Preferred
ADMINISTRATORS

UNIVERSITY MEDICAL CENTER OF EL PASO AND ITS AFFILIATES

Associate And Retiree Health Benefit Fund Plan

PLAN DOCUMENT

Si usted requiere este manual en Español, por favor comuníquese con Preferred Administrators al 915-532-3778 o gratis al 1-877-532-3778 si llama fuera de El Paso de 7 am a 5 pm de Lunes a Viernes.

Effective October 1, 2023

UNIVERSITY MEDICAL CENTER
OF EL PASO

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MEMBER RIGHTS AND RESPONSIBILITIES

As a Plan Member you have certain rights and responsibilities, as outlined below.

YOU HAVE THE RIGHT TO:

- Receive medical treatment that is available when you need it and is handled in a way that respects your privacy and dignity.
- Get the information you need about your health care plan, including information about services that are covered, and services that are not covered.
- Have access to a current list of providers in the Preferred Administrators Network and have access to information about a particular provider's education, training and practice.
- Have your medical information kept confidential by the Plan and your health care provider.
- Learn about any care you receive. You should be asked for your consent for all care, unless there is an emergency and your life and health are in serious danger.
- Be heard. Our complaint-handling process is designed to hear and act on your complaint or concern about the Plan and/or the quality of care you receive.
- Preferred Administrators, the Third Party (Claim) Administrator, understands your concerns. For assistance on any complaints or inquires, you can contact the Customer Service Helpline at **915-532-3778** from 7:00 am to 5:00 pm.

YOU HAVE THE RESPONSIBILITY TO:

- Review and understand the information you receive about the Plan. Please call the Customer Service Helpline when you have questions or concerns at **915-532-3778.** Customer Service representatives are available to assist you from 7:00 am to 5:00 pm Monday to Friday.
- Show your Preferred Administrators HealthCare ID card before you receive care.
- Build a comfortable relationship with your practitioner or provider; ask questions about things you don't understand; and provide honest, complete information to the providers caring for you.
- Know what medicine you take, why and how to take it.
- Pay all co-payments, deductibles and coinsurance for which you are responsible, at the time service is rendered.
- Follow up on your bills received from your provider in a timely manner. All claims need to be filed according to their timely filing, as outlined in Article VIII, Member Reimbursement Claims.
- Before you receive services, you should always verify that your provider is still in-network with Preferred Administrators by calling **915-532-3778** from 7:00 am to 5:00 pm Monday to Friday.
- Voice your opinions, concerns or complaints to Preferred Administrators.
- Notify the Plan Administrator about any changes in family size, address, phone number or membership status. Please contact the Plan Administrator at **915-521-7950** Monday to Friday.
- Notify Preferred Administrators if you have other insurance by calling **915-532-3778** from 7:00 am to 5:00 pm Monday to Friday.
- To ask questions, if you don't understand your rights and responsibilities.

UNIVERSITY MEDICAL CENTER

OF EL PASO

Preferred ADMINISTRATORS

COBRA NOTIFICATION PROCEDURES

It is the Plan participant's responsibility to provide the following notices as they relate to COBRA Continuation Coverage:

Notice on COBRA Continuation Coverage Election – This notice contains important information about your right to continue your health care coverage in the Plan, as well as other health coverage alternatives that may be available to you through the Health Insurance Marketplace. There may be other coverage options for you and your family. When key parts of the health care law take effect, you'll be able to buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

Notice of Divorce or Legal Separation – Notice of the occurrence of a Qualifying Event that is a divorce or legal separation of a covered Associate from his or her spouse.

Notice of Child's Loss of Dependent Status – Notice of a Qualifying Event that is a child's loss of Dependent status under the Plan (e.g., a Dependent child reaching the maximum age limit).

Notice of Second Qualifying Event – Notice of the occurrence of a second Qualifying Event after a Qualified Beneficiary has become entitled to COBRA Continuation Coverage with a maximum duration of 18 (or 29) months.

Notice Regarding Disability – Notice that: (a) a Qualified Beneficiary entitled to receive COBRA Continuation Coverage with a maximum duration of 18 months has been determined by the Social Security Administration to be disabled at any time during the first 60 days of continuation coverage, or (b) a Qualified Beneficiary as described in "(a)" has subsequently been determined by the Social Security Administration to no longer be disabled.

Notice Regarding Address Changes – It is important that the Plan Administrator be kept informed of the current addresses of all Members or beneficiaries who are or may become Qualified Beneficiaries.

Notification must be made in accordance with the following procedures. Any individual who is the covered Associate, a Qualified Beneficiary with respect to the Qualifying Event, or any representative acting on behalf of the covered Associate or Qualified Beneficiary may provide the Notice. Notice by one individual shall satisfy any responsibility to provide Notice on behalf of all related Qualified Beneficiaries with respect to the Qualifying Event.

Form of Notification and Delivery – Notification of the Qualifying Event must be made on a specific form. The form can be obtained, free of charge, by contacting the COBRA Service Provider. The completed form must be delivered to the COBRA Service Provider or the Plan Sponsor's Human Resources Office.

Content – Notification must include evidence regarding the Qualifying Event or other event extending coverage such as: copy of divorce decree, copy of child's birth certificate, copy of the Social Security Administration's disability determination letter.

Time Requirements for Notification – In the case of a divorce, legal separation or a child losing dependent status, Notice must be delivered within 60 days from the later of: (1) the date of the Qualifying Event, (2) the date health plan coverage is lost due to the event, or (3) the date the Qualified Beneficiary is notified of the obligation to provide Notice through the Plan Document or the Plan Sponsor's General COBRA Notice.

If an Associate or Qualified Beneficiary is determined to be disabled under the Social Security Act, Notice must be delivered within 60 days from the later of: (1) the date of the determination, (2) the date of the Qualifying Event, (3) the date coverage is lost as a result of the Qualifying Event, or (4) the date the covered Associate or Qualified Beneficiary is advised of the Notice obligation through the Plan Document or the Plan Sponsor's General COBRA Notice. Notice must be provided within the 18-month COBRA coverage period. Any such Qualified Beneficiary must also provide Notice within 30 days of the date he is subsequently determined by the Social Security Administration to no longer be disabled.

The Plan will not reject an incomplete Notice as long as the Notice identifies, the Plan, the covered Associate and Qualified Beneficiary(ies), the Qualifying Event/disability determination and the date on which it occurred. However, the Plan is not prevented from rejecting an incomplete Notice if the Qualified Beneficiary does not comply with a request by the Plan for more complete information within a reasonable period of time following the request.

IMPORTANT INFORMATION

WHO TO CONTACT FOR ADDITIONAL INFORMATION

A Plan participant can obtain additional information about the coverage of a specific drug, treatment, procedure, preventive service, etc. from the office that handles claims on behalf of the Plan (the "Plan Administrator"). The name, address and phone number of the Plan Administrator is:

University Medical Center of El Paso
4815 Alameda Avenue
El Paso, TX 79905
(915) 521-7950

THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Group health plans and health insurance issuers 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 delivery. 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).

MENTAL HEALTH PARITY

Pursuant to the Mental Health Parity Act of 1996 (MHPA) and the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), this Plan applies its terms uniformly and enforces parity between covered health care benefits and covered mental health and substance disorder benefits relating to financial cost sharing restrictions and treatment duration limitations. For further details, please contact the Plan Administrator.

DEFINITIONS

Some of the terms used in this document begin with a capital letter. These terms have special meanings and are included in the Definitions section. When reading this document, it will be helpful to refer to this section. Becoming familiar with the terms defined will provide a better understanding of the benefits and provisions.

NOTICE OF MINIMUM ESSENTIAL COVERAGE AND MINIMUM VALUE STANDARD

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." This plan or policy does provide minimum essential coverage. The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

ARTICLE I
ESTABLISHMENT OF THE PLAN; ADOPTION OF THE PLAN DOCUMENT

THIS PLAN DOCUMENT, made by the University Medical Center of El Paso (the "Company" or the "Plan Sponsor") as of October 1, 2023 hereby amends and restates the University Medical Center of El Paso and its Affiliates Associates Benefit Fund (the "Plan"), which was originally adopted by the Company, effective October 1, 2002. Any wording which may be contrary to Federal Laws or Statutes is hereby understood to meet the standards set forth in such. Also, any changes in Federal Laws or Statutes which could affect the Plan are also automatically a part of the Plan, if required.

1.01 Effective Date

The Plan Document is effective as of the date first set forth above, and each amendment is effective as of the date set forth therein, or on such other date as specified in an applicable collective bargaining agreement (if any) with respect to the Associates covered by such agreement (the "Effective Date").

1.02 Adoption of the Plan Document

The Plan Sponsor, as the settler of the Plan, has adopted this Plan Document as the written description of the Plan. This Plan Document represents both the Plan Document and the Summary Plan Description. This Plan Document amends and replaces any prior statement of the health care coverage contained in the Plan or any predecessor to the Plan.

IN WITNESS WHEREOF, the Plan Sponsor has caused this Plan Document to be executed.

University Medical Center of El Paso

By: _____

Name: R. JACOB CINTRON

Date: **October 1, 2023**

Title: President & CEO

ARTICLE II
INTRODUCTION AND PURPOSE; GENERAL PLAN INFORMATION

2.01 Introduction and Purpose

The purpose of the Plan is to provide eligible and enrolled Member's benefit coverage according to a *Schedule of Benefits,* for Medically Necessary and Appropriate treatment administered by licensed medical providers.

This Plan has been designed to provide eligible Members with coverage options that provide benefits based on point of service decisions made by the Member. When Members select providers and receive medical services, benefit coverage amounts will be determined based on the contracted status of the provider. As the contract status of providers is improved, benefit coverage amounts are increased for the Member. Because of the cost of medical care, Members are encouraged to be selective consumers of healthcare and to be aware of the increases in benefit coverage amounts that have been made available to Members when they select University Medical Center of El Paso and other preferred providers for their medical services.

We expect and encourage you to review this booklet which describes the benefits provided by this Plan. Participating in the Health Risk Assessment Program is on voluntary basis. Associates are encouraged to participate in the Health Risk Assessment Program which is provided through the University Medical Center of El Paso Wellness Program.

2.02 General Plan Information

NAME OF PLAN:	University Medical Center of El Paso and its Affiliates Associates Benefit Fund
PLAN SPONSOR:	University Medical Center of El Paso 4815 Alameda Avenue El Paso, TX 79905
PLAN ADMINISTRATOR: **(Named Fiduciary)**	University Medical Center of El Paso 4815 Alameda Avenue El Paso, TX 79905
PLAN SPONSOR ID NO. (EIN):	76-6000756
SOURCE OF FUNDING:	Self-Funded
APPLICABLE LAW:	Federal and the State of Texas/Non-ERISA Plan
PLAN YEAR:	October 1 through September 30
PLAN STATUS:	Non-Grandfathered
PLAN TYPE:	Medical Prescription Drug
THIRD PARTY ADMINISTRATOR:	Preferred Administrators P.O. Box 971100 El Paso, TX 79997 Phone: (915) 532-3778 or (877) 532-3778 Fax: (915) 532-2877
PARTICIPATING EMPLOYER(S):	University Medical Center of El Paso 4815 Alameda Avenue El Paso, TX 79905

AGENT FOR SERVICE OF PROCESS: University Medical Center of El Paso
Attn: Legal Department
4815 Alameda Avenue
El Paso, TX 79905

The Plan shall take effect for each Participating Employer on the Effective Date, unless a different date is set forth above opposite such Participating Employer's name.

Legal Entity; Service of Process

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

Not a Contract

This Plan Document and any amendments constitute the terms and provisions of coverage under this Plan. The Plan Document shall not be deemed to constitute a contract of any type between the Company and any Member or to be consideration for, or an inducement or condition of, the employment of any Member. Nothing in this Plan Document shall be deemed to give any Member the right to be retained in the service of the Company or to interfere with the right of the Company to discharge any Member at any time; provided, however, that the foregoing shall not be deemed to modify the provisions of any collective bargaining agreements which may be entered into by the Company with the bargaining representatives of any Associates.

Applicable Law

This Plan is a governmental (sponsored) plan and as such it is exempt from the requirements of the Employee Retirement Income Security Act of 1974 (also known as ERISA), which is a Federal law regulating Employee welfare and pension plans. The Participants' rights in the Plan are governed by the plan documents and applicable State law and regulations. To the extent not preempted by federal law, the provisions of this Plan are construed, enforced and administered according to the laws of Texas.

Discretionary Authority

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

This Plan is not a "Grandfathered Health Plan" under the Patient Protection and Affordable Care Act. This group health plan believes this coverage is not a "Grandfathered Health Plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). Questions about the Plan can be directed to the Plan Administrator at the following address and phone number:

Preferred Administrators
1145 Westmoreland Drive
El Paso, TX 79925
Phone: 915-532-3778

For individual market policies and non-federal governmental plans: You may also contact Employee Benefits Security Administration, U.S. Department of Labor at **1-866-444-3272 https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers** or the U.S. Department of Health and Human Services at **https://www.healthcare.gov/health-care-law-protections/grandfathered-plans.** This website has a table summarizing which protections do and do not apply to Grandfathered Health Plans.

ARTICLE III
SCHEDULE OF BENEFITS FOR PARTICIPATING PROVIDERS

3.01 Preferred Provider Organization (PPO) Providers

A current list of PPO Providers is available, without charge, through Preferred Administrators' website at **www.preferredadmin.net.**

This Plan provides options for Members to receive medical services from providers who have contracted with the provider networks contracted by the Plan. This Plan rewards Members with increased benefit coverage amounts based on the providers selected as described in the *Schedule of Benefits.* The greatest benefit amounts are provided when Members use University Medical Center of El Paso facilities and services. Benefit coverage amounts are based on a traditional benefit plan design using Preferred Provider Networks. For this Plan the preferred providers are:

(1) University Medical Center of El Paso, El Paso Children's Hospital and Texas Tech Physicians

NOTE: If your medical care is not available at UMC or Texas Tech, but it is offered with a PPO provider, your benefit will be applied at PPO. We are working diligently with UMC and Texas Tech to be able to provide you with the best medical care.

NOTE: If you receive medical care at an Out of Network (OON) facility, from any UMC, Texas Tech, or El Paso Children's provider, your professional services will be applied at PPO.

(2) Preferred Administrators Network in El Paso and other providers contracted by Preferred Administrators Network on behalf of this Plan

NOTE: If your medical care is not available within a PPO Network and you receive services from an Out-of-Network provider, your benefit will be PPO, but additional charges (Balance Billing) may be incurred when receiving services from a noncontracted provider.

NOTE: Preferred Administrators Network physicians, who provide services at UMC or EPCH, will have professional services paid at the contracted rate. Member's responsibilities will be UMC/EPCH/Texas Tech benefit coverage level.

NOTE: Except as outlined in "No Surprises Act – Emergency Services and Surprise Bills" below, if the charge billed by a Non-Network Provider for any covered service is higher than the Maximum Allowable Charge determined by the Plan, Members are responsible for the excess unless the Provider accepts assignment of benefits as consideration in full for services rendered. Since Network Providers have agreed to accept a negotiated discounted fee as full payment for their services, Members are not responsible for any billed amount that exceeds that fee. The Plan Administrator reserves the right to revoke any previously-given assignment of benefits or to proactively prohibit assignment of benefits to anyone, including any Provider, at its discretion.

NOTE: To receive benefit consideration, Members may need to submit claims for services provided by Non-Network Providers to the Third Party Administrator. Network Providers have agreed to bill the Plan directly, so that Members do not have to submit claims themselves.

If a Member receives information with respect to an item or service from the Plan, its representative, or a database maintained by the Plan or its representative indicating that a particular Provider is an In-Network Provider and the Member receives such item or service in reliance on that information, the Member's Coinsurance, Copayment, Deductible, and out-of-pocket maximum will be calculated as if the Provider had been In-Network despite that information proving inaccurate.

3.02 SCHEDULE OF BENEFITS FOR MEMBERS LIVING OUTSIDE OF THE AREA OF EL PASO

This Plan enables you to continue to access participating PPO providers through Multiplan and PHCS. Through the Multiplan and PHCS, the same advantages are provided to members who live, work, or travel outside of the service area. This is done by utilizing the Multiplan/PHCS extended national network.

Providers within Multiplan and PHCS participating providers have agreements to accept our payment (after the member's coinsurance and deductible) as payment in full. If you obtain services through a preferred provider, you will receive benefits at the PPO in-network level.

Participating providers outside the El Paso Area must submit prior authorization for scheduled inpatient admissions and elective outpatient surgeries. Prior Authorization is not a guarantee of payment. All benefit determinations are subject to eligibility enrollment, and the terms of coverage defined in this Plan.

(1) Out of area members can use the Multiplan/PHCS within their local area to locate participating providers. If your provider is participating with Multiplan/PHCS, your benefit will be in-network at PPO benefit level.

(2) Out of network benefits will be applied if your provider is not participating with Multiplan/PHCS.

(3) If your specialty care is not available in your residing area, you must contact Preferred Administrators at **915-532-3778,** prior to receiving your specialty services. Preferred Administrators will help you coordinate these services.

(4) Members are responsible to update their Out of State/Out of area address with Preferred Administrators and verify if the provider is a contracted provider with (Multiplan/PHCS) at **1-800-922-4362** and or you can verify on line at **www.multiplan.com/PAPHCS.** This will determine how the Member's benefits will be applied.

(5) PPO Benefits will be applied when using a contracted Out-of-Area Provider when the treatment is for a sudden acute medical illness or injury that presents an urgent or emergency situation. If the provider is a contracted provider, the Benefit Percentage will be applied to the contracted allowable amounts for the contracted allowable amounts. If the provider is not a contracted provider with our Wrap Network, the PPO Benefit will be applied but additional charges (Balance Billing) may be incurred when receiving services from a Non-Contracted Provider.

3.03 SCHEDULE OF BENEFITS FOR MEMBERS LIVING INSIDE THE AREA OF EL PASO

(1) Members residing inside the area of El Paso should utilize their local provider network for all services.

(2) Out-of-area benefits will be covered for emergency services only.

(3) If you are receiving or plan to receive elective and non-emergency services, they will be treated as out of network.

(4) If your specialty care is not available within the El Paso Regional Area, you must contact Preferred Administrators at **915-532-3778,** prior to receiving your specialty services. Preferred Administrators will help you coordinate these services.

(5) Prior Authorization will be required for Member's receiving services outside of the El Paso area.

3.04 SCHEDULE OF BENEFITS FOR MEMBERS RECEIVING SERVICES BY AN OUT-OF-NETWORK PROVIDER

If a Member electively chooses to receive services from an out-of-network/out of area provider, the Member will be responsible for out-of-network benefits as explained in this Plan Document.

If you receive services from an out-of-network/out of area provider, You will be required to do the following.

- You will be required to get a prior authorization for any services rendered with an out-of-network/out of area provider. **Failure to obtain prior authorization will result in a loss of coverage for the service or procedure.**
- You will be required to satisfy a higher deductible and co-insurance.
- You will be required to pay the difference between the amounts the provider charges and the sum the Plan pays. Additional charges (Balance Billing) will be incurred when receiving services from a non-contracted provider.

FINDING A CONTRACTED PROVIDER:

(1) For Members living in the El Paso area, you can find providers in your El Paso Area Network at **www.preferredadmin.net** or call **915-532-3778.**

(2) To locate a provider outside the area for emergency only, visit **www.multiplan.com/UMCHD.**

(3) For Members living outside of the El Paso area. You can find providers at **www.multiplan.com/PAPHCS** or call **1-800-922-4362.**

(4) If you have any questions, you can reach our Member Services Department at **915-532-3778** or **1-877-532-3778** if outside of the calling area. **Member Services is available Monday through Friday from 7 a.m. to 5 p.m., Mountain Time.**

3.05 Utilization Review

UTILIZATION REVIEW: The Plan requires prior authorization for all scheduled inpatient admissions and specified outpatient procedures and diagnostic tests. Failure to obtain prior authorization for a scheduled inpatient and outpatient procedure will result in a loss of coverage for the service or procedure. Please contact TPA Administration to verify payment, eligibility and benefits.

Prior Authorization is not a guarantee of payment. All benefit determinations are subject to eligibility enrollment, and the terms of coverage defined in this Plan.

PRIOR AUTHORIZATION

All out-of-network services provided by non-participating facility, provider, lab, or vendor require pre-authorization. In addition, the Plan requires that a Provider obtain a prior authorization for the following covered services or procedures received within the local area of El Paso:

Inpatient Admissions

- Acute Hospital
- Behavioral Health/Residential
- Chemotherapy
- Surgical
- Non-Surgical
- Rehab
- Hospice
- Skilled Nursing
- Maternity and Newborn
  (Please reference **THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT)**
- Behavioral Health/Substance Abuse
- Pre-Scheduled

Outpatient

- Physical Therapy *(No authorization is required for the initial evaluation and reevaluation)*
- Speech Therapy *(No authorization is required for the initial evaluation and reevaluation)*
- Occupational Therapy *(No authorization is required for the initial evaluation and reevaluation)*
- Chiropractic *(No authorization is required for the initial evaluation)*
- Radiation Therapy
- Chemotherapy
- Infusion Therapy
- Home Health *(No authorization is required for the initial evaluation)*

Radiology/Diagnostic Imaging

- PET Scans
- Fetal Echocardiography, 76825-76828

NO Authorization required for MRI, MRA, CT scans, EKG's, or X-Rays when done by a participating provider

Outpatient Procedures/Clinical Administered Drugs

- Ambulatory Surgical Center
- Endoscopy Center
- Cardiac Catheter Center
- Wound Clinic
- Outpatient Hospital
- Vein Clinic
- Growth Hormones
- Biologicals/Biosimilars (e.g. cytokines, growth factors, gene and cellular therapies, etc.)
- Synagis – Clinician Administered Drugs, Oral, IV, Injectable over $500 (in office or outpatient setting)
- Specialty Medicines

NOTE: Buy and Bill process will be in place for specialty medications provided inpatient or outpatient facility.

Durable Medical Equipment ($500 and over)

- All DME rentals exceeding 2 months require a prior authorization maximum up to 12 months, not to exceed purchase price, with the exception of breast pumps. Prior Authorization must be accompanied by the Physician's prescription.

Other Services

- Allergy Immunotherapy
- BRCA Testing
- Clinical Trials
- Dental Anesthesia
- Genetic Testing
- Implantable Devices
- Laser Surgeries
- Oral Surgery
- Orthotics and Prosthetics ($200 and over for Adult and Children)
- Transfers (i.e. scheduled non-emergent facility to facility)
- Transplants (to include evaluation services by Transplant Facility)
- Transportation (Non-Emergency Air Transport and Non-Emergent Ambulance)
- Venous Procedures in office and outpatient excluding for dialysis access.

PRIOR AUTHORIZATION FOR SERVICES OUTSIDE THE AREA OF EL PASO

Participating providers outside the El Paso Area must submit prior authorization for scheduled inpatient admissions and elective outpatient surgeries.

INPATIENT ADMISSIONS:

All elective (non-emergency) admissions require prior authorization. The prior authorization process will review the medical necessity and appropriateness for the requested admission. Prior authorization will also identify appropriate alternative facility providers or settings for the requested admission, such as an alternative use of an outpatient facility when the requested service can be safely and effectively done in an outpatient rather than an inpatient setting.

All emergency admissions (those through an Emergency Room or a direct admit from a physician's office) require notification within twenty four (24) hours following the emergency admission. Failure to notify Preferred Administrators of an emergency admission will result in denial of a claim. When emergency admissions occur and the patient will be confined beyond twenty four (24) hours, transfer to UMC will be offered when the patient's condition can appropriately be treated at UMC and the patient is medically stable and able to be transported to UMC.

All inpatient stays of less than 24 hours are considered an observation stay. A 24-hour notification is required for conversion from observation status to inpatient status.

NOTE: All Out-of-Area/Out-of-Network Transfers must be Pre-Authorized

Although it is the Provider's responsibility to request authorization for the health care services to be delivered, it is ultimately the Member's responsibility to ensure that the requested services have been preauthorized to avoid delay in services or unpaid claims. We encourage you to always call Preferred Administrators at **915-532-3778** to verify if the provider requested an authorization before services are rendered.

INPATIENT MATERNITY:

All Inpatient Maternity Admissions require notification from your provider within twenty four (24) hours following the delivery. Failure to notify Preferred Administrators of an emergency admission will result in denial of a claim.

Prior authorization is not required for Emergent Medical or Behavioral Health Admissions. Notification of admission is required within one (1) business day.

Requires prior authorization for in-network or out-of-network facility physician services for a mother and her newborn(s) after 48 hours following uncomplicated vaginal delivery and after 96 hours following an uncomplicated delivery by caesarian section.

NOTE: A Preauthorization does not guarantee payment of benefits nor verify eligibility. Payment of benefits is subject to all terms and conditions, limitations and exclusions of the Member's contract, regardless of a determination, medical, decisions regarding a course of treatment are solely between the physician and the patient.

CONCURRENT REVIEW AND DISCHARGE PLANNING:

All inpatient admissions are monitored for compliance with the certified length of stay. Admissions which are continued beyond the expected length of stay, are reviewed to determine the medical necessity for the continued stay, and to identify the expected discharge date of the patient. The Preferred Administrators Case Manager will work collaboratively with the facility when a patient can appropriately be transferred to an alternative care setting; or when a patient is discharged from an acute care setting to an alternative care setting such as home health care.

CASE MANAGEMENT:

As a Plan Member, you qualify for certain Case Management benefits determined to be necessary and appropriate at no charge to the Member. Case Management will require full participation by the Member.

The Health Service Department staff which includes Medical Directors, Registered Nurses, Licensed Vocational Nurses, Case Managers, Speech Language Pathologist, and Social Workers are available to assist Members when situations emerge involving potentially high cost medical services, complex medical care needs, catastrophic medical illness or injury, or out of area medical services. Case Managers will consult with the treating physicians and facility representatives regarding medical service needs and potential alternative treatment plans. The focus of Case Management is to assist the Member by monitoring the situation, identifying available clinical resources, plan options, helping the Member understand a disease process, a treatment plan or medical terminology, which may include the following:

- personal support to the Member and family;
- monitoring hospital stays and sub-acute facilities;
- identifying appropriate alternative care options;
- assisting in obtaining any necessary equipment or supplies;
- coordinating the care plan among physician(s) and other health care professionals

Participation in Case Management is Voluntary. Accepting Medical Case Management recommendations is voluntary and there will be no reduction of benefits if the Member chooses not to accept recommendations presented by the Case Manager.

BENEFIT PERCENTAGE, DEDUCTIBLES AND LIMITATIONS

Benefit Description	UMC, University Medical Center of El Paso, EPCH	Texas Tech Provider	Wrap Network Preferred Administrators Network / PPO Benefit	Out of Area / Non-Contracted Providers
BENEFIT PERCENTAGE or COINSURANCE PERCENTAGE (payable by the Plan)				
Inpatient Hospital Admissions (per admission)	$250 co-pay and 100% coverage once deductible is met	N/A	$1,000 co-pay and 70% coverage once deductible is met	$2,500 co-pay and 50% coverage once deductible is met
Other Outpatient Surgery including Birthing Centers (unless specified otherwise)	$100 co-pay and 100% coverage once deductible is met	N/A	$300 co-pay and 70% coverage once deductible is met	$1,000 co-pay and 50% coverage once deductible is met
Failure to obtain Prior Authorization or to comply with the determination of the Medical Review process may result in the denial of a claim for benefits. See the preceding provision for Medical Management and Prior Authorization requirements. The Benefit Percentage will be applied to the contracted allowable amounts for the Participating Contracted Providers and Out-of-Network benefits will be applied to Non-Contracted Providers. PPO benefits will also be applied when using Out-of-Area Providers for: • Treatment for a sudden acute medical illness or injury that presents an urgent or emergency situation provided by Non-Network / Non-Contracted Providers; • Treatment by Out-of-Area / Non-Contracted emergency room physicians who staff an emergency room of an Out-of-Area / Non-Contracted hospital. • ***SPECIAL NOTICE: Additional charges (Balance Billing) may be incurred when receiving services from Non-Contracted Providers.***				
DEDUCTIBLE PER FISCAL YEAR Per Member	**$300**		**$1,500**	**$5,000**
Maximum Family Deductible Limit	$900		$4,500	$15,000
After the member deductible is met, the Plan pays the Benefit Percentage (co-insurance percentage) of Covered Expenses incurred in the balance of the Fiscal Year for each individual up to the Out-of-Pocket maximum. Family deductible is considered satisfied if family amount is met AND Subscriber's individual deductible is met. The subscriber deductible must be met for family max deductible to be met. If a Subscriber deductible does not meet their individual deductible, a family max will not be satisfied until the Subscriber has met their individual deductible.				
ANNUAL LIMIT (Per Member)	**No annual limit.**			

Benefit Description		UMC, University Medical Center of El Paso, EPCH	Texas Tech Provider	Wrap Network Preferred Administrators Network / PPO Benefit	Out of Area/ Non-Contracted Providers
OUT-OF-POCKET MAXIMUM PER FISCAL YEAR		All Members cost share from UMC / EPCH / TT / PPO will be applied towards the Out-of Pocket maximum. Once you have met your deductible at UMC, EPCH, or Texas Tech, the Plan will pay 100% of covered expenses incurred for the current Fiscal Year.			Unlimited
Per Member	$9,450				
Family Out-of-Pocket	$18,900				
NOTE: All charges used to apply toward a "Per Member" maximum out-of-pocket amount will be applied toward the "Family" maximum out-of-pocket amount. No individual out-of-pocket maximums will exceed $9,100 for that fiscal year.					
The Out-of-Pocket maximum includes any applicable deductibles, co-insurance, and co-pays from any in-network provider. The annual Out-of-Pocket maximum applies to all in-network services Medical and Pharmacy. Once the Out-of-Pocket maximum has been reached, the Plan will pay 100% of eligible in-network expenses for the remainder of the Fiscal Year. The Out-of-Pocket is combined with medical and pharmacy. The Out-of-Pocket maximum does not include non-compliance penalties and amounts in excess of allowable amounts or any non-covered expenses.					
ANNUAL LIMIT (Per Member)		**No annual limit.**			

3.07 Balance Billing

In the event that a claim submitted by a Preferred or Non-Preferred Provider is subject to a medical bill review or medical chart audit and some or all of the charges in connection with such claim are repriced because of billing errors and/or overcharges, it is the Plan's position that the Member should not be responsible for payment of any charges denied as a result of the medical bill review or medical chart audit, and should not be balance billed for the difference between the billed charges and the amount determined to be payable by the Plan Administrator, although the Plan has no control over any Provider's actions, including balance billing.

In addition, with respect to services rendered by a Preferred Provider being paid in accordance with a discounted rate, it is the Plan's position that the Member should not be responsible for the difference between the amount charged by the Preferred Provider and the amount determined to be payable by the Plan Administrator, and should not be balance billed for such difference. Again, the Plan has no control over any Preferred Provider that engages in balance billing practices, except to the extent that such practices are contrary to the contract governing the relationship between the Plan and the Preferred Provider.

The Member is responsible for any applicable payment of co-insurances, deductibles, and out-of-pocket maximums and may be billed for any or all of these.

3.08 Claims Audit

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

The analysis will be employed to identify charges billed in error and/or charges that exceed the Maximum Allowable Charge or services that are not Medically Necessary, and may include a patient medical billing records review and/or audit of the patient's medical charts and records.

Upon completion of an analysis, a report will be submitted to the Plan Administrator or its agent to identify the charges deemed in excess of the Maximum Allowable Charge or other applicable provisions, as outlined in this Plan Document.

Despite the existence of any agreement to the contrary, the Plan Administrator has the discretionary authority to reduce any charge to the Maximum Allowable Charge, in accord with the terms of this Plan Document.

3.09 No Surprises Act – Emergency Services and Surprise Bills

For Non-Network claims subject to the No Surprises Act ("NSA"), Member cost-sharing will be the same amount as would be applied if the claim was provided by a Network Provider and will be calculated as if the Plan's Allowable Expense was the Recognized Amount, regardless of the Plan's actual Maximum Allowable Charge. The NSA prohibits Providers from pursuing Members for the difference between the Maximum Allowable Charge and the Provider's billed charge for applicable services, with the exception of valid Plan-appointed cost-sharing as outlined above. Any such cost-sharing amounts will accrue toward In-Network Deductibles and out of pocket maximums.

If member signs a notice of consent to waive their rights under NSA, please note that the member may not be protected under NSA and in this case the member may be balanced billed.

Benefits for claims subject to the NSA will be denied or paid within 30 days of receipt of an initial claim, and if approved will be paid directly to the Provider.

Claims subject to the NSA are those which are submitted for:

- Emergency Services;
- Non-emergency services rendered by a Non-Network Provider at a Participating Health Care Facility, provided the Member has not validly waived the applicability of the NSA; and
- Covered Non-Network air ambulance services.

3.10 Continuity of Care

In the event a Member is a continuing care patient receiving a course of treatment from a Provider which is In-Network or otherwise has a contractual relationship with the Plan governing such care and that contractual relationship is terminated, not renewed, or otherwise ends for any reason other than the Provider's failure to meet applicable quality standards or for fraud, the Member shall have the following rights to continuation of care.

The Plan shall notify the Member in a timely manner, but in no event later than 7 calendar days after termination that the Provider's contractual relationship with the Plan has terminated, and that the Member has rights to elect continued transitional care from the Provider. If the Member elects in writing to receive continued transitional care, Plan benefits will apply under the same terms and conditions as would be applicable had the termination not occurred, beginning on the date the Plan's notice of termination is provided and ending 90 days later or when the Member ceases to be a continuing care patient, whichever is sooner.

For purposes of this provision, "continuing care patient" means an individual who:

1. is undergoing a course of treatment for a serious and complex condition from a specific Provider,
2. is undergoing a course of institutional or Inpatient care from a specific Provider,
3. is scheduled to undergo non-elective surgery from a specific Provider, including receipt of postoperative care with respect to the surgery,
4. is pregnant and undergoing a course of treatment for the Pregnancy from a specific Provider, or
5. is or was determined to be terminally ill and is receiving treatment for such illness from a specific Provider.

Note that during continuation, Plan benefits will be processed as if the termination had not occurred, however, the Provider may be free to pursue the Member for any amounts above the Plan's benefit amount.

3.11 Alphabetical Schedule of Plan Benefits

Payment for any of the expenses listed below is subject to all Plan exclusions, limitations and provisions.

NOTE: Non-Contracted Providers will be paid at the Maximum Allowable Charge. Please see definition on *page 46.*

ALPHABETICAL SCHEDULE OF PLAN BENEFITS

Benefit Description	UMC, University Medical Center of El Paso, EPCH	Texas Tech Provider	Wrap Network Preferred Administrators Network / PPO Benefit	Out of Area/ Non-Contracted Providers
ALLERGY TESTING AND INJECTIONS				
Allergy Testing and Injections	100% after deductible	100% after deductible	70% after deductible	50% after deductible
Allergy Serum Vials Dispensed in a Physician's Office	100% after deductible	100% after deductible	70% after deductible	50% after deductible
Allergy Serum Vials Dispensed by a Pharmacist	Covered as a Prescription Drug			
AMBULANCE (AIR AND GROUND)				
Ambulance (patient must be transported)	N/A	N/A	70% co-insurance	70% co-insurance
Emergency air and ground ambulance transportation covered to the nearest appropriate facility. Non-emergency ground ambulance transportation that is medically necessary for local area transfer between inpatient facilities (acute, subacute or hospice) when appropriate. Non-emergency air or ground transportation for any other reason requires Prior Authorization review. Benefit amounts based on the Maximum Allowable Charge rate or the provider's contracted rate if applicable. Out of Network Air Ambulance charges will accrue toward the in-network deductible and out of pocket maximums.				
CHEMOTHERAPY, HEMATOLOGY / ONCOLOGY / INFUSION / RADIATION				
Benefit	100% after deductible	100% after deductible	70% after deductible	50% after deductible
COVID-19 DIAGNOSTIC TESTING				
Covered expenses associated with testing of COVID 19 will be covered and applicable benefits member costs share will apply depending where services are rendered.	**UMC, University Medical Center of El Paso, EPCH**	**Texas Tech Provider**	**Wrap Network Preferred Administrators Network / PPO Benefit**	**Out of Area/ Non-Contracted Providers***
Benefit Coverage	100% after deductible	100% after deductible	70% after deductible	50% after deductible
COVID-19 TREATMENT				
Covered expenses associated with testing of COVID 19 will be covered and applicable benefits member costs share will apply depending where services are rendered.	**UMC, University Medical Center of El Paso, EPCH**	**Texas Tech Provider**	**Wrap Network Preferred Administrators Network / PPO Benefit**	**Out of Area/ Non-Contracted Providers***
Benefit Coverage	100% coverage after deductible	100% coverage after deductible	70% coverage after deductible	50% after deductible
***NOTE:** Member will be financially responsible for services rendered by Non-Contracted Providers as explained in the Plan Document.				

Benefit Description	UMC, University Medical Center of El Paso, EPCH	Texas Tech Provider	Wrap Network Preferred Administrators Network / PPO Benefit	Out of Area/ Non-Contracted Providers
DIAGNOSTIC X-RAY, PATHOLOGY AND LABORATORY SERVICES				
Radiology, Pathology, and Laboratory Benefits	inpatient or outpatient 100% after deductible	inpatient or outpatient 100% after deductible	inpatient or outpatient 70% after deductible	inpatient or outpatient 50% after deductible
NOTE: If a woman receives a mammogram younger than 40 years of age, it will be considered diagnostic and your deductibles or PPO co-insurance will apply.				
DURABLE MEDICAL EQUIPMENT				
Hospital Inpatient / Outpatient or Other Medical / DME Provider (DME over $500.00 requires Prior Authorization)	N/A	100% after deductible	70% after deductible	50% after deductible

EMERGENCY CARE BENEFITS					
UMC of El Paso No Balance Billing		**Wrap Network PPO "Warning"**		**Non-Contracted Providers "Warning"**	
Facility	**Professional**	**Facility**	**Professional**	**Facility**	**Professional**
100% of Maximum Allowable Charge after co-pay of $200	100% of Maximum Allowable Charge	100% of Maximum Allowable Charge after co-pay of $200	100% Maximum Allowable Charge Amount	100% Maximum Allowable Charge Amount $200 co-pay	100% Maximum Allowable Charge Amount
NOTE: ***Deductible/Coinsurance does not apply when obtaining emergency services.***					

HOME HEALTH CARE				
Benefit	N/A	N/A	70% after deductible	50% after deductible
Maximum Benefits	N/A	N/A	60 visits per Fiscal Year	60 visits per Fiscal Year
HOSPICE CARE				
Hospice Care Outpatient	N/A	N/A	70% after deductible	50% after deductible
Maximum visits per Fiscal Year	180			
Hospice Inpatient Care	N/A	N/A	$1,000 co-pay 70% after deductible	$2,500 co-pay 50% after deductible

Benefit Description	UMC, University Medical Center of El Paso, EPCH	Texas Tech Provider	Wrap Network Preferred Administrators Network / PPO Benefit	Out of Area/ Non-Contracted Providers
HOSPITAL SERVICES				
Hospital Services – Inpatient Admissions	$250 co-pay 100% after deductible	N/A	$1,000 co-pay 70% after deductible	$2,500 co-pay 50% after deductible
Hospital Services – Long Term Admissions (LTAC)	$250 co-pay 100% after deductible	N/A	$1,000 co-pay 70% after deductible	$2,500 co-pay 50% after deductible
Hospital Services – Outpatient Surgery	$100 co-pay 100% after deductible	N/A	$300 co-pay 70% after deductible	$1,000 co-pay 50% after deductible
Hospital Services – Observation (Less than 24 hours in the hospital)	$50 co-pay and 100% coverage	N/A	$50 co-pay and 100% coverage	$50 co-pay and 100% Maximum Allowable Charge Amount
Hospital Inpatient Services (Professional)	100% after deductible	N/A	70% after deductible	50% after deductible
Hospital Outpatient Services (Professional)	100% after deductible	N/A	70% after deductible	50% after deductible
Hospital Observation Services (Less than 24 hours in the hospital) (Professional)	100% coverage	N/A	100% coverage	100% of Maximum Allowable Charge Amount
HOSPITAL ROOM AND BOARD CHARGES				
Room and Board Charges (Including Medically Necessary Private Room Isolation)	N/A		70% after deductible	50% after deductible
Intensive Care (Allowable Room Rate)	N/A		70% after deductible	50% after deductible
Private Room Charges for Hospitals Charges with Private Rooms Only	N/A		70% after deductible	50% after deductible
BEHAVIORAL HEALTH, MENTAL HEALTH AND SUBSTANCE ABUSES **Crisis Hotline – 1-877-377-6147 Preferred Administrators provides a Crisis Hotline that offers immediate support for associates who are experiencing emotional and behavioral distress.**				
Outpatient Office Visit	N/A	$30 co-pay	$40 co-pay	50% after deductible
Intensive Outpatient Visit	N/A	N/A	$40 co-pay	50% after deductible
Partial Hospitalization/ Psychiatric Day Treatment	N/A	N/A	70% after deductible	50% after deductible

Benefit Description	UMC, University Medical Center of El Paso, EPCH	Texas Tech Provider	Wrap Network Preferred Administrators Network / PPO Benefit	Out of Area/ Non-Contracted Providers
Inpatient Behavioral/ Residential Admission	N/A	N/A	$1,000 co-pay 70% after deductible	$2,500 co-pay 50% after deductible
Inpatient Substance Abuse Admission	N/A	N/A	$1,000 co-pay 70% after deductible	$2,500 co-pay 50% after deductible
CO-PAY PROVIDES FOR THE OFFICE VISIT/CONSULTATION ONLY. All other Covered Expenses provided during an office visit are covered at the 100%, 70% or 50% Benefit Percentage according to the network contracted status of the service provider.				
Covered Expenses During Office Visit (Lab, X-Ray)	100% after deductible	100% after deductible	70% after deductible	50% after deductible
(No Maximum Visits)				
The Employee Assistance Program (EAP) offers 8 free counseling sessions for therapy and counseling by providers within the EAP Program. You can call the EAP program at 915-351-4680 to make your appointment. **NOTE: EAP Program is available to Retirees and their Dependents**				
Prior Authorization for professional services is required through the Health Service Department of Preferred Administrators.				
NUTRITIONAL COUNSELING by A Registered Dietitian or Nutritionist **** All Medically Necessary according to evaluation by a Registered Dieticians will be covered at 100% when provided at EPCH, UMC, Texas Tech, or PPO Providers, limited to twelve sessions per Fiscal Year ******				
You will be covered at 100% if you meet specific guidelines according to the United States Preventive Services Task Force (USPSTF) A & B Recommendations	100%	100%	100%	Not Covered
OCCUPATIONAL THERAPY – Non-Workers' Compensation				
Occupational Therapy Office Visits (First Evaluation and Re-Evaluations)	$15 co-pay	$30 co-pay	$40 co-pay	50% after deductible
Occupational Therapy Treatment	100% after deductible	100% after deductible	70% after deductible	50% after deductible
(No Maximum Visits)				
OFFICE VISITS				
Physician, Nurse Practitioner, or Certified Nurse Midwife to include first evaluations of Occupational Therapy, Physical Therapy, and Speech Therapy	$15 co-pay	$30 co-pay	$40 co-pay	50% after deductible
Covered Expenses During Office Visit (Lab, X-Ray)	100% after deductible	100% after deductible	70% after deductible	50% after deductible
Co-pay provides for the office visit/consultation only. All other Covered Expenses provided during an office visit are covered at a 100%, 70% or 50% Benefit Percentage according to the network / Out-of-Area / contracted status of the service provider.				

Benefit Description	UMC, University Medical Center of El Paso, EPCH	Texas Tech Provider	Wrap Network Preferred Administrators Network / PPO Benefit	Out of Area/ Non-Contracted Providers
ORGAN TRANSPLANTS				
Benefits	N/A	N/A	70% after deductible	50% after deductible
Organ Transplant services are provided through the transplant network (Interlink) or contracted transplant facility approved by the Plan Administrator and stop loss carrier. Organ Transplant facilities must be a Center of Excellence with the exception of Member meeting a Medical Hardship, as listed on *pages 78-79.* Multiple listings are not covered under this Plan.				
ORTHOTICS				
Benefits	N/A	N/A	70% after deductible	50% after deductible
One device/pair of orthopedic shoes, orthotics, and other supportive devices for the feet for adults. Limited to one orthotic device/pair per fiscal year. Orthotic devices for dependent children will be covered as needed for medical necessity.				
Orthoses, including orthopedic shoes, wedges, and lifts are a benefit when provided by a licensed orthoptist or a licensed prosthetist/orthoptist/DME.				
PHYSICAL THERAPY				
Physical Therapy Office Visits (First Evaluation and Re-Evaluations)	$15 co-pay	$30 co-pay	$40 co-pay	60% after deductible
Outpatient therapy treatment performed by a licensed therapist or Physician	100% after deductible	100% after deductible	70% after deductible	50% after deductible
(No Maximum Visits)				
PREGNANCY EXPENSES				
Covered Associates and Spouses	Global Maternity for all confirmed pregnancies starting October 1, 2012			
Covered Dependent Daughters	Global Maternity for all confirmed pregnancies starting October 1, 2012			
All Inpatient Maternity admissions require notification from your provider within twenty four (24) hours or the next business day following the delivery. Failure to notify Preferred Administrators of an emergency admission will result in denial of a claim.				
PRESCRIPTION DRUGS				
Co-Payments	**University Medical Center of El Paso Pharmacies** $10 Generic $30 Brand $60 Non-Formulary		**All Retail Pharmacies** $40 Generic $65 Brand $90 Non-Formulary	
Prescription Drug Deductible	UMC Pharmacies Separate $50 Fiscal Year Deductible per Member Retail Pharmacies Separate $100 Fiscal Year Deductible per Member Prescription Drug Deductible does not apply to Medical Plan Deductible, however it does apply towards Out-of-Pocket Maximum.			

Benefit Description	UMC, University Medical Center of El Paso, EPCH	Texas Tech Provider	Wrap Network Preferred Administrators Network / PPO Benefit	Out of Area/ Non-Contracted Providers
Maintenance Medication	**University Medical Center of El Paso Pharmacies Only** A 90 day supply (after prescription deductible) $10 Generic $30 Brand $60 Non-Formulary			
Specialty Drug Medication	**University Medical Center of El Paso Pharmacies Only or mail order** $150 Co-pay and will be dispensed at 30 day supply. Please go to **www.navitus.com** for a complete list of specialty medicines. Specialty medications can be purchased at University Medical Center (UMC) pharmacy at **1-915-521-7705** or can also be purchased through Navitus Specialty RX **855-847-3553.**			
Prescriptions over $500 ***Authorization Required**	Co-pay applies. 50% after prescription drug deductible.		All Network Pharmacies	
If you have any questions regarding Pharmacy, you can contact Navitus Customer Care toll-free at **855-673-6504.** To login to your pharmacy account, please visit **www.navitus.com** and go to Members.				

PHARMACY Benefit Description		University Medical Center of El Paso	All Network Pharmacies	Non-Contracted Providers
PHARMACY OUT-OF-POCKET MAXIMUM PER FISCAL YEAR		All Member's cost share from UMC Pharmacies and all in-network pharmacies will be applied towards the Pharmacy Out-of-Pocket maximum.		Unlimited
Per Member	$9,450			
Family Out-of-Pocket	$18,900			
The Pharmacy Out-of-Pocket maximum includes any applicable co-pays and deductibles from any in-network Pharmacy provider. The Out-of-Pocket maximum applies to all in-network Pharmacy providers and Medical in-network providers. Once the Out-of-Pocket maximum has been reached, the Plan will pay 100% of eligible in-network expenses for the remainder of the current Fiscal Year. The Out-of-Pocket maximum does not include non-compliance penalties and amounts in excess of allowable amounts or any non-covered expenses.				
THE PHARMACY OUT-OF-POCKET IS COMBINED WITH THE MEDICAL OUT-OF-POCKET MAXIMUM				Unlimited

PRESCRIPTION DRUGS – ***continued***

Examples of Covered Drugs

- Adderall, Dexedrine, and Dextrostat
- Drugs requiring a prescription under the applicable state law
- Federal legend prescription drugs
- Injectable insulin, insulin syringes, chemstrips, and blood lancets
- Injectables (other than insulin)
- I.V. medications prescribed by a licensed physician and dispensed by a licensed pharmacist
- Non-insulin needles/syringes
- Oral and injectable contraceptives
- Prescription pre-natal vitamins

Benefit Description	UMC, University Medical Center of El Paso, EPCH	Texas Tech Provider	Wrap Network Preferred Administrators Network / PPO Benefit	Out of Area/ Non-Contracted Providers
Examples of Excluded Drugs • Anabolic steroids • Anorectics (any drug used for the purpose of weight loss) • Cosmetics • Fertility medications • Fluoride supplements, except as covered for children under Preventive Care • Investigational or experimental drugs including compounded medications for non-FDA approved use • Out dated drugs or medicines (dispensed more than a year after the date of the Prescription) • Medical devices and other supplies (example Diabetes blood level monitor is covered under the Plan) • Non-legend drugs other than insulin • No charge prescription under Workers' Compensation, or other governmental program • Rogaine • Viagra and similar drugs for sexual dysfunction • Vitamins other than prescription pre-natal vitamins. This exclusion does not apply to the over-the-counter vitamins and supplements covered under Preventive Care if prescribed by a physician.				
PREVENTIVE CARE				
Office Visits for Annual Physical Exams (PCP). One per Fiscal Year for Male/Female.	100%	100%	100%	Not Covered
Office Visits for Annual Well Women's (OB/GYN). One per Fiscal Year.	100%	100%	100%	Not Covered
Well Adult routine immunizations recommended by the Centers for Disease Control and Prevention (CDC) will be covered over the age of 18. These services come with specific age guidelines.				
Covered Preventive Screenings – You will be covered at 100% if you meet specific guidelines according to the United States Preventive Services Task Force (USPSTF) A & B Recommendations and Women's Preventive Care	100%	100%	100%	Not Covered
NOTE: These services come with specific Guidelines (e.g., frequency).				
Mammogram – Covered at 100% for women ages 40 and older. One per Fiscal Year.	100%	100%	100%	Not Covered
NOTE: If a woman receives a mammogram younger than 40 years of age, it will be considered Diagnostic and your deductibles or PPO co-insurance will apply.				
Flu Shots – Covered	100%	100%	100%	Not Covered
HPV – Age 9 up to 26. (Series must be completed before Member reaches age 26.)	100%	100%	100%	Not Covered
Meningococcal Vaccine	100%	100%	100%	Not Covered
Respiratory Syncytial Virus (RSV) – Age 60 and over.	100%	100%	100%	Not Covered
Zostavax – Age 60 and over. (Shingles)	100%	100%	100%	Not Covered
Shingrix – Age 50 and over. (Shingles)	100%	100%	100%	Not Covered

Benefit Description	UMC, University Medical Center of El Paso, EPCH	Texas Tech Provider	Wrap Network Preferred Administrators Network / PPO Benefit	Out of Area/ Non-Contracted Providers
Well Baby and Well Child Preventative Care/Physical Exams and routine immunizations for covered Members under 18 years of age.	100%	100%	100%	Not Covered
• Routine preventive exams will be covered at 100% according to the American Academy of Pediatric Periodicity Schedule to include; • Routine Vision Exams • Routine Hearing Exams				
All Immunizations required by the Centers for Disease Control and Prevention (CDC) are covered for children and adult through this medical plan and through pharmacy plan (Navitus). Preferred Administrators follows CDC age restrictions and limitations.				
Routine Immunizations include: Diphtheria, Hepatitis B, Rotavirus, Haemophilus Influenza Type B (Hib), Pneumococcal, Pediarix, Measles, Mumps, Rubella (MMR), Pertussis, Polio, Tetanus, and Varicella.				
Tetanus – After age 11 and boosters no more than every 10 years or unless medically necessary.				
REHABILITATION (PHYSICAL) FACILITIES				
Outpatient Services (Cardiac, Occupational Therapy, Physical Therapy, and Speech Therapy)	100% after deductible		70% after deductible	50% after deductible
Covered Expenses During Rehab Stay (Lab, X-Ray)	100% after deductible	100% after deductible	70% after deductible	50% after deductible
SKILLED NURSING FACILITIES				
Benefit	N/A	N/A	70% after deductible	50% after deductible
Maximum Days per Fiscal Year	60			
Confinement must begin within 7 days of the Hospital stay for the same or related conditions unless the admission is certified by medical review as an alternative to an admission to an acute care facility.				
SPEECH THERAPY				
Speech Therapy Office Visits (First Evaluation and Re-Evaluations)	$15 co-pay	$30 co-pay	$40 co-pay	50% after deductible
Speech Therapy Treatment Benefit	100% after deductible	100% after deductible	70% after deductible	50% after deductible
(No Maximum Visits)				
SPINAL ADJUSTMENT / CHIROPRACTIC ADJUSTMENT				
Office Visit	N/A	N/A	$40 co-pay	50% after deductible
Covered Expenses During Office Visit (Lab, X-Ray)	N/A	100% after deductible	70% after deductible	50% after deductible
Co-pay provides for the office visit/consultation only. All other Covered Expenses provided during an office visit are covered at a 100%, 70% or 50% Benefit Percentage according to the network / Out-of-Area / contracted status of the service provider.				
(No Maximum Visits)				

Benefit Description	UMC, University Medical Center of El Paso, EPCH	Texas Tech Provider	Wrap Network Preferred Administrators Network / PPO Benefit	Out of Area/ Non-Contracted Providers
SURGICAL EXPENSES				
Anesthesiology	inpatient or outpatient 100% after deductible	inpatient or outpatient 100% after deductible	inpatient or outpatient 70% after deductible	inpatient or outpatient 50% after deductible
Primary Surgeon	inpatient or outpatient 100% after deductible	inpatient or outpatient 100% after deductible	inpatient or outpatient 70% after deductible	inpatient or outpatient 50% after deductible
Pathology and Radiology	inpatient or outpatient 100% after deductible	inpatient or outpatient 100% after deductible	inpatient or outpatient 70% after deductible	inpatient or outpatient 50% after deductible
TELEHEALTH / TELEMEDICINE				
	UMC, University Medical Center of El Paso, EPCH	**Texas Tech Provider**	**Wrap Network Preferred Administrators Network / PPO Benefit**	**Out of Area/ Non-Contracted Providers***
Includes office visits, psychotherapy, consultants	$15 co-pay	$30 co-pay	$40 co-pay	50% after deductible
***NOTE:** Member will be financially responsible for services rendered by Non-Contracted Providers as explained in the Plan Document.				
Benefit Description	**UMC, University Medical Center of El Paso, EPCH**	**Texas Tech Provider**	**Wrap Network Preferred Administrators Network / PPO Benefit**	**Out of Area/ Non-Contracted Providers**
URGENT CARE / WALK-IN CLINICS				
Urgent Care Services – after hours and weekend medical services for non-emergency illnesses and minor injuries.	$50 co-pay	N/A	$50 co-pay	50% after deductible
Covered Expenses During an Office Visit (For example Labs, X-Ray, Injections, etc.)	100% after deductible	N/A	70% after deductible	50% after deductible

UNITED STATES PREVENTIVE SERVICES TASK FORCE (USPSTF) A & B RECOMMENDATIONS

NOTE: For non-grandfathered health plans, Preferred Administrators will cover the recommended preventive services under the Preventive Care Services benefit as mandated by PPACA, with no cost sharing when provided by a Network provider. These services are described in the United States Preventive Services Task Force A and B recommendations, the Advisory Committee on Immunization Practices (ACIP) of the CDC, and Health Resources and Services Administration (HRSA) Guidelines including the American Academy of Pediatrics Bright Futures periodicity guidelines. While the federal guidelines are subject to change, we recommend referring to the applicable federal websites for the most up-to-date guidelines:

https://www.healthcare.gov/coverage/preventive-care-benefits/;
https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations;
https://www.cdc.gov/vaccines/hcp/acip-recs/index.html;
https://www.aap.org/periodicityschedule; https://www.hrsa.gov/womensguidelines/

Abdominal aortic aneurysm screening: men The USPSTF recommends one-time screening for abdominal aortic aneurysm by ultrasonography in men aged 65 to 75 who have ever smoked.
Alcohol – unhealthy use of; screening and counseling The USPSTF recommends screening and behavioral counseling interventions to reduce alcohol misuse by adults, including pregnant women, in primary care settings.
Anxiety in Children and Adolescents: Screening The USPSTF recommends screening for anxiety in children and adolescents aged 8 to 18 years
Anemia screening: pregnant women The USPSTF recommends routine screening for iron deficiency anemia in asymptomatic pregnant women.
Aspirin Use to Prevent Preeclampsia and Related Morbidity and Mortality: Preventive Medication: pregnant persons at high risk for preeclampsia The USPSTF recommends the use of low-dose aspirin (81 mg/day) as preventive medication after 12 weeks of gestation in persons who are at high risk for preeclampsia. See the Practice Considerations section for information on high risk and aspirin dose.
Aspirin to prevent CVD and colorectal cancer The USPSTF recommends initiating low-dose aspirin use for the primary of cardiovascular disease (CVD) in adults aged 50 to 59 years with a high cardiovascular risk.
Blood pressure screening The USPSTF recommends screening for high blood pressure in adults aged 18 and older.
BRCA Lab Screening and Genetic Counseling and Evaluation for BRCA Testing The USPSTF recommends that primary care providers screen women who have family members with breast, ovarian, tubal, or peritoneal cancer with one of several screening tools designed to identify a family history that may be associated with an increased risk for potentially harmful mutations in breast cancer susceptibility genes (BRCA1 or BRCA2). Women with positive screening results should receive genetic counseling and, if indicated after counseling, BRCA testing.
Breast Cancer: Medication Use to Reduce Risk: women at increased risk for breast cancer aged 35 years or older The USPSTF recommends that clinicians offer to prescribe risk-reducing medications, such as tamoxifen, raloxifene, or aromatase inhibitors, to women who are at increased risk for breast cancer and at low risk for adverse medication effects.
Breast cancer screening The USPSTF recommends screening mammography for women, with or without clinical breast examination, every 1-2 years for women aged 40 and older.

Breastfeeding counseling
The USPSTF recommends interventions during pregnancy and after birth to promote and support breastfeeding.

Cardiovascular Disease Prevention
The USPSTF recommends offering or referring adults with cardiovascular risk factors to behavioral counseling interventions to promote a healthy diet and physical activity.

Cervical cancer screening (women aged 21 to 65)
The USPSTF strongly recommends screening for cervical cancer in women who have been sexually active and have a cervix.

Chlamydia and Gonorrhea infection screening: non-pregnant women
The USPSTF recommends screening for Chlamydia infection for all sexually active non-pregnant young women age 24 and younger and for older non-pregnant women who are at increased risk.

Chlamydia and Gonorrhea infection screening: pregnant women
The USPSTF recommends screening for Chlamydia infection for all pregnant women age 24 and younger and for older pregnant women who are at increased risk.

Cholesterol abnormalities screening: men 35 and older
The USPSTF strongly recommends screening men aged 35 and older for lipid disorders.

Cholesterol abnormalities screening: men younger than 35
The USPSTF recommends screening men aged 20 to 35 for lipid disorders if they are at increased risk for coronary heart disease.

Cholesterol abnormalities screening: women 45 and older
The USPSTF strongly recommends screening women aged 45 and older for lipid disorders if they are at increased risk for coronary heart disease.

Cholesterol abnormalities screening: women younger than 45
The USPSTF recommends screening women aged 20 to 45 for lipid disorders if they are at increased risk for coronary heart disease.

Cholesterol abnormalities screening: women younger than 45
The USPSTF recommends screening women aged 20 to 45 for lipid disorders if they are at increased risk for coronary heart disease.

Cholesterol screening for adults

Colorectal cancer screening
The USPSTF recommends screening for colorectal cancer using fecal occult blood testing, sigmoidoscopy, or colonoscopy, in adults, beginning at age 45 years and continuing until age 75 years. The risks and benefits of these screening methods vary.

** *Colorectal Cancer Screening is restricted to primary diagnosis and claim will pay as preventive if billed with primary diagnosis listed. If preventive diagnosis is not billed as primary, the claim will process as medical and member will have cost share.*
** *Colorectal Cancer Screenings are only for adults beginning at age 45 years and continuing until age 75.*
** *Colonoscopy Screening are recommend every 10 years (normal risk)*
** *Flexible Sigmoidoscopy Screenings are recommended every 5 years, or 10 years (normal risk)*
** *Colonoscopy Screening are recommend once every 4 years (high risk)*
** *Flexible Sigmoidoscopy Screenings are recommended every 2 years, (high risk)*

Contraceptive methods to include Sterilization and Contraceptive Counseling
All Contraceptive methods, services, and supplies covered must be approved by the Food and Drug Administration (FDA). Coverage includes counseling services on contraceptive methods provided by a Physician, Obstetrician or Gynecologist. Covered Contraceptive to include Female Generic Prescription Drugs are covered. All IUDs are covered by the Medical Plan to include its insertion and removal. Please refer to the list of female generic medications posted online. These medications are reimbursed by our RX Pharmacy Vendor (NAVITUSRx).

Dental caries chemoprevention: preschool children The USPSTF recommends that primary care clinicians prescribe oral fluoride supplementation at currently recommended doses to preschool children older than 6 months of age whose primary water source is deficient in fluoride. (Reimbursed by Pharmacy (NAVITUS)
Dental caries screening: children from birth through age 5 years Dental caries prevention with the application of fluoride varnish on primary teeth when performed by a pediatrician.
Depression and Suicide Risk in Children and Adolescents: Screening: adolescents aged 12 to 18 years The USPSTF recommends screening for major depressive disorder (MDD) in adolescents aged 12 to 18 years.
Depression screening: adolescents The USPSTF recommends screening of adolescents (12-18 years of age) for major depressive disorder when systems are in place to assure accurate diagnosis, psychotherapy (cognitive-behavioral or interpersonal), and follow-up.
Depression screening: adults,including pregnant and postpartum women The USPSTF recommends screening adults for depression when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment, and follow-up.
Diabetes screening: Prediabetes and Type 2 The USPSTF recommends screening for Prediabetes and Type 2 in adults aged 35 to 70 years who are overweight or obese.
Falls prevention in community-dwelling older adults The USPSTF recommends exercise interventions to prevent falls in community-dwelling adults 65 years or older who are at increased risk for falls.
Folic Acid supplementation The USPSTF recommends that all women planning or capable of pregnancy take a daily supplement containing 0.4 to 0.8 mg (400 to 800 µg) of folic acid. (Reimbursed by Pharmacy (NAVITUS)
Gestational Diabetes screening in pregnant women The USPSTF recommends gestational diabetes screening in pregnant women between 24 and 28 weeks of gestation and at the first prenatal visit for pregnant women identified to be at high risk for diabetes.
Gonorrhea prophylactic medication: newborns The USPSTF strongly recommends prophylactic ocular topical medication for all newborns against gonococcalophthalmianeonatorum. (Reimbursed by Pharmacy (NAVITUS)
Gonorrhea screening: women The USPSTF recommends that clinicians screen all sexually active women, including those who are pregnant, for gonorrhea infection if they are at increased risk for infection (that is, if they are young or have other individual or population risk factors).
Healthy diet counseling The USPSTF recommends intensive behavioral dietary counseling for adult patients with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic disease. Intensive counseling can be delivered by primary care clinicians or by referral to other specialists, such as nutritionists or dietitians.
Hearing loss screening: newborns The USPSTF recommends screening for hearing loss in all newborn infants.
Hemoglobinopathies screening: newborns The USPSTF recommends screening for sickle cell disease in newborns.
Hepatitis B screening The USPSTF recommends screening for hepatitis B virus (HB) infection in adolescents and adults at increased risk for infection. The USPSTF recommends screening for hepatitis B virus (HBV) infection in pregnant women at their first prenatal visit.

Hepatitis C screening Recommends screening for adults ages 18-79, and other ages at increased risk.
Human Immunodeficiency Virus HIV screening and prevention of HIV infection Strongly recommends that clinicians screen for human immunodeficiency virus (HIV) for everyone ages 15-65, and other ages at increased risk for HIV infection. Preexposure Prophylaxis (PrEP), for individuals at high risk of infection. That includes anyone with an HIV-positive sex partner; who has sex without a condom with someone at high risk of HIV; or who shares needles while injecting drugs. Cost-sharing protections extend to the ancillary and support services that are needed for an effective PrEP regimen.
Human papillomavirus testing The USPSTF recommends screening for high-risk human papillomavirus DNA testing in women with normal cytology results. Screening should begin at 30 years of age and should occur no more frequently than every 3 years.
Hypertension in Adults: screening for adults 18 years or older without known hypertension The USPSTF recommends screening for hypertension in adults 18 years or older with office blood pressure measurement (OBPM). The USPSTF recommends obtaining blood pressure measurements outside of the clinical setting for diagnostic confirmation before starting treatment.
Hypothyroidism screening: newborns The USPSTF recommends recommends screening for congenital hypothyroidism in newborns.
Intimate partner violence screening and counseling The USPSTF recommends screening and counseling for intimate partner violence. Coverage for PCP, LPC and LSW.
Iron Supplementation in children The USPSTF recommends routine iron supplementation for asymptomatic children aged 6 to 12 months who are at increased risk for iron deficiency anemia.
Latent Tuberculosis Infection The USPSTF recommends screening for latent tuberculosis infection (LTBI) in populations at increased risks.
Lung cancer screening USPSTF recommends annual screening for lung cancer with low-dose computed tomography in adults ages 50 to 80 years who have a 20 pack-year smoking history and currently smoke or have quit within the past 15 years.
Obesity prevention and Weight loss counseling: adults The USPSTF recommends that clinicians offer or refer adults with a body mass index (BMI) or 30 or higher to intensive counseling and behavioral interventions to promote sustained weight loss for obese adults.
Obesity screening and counseling: children The USPSTF recommends that clinicians screen children aged 6 years and older and offer them or refer them to comprehensive, intensive behavioral interventions to promote improvement in weight status.
Ocular Prophylaxis for Gonococcal Ophthalmia Neonatorum: Preventive Medication The USPSTF recommends prophylactic ocular topical medication for all newborns to prevent gonococcal ophthalmia neonatorum.
Osteoporosis screening For women age 65 and older, and postmenopausal women younger than 65 who are at increased risk of osteoporosis. Frequency is every two years.
Preeclampsia prevention and screening for pregnant women with high blood pressure
Preventive Annual/ Physical Exams for Male/Female: Age Group — 0-1 year The frequency of visits are 3-5 days, 1 month, 2 months, 4 months, 6 months, and 9 months

Preventive Annual/ Physical Exams for Male/Female: Age Group — 1-4 years *After 1 year of age, exams are covered, 15 months, 24 months, 30 months, 3 years
Preventive Annual/ Physical Exams for Male/Female: Age Group — 5-11 years *After 1 year of age, exams are only covered, one per Fiscal Year
Preventive Annual Physical Exams for Male/Female: Age Group — 18-39 age This would include Well Adult Visit (Physicals). (One per Fiscal Year)
Preventive Annual Physical Exams for Male/Female: Age Group — 40-64 age This would include Well Adult Visit (Physicals). (One per Fiscal Year)
Preventive Annual Physical Exams for Male/Female: Age Group — 65-older This would include Well Adult Visit (Physicals). (One per Fiscal Year)
Preventive Well Women Annual Visits with OB/GYN (One per Fiscal Year)
Prostate Cancer Screening for men age 40 and older
Routine Immunizations and Administration of Vaccines for Children and Adult
Rh incompatibility screening: first pregnancy visit The USPSTF strongly recommends Rd (D) blood typing and antibody testing for all pregnant women during their first visit for pregnancy-related care.
Rh incompatibility screening: 24-28 weeks gestation The USPSTF recommends repeated Rh (D) antibody testing for all unsensitized Rh (D)-negative women at 24-28 weeks gestation, unless the biological father is known to be Rh (D)-negative.
Skin Cancer Prevention: Behavioral Counseling: young adults, adolescents, children, and parents of young children The USPSTF recommends counseling young adults, adolescents, children, and parents of young children about minimizing exposure to ultraviolet (UV) radiation for persons aged 6 months to 24 years with fair skin types to reduce their risk of skin cancer.
Statin screening for adults at higher risk
Statin use for the primary prevention of cardiovascular disease: adults The USPSTF recommends that adults without a history of cardiovascular disease (CVD) (i.e., symptomatic coronary artery disease or ischemic stroke) use a low- to moderate-dose statin for the prevention of CVD events and mortality when all of the following criteria are met: 1) they are aged 40 to 75 years; 2) they have 1 or more CVD risk factors (i.e., dyslipidemia, diabetes, hypertension, or smoking), and 3) they have a calculated 10-year risk of a cardiovascular event of 10% or greater. Identification of dyslipidemia and calculation of 10-year CVD event risk requires universal lipids screening in adults aged 45 to 75 years.
Sterilization for women and men All voluntary sterilization for both women and men are covered.
STIs counseling The USPSTF recommends high-intensity behavioral counseling to prevent sexually transmitted infections (STIs) for all sexually active adolescents and for adults at increased risk for STIs.
Syphilis screening: non-pregnant adults The USPSTF strongly recommends that clinicians screen persons at increased risk for syphilis infection.
Syphilis screening: pregnant women The USPSTF recommends that clinicians screen all pregnant women for syphilis infection.
Tobacco use counseling: non-pregnant adults The USPSTF recommends that clinicians ask all adults about tobacco use and provide tobacco cessation interventions for those who use tobacco products.

Tobacco use counseling: pregnant women The USPSTF recommends that clinicians ask all pregnant women about tobacco use and provide augmented, pregnancy-tailored counseling to those who smoke.
Tobacco use screening for all adults and cessation interventions for tobacco users. The recommendation is that clinicians ask all adults about tobacco use, advise them to stop using tobacco, and provide behavioral interventions and U.S. Food and Drug Administration (FDA)-approved pharmacotherapy for cessation to adults who use tobacco.
Tuberculosis screening for adults at increased risk
Unhealthy Drug Use Screening. The USPSTF recommends screening by asking questions about unhealthy drug use in adults age 18 years or older. Screening should be implemented when services for accurate diagnosis, effective treatment, and appropriate care can be offered or referred.
Urinary tract or other infection screening
Visual acuity screening in children The USPSTF recommends screening to detect amblyopia, strabismus, and defects in visual acuity in children younger than age 5 years.

WOMEN'S PREVENTIVE SERVICES

1. Anemia screening on a routine basis.
2. Asymptomatic bacteriuria screening in pregnant women at 12 to 16 weeks gestation or at their first prenatal visit using urine culture.
3. Breast cancer chemoprevention counseling and medications for women at higher risk. For women who are at increased risk for breast cancer and at low risk for adverse medication effects, clinicians should offer to prescribe risk-reducing medications, such as tamoxifen or raloxifene.
4. Breast cancer genetic test counseling (BRCA) for women at higher risk.
5. Breast cancer mammography screenings every 1 to 2 years for women over 40.
6. Breastfeeding comprehensive support and counseling from trained providers, and access to breast feeding supplies, for pregnant and nursing women.

   Please see note below regarding Breast Pump Reimbursement.

   <u>Breastfeeding support, supplies, and counseling</u> *(see note)* – Recommends comprehensive lactation support and counseling, by a trained provider during pregnancy and/or in the postpartum period, and costs for renting breastfeeding equipment.**

   ****<u>NOTE: Breastfeeding Support/Supplies</u>**
   The purchase of a portable double electric pump (non-hospital grade)
   A purchase will be covered once every five years following the date of the birth. If a portable double electric pump was purchased within the previous period, the purchase of a portable double electric pump will not be covered until a five year period has elapsed from the last purchase of this type of electric pump.

   <u>The purchase of a manual breast pump</u>
   A purchase will be covered once every five years following the date of the birth. If a manual pump was purchased within the previous period, the purchase of a manual pump will not be covered until a five year period has elapsed from the last purchase of this type of pump.

   <u>Breast Pump Supplies</u>
   Coverage is limited to only one per pregnancy in a year where a covered female would not qualify for the purchase of a new pump. Coverage for the purchase of breast pump equipment is limited to one item of equipment for the same or similar purpose and the accessories and supplies needed to operate the item.

   <u>Breast Pump Reimbursement</u>
   Preferred Administrators will reimburse members for the purchase of a portable double electric non-hospital grade breast pump up to $200.00 once every 5 years or up to $50.00 once per pregnancy for supplies, if they already have a breast pump. Breast Pump Reimbursement Forms can be found at www.preferredadmin.net

   The Member is responsible for the entire cost of any additional same or similar equipment that is purchased or rented for personal convenience or mobility.
7. Cervical cancer screening from ages 21-65. Screening for cervical cancer every 3 years with cervical cytology alone in women aged 21 to 29 years. For women aged 30 to 65 years, screening every 3 years with cervical cytology alone, every 5 years with high-risk human papillomavirus (hrHPV) testing alone, or every 5 years with hrHPV testing in combination with cytology (cotesting).
8. Chlamydia infection screening for sexually active women age 24 years and younger and older women who are at increased risk for infection.
9. Contraception: Food and Drug Administration – Approved contraceptive methods, sterilization procedures, and patient education and counseling, as prescribed by a health care provider for women with reproductive capacity (not including abortifacient drugs). This does not apply to health plans sponsored by certain exempt "religious employers."
10. Counseling and screening for human immune-deficiency virus (HIV) – Recommends annual Counseling and screening for human immune-deficiency virus(HIV) infection for all sexually active women.

11. Counseling for sexually transmitted infections – Recommends annual counseling on sexually transmitted infections for all sexually active women.
12. Depression screening for women during pregnancy and in the postpartum period.
13. Diabetes screening for women with a history of gestational diabetes who aren't currently pregnant and who haven't been diagnosed with type 2 diabetes before.
14. Expanded tobacco intervention and counseling for pregnant tobacco users.
15. Folic acid supplements for women who may become pregnant.
16. Gestational diabetes screening – Recommends that all pregnant women between 24 and 28 weeks of gestation and at the first prenatal visit for pregnant women identified to be at high risk for diabetes.
17. Gestational diabetes screening for women 24 weeks pregnant or after and those at high risk of developing gestational diabetes.
18. Gonorrhea screening for sexually active women age 24 years and younger and in older women who are at increased risk for infection.
19. Hepatitis B screening for pregnant women at their first prenatal visit.
20. Human Immunodeficiency Virus (HIV) screening and counseling for sexually active women.
21. Human Papillomavirus (HPV) DNA test with the combination of a Pap smear every 5 years for women 30 to 65 who don't want a Pap smear every 3 years.
22. Human papillomavirus (HPV) testing – Recommends High-risk human papillomavirus DNA testing in women with normal cytology results. Screening should begin at 30 years of age and should occur no more frequently than every 3 years.
23. Intimate partner violence screening, which includes providing or referring women who screen positive to ongoing support services.
24. Obesity counseling to prevent and reduce obesity in midlife women (ages 40 to 60).
25. Osteoporosis screening for women 65 and older, and postmenopausal women younger than 65 who are at increased risk of osteoporosis.
26. Other covered preventive services for women
    a. Pap test (also called a Pap smear) every 3 years for women 21 to 65
27. Preeclampsia prevention and screening for pregnant women with high blood pressure measurements throughout pregnancy.
28. Rh incompatibility screening for all pregnant women and follow-up testing for women at higher risk.
29. Screening for Diabetes Mellitus After Pregnancy – Recommended for women with a history of gestational diabetes mellitus (GDM) who are not currently pregnant and who have not previously been diagnosed with type 2 diabetes mellitus should be screened for diabetes mellitus. Initial testing should ideally occur within the first year postpartum and can be conducted as early as 4-6 weeks postpartum. Women with a negative initial postpartum screening test result should be rescreened at least every 3 years for minimum of 10 years after pregnancy.
30. Sexually transmitted infections counseling for sexually active women.
31. Syphilis screening for all pregnant women and women at increased risk.
32. Tobacco use screening and interventions. The recommendation is that clinicians ask all pregnant women about tobacco use, advise them to stop using tobacco, and provide behavioral interventions for cessation to pregnant women who use tobacco.
33. Urinary incontinence screening for women yearly.
34. Urinary tract or other infection screening.
35. Well-woman visits recommended services for women under 65. Well women exams are covered once per Fiscal Year.

ARTICLE IV
DEFINITIONS

4.01 **Accidental Injury** means accidental bodily Injury caused by unexpected external means, resulting, directly and independently of all other causes, in necessary care rendered by a Physician.

4.02 **Actively at Work** means the active expenditure of time and energy in the service of the Employer, except that an Associate is deemed Actively at Work on each day of a regular paid vacation or on a regular non-working day, provided he was Actively at Work on the last preceding regular working day.

4.03 **ADA** means the American Dental Association.

4.04 **Administrative Denial** means a determination that is issued due to benefit exclusions, benefit exhaustions, and includes, but is not limited to determinations for failure to follow health plan notification timelines and prior authorization procedures.

A Provider may request a review of an Administrative Denial which is not related to a review for medical necessity for the below administrative actions:

- The failure of Preferred Administrators to act within the described timeframes;
- The denial in whole or in part of payment for a service not related to medical necessity;
- A dispute for a claims coding issue

NOTE: Non-covered benefits are not eligible for a second review. However, a Provider may file a complaint relating to denials of non-covered benefits.

4.05 **Adverse Benefit Determination** means any of the following: a denial, reduction, rescission of coverage (even if the rescission does not impact a current claim for benefits), or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be not medically necessary or appropriate.

Preferred Administrators has a split process for handling Adverse Benefit Determination decisions. Please refer to Administrative Denial and Adverse Determination definitions in this section.

Appeals involving benefits exclusions such relating to experimental, investigational or not medically necessary are part of an Adverse Benefit Determination.

4.06 **Adverse Determination** – A determination by a URA made on behalf of any payor that the health care services provided or proposed to be provided to a Member are not medically necessary or appropriate or are experimental or investigational. The term does not include a denial of health care services due to the failure to request prospective or concurrent utilization review.

4.07 **Adverse Determination Appeal** – A URA's formal process by which an enrollee, an individual acting on behalf of an enrollee, or an enrollee's provider of record may request reconsideration of an adverse determination.

4.08 **Affiliates** means University Medical Center of El Paso, and any other qualifying or eligible employer authorized to adopt the Plan by the Employer and who has adopted the Plan by its duly authorized board.

4.09 **AHA** means the American Hospital Association.

4.10 **Allowable Expense(s)** means the Maximum Allowable Charge for any Medically Necessary, eligible item of expense, at least a portion of which is covered under this Plan. When some Other Plan pays first in accordance with the Coordination of Benefits section, this Plan's Allowable Expenses shall in no event exceed the Other Plan's Allowable Expenses.

When some "Other Plan" provides benefits in the form of services (rather than cash payments), the Plan Administrator shall assess the value of said benefit(s) and determine the reasonable cash value of the service or services rendered, by determining the amount that would be payable in accordance with the terms of the Plan. Benefits payable under any Other Plan include the benefits that would have been payable had the claim been duly made therefore, whether or not it is actually made.

4.11 **Ambulatory Surgical Facility** means any public or private specialized facility (state licensed and approved whenever required by law) with an organized medical staff of Physicians, that:

(a) has permanent facilities equipped and operated primarily for the purpose of performing surgical procedures on an outpatient basis; and
(b) has continuous Physician services and registered professional nursing service whenever a patient is in the facility; and
(c) does not provide accommodations for patients to stay overnight.

4.12 **Ancillary Services** means services rendered in connection with inpatient or outpatient care in a Hospital or in connection with a Medical Emergency including the following: ambulance, anesthesiology, assistant surgeon, pathology, and radiology. This term also includes services of the attending Physician or primary surgeon in the event of a Medical Emergency.

4.13 **Approved Clinical Trial** means a Phase I, II, III or IV clinical trial for the prevention, detection or treatment of cancer or other life-threatening condition or disease including federally funded trials, trials conducted under an investigational new drug application reviewed by the FDA or drug trials exempt from having an investigational new drug application.

A life-threatening condition is any disease or condition from which the likelihood of death is probable unless the course of the disease is interrupted.

4.14 **Assignment of Benefits**

For this purpose, the term "Assignment of Benefits" (or "AOB") is defined as an arrangement whereby a Member of the Plan, at the discretion of the Plan Administrator, assigns its right to seek and receive payment of eligible Plan benefits, less Deductible, Copayments and Coinsurance amounts, to a medical Provider. If a Provider accepts said arrangement, the Provider's rights to receive Plan benefits are equal to those of the Member, and are limited by the terms of this Plan Document. A Provider that accepts this arrangement indicates acceptance of an AOB and Deductibles, Copayments, and Coinsurance amounts, as consideration in full for treatment rendered.

The Plan Administrator may revoke an AOB at its discretion and treat the Member of the Plan as the sole beneficiary. Benefits for medical expenses covered under this Plan may be assigned by a Member to the Provider as consideration in full for services rendered; however, if those benefits are paid directly to the Member, the Plan will be deemed to have fulfilled its obligations with respect to such benefits. The Plan will not be responsible for

determining whether any such assignment is valid. Payment of benefits which have been assigned may be made directly to the assignee unless a written request not to honor the assignment, signed by the Member, has been received before the proof of loss is submitted, or the Plan Administrator – at its discretion – revokes the assignment.

No Member shall at any time, either during the time in which he or she is a Member in the Plan, or following his or her termination as a Member, in any manner, have any right to assign his or her right to sue to recover benefits under the Plan, to enforce rights due under the Plan or to any other causes of action which he or she may have against the Plan or its fiduciaries. A medical Provider which accepts an AOB does as consideration in full for services rendered and is bound by the rules and provisions set forth within the terms of this document.

4.15 **Associate** means the following:

(1) **Full-time, Regular**
Regularly scheduled to work on a consistent basis at least thirty (30) hours per week; jobs may be classified as exempt or nonexempt.

(2) **Part-time, Regular**
Regularly scheduled to work on a consistent basis at least twenty (20) but less than thirty (30) hours per week; jobs may be classified as exempt or nonexempt.

and who is performing his customary duties at the Employer's facility or other location designated by the Employer. Associate does not include:

(a) any individual who is classified as an independent contractor for purposes of federal income tax reporting and withholding;
(b) any individual who performs services as a leased employee within the meaning of Code Section 414(n), or who otherwise performs services through an agreement with a leasing organization or outsourcing provider;
(c) relief personnel;
(d) temporary employees; or
(e) PRNs.

4.16 **Balance Billing** occurs when physicians or other medical providers and hospitals or facilities who are not contracted within the preferred provider benefit plan bill you for the difference between the amount the health plan pays them and the amount the provider or facility has billed.

4.17 **Benefit Percentage** means the portion of eligible expenses payable by the Plan in accordance with the coverage provisions as stated in the Plan.

4.18 **Benefit Management Advisors** means the team established by the Plan Sponsor to oversee the operations of the Plan including the development of recommendations regarding coverage and plan provisions, establishing the budget for the Plan, and making final determinations regarding complaints and appeals after exhausting all level of appeals with Preferred Administrators. The advisory team is comprised of the positions of Chief Financial Officer, Chief Administrative Officer, Chief Executive Officer El Paso Health Plans, Chief Medical Officer El Paso Health, and Administrative Director of Human Resources. The team is staffed by the Benefits section of the Human Resources Department.

4.19 **Birthing Center** means a freestanding facility that:

(a) is licensed to provide a setting for pre-natal care, delivery and immediate postpartum care; and
(b) has an organized staff of Physicians; and
(c) has permanent facilities that are equipped and operated primarily for Dependent Childbirth; and

(d) has a contract with at least one nearby Hospital for immediate acceptance of patients who require Hospital care; and
(e) does not provide accommodations for patients to stay overnight; and
(f) provides continuous services of Physicians, registered nurses, or certified nurse midwife practitioners when a patient is in the facility.

4.20 **Centers of Excellence** means transplant centers with proven credentials and outcome statistics.

4.21 **Certified IDR Entity** means an entity responsible for conducting determinations under the No Surprises Act and that has been properly certified by the Department of Health and Human Services, the Department of Labor, and the Department of the Treasury.

4.22 **Change in Family Status** means:

(a) the marriage or divorce of the Member;
(b) the death of the Member's Spouse or Dependent;
(c) the birth, adoption, or placement for adoption of a child of the Member;
(d) a Dependent ceases to satisfy the requirements of Dependent coverage due to attainment of age, or any similar circumstance as provided in a Benefit Program;
(e) the termination of employment (or commencement of employment) of his Spouse;
(f) the strike or lockout of the Member, or his Spouse or Dependent;
(g) the switching from part-time to full-time employment status or from full-time to part-time status by the Member or his Spouse;
(h) the taking of an unpaid leave of absence by the Member or his Spouse;
(i) a significant change in the health coverage of the Member or Spouse attributable to the Spouse's employment; or
(j) any other event determined by the Plan Administrator to be a Change in Family Status consistent with Code Section 125.

4.23 **Change in Status or Coverage** means:

(a) the marriage or divorce of the Member;
(b) the death of his Spouse or Dependent;
(c) the birth, adoption, or placement for adoption of a Dependent Child;
(d) a Dependent ceases to satisfy the requirements of Dependent coverage due to attainment of age, or any similar circumstance as provided in a Benefit Program;
(e) the termination of employment (or commencement of employment) of the Member's Spouse;
(f) the strike or lockout of the Member, or the Spouse or Dependent Child;
(g) the change in residence or worksite of the Member, or the Spouse or Dependent;
(h) the switching from part-time to full-time employment status or from full-time to part-time status by the Member or his Spouse;
(i) the taking of an unpaid leave of absence by the Member or his Spouse;
(j) a significant change in the health coverage of the Member or his Spouse attributable to the Spouse's employment;
(k) the change in employment status of the Member, Spouse or Dependent Child that affects eligibility for a Benefit Program or a plan of the employer of his Spouse or Dependent Child;
(l) the addition of a Benefit Program, or of an option for coverage under a Benefit Program providing accident or health benefits;
(m) the significant improvement of coverage under a Benefit Program or Benefit Program option providing accident or health benefits;
(n) a coverage change made under the plan of the employer of a Member's Spouse or Dependent, including an election change made during the open enrollment of a Member's Spouse;
(o) the change in a Member's, or a Member's Spouse's or Dependent's, entitlement for Medicare or Medicaid;

(p) 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); or
(q) 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; or
(r) an HMO ceasing operations; or
(s) a plan no longer offering any benefits to a class of similarly situated individuals; or
(t) cessation of employer contributions for the other health coverage; or
(u) the exhausting of COBRA continuation coverage; or
(v) any other event determined by the Plan Administrator to be a Change in Status or Coverage consistent with Code Section 125.

4.24 **Child** means, in addition to the Associate's own blood descendant of the first degree or lawfully adopted Child, a Child placed with a covered Associate in anticipation of adoption; a covered Associate's Child who is an alternate recipient under a Qualified Medical Child Support Order as required by the Federal Omnibus Budget Reconciliation Act of 1993; any stepchild; an "eligible foster child," which is defined as an individual placed with the Associate by an authorized placement agency or by judgment, decree, or other order of a court of competent jurisdiction; a newborn Child born via surrogacy, provided that such Child is the legal Child of an Associate as evidenced by an order of a court of competent jurisdiction validating the Associate's gestational agreement, and further provided that the Associate enrolls such Child in the plan within 30 days of such Child's birth pursuant to Section 5.01; or any other Child for whom the Associate has obtained legal guardianship.

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

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

4.27 **Clean Claim** means a claim that may be processed without obtaining additional information from the provider of service or from a third party, but does not include a claim under investigation for fraud or abuse or under review for medical necessity. For electronic claims, a clean claim must meet all requirements for accurate and complete data as defined in the appropriate 837-(claim type) encounter guides as follows:

- 837 Professional Combined Implementation Guide
- 837 Institutional Combined Implementation Guide
- 837 Professional Companion Guide
- 837 Institutional Companion Guide

Preferred Administrators may require Provider to submit documentation that conflicts with the requirements of Texas Administrative Code, Title 28, Part 1, Chapter 21, Subchapters C and T.

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

4.29 **Complaint** means any dissatisfaction, expressed by a complainant, orally or in writing to El Paso Health, with any aspect of El Paso Health's operation, including, but not limited to, dissatisfaction with plan administration, the denial, reduction, or termination of a service for reasons not related to medical necessity; the way a service is provided; or disenrollment decisions. The term does not include misinformation that is resolved promptly by supplying the appropriate information or clearing up the misunderstanding to the satisfaction of the complainant.

4.30 **Complete Claim** means a claim submitted by an Associate or a Provider that complies with Subchapter J, Chapter 843 of the Texas Insurance Code, as updated or amended, and supplies all the information required by Texas Admin. Code § 21.2803, as updated or amended.

4.31 **Coordination of Benefits (COB)** means the technique used to determine the amount of benefits paid on a claim when the Member has more than one source of medical benefit coverage.

4.32 **Cosmetic Surgery or Procedures** means any Surgery, service, Drug or supply designed to improve the appearance of an individual by alteration of a physical characteristic which is within the broad range of normal but which may be considered unpleasing or unsightly, except when necessitated by an Injury.

4.33 **Coverage Date** means the date an Associate or Dependent has met all of the eligibility requirements for coverage.

4.34 **Covered Expense(s)** a service or supply provided in accordance with the terms of this document, whose applicable charge amount does not exceed the Maximum Allowable Charge for an eligible Medically Necessary service, treatment or supply, meant to improve a condition or Member's health, which is eligible for coverage under this Plan. Covered Expenses will be determined based upon all other Plan provisions. When more than one treatment option is available, and one option is no more effective than another, the Covered Expense is the least costly option that is no less effective than any other option.

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

4.35 **Creditable Coverage** means prior continuous health coverage and includes prior coverage under:

(a) another group health plan;
(b) group or individual health insurance coverage issued by a state regulated insurer or an HMO;
(c) COBRA;
(d) Medicaid;
(e) Medicare;
(f) State Children's Health Insurance Program (SCHIP);
(g) the Active Military Health Program;
(h) Tricare/CHAMPUS;
(i) American Indian Health Care Programs;
(j) a State health benefits risk pool;
(k) the Federal Employees Health Plan;
(l) the Peace Corp Health Program; or
(m) a public health plan, including plans established or maintained by a state, the United States government, a foreign country, or any political subdivision of a state, the United States government, or a foreign country that provides health coverage to individuals who are enrolled in the plan (for example, coverage through the United States Veterans Administration and coverage from a state or federal penitentiary).

4.36 **Custodial Care** means 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 individuals who have no medical training. Examples of custodial care include help in walking and getting out of bed; assistance in bathing, dressing, and feeding; or supervision over medication, which could normally be self-administered.

4.37 **Deductible** means the amount of covered medical expenses which must be paid by a Member each Fiscal Year before benefits are payable under this Plan. A separate deductible applies to a covered Associate and each of the Associate's Dependents, subject to the family deductible limit. As applied to dental benefits under this Plan, this term means the amount of covered dental expenses which must be paid by a Member each Fiscal Year before benefits are payable under this Plan. A separate deductible applies to a covered Associate and each of the Associate's Dependents, subject to the family deductible limit.

4.38 **Dentist** means a currently licensed dentist practicing within the scope of the license or any other Physician furnishing dental services which the Physician is licensed to perform.

4.39 **Dependent** means one or more of the following person(s):

1. A covered Associate's or Retiree's lawfully married spouse possessing a marriage license who is not divorced from the Associate or Retiree. Please reference to definition of Spouse under section 4.112.
2. A Member's grandchild, for medical coverage only, when the grandchild is a legal adopted child of the Associate or Retiree. A grandchild will be eligible as a Dependent provided the grandchild is:
   (a) under the age of 26, or over the age of 26 if Totally Disabled. Upon reaching the age of 26, proof of Total Disability provided to the Plan Administrator within 30 days of age 26 and may be required from time to time but not more frequently than annually, Total Disability is continuous, and the grandchild is continuously covered by the Plan;
   (b) A Dependent Child up to the age of 26 and being an active dependent on the current fiscal year, provided the disability before the age of 26.
3. An Associate's or Retiree's Dependent Child or Children, for coverage under the medical plan only, the Associate's or Retiree's natural children, legally adopted children (including children placed for adoption for whom legal adoption proceedings have been started), step-children, children the Member has obtained legal guardianship for; and children required to be covered under a Qualified Medical Child Support Order (QMCSO). A Dependent Child includes foster children. A Dependent Child includes a newborn child born via surrogacy, provided that such child is the legal child of an Associate or Retiree as evidenced by an order of a court of competent jurisdiction validating the Associate's or Retiree's gestational agreement, and further provided that the Associate or Retiree enrolls such child in the plan within 30 days of such child's birth pursuant to Section 5.01. A Dependent Child must also meet the following requirements:
   (a) Under the age of 26, or over the age of 26 if Totally Disabled. Upon reaching the age of 26 and being an active dependent on the plan, proof of Total Disability is provided to the Plan Administrator within 30 days of age 26 and may be required from time to time but not more frequently than annually, Total Disability is continuous, and the Dependent Child is continuously covered by the Plan;
   (b) A Dependent up to the age of 26 and being an active dependent on the current fiscal year, provided the disability before the age of 26.
   (c) Coverage for Dependent Children up to the age of 26 to continue their coverage under their parent's insurance even if they were eligible for other employer-sponsored coverage. Coverage for Dependent Children will terminate at the end of the month in which they reach age 26. This coverage does not extend to your child's spouse or their children.

4.40 **Durable Medical Equipment** means equipment prescribed by the attending Physician which: is Medically Necessary; is not primarily or customarily used for non-medical purposes; is designed for prolonged use; and serves a specific therapeutic purpose in the treatment of an Accidental Injury or Illness. Durable Medical Equipment includes surgical equipment and accessories needed to operate the equipment.

4.41 **Effective Date** means October 1, 2002 and the dates of subsequent amendments and restatements. The current restatement effective date is October 1, 2023.

4.42 **Eligible Expense** means the Maximum Allowable Charge charges incurred for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body or the expense that is agreed upon as a health services fee for health services and supplies covered under a health plan. The reasonable charge is the lesser of:

(a) the contracted rate with the PPO provider Preferred Administrators network; or
(b) the lesser of the contracted rate for a provider who is contracted with the wrap; or
(c) network for Non-Preferred / Out-of-Area services or the Medicare allowable amount; or
(d) the Maximum Allowable Charge allowable amount for Non-Preferred providers; or
(e) the actual charge issued by the provider.

In the event the actual charge is less than a contracted charge, the lesser amount will be considered the Eligible Amount unless prohibited by the terms of the applicable contract.

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

4.44 **Emergency Services** means, with respect to an Emergency Medical Condition, the following:

1. An appropriate medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a Hospital or of an Independent Freestanding Emergency Department, as applicable, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition; and

2. Within the capabilities of the staff and facilities available at the Hospital or the Independent Freestanding Emergency Department, as applicable, such further medical examination and treatment as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd), or as would be required under such section if such section applied to an Independent Freestanding Emergency Department, to stabilize the patient (regardless of the department of the Hospital in which such further examination or treatment is furnished).

When furnished with respect to an Emergency Medical Condition, Emergency Services shall also include an item or service provided by a Non-Network Provider or Non-Participating Health Care Facility (regardless of the department of the Hospital in which items or services are furnished) after the Member is stabilized and as part of Outpatient observation or an Inpatient or Outpatient stay with respect to the visit in which the Emergency Services are

furnished, until such time as the Provider determines that the Member is able to travel using non-medical transportation or non-emergency medical transportation, and the Member is in a condition to, and in fact does, give informed consent to the Provider to be treated as a Non-Network Provider.

4.45 **Employer** means University Medical Center of El Paso and/or its Affiliates, as the circumstances relating to a particular Associate or situation dictate.

4.46 **ERISA** means the Employee Retirement Income Security Act of 1974, as amended.

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

4.48 **Experimental and/or Investigational ("Experimental")** means services or treatments that are not widely used or accepted by most practitioners or lack credible evidence to support positive short or long-term outcomes from those services or treatments, and that are not the subject of, or in some manner related to, the conduct of an Approved Clinical Trial, as such term is defined herein; these services are not included under or as Medicare reimbursable procedures, and include services, supplies, care, procedures, treatments or courses of treatment which:

(1) Do not constitute accepted medical practice under the standards of the case and by the standards of a reasonable segment of the medical community or government oversight agencies at the time rendered; or

(2) Are rendered on a research basis as determined by the United States Food and Drug Administration and the AMA's Council on Medical Specialty Societies.

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

(1) If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished;

(2) If reliable evidence shows that the drug, device or medical treatment or procedure is the subject of ongoing Phase I, II, or III clinical trials or under study to determine its:
   (a) maximum tolerated dose;
   (b) toxicity;
   (c) safety;
   (d) efficacy; and
   (e) efficacy as compared with the standard means of treatment or diagnosis; or

(3) If reliable evidence shows that the consensus among experts regarding the drug, device, or medical treatment or procedure is that further studies or clinical trials are necessary to determine its:
   (a) maximum tolerated dose;
   (b) toxicity;
   (c) safety;
   (d) efficacy; and
   (e) efficacy as compared with the standard means of treatment or diagnosis.

Reliable evidence shall mean:

(1) Only published reports and articles in the authoritative medical and scientific literature.

(2) The written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, or medical treatment or procedure; or

(3) The written informed consent used by the treating facility or by another facility studying substantially the same drug, device, or medical treatment or procedure.

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

4.49 **FMLA** means the Family and Medical Leave Act of 1993, as amended.

4.50 **Family Deductible Limit** Family deductible is considered satisfied if family amount is met AND Subscriber's individual deductible is met. The subscriber deductible must be met for family max deductible to be met. If a Subscriber deductible does not meet their individual deductible, a family max will not be satisfied until the Subscriber has met their individual deductible.

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

4.52 **Global Maternity** means global maternity care, which includes routine ante-partum care, delivery and post-partum care.

4.53 **Health Care Spending Account** means the Health Care Spending Account under the University Medical Center of El Paso Section 125 Cafeteria Plan, or any subsequent cafeteria plan maintained by the Employer.

4.54 **Health Risk Assessment (HRA)** means the University Medical Center of El Paso annual program which evaluates an Associate's overall health condition through a series of questionnaires, lab work, fitness testing, etc.

4.55 **HIPAA** means the Health Insurance Portability and Accountability Act of 1996, as amended.

4.56 **Home Health Care Agency** means an agency or organization that:

(a) is licensed and primarily engaged in providing skilled nursing care and other therapeutic services; and

(b) has policies established by a professional group associated with the agency or organization that includes at least one Physician and one registered nurse (R.N.) who provide full-time supervision of such services; and

(c) maintains complete medical records on each individual and has a full-time administrator.

(d) Personal Care Providers are not covered. The following are examples of a Personal Care Provider:

— Assisting with eating, bathing, dressing, personal hygiene, housekeeping chores, transportation and daily activity living.

4.57 **Hospice Care** means a coordinated treatment plan of home and inpatient care, which treats the terminally ill patient and family as a unit. This treatment plan provides care to meet the special needs of the family unit during the final stages of a terminal Illness and during bereavement. A team made up of trained medical personnel and counselors provides care. The team acts under an independent hospice administrator to help the family unit cope with physical, psychological, spiritual, social and economic stresses.

4.58 **Hospice Care Program** means a formal program directed by a Physician to help care for a person with a life expectancy of six months or less. It must meet the standards set by the National Hospice Organization. If such Program is required by a state to be licensed, certified, or registered, it must also meet that requirement to be considered a Hospice Care Program.

4.59 **Hospital** means an institution that:

(a) is licensed to provide and is engaged primarily in providing on an inpatient basis, for compensation from its patients, diagnostic and therapeutic facilities for the surgical, medical diagnosis, treatment and care of ill and injured persons;

(b) operates 24 hours a day every day under continuous supervision of a staff of doctors (MD, DO);

(c) continuously provides on the premises of the facility 24 hours a day skilled nursing services by licensed nurses under the direction of a full-time registered nurse (R.N.);

(d) provides, or has a written agreement with another Hospital in the area for the provision of, generally accepted diagnostic or therapeutic services that may be required during a confinement; and

(e) is not, other than incidentally, a place for rest, a place for the aged, a nursing home, a residential treatment center, or a convalescent Hospital.

4.60 **Hospital Expenses** means charges by a Hospital for room and board and/or for care in an intensive care unit, provided that its charges for such care are furnished at the direction of a Physician. Hospital expenses for private room accommodations, which are in excess of the average charge for semi-private accommodations in the facility, shall not be considered under this Plan for any purpose (except as specified in the *Schedule of Benefits).*

4.61 **Illness** means a bodily disorder, disease, physical or mental sickness, functional nervous disorder, pregnancy or complication of pregnancy. The term Illness when used in connection with a newborn Dependent Child includes, but is not limited to, congenital defects and birth abnormalities, including premature birth.

4.62 **Immediate Family** means an individual who is related to a Member, either by blood or created by law, including a Spouse, parent, Dependent Child, brother, or sister.

4.63 **Incomplete Claim** means a claim which, if properly corrected to completion, may be compensable for the covered procedure, but lacks important or material elements which prevent payment of the claim. Incomplete Claims shall be denied if not cured within 30 days of notice of the lack of completeness. Incomplete Claims shall be required to be completed within one year of the date of service being billed.

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

4.65 **Independent Freestanding Emergency Department** means a health care facility that is geographically separate and distinct, and licensed separately, from a Hospital under applicable state law, and which provides any Emergency Services.

4.66 **Independent Review Organization (IRO)** means independent third parties who conduct external review of a service denied by a health plan. Preferred Administrators will use IROs accredited by URAC or by a similar nationally-recognized accrediting organization to conduct the external review.

4.67 **Injury** means a condition caused by accidental means that result in damage to the Covered Person's body from an external force.

4.68 **In-Network** means University Medical Center of El Paso, Texas Tech providers, and the medical providers contracted by Preferred Administrators Network/PPO and Wrap Network.

4.69 **Inpatient Behavioral Services** means an acute inpatient program designed to provide medically necessary, intensive assessment, psychiatric treatment and support to individuals with a severe and/or persistent mental illness and/or co-occurring disorder experiencing an acute exacerbation of a psychiatric condition. The acute inpatient setting is equipped to serve patients at high risk of harm to self or others and in need of a safe, secure, locked setting. The purpose of the services provided within an acute inpatient setting is to stabilize the patient's acute psychiatric condition. Medical necessity drives the number of days a patient is able to stay at this level of care.

4.70 **Inpatient Substance Abuse Services** means an acute program for patients with alcohol and other addictive disorders that provides inpatient detoxification and/or recovery. Patients work with a team of professionals including physicians, nurses, and therapists to address triggers to alcohol or drug use and relapse and are taught coping skill. Treatment is structured, short-term and intensive. The length of stay is based on clinical need.

4.71 **Intensive Care Unit** means an accommodation in a Hospital which is reserved for critically and seriously ill patients requiring constant audio-visual observation as prescribed by the attending Physician, and which provides room and board, nursing care by registered nurses whose duties are confined to care of patients in the intensive care unit, and special equipment or supplies immediately available on a standby basis segregated from the rest of the Hospital's facilities.

4.72 **Intensive Outpatient Program** means an intermediate level of mental health care where individuals are seen in a group setting 2 to 5 times a week for 2 to 3 hours at a time (depending on the structure of the individual program). The clinical work is primarily done in a group setting, with individual sessions scheduled as needed outside of group hours. Medical necessity drives the number of days a patient is able to stay at this level of care.

4.73 **Interlink Transplant Network** means a national network and an established leader in the transplant network industry, often referred to as being one of the most used and respected transplant networks in the United States.

4.74 **Leave of Absence** means a period of time during with the Associate must be away from his or her primary job with the Employer, while maintaining the status of Associate during said time away from work, generally requested by an Associate and having been approved by his or her Participating Employer, and as provided for in Participating Employer's rules, policies, procedures and practices where applicable.

4.75 **Late Entrant** means an individual who enrolls other than during the initial enrollment period or a special enrollment period as provided under Article III.

4.76 **Legal Separation and/or Legally Separated** means an arrangement under the applicable state laws to remain married but maintain separate lives, pursuant to a valid court order.

4.77 **Lifetime** means while a person is covered under this Plan. Lifetime does not mean during the lifetime of the Member.

4.78 **Long-Term Acute Care (LTAC)** – LTAC hospitals are appropriate for members who require daily monitoring and complex medical interventions. Appropriate admission to LTAC may include those with complex wounds, chest tubes, ventilatory dependency, or multiorgan failure. LTACs provide care to members with conditions that are more medically complex than would be appropriate for other levels of care (e.g., inpatient rehabilitation facility)

Criteria for admission to LTAC:

- Patient is stable for transfer from acute care facility to LTAC, as indicated by:
- Hypotension absent
- Cardiovascular status acceptable
- Stable chest findings
- Renal function acceptable
- Pain adequately managed
- No acute severe unstable neurologic abnormalities (e.g., obtundation, coma, evidence of ongoing CNS embolization or ischemia, worsening hydrocephalus)
- No acute significant hepatic dysfunction (e.g., no severe coagulopathy)
- No active bleeding or unstable disorders of hemostasis (e.g., no recent need for transfusion, severe thrombocytopenia with bleeding)
- Long-term enteral feeding (e.g., PEG) and intravenous access established upon intake

Interdisciplinary LTAC care is appropriate for the member's medically complex situation, as indicated by these common scenarios:

- Respiratory failure requiring ventilation management and weaning
- Infectious disease condition requiring LTAC care (e.g., long-term IV antibiotics or heart failure requiring daily adjustment and monitoring of diuretic therapy)
- Complex wound care condition requiring daily physician supervision
- Cardiovascular condition requiring LTAC care (e.g., heart failure with need for intravenous vasoactive drugs (e.g., dobutamine), need for continued support with high-concentration oxygen
- Other complex medical management situations (e.g., chest tube management, traumatic brain injury)

4.79 **Maximum Allowable Charge** The "Maximum Allowable Charge" shall mean the amount payable for a specific covered item under this Plan. The Maximum Allowable Charge will be a negotiated rate, if one exists.

For claims subject to the No Surprises Act (see "No Surprises Act – Emergency Services and Surprises Bills" within the section *"Schedule of Benefits For Participating Providers,")* if no negotiated rate exists, the Maximum Allowable Charge will be:

- An amount determined by an applicable all-payer model agreement; or
- If no such amount exists, an amount determined by applicable state law; or
- The Qualifying Payment Amount (QPA)

For Out of Network and claims NOT subject to the No Surprises Act, if no negotiated rate exists, the Maximum Allowable Charge will be:

- The Plan's Qualifying Payment Amount (QPA) or if no QPA is available.
- The Maximum Allowable Charge will be determined by the Plan to be the Medicare reimbursement rates presently utilized by the Centers for Medicare and Medicaid Services ("CMS") either multiplied by a 130%, percentage that the particular Provider and/or others in the area customarily accept from all payers.
- If no Medicare reimbursement rate is available for a given item of service or supply, the Maximum Allowable Charge will be derived from the use of industry data.

If and only if none of the factors above is applicable, the Plan Administrator will exercise its discretion to determine the Maximum Allowable Charge based on any of the following:

Medicare cost data, amounts actually collected by Providers in the area for similar services, or average wholesale price (AWP) or manufacturer's retail pricing (MRP). These ancillary factors will take into account generally-accepted billing standards and practices.

4.80 **Maximum Benefit per Plan Year** means the maximum benefit payable for certain expenses during the Plan Year, which commences October 1 of each year.

4.81 **Medical Emergency** means onset of an acute medical Illness or Injury which occurs suddenly and unexpectedly, requiring immediate medical care and use of the most accessible Hospital equipped to furnish care to prevent the death or serious impairment of the Member. Such conditions include but are not limited to suspected heart attack, loss of consciousness, actual or suspected poisoning, acute appendicitis, heat exhaustion, convulsions, emergency medical care rendered in the case of Accidental Injury cases and other acute conditions. For purposes of benefits payable under this Plan, the Claim Administrator will determine the existence of a Medical Emergency.

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

(a) Its purpose must be to restore health.
(b) It must not be primarily custodial in nature.
(c) It is ordered by a Physician for the diagnosis or treatment of a sickness or Injury.
(d) It must not be a listed item or treatment not allowed for reimbursement by CMS (Medicare).

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

To be Medically Necessary all of the above criteria must be met. The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary based on recommendations of the Plan Administrator's own medical advisors, the findings of the American Medical Association or similar organization, or any other sources that the Plan Administrator deems appropriate.

4.83 **Medically Necessary Leave of Absence** means a Leave of Absence by a full-time student Dependent at a post-secondary educational institution that:

(a) Commences while such Dependent is suffering from an Illness or Injury;
(b) Is Medically Necessary; and
(c) Causes such Dependent to lose student status for purposes of coverage under the terms of the Plan.

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

4.85 **Medicare** means the program of medical care benefits provided under Title XVIII of the Social Security Act of 1965, as amended.

4.86 **Member** means a person covered under the plan, either the Associate, eligible Dependent, or Retiree.

4.87 **Mental Health Parity Act of 1996 (MHPA) and Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), Collectively, the Mental Health Parity Provisions** means in the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health or Substance Use Disorder benefits, such plan or coverage shall ensure that all of the following requirements are met:

1. The financial requirements applicable to such mental health or Substance Use Disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the Plan (or coverage).
2. There are no separate cost sharing requirements that are applicable only with respect to mental health or Substance Use Disorder benefits, if these benefits are covered by the group health plan (or health insurance coverage is offered in connection with such a plan).
3. The treatment limitations applicable to such mental health or Substance Use Disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the Plan (or coverage).
4. There are no separate treatment limitations that are applicable only with respect to mental health or Substance Use Disorder benefits, if these benefits are covered by the group health plan (or health insurance coverage is offered in connection with such a plan).

4.88 **Mental Disorder, Behavioral Disorder, or Neurodevelopmental Nervous Disorder** means any Illness or condition, regardless of whether the cause is organic, that is classified as a Mental Behavioral Disorder, or Neurodevelopmental Disorder in the current edition of the International Classification of Diseases, published by the U.S. Department of Health and Human Services, is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association or other relevant State guideline or applicable sources. The fact that a disorder is listed in any of these sources does not mean that treatment of the disorder is covered by the Plan.

4.89 **NAVITUS** means the Prescription Drug Benefit Administrator.

4.90 **Non-Preferred Provider** means a legally licensed health care Provider who has not entered into a contract with Preferred Administrators.

4.91 **Organ Transplant Services** means the services of a contracted network or contracted facility for the transplantation of human organs as described under Medical Benefits.

4.92 **Orthotic Device** means an apparatus used to support, align, prevent, or correct deformities, or to improve the function of movable parts of the body.

4.93 **Other Plan** shall include, but is not limited to:

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

4.94 **Out-of-Area** means outside of El Paso County and the immediate surrounding areas (including Doña Ana County in southern New Mexico) where active Member reside and may receive routine or other medical services.

4.95 **Out-of-Network Provider** – A provider that has not agreed to accept a signed contract agreement and does not accept assignment from Preferred Administrators.

4.96 **Out-of-Pocket or Maximum Out-of-Pocket** means the amounts for which the Member is financially responsible for eligible services in one Fiscal Year. The Out-of-Pocket amount include deductibles, co-insurance and co-pays but not any non-compliance penalty amounts, any charges for any services not defined as a Covered Charge, charges that exceed maximum amounts specified in the *Schedule of Benefits,* and charges that are in excess of the allowable amount for any service.

4.97 **Outpatient Behavioral Health Services** means office visits to a licensed behavioral health practitioner that occur in a community location on a regular basis. Treatment at this level can include psychotherapy and/or medication management. These services can be delivered in an individual, family or group setting.

4.98 **Participating Health Care Facility** means Hospital or Hospital Outpatient department, critical access Hospital, Ambulatory Surgical Center, or other Provider as required by law, which has a direct or indirect contractual relationship with the Plan with respect to the furnishing of a healthcare item or service. A single direct contract or case agreement between a health care facility and a plan constitutes a contractual relationship for purposes of this definition with respect to the parties to the agreement and particular individual(s) involved.

4.99 **Pharmacy** means a licensed establishment where prescription drugs are filled and dispensed by a pharmacist licensed under the laws of the state where the pharmacist practices.

4.100 **Physician** means a duly licensed doctor of medicine (M.D.), a doctor of osteopathy (D.O.), a licensed podiatrist (D.P.M.), a doctor of optometry (O.D.), Chiropractor (D.C.) or other similarly licensed healthcare professional who is acting within the scope of the license.

4.101 **Plan** means the University Medical Center of El Paso and Its Affiliates Associate and Retiree Member Benefit Fund.

4.102 **Plan Administrator** means the Plan Sponsor.

4.103 **Plan Sponsor** means the University Medical Center of El Paso.

4.104 **Plan Year** means the 12-month period starting on October 1 and ending September 30.

4.105 **Preferred Provider** means University Medical Center of El Paso, Texas Tech Providers, and Providers contracted by El Paso First Health Plans, d.b.a. Preferred Administrators.

4.106 **Preventive Care** means Preventive Care services.

Benefits mandated through the PPACA legislation include preventive care such as immunizations, screenings, and other services that are listed as recommended by the United States Preventive Services Task Force (USPSTF), the Health Resources Services Administration (HRSA), and the Federal Centers for Disease Control (CDC). Preferred Administrators follows CDC age restrictions and limitations.

See **https://www.healthcare.gov/coverage/preventive-care-benefits/** or **www.preferredadmin.net** for more details. **Important Note:** The preventive care services identified through the above links are recommended services. It is up to the provider of care to determine which services to provide; the Plan Administrator has the authority to determine which services will be covered. Preventive Care services will be covered at 100% with any Contracted Provider.

4.107 **Prior to Effective Date or After Termination Date** are dates occurring before an Associate gains eligibility from the Plan, or dates occurring after a Member loses eligibility from the Plan, as well as charges incurred prior to the effective date of coverage under the Plan or after coverage is terminated, unless continuation of benefits applies.

4.108 **Protected Health Information or Sensitive Personal Information** means health information maintained in any medium and collected from an individual that is created or received by a health care provider, health plan, employer, or health care clearinghouse and that relates to past, present, or future physical or mental health or condition of the individual; to the provision of health care to an individual; or to the past, present, or future payment for the provision of health care to an individual and that identifies an individual or with respect to which there is a reasonable basis to believe the information could be used to identify an individual. Sensitive Personal Information (SPI) is an individual's first name or first initial and last name in combination with any one or more of the following items, if the name and items are not encrypted: social security number, driver's license number of government-issued identification number, account number or credit or debit card number in combination with any required code, or password that would permit access to the account, or identifying information that relates to the physical or mental health condition of the individual, the provision of health care to the individual, or the payment for the provision of health care to the individual.

4.109 **Provider** means a Birthing Center, Certified Nurse Midwife, Home Health Care Agency, Hospice, Hospital, Licensed Dietician, Long-term Acute Care Facility, Pharmacy, Physician, Psychiatric Day Treatment Facility, Psychologist, Rehabilitation Facility, or Skilled Nursing Facility, and any other licensed practitioner who is required to be recognized for health insurance by law or regulation and is acting within the scope of the license, as the context may indicate.

4.110 **Psychiatric Day Treatment Facility** means an institution that:

(a) is a mental health facility which provides treatment for individuals suffering from acute mental, nervous or emotional disorders, in a structured psychiatric program utilizing individualized treatment plans with specific attainable goals and objectives appropriate both to the patient and the treatment modality of the program, and is clinically supervised by a doctor of medicine who is certified in psychiatry by the American Board of Psychiatry and Neurology; and

(b) is accredited by the Program for Psychiatric Facilities or its successor, or the Joint Commission on Accreditation of Hospitals; and

(c) treats its patients for not more than 8 hours in any 24-hour period.

4.111 **Qualified Dependent** means a Dependent who loses coverage under a Welfare Program due to a Qualifying Event.

4.112 **Qualifying Event** means any of the following events that, but for COBRA continuation coverage, would result in Member's or eligible Dependent's loss of coverage:

(a) death of a Member;
(b) termination of employment of a Member;
(c) reduction in hours of a Member;
(d) divorce or legal separation of the Member;
(e) the Member's entitlement to Medicare benefits; or
(f) Dependent Child ceasing to qualify as a Dependent under a Welfare Program.

4.113 **Qualifying Payment Amount** means the median of the contracted rates recognized by the Plan, or recognized by all plans serviced by the Plan's Third Party Administrator (if calculated by the Third Party Administrator), for the same or a similar item or service provided by a Provider in the same or similar specialty in the same geographic region. If there are insufficient (meaning fewer than three) contracted rates available to determine a Qualifying Payment Amount, said amount will be determined by referencing a state all-payer claims database or, if unavailable, any eligible third-party database in accordance with applicable law.

4.114 **Qualified Individual for an Approved Clinical Trial** means (1) the Member is eligible to participate in the trial according to its protocol; and (2) either a participating provider who has referred the individual to the trail concludes that participation would be appropriate, or the individual provides medical and scientific information that establishes that the individual's participation is appropriate and consistent with the trial protocol.

4.115 **Qualified Medical Dependent Child Support (QMCSO)** means a Qualified Medical Dependent Child Support Order in accordance with the Omnibus Budget Reconciliation Act of 1993 (OBRA), as amended.

4.116 **Recognized Amount** means, except for Non-Network air ambulance services, an amount determined under an applicable all-payer model agreement, or if unavailable, an amount determined by applicable state law. If no such amounts are available or applicable and for Non-Network air ambulance services generally, the Recognized Amount shall mean the lesser of a Provider's billed charge or the Qualifying Payment Amount.

4.117 **Rehabilitation (Physical) Facility** means a facility that provides services of non-acute rehabilitation. All services are provided under the direction of a psychiatrist, a medical doctor with a specialty in rehabilitation and physical medicine. Registered nurses staff the facility around the clock and it does not provide services of a custodial nature. The facility must be Medicare certified, licensed by the State Department of Health as a special Hospital and accredited by the Joint Commission on Accreditation of Healthcare Organizations. The Commission on Accreditation of Rehabilitation Facilities also accredits it.

4.118 **Retiree** means a retiree covered under the Plan. Please see the Eligibility and Participation Requirements section for the Plan's definition of a qualified retiree.

4.119 **Schedule of Medical Benefits** means the listing of Medical Benefits and description of the benefit levels provided in the Introduction.

4.120 **Skilled Nursing Facility** (this term also applies to a facility which refers to itself as an extended care facility or convalescent facility) means a facility that meets all of the following:

(a) is licensed to provide professional nursing services on an inpatient basis to patients convalescing from Injury or Illness to help restore patients to self-care in essential daily living activities;
(b) provides continuous nursing services by licensed nurses for 24 hours of every day, under the direction of a full-time registered nurse (R.N.);
(c) provides services for compensation and under the full-time supervision of a Physician;

(d) maintains a complete medical record on each patient;
(e) has an effective utilization review plan; and
(f) is not, other than incidentally, a clinic, a place for rest, a place devoted to care of the aged, a place for treatment of mental disorders or intellectual disability, or a place for custodial care.

4.121 **Specialty Medications** mean high-cost oral or injectable medications used to treat complex chronic conditions. These are highly complex medications, typically biology-based, that structurally mimic compounds found within the body. High-touch patient care management is usually required to control side effects and ensure compliance. Specialized handling and distribution are also necessary to ensure appropriate medication administration.

4.122 **Spouse** is "an Associate's or Retiree's present spouse, thereby possessing a valid marriage license, not annulled or voided in any way. Further, the rule confirms that "Spouse" also includes individuals in a lawful same-sex or common law marriage entered into outside of the United States if such marriage could have been entered into in at least one state. A common law spouse is defined as being a legally recognized spouse in the jurisdiction in which the Associate or Retiree has his or her principal residence and the Associate or Retiree and his or her spouse has satisfied all applicable requirements to attain such status. A spouse shall therefore not be one who is divorced or legally separated from the Associate.

Associate and spouse shall have been cohabitating at the same residence for the majority of the applicable plan year. When an Associate or spouse is traveling or residing elsewhere as part of their profession, to care for a family member (due, for instance, to Illness or Injury), and/or is residing elsewhere due to their own Illness or Injury, for more than half of the applicable plan year (and thus residing with each other for less than the majority of the applicable plan year), but the primary residence of the Associate is also the spouse's primary residence for all legal, regulatory, and statutory purposes, this constitutes cohabitation as required by this provision.

4.123 **Subrogation** means the benefits provided by the Plan are secondary when a Member is entitled to receive money from any other source, including but not limited to any party's liability insurance or uninsured/underinsured motorist proceeds.

4.124 **Substance Abuse or Substance Use Disorder** means any disease or condition that is classified as a Substance Use Disorder as listed in the current edition of the International Classification of Diseases, published by the U.S. Department of Health and Human Services, as listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association, or other relevant State guideline or applicable sources.

The fact that a disorder is listed in any of the above publications does not mean that treatment of the disorder is covered by the Plan.

4.125 **Temporomandibular Joint Dysfunction (TMJ)** means jaw joint disorders including conditions of structures linking the jaw bone and skull and the complex muscles, nerves and other tissues related to the temporomandibular joint.

4.126 **Third Party (Claim) Administrator** means Preferred Administrators to whom the Plan Administrator has delegated the duty to process and/or review claims for benefits under the Plan. The Third Party (Claim) Administrator does not assume any financial risk or obligation with respect to those claims. The Third Party (Claim) Administrator is not an insurer of health benefits under this Plan, is not a fiduciary of the Plan, and does not exercise any of the discretionary authority and responsibility granted to the Plan Administrator. The Third Party (Claim) Administrator is not responsible for Plan financing and does not guarantee the availability of benefits under this Plan.

4.127 **Thomason Hospital or R.E. Thomason General Hospital** means University Medical Center of El Paso.

4.128 **Totally Disabled** means the complete inability of an Associate to substantially perform the important daily duties of the Associate's own occupation, for which the Associate is reasonably suited by education, training or experience. A Dependent who is Totally Disabled means that the Dependent is prevented solely because of a non-occupational Injury or non-occupational Illness from engaging in all of the normal activities of a person of like age and sex and in good health. A Dependent Child or grandchild will be considered Totally Disabled if they are incapable of self-support because of developmental disability or physical handicap. The Third Party Administrator may require proof of continuing Total Disability from time to time.

4.129 **USERRA** means the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended.

4.130 **University Medical Center of El Paso** means its Affiliates Associate and Retiree Member Benefit Fund.

4.131 **Visit Limit** – this limit accumulates the maximum by the number of visits submitted. A visit is defined as a claim billed by a provider for a given date of service, regardless of the number of services performed.

4.132 **Wrap Network** – A group of doctors, hospitals and other health care providers contracted by Multiplan and PHCS to provide services to insurance companies customers for less than their usual fees. Provider networks can cover a large geographic market or a wide range of health care services.

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

ARTICLE V
ELIGIBILITY AND PARTICIPATION REQUIREMENTS

5.01 Eligibility

(a) Associate Eligibility. All full-time regular Associates and part-time regular Associates are eligible to participate in the Plan on the first of the month following 30 days of regular full-time or part-time employment. An Associate who is not Actively at Work for any reason other than medical disability on his Coverage Date will become covered once he is Actively at Work.

Coverage under the Plan requires participation under the University Medical Center of El Paso Flexible Benefits Plan. The benefits elected must be for a 12-month period as described under the Flexible Benefits Plan unless the Member experiences a change in family status or a change in coverage. For more detailed information on Flexible Spending Accounts (FSA), you can download a FSA Manual at **www.preferredadmin.net** or University Medical Center of El Paso intranet.

If an individual becomes an Associate due to the acquisition of an Affiliate, his continuous service with the Affiliate shall count toward the waiting period. The Plan Administrator may waive the waiting period with respect to all similarly situated Associates who were covered under the other employer's group health plan at the time of the acquisition and/or honor the prior employer's group health plan waiting period.

Any Associate covered as a Member may be covered as a Dependent under this Plan. If an Associate's Spouse is covered under this Plan as the Associate's Dependent, the Spouse cannot also be covered as an Associate. If both parents are Associates, Dependent Children can be covered as Dependents of one parent only.

(b) Dependent Eligibility.

(i) Dependents are eligible to participate at the same time as the Associate, or on the first day of the month after they become Dependents, if later. Newborn and adopted Dependent Children participate in the Plan immediately upon birth or adoption (or placement for adoption), provided that the Associate enrolls the child within 30 days of birth or adoption (or placement for adoption).

(ii) Dependent coverage may continue under this Plan following an Associate's election of Medicare as primary. The Dependent will be treated in the same manner as if the Associate had remained on the Plan, as long as the Associate continues to meet the eligibility requirements and completes all necessary agreements on a timely basis.

(iii) A Dependent may be added to the Plan pursuant to a Qualified Medical Dependent Child Support Order (QMCSO) issued by a court of competent jurisdiction or administrative body that requires the Plan to provide medical coverage to the Dependent Child of an Associate. The Plan Administrator will establish reasonable procedures for determining whether a court order or administrative decree requiring medical coverage for a Dependent Child meets the requirements for a QMCSO. The Plan Administrator shall have the authority to enroll both the Associate and Dependent Child, if the Associate is not a current participant at the time the QMCSO is received. The cost of coverage or any additional cost of such coverage, if any, is borne by the Associate. A Member of this Plan may obtain, without charge, a copy of the procedures governing QMCSO determinations from the Plan Administrator.

(iv) Documentation may be required to confirm that a Dependent meets the Plan's Dependent eligibility requirements.

(c) Retiree Eligibility.

Any Retiree who retired, prior to May 1, 2018, under the terms of the plan as it existed prior to this amendment shall remain eligible for the plan benefits on and after May 1, 2018 as they are proscribed in this amendment effective on and after May 1, 2018, even though such Retiree might not have met the eligibility provisions in effect on and after May 1, 2018 as described below. The following are the eligibility requirements for Retirees who retire on or after May 1, 2018 to participate in the Plan:

(i) Retirees who are at least 60 years old, with 20 or more years of service with UMC in a full time or part time capacity, with both age and service measured as of the last day of the month in which the Associate retired, and who have retired on or after May 1, 2018;

(ii) Retirees who are at least 60 years old, with 20 years of service in a full time or part time capacity at either UMC (hospital/clinics), El Paso First Health Plans or UMC Foundation, with both age and service measured as of the last day of the month in which the Associate retired, provided they are eligible for retirement according to Texas County and District Retirement System (TCDRS) rules and have retired on or after May 1, 2018;

(iii) Eligible Retirees must have been participating in this Plan for 5 continuous years and are currently participating in this Plan at time of retirement;

(iv) Eligible Retirees will be able to enroll their eligible Spouse and Dependents; and

(v) Retiree benefits will only be offered up to the earlier of when the Retiree reaches the age of 65 or starts receiving Medicare.

NOTE: PRN's do not qualify as Retirees under the Plan since they don't qualify under TCDRS Retirement Plan.

COBRA

Retiree benefits are offered in lieu of COBRA coverage. COBRA is no longer offered to the Retiree when Retiree benefits end as the Retiree has already waived COBRA rights; however, if Retiree changes their mind to keep COBRA within the 60 day election time period of COBRA, the Plan will reinstate the loss of coverage as of the COBRA waive date.

Dependents of Retirees: If a qualifying event occurs and a qualifying dependent loses the Retiree benefits under the Plan, COBRA is offered to the affected family members for 36 months from the date the Retiree benefits stopped, not back from the retirement date.

5.02 Failure to Elect Medical Insurance During Open Enrollment

Pursuant to the provisions of the Flex Plan, if a Member fails to timely complete and submit a Benefits Enrollment/Change agreement or enroll on-line for the Plan Year commencing October 1, 2002, he shall be deemed to have elected Associate Only Medical Coverage.

Effective for Plan Years on and after October 1, 2003, if a Member fails to timely complete and submit a Benefits Enrollment/Change agreement or enroll on-line he shall be deemed to have made the same Medical elections as was in effect on the last day of the prior Coverage Period. Newly hired/eligible Associates have the option of opting out of this insurance.

Open Enrollment

Prior to the start of a Plan Year, this Plan has an Open Enrollment Period. Eligible Members who are not covered under this Plan may enroll for coverage during Open Enrollment Periods. Retirees currently active under the Retiree Plan will be eligible for the Open Enrollment Period. Retirees not active in the Retiree Plan will not be eligible for Open Enrollment Period. Associates who are enrolled will be given an opportunity to change their coverage effective the first day of the upcoming Plan Year. A covered Member who fails to

make an election during the Open Enrollment Period will automatically retain his or her present coverages. Coverage for covered Members enrolling during an Open Enrollment Period will become effective on October 1st, unless the Associate has not satisfied the Service Waiting Period, in which event coverage for the Associate and his or her Dependents will become effective on the day following completion of the Service Waiting Period.

The terms of the Open Enrollment Period, including duration of the election period, shall be determined by the Plan Administrator and communicated prior to the start of an Open Enrollment Period.

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

5.03 Enrollment

(a) Effective Date. Each Associate on the Effective Date shall be eligible to participate in this Plan as of such date. Any new Associate shall participate effective as of the date coinciding with his eligibility for the Benefit Programs and be permitted to enroll in the Plan during the first 30 days of employment. Any reclassified Associate will be permitted to enroll in the Plan or change his enrollment in the Plan the 1st of month following 30 days of service of the status reclassification. An Associate cannot change their elections to decrease or increase the amount's elected to contribute to their account(s), once the plan year begins. However, an Associate can make a mid-year election change if they experience a change in Family Status for a Change in Status or Coverage. If the Associate experiences such change in status as listed on *page 37,* an Associate must submit a written notification to Human Resources University Medical Center within 30 days of the change in status.

Initial enrollment for Retirees will be continuous from the effective date with no gap in coverage. Coverage takes place at the time of retirement date and the completion of the required enrollment forms. If a Retiree does not enroll in the Plan within the first 60 days of retirement, it is considered a waiver of coverage. A Retiree may decline coverage at the time of retirement but they will not be allowed to enroll in the Plan in any future period.

(b) Late Enrollment for Associates. If enrollment is not requested within 31 consecutive days after satisfying the waiting period and becoming eligible to enroll in the Plan, then the Associate may only request enrollment for himself and/or his eligible Dependent(s) as a Late Enrollee.

(c) Loss of Other Coverage – Special Enrollment. An Associate or Late Enrollee is eligible during a special enrollment period for an Associate who either initially declined coverage for himself and/or his eligible dependent(s) because of existing other health coverage, or who previously declined coverage for himself and/or his eligible dependent(s) at a subsequent opportunity to enroll under a special enrollment period or as a late entrant because of existing other health coverage (such notice provided to the Plan Administrator in writing), if the Associate requests enrollment for himself and/or such dependents not later than 30 days after loss of the other health coverage provided that the other coverage was terminated due to:

(i) loss of eligibility as a result of legal separation, divorce, cessation of dependent status (such as attaining the limiting age for a dependent child), death, termination of employment, or reduction in hours; or

(ii) a Health Maintenance Organization (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); or

(iii) 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; or

(iv) an HMO ceasing operations; or

(v) a plan no longer offering any benefits to a class of similarly situated individuals; or

(vi) cessation of employer contributions for the other health coverage; or

(vii) the exhausting of COBRA continuation coverage.

If coverage is requested within 30 days of the loss of other health coverage as described above, coverage under this Plan will become effective on the first day of the month immediately following notification in writing to the Plan Administrator of the change-in-status event. (However, if an Associate or dependent lost other coverage as a result of the individual's failure to pay premiums or for cause, such as making a fraudulent claim, that individual does not have a special enrollment right.)

(d) New Dependent – Special Enrollment. If an Associate has a new Dependent due to marriage, birth, adoption, Placement for Adoption, legal guardianship, or a foster child being placed with the Associate, the Associate may enroll himself, his Spouse, and his new Dependent in the Plan. The Associate must submit a written request for enrollment within 30 days after the marriage, legal guardianship, a foster child being placed with the Associate, birth, adoption, or Placement for Adoption. Coverage for the Dependent Child will be effective to the date of marriage, birth, adoption or Placement for Adoption. For a legal guardianship, the effective date of coverage will be on the date on which such child is placed in the covered Associate's home pursuant to a court order appointing the covered Associate as legal guardian for the child. In the case of a foster child being placed with the Associate, on the date on which such child is placed with the Associate by an authorized placement agency or by judgment, decree or other order of a court of competent jurisdiction.

(e) Change in Family Status Change. The Associate or Retiree must request enrollment for himself and/or such Dependent(s) within a 31-day period, which begins on the date of the Change in Status event. Coverage will be effective on the first of the month following notification.

(f) Court Ordered Coverage. Coverage for a Dependent Child pursuant to a QMCSO will be effective as of the date of the decree provided the Associate requests enrollment for the Dependent Child within 30 days of the QMCSO.

(g) Significant Change in Cost. Enrollment may commence as of the first day of the next payroll period if the Associate has experienced a significant change (increase in cost or significant curtailment of coverage) provided that the Associate requests enrollment for himself and/or such Dependent(s) within a 31-day period which begins on the date that the significant increase in cost or significant curtailment of coverage occurs.

(h) Significant Change in Coverage. Enrollment may commence as of the first day of the next payroll period following notification due to a significant change in health coverage attributable to a Spouse's employment provided that the request for enrollment is necessary or appropriate due to the significant change. The Associate must request enrollment for himself and/or his Dependent(s) within a 31-day period beginning on the date that the significant change in health coverage occurs.

5.04 Coverage During a Leave of Absence

(a) Total Disability Leave of Absence. If a Covered Person is Totally Disabled on the date their Medically Necessary Leave of Absence commences under the Plan, coverage for the Injury or Illness which caused the Total Disability may be continued at the Associate rate, up to the earliest of the following dates:

(i) the date that the Total Disability ends;
(ii) 6 months; or
(iii) the date the Covered Person becomes covered, with respect to such disability, under any other group benefit program.

In lieu of this coverage, the Associate may elect COBRA at the COBRA premium rates.

(b) Personal Leave of Absence. If an Associate receives authorization for an educational or personal Leave of Absence coverage while on a:

(i) paid leave will continue at the Associate rate through the end of the paid leave. Coverage for periods thereafter will be through COBRA.
(ii) unpaid leave will continue through the end of the month at the regular Associate contribution rate (paid through either payroll deduction or on an after-tax basis). Coverage for periods thereafter will be through COBRA.
(iii) temporary layoff will continue for up to a 3-month period at the regular Associate contribution rate (paid through either payroll deduction or on an after-tax basis).

In lieu of this coverage, the Associate may elect COBRA at the COBRA premium rates.

(c) Family or Medical Leave of Absence. During any period during which a Member is on a family or medical leave as defined in the Family or Medical Leave Act (FMLA), any benefit elections in force for the Member shall remain in effect. While the Member is on paid leave, contributions shall continue.

Prior to commencing an unpaid leave, the Member may elect to prepay all or a portion of required contributions on a pre-tax basis. Alternatively, the Member may elect to make such payments on an after-tax basis monthly in accordance with an arrangement that the Plan Administrator shall provide. If coverage is not continued during the entire period of the family or medical leave because the Member declines to pay the premium, the coverage will be reinstated upon reemployment with no exclusions or waiting periods.

Benefits will be cancelled if payment is more than 30 days late. Upon return from FMLA or upon notification that the Member will not be returning to work, the Member must pay the full cost of any healthcare coverage that was continued on his behalf during the leave. These rules apply to the COBRA Eligible Welfare Programs and Health Care Spending Accounts.

(d) Military Leave. Pursuant to the provisions of the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), an Associate on military leave will be considered to be on a leave of absence and will be entitled during the leave to the health and welfare benefits that would be made available to other similarly situated Associates if they were on a leave of absence. This entitlement ends if the Associate provides written notice of intent not to return to work following the completion of the military leave. The Associate shall have the right to continue his coverage, including any Dependent coverage, for the lesser of the length of the leave or 18 months (24 months for elections made on or after December 10, 2004). If the military leave is for a period of 30 days or more, the Member can be required to pay 102 percent of the total premium (determined in the same manner as a COBRA continuation coverage premium).

If coverage is not continued during the entire period of the military leave because the Member declines to pay the premium or the leave extends beyond 18 months (24 months for elections made on or after December 10, 2004), the coverage must be reinstated upon reemployment within the time specified by law.

5.05 Continuation of Coverage Under COBRA

NOTE: Retirees covered under the Plan have waived their COBRA rights. However, COBRA will be offered to a Retiree's Dependents who have a qualifying event, as defined below. Continuation of health coverage under COBRA (Consolidated Omnibus Budget Reconciliation Act) shall not duplicate health coverage continued under any state or Federal law.

****Important Note**** There may be other coverage options for you and your family. When key parts of the health care law take effect, you'll be able to buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll.

Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

A. DEFINITIONS

As used in this provision, the following terms shall mean:

1. **"Entitlement to Medicare"** or **"Entitled to Medicare"** means the covered Associate has enrolled in either Medicare Part A or Part B.

2. **"Qualified Beneficiary"** means:
   a. a covered Associate, for termination or reduced hours:
   b. a spouse or a dependent child who were covered dependents under the Plan on the day before the covered Associate's Qualifying Event occurred:
   c. a child who is born to a covered Associate, or placed with a covered Associate for adoption, during a period of COBRA continuation coverage;
   d. a spouse or a dependent child of a Retiree.

3. **"Qualifying Event"** for a covered Associate means a loss of coverage due to:
   a. termination of employment for any reason other than gross misconduct;
   b. reduction in hours of employment.

   "Qualifying Event" for a covered dependent means a loss of coverage due to:
   a. a covered Associate's termination of employment (for any reason other than gross misconduct) or reduction in hours of employment;
   b. a covered Associate's or Retiree's death;
   c. a spouse's divorce or legal separation from a covered Associate or Retiree;
   d. a covered Associate's or Retiree's entitlement to Medicare;
   e. a dependent child's loss of dependent status under the Plan.

   Termination of employment following a Qualifying Event that is a reduction in hours of employment is not a second Qualifying Event entitling the Qualified Beneficiary to an extension of the period of COBRA coverage continuation.

4. **"Timely Contribution Payment"** means that the required contribution payment is made within the applicable time period (for the initial contribution payment, within **45** days of the date that the Qualified Beneficiary made the initial election for continuation coverage; for subsequent contribution payments, within **30** days of the due date). A Timely Contribution Payment is deemed to have been made if it is not significantly less than the amount due unless the Qualified Beneficiary is notified of the deficiency and given **30** days to pay the balance.

B. CONTINUATION OF HEALTH COVERAGE NOTICE AND ELECTION PROCEDURES

The following procedures for continuation of benefits under COBRA are hereby adopted by the Plan:

GENERAL NOTICE (INITIAL COBRA NOTICE):

A group health plan subject to the requirements of COBRA must provide written notice to each covered Associate and spouse (if applicable) within **90** days after coverage under the Plan commences of the right to continue coverage. (If a Qualifying Event occurs during the first **90** days of coverage under the Plan and before the general notice has been distributed, the Plan may provide only the COBRA election notice, as described below). In lieu of, or in addition to, such written notice, the Plan Administrator is hereby providing the general notice to the Associate by delivery of the Summary Plan Description.

The Plan may notify a covered Associate and the covered Associate's spouse with a single general notice addressed to their joint residence, provided the Plan's latest information indicates that both reside at that address. However, when a spouse's coverage under the Plan begins later than the Associate's coverage, a separate general notice must be sent to the spouse within **90** days after the spouse's coverage commences.

NOTE: It is important for the Plan Administrator to be kept informed of the current addresses of all Covered Persons under the Plan who are, or who may become, Qualified Beneficiaries.

EMPLOYER'S NOTICE OF QUALIFYING EVENT AND NOTICES THAT QUALIFIED BENEFICIARIES MUST PROVIDE:

Continuation of health coverage shall be available to an Associate and/or his covered dependents upon the occurrence of a Qualifying Event.

To continue health coverage, the Plan Administrator must be notified in writing of a Qualifying Event by:

1. the Employer, within **30** days of the later of: (1) the date of such event or, (2) the date of loss of coverage due to the event, if the Qualifying Event is:
    a. for a covered dependent, the covered Associate's death;
    b. the covered Associate's termination (other than for gross misconduct) or reduction in hours;
    c. for a covered dependent, the covered Associate's entitlement to Medicare.
2. the Associate or a Qualified Beneficiary, within **60** days of the later of: (1) the date of such event, (2) the date of loss of coverage due to the event, or (3) the date on which a Qualified Beneficiary is informed through the Plan's Summary Plan Description or general notice of both his obligation to provide notice and the procedures for providing such notice, if the Qualifying Event is:
    a. for a spouse, divorce or legal separation from a covered Associate;
    b. for a dependent child, loss of dependent status under the Plan; or
    c. the occurrence of a second Qualifying Event after a Qualified Beneficiary has become entitled to continuation coverage with a maximum duration of **18** (or **29)** months.

An Associate or Qualified Beneficiary who does not provide timely notice to the Employer of one of the above such Qualifying Events may lose his rights under COBRA.

Upon termination of employment or reduction in hours, a Qualified Beneficiary who is determined under Title II or Title XVI of the Social Security Act to be disabled on such date, or at any time during the first **60** days of COBRA continuation coverage,

will be entitled to continue coverage for up to **29** months if the Plan Administrator is notified of such disability within **60** days from the later of (and before the end of the **18**-month period): (1) the date of determination, (2) the date on which the Qualifying Event occurs, (3) the date on which the Qualified Beneficiary loses coverage, or (4) the date on which the Qualified Beneficiary is informed through the Plan's Summary Plan Description or general notice of both the obligation to provide the disability notice and the Plan's procedures for providing such notice. If a Qualified Beneficiary entitled to the disability extension has non-disabled family members who are entitled to COBRA continuation coverage, the non-disabled family members are also entitled to the disability extension.

A Qualified Beneficiary who is disabled under Title II or Title XVI of the Social Security Act must notify the Plan Administrator within **30** days from the later of: (1) the date of final determination that he is no longer disabled, or (2) the date on which the individual is informed through the Plan's Summary Plan Description or general notice of both the responsibility to provide such notice and the Plan's procedures for providing such notice.

PLAN ADMINISTRATOR'S NOTICE OBLIGATION – ELECTION NOTICE:

The Plan Administrator must, within **14** days of receiving notice of a Qualifying Event, notify any Qualified Beneficiary of his right to continue coverage under the Plan. Notice to a Qualified Beneficiary who is the Associate's spouse shall be notice to all other Qualified Beneficiaries residing with such spouse when such notice is given.

ELECTION PROCEDURES:

A Qualified Beneficiary must elect Continuation of Health Coverage within **60** days from the later of the date of the Qualifying Event or the date notice was sent by the Plan Administrator.

A new spouse, a newborn child, or a child placed with a Qualified Beneficiary for adoption during a period of COBRA continuation coverage may be added to the Plan according to the enrollment requirements for dependent coverage under the "ELIGIBILITY REQUIREMENTS" section of the Plan. A Qualified Beneficiary may also add new dependents during an open enrollment period held once each year at a time and in accordance with the procedures established by the Plan Administrator.

Any election by an Associate or his spouse shall be deemed to be an election by any other Qualified Beneficiary, though each Qualified Beneficiary is entitled to an individual election of continuation coverage.

Upon election to continue health coverage, a Qualified Beneficiary must, within **45** days of the date of such election, pay all required contributions to date to the Plan Administrator.

All future contribution payments by a Qualified Beneficiary must be made to the Plan Administrator and are due the first of each month with a **30**-day grace period.

If the initial contribution payment is not made within **45** days of the date of the election, COBRA coverage will not take effect. If future contribution payments are not made within the allotted **30**-day grace period, COBRA coverage will be terminated retroactively back to the end of the month in which the last full contribution payment was made.

Except as provided herein, if the initial coverage election and required contribution payments are made in a timely manner, as described in this section, coverage under the Plan will be reinstated retroactively back to the date of the Qualifying Event.

If a Qualified Beneficiary waives COBRA coverage, he may revoke the waiver at any time during the election period. The Qualified Beneficiary would be eligible for continuation of coverage prospectively from the date that the waiver is revoked, if all other requirements, such as Timely Contribution Payments, are met.

PLAN ADMINISTRATOR'S NOTICE OBLIGATION –
NOTICE OF UNAVAILABILITY OF CONTINUATION COVERAGE:

The Plan Administrator must provide a notice of unavailability to an individual within **14** days after receiving a request for continuation coverage if the Plan determines that such individual is not entitled to continuation coverage. The notice must include an explanation as to why the individual is not entitled to COBRA. This notice must be provided regardless of the basis of the denial and regardless of whether it involves a first or second Qualifying Event or a request for disability extension.

PLAN ADMINISTRATOR'S NOTICE OBLIGATION – EARLY TERMINATION NOTICE:

The Plan Administrator must provide a notice to Qualified Beneficiaries when COBRA terminates earlier than the maximum period of COBRA applicable to the Qualifying Event as soon as practicable following its determination that continuation coverage shall terminate. This notice must contain the reason that continuation coverage has terminated earlier than the maximum period triggered by the Qualifying Event, the date of termination of continuation coverage, and any rights the Qualified Beneficiary may have under the Plan or under applicable law to elect alternative group or individual coverage (such as a conversion right).

TRADE REFORM ACT AND CONSOLIDATED APPROPRIATIONS ACT, 2022.

The Consolidated Appropriations Act, 2022 has extended certain provisions of the Trade Reform Act, which created a special COBRA right applicable to certain employees who have been terminated or experienced a reduction of hours and who qualify for a "trade readjustment allowance" or "alternative trade adjustment assistance." These individuals can either take a Health Coverage Tax Credit (HCTC) or get advance payment of the applicable percentage of premiums paid for qualified health insurance coverage, including COBRA continuation coverage. These individuals are also entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage). This election must be made within the **60**-day period that begins on the first day of the month in which the individual becomes eligible for assistance under the Trade Reform Act. However, this election may not be made more than six months after the date the individual's group health plan coverage ends.

A Member's eligibility for subsidies under the Consolidated Appropriations Act, 2022, affects his or her eligibility for subsidies that provide premium assistance for coverage purchased through the Health Insurance Marketplace. For each coverage month, a Member must choose one or the other, and if he or she receives both during a tax year, the IRS will reconcile his or her eligibility for each subsidy through his or her individual tax return. Members may wish to consult their individual tax advisors concerning the benefits of using one subsidy or the other.

Members may contact the Plan Administrator for additional information or if they have any questions, they may call the Health Coverage Tax Credit Customer Contact Center toll-free at **1-866-628-4282.** TTD/TTY callers may call toll-free at **1-866-626-4282.** More information about the Trade Reform Act is available at **www.doleta.gov/tradeact;** for information about the Health Coverage Tax Credit (HCTC), please see: **https://www.irs.gov/Credits-&-Deductions/Individuals/HCTC.**

C. PREMIUMS FOR COBRA COVERAGE

The Qualified Beneficiary may be required to pay premiums for any period of COBRA coverage equal to 102% of the applicable premium, in accordance with applicable law. However, any Qualified Beneficiary (including all family members of such individual who are Qualified Beneficiaries) who is entitled to the disability extension (as specified above), may be required to pay premiums equal to 150% of the applicable premium for the coverage period following the initial **18**-month period.

A Qualified Beneficiary will be notified by the Plan Administrator of the amount of the required contribution payment and the contribution payment options available. The cost of COBRA coverage may be subject to future increases during the period it remains in effect.

D. TERMINATION OF COVERAGE FOR COBRA

COBRA continuation coverage will end upon the earliest of the following to occur:

1. if an Associate is terminated or has his/her hours reduced:
   a. **18** months from the date of the Qualifying Event; or
   b. **29** months from the date of the Qualifying Event if the Qualified Beneficiary is determined under Title II or Title XVI of the Social Security Act to be disabled on such date or at any time during the first **60** days of COBRA continuation coverage and provides notice as required by the Plan (including COBRA continuation coverage of non-disabled family members of the Qualified Beneficiary entitled to the disability extension).
2. the day, after the **18**-month continuation period, which begins more than **30** days from the date of a final determination under Title II or Title XVI of the Social Security Act that a Qualified Beneficiary, entitled to **29** months, is determined to be no longer disabled (including COBRA continuation coverage of non-disabled family members of the Qualified Beneficiary entitled to the disability extension who is no longer disabled).
3. for a covered dependent, **36** months from the date of the Qualifying Event if the Qualifying Event is:
   a. the covered Associate's death;
   b. the covered Associate's entitlement to Medicare;
   c. a spouse's divorce or legal separation from a covered Associate; or
   d. a dependent child's loss of dependent status under the Plan.
4. if any of the Qualifying Events listed in 3. occurs during the **18**-month period (or **29**-month period if there is a disability extension) after the date of the initial Qualifying Event listed in 1., coverage terminates **36** months after the date of the initial Qualifying Event listed in
5. the date on which the Employer ceases to provide any group health plan coverage to any Associate.
6. the date of the Qualifying Event if the Qualified Beneficiary fails to make the initial contribution payment within **45** days of the date of the election.
7. the last day of the month in which the last contribution payment was made if the Qualified Beneficiary fails to make future contribution payments within the allotted **30**-day grace period as described in this section.

8. a qualified beneficiary becomes covered, after electing continuation coverage under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary. **(Note:** there are limitations on plans' imposing a pre-existing condition exclusion and such exclusions will become prohibited beginning in 2014 under the Affordable Care Act).
9. the first day of the month in which a Qualified Beneficiary becomes entitled to Medicare.
10. the date this Plan terminates.

5.06 Termination of Coverage

(a) An Associates coverage under the Plan terminates on the earliest of the following:
- (i) date of termination;
- (ii) date of termination of the Plan;
- (iii) date of Medicare entitlement;
- (iv) date an Associate ceases to meet the Plan's eligibility requirements;
- (v) date all coverage or certain benefits are terminated for Associates by modification of the Plan;
- (vi) last day of the month for which the required contribution has been paid if the required contribution for **1** pay period is more than **30** days in arrears;
- (vii) date an Associate becomes covered under another Group Health Plan as a Dependent; or
- (viii) date the Associate's coverage terminates for any reason.

(b) A Retiree's coverage under the Plan terminates on the earliest of the following:
- (i) date of death;
- (ii) date of termination of the Plan;
- (iii) date of Medicare eligibility;
- (iv) date a Retiree ceases to meet the Plan's eligibility requirements;
- (v) date all coverage or certain benefits are terminated for Retirees by modification of the Plan;
- (vi) last day of the month for which the required contribution has been paid if the required contribution for **1** pay period is more than **30** days in arrears; or
- (vii) date the Retiree's coverage terminates for any reason.

(c) Dependent coverage under the Plan shall terminate on the earliest of the following:
- (i) date of Plan termination;
- (ii) date in which the Associate terminates employment, unless the Associate is eligible for Retiree coverage;
- (iii) date an Associate ceases to meet the Plan's eligibility requirements, unless the Associate is eligible for Retiree coverage;
- (iv) for Dependents of Retirees date a Retiree ceases to meet the Plan's eligibility requirements;
- (v) date all coverage or certain benefits are terminated for Dependents by modification of the Plan;
- (vi) the last day of the month in which a Dependent fails to meet the definition of a Dependent;
- (vii) last day of the month for which the required contribution has been paid if the required contribution for **1** pay period is more than **30** days in arrears;
- (viii) date the Dependent becomes covered under another Group Health Plan as an Associate;
- (ix) date the Associate's, Retiree's or Dependent's coverage terminates for any reason; or
- (x) date the Dependent attains Medicare entitlement.

5.07 Transferred or Rehired Associates

Transferred Associates. If an Associate transfers with no break in service between Affiliates who are Employers in the Plan, coverage shall continue and all limitations, exclusions and deductibles and maximums shall apply as if there were no transfer.

Rehired Associates. For purposes of the Affordable Care Act's Employer Shared Responsibility provisions ("Employer Mandate"), if an Associate's coverage terminates and his/her employment resumes within 13 continuous weeks, coverage should be reinstated on the day of his/her return to work and he/she should not be treated as a new hire.

5.08 Premium Contributions

Premiums shall be determined on an annual basis and shall be communicated prior to the annual election period under the University Medical Center of El Paso and Its Affiliates Flexible Benefits Plan. Participation in the Health Risk Assessment (HRA) program is not a mandatory requirement for eligibility in the health plan. Associates are encouraged to participate in the Health Risk Assessment Program which is provided through the University Medical Center of El Paso Wellness Program.

ARTICLE VI
MEDICAL BENEFITS

6.01 Benefits Provided

The Plan provides coverage for a wide range of services and supplies provided that they are considered Covered Expenses. Covered Expenses will be eligible for reimbursement if they are:

(a) Medically Necessary;
(b) Prescribed, rendered or furnished by a Provider;
(c) Not in excess of the Maximum Allowable Charge; and
(d) Provided for care and treatment of a covered Illness or Accidental Injury.

6.02 Deductibles and Co-Pays

Applicable deductible and/or co-pay amounts and Benefit Percentages payable are listed in the *Schedule of Benefits.* Covered medical expenses are subject to any limitations specified in the *Schedule of Benefits.*

6.03 Covered Medical Expenses

Covered medical expenses include, but are not limited to, charges for the following:

1) **Abortion.** An abortion for a life-threatening condition must be due to a physical disorder, injury, or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself that would place the woman in danger of death unless an abortion was performed. Reimbursement of an abortion is based on the physician's certification that the abortion was performed to save the life of the mother, to terminate pregnancy resulting from rape, or to terminate pregnancy resulting from incest. Medical complications that arise from an abortion are also covered.

2) **Allergy Testing, Allergy Injections and Allergy Serums.** Allergy testing, allergy injections, and allergy serums dispensed and/or administered at a Physician's office, and the syringes necessary to administer them.

3) **Ambulance Services.** Air ambulance (if Medically Necessary) or ground ambulance for transportation to or from the nearest appropriate Hospital by a licensed ambulance service.

4) **Ambulatory Surgical Facility.** Treatment, services and supplies furnished by an ambulatory surgical facility.

5) **Anesthetics.** Anesthetics and their professional administration and services of an anesthesiologist.

6) **Approved Clinical Trial and Routine Patient Costs for Participation in an Approved Clinical Trial.** Charges for any Medically Necessary services, for which benefits are provided by the Plan, when a Member is participating in a phase I, II, III or IV clinical trial, conducted in relation to the prevention, detection or treatment of a life-threatening Disease or condition, as defined under the ACA, provided:

   1. The clinical trial is approved by any of the following:
      a. The Centers for Disease Control and Prevention of the U.S. Department of Health and Human Services.
      b. The National Institute of Health.
      c. The U.S. Food and Drug Administration.
      d. The U.S. Department of Defense.
      e. The U.S. Department of Veterans Affairs.

f. An institutional review board of an institution that has an agreement with the Office for Human Research Protections of the U.S. Department of Health and Human Services.

2. The research institution conducting the Approved Clinical Trial and each health professional providing routine patient care through the Institution, agree to accept reimbursement at the applicable Allowable Expense, as payment in full for routine patient care provided in connection with the Approved Clinical Trial.

Coverage will not be provided for:

1. The cost of an Investigational new drug or device that is not approved for any indication by the U.S. Food and Drug Administration, including a drug or device that is the subject of the Approved Clinical Trial.
2. The cost of a service that is not a health care service, regardless of whether the service is required in connection with participation in an Approved Clinical Trial.
3. The cost of a service that is clearly inconsistent with widely accepted and established standards of care for a particular Diagnosis.
4. A cost associated with managing an Approved Clinical Trial.
5. The cost of a health care service that is specifically excluded by the Plan.
6. The cost of a health care service that is specifically excluded by the Plan.
7. Services that are part of the subject matter of the Approved Clinical Trial and that are customarily paid for by the research Institution conducting the Approved Clinical Trial.

7) **Birth Control (Family Planning/Contraceptive Counseling).** Charges for:

- Office visit for contraceptive purposes.
- Depo-Provera injections dispensed and/or administered at a Physician's office if Medically Necessary or for contraceptive purposes.
- Lunelle injections dispensed and/or administered at a Physician's office for contraceptive purposes.
- Services and supplies related to insertion and removal of Norplant and other birth control devices are covered the same as any other Illness.
- Depo-Provera and Lunelle injections dispensed by a pharmacist, are covered under the *Schedule of Benefits* (Prescription Drug Benefits).
- Contraceptive methods to include sterilization for male and female.

8) **Birthing Center.** Care, treatment and services furnished by a birthing center (please rely on the advice of your Physician when considering a birthing center).

9) **Blood and Blood Derivatives.** Blood transfusion services, including the cost of whole blood or blood plasma not donated or replaced.

10) **BRCA Testing.** The Plan considers molecular susceptibility testing for breast (BRCA testing) medically necessary for women who are 18 years of age or older and has a personal history of breast cancer. Breast cancer gen 1, early onset (BRCA1) and breast cancer gen 2, susceptibility protein (BRCA2) are tumor repressor genes responsible for keeping breast cells from growing too rapidly or in an uncontrolled way. Mutations within the gene interrupt this regulatory function and increase the risk of breast cancer.

NOTE: Guidelines for BRCA mutation testing are based on guidelines established by the U.S. Preventative Services Task Force.

NOTE: Prior Authorization is required for BRCA testing and medical criteria must be met.

11) **Chemotherapy/Radiation Therapy.** Chemotherapy, radiation therapy, and treatment with radioactive substances; materials and services of a technician.

12) **Colorectal Cancer Screening (CRC).** Persons at risk for CRC (family history of CRC, previous adeomatous polyps, inflammatory bowel disease, previous resection of CRC, genetic syndromes) may use more intensive screening efforts which includes AMA recommended screening for colorectal cancer including:

a. an annual fecal occult blood testing;
b. flexible sigmoidoscopy every 3 to 5 years from age 50 for persons at average risk;
c. colonoscopy;
d. double-contrast barium enema procedures which screen the entire colon.

13) **Contact Lenses or Eyeglasses.** Initial purchase of contact lenses or eyeglasses but not both if required following cataract surgery.

14) **Cosmetic Procedures/Reconstructive Surgery.** Reconstructive surgery is performed incidental to an injury, sickness, or congenital anomaly when the primary purpose is to improve functioning of the involved part of the body. The fact that physical appearance may change or improve as a result of reconstructive surgery does not classify such surgery as cosmetic when a functional impairment exists, and the surgery restores or improves function. For reconstructive surgery to be considered medically necessary there must be a reasonable expectation that the procedure will improve the functional impairment.

15) **Counseling.** For bereavement, marriage, family, mental health, substance abuse, rehabilitation, and educational counseling.

16) **COVID-19 Diagnostic Testing.** Covered expenses associated with testing of COVID 19 include the following with an in-network and out of network provider. Applicable benefits/cost share will apply depending where services are rendered:

Diagnostic Tests.

In vitro diagnostic products for the detection of SARS-CoV-2 or the diagnosis of the virus that causes COVID-19 (including all costs relating to the administration of such in vitro diagnostic products) which satisfy one of the following conditions:

- that are approved, cleared, or authorized by the FDA;
- for which the developer has requested or intends to request emergency use authorization under Section 564 of the Federal Food, Drug, and Cosmetic Act, unless and until such emergency use authorization request has been denied or the developer does not submit a request within a reasonable timeframe;
- that are developed in and authorized by a State that has notified the Secretary of Health and Human Services of its intention to review tests intended to diagnose COVID-19; or
- that are deemed appropriate by the Secretary of Health and Human Services.
- items and services furnished during an office visit (including both in-person and telehealth), urgent care visit, or emergency room visit which results in an order for or administration of an in vitro diagnostic product described above. Such items and services must relate to the furnishing of such diagnostic product or evaluation of the individual for purposes of determining the need for such product.

Qualifying Coronavirus Preventive Services.

The following items are covered at 100%, and do not require prior authorization.

- An item, service, or immunization that has in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force; and
- An immunization that has in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved.

17) **COVID-19 Treatment.** Covered expenses associated with treatment of COVID 19 include the following with an in-network provider and out of network provider. Applicable benefits/cost share will apply depending where services are rendered.

1) services for telehealth and telemedicine with cost sharing.
2) necessary medical equipment, supplies, and services related to COVID-19 treatment.
3) In-network facility requirements for pre-authorization, referrals, notification of hospital admission, or medical necessity reviews for COVID-19 treatment services consistent with CDC guidance.

18) **Dental Treatment in Mouth or Oral Cavity.** Coverage is limited to:

- surgical treatment of fractures and dislocations of the jaw or for treatment of an Accidental Injury to sound, natural teeth, including replacement of such teeth, within six months after the date of the Accidental Injury (except when delay of treatment is Medically Necessary);
- surgery needed to correct an Accidental Injury to the jaws, cheeks, lips, tongue, floor and roof of the mouth;
- If crowns, dentures, bridges, or in-mouth appliances are installed due to injury, covered expenses only include charges for:
  - The first denture or fixed bridgework to replace lost teeth;
  - The first crown needed to repair each damaged tooth; and
  - An in-mouth appliance used in the first course of orthodontic treatment after the injury
  - Replacement of such teeth will be covered, within six months after the date of the Accidental Injury (except when delay of treatment is Medically Necessary)
- removal of non-odontogenic lesions, tumors or cysts;
- incision and drainage of non-odontogenic cellulitis;
- surgical treatment of accessory sinuses, salivary glands, ducts and tongue;
- treatment to correct a non-odontogenic congenital defect that results in a functional defect of a covered Dependent Child.

19) **Dental Deep Sedation/General Anesthesia and I.V. Sedation for Oral Maxillofacial Surgery and Dental Services.** Medically necessary general anesthesia or IV sedation for oral maxillofacial surgery (OMS) and dental-type services that are covered under the medical plan. Anesthesia or IV sedation in conjunction with dental or OMS services are covered, when the following criteria is met.

- The Member is a child, up to 6 years old, with a dental condition (such as baby bottle syndrome) that requires repairs of significant complexity (for example, multiple amalgam and/or resin-based composite restorations, pulpal therapy, extractions or any combinations of these noted or other dental procedures)
- The Member has physical, intellectual, or medically compromising conditions for which dental treatment under local anesthesia, with or without additional adjunctive techniques and modalities, cannot be expected to provide a successful result and which, under anesthesia, can be expected to produce a superior result. Conditions include but are not limited to intellectual disability, cerebral palsy, epilepsy, cardiac problems and hyperactivity (verified by appropriate medical documentation)
- The Member is extremely uncooperative, fearful, unmanageable, anxious, or uncommunicative with dental needs so serious that treatment should not be postponed or deferred and for whom lack of treatment can be expected to result in dental or oral pain, infection, loss of teeth, or other increased oral or dental morbidity
- Members for whom local anesthesia is ineffective (for reasons such as acute infection, anatomic variations or allergy)
- Members who have sustained extensive oral-facial and/or dental trauma, for which treatment under local anesthesia would be ineffective or compromised

20) **Diabetic Education.** Participation in the University Medical Center of El Paso Diabetic Management Program will be provided at 100% or with a PPO Provider.

21) **Diagnostic X-Ray and Laboratory Services.** Diagnostic X-ray and laboratory examinations; services of a radiologist or pathologist.

22) **Dialysis Kidney Treatment** (including hemodialysis and peritoneal dialysis) is covered in the following settings until the patient becomes enrolled in end-stage renal disease dialysis benefits under Medicare or has been terminated from Plan.
    - Dialysis (peritoneal and hemodialysis) services and all medically necessary equipment and supplies used to furnish dialysis in a Medicare certified dialysis center, member's home or inpatient hospital facility are covered in accordance with Medicare coverage criteria.
    - At home, when provided, supervised, and arranged by a physician and the patient has registered with an approved kidney disease treatment center (professional assistance to perform dialysis and any furniture, electrical, plumbing, or other fixtures needed in the home to permit home dialysis treatment are not covered)
    - In a hospital-based or free-standing facility (in-network only) and Medicare certified dialysis center
    - All out of network dialysis treatments, professional services to include dialysis labs require a prior authorization with an out of network provider.
        — All in network dialysis treatments, professional services to include dialysis labs do not require a prior authorization.

23) **Durable Medical Equipment.** Rental, initial purchase, or replacement of Durable Medical Equipment. Purchase is covered only if long-term use is planned and the equipment cannot be rented or it is less costly to purchase than to rent. Repair or replacement will be covered when required due to growth or development of a Dependent Child, Medical Necessity because of a change in the Member's physical condition, or deterioration from normal wear and tear if prescribed by the attending Physician. Replacement is covered if it is likely to cost less to buy a replacement than repair or rent like equipment. Covered items include, but are not limited to, crutches and braces, a durable brace specially made for and fitted to the Member, and rental of wheelchairs and Hospital beds. Charges for more than one item of equipment for the same or similar purpose are not covered.

24) **Flexible Spending Account** – means the account established by the Plan Administrator on behalf of the Associate through which the Associate may elect to reduce his or her salary in order to pay qualified medical/dependent flexible spending expenses.

25) **Gender Affirming** – The Plan covers the following gender affirming services when ordered by a Provider or Physician.
    - Psychotherapy.
    - Pre- and post-surgical hormone therapy.
    - Gender affirming surgery/ies. Surgery must be performed by a qualified Provider. The service requires prior authorization.

    All gender affirming surgeries will require a prior authorization to include any hormone therapy, breast augmentation surgery (mammoplasty), mastectomy, and pelvic reconstruction for the treatment of gender identity disorders, the medical criteria and guidelines shown above will be utilized to determine the medical necessity for the requested procedure or treatment. Before undertaking gender affirming surgeries, candidates 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.

26) **Genetic Testing.** All medically necessary genetic testing will require a pre authorization and all experimental genetic testing will not be covered.

27) **Global Maternity.** Maternity Care for all confirmed pregnancies effective October 1, 2012 consists of antepartum care, delivery and postpartum care, including the following:

- Hospital admission
- Patient history
- Labor management
- Postpartum office visit, vaginal or cesarean section delivery
- Vaginal or cesarean section delivery, after previous cesarean delivery
- Hospital discharge
- and all applicable postoperative care.

Services that are not included in the global basis include:

- Antepartum consultation paid to the same provider, for dates of service either within the from-through period of the global billing within 270 days prior to the global OB delivery date
- Hospital visits that are related to the OB delivery
- Postpartum consultations that are related to the delivery paid to the same provider within the 45 day follow-up period of the global OB delivery date. Global claims are subject to the 1 year timely filing, based on the delivery date.

28) **Hearing Exam.** Covered Expenses include charges for an audiometric hearing exam if the exam is performed by:

- The Primary Care Provider who can also refer for more specialized care to a certified physician in the following categories:
- A physician certified as an otolaryngologist or otologist; or
- An audiologist who:
  - Is legally qualified in audiology; or
  - Holds a certificate of Clinical Competence in Audiology from the American Speech and Hearing Association in the absence of any applicable licensing requirements); and
  - Performs the exam at the written direction of a legally qualified otolaryngologist or otologist.

Routine hearing exams are covered at 100% and according to the American of Pediatrics Periodicity Schedule.

All adult covered expenses for the hearing exam are subject to any applicable deductible, co-pay and payment percentage shown in your *Schedule of Benefits.*

Hearing Aids and Cochlear Implant

- Replacement parts or repairs for a hearing aid; and
- Any tests, appliances, and devices for the improvement of hearing (including hearing aids and amplifiers), loss or devices that simulate speech, except otherwise provided.
- Surgical Implants including the Cochlear Ear.
  (Implants will be covered within the area of El Paso, unless living outside of the area)
- Upgrading of a traditional Cochlear Implant System.
- Replacements of Cochlear Implant Parts to include tool kits.

For members who are 20 years of age and younger, 1 hearing aid device per ear may be reimbursed every 5 years from the month it is dispensed.

For members who are 21 years of age and older and has at least a 35 dB hearing loss in both ears, 1 hearing aid device may be reimbursed every 5 years from the month it is dispensed.

29) **Home Health Care and Skilled Nursing.** For covered Members who meet the criteria for "Homebound Status": 1. Patients leave home infrequently for only short durations of time for reasons other than to seek medical care that they cannot receive at home; 2. When homebound patients leave home, it must take great and taxing effort and/or require maximum assistance. Patients may, however, leave home to attend adult day care programs that meet certain requirements and religious services and remain homebound.

Charges by a Home Health Care Agency on its own behalf for Covered Expenses and supplies furnished in the patient's home in accordance with a home health care plan made by the attending Physician; part-time or intermittent nursing care by a registered nurse (R.N.) or a licensed practical nurse (L.P.N.) or licensed vocational nurse (L.V.N.); and home health aide services provided in conjunction with nursing services are covered under the Plan if the attending Physician certifies that treatment of the condition would require confinement as a Hospital inpatient in the absence of home health care. Home health care expenses shall not include charges for: services or supplies not included in the home health care plan; services of a person who ordinarily resides in the patient's home or is a member of the patient's family, or Dependents of the patient; transportation services; custodial care.

Personal Care Providers are not covered. The following are examples of a Personal Care Provider:

- Assisting with eating, bathing, dressing, personal hygiene, housekeeping chores, transportation and daily activity living.

30) **Hospice Care.** Services and supplies furnished in a licensed inpatient hospice facility or in the patient's home by a licensed hospice care program when the attending Physician certifies that life expectancy is 6 months or less. Hospice care expenses include charges for bereavement counseling of the Member's immediate family prior to, and within 3 months after, the Member's death and charges for respite care provided to give temporary relief to the family or other caregivers in emergencies and/or from the daily demands of caring for a terminally ill person.

31) **Hospital Care (Inpatient).** The following services and supplies while an inpatient is at a Hospital:

- daily room charge in a Hospital, but not to exceed the daily rate equal to the average Hospital semi-private room charge (charges when a Hospital private room accommodation has been used will be reimbursed at the average semi-private room rate in the facility);
- charges for confinement in an intensive care unit;
- meals, special diets, nursing care;
- maternity and routine nursing care while mother is Hospital confined. A Hospital length of stay for the mother or newborn Dependent Child will be at least 48 hours following a vaginal delivery, or 96 hours following a cesarean section. The 48-hour period [or 96-hour period if applicable] begins at the time a delivery occurs in the Hospital [or in the case of multiple births, at the time of the last delivery] or, if the delivery occurs outside the Hospital, at the time a mother and/or newborn are admitted. The mother's or newborn's attending provider, after consulting with the mother, may discharge the mother or her newborn earlier than 48 hours [or 96 hours, if applicable] after delivery;
- operating, delivery, recovery and other treatment rooms;
- prescribed drugs and medications;
- dressings and casts;
- use of Hospital equipment, laboratory and radiology services;
- treatment by a Physician or surgeon.

32) **Hospital Care (Outpatient).** Treatment, services and supplies furnished by a Hospital on an outpatient basis to a Member not admitted as a registered bed patient.

33) **Immunizations.** Expenses related to Immunizations as required by law or as prescribed by a Physician subject to coverage limits specified in the *Schedule of Benefits.*

34) **Injectable and Intravenous Prescription Medications.** Covered Expenses as set forth in the *Schedule of Benefits* under Prescription Drugs.

35) **Insulin and Diabetic Supplies.** Refer to Prescription Drug Benefits in the Summary of Plan Benefits for coverage of injectable insulin, insulin syringes, chemstrips and blood lancets. Insulin pumps and blood glucose monitors are covered through the Plan if not used as convenience items.

36) **Long-term Acute Care Hospitals (LTAC).** Long-term acute care hospitals (LTAC) – LTAC hospitals are appropriate for members who require daily monitoring and complex medical interventions. Appropriate admission to LTAC may include those with complex wounds, chest tubes, ventilatory dependency, or multiorgan failure. LTACs provide care to members with conditions that are more medically complex than would be appropriate for other levels of care (e.g., inpatient rehabilitation facility)

Capabilities of LTAC facilities:

- Response to resuscitation: Equipment and trained staff available at LTAC
- Access to complex diagnostic/therapeutic modalities: Radiograph, ultrasound, laboratory onsite
- Availability of subspecialty consultants: Psychiatry, Pain Management, Orthopedics, Neurology, Physical Medicine & Rehab.
- Intensity of RN services: Five to six hours per patient per day
- Intensity of physician services: 24-hour, on-site physician
- Intensity of rehabilitation services: All modalities available

Criteria for admission to LTAC:

- Patient is stable for transfer from acute care facility to LTAC, as indicated by:
- Hypotension absent
- Cardiovascular status acceptable
- Stable chest findings
- Renal function acceptable
- Pain adequately managed
- No acute severe unstable neurologic abnormalities (e.g., obtundation, coma, evidence of ongoing CNS embolization or ischemia, worsening hydrocephalus)
- No acute significant hepatic dysfunction (e.g., no severe coagulopathy)
- No active bleeding or unstable disorders of hemostasis (e.g., no recent need for transfusion, severe thrombocytopenia with bleeding)
- Long-term enteral feeding (e.g., PEG) and intravenous access established upon intake

Interdisciplinary LTAC care is appropriate for the member's medically complex situation, as indicated by these common scenarios:

- Respiratory failure requiring ventilation management and weaning
- Infectious disease condition requiring LTAC care (e.g., long-term IV antibiotics or heart failure requiring daily adjustment and monitoring of diuretic therapy)
- Complex wound care condition requiring daily physician supervision
- Cardiovascular condition requiring LTAC care (e.g., heart failure with need for intravenous vasoactive drugs (e.g., dobutamine), need for continued support with high-concentration oxygen
- Other complex medical management situations (e.g., chest tube management, traumatic brain injury)

37) **Mastectomy.** The Federal Women's Health and Cancer Rights Act, signed into law on October 21, 1998, contains coverage requirements for breast cancer patients who elect reconstruction in connection with a Mastectomy. The Federal law requires group health plans that provide Mastectomy coverage to also cover breast reconstruction Surgery and prostheses following Mastectomy. As required by law, you are being provided this notice to inform you about these provisions. The law mandates that individuals receiving benefits for a Medically Necessary Mastectomy will also receive coverage for:

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

The Plan's coverage of a medically necessary mastectomy also includes post-mastectomy coverage for reconstruction of the breast, surgery on the other breast to achieve the appearance of symmetry, prostheses, and physical complication during any stage of the mastectomy, including lymphedemas. This coverage will be subject to the same annual Deductible and coinsurance provisions that currently apply to Mastectomy coverage, and will be provided in consultation with the Member and his/her attending Physician.

38) **Medical and Surgical Supplies.** Casts, splints, trusses, surgical dressings, and other devices used in the reduction of fractures and dislocations.

39) **Mental and Nervous Disorders.** Services provided for treatment of Mental and Nervous Disorders and services provided by a Physician, including Group Therapy and collateral visits with members of the patient's immediate family.

40) **Newborn Care.** Routine care of a hospital-confined newborn child, provided that coverage for the newborn child is requested, if necessary, according to the eligibility requirements of the Plan. The Plan will cover up to 5 days of hospitalization or until the mother's discharge, whichever occurs first, on the same basis as an Illness of such newborn child, including routine nursery care, physician charges, necessary laboratory tests, and circumcision. Such charges will be considered separate from the mother's charges. This benefit does not cover a newborn of a dependent daughter.

41) **Nursing Services.** Services of a registered nurse (R.N.), licensed vocational nurse (L.V.N.), or licensed practical nurse (L.P.N.), other than a person related by blood or marriage.

The Plan provides benefits for skilled nursing care furnished by a registered nurse or a licensed practical or vocational nurse if the services of a registered nurse are not available. In-Hospital private duty nursing services are not covered. Charges for skilled nursing services provided in the home are covered under the Home Health Care provision. Full-time nursing care in the home is not covered.

42) **Nutritional Counseling.** Expenses related to Nutritional Counseling which are Medically Necessary according to evaluation by a Registered Dietician when provided at University Medical Center of El Paso, Texas Tech Physicians or PPO Providers, limited to twelve sessions per fiscal year.

43) **Occupational Therapy.** Charges for services requiring the technical medical proficiency and skills of a registered or licensed occupational therapist and rendered in accordance with a Physician's specific instructions as to type and duration to restore or improve lost or impaired function. Services for outpatient occupational therapy are covered only when the Member is able to actively participate in such therapy, and there is documented continuous physical improvement. No coverage will be made for Workers' Compensation related Illness or Injuries.

All children from birth to 3 years with a development delay will be referred to Early Childhood Intervention (ECI). All children from birth to 3 years with a delay of speech development will be referred to Early Childhood Intervention (ECI). You can reach ECI by calling **915-534-4324** or online at **www.elpasoeci.org.** If Member does not choose ECI, Occupational therapy treatment will apply as stated on this *Schedule of Benefits.*

44) **Ophthalmology Services** – for eye care, vision, prevention of eye disease and injury, both medical and surgical, including:

- Cataract Treatment and Surgery
- Corneal Cross-Linking Treatment and Surgery
- Cornea Transplant
- Diabetic Retinopathy
- Dry Eye
- Eyelid Surgery if Medical Necessary
- Glaucoma
- Macular Degeneration Treatment
- Pink Eye Conjunctivitis
- Retinal Treatment

45) **Oral Mandibular Appliances.** Oral appliances (mandibular advancement devices) are an alternative treatment for obstructive sleep apnea. Custom fitted by dentists and worn during sleep, these oral appliances are designed to open and advance the mandible anteriorly while repositioning the tongue, with the goal of maintaining oropharyngeal patency."

An Oral Appliance (mandibular advancement device) is indicated when the following criteria are met:

Member has been diagnosed with Obstructive Sleep Apnea (OSA) with these criteria:

1. The apnea-hypopnea index (AHI) or Respiratory Disturbance Index (RDI) is
   a. greater than or equal to 15 events per hour with a minimum of 30 events; or,
   b. greater than or equal to 5 and less than or equal to 14 events per hour with a minimum of 10 events and
      A. documentation of excessive daytime sleepiness, impaired cognition, mood disorders, or insomnia;
2. Criteria regarding inability to use CPAP as a long-term treatment, as indicated by 1 or more of the following:
   a. Patient is intolerant of CPAP.
   b. Patient refuses CPAP.
3. Does not have:
   a. active temporomandibular joint disorder

Order criteria:

4. The device is ordered by the treating practitioner following a review of the report of the sleep test.
5. The device is provided and billed for by a licensed dentist (DDS or DMD) that meets the following:
   a. Certification in dental sleep medicine by a non-profit organization, such as the American Board of Dental Sleep Medicine (ABDSM), or

Exclusions:

The following items (not all-inclusive) are considered to be dental devices and will be denied as non-covered, not DME:

1. Oral occlusal appliances used to treat temporomandibular joint (TMJ) disorders
2. Tongue retaining devices used to treat OSA and/or snoring
3. All oral appliances used only to treat snoring without a diagnosis of OSA
4. Oral appliances used to treat other dental conditions
5. Fitting and/or adjustments of Oral Appliances, beyond the first 90-days, in order to maintain fit and/or effectiveness.

46) **Organ Transplants.** Covered Expenses incurred for human-to-human organ or tissue transplants are covered subject to the following:

- Eligible organ transplant procedures which are medically necessary and appropriate for the condition being treated and which have been confirmed by medical management / utilization review and a complete second opinion by a board certified physician and an organ transplant review committee are:
- heart transplants
- heart and lung transplants
- kidney transplants
- liver transplants
- cornea transplant
- bone marrow transplants/stem cell transplants
  - If the transplant procedure is a hematopoetic stem cell transplant, coverage will be provided for the cost of the acquisition of stem cells. This may be either peripherally or via bone marrow aspiration as clinically indicated, and is applicable to both the patient as the source (autologous) and related or unrelated donor as the source (allogeneic). Coverage will also be provided for search charges to identify an unrelated match, treatment and storage costs of the stem cells, up to the time of reinfusion. (The harvesting of the stem cells need not be performed within the transplant benefit period.) "Benefit Period" means the period that begins on the date of the initial evaluation and ends on Member's last day of termination date. (If the transplant is a bone marrow transplant, the date the marrow is reinfused is considered the date of the transplant.)
- Tissue Transplant Procedures Covered medical expenses to include joint replacements and other specified procedures which are medically necessary and appropriate for the condition being treated and which have been confirmed by medical management / utilization review and a complete second opinion by board certified physicians are:
  - artery or vein transplants
  - joint replacements
  - heart valve replacements
  - implantable prosthetic lenses in connection with cataracts
  - prosthetic bypass or replacement vessels

Additional consideration for organ transplant include:

- benefits are available for human organ, tissue, and bone marrow transplantation, subject to determination made on an individual case by case basis in order to establish Medical Necessity.

Covered Transplant Expenses

The term "Covered Expenses" with respect to transplants includes the reasonable and customary expenses for services and supplies which are covered under this plan (or which are specifically identified as covered only under this provision) and which are medically necessary and appropriate to the transplant, including:

- Organ Transplant Services are provided only through the Preferred Administrators Network, Interlink Transplant Network or other facility contracts as approved by the Plan Administrator and the stop loss company. No benefits are provided for organ transplant procedures unless the facility and network contract is approved by Preferred Administrators.
- Benefits will be provided only when the Hospital and Physician customarily charge a transplant recipient for such care and services.
- Donor expenses (professional fees and facility charges) will be considered eligible expenses when a Member is the recipient of the organ donation as follows:
  1) if the donor is covered by another benefit / insurance plan that plan will be considered primary for the expenses associated with the organ harvesting procedure and this Plan will be secondary;
  2) if the donor is not covered by another benefit / insurance plan this Plan will be primary.
  3) if the donor is not a Member under Preferred Administrators, then donor expenses do not apply to the out-of-pocket maximum of the recipient.
- Donor expenses (professional fees and facility expenses) will be considered eligible expenses when a Member is the donor of the organ for a person who is not covered by this Plan as follows:
  1) if the recipient's benefit / insurance plan provides coverage for organ donation, that plan will be considered primary and this plan will be secondary;
  2) if the recipient's benefit / insurance plan does not provide for organ donation this Plan will provide a benefit allowance for the donation procedure expenses.
- When the donor and recipient are both Covered Members, benefits will be paid under recipient.
- Benefits for organ procurement expenses will be considered eligible expenses.
- Benefits paid for organ donor expenses and procurement will be applied to the benefit maximums of the Member.
- Living donor complications will not be covered under this plan.
- If living donor is covered by another benefit/insurance plan that plan will be considered primary for donor complications.
- Multiple Listing Coverage are not covered under this Plan.

INTERLINK Exclusive Provider Organization (EPO) Network Benefits

The plan includes a Centers of Excellence transplant benefit and offers transplant benefits to eligible candidates through the INTERLINK Health Services ("INTERLINK") Transplant COE EPO network. Coverage for transplant services rendered at an INTERLINK credentialed Transplant COE program will be paid at the benefit coverage amounts based on the providers selected *Schedule of Benefits.* Co-payments, deductibles and other Member responsibilities still apply. To view the current list of eligible Transplant COE transplant providers, please visit **www.interlinkhealth.com/TransplantCOE.**

- Interlink referral will be made at the time of approved prior authorization request for an organ transplant evaluation.
- Case Manager will receive Interlink Confirmation Letter.
- Financial Rate information will be forward to Contracting Department.
- Contracting Department will review Contract Rate Summary and Memorandum of Understanding.
- If MOU meet's Plan's terms, the MOU will be sent back to Interlink and sent to Claims Department.
- Interlink will forward the executed MOU to transplant facility. Interlink will notify facility that all claims should be sent to Interlink for repricing. For questions on Interlink agreement or claims, you can contact Interlink at **800-599-9119.**

Emergency Transplant Care at NON-INTERLINK Transplant COE Providers

Coverage for unplanned and unscheduled emergency transplantation ("Emergency Transplant") is a benefit included in the plan, to be paid according to the contract terms negotiated by INTERLINK and agreed to by Plan, or Plan's agent, and Provider; however, if payment terms cannot be agreed upon within 10 days of the emergency transplant, then the transplant shall be paid at 110% of Medicare allowable and be considered payment in full. The transplanting hospital must provide the following documents to INTERLINK, who will then forward them onto the Plan, within 24 hours of the Emergency Transplant:

1) A letter from the transplanting hospital's Surgical Director detailing the medical conditions leading to the Emergency Transplant;
2) A copy of the United Network For Organ Sharing ("UNOS") Status 1 Listing Request and Status 1A confirmation Notice From UNOS; and
3) A detailed contract proposal for the Emergency Transplant.

Medical Hardships Proposed Transplant Care: NON-EPO Transplant Exceptions

The Plan may approve non-Transplant COE transplant care for documented Medical Hardship cases, to be paid according to the contract terms negotiated by INTERLINK and agreed to by Plan, or Plan's agent, and Provider; however, if payment terms cannot be agreed upon within 10 days of Provider's billing proposal to Plan, then payment shall be paid at 110% of Medicare allowable. Medical Hardship, as used here, could include such instances where the patient may be too medically frail to travel, retransplantation following a successful transplant by the same transplant team, or a living donor hardship. For consideration, Medical Hardship forms must be submitted to INTERLINK within 3 business days of the plan being contacted for transplant benefits or approval for evaluation. All information will be forwarded to the plan for consideration. Medical Hardship will not apply to Multiple Listings since they are not covered under this Plan. For Medical Hardship transplant benefit consideration, the transplant center must complete and submit the following forms:

1) A letter from the Surgical Director to the plan detailing the medical conditions supporting the Medical Hardship;
2) A completed Medical Hardship Form: Key Outcome Indicators Worksheet;
3) A completed Medical Hardship Form: Transplant Billing Report Table for the prior three years of transplant billing history; and
4) A detailed contract proposal for the proposed Medical Hardship transplant. Medical Hardship Forms can be downloaded from **http://tinyurl.com/medicalhardship.**

COVERAGE FOR ORGAN AND/OR TISSUE TRANSPLANTS

Pre-Authorization Requirement for Organ Transplant

Covered Expenses incurred in connection with any organ or tissue transplant listed in this provision will be covered subject to referral to and pre-authorization by the Plan Administrator's authorized review specialist. Transplant coverage is offered under this plan through an EPO network of credentialed and volume monitored transplant professionals and facilities. Coverage is also provided for transplant services obtained outside the EPO for Emergency Transplants, and for certain transplant cases involving a Plan approved Medical Hardship condition.

No benefits are provided for organ transplant procedures unless the facility and network contract is approved by Preferred Administrators. Transplant service must be received at an approved facility in the designated transplant network.

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 Covered Person's physician should contact the Plan Administrator for referral to the network's medical review specialist for evaluation and pre-authorization. A comprehensive treatment plan must be developed for this plan's medical review, and must include such information as diagnosis, the nature of the transplant, the setting of the procedure, (i.e., name and address of the hospital), any secondary medical complications, a five year prognosis, two (2) qualified opinions confirming the need for the procedure, as well as a description and the estimated cost of the proposed treatment. (One or both confirming second opinions may be waived by the plan's medical review specialist.) Additional attending physician's statements may also be required. A non-network hospital may provide a comprehensive treatment plan independent of the EPO, but this will be subject to a Medical Hardship review and may result in no benefit coverage for the transplant at that center. All potential transplant cases will be assessed for their appropriateness for Large Case Management.

Organ Transplant Network

As a result of the pre-authorization review, the Covered Person will be asked if they wish for assistance gathering information about participating transplant programs. The term "participating transplant program" means a licensed healthcare facility and transplant program that has met INTERLINK's Quality Assurance Program standards for participation, and been declared a Transplant COE program by INTERLINK Health Services' Quality Assurance Committee. The transplant network's goal is to perform necessary transplants in the most appropriate setting for the procedure using some of the nation's most experienced and qualified transplant teams.

Multiple Listings

Multiple listings are not covered under this Plan. All Organ Transplant must be with a Center's of Excellence (CEO). If member's chooses to go to facility that is not a CEO, they must a Medical Hardship. For a Medical Hardship transplant benefit consideration, the transplant center must complete specific forms, as listed on *page 37* under (Medical Hardship).

Re-Transplantation

Re-transplantation will be covered up to two re-transplants, for a total of three transplants. The new Transplant Benefit Period begins 1 day prior to the retransplantation.

Transplant Benefit Period

Covered Expenses will accumulate during a Transplant Benefit Period. The term "Transplant Benefit Period" means the period that begins on the date of the initial evaluation and ends on the date, which is twelve (12) consecutive months following the date of the transplant. (If the transplant is a bone marrow transplant, the date the marrow is reinfused is considered the date of the transplant).

47) **Orthotic Devices.** Orthotic Devices used to support, align, prevent or correct deformities, or to improve the function of movable parts of the body. Repair or replacement of covered Orthotic Devices will be covered when required due to growth or development of a Dependent Child, medical necessity because of a change in the Member's physical condition, or deterioration from normal wear and tear for dependent children up to age 18, if recommended by the attending physician. Orthotic devices for dependent children are based on medical necessity.

Supportive foot devices for adults (such as arch supports) and orthopedic shoes are covered when prescribed by an In-Network Physician.

48) **Oxygen.** Oxygen or other gases and rental of equipment for its administration including IPPB (Intermittent Positive Pressure Breathing) equipment.

49) **Pervasive Developmental Disorders** are a group of conditions originating in childhood in several areas, including physical, behavioral, cognitive, and social, and language developmental. Some examples of these disorders are (Asperger's Syndrome, Down Syndrome, Rett Syndrome, and Childhood Disintegrative Disorders).

The following services are eligible for development disorders:

- Evaluation services;
- Speech therapy (ST);
- Occupational therapy (OT);
- Physical therapy (PT);
- Applied behavior Analysis and Behavior Training Management

50) **Physical Therapy.** Services of a licensed physical therapist or Physician for non-Workers' Compensation Illnesses or Injuries, but limited to services requiring the technical medical proficiency and skills of a recognized physical therapist and rendered in accordance with a Physician's specific instructions as to type and duration.

NOTE: All children from birth to 3 years with a development delay will be referred to Early Childhood Intervention (ECI). All children from birth to 3 years with a delay of speech development will be referred to Early Childhood Intervention (ECI). You can reach ECI by calling **915-534-4324** or online at **www.elpasoeci.org.** If Member does not choose ECI, Physical therapy treatment will apply as stated on this *Schedule of Benefits.*

51) **Physician Care.** Professional services of a Physician for surgical and medical care, including but not limited to, surgery, anesthesia, inpatient medical visits, consultations, office visits, and office treatment. FDA approved COVID-19 diagnostic testing and treatment.

52) **Preadmission or Preoperative Testing.** Tests or exams relating to surgery for a Member who is scheduled for surgery.

53) **Prescription Drugs.** Drugs requiring a prescription under the applicable state law. Examples of covered Prescription Drugs include:

- Adderall
- Contraceptives (oral and injectable)
- Dexedrine
- Dextrostat
- Federal legend prescription drugs
- Injectable insulin, insulin syringes, chemstrips, and blood lancets
- Injectables (other than insulin)
- I.V. medications prescribed by a licensed physician and dispensed by a licensed pharmacist
- Non-insulin needles/syringes
- Pre-natal prescription vitamins

54) **Pregnancy Care.** Pregnancy shall mean carrying a child, resulting childbirth, miscarriage and non-elective abortion (see "Abortion" benefit language above). The Plan considers Pregnancy as an Illness Sickness for the purpose of determining benefits. Care and treatment for pregnancy and complications of pregnancy are covered for a covered Associate, Spouse or dependent daughter.

55) **Preventive Care.** Preventive Benefits as specified in the *Schedule of Benefits.*

56) **Prosthetic Devices.** Prosthetic devices such as artificial limbs or eyes. After a mastectomy an external breast prosthesis is covered, and also the first bra made solely for use with the external breast prosthesis. Prosthetic device repair or replacement will be covered when required due to growth or development of a Dependent Child, Medical Necessity because of a change in the Member's physical condition.

57) **Psychiatric Day Treatment Facilities.** Covered Expenses incurred for treatment in a psychiatric day treatment facility for a mental or nervous disorder if the attending Physician certifies that such treatment is in lieu of Hospitalization, will be subject to the same benefits and limitations as applicable to treatment provided on an inpatient basis for mental or nervous disorders, as specified in the *Schedule of Benefits.* Any benefits so provided are considered as inpatient care and treatment in a Hospital.

58) **Rehabilitation Facilities.** Services and supplies including room and board furnished by a rehabilitation facility. The Member must be under the continuous care of a Physician and the attending Physician must certify that the individual requires nursing care 24 hours a day. A registered nurse or a licensed vocational or practical nurse must render nursing care. The confinement cannot be primarily for domiciliary, custodial, personal type care, care due to senility, alcoholism, drug abuse, blindness, deafness, mental deficiency, tuberculosis, or mental and nervous disorders. Charges for vocational therapy or custodial care are not covered.

59) **Routine Care.** Services as specified in the *Schedule of Benefits* as well as gamma globulin injections.

60) **Skilled Nursing Facilities.** Services and supplies including room and board furnished by a skilled nursing facility.

61) **Skin Treatments.** Services and procedures are covered when meeting medical necessity. Some examples of covered treatments are the following:
- Ultraviolet A light (PUVA)
- Photochemotherapy
- Phototherapy
- Laser Treatment
- Benign Skin Lesion Removal
- Radiation Treatment
- Pulsed Dye Laser Treatment
- Actinic Keratoses Treatment

62) **Specialty Medications.** "Specialty" medications mean high-cost oral or injectable medications used to treat complex chronic conditions. These are highly complex medications, typically biology-based, that structurally mimic compounds found within the body. High-touch patient care management is usually required to control side effects and ensure compliance. Specialized handling and distribution are also necessary to ensure appropriate medication administration.

63) **Speech Therapy.** Charges for services of a licensed speech therapist (or, in states not requiring a license, one who holds a Certificate of Clinical Competence from the American Speech and Hearing Association) when rendered in accordance with a Physician's specific instructions as to type and duration but only when necessary:
- to restore loss of functional speech or swallowing after a loss or impairment of a demonstrated, previous ability to speak or swallow;
- to develop or improve speech after surgery to correct a defect that both existed at birth and impaired or would have impaired the ability to speak;

- Language and Articulation delays;
- treatment of fluency (stuttering) disorders;
- voice disorders;
- to program and treat on the usage of an Augmentative Communication Device;
- dysphagia disorders.

Treatment of congenital anomaly which includes but are not limited to down syndrome, cleft palate, and tongue tie. Speech therapy for developmental disorders (including autism spectrum, and Asperger's are covered. For pervasive developmental disorder benefits, please refer to *page 80.*

NOTE: All children from birth to 3 years with a development delay will be referred to Early Childhood Intervention (ECI). All children from birth to 3 years with a delay of speech development will be referred to Early Childhood Intervention (ECI). You can reach ECI by calling **915-534-4324** or online at **www.elpasoeci.org.** If Member does not choose ECI, Speech therapy treatment will apply as stated on this *Schedule of Benefits.*

64) **Spinal Adjustments.** 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 performed by a Physician or Chiropractor to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

65) **Sterilization Procedures.** Voluntary sterilization procedures for women and men are covered at 100% with any of our In-Network Providers.

66) **Substance Abuse.** Services provided for treatment of substance abuse conditions.

67) **Temporomandibular Joint Dysfunction (TMJ).** Only open-curing operations for treatment of TMJ surgical are covered. Open surgical procedures including, but not limited to meniscus or disc repositioning. TMJ surgery may also be considered medically necessary in cases where there is conclusive evidence that severe pain or functional disability is produced by an intra-capsular condition, confirmed by magnetic resonance imaging (MRI), computed tomography or other imaging, which has not responded to nonsurgical management, and surgery is the considered to be the only remaining option.

The following services are eligible for TMJ prior to surgery. This may be covered when all other treatment has failed.

- Evaluations, consultations, office visits, examinations
- Diagnostic testing
- Anthrocentesis, TMJ
- Arthroplasty, TMJ
- Arthroscopy, TMJ
- Arthrotomy, TMJ
- TMJ Splints, TMJ
- Trigger point injections, TMJ
- Injections of corticosteroids, TMJ
- Physical therapy for TMJ – physical therapy for TMJ is subject to physical therapy benefit limitations on this plan

Orthodontic and Orthognathic Surgery are not covered under this medical plan.

68) **Transcranial Magnetic Stimulation (TMS).** Therapy is considered medically necessary for the treatment of depression.

TMS is covered for members who have moderate to severe Major Depressive Disorder (MDD) as diagnosed by a psychiatrist. Patients must also have tried at least two medications for depression that have not been helpful and attempted to treat their depression and at least two months of psychotherapy in the past.

69) **Vaccinations.** Expenses for medically necessary vaccinations are covered at 100% with any of our in-network providers. Please note that immunizations that are administered solely for the purpose of travel or occupation are not covered.

6.04 Expense Limitations

Covered Expenses are subject to any limitations specified in the *Schedule of Benefits* as well as Article VII.

ARTICLE VII
EXCLUSIONS

7.01 Claims Submitted After One Year

No benefits will be paid for any claims filed more than one year after a covered service or supply was incurred.

7.02 Miscellaneous Restrictions on Benefits

No coverage is provided under the Plan for expenses incurred for treatment, services and supplies due to an Injury or Illness which:

(a) the Member has no legal obligation to pay;
(b) are provided by a member of the patient's immediate family;
(c) no charge would have been made if the patient had no health coverage;
(d) result directly or indirectly from war, whether declared or undeclared;
(e) are furnished in a government owned or operated facility or any other Hospital where care is provided at government expense, unless it is non-service related;
(f) results from or sustained due to participation in a riot or insurrection;
(g) are for the preparation of medical reports or itemized bills; or
(h) are for travel or accommodations, whether or not recommended by a Physician.

7.03 Exclusions

Coverage is not available from the Plan for charges arising from care, supplies, treatment, and/or services:

Abortion Elective. Termination of pregnancy initiated by the Member. In order to be a Covered Expense under the Plan, an abortion for a life-threatening condition must be due to a physical disorder, injury, or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself that would place the woman in danger of death unless an abortion was performed. Reimbursement of an abortion is based on the physician's certification that the abortion was performed to save the life of the mother, to terminate pregnancy resulting from rape, or to terminate pregnancy resulting from incest.

Acupuncture or Hypnosis. For acupuncture or hypnosis unless performed by a Physician and in lieu of anesthesia.

Administrative Costs. That are solely for and/or applicable to administrative costs of completing claim forms or reports or for providing records wherever allowed by applicable law and/or regulation.

Alcohol. That arise from a Member taking part in any activity made illegal either due to the use of alcohol or a state of intoxication. It is not necessary that an arrest occur, criminal charges be filed, or, if filed, that a conviction result. Proof beyond a reasonable doubt is not required to be deemed an activity made illegal due to the use of alcohol or a state of intoxication. Expenses will be covered for Injured Members other than the person partaking in an activity made illegal due to the use of alcohol or a state of intoxication, and expenses may be covered for Substance Abuse treatment as specified in this Plan, if applicable. This exclusion does not apply if the injury (a) resulted from being the victim of an act of domestic violence or (b) resulted from a documented medical condition (including both physical and mental health conditions).

Broken Appointments. That are charged solely due to the Member's having failed to honor an appointment.

Complications Arising under Excluded Benefit Treatments. For treatment of any Benefits excluded under this Section, except for abortions. This exclusion includes charges for complications resulting from any excluded coverage, including, but not limited to, any reversal procedure unless otherwise covered.

Court Ordered Treatment or Hospitalizations.

Cosmetic Surgery/Procedures. For Cosmetic Surgery, with the following exceptions:

(a) Treatment provided for the correction of defects incurred in an accidental injury sustained by the participant; or
(b) Treatment provided for reconstructive surgery following cancer surgery; or
(c) Surgery performed on a newborn child for the treatment or correction of a congenital defect; or
(d) Surgery performed on a covered dependent child (other than a newborn child) under the age of 19 for the treatment or correction of congenital defect other than conditions of the breast; or
(e) Reconstruction of the breast on which a mastectomy has been performed; surgery and reconstruction of the other breast to achieve a symmetrical appearance; and prosthesis and treatment of physical complications, including lymphedemas, at all stages of the mastectomy; or
(f) Reconstructive surgery performed on a covered dependent child under the age of 19 due to craniofacial abnormalities to improve the function of, or attempt to create a normal appearance of an abnormal structure caused by a congenital defect, developmental deformities, trauma, tumors, infections, or disease.

Custodial Care. That do not restore health or are provided mainly as a rest cure or for maintenance care, unless specifically mentioned otherwise. Deductible Applicable. That are not payable due to the application of any specified deductible provisions contained herein.

Deductible. That are amounts applied toward satisfaction of Deductibles and expenses that are defined as the Member's responsibility in accordance with the terms of the Plan.

Dental Services. For any treatment, services or supplies related to the care, filling, removal or replacement of teeth and the treatment of injuries and diseases of the teeth, gums, and other structures supporting the teeth. This includes but is not limited to:

- services of dentists, oral surgeons, dental hygienists, and orthodontists including apicoectomy (dental root resection), root canal treatment, soft tissue impactions, removal of bony impacted teeth, treatment of periodontal disease, alveolectomy, augmentation and vestibuloplasty and fluoride and other substances to protect, clean or alter the appearance of teeth;
- dental implants, false teeth, prosthetic restoration of dental implants, plates, dentures, braces, mouth guards, and other devices to protect, replace or reposition teeth; and
- non-surgical treatments to alter bite or the alignment or operation of the jaw, including treatment of malocclusion or devices to alter bite or alignment.
- anesthesia/sedation for routine dental services is not a covered benefit under the Plan. Please refer to covered benefit under Dental Treatment in Mouth or Oral Cavity on *page 69.*
- General anesthesia and monitored anesthesia are not covered under this Plan for neither adult nor children, unless meeting medical necessity of treatment in mouth or oral cavity, please refer to *page 69.*
- Removal of bony impacted wisdom teeth.

Durable Medical Equipment. For purchase, or replacement of more than one item of Durable Medical Equipment or surgical equipment over $500.00, if it is for the same or similar purpose.

Educational Services. That are related to education, training services or testing, including:

- Special education;
- Remedial education, job training and job hardening programs;
- treatment of learning disabilities, minimal brain dysfunction, behavioral disorders, (including pervasive developmental disorders) training
- educational testing and training related to behavioral (conduct) problems, learning disabilities and delays in developing skills.
- Applied behavior analysis
- Behavior training and behavior management

Error. That are required to treat injuries that are sustained or an illness that is contracted, including infections and complications, while the Member was under, and due to, the care of a Provider wherein such illness, injury, infection or complication is not reasonably expected to occur. This exclusion will apply to expenses directly or indirectly resulting from the circumstances of the course of treatment that, in the opinion of the Plan Administrator, in its sole discretion, unreasonably gave rise to the expense.

Excess. That exceed Plan limits, set forth herein and including (but not limited to) the Maximum Allowable Charge in the Plan Administrator's discretion and as determined by the Plan Administrator, in accordance with the Plan terms as set forth by and within this document.

Exercise and Exercise Equipment. For exercise equipment or exercise programs such as for weight reduction (except for a Medically Necessary cardiac rehabilitation program following myocardial infarction and/or cardiac surgery).

Experimental or Investigational. For services that are considered Experimental or Investigational as described by this Plan.

Family Member. That are performed by a person who is related to the Member as a spouse, parent, child, brother or sister, whether the relationship exists by virtue of "blood" or "in law".

Foot Care. For the treatment of flat foot, routine foot care and supportive devices for feet are not covered. The following services, whether performed by a podiatrist, osteopath, or doctor of medicine, and without regard to the difficulty or complexity of the procedure, are not covered.

- **Treatment of Flat Foot.** The term "flat foot' is defined as a condition in which one or more arches of the foot have flattened out. Services or devices toward the care or correction of such conditions, including the prescription of supportive devices, are not covered
- **Routine Foot Care** – Services that normally are considered routine are not covered include the following:
  - The cutting or removal of corns and calluses;
  - The trimming, cutting, clipping, and debriding of nails; and
  - Other hygienic and preventive maintenance care, such as cleaning and soaking the feet, the use of skin creams to maintain skin tone of either ambulatory or bedfast patients, and any other service performed in the absence of localized illness, injury, or symptoms involving foot care.

Genetic Testing to determine sex of baby.

Government. That are expenses to the extent paid, or which the Member is entitled to have paid or obtain without cost, in accordance with the laws or regulations of any government.

Hair Loss. Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician, except for wigs after chemotherapy treatment.

Hazardous Pursuit, Hobby or Activity. That are of an Injury or Illness that results from engaging in a hazardous pursuit, hobby or activity. A pursuit, hobby or activity is hazardous if it involves or exposes an individual to risk of a degree or nature not customarily undertaken in the course of the Member's customary occupation or if it involves leisure time activities commonly considered as involving unusual or exceptional risks, characterized by a constant threat of danger or risk of bodily harm including but not limited to: hang gliding, skydiving, bungee jumping, parasailing, use of all terrain vehicles, rock climbing, use of explosives, automobile racing, motorcycle racing, aircraft racing, or speed boat racing, reckless operation of a vehicle or other machinery, and travel to countries with advisory warnings.

Home Health Care. For: services or supplies not included in the home health care plan; services of a person who ordinarily resides in the patient's home or is a member of the patient's family, or Dependents of the patient.

Personal Care Providers are not covered. The following are examples of a Personal Care Provider:

- Assisting with eating, bathing, dressing, personal hygiene, housekeeping chores, transportation and daily activity living. Hospitalization and/or Surgery. For:
- substance abuse, unless the patient is undergoing a program of therapy supervised by a Physician who certifies that a follow-up program has been established which includes therapy at least once a month or includes attendance at least twice a month at a meeting of organizations devoted to the treatment of the condition.
- non-emergency Hospital admissions on either a Friday or a Saturday unless a surgical procedure is performed within 24 hours of admission.
- primary control or change of the patient's environment and/or during which the patient receives psychiatric care that could have been safely and adequately provided on an outpatient basis or in a lesser facility than a Hospital.
- care in a health resort, rest home, nursing home, residential treatment center, or any institution primarily providing custodial care.
- custodial care for a Member who is mentally or physically disabled and is not under specific medical, surgical or psychiatric treatment which is likely to reduce the disability or enable the patient to live outside an institution providing care.
- hospital care and services or supplies when the Member's condition does not require constant direction and supervision by a Physician, constant availability of licensed nursing personnel and immediate availability of diagnostic therapeutic facilities and equipment found only in the Hospital setting or if the primary cause of such a confinement was for rest or custodial care.
- in-Hospital private duty nursing services.
- surgery utilized as treatment of neurosis, psychoneurosis, psychopathy, psychosis and other mental, nervous and emotional Illness.

Incurred by Other Persons. For expenses actually Incurred by other persons.

Injury Caused by Engaging in Illegal Act. For injury caused by or contributed to by engaging in an illegal act or occupation, by committing or attempting to commit any crime, criminal act, or other criminal behavior. It is not necessary for a person to be charged or convicted in order for this exclusion to apply.

Massage. For massage or for any rolfing services and/or supplies. Rolf therapy or structural integration, is a holistic system of bodywork that uses deep manipulation of the body's soft tissue to realign and balance the body's myofascial structure. Rolfing improves posture, relieves chronic pain, and reduces stress.

Morbid Obesity and Obesity. That are in connection with treatments, surgical procedures or programs for obesity, morbid obesity, dietary control or weight reduction, whether Medically Necessary or not, and for any complications arising out of non-covered services. This exclusion does not apply to the obesity screening and counseling benefit that are part of Preventive Care services.

Negligence. For Injuries resulting from negligence, misfeasance, malfeasance, nonfeasance or malpractice on the part of any licensed Physician.

No Legal Obligation. That are provided to a Member for which the Provider of a service customarily makes no direct charge, or for which the Member is not legally obligated to pay, or for which no charges would be made in the absence of this coverage, including but not limited to fees, care, supplies, or services for which a person, company or any other entity except the Member or this benefit plan, may be liable for necessitating the fees, care, supplies, or services.

Not Acceptable. That are not accepted as standard practice by the American Medical Association (AMA), American Dental Association (ADA), or the Food and Drug Administration (FDA).

Not Actually Rendered. That are not actually rendered.

Not Medically Necessary. For treatment and care which are not generally accepted in the United States as being necessary and appropriate for the treatment of the patient's Illness or Injury.

Not Transported. For transportation, including ambulance charges, when transportation of the patient was not necessary, did not occur, or was refused by the patient.

Occupational. For any condition, Illness, Injury or complication thereof arising out of or in the course of employment, including self-employment, or an activity for wage or profit.

If you are covered as an Associate or a Dependent under this Plan and you are self-employed or employed by an employer that does not provide health benefits, make sure that you have other medical benefits to provide for your medical care in the event that you are hurt on the job. In most cases workers compensation insurance will cover your costs, but if you do not have such coverage you may end up with no coverage at all.

Orthognathic Conditions. That are related to treatment of Orthognathic conditions, including associated diagnostic procedures.

Other than Attending Physician. That are other than those certified by a Physician who is attending the Member as being required for the treatment of Injury or Disease, and performed by an appropriate Provider.

Out of Country. For medical care or services rendered outside of the United States (including its territories) EXCEPT for treatment of injury or sudden acute illness while traveling for a period not to exceed ninety (90) days, or while attending an accredited school abroad on a full-time basis and meeting all of the requirements defined in the provisions for eligibility.

Personal Hygiene. For personal hygiene, comfort, or convenience items, including, but not limited to, air conditioners, humidifiers, air purification units, electric heating units, orthopedic mattresses, blood pressure instruments, scales, and first aid supplies.

Personal Support Services. For support services provided to beneficiaries who require assistance due to physical, cognitive, or behavioral limitations related to their disability or chronic health condition.

The following provider services are not covered.

- ADL's – include, but not limited to eating, toileting, grooming, dressing, bathing, transferring, maintaining, continence, positioning, mobility.
- IADL's – include, but not limited to personal hygiene, meal preparation, grocery shopping, light housework, laundry, communication, transportation, and money management.

Personal Comfort and Convenience Items. That is primarily for the Member's convenience and personal comfort or that of a third party, including: Telephone, television, internet, barber or beauty service or other guest services; housekeeping, cooking, cleaning, shopping, monitoring, security or other home services; and travel, transportation, or living expenses, rest cures, recreational or diversional therapy.

Prophylactic Mastectomy. For a prophylactic mastectomy surgery to remove one or both breasts to reduce the risk of developing breast cancer.

Prescription Drugs. For the following list of prescription drugs. This list is not inclusive of all covered/not covered drugs. For an inclusive list review the Prescription Solutions drug formulary at **www.preferredadmin.net.**

- Anabolic steroids
- Anorectics (any drug used for the purpose of weight loss)
- Anorexiants (except for Adderall, Dexedrine, and Dextrostat)
- Cosmetics
- Drugs or medicines dispensed more than one year after the date of the Prescription order
- Fertility medications
- Fluoride supplements, except as covered for children under Preventive Care services.
- Investigational or experimental drugs including compounded medications for non-FDA approved use
- Medical devices and other supplies (example Diabetes blood level monitor is covered under the Plan)
- No charge prescriptions available under Workers' Compensation, or other city, state or federal governmental program
- Non-legend drugs other than insulin
- Retin A after age 26
- Rogaine
- Viagra and similar drugs (unless prescribed for heart conditions)
- Vitamins (prescription or otherwise) except for prescription pre-natal vitamins. This exclusion does not apply to the over-the-counter vitamins and supplements covered under Preventive Care if prescribed by a physician.

Prior to Coverage. That are rendered or received prior to or after any period of coverage hereunder, except as specifically provided herein.

Prohibited by Law. That are to the extent that payment under this Plan is prohibited by law.

Prosthetic Devices. That are over $500.00 for repair or replacement of prosthetic devices, except when required due to growth or development of a Dependent Child, Medical Necessity because of a change in the Member's physical condition, or deterioration from normal wear and tear if recommended by the attending Physician.

Provider Error. That are required as a result of unreasonable Provider error.

Radioactive Materials. For charges in connection with treatment for exposure to radioactive materials.

Self Inflicted Injuries. For intentionally self-inflicted Injury, unless such Injury results from a documented medical condition (physical or mental health condition) or being a victim of an act of domestic violence.

Sexual Health and Family Planning. For:

- Treatment of infertility with the confirmed diagnosis of infertility if the purpose of treatment is for discovery of infertility. Infertility treatment is not covered for services and fertilization attempts, including but not limited to: artificial insemination, Personal therapy for infertility, in-vitro fertilization, microsurgery for infertility treatment, and HCG injections are not a covered benefit.
- expenses related to adoption
- surrogate mother (unless the surrogate is a Member, in which case the Preventive Care and/or pregnancy expenses will be covered in accordance with the Plan provisions) and all related newborn Dependent Child expenses (unless the newborn Dependent Child is the legal child of a Member, as evidenced by an order of a court of competent jurisdiction validating the Member's gestational agreement, and further provided that the Member enrolls such child in the plan within 30 days of such child's birth pursuant to Section 5.01)
- treatment of sexual dysfunctions not related to organic disease
- reversal or attempted reversal of sterilization

Subrogation, Reimbursement, and/or Third Party Responsibility. For an Injury or illness not payable by virtue of the Plan's subrogation, reimbursement, and/or third party responsibility provisions.

Transportation. To and from provider/hospital visits are not covered. Non-emergency transportation is not covered.

Therapy. For physical or psychological therapy where the method of treatment is art, play, music, drama, reading, massage, home economics or recreational activities.

Temporomandibular Joint Dysfunction (TMJ). For treatment, other than by an open-cutting operation, as stated in the Medical Benefits section, of temporomandibular joint dysfunction. Charges for orthodontic treatment or services are not covered. Orthognathic surgery is not covered under this plan.

Tuition and/or Special Training. For tuition or special education and for educational testing or training are not covered.

Unauthorized Services. For unauthorized services. This includes any service obtained by or on behalf of a covered person without prior authorization by Preferred Administrators when required. This exclusion does not apply in a Medical Emergency or in an Urgent Care situation as long as the Medical Emergency does not turn into an Inpatient Stay.

Unreasonable. That are required to treat Illness or Injuries arising from and due to error(s) caused at the time of treatment by the treating Provider, including, but not limited to, a Physician or Hospital, wherein such Illness, Injury, infection or complication is not reasonably expected to occur. This exclusion will apply to expenses directly or indirectly resulting from circumstances that, in the opinion of the Plan Administrator in its sole discretion, gave rise to the expense, which was caused directly or indirectly by the treating Provider, and are not generally foreseeable or expected amongst professionals practicing the same or similar type(s) of medicine as the treating Provider whose error caused the loss(es).

Vax-D Therapy. For Vax-D therapy is not covered. The VAX-D Therapeutic Table is designed to relieve pressure on structures that may be causing low back pain. It relieves the pain associated with herniated discs, degenerative disc disease, posterior facet syndrome and radicular pain. It achieves these effects through decompression of intervertebral discs, that is, unloading, due to distraction and positioning.

Vision. For vision-related services and supplies, except as described in the Medical Benefits section. The Plan does not cover:

- Special supplies such as non-prescription sunglasses and subnormal vision aids;
- Vision service or supply which does not meet professionally accepted standards;
- Eye exams during your stay in a hospital or other facility for health care;
- Eye exams for contact lenses or their fitting;
- Eye exercises;
- Eyeglasses or duplicate or spare eyeglasses or lenses or frames;
- Replacement of lenses or frames that are lost or stolen or broken;
- Acuity tests;
- Eye surgery for the correction of vision, including radial keratotomy, LASIK and similar procedures; and
- Services to treat errors of refraction.
- Visual Training (orthoptics);
- Radial keratotomy surgery, orthokeratology, and any eye surgeries in lieu of corrective lenses

War. That Incurred as a result of war or any act of war, whether declared or undeclared, or any act of aggression, when the Member is a member of the armed forces of any country, or during service by a Member in the armed forces of any country. This exclusion does not apply to any Member who is not a member of the armed forces, and does not apply to victims of any act of war or aggression.

Weight Loss. Related to care and treatment of obesity, weight loss or dietary control. Specifically excluded are charges for bariatric surgery, including but not limited to, gastric bypass, stapling and intestinal bypass, and lap band surgery, including reversals. This exclusion does not apply to obesity screening and counseling that are covered under Preventive Care.

With respect to any Injury which is otherwise covered by the Plan, the Plan will not deny benefits otherwise provided for treatment of the Illness or Injury if the Illness or Injury results from being the victim of an act of domestic violence or a documented medical condition. To the extent consistent with applicable law, this exception will not require this Plan to provide particular benefits other than those provided under the terms of the Plan.

ARTICLE VIII
MEMBER REIMBURSEMENT PROCEDURES

Assignments

For this purpose, the term "Assignment of Benefits" (or "AOB") is defined as an arrangement whereby a Member of the Plan, at the discretion of the Plan Administrator, assigns its right to seek and receive payment of eligible Plan benefits, less Deductible, Copayments and Coinsurance amounts, to a medical Provider. If a Provider accepts said arrangement, the Provider's rights to receive Plan benefits are equal to those of the Member, and are limited by the terms of this Plan Document. A Provider that accepts this arrangement indicates acceptance of an AOB and Deductibles, Copayments, and Coinsurance amounts, as consideration in full for treatment rendered.

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

No Member shall at any time, either during the time in which he or she is a Member in the Plan, or following his or her termination as a Member, in any manner, have any right to assign his or her right to sue to recover benefits under the Plan, to enforce rights due under the Plan or to any other causes of action which he or she may have against the Plan or its fiduciaries. A medical Provider which accepts an AOB does as consideration in full for services rendered and is bound by the rules and provisions set forth within the terms of this document.

8.01 Member Reimbursement

Member Reimbursement's shall be submitted directly to Preferred Administrators.

8.02 Reporting of Member Reimbursements

A Reimbursement Form can be downloaded at **www.prefererredadmin.net.** This form needs to be completed if the provider is not submitting the claim on the Member's behalf. Members must submit an itemized bill for a claim to be processed. Receipts, balance due statements and cancelled checks are not acceptable replacements for the itemized bill. Completed claim forms and original bills for Covered Expenses must be submitted within one year after the date of service. If Members have additional questions, please contact **Preferred Administrators Customer Service Department at 915-532-3778** from 7:00 am to 5:00 pm.

(a) **All member reimbursements from Members, should be reported promptly.** The deadline for member reimbursements is one year after the date of service. These time filing deadlines are not applicable to provider time filings. For more detailed provider time filing deadlines, provider must review their contract.

(b) **No payment will be made for member reimbursements submitted after one year from date of service, except due to the legal incapacity of the Members.**

(c) **All member reimbursements will be processed accordingly to benefits applied and provider participation.**

8.03 Receipt of a Member Reimbursement

Upon receipt, Preferred Administrators will approve or deny the claim within thirty (30) days and will provide the Member with an Explanation of Benefits Statement that describes the benefit determination and the amount paid. If the Member disagrees with the benefit determination, the Member may contact Preferred Administrators to appeal the Adverse Benefit Determination.

8.04 Receipt of Member Reimbursement

Upon receipt, Preferred Administrators will advise the Member of the need for additional information or that a request for additional information has been made to the provider, within thirty (30) days of receipt of the claim. Preferred Administrators will wait for thirty (30) days for the requested information to complete the claim. If the requested information is not submitted by the Member or the provider within thirty (30) days, Preferred Administrators will deny the claim and so advise the Member. If the Member or the provider submits the requested claims information within the thirty (30) days, Preferred Administrators will complete the processing of the claim within 30 days of the receipt of the requested information and issue an Explanation of Benefits Statement to the Member.

(a) Definition for Incomplete Member Reimbursement Form – shall mean a claim which, if properly corrected to completion, may be compensable for the covered procedure, but lacks important or material elements which prevent payment of the claim.

(b) If the Member or the provider has not submitted the requested claims information within the thirty (30) days, Preferred Administrators shall deny the claim. Any change in the claim payment status shall be appealed under the Plan Complaints and Appeals Process.

(c) No payment shall be made for incomplete claims which are not corrected to completion within one year from date of service.

8.05 Member's Responsibilities to Update Records

(a) Each Member must provide Preferred Administrators with the each Dependent's current address. Any notices concerning the Plan will be deemed given if directed to the address on file and mailed by regular United States mail. Preferred Administrators shall have no obligation or duty to locate a Member. If a Member becomes entitled to a payment under this Plan and payment is delayed or cannot be made because:

(b) the current address according to Employer records is incorrect;

(c) the Member fails to respond to the notice sent to the current address according to Employer records;

(d) of conflicting claims to the payments;

(e) of any other reason; or

(f) the amount of payment, if and when made, will be determined under the provisions of this Plan without payment of any interest or earnings.

ARTICLE IX
COMPLAINT AND APPEAL PROCESS

COMPLAINT PROCESS

9.01 <u>All Complaints will be handled by the Complaints and Appeals Department</u>

El Paso Health (d/b/a Preferred Administrators) has a process in place for Plan complaints received. The Complaints and Appeals Department, in collaboration with the Compliance Department, Member Services Department, Provider Relations Department, Claims Department, Quality Improvement Department, Contracting and Credentialing Department, Health Services Department, Medical Director and Third Party Administrator coordinates the complaints. The Chief Executive Officer (CEO) has primary responsibility for ensuring that complaints are resolved in compliance with written policies and within the time required.

Preferred Administrators has designated Call Center Representatives to assist Members with the complaints process. Complaints can be submitted orally or in writing. Written complaints will be accepted from the Member or the Member's Legal Representative. Oral complaints can be submitted by calling Preferred Administrators Customer Service Department.

1. **<u>Complaint</u>** means any dissatisfaction, expressed by a complainant in writing to El Paso Health, with any aspect of El Paso Health's operation, including, but not limited to, dissatisfaction with plan administration, the denial, reduction, or termination of a service for reasons not related to medical necessity; the way a service is provided; or disenrollment decisions. The term does not include misinformation that is resolved promptly by supplying the appropriate information or clearing up the misunderstanding to the satisfaction of the complainant.

2. Written complaints can be mailed or faxed to:

   Preferred Administrators
   Complaints and Appeals Department
   1145 Westmoreland Drive
   El Paso, Texas 79925
   Fax (915) 298-7872

3. The following data will be required:

   (1) Member's name and address
   (2) Member's phone number
   (3) Provider's name
   (4) Health Plan identification number
   (5) Date of service
   (6) Details of the exact nature of the complaint
   (7) Documentation to support the complaint

4. Within five (5) business days of receipt of the verbal or written complaint, the Complaints and Appeals Department will mail the Member an acknowledgment letter. The complaint resolution will be completed no later than thirty (30) calendar days following the receipt of the complaint.

5. All documentation relating to complaints will be logged and readily available for review.

6. Members have the right to appeal a dissatisfaction or disagreement of a complaint resolution *(see Administrative Appeals Process).*

9.02 Administrative Appeals

All Administrative Appeals will be handled by the Complaints and Appeals Department.

1. **Administrative Appeal** means the formal process by which a Member requests a review that does not require a medical review:

   (1) The failure of Preferred Administrators to act within the described timeframes
   (2) The denial in whole or in part of payment for service not related to medical necessity
   (3) Reimbursement dispute
   (4) Claims Coding dispute

   Appeals involving benefits exclusions such as experimental, investigational or non-covered benefits are not eligible for review.

2. The administrative appeal must be submitted orally or in writing. It can be mailed or faxed to:

   Preferred Administrators
   Complaints and Appeals Department
   1145 Westmoreland Drive
   El Paso, Texas 79925
   Fax: (915) 298-7872
   Email: Complaints&AppealsTeam@elpasohealth.com

3. The following data will be required:

   (1) Member's name and address
   (2) Member's phone number
   (3) Provider's name
   (4) Health Plan identification number
   (5) Date of service
   (6) Details of the exact nature of the appeal
   (7) Documentation to support the appeal

4. Within five (5) business days of receipt of the written appeal, the Complaints and Appeals Department will mail the Member an acknowledgment letter. The appeal resolution will be completed no later than thirty (30) calendar days following receipt the written appeal.

5. All documentation relating to appeals will be logged and readily available for review.

6. Members must exhaust Preferred Administrators complaints and appeals process before filing a complaint with the U.S Department of Labor's Employee Benefits Security Administration (DOL). They may be contacted at:

   U.S. Department of Labor's Employee
   Benefits Security Administration Texas
   Dallas Regional Office
   525 South Griffin St, Rm 900
   Dallas, TX 75202-5025
   Tel: (972) 850-4500
   Toll Free: **866-444-3272**
   Fax: (214) 767-1055

   to speak with a benefits advisor
   http://www.dol.gov/

   Appeals related to a medical determination, denial, reduction, suspension or termination must follow the Adverse Determination Appeal Process, *see section 9.03.*

9.03 Adverse Internal Appeal Process

DEFINITIONS:

Adverse Internal Appeal Process: a URA's form process by which the enrollee or someone acting on the enrollee's behalf and the provider of record have the right to appeal this adverse determination (denial) orally or in writing. A physician who has not previously reviewed the case will make the appeal decision. The appealing party must send us the appeal no later than one hundred and eighty (180) days after the date of this letter.

- **Written Appeal:** To submit a written appeal, mail or fax the written appeal to the following address or fax number: Preferred Administrators, 1145 Westmoreland Dr., El Paso, TX 79925 or fax it to **915-298-7872** or toll-free at **844-298-7872.**
- **Oral Appeal:** To file an oral appeal, call the following toll-free number: **877-532-3778**

There are four types of appeals:

- **Standard Appeal:** An appeal that does not involve urgent care such as emergency care, life-threatening conditions, or continued hospitalization.
- **Expedited Appeal:** An expedited appeal is available for emergency care, life-threatening conditions, and hospitalized enrollees. An expedited appeal is also available for denials of prescription drugs and intravenous infusions for which the enrollee is currently receiving benefits and for a denied step therapy protocol exception request.
- **Specialty Appeal:** This appeal is available only after we decide the initial appeal. Please see below for more information.
- **Acquired Brain Injury Appeal:** An appeal of denied services concerning an acquired brain injury.

Appeal Acknowledgment: Within five (5) working days of receipt of the appeal, we will send the appealing party a letter acknowledging the date that we received the appeal and a list of documents that we may need for the appeal. If the appeal is oral, we will send the appealing party a one-page appeal form. The appealing party does not have to return the appeal form but we encourage its return because the form will help us resolve the appeal.

Our deadlines to resolve the internal appeal and send a written decision to the enrollee or someone acting on the enrollee's behalf and the provider of record are:

- **Standard Appeal:** 30 calendar days of receipt of the appeal.
- **Expedited Appeal:** One (1) working day from the date we receive all the information we need to complete the appeal, but not later than seventy two (72) hours from receipt of the request. We may provide the determination by telephone or electronic transmission, but will provide written determination in writing within three (3) working days of the initial telephonic or electronic notification.
- **Retrospective (Claim) Appeal:** Thirty (30) calendar days after receipt of appeal. However, we may extend this deadline once for a period not to exceed fifteen (15) days.
- **Acquired Brain Injury Appeal:** Not later than three (3) business days after the date on which the individual submits the appeal. The notification of the determination must be provided through a direct telephone contact to the individual making the request. We will provide a written determination within 30 calendar days of receipt of the appeal.

Specialty Appeal: If we deny the appeal, the provider of record may request a specialty appeal, which requests that a specific type of specialty review the case. The provider must request this type of appeal in writing within ten (10) working days from the denial and must show good cause for the specialty appeal. We will complete the specialty appeal and send our written decision to the enrollee or the person acting on the enrollee's behalf and the provider within fifteen (15) working days of receipt of the request for the specialty appeal.

9.04 External Appeal Process

External Review Process: The Federal external review process does not apply to a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a Claimant or beneficiary fails to meet the requirements for eligibility under the terms of a group health plan.

The Federal external review process, in accordance with the current Affordable Care Act regulations and other applicable law, applies only to:

1. Any eligible Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination) by a plan or issuer that involves medical judgment (including, but not limited to, those based on the plan's or issuer's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; its determination that a treatment is Experimental or Investigational; its determination whether a Claimant or beneficiary is entitled to a reasonable alternative standard for a reward under a wellness program; its determination whether a plan or issuer is complying with the nonquantitative treatment limitation provisions of Code section 9812 and § 54.9812-1, which generally require, among other things, parity in the application of medical management techniques), as determined by the external reviewer.
2. An Adverse Benefit Determination that involves consideration of whether the Plan is complying with the surprise billing and cost-sharing protections set forth in the No Surprises Act.
3. A rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time).

Right to an Immediate IRO: If the patient has a life-threatening condition or receives a denial for prescription drugs or intravenous infusions for which they are currently receiving benefits, the patient, or someone acting on the patient's behalf, and the provider of record can request an immediate review by an independent review organization (IRO) and is not required to follow our internal appeal procedures. See below for more information about the independent review.

Exhaustion of Internal Appeals: We will not require exhaustion of our internal appeals process if: (a) we fail to meet our internal appeal process timelines, or (b) the claimant with an urgent care situation files an external review before exhausting our internal appeal process, or (c) we decide to waive the appeal process requirements.

Independent Review:

HHS-administered Federal External Review: For a standard IRO review, you or someone you name to act for you may file a request for external review within four months of receiving this letter. If you want to send more information to include in the review, you can send it with your request. You don't have to pay for this review or any filing fees.

If you would like to have another person make an external review request on your behalf, both you and your authorized representative will need to complete and sign the HHS Federal External Review Process Appointment of Representative Form.

Mail: **MAXIMUS Federal Services**
State Appeals East
3750 Monroe Avenue, Suite 705
Pittsford, NY 14534
Fax: **1-888-866-6190**
Online: **https://www.externalappeal.com/ferpportal**

If you believe your case should be expedited, you can select "expedited" if submitting the review request online, or by emailing **FERP@maximus.com,** or calling Federal External Review Process at **1-888-866-6205,** ext. 3326. MAXIMUS will give you and the health plan the external review decision as quickly as medical circumstances require, but no later than within 72 hours of receiving the request. The decision can be given orally, but it must be followed up by a written version of the decision within 48 hours of the oral notification.

When MAXIMUS receives your request, they will notify us and we'll send them all of the case information for review. If you send them any more information they'll share it with us. We may change our decision. If not, the IRO will continue the review. MAXIMUS must give you written notice of the final external review decision as soon as possible, but no later than 45 days after it receives the request for an external review.

If MAXIMUS decides to overturn our decision, we will provide coverage or payment for your health care item or service. If you have questions about your external review, call **1-888-866-6205.**

Peer-to-Peer Discussion

Your provider of record was provided the opportunity to request a peer-to-peer discussion for the services under review prior to the issuance of this adverse determination. If your provider contacts us during the hours of 8:00 a.m. and 5:00 p.m. MST at **915-532-3778** or toll free at **877-532-3778** to request a peer-to-peer discussion after issuance of the adverse determination and still disagrees with the initial denial, Preferred Administrators will accept and process this disagreement as an oral appeal.

Complaint Procedures

You can send a complaint to us (Preferred Administrators): Enrollees, individuals acting on behalf of enrollees, and health care providers may file a written or oral complaint about our utilization review process or procedures to: Preferred Administrators, 1145 Westmoreland Dr., El Paso, TX 79925 or fax it to **915-298-7872** or toll-free at **844-298-7872.** We will respond to your complaint in writing within thirty (30) days.

Complaints to DOL: A complainant also has the right to file a complaint with the U.S Department of Labor's Employee Benefits Security Administration (DOL). They may be contacted at:

U.S. Department of Labor's Employee
Benefits Security Administration Texas
Dallas Regional Office
525 South Griffin St, Rm 900
Dallas, TX 75202-5025
Tel: (972) 850-4500
Toll Free: **866-444-3272**
Fax: (214) 767-1055

to speak with a benefits advisor
http://www.dol.gov/

ARTICLE X
MISCELLANEOUS

10.01 Plan Interpretation

The Plan Administrator has the authority and discretion to interpret the terms of the Plan, including the authority and discretion to resolve inconsistencies or ambiguities between the provisions of this document and the provisions of the Plan's *Schedule of Benefits,* or any other document that forms a part of the Plan. However, the terms of this document may not enlarge the rights of a Member to benefits available under any Welfare Program.

10.02 Exclusive Benefit

This Plan has been established for the exclusive benefit of Members and except as otherwise provided herein, all contributions under the Plan may be used only for such purpose.

10.03 Non-Alienation of Benefits

No benefit, right or interest of any Member under the Plan are subject to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, seizure, attachment or legal, equitable or other process, or be liable for, or subject to, the debts, liabilities or other obligations of such person, except as otherwise required by law, or as otherwise provided in a Welfare Program.

10.04 Limitation of Rights

The establishment, existence or amendment to the Plan shall not operate or be construed to:

(a) give any person any legal or equitable right against the Employer or its Affiliates, except as expressly provided herein or required by law; or

(b) create a contract of employment with any Associate, obligate the Employer or one of its Affiliates to continue the service of any Associate, or affect or modify the terms of an Associate's employment in any way.

10.05 Governing Laws

This Plan is a governmental (sponsored) plan and as such it is exempt from the requirements of the Employee Retirement Income Security Act of 1974 (also known as ERISA), which is a Federal law regulating Employee welfare and pension plans. The Participants' rights in the Plan are governed by the plan documents and applicable State law and regulations. To the extent not preempted by federal law, the provisions of this Plan are construed, enforced and administered according to the laws of Texas.

10.06 Severability

If any provision of the Plan is held invalid or unenforceable, its invalidity or unenforceability shall not affect any other provision of the Plan, and the Plan are construed and enforced as if such invalid or unenforceable provision had not been included herein.

10.07 Captions

Captions are used as a matter of convenience and for reference, and do not define, limit, enlarge or describe the scope or intent of the Plan nor affect the Plan or the construction of any of its provisions.

10.08 Construction

Whenever used in this Plan, the masculine gender shall include the feminine and the plural form shall include the singular.

10.09 Expenses

The expenses of administering the Plan, including without limitation the expenses of the Plan Administrator properly incurred in the performance of its duties under the Plan, will be paid by the Plan, and all such expenses incurred by the Employers will be reimbursed by the Plan, unless the Employers in their discretion elect to pay such expenses from assets other than assets of the Plan or not to submit such expenses for reimbursement.

10.10 Claim Determination Period

The claims determination period starting October 1, 2002 shall be the Fiscal Year. However, it does not include any part of a year during which a person has no coverage under this Plan or any part of a year before the date this Coordination of Benefits (COB) provision or a similar provision takes effect.

10.11 Right to Receive and Release Necessary Information

The Third Party Administrator may release or obtain any information deemed necessary to implement this Plan unless otherwise mandated by law. Any person who claims benefits under the Plan shall be required to provide any information requested by the Plan Administrator.

10.12 Facility of Payment

Payments under another plan may be reimbursed to that Plan if, at the discretion of the Plan Administrator, payment was due under this Plan. Such payment will fulfill the Plan Sponsor's responsibility to the extent of such payment.

10.13 Recovery of Payments

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

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

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

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

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

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

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

The deduction may be made against any claim for benefits under this Plan by a Member or by any of his covered Dependents if such payment is made with respect to the Member or any person covered or asserting coverage as a Member. If the Plan seeks to recoup funds from a Provider, due to a claim being made in error, a claim being fraudulent on the part of the Provider, and/or the claim that is the result of the Provider's misstatement, said Provider shall, as part of its assignment to benefits from the Plan, abstain from billing the Member for any outstanding amount(s).

10.14 Clerical Error/Delay

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

10.15 Fraud

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

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

10.16 No Waiver or Estoppel

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

10.17 Plan Contributions

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

The Plan Sponsor shall fund the Plan in a manner consistent with the provisions of the Internal Revenue Code, and such other laws and regulations as shall be applicable to the end that the Plan shall be funded on a lawful and sound basis; but, to the extent permitted by governing law, the Plan Administrator shall be free to determine the manner and means of funding the Plan.

Notwithstanding any other provision of the Plan, the Plan Administrator's obligation to pay claims otherwise allowable under the terms of the Plan shall be limited to its obligation to make contributions to the Plan as set forth in the preceding paragraph. Payment of said claims in accordance with these procedures shall discharge completely the Company's obligation with respect to such payments.

In the event that the Company terminates the Plan, then as of the effective date of termination, the Employer and eligible Associates shall have no further obligation to make additional contributions to the Plan and the Plan shall have no obligation to pay claims Incurred after the termination date of the Plan.

10.18 Written Notice

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

10.19 Statements

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

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

10.20 Binding Arbitration

Any dispute or claim, of whatever nature, arising out of, in connection with, or in relation to this Plan, or breach or rescission thereof, or in relation to care or delivery of care, including any claim based on contract, tort or statute, must be resolved by arbitration if the amount sought exceeds the jurisdictional limit of the small claims court. Any dispute regarding a claim for damages within the jurisdictional limits of the small claims court will be resolved in such court.

The Federal Arbitration Act shall govern the interpretation and enforcement of all proceedings under this Binding Arbitration provision. To the extent that the Federal Arbitration Act is inapplicable, or is held not to require arbitration of a particular claim, State law governing agreements to arbitrate shall apply.

The Member and the Plan Administrator agree to be bound by this Binding Arbitration provision and acknowledge that they are each giving up their right to a trial by court or jury.

The Member and the Plan Administrator agree to give up the right to participate in class arbitration against each other. Even if applicable law permits class actions or class arbitrations, the Member waives any right to pursue, on a class basis, any such controversy or claim against the Plan Administrator and the Plan Administrator waives any right to pursue on a class basis any such controversy or claim against the Member.

The arbitration findings will be final and binding except to the extent that State or Federal law provides for the judicial review of arbitration proceedings.

The arbitration is begun by the Member making written demand on the Plan Administrator. The arbitration will be conducted by Judicial Arbitration and Mediation Services ("JAMS") according to its applicable Rules and Procedures. If, for any reason, JAMS is unavailable to conduct the arbitration, the arbitration will be conducted by another neutral arbitration entity, by mutual agreement of the Member and the Plan Administrator, or by order of the court, if the Member and the Plan Administrator cannot agree.

The costs of the arbitration will be allocated per the JAMS Policy on Consumer Arbitrations. If the arbitration is not conducted by JAMS, the costs will be shared equally by the parties, except in cases of extreme financial hardship, upon application to the neutral arbitration entity to which the parties have agreed, in which cases, the Plan Administrator will assume all or a portion of the costs of the arbitration.

If the individual has any other dispute which does not involve an Adverse Benefit Determination, this Binding Arbitration provision applies.

10.21 Unclaimed Self-Insured Plan Funds

In the event a benefits check issued by the Third Party Administrator for this self-insured Plan is not cashed within one year of the date of issue, the check will be voided and the funds will be retained by this Plan and applied to the payment of current benefits and administrative fees under this Plan. In the event a Member subsequently requests payment with respect to the voided check, the Third Party Administrator for the self-insured Plan shall make such payment under the terms and provisions of the Plan as in effect when the claim was originally processed. Unclaimed self-insured Plan funds may be applied only to the payment of benefits (including administrative fees) under the Plan pursuant to any applicable State law(s).

ARTICLE XI
SUBROGATION, REIMBURSEMENT, AND THIRD PARTY RECOVERY PROVISION

11.01 Payment Condition

The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an Injury, Illness or disability is caused in whole or in part by, or results from the acts or omissions of Members, and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Member(s)") or a third party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to crime victim restitution funds, civil restitution funds, no-fault restitution funds (including vaccine injury compensation funds), uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or guarantor(s) of a third party, any medical, applicable disability, or other benefit payments, and school insurance coverage (collectively "Coverage").

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

In the event a Member(s) settles, recovers, or is reimbursed by any Coverage, the Member(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Member(s). When such a recovery does not include payment for future treatment, the Plan's right to reimbursement extends to all benefits paid or that will be paid by the Plan on behalf of the Member(s) for charges Incurred up to the date such Coverage or third party is fully released from liability, including any such charges not yet submitted to the Plan. If the Member(s) fails to reimburse the Plan out of any judgment or settlement received, the Member(s) will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money. Nothing herein shall be construed as prohibiting the Plan from claiming reimbursement for charges Incurred after the date of settlement if such recovery provides for consideration of future medical expenses.

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

11.02 Subrogation

As a condition to participating in and receiving benefits under this Plan, the Member(s) agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Member(s) is entitled, regardless of how classified or characterized, at the Plan's discretion, if the Member(s) fails to so pursue said rights and/or action.

If a Member(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Member(s) may have against any Coverage and/or party causing the Illness or Injury to the extent of such conditional payment by the Plan plus reasonable costs of collection. The Member is obligated to notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds. The Member is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

The Plan may, at its discretion, in its own name or in the name of the Member(s) commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.

If the Member(s) fails to file a claim or pursue damages against:

1. The responsible party, its insurer, or any other source on behalf of that party.
2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage, including any similar coverage under a different name in a particular state.
3. Any policy of insurance from any insurance company or guarantor of a third party, including but not limited to an employer's policy.
4. Workers' compensation or other liability insurance company.
5. Any other source of Coverage, including, but not limited to, the following:
   - Crime victim restitution funds
   - Civil restitution funds
   - No-fault restitution funds such as vaccine injury compensation funds
   - Any medical, applicable disability or other benefit payments
   - School insurance coverage

The Member(s) authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Member's/Members' and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Member(s) assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

11.03 Right of Reimbursement

The Plan shall be entitled to recover 100% of the benefits paid or payable benefits Incurred, that have been paid and/or will be paid by the Plan, or were otherwise Incurred by the Member(s) prior to and until the release from liability of the liable entity, as applicable, without deduction for attorneys' fees and costs or application of the common fund doctrine, made whole doctrine, or any other similar legal or equitable theory, and without regard to whether the Member(s) is fully compensated by his or her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The

obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses and extends until the date upon which the liable party is released from liability. If the Member's/ Members' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved. Any funds received by the Member are deemed held in constructive trust and should not be dissipated or disbursed until such time as the Member's obligation to reimburse the Plan has been satisfied in accordance with these provisions. The Member is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, express written consent of the Plan. Additionally, the Member shall indemnify the Plan against any of the Member's attorney's fees, costs, or other expenses related to the Member's recovery for which the Plan becomes responsible by any means other than the Plan's explicit written consent. Additionally, the Member shall indemnify the Plan against any of the Member's attorney's fees, costs, or other expenses related to the Member's recovery for which the Plan becomes responsible by any means other than the Plan's explicit written consent.

The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Member(s), whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.

These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Member(s).

This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable Illness, Injury, or disability.

11.04 Member is a Trustee Over Plan Assets

Any Member who receives benefits and is therefore subject to the terms of this section is hereby deemed a recipient and holder of Plan assets and is therefore deemed a trustee of the Plan solely as it relates to possession of any funds which may be owed to the Plan as a result of any settlement, judgment or recovery through any other means arising from any injury or accident. By virtue of this status, the Member understands that he or she is required to:

1. Notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds.
2. Instruct his or her attorney to ensure that the Plan and/or its authorized representative is included as a payee on all settlement drafts.
3. In circumstances where the Member is not represented by an attorney, instruct the insurance company or any third party from whom the Member obtains a settlement, judgment or other source of Coverage to include the Plan or its authorized representative as a payee on the settlement draft.
4. Hold any and all funds so received in trust, on the Plan's behalf, and function as a trustee as it applies to those funds, until the Plan's rights described herein are honored and the Plan is reimbursed.

To the extent the Member disputes this obligation to the Plan under this section, the Member or any of its agents or representatives is also required to hold any/all settlement funds, including the entire settlement if the settlement is less than the Plan's interests, and without reduction in consideration of attorneys' fees, for which he or she exercises control, in an account segregated from their general accounts or general assets until such time as the dispute is resolved.

No Member, beneficiary, or the agents or representatives thereof, exercising control over plan assets and incurring trustee responsibility in accordance with this section will have any authority to accept any reduction of the Plan's interest on the Plan's behalf.

11.05 Release of Liability

The Plan's right to reimbursement extends to any incident related care that is received by the Member(s) (Incurred) prior to the liable party being released from liability. The Member's/Members' obligation to reimburse the Plan is therefore tethered to the date upon which the claims were Incurred, not the date upon which the payment is made by the Plan. In the case of a settlement, the Member has an obligation to review the "lien" provided by the Plan and reflecting claims paid by the Plan for which it seeks reimbursement, prior to settlement and/or executing a release of any liable or potentially liable third party, and is also obligated to advise the Plan of any incident related care incurred prior to the proposed date of settlement and/or release, which is not listed but has been or will be incurred, and for which the Plan will be asked to pay.

11.06 Excess Insurance

If at the time of Injury, Illness or disability there is available, or potentially available any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage, except as otherwise provided for under the Plan's Coordination of Benefits section.

The Plan's benefits shall be excess to any of the following:

1. The responsible party, its insurer, or any other source on behalf of that party.
2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage, including any similar coverage under a different name in a particular state.
3. Any policy of insurance from any insurance company or guarantor of a third party, including but not limited to an employer's policy.
4. Workers' compensation or other liability insurance company.
5. Any other source of Coverage, including, but not limited to, the following:
   - Crime victim restitution funds
   - Civil restitution funds
   - No-fault restitution funds such as vaccine injury compensation funds
   - Any medical, applicable disability or other benefit payments
   - School insurance coverage

11.07 Separation of Funds

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

11.08 Wrongful Death

In the event that the Member(s) dies as a result of his or her injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply, and the entity pursuing said claim shall honor and enforce these Plan rights and terms by which benefits are paid on behalf of the Member(s) and all others that benefit from such payment.

11.09 Obligations

It is the Member's/Members' obligation at all times, both prior to and after payment of medical benefits by the Plan:

1. to cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights;
2. to provide the Plan with pertinent information regarding the sickness, disease, disability, or injury, including accident reports, settlement information and any other requested additional information;
3. to take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;
4. to do nothing to prejudice the Plan's rights of subrogation and reimbursement;
5. to promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received;
6. to notify the Plan or its authorized representative of any incident related claims or care which may be not identified within the lien (but has been Incurred) and/or reimbursement request submitted by or on behalf of the Plan;
7. to notify the Plan or its authorized representative of any settlement prior to finalization of the settlement;
8. to not settle or release, without the prior consent of the Plan, any claim to the extent that the Member may have against any responsible party or Coverage;
9. to instruct his or her attorney to ensure that the Plan and/or its authorized representative is included as a payee on any settlement draft;
10. in circumstances where the Member is not represented by an attorney, instruct the insurance company or any third party from whom the Member obtains a settlement to include the Plan or its authorized representative as a payee on the settlement draft; and
11. to make good faith efforts to prevent disbursement of settlement funds until such time as any dispute between the Plan and Member over settlement funds is resolved.

If the Member(s) and/or his or her attorney fails to reimburse the Plan for all benefits paid, to be paid, Incurred, or that will be Incurred, prior to the date of the release of liability from the relevant entity, as a result of said Injury or condition, out of any proceeds, judgment or settlement received, the Member(s) will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Member(s).

The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Member's/Members' cooperation or adherence to these terms.

11.10 Offset

If timely repayment is not made, or the Member and/or his/her attorney fails to comply with any of the requirements of the Plan, the Plan has the right, in addition to any other lawful means of recovery, to deduct the value of the Member's amount owed to the Plan. To do this, the Plan may refuse payment of any future medical benefits and any funds or payments due under this Plan on behalf of the Member(s) in an amount equivalent to any outstanding amounts owed by the Member to the Plan. This provision applies even if the Member has disbursed settlement funds.

11.11 Minor Status

In the event the Member(s) is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.

If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

11.12 Language Interpretation

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

11.13 Severability

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

ARTICLE XII
COORDINATION OF BENEFITS

12.01 Benefits Subject to This Provision

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

12.02 Excess Insurance

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

(a) any primary payer besides the Plan;

(b) any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage, including any similar coverage under a different name in a particular state.

(c) any policy of insurance from any insurance company or guarantor of a third party;

(d) workers' compensation or other liability insurance company; or

(e) any other source of coverage, including, but not limited to, the following:

- Crime victim restitution funds
- Civil restitution funds
- No-fault restitution funds such as vaccine injury compensation funds
- Any medical, applicable disability or other benefit payments
- School insurance coverage.

12.03 Vehicle Limitation

When medical payments are available under any vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan and/or policy deductibles. This Plan shall always be considered secondary to such plans and/or policies and will exclude benefits subject to the exclusions in this Plan up to the maximum amount available to the Member under applicable state law, regardless of a Member's election of lesser coverage amount. This applies to all forms of medical payments under vehicle plans and/or policies regardless of their names, titles or classification.

Allowed Amount: This is the amount of a billed charge that a carrier determines to be covered for services provided by a non-contracted health care provider. The allowed amount includes the carrier's payment and any applicable deductible, copayment, or coinsurance amounts for which the insured is responsible.

12.04 Allowable Expenses

Allowable Expense(s) means the Maximum Allowable Charge for any Medically Necessary, eligible item of expense, at least a portion of which is covered under this Plan. When some Other Plan pays first in accordance with the Coordination of Benefits section, this Plan's Allowable Expenses shall in no event exceed the Other Plan's Allowable Expenses.

When some "Other Plan" provides benefits in the form of services (rather than cash payments), the Plan Administrator shall assess the value of said benefit(s) and determine the reasonable cash value of the service or services rendered, by determining the amount that would be payable in accordance with the terms of the Plan. Benefits payable under any Other Plan include the benefits that would have been payable had the claim been duly made therefore, whether or not it is actually made.

Any health care expense, including coinsurance or copayments and without reduction for any applicable deductible, that is covered in full or in part by any of the plans covering the member, except as otherwise provided in 28 TAC §3.3505 or where a statute requires a different definition. When a Plan providers benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense service that is not covered by any of the Plan is not an allowable expense.

12.05 Birthday

Refers only to day and month in a calendar year and does not include the year of birth.

12.06 Claim Determination Period

"Claim Determination Period" shall mean each calendar year.

12.07 Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)

Coverage provided under a right of continuation under federal law.

12.08 Coordination of Benefits (COB)

A provision establishing an order in which plans pay their claims and permitting secondary plans to reduce their benefits so that the combined benefits of all plans do not exceed total allowable expenses.

12.09 Custodial Parent

The parent with the right to designate the primary residence of a child by a court order under the Family Code or other applicable law; or in the absence of a court order, the parent with whom the child resides more than one-half of the calendar year without regard to any temporary visitation.

Referrals and Authorizations

1. If Preferred Administrators this Plan is secondary, referrals and authorization for services are required. Referrals and authorizations will be approved according to the Preferred Administrators Utilization Management Program Description.
2. Exception: When a motor vehicle accident or worker's compensation is involved, precertification and referral requests will be reviewed as required by the Preferred Administrators Utilization Management Program Description.
3. If a referral or authorization has not been requested or entered, Preferred Administrators will not waive the requirement deferring to the primary carrier's requirements. In addition, other requirements are not waived (e.g. itemized bills, student verification, consent for Behavioral Health exchange, etc.).
4. If a member's COB status changes from Preferred Administrators this Plan being secondary to primary, Preferred Administrators' standard pre-certification guidelines apply for all dates of service after the change in status. Prior authorization requirements will not apply for all dates of service between the effective date of the status change and the date that Preferred Administrators record is updated.

Maximum Allowed Amount as Both Primary and Secondary

1. If it is determined that Preferred Administrators this Plan is both primary and secondary carrier, the claim is processed under both Member ID numbers.
2. The original claim is processed under the primary ID following Standard processing guidelines.
3. Once the claim has been processed under the primary ID number, the processor splits the claim and reimburses the split claim as secondary following COB Processing Guidelines.

12.10 Effect on Benefits on COB

A. Application to Benefit Determinations

Preferred Administrators does not process as a primary carrier if the services qualify for COB benefits unless the services have not been allowed or were denied by the primary carrier. The remittance advice on the primary carrier should reflect the denial.

Preferred Administrators uses Method 1 to calculate the steps and determine Coordination of Benefits.

Calculation of Steps for determining Coordination of Benefits

Step 1: Determine the amount that would be paid if Preferred Administrators were primary.

Step 2: Subtract your primary carrier's payment amount from your primary carrier's allowed amount to obtain the secondary payment amount.

Step 3: Compare the amount that would be paid if Preferred Administrators were primary and pay the lesser of the two amounts with the amount calculated in Step 2 and pay the lesser of the two amounts. Deductibles, Co-payments, and Co-insurance may apply if Preferred Administrators is the lesser of the both.

Once Step 3 has been calculated, this will determine if applicable deductibles will still be applied with Preferred Administrators.

The secondary and subsequent plans will pay the balance due up to 100% of the total Allowable Expenses. When there is a conflict in the rules, this Plan will never pay more than 50% of Allowable Expenses when paying secondary. Benefits will be coordinated on the basis of a Claim Determination Period.

Explanation of Benefits (EOB): A form, in paper or electronic format, which provides an explanation of benefits. It is used to explain a payment or denial of a claim. (25 TAC §61.2)

Plan: A form of coverage with which coordination is allowed.

Reason Code: Explanation of the reasons for any financial adjustments, such as denials, reductions or increases in payment. These codes may be used at the service or claim level, as appropriate. (CMS Medicare Claims Processing Manual, Chapter 22, Section 130.2 – Claim Adjustment Reason Codes, Rev. 2205)

Remittance Advice (RA): Notice sent to providers as a companion to claim payments; RAs explain the payment and any adjustment(s) made during claim adjudication. For each claim or line item payment, and/or adjustment, there is an associated remittance advice item. (CMS Medicare Claims Processing Manual, Chapter 22, Section 10 – Background, Rev. 2843)

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

When some "Other Plan" provides benefits in the form of services (rather than cash payments), the Plan Administrator shall assess the value of said benefit(s) and determine the reasonable cash value of the service or services rendered, by determining the amount that would be payable in accordance with the terms of the Plan.

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

1. The Other Plan would, according to its rules, determine its benefits after the benefits of this Plan have been determined; and
2. The rules in the section entitled "Order of Benefit Determination" would require this Plan to determine its benefits before the Other Plan.

B. Order of Benefit Determination

The order of benefit determination rules state whether Preferred Administrators is the primary plan or secondary plan as to another plan covering the person.

- When Preferred Administrators is the primary plan, the plan benefits are determined before benefits of the secondary plan without consideration of the secondary plan's benefits.
- When Preferred Administrators is the secondary plan, the plan benefits are determined only after those of the primary carrier have been determined and may be reduced because of the primary plan's benefits.
- Your primary insurance will always need to be billed first. A member can not choose which insurance is used when scheduling or receiving health or pharmacy benefits.

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

1. A plan without a coordinating provision will always be the primary plan. The primary plan pays first without regard to the possibility that another plan may cover some expenses.
2. Preferred Administrators will be the primary plan for active employees or non-active employees receiving continued enrollment benefits through COBRA. Preferred Administrators will be the primary plan for those who receive spouse coverage from the corresponding active employee. Spouse coverage under Preferred Administrators will be secondary only when spouse has coverage as an active employee with another plan.
3. The plan that covers a person as an employee who neither laid off nor retired or as a dependent of an active employee, is the primary plan. The plan covering that same person as a retired or laid off employee or as a dependent of a retired or laid off employee is the secondary plan.
4. The benefits of a plan which covers the person on whose expenses claim is based, other than as a dependent, shall be determined before the benefits of a plan which covers such person as a dependent;
5. If the person for whom claim is made is a dependent child covered under both parents' plans, the plan covering the parent whose birthday (month and day of birth, not year) falls earlier in the year will be primary, except:
    a. When the parents are separated or divorced, and the parent with the custody of the child has not remarried, the benefits of a plan which covers the child as a dependent of the parent with custody will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody; or
    b. When the parents are divorced and the parent with custody of the child has remarried, the benefits of a plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a plan which covers that child as a dependent of the stepparent, and the benefits of a plan which covers that child as a dependent of the stepparent will be determined before the benefits of a plan which covers that child as a dependent of the parent without custody.

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

6. When the rules above do not establish an order of benefit determination, the benefits of a plan which has covered the person on whose expenses claim is based for the longer period of time shall be determined before the benefits of a plan which has covered such person the shorter period of time.
7. To the extent required by Federal and State regulations, this Plan will pay before any Medicare, Tricare, Medicaid, State child health benefits or other applicable State health benefits program.

Nondependent or Dependent Members

1. If this Plan covers a Member as the Associate (non-Dependent), then this Plan is the primary plan.
   a. Benefits will be paid out as if no other plan were involved or existed.
2. However, if a Member is covered by this Plan as a Dependent, but the same person is the subscriber in another plan, then this Plan is secondary.
   a. In which case, benefits will pay on the balance due up to 100% of the total allowable expenses.
   b. If there is a conflict of rules regarding COB, then this Plan will not pay more than 50% of the Allowable Expenses.

Length of Time

1. If order of benefits determination cannot be established, then length of time is used as the determining factor.
   a. The plan that has covered a person for the longest time is primary.
   b. The plan that has covered a person for the shortest time is secondary.
2. A person's length of time under a plan is measured from the person's first date when coverage began. In cases when a person is under a group plan and the date cannot be readily determined, then the date the person first became a member of the group is used to determine length of time.
3. Two successive plans must be treated as one if the person was eligible for the second plan within 24 hours after coverage under the first plan ended.

Dependent Child

COB for a dependent child covered under more than one plan is as follows:

1. If the parents are married or living together, regardless of matrimonial status:
   a. The plan of the parent whose birthday falls earlier in the calendar year is primary and the other parent's is secondary.
   b. However, if the birthday is the same for both parents, the plan that has covered a parent the longest is primary and the other parent's is secondary.
2. If the parents are divorced or not living together, regardless of whether or not they were ever married:
   a. If a court order mandates one parent to be responsible for healthcare expenses or coverage, that parent's plan is considered primary. In cases where the responsible parent has no health coverage, but his or her spouse has coverage, then that plan is primary.

b. If a court order mandates that both parents are responsible for healthcare expenses or coverage, then the COB outlined in Step 1 determines the order of benefits.
c. If a court gives joint custody to both parents but does not specify which parent has responsibility for health care expenses or coverage, the COB outlined in Step 1 determines the order of benefits.
d. If there is no court order allocating responsibility for healthcare expenses or coverage, then the order of benefits is as follows:
    i. Plan covering custodial parent;
    ii. Plan covering the custodial parent's spouse;
    iii. Plan covering the noncustodial parent; then
    iv. Plan covering the noncustodial parent's spouse

3. In cases where a dependent child is covered under more than one plan by individuals who are not her or his parents, then COB outlined in Steps 1 and 2 are followed to determine the order of benefits.
4. A dependent child may also be covered under one or both parents' plan in addition to his or her spouse's.
    a. COB is done under Length of Time order of benefits.
    b. In cases where coverage under the spouse begins on the same day as coverage under one or both parents, then the birthday rule is used to determine order of benefits.

Medicare Coordination

Applicable to Active Associates and Their Spouses Ages 65 and Over

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

Applicable to All Other Members Eligible for Medicare Benefits

To the extent required by Federal regulations, this Plan will pay before any Medicare benefits. There are some circumstances under which Medicare would be required to pay its benefits first. In these cases, benefits under this Plan would be calculated as secondary payor. If the provider accepts assignment with Medicare, Covered Expenses will not exceed the Medicare approved expenses.

Applicable to Medicare Services Furnished to End Stage Renal Disease ("ESRD") Members Who Are Covered Under This Plan

If any Member is enrolled in Medicare coverage because of ESRD, the benefits of the Plan will be determined before Medicare benefits for the first 30 months of the Member's Medicare entitlement, regardless of the date of enrollment, unless applicable Federal law provides to the contrary, in which event the benefits of the Plan will be determined in accordance with such law.

1. When a Member is an active Associate and is a Medicare beneficiary, then this Plan is primary and Medicare is secondary.
2. For a Member who is aged 65 or older, has Medicare Part A coverage and is also covered as a Dependent of an active Associate, this Plan is primary and Medicare is secondary.

3. If the Member has Medicare due to End Stage Renal Disease (ESRD), this Plan is primary for the first 30 months. This is known as the coordination period.
    a. The coordination period begins to run from the first day of the first month of dialysis treatment.
    b. If the Member does not already have Medicare, there is a 3 month waiting period.
    c. Then, after the 3 month waiting period, this Plan is primary for the following 30 months.
    d. When member is eligible for or entitled to Medicare due to ESRD, during a coordination period of up to 30 months, COBRA pays first. Medicare pays second, to the extent COBRA coverage overlaps the first 30 months of Medicare eligibility or entitlement based on ESRD.
4. Medicare is always primary to a direct-pay policy such as Individual Product regardless of the diagnosis of ESRD.
5. If a subscriber is not actively at work, Medicare is primary over any plan.

12.11 Right to Receive and Release Necessary Information

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

12.12 Facility of Payment

Whenever payments which should have been made under this Plan in accordance with this provision have been made under any Other Plans, the Plan Administrator may, in its sole discretion, pay any organizations making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision, and amounts so paid shall be deemed to be benefits paid under this Plan and, to the extent of such payments, this Plan shall be fully discharged from liability.

12.13 Pharmacy of Coordination of Benefits

NAVITUSRx administers the prescription drug benefit offered in the Plan. A Direct Member Reimbursement form will need to be filled out by any Member. The form must be submitted to NAVITUSRx if any of the following scenarios apply to your prescription claim or the prescription claim of your dependent(s):

- If the primary insurance of your Dependent or Spouse has already paid. An explanation of payment from the primary insurance must include the dollar amount paid by the primary insurance.
- If you or your Dependent purchases a covered prescription drug at retail cost and are seeking reimbursement.

Your primary insurance is always billed first. A member cannot choose which insurance is used when you schedule or receive health care or pharmacy services.

Direct Member Reimbursement forms are available at **NAVITUSRx.com** or by calling us directly at **1-855-673-6504.** Additionally, Direct Member Reimbursement forms are available through your UMC Human Resources Department.

NOTE: All forms must be submitted with the original Prescription label receipt(s) within 90 days of purchase.

ARTICLE XIII
AMENDMENT AND TERMINATION

13.01 Amendment

The Employer reserves the right to amend the Plan at any time. Each amendment to the Plan will be made only pursuant to action by the Human Resources Department. Upon such action, the Plan will be deemed amended as of the date specified as the effective date by such action or in the instrument of amendment. The effective date of any amendment may be before, on or after the date of such action.

13.02 Termination

The Employer expects to continue the Plan indefinitely, but continuance is not assumed as a contractual obligation and each Employer reserves the right at any time by action of its Board of Directors or other governing body to terminate the Plan, in whole or in part, at any time. If the Plan is terminated, no Salary Reduction shall be made.

13.03 Effect on Other Benefits

The right to amend or terminate the Plan includes the right to change, limit, curtail, or eliminate coverage or benefits for any treatment, procedure, or service (including with respect to Members who are receiving benefits or Members who are Former Associates or Retirees), regardless of whether the coverage or benefits relate to an Injury, defect, Illness, or disease that was contracted or that occurred before the effective date of amendment or termination.

ARTICLE XIV
HIPAA PRIVACY RULE

Effective April 14, 2003, the Plan conforms with the requirements of § 164.504(f) of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations, 45 C.F.R. parts 160 through 164 (the regulations are referred to herein as the "HIPAA Privacy Rule" and § 164.504(f) is referred to as "the '504' provisions") by establishing the extent to which the Plan Sponsor will receive, use, and/or disclose Protected Health Information and Sensitive Personal Information (hereinafter referred to as "PHI" and "SPI", respectively"). Effective February 18, 2010, the Plan complied with the HITECH Privacy Act provisions. Effective September 1, 2012, the Plan complied with Texas Privacy Law as updated by HP300 (2011). Members can request a copy of the Notice of Privacy Practice or it can be accessed through **www.preferredadmin.net.**

14.01 Plan's Designation of Person/Entity to Act on Its Behalf

The Plan has determined that it is a group health plan within the meaning of the HIPAA Privacy Rule, and the Plan designates Preferred Administrators to take all actions required to be taken by the Plan in connection with the HIPAA Privacy Rule (e.g., entering into business Associate contracts; accepting certification from the Plan Sponsor).

14.02 The Plan's Disclosure of PHI/SPI to the Plan Sponsor/ Required Certification of Compliance by Plan Sponsor

Except as provided below with respect to the Plan's disclosure of summary health information, the Plan will (a) disclose PHI/SPI to the Plan Sponsor, or (b) provide for or permit the disclosure of PHI/SPI to the Plan Sponsor by a health insurance issuer or HMO with respect to the Plan, only if the Plan has received a certification (signed on behalf of the Plan Sponsor) that:

(a) the Plan Document has been amended to establish the permitted and required uses and disclosures of such information by the Plan Sponsor, consistent with the "504" provisions;

(b) the Plan Document has been amended to incorporate the Plan provisions set forth in this section; and

(c) the Plan Sponsor agrees to comply with the Plan provisions as modified by this section.

14.03 Permitted Disclosure of Individuals' SPI to the Plan Sponsor

The Plan (and any business Associate acting on behalf of the Plan), or any health insurance issuer or HMO servicing the Plan, will disclose individuals' PHI/SPI to the Plan Sponsor only to permit the Plan Sponsor to carry out plan administration functions. Such disclosure will be consistent with the provisions of this section.

All disclosures of the PHI/SPI of the Plan's individuals by the Plan's Business Associate, health insurance issuer, or HMO to the Plan Sponsor will comply with the restrictions and requirements set forth in this section and in the "504" provisions.

The Plan (and any Business Associate acting on behalf of the Plan) may not permit the health insurance issuer or HMO, to disclose individuals' PHI/SPI to the Plan Sponsor for employment-related actions and decisions, or in connection with any other benefit or Associate benefit plan of the Plan Sponsor.

The Plan Sponsor will not use or further disclose individuals' PHI/SPI other than as described in the plan document and permitted by the "504" provisions.

The Plan Sponsor will ensure that any agent(s), including a subcontractor, to whom it provides individuals' PHI/SPI received from the Plan (or from the Plan's health insurance issuer or HMO), agrees to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI/SPI.

The Plan Sponsor will not use or disclose individuals' PHI/SPI for employment-related actions and decisions, or in connection with any other benefit or Associate benefit plan of the Plan Sponsor.

The Plan Sponsor will report to the Plan any use or disclosure of PHI/SPI that is inconsistent with the uses or disclosures provided for in the Plan Documents (as amended) and in the "504" provisions, of which the Plan Sponsor becomes aware.

14.04 Disclosure of Individuals' PHI/SPI/Disclosure by the Plan Sponsor

The Plan Sponsor will make the PHI/SPI of the individual who is the subject of the PHI/SPI available to such individual in accordance with 45 C.F.R. § 164.524.

In accordance with Texas HB 300, the Plan Sponsor will make an electronic record available within 15 days of an individual's written request. All electronic PHI or sensitive personal information created or received by the Plan Sponsor is subject to electronic disclosure.

The Plan Sponsor will make individuals' PHI/SPI available for amendment and incorporate any amendments to individuals' PHI/SPI in accordance with 45 C.F.R. § 164.526.

The Plan Sponsor will make and maintain an accounting so that it can make available those disclosures of individuals' PHI/SPI that it must account for in accordance with 45 C.F.R. § 164.528.

The Plan Sponsor will make its internal practices, books and records relating to the use and disclosure of individuals' PHI/SPI received from the Plan available to the U.S. Department of Health and Human Services for purposes of determining compliance by the Plan with the HIPAA Privacy Rule.

The Plan Sponsor will, if feasible, return or destroy all individuals' PHI/SPI received from the Plan (or a health insurance issuer or HMO with respect to the Plan) that the Plan Sponsor still maintains in any form after such information is no longer needed for the purpose for which the use or disclosure was made. Additionally, the Plan Sponsor will not retain copies of such PHI/SPI after such information is no longer needed for the purpose for which the use or disclosure was made. If, however, such return or destruction is not feasible, the Plan Sponsor will limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

Any breach of unencrypted PHI or sensitive personal information will be disclosed as quickly as possible to the individual whose information was, or believed to have been acquired by an unauthorized person. This disclosure also applies to non-Texas residents.

The Plan Sponsor will ensure that the required adequate separation, described elsewhere in this section, is established and maintained.

14.05 Disclosures of Summary Health Information and Enrollment and Disenrollment Information to the Plan Sponsor

The Plan, or a health insurance issuer or HMO with respect to the Plan, may disclose summary health information to the Plan Sponsor without the need to amend the Plan documents as provided for in the "504" provisions, 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 the Plan; or

(b) modifying, amending, or terminating the Plan.

The Plan, or a health insurance issuer or HMO with respect to the Plan, may disclose enrollment and disenrollment information to the Plan Sponsor without the need to amend the Plan Documents as provided for in the "504" provisions.

14.06 Required Separation between the Plan and the Plan Sponsor

In accordance with the "504" provisions, following is a description of the Associates, classes of Associates, or workforce members under the control of the Plan Sponsor who may be given access to individuals' PHI/SPI received from the Plan or from a health insurance issuer or HMO servicing the Plan.

1. Analysts/Administrators;
2. Human Resources Personnel;
3. Information Technology Personnel;
4. Clerical Personnel;
5. Supervisors/Managers;
6. Compliance Personnel Quality Assurance Unit.

The above list reflects the Associates, classes of Associates, or other workforce members of the Plan Sponsor who receive individuals' PHI/SPI relating to payment under, health care operations of, or other matters pertaining to plan administration functions that the Plan Sponsor provides for the Plan. These individuals will have access to individuals' PHI/SPI solely to perform these identified functions, and they will be subject to disciplinary action and/or sanctions (including termination of employment or affiliation with the Plan Sponsor) for any use or disclosure of individuals' PHI/SPI in violation of, or non-compliance with, the provisions of this section.

The Plan Sponsor will promptly report any such breach, violation, or non-compliance to the Plan and will cooperate with the Plan to correct the violation or non-compliance, to impose appropriate disciplinary action and/or sanctions, and to mitigate any deleterious effect of the violation or non-compliance.

14.07 Request a Copy of the Notice of Privacy Practice

Members can request a copy of the Notice of Privacy Practice or it can be accessed through **www.preferredadmin.net.**

ARTICLE XV
HIPAA SECURITY STANDARDS

This section is intended to bring the University Medical Center of El Paso and Its Affiliates Member Benefit Fund (hereinafter "Plan") into compliance with the requirements of 45 C.F.R. § 164.314(b)(1) and (2) of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations, 45 C.F.R. parts 160, 162, and 164 (the regulations are referred to herein as the "HIPAA Security Standards") by establishing the Plan Sponsor's obligations with respect to the security of Electronic Protected Health Information. The obligations set forth below are effective on April 20, 2005.

15.01 Definitions

1. "Electronic Protected Health Information" has the meaning set forth in 45 C.F.R. § 160.103, as amended from time to time, and generally means protected health information that is transmitted or maintained in any electronic media.
2. "Plan" means the University Medical Center of El Paso and Its Affiliates Associate and Retiree Member Benefit Fund.
3. "Plan Document" means the group health plan's governing documents and instruments (i.e., the documents under which the group health plan was established and is maintained), including but not limited to the Plan Document of the University Medical Center of El Paso and Its Affiliates Member Benefit Fund.
4. "Plan Sponsor" means the entity as defined at section 3(16)(B) of ERISA, 29 U.S.C. § 1002(16)(B). The Plan Sponsor is University Medical Center of El Paso.
5. "Security Incidents" has the meaning set forth in 45 C.F.R. § 164.304, as amended from time to time, and generally means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operations in an information system.

15.02 Plan Sponsor Obligations

Where Electronic Protected Health Information will be created, received, maintained, or transmitted to or by the Plan Sponsor on behalf of the Plan, the Plan Sponsor shall reasonably safeguard the Electronic Protected Health (PHI/SPI) Information as follows:

1. Plan Sponsor shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic PHI/SPI that Plan Sponsor creates, receives, maintains, or transmits on behalf of the Plan;
2. Plan Sponsor shall ensure that the adequate separation that is required by 45 C.F.R. § 164.504(f)(2)(iii) of the HIPAA Privacy Rule is supported by reasonable and appropriate security measures;
3. Plan Sponsor shall ensure that any agent, including a subcontractor, to whom it provides Electronic Protected Health Information PHI/SPI agrees to implement reasonable and appropriate security measures to protect such Information; and

4. Plan Sponsor shall report to the Plan any Security Incidents of which it becomes aware as described below:

   (a) Plan Sponsor shall report to the Plan within a reasonable time after Plan Sponsor becomes aware, any Security Incident that results in unauthorized access, use, disclosure, modification, or destruction of the Plan's Electronic Protected Health.

   (b) Plan Sponsor shall report to the Plan any other Security Incident on an aggregate basis every year, or more frequently upon the Plan's request.

   NOTE: The Plan Sponsor shall have a reasonable period of time after learning of a security incident to report any successful attempt to the Plan, but can aggregate the data relating to unsuccessful attempts and report that information to the Plan on a less frequent basis.

   Your health information (Protected Health Information/Sensitive Personal Information) created or received by Preferred Administrators is subject to electronic disclosure.

   (c) Effective September 23, 2013, the Plan complied with the HIPAA final rule ("Omnibus Rule").

APPENDIX A:
NOTICE OF NONDISCRIMINATION

(for covered entities subject to ACA Section 1557)

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

Preferred Administrators:

- 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 Preferred Administrators and/or University Medical Center of El Paso.

If you believe that Preferred Administrators 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: Complaints Department, 1145 Westmoreland, **1-877-532-3778,** (TTY: **1-855-532-3740** or **915-532-3740), 915-298-7872, preferredadmin@elpasohealth.com.** You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Our Member Services Department 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, 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 1-877-532-3778 (TTY: 1-855-532-3740 or 915-532-3740).

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 1-877-532-3778 (TTY: 1-855-532-3740 or 915-532-3740)。

VIETNAMESE

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-532-3778 (TTY: 1-855-532-3740 or 915-532-3740).

KOREAN

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-532-3778 (TTY: 1-855-532-3740 or 915-532-3740) 번으로 전화해 주십시오.

TAGALOG–FILIPINO

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877-532-3778 (TTY: 1-855-532-3740 or 915-532-3740).

RUSSIAN

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-532-3778 (телетайп: 1-855-532-3740 or 915-532-3740).

ARABIC

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-877-532-3778 (رقم هاتف الصم والبكم: (TTY: 1-855-532-3740 or 915-532-3740).

FRENCH CREOLE

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-877-532-3778 (TTY: 1-855-532-3740 or 915-532-3740).

FRENCH

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-532-3778 (ATS: 1-855-532-3740 or 915-532-3740).

POLISH

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-877-532-3778 (TTY: 1-855-532-3740 or 915-532-3740).

PORTUGUESE

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-877-532-3778 (TTY: 1-855-532-3740 or 915-532-3740).

GERMAN

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-877-532-3778 (TTY: 1-855-532-3740 or 915-532-3740).

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。1-877-532-3778（TTY: 1-855-532-3740 or 915-532-3740）まで、お電話にてご連絡ください。

HINDI

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-877-532-3778 (TTY: 1-855-532-3740 or 915-532-3740) पर कॉल करें।

GUJARATI

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-877-532-3778 (TTY: 1-855-532-3740 or 915-532-3740).

URDU

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال
1-877-532-3778 (TTY: 1-855-532-3740 or 915-532-3740). کریں

PUNJABI

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-877-532-3778 (TTY: 1-855-532-3740–or–915-532-3740.) 'ਤੇ ਕਾਲ ਕਰੋ।

LAO

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-877-532-3778 (TTY: 1-855-532-3740 or 915-532-3740).

Effective October 1, 2023