by the rendering provider, the Allowable Charge shall mean the amount established by applicable law for that Covered Charge.

For Covered Charges rendered by a Physician, Hospital, or Ancillary Provider that is a contracted provider with the Aetna network, the negotiated rate of that preferred provider arrangement shall be the Allowable Charge.

The Plan Administrator or its designee has the *ultimate discretionary authority* to determine an Allowable Charge, including establishing the negotiated terms of a provider arrangement as the Allowable Charge even if such negotiated terms do not satisfy the lesser of test described above.

Ambulatory Surgical Center is a licensed facility that is used mainly for performing outpatient surgery, has a staff of Physicians, has continuous Physician and nursing care by registered nurses (R.N.s) and does not provide for overnight stays.

Birthing Center means any freestanding health facility, place, professional office or institution which is not a Hospital or in a Hospital, where births occur in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the facility is located.

The Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a Physician and either a registered nurse (R.N.) or a licensed nurse-midwife; and have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement.

Calendar Year means January 1st through December 31st of the same year.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Covered Charge(s) means those Medically Necessary services or supplies that are covered under this Plan.

Covered Person is an Employee, a pre-Medicare eligible Retiree or a Dependent who is covered under this Plan.

Credited Service as defined under the El Paso County Retirement Plan Plan Document (as amended).

Custodial Care is care (including Room and Board needed to provide that care) that is given principally for personal hygiene or for assistance in daily activities and can, according to generally accepted medical standards, be performed by persons who have no medical training. Examples of Custodial Care are help in walking and getting out of bed; assistance in bathing, dressing, feeding; or supervision over medication which could normally be self-administered.

Durable Medical Equipment means equipment which (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) generally is not useful to a person in the absence of an Illness or Injury and (d) is appropriate for use in the home.

Employee means a person who is an Active, regular Employee of the Employer, regularly scheduled to work for the Employer in an Employee/Employer relationship.

The term "Employee" does not include Employees who are part-time, temporary, or seasonal, or who are expected to work less than 30 hours per week for the Employer.

Please refer to the Eligibility, Funding, Effective Date and Termination Provisions section of this Plan for detailed requirements for Employee coverage.

Employer is El Paso County.

Enrollment Date is the first day of coverage or, if there is a Waiting Period, the first day of the Waiting Period.

Experimental and/or Investigational means services, supplies, care and/or treatment which does not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical and dental community or government oversight agencies at the time services were rendered.

The Plan Administrator or its designee must make an independent evaluation of the experimental/non-experimental standings of specific technologies. The Plan Administrator or its designee may request specific documentation, including but not limited to the covered person's plan of care, treatment protocol and/or informed consent. The Plan Administrator or its designee shall be guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The decision of the Plan Administrator or its designee will be final and binding on the Plan. The Plan Administrator or its designee will be guided by the following principles:

- (1) If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or
- (2) If the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or
- (3) Except as otherwise stated below for cancer treatment, if Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research experimental, study or investigational arm of an on-going phase III clinical trial, or is otherwise 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) If Reliable Evidence shows that the drug, device, medical treatment or procedure is under study, prior to or in the absence of any clinical trial, 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

- (5) If Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary 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.

Reliable Evidence shall mean 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, service, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

For purposes of this Plan, routine patient services for cancer clinical trials are a Covered Charge as specifically stated as a benefit under this Plan.

Drugs are considered Experimental if they are not commercially available for purchase and/or they are not approved by the Food and Drug Administration for general use.

Family Unit is the covered Employee and the family members who are covered as Dependents under the Plan.

Home Health Care Agency is an organization that meets all of these tests: its main function is to provide Home Health Care Services and Supplies; it is federally certified as a Home Health Care Agency; and it is licensed by the state in which it is located, if licensing is required.

Home Health Care Plan must meet these tests: it must be a formal written plan made by the patient's attending Physician which is reviewed at least every 30 days; it must state the diagnosis; it must certify that the Home Health Care is in place of Hospital confinement; and it must specify the type and extent of Home Health Care required for the treatment of the patient.

Home Health Care Services and Supplies include: part-time or intermittent nursing care by or under the supervision of a registered nurse (R.N.); part-time or intermittent home health aide services provided through a Home Health Care Agency (this does not include general housekeeping services); physical, occupational and speech therapy; medical supplies; and laboratory services by or on behalf of the Hospital.

Hospice Agency is an organization where its main function is to provide Hospice Care Services and Supplies and it is licensed by the state in which it is located, if licensing is required.

Hospice Care Plan is a plan of terminal patient care that is established and conducted by a Hospice Agency and supervised by a Physician.

Hospice Care Services and Supplies are those provided through a Hospice Agency and under a Hospice Care Plan and include inpatient care in a Hospice Unit or other licensed facility, home care, and family counseling during the bereavement period.

Hospice Unit is a facility or separate Hospital Unit that provides treatment under a Hospice Care Plan and admits at least two unrelated persons who are expected to die within six months.

Hospital is an institution that is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and that fully meets these tests: it is approved by Medicare as a Hospital; it maintains diagnostic and therapeutic facilities on the premises for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of Physicians; it continuously provides on the premises 24-hour nursing services by or under the supervision of registered nurses (R.N.s); and it is operated continuously with organized facilities for operative surgery on the premises.

The definition of "Hospital" shall be expanded to include the following:

- A facility operating legally as a psychiatric Hospital or residential treatment facility for mental health and licensed as such by the state in which the facility operates.

- A facility operating primarily for the treatment of Substance Abuse if it has received accreditation from the Commission of Accreditation of Rehabilitation Facilities (CARF) or The Joint Commission (TJC) or if it meets these tests: maintains permanent and full-time facilities for bed care and full-time confinement of at least 15 resident patients; has a Physician in regular attendance; continuously provides 24-hour nursing service by a registered nurse (R.N.); has a full-time psychiatrist or psychologist on the staff; and is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of Substance Abuse.

Illness means a bodily disorder, disease, physical sickness or Mental Disorder. Illness includes Pregnancy, childbirth, miscarriage or complications of Pregnancy.

Injury means an accidental physical Injury to the body caused by unexpected external means.

Intensive Care Unit is defined as a separate, clearly designated service area which is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a "coronary care unit" or an "acute care unit." It has: facilities for special nursing care not available in regular rooms and wards of the Hospital; special life saving equipment which is immediately available at all times; at least two beds for the accommodation of the critically ill; and at least one registered nurse (R.N.) in continuous and constant attendance 24 hours a day.

Late Enrollee means a Plan Participant who enrolls under the Plan other than during the first 31-day period in which the individual is eligible to enroll under the Plan or during a Special Enrollment Period.

Medical Care Facility means a Hospital, a facility that treats one or more specific ailments or any type of Skilled Nursing Facility.

Medical Emergency means a sudden onset of a condition with acute symptoms requiring immediate medical care and includes such conditions as heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions or other such acute medical conditions.

Medical Non-Emergency Care means care which can safely and adequately be provided other than in a Hospital.

Medically Necessary care and treatment is recommended or approved by a Physician; is consistent with the patient's condition or accepted standards of good medical practice; is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of the patient or provider of medical services; and is the most appropriate level of services which can be safely provided to the patient.

All of these criteria must be met; merely because a Physician recommends or approves certain care does not mean that it is Medically Necessary.

The Plan Administrator or its designee has the discretionary authority to decide whether care or treatment is Medically Necessary.

Medicare is the Health Insurance For The Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

Mental Disorder means any disease or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

Morbid Obesity is a serious disease associated with a high incidence of medical complications and a significantly shortened life span. The current clinical standard measure for Morbid Obesity is a Body Mass Index (BMI) of 40+. The BMI is a factor produced by dividing a person's weight (in kilograms) by his or her height squared (in meters).

No-Fault Auto Insurance is the basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.

Outpatient Care and/or Services is treatment including services, supplies and medicines provided and used at a Hospital under the direction of a Physician to a person not admitted as a registered bed patient; or services rendered in a Physician's office, laboratory or X-ray facility, an Ambulatory Surgical Center, or the patient's home.

Physician means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Audiologist, Certified Nurse Anesthetist, Licensed Professional Counselor, Licensed Professional Physical Therapist, Master of Social Work (M.S.W.), Midwife, Occupational Therapist, Physiotherapist, Psychiatrist, Psychologist (Ph.D.), Speech Language Pathologist and any other practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license.

Plan means El Paso County, which is a benefits plan for certain Employees of El Paso County and is described in this document.

Plan Participant is any Employee, pre-Medicare eligible Retiree or Dependent who is covered under this Plan.

Plan Year is the 12-month period beginning on January 1st and ending December 31st.

Pregnancy is childbirth and conditions associated with Pregnancy, including complications.

Prescription Drug means any of the following: a Food and Drug Administration-approved drug or medicine which, under federal law, is required to bear the legend: "Caution: federal law prohibits dispensing without prescription"; injectable insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician. Such drug must be Medically Necessary in the treatment of a Sickness or Injury.

Sickness is a person's Illness, disease or Pregnancy (including complications).

Skilled Nursing Facility is a facility that fully meets all of these tests:

- (1) It is licensed to provide professional nursing services on an inpatient basis to persons convalescing from Injury or Sickness. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided.
- (2) Its services are provided for compensation and under the full-time supervision of a Physician.
- (3) It provides 24 hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse.
- (4) It maintains a complete medical record on each patient.
- (5) It has an effective utilization review plan.
- (6) It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mentally disabled, Custodial or educational care or care of Mental Disorders.
- (7) It is approved and licensed by Medicare.

This term also applies to charges incurred in a facility referring to itself as an extended care facility, convalescent nursing home, rehabilitation hospital, long-term acute care facility or any other similar nomenclature.

Spinal Manipulation/Chiropractic Care means skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a Physician to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

Substance Abuse is regular excessive compulsive drinking of alcohol and/or physical habitual dependence on drugs. This does not include dependence on tobacco and ordinary caffeine-containing drinks.

Temporomandibular Joint (TMJ) syndrome is the treatment of jaw joint disorders including conditions of structures linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the temporomandibular joint.

Total Disability (Totally Disabled) means: In the case of a Dependent child, the complete inability as a result of Injury or Sickness to perform the normal activities of a person of like age and sex in good health.

PLAN EXCLUSIONS

For all Medical Benefits shown in the Schedule of Benefits, a charge for the following is not covered:

- (1) **Abortion.** Services, supplies, care or treatment in connection with an abortion unless the life of the mother is endangered by the continued Pregnancy or the Pregnancy is the result of rape or incest.
- (2) **Acupuncture.** Care, treatment, services and supplies in connection with acupuncture or acupressure.
- (3) **Biologicals.** The cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
- (4) **Clinical indication.** Regardless of clinical indication charges for blepharoplasty; rhinoplasty; dance therapy; movement therapy; applied kinesiology; rolfing; prolotherapy; and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
- (5) **Coding Guidelines.** Charges for inappropriate coding in accordance to the industry standard guidelines in effect at the time services were received.
- (6) **Complications of non-covered treatments.** Care, services or treatment required as a result of complications from a treatment not covered under the Plan are not covered.
- (7) **Cosmetics.** Cosmetics, dietary supplements and health and beauty aids.
- (8) **Cosmetic surgery.** Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem to treat psychological symptomatology or psychosocial complaints related to one's appearance.
- (9) **Counseling.** Care and treatment for marital, pre-marital counseling, educational, vocational, religious, or occupational counseling.
- (10) **Custodial care.** Services or supplies provided mainly as a rest cure, maintenance or Custodial Care, except as specifically stated as a benefit under this Plan.
- (11) **Dental care.** Care, treatment, services and supplies for treatment of the teeth or dental care, except as specifically stated as a benefit under this Plan for dental injuries.
- (12) **Dental implants.** Dental implants for any condition.
- (13) **Devices.** Aids and devices that assist with nonverbal communication, including but not limited to communication boards, prerecorded speech devices, computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
- (14) **Educational or vocational testing.** Services for educational or vocational testing or training, except as specifically stated as a benefit under this Plan.
- (15) **Excess charges.** The part of an expense for care and treatment of an Injury or Sickness that is in excess of the Allowable Charge.
- (16) **Exercise programs.** Exercise programs, health clubs, or weight loss programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, occupational or physical therapy covered by this Plan.
- (17) **Experimental or not Medically Necessary.** Care and treatment that is either Experimental / Investigational or not Medically Necessary.

- (18) **Eye care.** Radial keratotomy or other eye surgery to correct refractive disorders. Also, routine eye examinations, including refractions, lenses for the eyes and exams for their fitting. This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages.
- (19) **Foot care.** Treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions (except open cutting operations), and treatment of corns, calluses or toenails (unless needed in treatment of a metabolic or peripheral-vascular disease) or except as otherwise deemed Medically Necessary.
- (20) **Foreign travel.** Care, treatment or supplies out of the U.S. if travel is for the sole purpose of obtaining medical services.
- (21) **Government coverage.** Care, treatment or supplies furnished by a program or agency funded by any government. This does not apply to Medicaid or when otherwise prohibited by law.
- (22) **Hair loss.** Care and treatment for hair loss including hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician. Wigs, when deemed Medically Necessary, will only be payable as stated as a benefit under this Plan.
- (23) **Hearing aids and exams.** Charges for services or supplies in connection with hearing aids or exams for their fitting.
- (24) **Homeopathy.** Care, treatment, services and supplies in connection with homeopathic medicine.
- (25) **Hospital employees.** Professional services billed by a Physician or nurse who is an employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service.
- (26) **Illegal acts.** Charges for services received as a result of an Illness or Injury occurring directly, or indirectly as a result of a serious criminal act, or a riot or public disturbance, or regardless of causation, if such Illness or Injury occurs in connection with, or while engaged in, or attempting to engage in, a serious criminal act, or a riot or public disturbance. For the purposes of this exclusion, the term "serious criminal act" shall mean any act or series of acts by the Plan Participant, or by the Plan Participant in concert with another or others, for which, if prosecuted as a criminal offense, a sentence to a term of imprisonment in excess of one year could be imposed. For this exclusion to apply, it is not necessary that criminal charges be filed, or if filed, that a conviction result, or that a sentence of imprisonment for a term in excess of one year be imposed. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

Charges for services, supplies, care or treatment to a Plan Participant for an Injury or Illness which occurred as a result of that Plan Participant operating a motor vehicle while under the influence of alcohol or drugs or a combination thereof or operating a motor vehicle with a blood or breath alcohol content (BAC) above the legal limit. The arresting officer's determination of inebriation will be sufficient for this exclusion. It is not necessary for this exclusion to apply that criminal charges be filed, or if filed, that a conviction result. Expenses will be covered for injured Plan Participants other than the person operating the vehicle while under the influence or a BAC above the legal limit, and expenses may be covered for chemical dependency treatment as specified in this Plan. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

- (27) **Impotence.** Charges for treatment of erectile or sexual dysfunction, except as specifically stated as a benefit under this Plan.
- (28) **Infertility.** Care, supplies, services and treatment for infertility, artificial insemination, or in vitro fertilization. *Treatment for an underlying medical condition will be covered only up to the point an infertility condition is diagnosed and will be payable per normal Plan provisions.*
- (29) **Mailing or Sales Tax.** Charges for mailing, shipping, handling, conveyance and sales tax.

- (30) **Massage therapy.** Care, services, supplies and treatment in connection with massage therapy.
- (31) **Medical supplies.** Consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to, bandages and other disposable medical supplies, skin preparations, diabetic supplies (including test strips, alcohol swabs, syringes, lancets) except as deemed Medically Necessary in connection with Home Health Services or the Reconstructive Surgery benefits under this Plan.
- (32) **Naturopath.** Care, treatment, services and supplies in connection with naturopathic medicine.
- (33) **No charge.** Care and treatment for which there would not have been a charge if no coverage had been in force.
- (34) **Non-emergency Hospital admissions.** Care and treatment billed by a Hospital for non-Medical Emergency admissions on a Friday or a Saturday. This does not apply if surgery is performed within 24 hours of admission.
- (35) **Non-Participating Provider.** Medical treatment when payment is denied because treatment was received from a Non-Participating Provider, except as specifically stated as a benefit under this Plan.
- (36) **No obligation to pay.** Charges incurred for which the Plan has no legal obligation to pay.
- (37) **No Physician recommendation.** Care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the Covered Person is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the Injury or Sickness.
- (38) **Not specified as covered.** Non-traditional medical services, treatments and supplies which are not specified as covered under this Plan.
- (39) **Nutritional supplements** and formula except for infant formula needed for the treatment of inborn errors of metabolism.
- (40) **Obesity.** Care and treatment of obesity, weight loss or dietary control whether or not it is, in any case, a part of the treatment plan for another Sickness, except as specifically stated as a benefit under this Plan.
- (41) **Occupational Injury.** Care and treatment of an Injury or Sickness that is occupational – that is, arises from work for wage or profit including self-employment. This exclusion applies even though the Plan Participant:
 - (a) Has waived his/her rights to Workers' Compensation benefits;
 - (b) Was eligible for Workers' Compensation benefits and failed to properly file a claim for such benefits; or
 - (c) The Plan Participant is permitted to elect not to be covered under Workers' Compensation and has affirmatively made that election.
- (42) **Personal comfort items.** Personal comfort items, patient convenience items, or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, nonprescription drugs and medicines, and first-aid supplies and nonhospital adjustable beds.
- (43) **Plan design excludes.** Charges excluded by the Plan design as mentioned in this document.

- (44) **Prescription Drugs.** All noninjectable Prescription Drugs, injectable Prescription Drugs that do not require a Physician's supervision (i.e., self-administered drugs), non-Prescription Drugs, and Prescription Drugs considered Experimental / Investigational, except as specifically stated as a benefit under this Plan.
- (45) **Psychological testing.** Charges for psychological testing requested by or for a school system.
- (46) **Relative giving services.** Professional services performed by a person who ordinarily resides in the Covered Person's home or is related to the Covered Person as a Spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.
- (47) **Replacement braces.** Replacement of braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the Covered Person's physical condition to make the original device no longer functional.
- (48) **Reports.** Charges for reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court-ordered, forensic or custodial evaluations.
- (49) **Routine care.** Charges for routine or periodic examinations, screening examinations, evaluation procedures, preventive medical care, or treatment or services not directly related to the diagnosis or treatment of a specific Injury, Sickness or Pregnancy-related condition which is known or reasonably suspected, unless such care is specifically covered in the Schedule of Benefits.
- (50) **Services before or after coverage.** Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan or after coverage ceased under this Plan.
- (51) **Sleep disorders.** Care and treatment for sleep disorders unless deemed Medically Necessary.
- (52) **Smoking cessation.** Care and treatment for smoking cessation programs, including smoking deterrent products.
- (53) **Surgical sterilization reversal.** Care and treatment for reversal of surgical sterilization.
- (54) **Telephone.** Telephone, e-mail, Internet consultations and telemedicine.
- (55) **Travel or accommodations.** Charges for travel or accommodations, whether or not recommended by a Physician, except as specifically stated as a benefit under this Plan.
- (56) **War.** Any loss that is due to a declared or undeclared act of war.

HOW TO SUBMIT A CLAIM

When services are received from a health care provider, a Plan Participant should show his or her **EBMS/El Paso County Government** identification card to the provider. Preferred Providers may submit claims on a Plan Participant's behalf.

If it is necessary for a Plan Participant to submit a claim, he or she should request an itemized bill which includes procedure (CPT) and diagnostic (ICD) codes from his or her health care provider.

To assist the Claims Administrator in processing the claim, the following information must be provided when submitting the claim for processing:

- A copy of the itemized bill
- Group name and number (**El Paso County Government, Group #0000286**)
- Provider Billing Identification Number
- Employee's name and Identification Number
- Name of patient
- Name, address, telephone number of the provider of care
- Date of service(s)
- Place of service
- Amount billed

Note: A Plan Participant can obtain a claim form from the Claims Administrator. Claim forms are also available at <http://www.ebms.com>.

WHERE TO SUBMIT CLAIMS

Employee Benefit Management Services, Inc., is the Claims Administrator. Claims for expenses should be submitted to the Claims Administrator at the address below:

Employee Benefit Management Services, Inc.
P.O. Box 21367
Billings, Montana 59104
(406) 245-3575 or (800) 777-3575

WHEN CLAIMS SHOULD BE FILED

Claims should be received by the Claims Administrator within *365 days* from the date charges for the services were incurred. Benefits are based on the Plan's provisions in effect at the time the charges were incurred. Claims received later than that date will be denied.

The Plan Participant must provide sufficient documentation (as determined by the Claims Administrator) to support a Claim for benefits. The Plan reserves the right to have a Plan Participant seek a second medical opinion.

CLAIMS REVIEW PROCEDURES

A **Claim** means a request for a Plan benefit, made by a Claimant (Plan Participant or by an authorized representative of a Plan Participant that complies with the Plan's reasonable procedures for filing benefit Claims). A Claim does not include an inquiry on a Claimant's eligibility for benefits, or a request by a Claimant or his Physician for a pre-notification of benefits on a medical treatment. Pre-notification of certain services is strongly recommended, but not required by the Plan. A pre-notification of services by CareLink is not a determination by the Plan that a Claim will be paid. A benefit determination on a Claim will be made only after the Claim has been submitted. A pre-notification is not required as a condition precedent to paying benefits, and cannot be appealed under this section. Please refer to the Care Management Services section.

A Claimant may appoint an authorized representative to act upon his or her behalf with respect to the Claim. Only those individuals who satisfy the Plan's requirements to be an authorized representative will be considered an authorized representative. A healthcare provider is not an authorized representative simply by virtue of an assignment of benefits. Contact the Claims Administrator for information on the Plan's procedures for authorized representatives.

There are two types of claims:

Concurrent Care Determination

A **Concurrent Care Determination** is a reduction or termination of a previously approved course of treatment that is to be provided over a period of time or for a previously approved number of treatments. *If Case Management is appropriate for a Plan Participant, Case Management is not considered a Concurrent Care Determination. Please refer to the Care Management Services section.*

Post-Service Claim

A **Post-Service Claim** is a Claim for medical care, treatment, or services that a Claimant has already received.

All questions regarding Claims should be directed to the Claims Administrator. All Claims will be considered for payment according to the Plan's terms and conditions, limitations and exclusions, and industry standard guidelines in effect at the time charges were incurred. The Plan may, when appropriate or when required by law, consult with relevant health care professionals and access professional industry resources in making decisions about Claims involving specialized medical knowledge or judgment.

A Claim will not be deemed submitted until it is received by the Claims Administrator.

Initial Benefit Determination

The initial benefit determination on a Claim will be made within 30 days of the Claim Administrator's receipt of the Claim (or 15 days if the Claim is a Concurrent Care Determination). If additional information is necessary to process the Claim, the Claims Administrator will make a written request to the Claimant for the additional information within this initial period. The Claimant must submit the requested information within 45 days of receipt of the request from the Claims Administrator. **Failure to submit the requested information within the 45-day period may result in a denial of the Claim or a reduction in benefits.** If additional information is requested, the Plan's time period for making a determination is suspended until such time as the Claimant provides the information, or the end of the 45 day period, whichever occurs earlier. A benefit determination on the Claim will be made within 15 days of the Plan's receipt of the additional information.

Notice of Adverse Benefit Determination

If a Claim is denied in whole or in part, the Plan shall provide written or electronic notice of the determination that will include the following:

- (1) Information to identify the claim involved.
- (2) Specific reason(s) for the denial, including the denial code and its meaning.
- (3) Reference to the specific Plan provisions on which the denial was based.
- (4) Description of any additional information necessary for the Claimant to perfect the Claim and an explanation of why such information is necessary.
- (5) Description of the Plan's Claims Review Procedure and the applicable time limits. This will include a statement of the Claimant's right to bring a civil action once Claimant has exhausted all available review procedures.
- (6) Statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

If applicable:

- (7) Any internal rule, guideline, protocol, or other similar criterion that was relied upon in making the determination on the Claim.
- (8) If the Adverse Benefit Determination is based on the Medical Necessity or Experimental or Investigational exclusion or similar such exclusion, an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to the Claim.
- (9) Identification of medical or vocational experts, whose advice was obtained on behalf of the Plan in connection with a Claim.

If the Claimant has questions about the denial, the Claimant may contact the Claims Administrator at the address or telephone number printed on the Notice of Determination.

An Adverse Benefit Determination also includes a rescission of coverage, which is a retroactive cancellation or discontinuance of coverage due to fraud or intentional misrepresentation. A rescission of coverage does not include a cancellation or discontinuance of coverage that takes effect prospectively, or is a retroactive cancellation or discontinuance because of the Plan Participant's failure to timely pay required premiums.

Claims Review Procedure - General

A Claimant may appeal an Adverse Benefit Determination. The Plan offers a two-level internal review procedure to provide the Claimant with a full and fair review of the Adverse Benefit Determination.

The Plan will provide for a review that does not give deference to the previous Adverse Benefit Determination and that is conducted by an individual who is neither the individual who made the determination on a prior level of review, nor a subordinate of that individual. In addition, the Claims Administrator may:

- Take into account all comments, documents, records and other information submitted by the Claimant related to the claim, without regard as to whether this information was submitted or considered in a prior level of review.
- Provide to the Claimant, free of charge, any new or additional information or rationale considered, relied upon or created by the Plan in connection with the Claim. This information or new rationale will be provided sufficiently in advance of the response deadline for the final Adverse Benefit Determination so that the Claimant has a reasonable amount of time to respond.
- Consult with an independent health care professional who has the appropriate training and experience in the applicable field of medicine related to the Claimant's Adverse Benefit Determination if that determination was based in whole or in part on medical judgment, including determinations on whether a treatment, drug, or other item is Experimental and/or Investigational, or not Medically Necessary. A health care professional is "independent" to the extent the health care professional was not consulted on a prior level of review or is a subordinate of a health care professional who was consulted on a prior level of review. The Plan may consult with vocational or other experts regarding the Initial Benefit Determination.

Internal Appeal Procedure

First Level of Review

The written request for review must be submitted within 180 days of the Claimant's receipt of a Notice of the Initial Benefit Determination (or 15 days for an appeal of a Concurrent Care Determination). The Claimant should include in the appeal letter: his or her name, ID number, group health plan name, and a statement of why the Claimant disagrees with the Adverse Benefit Determination. The Claimant may include any additional supporting information,

even if not initially submitted with the Claim. The appeal should be addressed to:

Claims Administrator
% Employee Benefit Management Services, Inc. (EBMS)
P.O. Box 21367
Billings, Montana 59104
Attn: Claims Appeals

An appeal will not be deemed submitted until it is received by the Claims Administrator. The Claimant cannot proceed to the next level of internal review if the Claimant fails to submit a timely appeal.

The first level of review will be performed by the Claims Administrator on the Plan's behalf. The Claims Administrator will review the information initially received and any additional information provided by the Claimant, and determine if the Initial Benefit Determination was appropriate based upon the terms and conditions of the Plan and other relevant information. The Claims Administrator will send a written or electronic Notice of Determination to the Claimant within 30 days of the receipt of the appeal (or 15 days for an appeal of a Concurrent Care Determination). The Notice of Determination shall meet the requirements as stated above.

Second Level of Review

If the Claimant does not agree with the Claims Administrator's determination from the first Level of Review, the Claimant may submit a second level appeal in writing within 60 days of the Claimant's receipt of the Notice of Determination from the First Level of Review (or 15 days for an appeal of a Concurrent Care Determination), along with any additional supporting information to:

Claims Administrator
% Employee Benefit Management Services, Inc. (EBMS)
P.O. Box 21367
Billings, Montana 59104
Attn: Claims Appeals

An appeal will not be deemed submitted until it is received by the Claims Administrator on the Plan Administrator's behalf. The Claimant cannot file suit if the Claimant fails to submit a timely appeal.

The Second Level of Review will be done by the Claims Administrator. The Claims Administrator will review the information initially received and any additional information provided by the Claimant, and make a determination on the appeal based upon the terms and conditions of the Plan and other relevant information. The Claims Administrator will send a written or electronic Notice of Determination for the second level of review to the Claimant within 30 days of receipt of the appeal (or 15 days for an appeal of a Concurrent Care Determination). The Notice of Determination shall meet the requirements as stated above.

Before filing a lawsuit, the Claimant must exhaust all available levels of review as described in this section, unless an exception under applicable law applies. A legal action to obtain benefits must be commenced within one (1) year of the date of the Notice of Determination on the final level of review, whichever is applicable.

COORDINATION OF BENEFITS

Coordination of the benefit plans. The Plan's Coordination of Benefits provision sets forth rules for the order of payment of Covered Charges when two or more plans – including Medicare – are paying. The Plan has adopted the order of benefits as set forth in the National Association of Insurance Commissioners (NAIC) Model COB Regulations, as amended. When a Covered Person is covered by this Plan and another plan, or the Covered Person's Spouse is covered by this Plan and by another plan, or the couple's covered children are covered under two or more plans the plans will coordinate benefits when a claim is received.

The plan that pays first according to the rules will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance due up to 100% of the total Allowable Charges.

Benefit plan. This provision will coordinate the medical and dental benefits of a benefit plan. The term benefit plan means this Plan or any one of the following plans:

- (1) Group or nongroup insurance contracts and subscriber contracts;
- (2) Uninsured arrangements of group or group-type coverage;
- (3) Group and nongroup coverage through closed panel plans;
- (4) Group-type contracts;
- (5) The medical components of long-term care contracts, such as skilled nursing care;
- (6) Medicare or other government benefits, as permitted by law. This does not include Medicaid, or a government plan that by law, provides benefits that are in excess of those of any private insurance plan or other non-governmental plan;
- (7) The medical benefits coverage in automobile "no-fault" and traditional automobile "fault" type contracts;
- (8) Any third-party source, including but not limited to, automobile or homeowners liability insurance, umbrella insurance and premises liability insurance, whether individual or commercial, or on an insured, uninsured, under-insured or self-insured basis.

The term benefit plan does not include hospital indemnity, accident only, specified disease, school accident or non-medical long-term care coverage.

Allowable Charge(s). For a charge to be allowable it must be a usual, customary, and reasonable charge and at least part of it must be covered under this Plan. (See "Allowable Charge" in the Defined Terms section.)

In the case of HMO (Health Maintenance Organization) or other in-network only plans: This Plan will not consider any charges in excess of what an HMO or network provider has agreed to accept as payment in full. Also, when an HMO or network plan is primary and the Covered Person does not use an HMO or network provider, this Plan will not consider as an Allowable Charge any charge that would have been covered by the HMO or network plan had the Covered Person used the services of an HMO or network provider.

In the case of service type plans where services are provided as benefits, the reasonable cash value of each service will be the Allowable Charge.

Automobile limitations. When any medical benefits coverage is available under vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan deductibles.

Benefit plan payment order. When two or more plans provide benefits for the same Allowable Charge, benefit payment will follow these rules:

- (A) Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.
- (B) Plans with a coordination provision will pay their benefits up to the Allowable Charge. The first rule that describes which plan is primary is the rule that applies:
 - (1) The benefits of the plan which covers the person directly (that is, as a Member/Employee, Retiree, or subscriber) (“Plan A”) are determined before those of the plan which covers the person as a Dependent (“Plan B”).

For Qualified Beneficiaries, coordination is determined based on the person’s status prior to the Qualifying Event.

Special rule. If: (i) the person covered directly is a Medicare beneficiary, and (ii) Medicare is secondary to Plan B, and (iii) Medicare is primary to Plan A (for example, if the person is retired), THEN Plan B will pay first.

- (2) Unless there is a court decree stating otherwise for a Dependent child up to age 19, when a child is covered as a Dependent by more than one plan the order of benefits is determined as follows:

When a child is covered as a Dependent and the parents are married or living together, these rules will apply:

- The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year;
- If both parents have the same birthday, the benefits of the benefit plan which has covered the parent for the longer time are determined before those of the benefit plan which covers the other parent.

When a child’s parents are divorced, legally separated or not living together, whether or not they have ever been married, these rules will apply:

- A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the benefit plan of that parent will be considered before other plans that cover the child as a Dependent. If the financially responsible parent has no health care coverage for the Dependent child, but that parent’s spouse does, the plan of that parent’s spouse is the primary plan. This rule applies beginning the first of the month after the plan is given notice of the court decree.
- A court decree may state both parents will be responsible for the Dependent child’s health care expenses. In this case, the plans covering the child shall follow order of benefit determination rules outlined above when the parents are married or living together (as detailed above);
- If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a Dependent and the parents are married or living together.

If there is no court decree allocating responsibility for the Dependent child’s health care expenses, the order of benefits are as follows:

- 1st The plan covering the custodial parent,
- 2nd The plan covering the spouse of the custodial parent,
- 3rd The plan covering the non-custodial parent, and
- 4th The plan covering the spouse of the non-custodial parent.

When a child is covered as a Dependent under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined as if those individuals were parents of the child.

Unless specifically stated otherwise, court order and custody provisions apply up to age 19 for any Dependent child.

For a Dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, Rule (5) applies. If the Dependent child's coverage under the spouse's plan began on the same date as the Dependent child's coverage under either or both parents' plans, the birthday rule shall apply to the Dependent child's parents and the Dependent child's spouse.

- (3) The benefits of a benefit plan which covers a person as a Member/Employee who is neither laid off nor retired or as a Dependent of a Member/Employee who is neither laid off nor retired are determined before those of a plan which covers that person as a laid-off or Retired Member/Employee. This rule does not apply if Rule (1) can be used to determine the order of benefits. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.
 - (4) The benefits of a benefit plan which covers a person as a Member/Employee who is neither laid off nor retired or a Dependent of a Member/Employee who is neither laid off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary. This rule does not apply if Rule (1) can be used to determine the order of benefits.
 - (5) If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first. When there is a conflict in coordination of benefit rules, the Plan will never pay more than 50% of Allowable Charges when paying secondary.
- (C) Medicare will pay primary, secondary or last to the extent stated in federal law. When Medicare is to be the primary payer, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B, regardless of whether or not the person was enrolled under both of these parts. The Plan reserves the right to coordinate benefits with respect to Medicare Part D.
 - (D) If a Plan Participant is under a disability extension from a previous benefit plan, that benefit plan will pay first and this Plan will pay second.
 - (E) The Plan will pay primary to Tricare to the extent required by federal law.

Claims determination period. Benefits will be coordinated on a Calendar Year or Plan Year basis, as shown in the Schedule of Benefits section. This is called the claims determination period.

Right to receive or release necessary information. To make this provision work, this Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person. A Covered Person will give this Plan the information it asks for about other plans and their payment of Allowable Charges.

Facility of payment. This Plan may repay other plans for benefits paid that the Plan Administrator determines it should have paid. That repayment will count as a valid payment under this Plan.

Right of recovery. This Plan may pay benefits that should be paid by another benefit plan. In this case this Plan may recover the amount paid from the other benefit plan or the Covered Person. That repayment will count as a valid payment under the other benefit plan.

Further, this Plan may pay benefits that are later found to be greater than the Allowable Charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid.

Exception to Medicaid. The Plan shall not take into consideration the fact that an individual is eligible for or is provided medical assistance through Medicaid when enrolling an individual in the Plan or making a determination about the payments for benefits received by a Covered Person under the Plan.

THIRD PARTY RECOVERY PROVISION

Defined Terms

"Covered Person" means anyone covered under the Plan, including but not limited to minor dependents and deceased Covered Persons. Covered Person shall include the parents, trustee, guardian, heir, personal representative or other representative of a Covered Person, regardless of applicable law and whether or not such representative has access or control of the Recovery.

"Recover," "Recovered," "Recovery" means all monies recovered by way of judgment, settlement, reimbursement, or otherwise to compensate for any loss related to any Injury, Sickness, condition, and/or accident where a Third Party is or may be responsible. "Recovery" includes, but is not limited to, recoveries for medical or dental expenses, attorneys' fees, costs and expenses, pain and suffering, loss of consortium, wrongful death, wages and/or any other recovery of any form of damages or compensation whatsoever.

"Subrogation" means the Plan's right to exercise the Covered Person's rights to Recover or pursue Recovery from a Third Party who is liable to the Covered Person for expenses for which the Plan has paid or may agree to pay benefits.

"Third Party" means any third party including but not limited to another person, any business entity, insurance policy or any other policy or plan, including but not limited to uninsured or underinsured coverage, self-insured coverage, no-fault coverage, automobile coverage, premises liability (homeowners or business), umbrella policy.

Right to Reimbursement

This provision applies when the Covered Person incurs medical or dental expenses due to an Injury, Sickness, condition, and/or accident which may be caused by the act or omission of a Third Party or a Third Party may be responsible for payment. In such circumstances, the Covered Person may have a claim against a Third Party for payment of such expenses. To the extent the Plan paid benefits on the Covered Person's behalf, the Covered Person agrees that the Plan has an equitable lien on any Recovery whether or not such Recovery(s) is designated as payment for such expenses.

The Covered Person, and/or anyone on his or her behalf, agrees to hold in trust for the benefit of the Plan, that portion of any Recovery received or that may be received from a Third Party and to which the Plan is entitled for reimbursement of benefits paid by the Plan on the Covered Person's behalf. The Covered Person shall promptly reimburse the Plan out of such Recovery, in first priority for the full amount of the Plan's lien. The Covered Person will reimburse the Plan first, even if the Covered Person has not been fully compensated or "made whole" and/or the Recovery is called something other than a Recovery for healthcare, medical and/or dental expenses.

The Plan will not pay or be responsible for attorney fees and/or costs of recovery associated with a Covered Person pursuing a claim against a Third Party, unless the Plan agrees in writing to such a reduction in its equitable lien, is subject to a reduction by the terms of a court order, or is required to reduce its lien by applicable state law.

Right to Subrogation

This provision applies when the Covered Person incurs medical or dental expenses due to an Injury, Sickness, condition, and/or accident which may be caused by the act or omission of a Third Party or a Third Party may be responsible for payment. In such circumstances, the Covered Person may have a claim against a Third Party for payment of such expenses.

The Covered Person agrees that the Plan is subrogated to any and all claims, causes of action or rights that the Covered Person may have now or in the future against a Third Party who has or may have caused, contributed aggravated, and or be responsible for the Covered Person's Injury, Sickness, condition, and/or accident to the extent the Plan has paid benefits or has agreed to pay benefits.

The Covered Person further agrees that the Plan is subrogated to any and all claims or rights that the Covered Person may have against any Recovery, including the Covered Person's rights under the Plan to bring an action to clarify his rights under the Plan. The Plan may assert this Right of Subrogation independently of the Covered Person. The Plan is not obligated to pursue this right independently or on behalf of the Covered Person, but may choose to exercise this right, in its sole discretion.

Provisions Applicable to Both the Right to Reimbursement and Right to Subrogation

The Covered Person automatically assigns to the Plan, to the extent permissible by applicable state law, any and all rights he or she has or may have against any Third Party to the full extent of the Plan's equitable lien. The Covered Person agrees to:

- (a) Cooperate fully with the Plan and its agents, regarding the Plan's rights under this section;
- (b) Advise the Plan of any right or potential right to reimbursement and/or subrogation on the Plan's behalf;
- (c) Provide to the Plan in a timely manner any and all facts, documents, papers, information or other data reasonably related to the Covered Person's Injury, Sickness, condition, and/or accident, including any efforts by another individual to Recover on the Covered Person's behalf;
- (d) Execute all assignments, liens, or other documents that the Plan or its agents may request to protect the Plan's rights under this section;
- (e) Obtain the Plan's consent before releasing a Third Party from liability for payment of expenses related to the Covered Person's Injury, Sickness, condition, and/or accident;
- (f) Hold in trust that portion of any Recovery received by the Covered Person or on the Covered Person's behalf equal to the Plan's equitable lien;
- (g) Agree not to impair, impede or prejudice in any way, the rights of the Plan under this section; and
- (h) Do whatever else the Plan deems reasonably necessary to secure the Plan's rights under this section.

The Plan may take one or more of the following actions to enforce its rights under this section:

- (a) The Plan may require the Covered Person as a condition of paying benefits for the Covered Person's Injury, Sickness, condition, or accident, to execute documentation acknowledging the Plan's rights under this section;
- (b) The Plan may, to the extent of any benefits paid by the Plan, exercise its Right of Reimbursement against any Recovery received, or that will be received, by or on behalf of Covered Person; or
- (c) The Plan may, to the extent of any benefits paid by the Plan, exercise its Right of Subrogation directly against a Third Party who is or may be responsible.

The Plan Administrator is vested with full discretionary authority to interpret and apply the provisions of this section. In addition, the Plan Administrator is vested with the discretionary authority to waive or compromise any of the Plan's rights under this section. Any decision of the Plan Administrator made in good faith will be final and binding. The Plan Administrator is authorized to adopt such procedures as deemed necessary and appropriate to administrate the Plan's rights under this section.

COBRA CONTINUATION COVERAGE

Introduction

The right to COBRA Continuation Coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (“COBRA”). COBRA Continuation Coverage can become available to you and other members of your family when group health coverage would otherwise end. You should check with your Employer to see if COBRA applies to you and your Dependents.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse’s plan), even if that plan generally doesn’t accept late enrollees.

What is COBRA Continuation Coverage?

“COBRA Continuation Coverage” is a continuation of Plan coverage when coverage otherwise would end because of a life event known as a “Qualifying Event.” After a Qualifying Event, COBRA Continuation Coverage must be offered to each person who is a “Qualified Beneficiary.” You, your Spouse, and your Dependent children could become Qualified Beneficiaries if coverage under the Plan is lost because of the Qualifying Event. Under the Plan, Qualified Beneficiaries who elect COBRA Continuation Coverage must pay for COBRA Continuation Coverage. Life insurance, Accidental death and dismemberment benefits and weekly income or long-term disability benefits (if a part of your Employer’s plan) are not considered for continuation under COBRA. *A Domestic Partner is not a Qualified Beneficiary.*

If you are a covered Employee, you will become a Qualified Beneficiary if you lose your coverage under the Plan due to one of the following Qualifying Events:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

If you are the Spouse of a covered Employee, you will become a Qualified Beneficiary if you lose your coverage under the Plan due to one of the following Qualifying Events:

- Your Spouse dies;
- Your Spouse’s hours of employment are reduced;
- Your Spouse’s employment ends for any reason other than his or her gross misconduct;
- Your Spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your Spouse.

Note: Medicare entitlement means that you are eligible for and enrolled in Medicare.

Your Dependent children will become Qualified Beneficiaries if they lose coverage under the Plan due to one of the following Qualifying Events:

- The parent – covered Employee dies;
- The parent – covered Employee’s hours of employment are reduced;
- The parent – covered Employee’s employment ends for any reason other than his or her gross misconduct;
- The parent – covered Employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parent – covered Pre-Medicare Eligible Retiree becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child is no longer eligible for coverage under the plan as a “Dependent child.”

If this Plan provides retiree health coverage, 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 Employer, and that bankruptcy results in the loss of coverage of any retired Employee covered under the Plan, the retired Employee will become a Qualified Beneficiary with respect to the bankruptcy. The retired Employee's Spouse, surviving Spouse, and Dependent children also will become Qualified Beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA Continuation Coverage available?

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, reduction of hours of employment, death of the covered Employee, commencement of proceeding in bankruptcy with respect to the Employer, or the covered Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Plan Administrator must be notified of the Qualifying Event.

For all 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 within 60 days after the Qualifying Event occurs. You must provide this notice in writing to:

Plan Administrator

El Paso County Government
2880 International Circle
Colorado Springs, Colorado 80910
(719) 520-7420

Notice must be postmarked, if mailed, or dated, if emailed or hand-delivered on or before the 60th day following the Qualifying Event.

How is COBRA Continuation Coverage provided?

Once the Plan Administrator receives notice that a Qualifying Event has occurred, COBRA Continuation Coverage will be offered to each of the Qualified Beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA Continuation Coverage. Covered Employees may elect COBRA Continuation Coverage on behalf of their Spouses, and parents may elect COBRA Continuation Coverage on behalf of their children.

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

How long does COBRA Continuation Coverage last?

COBRA Continuation Coverage is a temporary continuation of coverage that generally last for 18 months due to the employment termination or reduction of hours of work. Certain Qualifying Events, or a second Qualifying Event during the initial period of coverage, may permit a Qualified Beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA Continuation Coverage can be extended, discussed below.

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

Medicare extension of COBRA Continuation Coverage

If you (as the covered Employee) become entitled to Medicare benefits, your Spouse and Dependents may be entitled

to an extension of the 18 month period of COBRA Continuation Coverage.

If you first become entitled to Medicare benefits, and later experience a termination or employment or a reduction of hours, then the maximum coverage period for Qualified Beneficiaries other than you ends on the later of (i) 36 months after the date you became entitled to Medicare benefits, and (ii) 18 months (or 29 months if there is a disability extension) after the date of the termination or reduction of hours. For example, if you become entitled to Medicare 8 months before the date on which your employment terminates, COBRA Continuation Coverage for your Spouse and Dependent children can last up to 36 months after the date of your Medicare entitlement.

If the first Qualifying Event is your termination of employment or a reduction of hours of employment, and you then became entitled to Medicare benefits less than 18 months after the first Qualifying Event, Qualified Beneficiaries other than you are not entitled to an extension of the 18 month period.

Disability extension of 18-month period of COBRA Continuation Coverage

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

Notice of the disability determination must be provided in writing to the Plan Administrator by the date that is 60 days after the latest of:

- The date of the disability determination by the SSA;
- The date on which a Qualifying Event occurs;
- The date on which the Qualified Beneficiary loses (or would lose) coverage under the Plan as a result of the Qualifying Event; or
- The date on which the Qualified Beneficiary is informed, through the furnishing of the Plan's Summary Plan Description of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Administrator.

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

The notice must include the name of the Qualified Beneficiary determined to be disabled by the SSA and the date of the determination. A copy of SSA's Notice of Award Letter must be provided within 30 days after the deadline to provide the notice.

You must provide this notice to:

Plan Administrator

El Paso County Government
2880 International Circle
Colorado Springs, Colorado 80910
(719) 520-7420

Second Qualifying Event extension of 18-month period of COBRA Continuation Coverage

If your family experiences another Qualifying Event while receiving 18 months of COBRA Continuation Coverage, the Spouse and Dependent children in your family can get up to 18 additional months of COBRA Continuation Coverage, for a maximum of 36 months, if the Plan Administrator is properly notified about the second Qualifying Event. This extension may be available to the Spouse and any Dependent children receiving COBRA Continuation Coverage if the covered Employee or former Employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the Dependent child stops being eligible under the Plan as a Dependent child. This extension is only available if the second Qualifying Event would have caused the Spouse or

Dependent child to lose coverage under the Plan had the first Qualifying Event not occurred.

Notice of a second Qualifying Event must be provided in writing to the Plan Administrator by the date that is 60 days after the latest of:

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

The notice must include the name of the Qualified Beneficiary experiencing the second Qualifying Event, a description of the event and the date of the event. If the extension of coverage is due to a divorce or legal separation, a copy of the decree of divorce or legal separation must be provided within 30 days after the deadline to provide the notice.

You must provide this notice to:

Plan Administrator

El Paso County Government
2880 International Circle
Colorado Springs, Colorado 80910
(719) 520-7420

Does COBRA Continuation Coverage ever end earlier than the maximum periods above?

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

- The date your Employer ceases to provide a group health plan to any Employee;
- The date on which coverage ceases by reason of the Qualified Beneficiary's failure to make timely payment of any required premium;
- The date that the Qualified Beneficiary first becomes, after the date of election, covered under any other group health plan (as an Employee or otherwise), or entitled to either Medicare Part A or Part B (whichever comes first), except as stated under COBRA's special bankruptcy rules;
- The first day of the month that begins more than 30 days after the date of the SSA's determination that the Qualified Beneficiary is no longer disabled, but in no event before the end of the maximum coverage period that applied without taking into consideration the disability extension; or
- On the same basis that the Plan can terminate for cause the coverage of a similarly situated non-COBRA participant.

How Do I Pay for COBRA Continuation Coverage?

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

Are There Other Coverage Options Besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA Continuation Coverage, there may be other coverage options for you and your

family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA Continuation Coverage. You can learn more about many of these options at www.healthcare.gov.

Additional Information

Additional information about the Plan and COBRA Continuation Coverage is available from the Plan Administrator or the COBRA Administrator:

Plan Administrator

El Paso County Government
2880 International Circle
Colorado Springs, Colorado 80910
(719) 520-7420

COBRA Administrator

Employee Benefit Management Services, Inc.
P.O. Box 21367
Billings, Montana 59104
(406) 245-3575 or (800) 777-3575

For more information about your rights under the Public Health Services Act, COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/agencies/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website). For more information about the Marketplace, visit www.HealthCare.gov.

Current Addresses

To protect your family's rights, let the Plan Administrator (who is identified above) know about 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.

RESPONSIBILITIES FOR PLAN ADMINISTRATION

PLAN ADMINISTRATOR. El Paso County is the benefit plan of El Paso County, the Plan Administrator, also called the Plan Sponsor. An individual may be appointed by El Paso County to be Plan Administrator and serve at the convenience of the Employer. If the Plan Administrator resigns, dies or is otherwise removed from the position, El Paso County shall appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Plan Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties.

DUTIES OF THE PLAN ADMINISTRATOR.

- (1) To administer the Plan in accordance with its terms.
- (2) To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.
- (3) To decide disputes which may arise relative to a Plan Participant's rights.
- (4) To prescribe procedures for filing a claim for benefits and to review claim denials.
- (5) To keep and maintain the Plan documents and all other records pertaining to the Plan.
- (6) To appoint a Claims Administrator to pay claims.
- (7) To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

PLAN ADMINISTRATOR COMPENSATION. The Plan Administrator serves **without** compensation; however, all expenses for plan administration, including compensation for hired services, will be paid by the Plan.

FUNDING THE PLAN AND PAYMENT OF BENEFITS

The cost of the Plan is funded as follows:

For Employee and Dependent Coverage: Funding is derived from the funds of the Employer and contributions made by the covered Employees.

The level of any Employee contributions will be set by the Plan Administrator. These Employee contributions will be used in funding the cost of the Plan as soon as practicable after they have been received from the Employee or withheld from the Employee's pay through payroll deduction.

Benefits are paid directly from the Plan through the Claims Administrator.

PLAN IS NOT AN EMPLOYMENT CONTRACT

The Plan is not to be construed as a contract for or of employment.

CLERICAL ERROR

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Plan Participant the amount of overpayment will be deducted from future benefits payable.

STANDARDS FOR PRIVACY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (THE "PRIVACY STANDARDS") ISSUED PURSUANT TO THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996, AS AMENDED (HIPAA)

Disclosure of Summary Health Information to the Plan Sponsor

In accordance with the Privacy Standards, the Plan may disclose Summary Health Information to the Plan Sponsor, if the Plan Sponsor requests the Summary Health Information for the purpose of (a) obtaining premium bids from health plans for providing health insurance coverage under this Plan or (b) modifying, amending or terminating the Plan.

"Summary Health Information" may be individually identifiable health information and it summarizes the claims history, claims expenses or the type of claims experienced by individuals in the plan, but it excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by five-digit zip code.

Disclosure of Protected Health Information (PHI) to the Plan Sponsor for Plan Administration Purposes

"Protected Health Information" (PHI) means individually identifiable health information, created or received by a health care provider, health plan, employer, or health care clearinghouse; and relates to the past, present, or future physical or mental health condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and is transmitted or maintained in any form or medium.

In order that the Plan Sponsor may receive and use PHI for Plan Administration purposes, the Plan Sponsor agrees to:

- (1) Not use or further disclose PHI other than as permitted or required by the Plan Documents or as Required by Law (as defined in the Privacy Standards);
- (2) Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;
- (3) Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the Privacy Standards;
- (4) Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;
- (5) Make available PHI in accordance with Section 164.524 of the Privacy Standards (45 CFR 164.524);
- (6) Make available PHI for amendment and incorporate any amendments to PHI in accordance with Section 164.526 of the Privacy Standards (45 CFR 164.526);
- (7) Make available the information required to provide an accounting of disclosures in accordance with Section 164.528 of the Privacy Standards (45 CFR 164.528);

- (8) Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services (“HHS”), or any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with Part 164, Subpart E, of the Privacy Standards (45 CFR 164.500 *et seq*);
- (9) If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and
- (10) Ensure that adequate separation between the Plan and the Plan Sponsor, as required in Section 164.504(f)(2)(iii) of the Privacy Standards (45 CFR 164.504(f)(2)(iii)), is established as follows:
 - (a) The following employees, or classes of employees, or other persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed:
 - Benefits Division Manager**
 - Lead Benefits Specialist**
 - Benefits Specialist**
 - Senior Benefits Specialist**
 - Wellness Coordinator**
 - (b) The access to and use of PHI by the individuals described in subsection (a) above shall be restricted to the Plan Administration functions that the Plan Sponsor performs for the Plan.
 - (c) In the event any of the individuals described in subsection (a) above do not comply with the provisions of the Plan Documents relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

"Plan Administration" activities are limited to activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend or terminate the Plan or solicit bids from prospective issuers. "Plan Administration" functions include quality assurance, claims processing, auditing, monitoring and management of carve-out plans, such as vision and dental. It does not include any employment-related functions or functions in connection with any other benefit or benefit plans.

The Plan shall disclose PHI to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor that (a) the Plan Documents have been amended to incorporate the above provisions and (b) the Plan Sponsor agrees to comply with such provisions.

Disclosure of Certain Enrollment Information to the Plan Sponsor

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

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

The Plan Sponsor hereby authorizes and directs the Plan, through the Plan Administrator or the Claims Administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters (MGUs) for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan.

Such disclosures shall be made in accordance with the Privacy Standards and any applicable Business Associate Agreement(s).

Other Disclosures and Uses of PHI

With respect to all other uses and disclosures of PHI, the Plan shall comply with the Privacy Standards.

STANDARDS FOR SECURITY OF ELECTRONIC PROTECTED HEALTH INFORMATION (THE “PRIVACY STANDARDS”) ISSUED PURSUANT TO THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996, AS AMENDED (HIPAA)

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

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

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

GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION

The Plan is a self-funded group health Plan and the administration is provided through a Third Party Claims Administrator. The funding for the benefits is derived from the funds of the Employer and contributions made by covered Employees. The Plan is not insured.

PLAN NAME

El Paso County

TAX ID NUMBER: 84-6000764

PLAN EFFECTIVE DATE: January 1, 2002

PLAN YEAR ENDS: December 31st

EMPLOYER INFORMATION

El Paso County
2880 International Circle
Colorado Springs, Colorado 80910
(719) 520-7420

PLAN ADMINISTRATOR

El Paso County
2880 International Circle
Colorado Springs, Colorado 80910
(719) 520-7420

CLAIMS ADMINISTRATOR

Employee Benefit Management Services, Inc.
P.O. Box 21367
Billings, Montana 59104
(406) 245-3575 or (800) 777-3575

Plan Name: El Paso County

Plan Option: Reach Your Peak Medical EPO

Effective Date: January 1, 2002

Restatement Date: January 1, 2017

I, _____, certify that I am the _____

Name

Title

of the Plan Sponsor/Administrator for the above named Health Plan, and further certify that I am authorized to sign this Plan Document/Summary Plan Description. I have read and agree with the above referenced Plan Document and am hereby authorizing its implementation as of the effective date stated above.

Signature: _____

Print Name: _____

Date: _____

**APPENDIX A
NOTICE OF NONDISCRIMINATION – COLORADO**

Your health plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Your health plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Your health plan:

Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact your Employee Benefits Division. If you believe that your health plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the **Civil Rights Coordinator in the Employee Benefits Division**,

**El Paso County Employee Benefits Division Attention:
Renee' Mabe
2880 International Circle
Colorado Springs, CO 80910
1 (719) 520-7420,
Fax: 1 (719) 520-7497
reneemabe@elpasoco.com**

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at:

<https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>

or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 1-800-537-7697 (TDD).

Complaint forms are available at:

<http://www.hhs.gov/ocr/office/file/index.html>

SPANISH:

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1 (719) 520-7420.

VIETNAMESE:

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1(719) 520-7420.

CHINESE:

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-(719) 520-7420。

KOREAN:

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1(719) 520-7420.

RUSSIAN:

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1 (719) 520-7420.

AMHARIC:

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያገዝዎት ተዘጋጅተዋል። ወደ ሚከተለው ቁጥር ይደውሉ
1 (719) 520-7420.

ARABIC:

(رقم هاتف الصم والبكم 1 (719) 520-7420 ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-

GERMAN:

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung.
Rufnummer: 1 (719) 520-7420.

FRENCH:

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1 (719) 520-7420.

NEPALI:

ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1 (719) 520-7420.

TAGALOG:

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1 (719) 520-7420.

JAPANESE:

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1 (719) 520-7420。

CUSHITE:

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1 (719) 520-7420.

PERSIAN (written translated tagline is provided in the Farsi language):

AKIYESI: Ti o ba nso ede Yoruba ofe ni iranlowo lori ede wa fun yin o. E pe ero ibanisoro yi 1 (719) 520-7420.

Kru*, Ibo*, Yoruba*:

Ige nti: O buru na asu Ibo asusu, enyemaka diri gi site na call 1 (719) 520-7420.