Preferred
ADMINISTRATORS

UNIVERSITY MEDICAL CENTER
OF EL PASO AND ITS AFFILIATES

Associate 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 2014

UNIVERSITY
MEDICAL CENTER
OF EL PASO

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PREFERRED ADMINISTRATORS

MEMBER RIGHTS AND RESPONSIBILITIES

As a Preferred Administrator 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 Preferred Administrators Associates 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 Preferred Administrators and/or the quality of care you receive.
- Preferred Administrators understands your concerns. We have a 24/7 Customer Support Hotline **915-504-5764** that you can call on any services related issues including scheduling of appointments, concerns, and complaints.

YOU HAVE THE RESPONSIBILITY TO:

- Review and understand the information you receive about Preferred Administrators. Please call our 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.
- 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 time filing.
- Before your 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.
- Voice your opinions, concerns or complaints to Preferred Administrators.
- Notify your employer University Medical Center Benefits Administrator about any changes in family size, address, phone number or membership status. Please contact them at **915-521-7950.**
- Notify Preferred Administrators if you have other insurance by calling **915-532-3778** from 7:00 am to 5:00 pm.

UNIVERSITY MEDICAL CENTER

OF EL PASO

Preferred ADMINISTRATORS

NOTICE TO PARTICIPANTS OF THE UNIVERSITY MEDICAL CENTER OF EL PASO AND ITS AFFILIATES ASSOCIATES BENEFIT FUND

Group health pans sponsored by State and local governmental employers must generally comply with Federal law requirements in title XXVII of the Public Health Service Act. However, these employers are permitted to elect to exempt a plan from the requirements listed below for a part of the plan that is "self-funded" by the employer, rather than provided through a health insurance policy. The University Medical Center of El Paso has elected to exempt University Medical Center of El Paso and its Affiliates Associate Health Benefit Fund from the following requirement:

Protections against having benefits for mental health and substance use disorders be subject to more restrictions than apply to medical and surgical benefits covered by the plan.

This exemption from these federal requirements will be in effect for the 2015 plan year beginning October 1, 2014 and ending September 30, 2015. The election may be renewed for subsequent years.

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 Preferred Administrators Benefit 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 Plan participants 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 Summary Plan Description (SPD) 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 SPD 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).

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 OR RIGHT TO RECEIVE A CERTIFICATE OF CREDITABLE COVERAGE

Under the Health Insurance Portability and Accountability Act of 1996 (commonly known as HIPAA), an Individual has the right to receive a certificate of prior health coverage, called a "certificate of creditable coverage" or "certificate of group health plan coverage," from the Plan Sponsor or its delegate. If Plan coverage or COBRA continuation coverage terminates the Plan Sponsor will automatically provide a certificate of creditable coverage. The certificate is provided at no charge and will be mailed to the person at the most current address on file. A certificate of creditable coverage will also be provided, on request, in accordance with the law (i.e., a request can be made at any time while coverage is in effect and within twenty-four (24) months after termination of coverage). Written procedures for requesting and receiving certificates of creditable coverage are available from the Plan Sponsor.

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 84% (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 AND SUMMARY PLAN DESCRIPTION

THIS PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION, made by the University Medical Center of El Paso (the "Company" or the "Plan Sponsor") as of October 1, 2014 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.

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: James N. Valenti

Name: JAMES N. VALENTI

Date: **October 1, 2014**

Title: Pres / CEO
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 Associates 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 Associates with coverage options that provide benefits based on point of service decisions made by the Associate. When Associates 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 Associate. Because of the cost of medical care, Covered Associates 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 Associates 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. Associates are mandated to participate in the Health Risk Assessment Program which is provided through the University Medical Center of El Paso Wellness Program and to be active participants of healthy lifestyles and preventive health practices.

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:	Texas
PLAN YEAR:	October 1 through September 30
PLAN NUMBER:	501
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 Participant or to be consideration for, or an inducement or condition of, the employment of any Associate. Nothing in this Plan Document shall be deemed to give any Associate the right to be retained in the service of the Company or to interfere with the right of the Company to discharge any Associate 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

The Plan is governed by the Code. In no event shall the Employer guarantee the favorable tax treatment sought by this Plan. 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 Plan Participants' 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 regarding which protections apply and which protections do not apply to a Grandfathered Health Plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at **915-532-3778.** Questions regarding which protections apply and which protections do not apply to a Grandfathered Health Plan and what might cause a plan to change from Grandfathered Plan status can be directed to the Plan Administrator at the following address:

Preferred Administrators
1145 Westmoreland Drive
El Paso, TX 79925

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 www/dol.gov/ebsa/healthreform** or the U.S. Department of Health and Human Services at **www.healthreform.gov.** This website has a table summarizing which protections do and do not apply to Grandfathered Health Plans.

ARTICLE III
SCHEDULE OF BENEFITS

3.01 PPO Providers and Preferred Providers

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

This Plan provides options for Associates to receive medical services from providers who have contracted with the provider networks contracted by the Plan. This Plan rewards Associates with increased benefit coverage amounts based on the providers selected as described in the Schedule of Benefits. The greatest benefit amounts are provided when Associates 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 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.

(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 non-contracted 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.

3.02 Wrap Network Criteria for Out-of-Area

If you receive services out-of-area (outside El Paso County and the immediate surrounding areas where active Associates reside), you will receive PPO Benefits as long as you meet the following criteria and as long as the provider is a contracted provider with our Wrap Network.

(1) The Covered Associate or Covered Dependent resides or is enrolled in school full time outside El Paso County and the provider is located in the City or County where the Associate or Covered Dependent resides or attends school, or

(2) The Wrap Network for Out-of-Area/Non-Contracted Providers Covered Associate or Covered Dependent is traveling on vacation and requires urgent or emergency medical care while outside of El Paso County, or

(3) The Covered Associate or Covered Dependent resides in the El Paso County and is seeking care outside the area of El Paso County and the provider is a contracted provider with our Wrap Network. If a member electively chooses to receive services from an out-of-network provider, the member will be responsible for Out-of-Network benefits as explained in this Plan Document.

******* Please NOTE the following: Services rendered by an Out-of-Network Provider *******

- — Prior authorization must be obtained for any services requiring a prior authorization as stated in *page 10-11.* Failure to obtain an 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 may 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.

SCHEDULE OF BENEFITS FOR WRAP NETWORK PROVIDERS

1. **Wrap Network Providers for covered associates and dependents,** residing outside of the State/ Area to include:

   — Benefits for medical services provided for members residing outside of El Paso County will be based on the "PPO Network" Schedule of Benefits, when the associate receives services from a contracted provider within our Wrap Network (Multiplan/PHCS).

   — Members will be 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 **Multiplan.com.** This will determine how the associate's benefits will be applied.

   Prior-Auth will be requested for services listed on *page 10-11.* 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.

2. **Wrap Network Providers for Out-of-Area.** Associates traveling or on vacation, requiring an emergency medical care.

   — PPO Benefits will be applied when using 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.

   — PPO Benefits will be applied when using Out-of-Area Provider when the treatment is for an emergency room physician who staffs an emergency room for Out-of-Area/Non-Contracted Providers. 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.

   All Emergency Admissions must be authorized within 24 hours of admission. 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.

3. **Wrap Network Providers** for medical services not being provided/performed by a provider in El Paso County and confirmed by the Medical Utilization Review Program

   — When services are not available within El Paso County but the services are available with one of our Wrap Network Providers (Multiplan/PHCS) or Interlink Centers of Excellence Providers the benefits will be applied at PPO Benefits. **If the member electively chooses a provider that is not contracted with our Wrap Network, the benefit will be Out-of-Network Benefits at 50/50 when services are not offered in El Paso County and confirmed by our Medical Utilization Review Program.**

— **PRIOR AUTHORIZATION MUST BE OBTAINED. Failure to obtain prior authorization will result in a loss of coverage for the service or procedure. 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.**

FINDING PROVIDERS:

(1) For El Paso Area Network Providers: **www.preferredadmin.net** or call **915-532-3778**

(2) For providers outside (State/Area): **www.multiplan.com** or call **1-800-678-7427** or to locate a PHCS provider, please contact **1-800-922-4362**

(3) 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.**

3.03 Utilization Review:

UTILIZATION REVIEW: Preferred Administrators 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: The Plan requires that a Provider obtains a prior authorization for the following Covered Services or procedures:

All out-of-network services provided by non-participating facility, provider, lab, or vendor require pre-authorization.

Inpatient Admissions

- Acute Hospital
- Surgical
- Non-Surgical
- Rehab
- Hospice
- Maternity and Newborn
- Behavioral Health
- Elective Admissions/Surgery

Outpatient Therapy

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

Radiology/Diagnostic Imaging

- PET Scans
- Obstetrical Ultrasounds (Member is allowed four ultrasounds without obtaining pre-authorization)

NO Authorization required for MRI, MRA, CT scans, EKG's, or X-Rays

Outpatient Procedures

- Ambulatory Surgical Center
- Endoscopy Center
- Cardiac Catheter Center
- Wound Clinic
- Outpatient Hospital

Pharmacy Medical

- Growth Hormones
- Synagis
- Oral Injectable or IV Drug Administration over $500

  NOTE: This includes oral, injectable, or IV provided in a Physician's office
- Specialty Medicines

  NOTE: Please go to www.preferredadmin.net for complete list of specialty medicines

Durable Medical Equipment ($500 and over)

- All DME rentals exceeding 2 months.
  Maximum up to 12 months, not to exceed purchase price.

Other Services

- Allergy Immunotherapy
- BRCA Testing
- Clinical Trials
- Genetic Testing
- Laser Surgeries
- Oral Surgery
- Orthotics and Prosthetics ($200 and over for Adult and Children)
- Podiatry (in office surgical procedures with the exception of debridement of nails, avulsion of nail plate, excision of nail and wedge excision of skin of nail)
- Transplants (To include evaluation services by Transplant Facility)
- Transportation (Air Transport and Non-Emergent Ambulance)

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 or the next business day 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.

Although it is the Provider's responsibility to request authorization for the health care services to be delivered, it is ultimately the Associate'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 you render the services.

INPATIENT MATERNITY:

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.

NOTE: A Preauthorization does not guarantee payment of benefits nor verify eligibility. Payment of benefits is subject to all terms 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.

PRIOR AUTHORIZATION FOR OUTPATIENT BEHAVIORAL HEALTH ADMISSIONS AND OUTPATIENT THERAPY:

All elective (non-emergency) Behavioral Health admissions for Mental & Nervous Disorders or Substance Abuse 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.

Outpatient therapy by a Psychiatrist M.D. or a Psychologist Ph.D. or counseling by a licensed professional based on a written referral for therapy or counseling requires prior authorization. An initial evaluation by an M.D. or Ph.D. does not require prior authorization. Subsequent therapy sessions or referral to a licensed professional for therapy or counseling requires prior authorization.

CASE MANAGEMENT:

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

The Health Service Department staff which includes Medical Directors, Associate Medical Directors, Registered Nurses, Licensed Vocational Nurses, Case Managers and Social Workers are available to assist Associates 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 Associate by monitoring the situation, identifying available clinical resources, making suggestions regarding treatment plan options, helping the Associate understand a disease process, a treatment plan or medical terminology, which may include the following:

- personal support to the Associate 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 required when it is determined to be an appropriate resource. Accepting Medical Case Management recommendations is voluntary and there will be no reduction of benefits if the Associate 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	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 Covered Participant	$125		$1,250	$3,000
Maximum Family Deductible Limit	$375		$3,750	$9,000
After the 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.				
ANNUAL LIMIT (Per Covered Participant)	No annual limit.			

Benefit Description		UMC, University Medical Center of El Paso, EPCH	Texas Tech Provider	Wrap Network Preferred Administrators Network / PPO Benefit	Non-Contracted Providers
MEDICAL 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 Covered Participant	$6,000				
Family Out-of-Pocket	$12,000				
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. 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 maximum does not include non-compliance penalties and amounts in excess of allowable amounts or any non-covered expenses.					
ANNUAL LIMIT (Per Covered Participant)		**No Annual Limit**			

3.05 Claims Bill Review

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 are not Usual and Customary and/or Medically Necessary and Reasonable, if any, and may include a patient medical billing records review and/or audit of the patient's medical charts and records.

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

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

3.06 Alphabetical Schedule of Plan Benefits

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

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	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%	70%
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 Usual and Customary rate or the provider's contracted rate if applicable.				
CHEMOTHERAPY, HEMATOLOGY/ONCOLOGY				
Benefit	100% after deductible	100% after deductible	70% after deductible	50% after deductible
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

Benefit Description	UMC, University Medical Center of El Paso, EPCH	Texas Tech Provider	Wrap Network Preferred Administrators Network / PPO Benefit	Non-Contracted Providers
EMERGENCY CARE BENEFITS				

UMC of El Paso No Balance Billing		Wrap Network PPO "Warning" *(You will be Balanced Billed from the Emergency Care Provider that treated you in the Emergency Department)*		Non-Contracted Providers "Warning" *(You will be Balanced Billed from Providers Not Contracted by Preferred Administrators)*	
Facility	**Professional**	**Facility**	**Professional**	**Facility**	**Professional**
100% of Contracted Amount after co-pay of $50	100% of Contracted Amount	100% of Contracted Amount after co-pay of $50	100% of Usual and Customary Charges	100% of Usual and Customary Charges after co-pay of $50	100% of Usual and Customary Charges

NOTE: ***Deductible/Coinsurance does not apply when obtaining emergency services. If you receive services at a PPO Hospital/Out-of-Network Hospital you will be balanced billed from the Professional ER Providers that are not contracted by Preferred Administrators. Additional Charges (Balance Billing) will be incurred when receiving services from a Non-Contracted Provider. El Paso Children's Hospital honors the same levels than UMC.***

HOME HEALTH CARE				
Benefit	N/A	N/A	70% after deductible	50% after deductible
Maximum Benefits	N/A	N/A	120 visits per Fiscal Year (Includes Skilled Nursing)	50 visits per Fiscal Year (Includes Skilled Nursing)
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
HOSPITAL SERVICES				
Hospital Charges – Inpatient Admissions (Medical and Surgical)	$250 co-pay 100% after deductible	N/A	$1,000 co-pay 70% after deductible	$2,500 co-pay 50% after deductible
Hospital Charges – Outpatient Surgery (Medical and Surgical)	$100 co-pay 100% after deductible	N/A	$300 co-pay 70% after deductible	$1,000 co-pay 50% after deductible
Hospital Charges – Observation (Medical and Surgical) (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% of usual and customary

Benefit Description	UMC, University Medical Center of El Paso, EPCH	Texas Tech Provider	Wrap Network Preferred Administrators Network / PPO Benefit	Non-Contracted Providers
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 with Private Rooms Only	N/A		70% after deductible	50% after deductible
BEHAVIORAL HEALTH MENTAL AND SUBSTANCE ABUSE **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	$35 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
Inpatient Behavioral 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
Maximum Benefit per Fiscal Year (Outpatient and Inpatient Treatment)	30 visits a year			
The Employee Assistance Program (EAP) offers 8 free counseling sessions for therapy and counseling by providers within the EAP Program. If you require more than 8 professional services a Prior Authorization will be required. You can call the EAP program at 915-351-4680 to make your appointment.				
Maximum Fiscal Year Benefit	None			None
Mental and Nervous and Substance Abuse charges (inpatient and outpatient) combined.				
Prior Authorization for professional services is required through the Health Service Department of Preferred Administrators. If Prior Authorization is not obtained your benefits will be denied.				

Benefit Description	UMC, University Medical Center of El Paso, EPCH	Texas Tech Provider	Wrap Network Preferred Administrators Network / PPO Benefit	Non-Contracted Providers
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 List, *pages 23-25.*	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
(Max 30 visits per Fiscal Year. All combined with OT, PT, and ST to include professional and facility out-patient services).				
NOTE: All children from birth to 3 years with a developmental delay will be referred to Early Childhood Intervention (ECI). ECI services will not count towards the maximum 30 visits combined with speech therapy, physical therapy, and occupational therapy. However, if the child does not receive services from ECI, then they are subject to a limit of visits based on medical necessity.				
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.				
ORGAN TRANSPLANTS				
Organ Transplant services are provided through the transplant network or contracted transplant facility approved by the Plan Administrator and stop loss carrier.				
ORTHOTICS				
Benefits	N/A	N/A	50% after deductible	70% 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.				

Benefit Description	UMC, University Medical Center of El Paso, EPCH	Texas Tech Provider	Wrap Network Preferred Administrators Network / PPO Benefit	Non-Contracted Providers
PHYSICAL THERAPY				
Physical Therapy Office Visits (First Evaluation and Re-Evaluations)	$15 co-pay	$35 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
(Max 30 visits per Fiscal Year. All combined with OT, PT, and ST to include professional and facility outpatient services).				
NOTE: All children from birth to 3 years with a developmental delay will be referred to Early Childhood Intervention (ECI). ECI services will not count towards the maximum 30 visits combined with speech therapy, physical therapy, and occupational therapy. However, if the child does not receive services from ECI, then they are subject to a limit of visits based on medical necessity.				
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 admission**s 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** $5 Generic $25 Brand $50 Non-Formulary		**All Network Pharmacies** $25 Generic $45 Brand $70 Non-Formulary	
Prescription Drug Deductible	Separate $50 Fiscal Year Deductible per member. Prescription Drug Deductible does not apply to Medical Plan Deductible or the Out-of-Pocket Maximum.			
Maintenance Medication	**University Medical Center of El Paso Pharmacies Only** A 90 day supply (after prescription deductible) $5 Generic $25 Brand $50 Non-Formulary			
Specialty Drug Medication	**University Medical Center of El Paso Pharmacies Only or mail order** $50 Co-pay and will be dispensed at 30 day supply. Please go to **www.preferredadmin.net** for a complete list of specialty medicines.			
Prescriptions over $500 *Authorization Required	Co-pay applies.		All Network Pharmacies 50% after prescription drug deductible.	
For Pharmacy Coordination of Benefits, *please see page 91.* *Prescription Drugs, continued on next page*				

PHARMACY Benefit Description		University Medical Center of El Paso	All Network Pharmacies	Non-Contracted Providers
PHARMACY OUT-OF-POCKET MAXIMUM PER FISCAL YEAR		All members cost share from UMC Pharmacies and all in-network pharmacies will be applied towards the Pharmacy Out-of-Pocket maximum.		Unlimited
Per Covered Participant	$6,000			
Family Out-of-Pocket	$12,000			
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. 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 SEPARATELY DETERMINED FROM 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

Examples of Excluded Drugs

- Anabolic steroids
- Anorectics (any drug used for the purpose of weight loss)
- Anorexiants (except for Adderall, Dexedrine, and Dextrostat)
- Cosmetics
- Fertility medications
- Fluoride supplements
- 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
- Vitamins other than prescription pre-natal vitamins

Benefit Description	UMC, University Medical Center of El Paso, EPCH	Texas Tech Provider	Wrap Network Preferred Administrators Network / PPO Benefit	Non-Contracted Providers
REHABILITATION (PHYSICAL) FACILITIES				
Outpatient Services	100% after deductible		70% after deductible	50% after deductible
Max 30 visits per Fiscal Year. (All combined with OT, PT, and ST to include professional and facility outpatient services).				
Covered Expenses During Rehab Stay (Lab, X-Ray)	100% after deductible	100% after deductible	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	Non-Contracted Providers
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
(Max 30 visits per Fiscal Year. All combined with OT, PT, and ST to include professional and facility out-patient services).				
NOTE: All children from birth to 3 years with a delay of speech developmental will be referred to Early Childhood Intervention (ECI). ECI services will not count towards the maximum 30 visits combined with speech therapy, physical therapy, and occupational therapy. However, if the child does not receive services from ECI, then they are subject to a limit of visits based on medical necessity.				
SPINAL ADJUSTMENT/CHIROPRACTIC ADJUSTMENT				
Office Visit	N/A	$30 co-pay	$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
(Max 10 visits per Fiscal Year)				
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.				
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
URGENT CARE/WALK-IN CLINICS				
Urgent Care Services – after hours and weekend medical services for non-emergency illnesses and minor injuries.	$15 co-pay	$30 co-pay	$40 co-pay	50% after deductible
Covered Expenses During an Office Visit (For example Labs, X-Ray, Injections, etc.)	100% after deductible	100% after deductible	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	Non-Contracted Providers
WELLNESS BENEFITS				
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, *listed on pages 23-26.* NOTE: These services come with specific Guidelines (e.g., frequency).	100%	100%	100%	Not Covered
Mammogram – Covered at 100% for women ages 40 and older. One per Fiscal Year.	100%	100%	100%	Not Covered
NOTE: If a women receives a mammogram younger than 40 years of age, it will be considered Diagnostic and your deductibles or PPO co-insurance will apply. *Please refer to page 15.*				
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
Zostavax – Age 60 and over. (Shingles)	100%	100%	100%	Not Covered
Well Baby and Well Child Preventative Care /Physical Exams and routine immunizations for covered participants under 18 years of age.	100%	100%	100%	Not Covered
• Routine Exams (The frequency of visits for children from 0-1 year are according to American Academy of Pediatrics as follows: 3-5 days, 1 month, 2 months, 4 months, 6 months, and 9 months) (The frequency of visits for children 1-17 years is once per Fiscal Year). • Routine Vision Exams (Children five years and under are covered at 100% and all children five years and older are covered as medical and applicable deductibles or co-insurance will apply.) • Routine Hearing Exams (Children five years and under are covered at 100% and all children five years and older are covered as medical and applicable deductibles or co-insurance will apply.)				
All Immunizations required by the Centers for Disease Control and Prevention (CDC) are covered for children and adult. Routine Immunizations include: Diphtheria, Hepatitis B, Rotavirus, Haemophilus Influenzae 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.				

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

Abdominal aortic aneurysm screening: men — Recommends one-time screening for abdominal aortic aneurysm by ultrasonography in men aged 65 to 75 who have ever smoked.
Alcohol misuse counseling — Recommends screening and behavioral counseling interventions to reduce alcohol misuse by adults, including pregnant women, in primary care settings.
Anemia screening: pregnant women — Recommends routine screening for iron deficiency anemia in asymptomatic pregnant women.
Aspirin to prevent CVD: men — Recommends the use of aspirin for men age 45 to 79 years when the potential benefit due to a reduction in myocardial infarctions outweighs the potential harm due to an increase in gastrointestinal hemorrhage.
Aspirin to prevent CVD: women — Recommends the use of aspirin for women age 55 to 79 years when the potential benefit of a reduction in ischemic strokes outweighs the potential harm of an increase in gastrointestinal hemorrhage.
Bacteriuria screening: pregnant women — Recommends screening for asymptomatic bacteriuria with urine culture for pregnant women at 12 to 16 weeks gestation or at the first prenatal visit, if later.
Blood pressure screening — Recommends screening for high blood pressure in adults aged 18 and older.
BRCA screening, counseling — Recommends that women whose family history is associated with an increased risk for deleterious mutations in BRCA1 or BRCA2 genes be referred for genetic counseling and evaluation for BRCA testing.
Breast cancer preventive medication — Recommends that clinicians discuss chemoprevention with women at high risk for breast cancer and at low risk for adverse effects of chemoprevention. Clinicians should inform patients of the potential benefits and harms of chemoprevention.
Breast cancer screening — Recommends screening mammography for women, with or without clinical breast examination, every 1-2 years for women aged 40 and older.
Breastfeeding counseling — Recommends interventions during pregnancy and after birth to promote and support breastfeeding.
Cervical cancer screening — Strongly recommends screening for cervical cancer in women who have been sexually active and have a cervix.
Chlamydia infection screening: non-pregnant women — Recommends screening for Chlamydia infection for all sexually active non-pregnant young women aged 24 and younger and for older non-pregnant women who are at increased risk.
Chlamydia infection screening: pregnant women — Recommends screening for Chlamydia infection for all sexually active non-pregnant young women aged 24 and younger and for older non-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 — 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 — 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 — Recommends screening women aged 20 to 45 for lipid disorders if they are at increased risk for coronary heart disease.
Colorectal cancer screening — Recommends screening for colorectal cancer using fecal occult blood testing, sigmoidoscopy, or colonoscopy, in adults, beginning at age 50 years and continuing until age 75 years. The risks and benefits of these screening methods vary.

Dental cares chemoprevention: preschool children — 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.
Depression screening: adolescents — 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 — 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 — Recommends screening for type 2 diabetes in asymptomatic adults with sustained blood pressure (either treated or untreated) greater than 135/80 mm Hg.
Folic acid supplementation — 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.
Gonorrhea prophylactic medication: newborns — Strongly recommends prophylactic ocular topical medication for all newborns against gonococcal ophthalmia neonatorum.
Gonorrhea screening: women — 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 — 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 — Recommends screening for hearing loss in all newborn infants.
Hemoglobinopathies screening: newborns — Recommends screening for sickle cell disease in newborns.
Hepatitis B screening: pregnant women — The USPSTF strongly recommends screening for hepatitis B virus infection in pregnant women at their first prenatal visit.
HIV screening — Strongly recommends that clinicians screen for human immunodeficiency virus (HIV) all adolescents and adults at increased risk for HIV infection.
Hypothyroidism screening: newborns — Recommends screening for congenital hypothyroidism in newborns.
Iron Supplementation in children — Recommends routine iron supplementation for asymptomatic children aged 6 to 12 months who are at increased risk for iron deficiency anemia.
Obesity screening and counseling: adults — Recommends that clinicians screen all adult patients for obesity and offer intensive counseling and behavioral interventions to promote sustained weight loss for obese adults.
Obesity screening and counseling: children — 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.
Osteoporosis screening: women — Recommends that women aged 65 and older be screened routinely for osteoporosis. Recommends that routine screening begin at age 60 for women at increased risk for osteoporotic fractures.
PKU screening: newborns — Recommends screening for phenylketonuria (PKU) in newborns.
Rh incompatibility screening: first pregnancy visit — 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 — 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.

STIs counseling — 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 persons — Strongly recommends that clinicians screen persons at increased risk for syphilis infection.
Syphilis screening: pregnant women — Recommends that clinicians screen all pregnant women for syphilis infection.
Tobacco use counseling: non-pregnant adults — 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 — Recommends that clinicians ask all pregnant women about tobacco use and provide augmented, pregnancy-tailored counseling to those who smoke.
Visual acuity screening in children — Recommends screening to detect amblyopia, strabismus, and defects in visual acuity in children younger than age 5 years.

NEW WOMEN'S PREVENTIVE SERVICES

Well-woman visits — Well-woman preventive care visit annually for adult women to obtain the recommended preventive services that are age and developmentally appropriate, including preconception and prenatal care.

Breastfeeding support, supplies, and counseling ** *(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.

****NOTE: Breastfeeding Support/Supplies**
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.

The purchase of a manual breast pump
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.

Breast Pump Supplies
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.

The covered Associate or dependent is responsible for the entire cost of any additional same or similar equipment that is purchased or rented for personal convenience or mobility.

Contraceptive methods and counseling ** *(see note)* — All Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity.

****NOTE: Contraceptive Methods and Sterilization:** Coverage includes counseling services on contraceptive methods provided by a physician, obstetrician or Gynecologist. **The following would be Covered Expenses: Voluntary Sterilization and Covered Contraceptives to include Female Generic Prescription Drugs.**

Counseling for sexually transmitted infections — Recommends annual counseling on sexually transmitted infections for all sexually active women.

Counseling and screening for human immune-deficiency virus — Recommends annual Counseling and screening for human immune-deficiency virus infection for all sexually active women.

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.

Human papillomavirus 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.

Screening and counseling for interpersonal and domestic violence — Recommends annual counseling for interpersonal and domestic violence.

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** shall mean the American Dental Association.

4.04 **Administrative Appeal:** The formal process by which a Provider requests a review of the any of the below actions that do not require a medical review:

(1) The failure of El Paso First to act within the described timeframes
(2) The denial in whole or in part of payment for service not related to medical necessity
(3) Dispute of a claim denial for a non-covered benefit
(4) Reimbursement dispute
(5) Claims Coding dispute

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

4.05 **Administrative Denial:** 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.

4.06 **Approved Clinical Trial:** An "approved clinical trial" is defined as 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.

4.07 **Adverse Benefit Determination** means any of the following: a denial, reduction, 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 as experimental, investigational or non-covered benefits are not eligible for review.

4.08 **Adverse Determination Appeal** – the formal process by which a Provider, a Member or their legal representative requests a review of any of actions requiring medical interpretation such as:

(1) The denial or limited authorization of a requested service, including the type or level of service
(2) The reduction, suspension, or termination of a previously authorized service
(3) Denial of a request to obtain services outside of the network
(4) A determination that a service is not medically necessary, experimental, or investigational in nature

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

4.09 **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.

4.10 **AHA** shall mean the American Hospital Association.

4.11 **Allowable Expense** All medically necessary, customary, and reasonable health care services that are to be provided pursuant to this Benefit Plan "Covered Services".

4.12 **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.

4.13 **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.

4.14 **Appeal** means a request by a Covered Participant for re-consideration of an Adverse Benefit Determination of a health service request or benefit that the Covered Participant believes they are entitled to receive.

4.15 **Assignment of Benefits** shall mean an arrangement whereby the Plan Participant assigns their right to seek and receive payment of eligible Plan benefits, in strict accordance with the terms of this Plan Document, to a Provider. If a provider accepts said arrangement, Providers' rights to receive Plan benefits are equal to those of a Plan Participant, and are limited by the terms of this Plan Document. A Provider that accepts this arrangement indicates acceptance of an "Assignment of Benefits" as consideration in full for services, supplies, and/or treatment rendered.

4.16 **Associate** means a person who is directly employed on a full-time basis (who is regularly scheduled to work a minimum of 36 hours per week), or on a part-time basis (who is regularly scheduled to work a minimum of 20 hours per week), 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.

4.17 **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.

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

4.19 **Benefit Management Advisors** 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. The advisory team is comprised of the positions of Chief Financial Officer, Chief Executive Officer El Paso First Health Plans, Corporate Controller, and Director Human Resources. The team is staffed by the Benefits section of the Human Resources Department.

4.20 **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.

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

4.22 **Change in Family Status** means

(a) the marriage or divorce of the Covered Participant;

(b) the death of the Covered Participant's Spouse or Dependent;

(c) the birth, adoption, or placement for adoption of a child of the Covered Participant;

(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 Covered Participant, 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 Covered Participant or his Spouse;
(h) the taking of an unpaid leave of absence by the Covered Participant or his Spouse;
(i) a significant change in the health coverage of the Covered Participant 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 Covered Participant;
(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 Covered Participant's Spouse;
(f) the strike or lockout of the Covered Participant, or the Spouse or Dependent Child;
(g) the change in residence or worksite of the Covered Participant, 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 Covered Participant or his Spouse;
(i) the taking of an unpaid leave of absence by the Covered Participant or his Spouse;
(j) a significant change in the health coverage of the Covered Participant or his Spouse attributable to the Spouse's employment;
(k) the change in employment status of the Covered Participant, 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 Covered Participant's Spouse or Dependent, including an election change made during the open enrollment of a Covered Participant's Spouse;
(o) the change in a Covered Participant's, or a Covered Participant'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** shall mean, 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 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** 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** Any dissatisfaction, expressed by a complainant, orally or in writing to El Paso First, with any aspect of El Paso First'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** – shall mean 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 Covered Participant has more than one source of medical benefit coverage.

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

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

4.35 **Covered Participant** means any Associate and/or Dependent covered under this Plan.

4.36 **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).

4.37 **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.

4.38 **Deductible** means the amount of covered medical expenses which must be paid by a Covered Participant 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 Covered Participant 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.

4.39 **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.

4.40 **Dependent** shall mean one or more of the following person(s):

1. A Covered Participant's lawfully married spouse possessing a marriage license who is not divorced from the Associate. For purposes of this section, "marriage or married" means a legal union between one man and one woman as husband and wife;
2. A Covered Participant's Grandchild, for medical coverage only, when the grandchild is a legal Dependent of the Associate for federal income tax purposes. The covered grandchild will not lose eligibility status if at a later date the Dependent Child and/or the covered grandchild can no longer be claimed as a Dependent for federal income tax purposes. 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 31 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;
3. An Associate's Dependent Child or Children, for coverage under the medical plan only, the Associate's natural children, legally adopted children (including children placed for adoption for whom legal adoption proceedings have been started), step-children, children the Covered Participant has obtained legal guardianship for; and children required to be covered under a Qualified Medical Child Support Order (QMCSO). A Dependent Child does not include foster children. 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, proof of Total Disability is provided to the Plan Administrator within 31 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) Young Adult living or not living at parents home;
   (c) Does not require to be on parent's tax return;
   (d) Does not require that Young Adult be a student. This applies to both married and unmarried children although their own spouses and children do not qualify;
   (e) Coverage for Young Adults allows children until age 26 to continue their coverage under their parent's insurance even if they were eligible for other employer-sponsored coverage.

4.41 **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.

4.42 **Effective Date** means October 1, 2002 and the dates of subsequent amendments and restatements. The current restatement effective date is October 1, 2014.

4.43 **Eligible Expense** means the Usual and Customary 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-Contracted / Out-of-Area services or the Medicare allowable amount; or

(d) the Usual and Customary allowable amount for Non-Contracted 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.

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

4.45 **Emergency Services** shall mean, with respect to an Emergency Medical Condition:

1. A 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, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition; and
2. Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd) to stabilize the patient.

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

4.47 **ERISA** shall mean the Employee Retirement Income Security Act of 1974, as amended.

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

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

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

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

All phases of clinical trials shall be considered Experimental.

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

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

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

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

Reliable evidence shall mean:

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

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

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

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

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

4.51 **Family Deductible Limit** means that once the combined individual deductibles of all Covered Participants in the same family reach the combined deductible limit, no further individual deductibles apply during the remainder of the Fiscal Year.

4.52 **GINA** shall mean the Genetic Information Non-discrimination 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.

4.53 **Global Maternity.** Global maternity care includes routine ante-partum care, delivery and post-partum care.

4.54 **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.

4.55 **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.

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

4.57 **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.

4.58 **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.

4.59 **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.

4.60 **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.

4.61 **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).

4.62 **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.

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

4.64 **Incomplete Claim** 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. 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.

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

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 the Utilization Review Accreditation Commission (URAC) or by a similar nationally-recognized accrediting organization to conduct the external review.

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

4.75 **Lifetime** means while a person is covered under this Plan. Lifetime does not mean during the lifetime of the Covered Participant.

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

(a) The Usual and Customary amount,
(b) The allowable charge specified under the terms of the Plan,
(c) The negotiated rate established in a contractual arrangement with a Provider, or
(d) The actual billed charges for the covered services.

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

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

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

4.78 **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 Covered Participant. 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.

4.79 **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 Covered Participant for the purposes of evaluation, diagnosis or treatment of that Covered Participant'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 Covered Participant's Illness or Injury. The Medically Necessary setting and level of service is that setting and level of service which, considering the Covered Participant's medical symptoms and conditions, cannot be provided in a less intensive medical setting. Such services, to be considered Medically Necessary, must be no more costly than alter-native 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 Covered Participant's Illness or Injury without adversely affecting the Covered Participant's medical condition.

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

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

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

4.80 **Medically Necessary Leave of Absence** shall mean 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 a serious 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.

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

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

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

4.84 **Optum** – Prescription Drug Benefit Administrator.

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

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

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

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

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

4.89 **Out-of-Pocket or Maximum Out-of-Pocket** means the amounts for which the Covered Participant 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.

4.90 **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.

4.91 **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.

4.92 **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.

4.93 **Plan** means the University Medical Center of El Paso and its Affiliates Associate Benefit Fund, as it may be amended from time to time.

4.94 **Plan Administrator** means the Plan Sponsor.

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

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

4.97 **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.

4.98 **Preventive Care Charges** for 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).*

See **http://www.healthcare.gov/law/provisions/preventive/index.html** or **www.preferredadmin.net** for more details. **Important Note:** The preventive care services identified through this link are recommended services, not mandated services. It is up to the provider of care to determine which services to provide.

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

4.100 **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.

4.101 **Provider** means a Birthing Center, Certified Nurse Midwife, Home Health Care Agency, Hospice, Hospital, Licensed Dietician, 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.

4.102 **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.

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

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

(a) death of a Covered Participant;

(b) termination of employment of a Covered Participant;

(c) reduction in hours of a Covered Participant;

(d) divorce or legal separation of the Covered Participant;

(e) the Covered Participant's entitlement to Medicare benefits; or

(f) Dependent Child ceasing to qualify as a Dependent under a Welfare Program.

4.105 **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.

4.106 **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.

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

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

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

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

4.108 **Rehabilitation (Physical) Facility** means a facility that provides services of non-acute rehabilitation. All services are provided under the direction of a physiatrist, 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.

4.109 **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 mental retardation, or a place for custodial care.

4.110 **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.

4.111 **Spouse** means the person recognized under Texas law as the covered Associate's husband or wife unless divorced or legally separated under the laws of the State. Documentation proving a legal marital relationship may be required. This Plan will recognize Common Law Marriage in Texas if the Associate provides documentation required by the State to substantiate Common Law Marriage including: (1) an agreement to be married; (2) holding yourself out to a third parry as being married and (3) living together. Requires Common Law Marriage Certificate from the County Clerk's Office.

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

4.113 **Substance Abuse** means the condition caused by physical and/or emotional dependence on drugs, narcotics, alcohol, or other addictive substances resulting in a chronic disorder, which affects physical health, and/or personal or social functioning. This does not include dependence on tobacco or ordinary caffeine-containing beverages.

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

(a) A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12-month period:

1. Recurrent substance use resulting in a failure to fulfill major role obligations at work, school or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions or expulsions from school; neglect of children or household)
2. Recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use)
3. Recurrent substance-related legal problems (e.g., arrests for substance-related disorderly conduct)
4. Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights)

(b) The symptoms have never met the criteria for Substance Dependence for this class of substance.

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

4.115 **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.

4.116 **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.

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

4.118 **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.

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

4.120 **Usual and Customary (U&C)** Usual Customary and Reasonable charges (UCR charges) refer to the base amount that is treated as the standard or most common charge for a particular medical service when rendered in a particular geographic area. Third-party payers including insurance carriers and employers use UCR charges to determine the amount to be paid on behalf of an enrollee, for services that are reimbursed under a health insurance policy or health plan. UCR charges should not exceed the amount ordinarily charged by most providers for comparable services and supplies in the locality where the services or supplies are received. The term "Usual and Customary" does not necessarily mean the actual charge made nor the specific service or supply furnished to a Plan Participant by a Provider of services or supplies, such as a physician, therapist, nurse, hospital, or pharmacist. The Plan Administrator will determine what the Usual and Customary charge is, for any procedure, service, or supply, and whether a specific procedure, service or supply is Usual and Customary. Usual and Customary charges may, at the Plan Administrator's discretion, alternatively be determined and established by the Plan using normative data such as, but not limited to, Medicare cost to charge ratios, average wholesale price (AWP) for prescriptions and/or manufacturer's retail pricing (MRP) for supplies and devices.

4.121 **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.

4.122 **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 31 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 Covered Participant experiences a Change in Family Status or a Change in Status or Coverage.

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 participant 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, provided that the Associate enrolls the child within 30 days of birth or 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. A stepchild not living with the Associate is not considered a Dependent Child for purposes of the QMCSO rules. 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.

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

5.02 Failure to Elect Medical Insurance During Open Enrollment

Pursuant to the provisions of the Flex Plan, if a Covered Participant 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 Covered Participant 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 will default to Associate Only Medical Coverage.

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 31 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 31 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 41,* an Associate must submit a written notification to Human Resources University Medical Center within 31 days of the change in status.

(b) Late Enrollment. 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 31 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) 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

(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 31 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, or Placement for Adoption, the Associate may enroll himself, his Spouse, and his new Dependent in the Plan. The Associate must submit a written request for enrollment within 31 days after the marriage, 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.

(e) Change in Family Status Change. The Associate 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 31 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 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; 6 months; or

(ii) 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 Covered Participant is on a family or medical leave as defined in the Family or Medical Leave Act, any benefit elections in force for the Covered Participant shall remain in effect. While the Covered Participant is on paid leave, contributions shall continue.

Prior to commencing an unpaid leave, the Covered Participant may elect to prepay all or a portion of required contributions on a pre-tax basis. Alternatively, the Covered Participant 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 Covered Participant 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 31 days late. Upon return from FMLA or upon notification that the Covered Participant will not be returning to work, the Covered Participant 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, 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 31 days or more, the Participant 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 Participant 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

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.

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 death;
   c. a spouse's divorce or legal separation from a covered Associate;
   d. a covered Associate'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 ACT OF 2002

The Plan shall fully comply with the Trade Act of 2002 as the Act applies to employee welfare benefit plans.

PAPERWORK REDUCTION ACT STATEMENT

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately four minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Office of the Chief Information Officer, Attention: Departmental Clearance Officer, 200 Constitution Avenue, N.W., Room N-1301, Washington, DC 20210 or email HYPERLINK **"mailto:DOL_PRA_PUBLIC@dol.gov" DOL_PRA_PUBLIC@dol.gov** and reference the OMB Control Number 1210-0123.

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 1.
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 **<u>Termination of Coverage</u>**

(a) An Associate's 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 election;
    (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) 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;
    (iii) date an Associate ceases to meet the Plan's eligibility requirements;
    (iv) date all coverage or certain benefits are terminated for Dependents by modification of the Plan;
    (v) date a Dependent fails to meet the definition of a Dependent;

(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 the Dependent becomes covered under another Group Health Plan as an Associate; or

(viii) date the Associate's or Dependent's coverage terminates for any reason.

5.07 Rehired or Transferred Associates

Rehired Associates. An Associate's or Dependent's coverage under the Plan that ends by reason of the Associate's termination of employment will become reinstated on the date the Associate resumes employment if such date is within the same Fiscal Year and is within **31** days immediately following the date of termination.

If an Associate is rehired after **31** days or in the following Fiscal Year, he will be treated as a new Associate (except in the case where COBRA has been elected and continued with no lapse in coverage).

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.

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. Mandatory participation in the Health Risk Assessment (HRA) program is a requirement for eligibility in the health plan.

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 Allowable Amount; 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) **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.

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

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

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

5) **Approved Clinical Trial.** An "approved clinical trial" is defined as 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. The following must be met:

   - The clinical trial must be Pre-Authorized.
   - The trial for which routine patient costs must be covered but must be approved or sponsored by number of federal agencies, including the National Institutes of Health, the Centers of Medicare and Medicaid Services and the Food and Drug Administration, This is not an inclusive list.
   - The members may qualify for clinical trials if they meet the protocols of the trial and a participating provider deems them eligible and refers them to the trial as appropriate for the purposes of the trial, consistent with the member's benefit plan documents. Members also can provide medical and scientific information to establish that their participation in the trial is appropriate.

- All medical necessary health care provided to the individual for purposes of the trial, consistent with this plan medical coverage (patient costs), Such services include those rendered by a physician, diagnostic, or laboratory tests, and other services provided during the course of treatment for a condition or one of its complications that are consistent with the usual and customary standard of care. Applicable co-pays, deductibles, co-insurance, and maximum out-of-pockets will apply as stated in the benefit's coverage.
- Routine patient costs do not include the actual device, equipment or drug that is being studies as part of the clinical trial. Also excluded are: items or services not used in the direct clinical management of the patient, such as those solely to satisfy data collection and analysis needs, or items and services clearly inconsistent with accepted standards of care for the particular diagnosis.

6) **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).

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

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

9) **BRCA Testing.** Preferred Administrators 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.

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

11) **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.

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

13) **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.

14) **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 damged 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;
- anesthesia for dental services is not a covered benefit under the medical plan;
- 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;
- anesthesia for dental services is covered only if the treatment in mouth or oral cavity medical criteria is met.

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

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

17) **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 Covered Participant'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 Covered Participant, and rental of wheelchairs and Hospital beds. Charges for more than one item of equipment for the same or similar purpose are not covered.

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

19) **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.

20) **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% for children five years and under. For children five years and older, the hearing exams are covered as medical and applicable co-pay, deductible, or co-insurance percentage shown in your Schedule of Benefits.

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

21) **Home Health Care and Skilled Nursing.** For covered participants who meet the criteria for "Homebound Status": 1. Patients leave home infrequently for only short durations of time for reasons other then 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.

22) **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 Covered Participant's immediate family prior to, and within 3 months after, the Covered Participant'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.

23) **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.

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

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

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

27) **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.

28) **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.

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

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

30) **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.

31) **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. Does not cover a newborn of a dependent daughter.

32) **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.

33) **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.

34) **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 Covered Participant 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.

35) **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
- 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 Covered Associates 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, 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:
- cornea transplant
- 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 Covered Participant 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.
- Donor expenses (professional fees and facility expenses) will be considered eligible expenses when a Covered Participant 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 Participants, 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 Covered Participant.

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.**

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, re-transplantation 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. 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 **www.interlinkhealth.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.

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.

Re-Transplantation

Re-transplantation will be covered up to two re-transplants, for a total of three transplants per person.

36) **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 covered participant'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.

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

38) **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);
- There is a maximum of 30 visits combined with speech therapy, physical therapy, and occupational therapy.
- Applied behavior analysis and behavior training management are not covered under this plan.

39) **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). ECI services will not count towards the maximum 30 visits combined with speech therapy, physical therapy, and occupational therapy. However, if the child does not receive services from ECI, then they are subject to a limit on number of visits based on medical necessity.

40) **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.

41) **Preadmission or Preoperative Testing.** Tests or exams relating to surgery for a Covered Participant who is scheduled for surgery.

42) **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

43) **Pregnancy Care.** Care and treatment for pregnancy and complications of pregnancy are covered for a covered Associate, Spouse or dependent daughter.

44) **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 Covered Participant's physical condition.

45) **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.

46) **Rehabilitation Facilities.** Services and supplies including room and board furnished by a rehabilitation facility. The Covered Participant 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.

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

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

49) **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.

50) **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;
- for a speech impediment due to cerebral palsy;
- to treat dysphasia following surgery;
- treatment of fluency (stuttering) disorders;
- voice disorders secondary to vocal abuse/misuse;
- dysphagia following surgery.

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 developmental disorder benefits, *please refer to page 64.*

NOTE: All children from birth to 3 years with a delay of speech development will be referred to Early Childhood Intervention (ECI). ECI services will not count towards the maximum 30 visits combined with speech therapy, physical therapy, and occupational therapy. However, if the child does not receive services from ECI, then they are subject to a limit on number of visits based on medical necessity.

Speech therapy for treatment of delays in speech development, except as specifically provided in this section of Medical Benefits.

51) **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.

52) **Sterilization Procedures.** Voluntary sterilization procedures for women are covered at 100% with any of our In-Network Providers. Any voluntary sterilization procedures for men are covered on the same basis as for any other Illness.

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

54) **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 or. 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.

55) **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.

56) **Wellness Benefit.** Preventive Benefits as specified in the *Schedule of Benefits.*

6.04 Expense Limitations

Covered Expenses are subject to any limitations specified in the *Schedule of Benefits* as well as Articles IV and V.

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 Covered Participant 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

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

Alcohol. To a Plan Participant, arising from taking part in any activity made illegal due to the use of alcohol. Expenses will be covered for Injured Plan Participants other than the person partaking in an activity made illegal due to the use of alcohol, and expenses may be covered for Substance Abuse treatment as specified in this Plan, if applicable. This exclusion does not apply (a) if the injury resulted from being the victim of an act of domestic violence, or (b) resulted from a medical condition (including both physical and mental health conditions).

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

Cosmetic Surgery/Procedures. Charges for Cosmetic Surgery with the following exceptions:

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

Counseling. Charges for marital counseling and other counseling services are not covered. Counseling charges are covered for Nutritional Counseling and for bereavement counseling under the Hospice Care provisions.

Dental Services. 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 medical plan. Please refer to covered benefit under Dental Treatment in Mouth or Oral Cavity, *please refer to page 54.*
- 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 54.*
- Removal of bony impacted wisdom teeth.

Durable Medical Equipment. Charges 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. Any charge for any services or supplies 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. Any charge for care, supplies, treatment, and/or services that are required to treat injuries that are sustained or an illness that is contracted, including infections and complications, while the Plan Participant 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 are not payable under the Plan due to application of any Plan maximum or limit or because the charges are in excess of the Usual and Customary amount, or are for services not deemed to be Reasonable or Medically Necessary, based upon the Plan Administrator's determination as set forth by and within the terms of this document.

Exercise and Exercise Equipment. Charges 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 Participant as a spouse, parent, child, brother or sister, whether the relationship exists by virtue of "blood" or "in law".

Foot Care. Charges for the treatment of bunions (excluding capsular or bone surgery), corns, calluses, fallen arches, flat feet, and routine trimming of toenails, except when Medically Necessary due to an Illness.

Hearing. Charges for are not covered for:

- Hearing Aids
- Replacement parts or repairs for a hearing aid; and
- Any tests, appliances, and devices for the improvement of hearing (including hearing aids and amplifiers), or to enhance other forms of communication to compensate for hearing loss or devices that simulate speech, except otherwise provided.
- Surgical Implants including the Cochlear Ear
- Upgrading of a traditional Cochlear Implant System.
- Replacements of Cochlear Implant Parts to include tool kits.

Home Health Care. Home health care expenses exclude 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.

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. Charges are not covered 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 Covered Participant 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 Covered Participant'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.

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 necessary for a person to be charged or convicted in order for this exclusion to apply.

Learning Deficiencies. Charges for learning deficiencies and behavioral problems (including associated diagnostic testing), whether or not associated with a manifest mental disorder or other disturbance, except for Attention Deficit Disorder (ADD) and Attention Deficit Hyperactivity Disorder (ADHD).

Massage. Charges 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. Charges 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.

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

Not-Medically Necessary. Charges 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. Charges 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.

On-Line Counseling or Consultations. Charges for on-line counseling, on-line consultations, and any related on-line services the Covered Person makes to or receives from any Physician, practitioner or facility.

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

Other than Attending Physician. Any charge for care, supplies, treatment, and/or services other than those certified by a Physician who is attending the Participant 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. Charges 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. 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. Any service or supply primarily for your 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 – a surgery to remove one or both breasts to reduce the risk of developing breast cancer.

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
- 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
- Vitamins (prescription or otherwise) except for prescription pre-natal vitamins

Prosthetic Devices. Charges 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 Covered Participant's physical condition, or deterioration from normal wear and tear if recommended by the attending Physician.

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

Self Inflicted Injuries. Charges for:

- intentionally self-inflicted Injury, unless such Injury results from medical condition (physical or mental health condition) or domestic violence.
- injury resulting from or sustained due to being engaged in an illegal occupation, commission of an assault or felonious act. This exclusion does not apply (a) if the injury resulted from being the victim of an act of domestic violence, or (b) resulted from a medical condition (including both physical and mental health conditions).

Sexual Health and Family Planning. Charges 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, Pergonal therapy for infertility, in-vitro fertilization, microsurgery for infertility treatment, and HCG injections are not a covered benefit.
- expenses related to adoption
- surrogate mother and all related newborn Dependent Child expenses
- elective abortions, unless the life of the mother is endangered or the pregnancy is the result of a criminal act
- sexual transformation, including sex transformation surgery and all expenses in connection with such surgery
- treatment of sexual dysfunctions not related to organic disease
- reversal or attempted reversal of sterilization

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

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. Charges for treatment, other than by an open-cutting operation, 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. Charges for tuition or special education and for educational testing or training are not covered.

Unauthorized Services. This includes any service obtained by or on behalf of a covered person without Precertification 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.

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. Vision-related services and supplies, except as described in the What the Plan Covers 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 surgies in lieu of corrective lenses

Vitamins. Charges for nutritional supplements and prescription vitamins (except for pre-natal vitamins requiring a prescription under the Prescription Drug Program).

ARTICLE VIII
MEMBER REIMBURSEMENT CLAIMS PROCEDURES

8.01 **Claims**

Claims shall be submitted directly to Preferred Administrators. *Instructions for submitting claims are described on the* ***Associate Identification Card.***

8.02 **Reporting of Claims from Associates**

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 Associate's behalf. Associates 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 Associates 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 filing a claim is one year after the date of service.

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

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

8.03 **Receipt of a Complete Claim**

Upon receipt of a complete claim, 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 an Incomplete Claim**

Upon receipt of an incomplete claim, 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 Claim** – 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 Unclaimed Benefits

(a) If any amount payable under the Plan is not claimed or any check issued remains uncashed for one year from the earlier of the date of service or the date the check was issued, the amount will be forfeited to the Plan and will cease to be a liability of the Plan, provided Preferred Administrators has exercised reasonable efforts to make such payments.

8.06 Covered Participant's Responsibilities to Update Records

(a) Each Covered Associate must provide Preferred Administrators with the Covered Associate's and 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 Covered Associate. If a Covered Associate 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 Covered Associate 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 All Complaints will be handled by the Compliance Department

1. El Paso First Health Plans, Inc. (d/b/a Preferred Administrators) has a process in place for Plan complaints and appeals. The Compliance Department, in collaboration with the Member Services Department, the Provider Relations Department, Claims Department and the Health Services Department, coordinates the complaints and appeals process. The Chief Executive Officer (CEO), through the Director of Compliance, has primary responsibility for ensuring that complaints are resolved in compliance with written policies and within the time required.

2. Preferred Administrators has designated Customer Service Representatives to assist Members and Covered Participants (hereafter referred to as Members) with the complaints process. All complaints must be submitted verbally or in writing. Written complaints will be accepted from the Member or the Member's Legal Representative. Members may contact Preferred Administrators Customer Service Department to request assistance on how to submit a verbal or written complaint. The complaint must be mailed or faxed to:

   Preferred Administrators
   Complaints and Appeals Unit
   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 Unit 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 verbal or written complaint.

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

APPEALS PROCESS

9.02 Administrative Appeals Process

All Administrative will be handled by the Compliance Department.

1. Members have the right to appeal a dissatisfaction or disagreement of a complaint resolution that was due to benefit exclusion for an experimental, investigational or non-covered benefit.

2. Appeals related to a medical determination, denial, reduction, suspension or termination must follow the Adverse Appeal Process.

3. The standard appeal must be mailed or faxed to:

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

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

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

9.03 <u>Adverse Determination Appeal</u>

1. A Member, a person acting on the behalf of the Member, a Member's provider of record, and the health care provider or facility who rendered the Member's services, if different from the attending physician, can appeal El Paso First's decision to deny or limit a service or medicine that is a covered benefit.

   IMPORTANT: Failure to include any theories or facts in the appeal will result in their being deemed waived. In other words, the Member will lose the right to raise factual arguments and theories which support this claim if the Member fails to include them in the appeal.

2. Benefit exclusions such as experimental, investigational or non-covered benefits will not be eligible for an appeal of an adverse determination.

3. Members may request an external Independent Review Organization (IRO) at any time in lieu of Preferred Administrators' internal review process. Please see criteria for requesting an IRO in Section 6.c.

4. **<u>Internal Standard Appeal</u>:** A member or their Representative has the right to appeal if the covered services requested were not approved or only partially approved.

   Appeals can be made verbally, by fax, or in writing. Instructions for filing the appeal shall be included in the adverse determination notification. The adverse determination notification is sent out within three (3) working days of receipt of an authorization request.

   Appeals should be submitted to the following:

   Preferred Administrators
   Attention: Health Services Appeals Unit
   1145 Westmoreland Drive
   El Paso, TX 79925
   Tel: 915-532-3778
   Toll Free: 877-532-3778
   Fax No.: 915-298-7866

   a. **PREFERRED ADMINISTRATORS REQUIRES THAT APPEALS BE FILED WITHIN THIRTY (30) DAYS OF THE NOTICE OF THE ADVERSE DETERMINATION.**

   b. Preferred Administrators requires the following information for the appeal:

      1) A cover letter – Letter must include the Member's name;
      2) Health Plan identification number;
      3) Preferred Administrator's reference number (from the Notice of Determination);
      4) Date of service;
      5) A statement in clear and concise terms of the reason(s) for disagreement with the determination;
      6) A copy of the medical record if not previously submitted; and
      7) Any new or additional information.

c. For verbal appeals, a Member Appeal Form will be filled out by phone, and mailed to the Member within twenty four hours of receipt for review.

d. All appeals are date stamped and logged in the Adverse Determination Appeals Log. Not later than the fifth (5th) working day of receipt of the appeal, Preferred Administrators will send a letter acknowledging the date of receipt of the appeal. The letter of acknowledgement will include:

- The date we received the appeal
- If we need additional information
- Your right to ask for an Independent Review Organization (IRO)
- What you need to do to ask for the IRO.
- The number to TDI if you wish to file a complaint.

e. A physician who has not involved in the previous determination will review the appeal.

f. A resolution to the appeal will be provided as soon as practicable, but not later than thirty (30) working days from the date the appeal was received. A copy of the resolution letter will be mailed to the Member, a person acting on the behalf of the Member, a Member's provider of record, and the health care provider or facility who rendered the Member's services, if different from the attending physician. The appeal resolution letter will include:

1) A clear and concise statement of the clinical basis for the denial;
2) The specialty of the physician or other health care provider who made the decision;
3) Your right to request a review by an IRO;
4) What you need to do to request an IRO and the forms that need to be completed;
5) What you need to do to file a complaint with Preferred Administrators; and
6) What you need to do to file a complaint with the Texas Department of Insurance (TDI).

5. **Specialty Review for an Adverse Determination.**

a. Preferred Administrators may consult a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, who is neither an individual who was consulted in connection with the previous medical determination nor the subordinate of any such individual.

b. A request for a Specialty Review must be made within ten (10) days of adverse determination. It must be made in writing by the Member's health care provider, and state a good cause for having a particular type of specialty provider review the case. A response to the Specialty Review will be made in writing, by letter, within 15 days of receipt.

c. Appeals involving benefits exclusions such as experimental, investigational or non-covered benefits will not be eligible for this review.

6. **External Appeal Process.**

a. **External Review by an IRO.** Besides the Internal Standard Appeal process described above, the Plan also allows an external review process, under limited circumstances by an IRO. The decision made by the IRO, is binding on the Member, the Member's Legal Representative and the Plan.

b. **An Independent Review Organization (IRO).** An IRO is an independent third party certified by the Texas Department of Insurance to review the medical necessity and appropriateness of health care services provided or proposed to be provided to the Member. Preferred Administrators will use IROs who are licensed in the state of Texas.

c. **Criteria for Requesting an IRO.** The following criteria must be met to request an IRO:

1) The Member is or was covered under Preferred Administrators at the time the health care service was requested; or in the case of a retrospective review, was covered under Preferred Administrators at the time the health care was provided.
2) The Adverse Determination does not relate to the Member's failure to meet the requirements for eligibility under the terms of Preferred Administrators.
3) The Member has exhausted Preferred Administrators internal appeals process.
4) The Member has provided all the information and forms required to process an external review.
5) The IRO does not apply to a denial, reduction, termination or a failure to provide payment for a benefit based on a determination that a Member or beneficiary fails to meet the requirements for eligibility under the terms of Preferred Administrators. Benefits not covered and payable under the provisions of Preferred Administrators will not be considered for review by an IRO.
6) The Member or their Legal Representative may request an external appeal within four (4) months of receipt of resolution letter excluding holidays and weekends at no cost to the Member and criteria for requesting the IRO must be met.

To request a review by an IRO, the Member must submit the request in writing to:

Preferred Administrators
Attention: Health Services Department – Appeals Unit
1145 Westmoreland Drive
El Paso, TX 79925

d. The following information will be required for the IRO:

1) any medical records relevant to the review;
2) any documents used by Preferred Administrators in making the determination;
3) the written notification sent by Preferred Administrators;
4) any documents and other written information submitted in support of the appeal;
5) a list of each physician or other health care provider who has provided care to the Member and may have medical records relevant to the appeal.

e. Preferred Administrators will conduct a preliminary review to determine whether the request meets the review ability requirements for external review to set forth in Section 6c: Criteria for Requesting IRO.

f. Upon a determination that a request is eligible for external review, Preferred Administrators will forward your request to the Texas Department of Insurance (TDI) within three days of receipt of the information. If the Member does not sign the request for IRO, no medical records can be released.

DO NOT SEND REQUESTS FOR IRO DIRECTLY TO TDI.

g. Preferred Administrators will provide all necessary documents and information to be considered to TDI by fax within three days of receipt of the information. TDI assign IRO Preferred Administrators will provide a list of each physician or other health care provider who have provided care to the enrollee and that may have medical records relevant to the appeal.

h. The IRO will review the documentation and information submitted. The IRO will provide a final external review decision within twenty days of receipt of an IRO request.

i. Immediate appeal to an IRO can be made in circumstances involving a Member's life threatening condition and will not be required to comply with procedures for an internal review of the utilization review agent's adverse determination.

j. For life threatening cases, the IRO will complete the review within four business days or less and notify the Member or the Member's representative orally, followed by a written notification within forty-eight hours of the oral notification.

7. **Expedited Appeal for an Adverse Determination.**

a. The Member or their representative may request an expedited appeal for denial of emergency care or continued hospitalization. The expedited appeal must be made in writing. The process for requesting an expedited appeal of an adverse determination will be made by a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, who is neither an individual who was consulted in connection with the previous medical determination nor the subordinate of any such individual.

b. The Member or their representative may request an expedited appeal if:

1) The adverse determination involves a medical condition of the Member for which the timeframe for completion of a standard internal appeal would seriously jeopardize the life or health of the Member, or would jeopardize the Member's ability to regain maximum function; or

2) The Member has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the claimant or would jeopardize the Member's ability to regain maximum function, or if the final internal determination concerns an admission, availability of care, continued stay or health care service for which the Member received emergency services, but has not been discharged from a facility.

c. Appeals involving benefits exclusions such as experimental, investigational or non-covered benefits will not be eligible for this review.

d. **Timeframe for Resolution of Expedited Appeal.** Resolution of an expedited appeal will be based on the medical immediacy of the condition, procedure, or treatment under review, provided that the resolution to the appeal does not exceed one (1) working day from the date all the information necessary to complete the appeal is received, but not later than seventy-two (72) hours from receipt of request. An expedited appeal determination may be provided by telephone or electronic transmission and will be followed with a letter, by mail, within three (3) calendar days of the initial telephonic or electronic notification.

8. **Determination of Appeal.**

a. If the final determination of the appeal is adverse to the Member and is upheld, Preferred Administrators will recover such costs.

b. If the determination of the appeal is reversed, Preferred Administrators will provide coverage or payment for the claim without delay, regardless of whether the plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

c. A copy of the resolution letter will be mailed to Member, a person acting on the behalf of the Member, a Member's provider of record, and the health care provider or facility who rendered the Member's services, if different from the attending physician.

9. **IMPORTANT TIMEFRAMES TO REMEMBER**

a. A determination for a requested service will be made within three (3) working days of receipt of information. Determination of the medical necessity will be made based on the information submitted for review. No additional information will be requested.

b. If services are considered not medically necessary or appropriate, the Member may appeal the decision within thirty (30) days of receipt of the Notice of Adverse Determination.

c. A letter of acknowledgement will be issued within five (5) days of receipt of the appeal.

d. The appeal will be reviewed within a reasonable period of time appropriate to the medical circumstances, but not later than thirty (30) days after receipt of the appeal.

e. The Member or their Legal Representative may request an external appeal within four (4) months of receipt of resolution letter excluding holidays and weekends.

f. Upon receipt of request for external review, Preferred Administrators will review the documentation to determine if the request meets the criteria for external review; and will submit the documentation to TDI as soon as possible, but not later than three (3) working days after receipt of the request for external review.

g. The IRO has twenty (20) days to make a decision for non-life threatening cases and four (4) days to make a decision for life threatening cases. The IRO will notify the Member, a person acting on the behalf of the Member, a Member's provider of record, and the health care provider or facility who rendered the Member's services, if different from the attending physician of its decision.

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 Covered Participant to benefits available under any Welfare Program.

10.02 Exclusive Benefit

This Plan has been established for the exclusive benefit of Covered Participants 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 Covered Participant 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

The Plan is governed by the Code. In no event shall the Employer guarantee the favorable tax treatment sought by this Plan. 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 Right to Recovery

In accordance with section 8.06B, whenever payments have been made by this Plan with respect to Allowable Expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this Article, the Plan shall have the right to recover such payments, to the extent of such excess, from any one or more of the following as this Plan shall determine: any person to or with respect to whom such payments were made, or such person's legal representative, any insurance companies, or any other individuals or organizations which the Plan determines are responsible for payment of such Allowable Expenses, and any future benefits payable to the Participant or his or her Dependents. Please see 8.06B above for more details.

ARTICLE XI
SUBROGATION, REIMBURSEMENT, AND THIRD PARTY RECOVERY PROVISION

11.01 Payment Condition

1. The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an injury, sickness, disease or disability is caused in whole or in part by, or results from the acts or omissions of Plan Participants, Plan Participants, and/or their dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Plan Participant(s)") or a third party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or grantor(s) of a third party (collectively "Coverage").
2. Plan Participant(s), his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain one hundred percent (100%) of the Plan's conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. By accepting benefits the Plan Participant(s) agrees the Plan shall have an equitable lien on any funds received by the Plan Participant(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Plan Participant(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts.
3. In the event a Plan Participant(s) settles, recovers, or is reimbursed by any Coverage, the Plan Participant(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Plan Participant(s). If the Plan Participant(s) fails to reimburse the Plan out of any judgment or settlement received, the Plan Participant(s) will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money.
4. If there is more than one party responsible for charges paid by the Plan, or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Plan Participant(s) is/are only one or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the Plan may seek reimbursement.

11.02 Subrogation

1. As a condition to participating in and receiving benefits under this Plan, the Plan Participant(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 Plan Participant(s) is entitled, regardless of how classified or characterized, at the Plan's discretion.
2. If a Plan Participant(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Plan Participant(s) may have against any Coverage and/or party causing the sickness or injury to the extent of such conditional payment by the Plan plus reasonable costs of collection.

3. The Plan may, at its discretion, in its own name or in the name of the Plan Participant(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.
4. If the Plan Participant(s) fails to file a claim or pursue damages against:
   (a) the responsible party, its insurer, or any other source on behalf of that party;
   (b) any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
   (c) any policy of insurance from any insurance company or guarantor of a third party;
   (d) worker's compensation or other liability insurance company; or,
   (e) any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage; the Plan Participant(s) authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Plan Participant(s)' and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Plan Participant(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 <u>Right of Reimbursement</u>

1. The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, without regard to whether the Plan Participant(s) is fully compensated by his/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. If the Plan Participant(s)' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved.
2. 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, expressed written consent of the Plan.
3. 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 Plan Participant(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.
4. 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 Plan Participant(s).
5. 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 sickness, injury, disease or disability.

11.04 Excess Insurance

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

   The Plan's benefits shall be excess to:

   (a) the responsible party, its insurer, or any other source on behalf of that party;
   (b) any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
   (c) any policy of insurance from any insurance company or guarantor of a third party;
   (d) workers' compensation or other liability insurance company; or
   (e) any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

11.05 Separation of Funds

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

11.06 Wrongful Death

1. In the event that the Plan Participant(s) dies as a result of his or her injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply, and the entity pursuing said claim shall honor and enforce these Plan rights and terms by which benefits are paid on behalf of the Plan Participant(s) and all others that benefit from such payment.

11.07 Obligations

1. It is the Plan Participant(s)' obligation at all times, both prior to and after payment of medical benefits by the Plan:

   (a) to cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights;
   (b) to provide the Plan with pertinent information regarding the sickness, disease, disability, or injury, including accident reports, settlement information and any other requested additional information;
   (c) to take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;
   (d) to do nothing to prejudice the Plan's rights of subrogation and reimbursement;
   (e) to promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received; and
   (f) to not settle or release, without the prior consent of the Plan, any claim to the extent that the Plan Participant may have against any responsible party or Coverage.

2. If the Plan Participant(s) and/or his or her attorney fails to reimburse the Plan for all benefits paid or to be paid, as a result of said injury or condition, out of any proceeds, judgment or settlement received, the Plan Participant(s) will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Plan Participant(s).
3. The Plan's rights to reimbursement and/or subrogation are in no way dependant upon the Plan Participant(s)' cooperation or adherence to these terms.

11.08 Offset

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

11.09 Minor Status

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

11.10 Language Interpretation

1. 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.

11.11 Severability

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

ARTICLE 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 Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage. The Plan's benefits will be excess to, whenever possible:

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

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. This applies to all forms of medical payments under vehicle plans and/or policies regardless of its name, title or classification.

12.04 Allowable Expenses

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

12.05 Claim Determination Period

"Claim Determination Period" shall mean each calendar year.

12.06 Effect on Benefits

A. **Application to Benefit Determinations**

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

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

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

1. The Other Plan would, according to its rules, determine its benefits after the benefits of this Plan have been determined; and
2. The rules in the section entitled "Order of Benefit Determination" would require this Plan to determine its benefits before the Other Plan.

B. **Order of Benefit Determination**

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

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

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

4. When the rules above do not establish an order of benefit determination, the benefits of a plan which has covered the person on whose expenses claim is based for the longer period of time shall be determined before the benefits of a plan which has covered such person the shorter period of time.

12.07 <u>Right to Receive and Release Necessary Information</u>

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.

12.08 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.

12.09 Right of Recovery

In accordance with section 8.06B, whenever payments have been made by this Plan with respect to Allowable Expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this Article, the Plan shall have the right to recover such payments, to the extent of such excess, from any one or more of the following as this Plan shall determine: any person to or with respect to whom such payments were made, or such person's legal representative, any insurance companies, or any other individuals or organizations which the Plan determines are responsible for payment of such Allowable Expenses, and any future benefits payable to the Participant or his or her Dependents. Please see 8.06B above for more details.

12.10 Coordination with Medicare

If an active Associate covered by the Plan is age 65 or older and has Medicare Part A, the Plan is the primary payer, and Medicare is the secondary payer of benefits provided under both the Plan and Medicare Part A or B. The same applies to a Spouse if the Spouse of an active Associate is age 65 or over and has Medicare Part A, or if the Spouse is employed and is age 65 or over and has Medicare Part A.

When a Covered Participant is eligible for Medicare, Medicare will pay primary or secondary to the extent stated in federal law. When Medicare is the primary payer, the Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B, regardless of whether the person was enrolled under both parts.

12.11 Pharmacy of Coordination of Benefits

OptumRx administers the prescription drug benefit offered to you by Preferred Administrators. A Direct Member Reimbursement form will need to be filled out by any Associate, Dependent, or Spouse. The form must be submitted to OptumRx 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.

Direct Member Reimbursement forms are available at **OptumRx.com** or by calling us directly at **1-800-788-7871.** 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 Covered Participants who are receiving benefits or Covered Participants 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, Preferred Administrators 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, Preferred Administrators complied with the HITECH Privacy Act provisions. Effective September 1, 2012, Preferred Administrators 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 /SPI to the Plan Sponsor, or (b) provide for or permit the disclosure of /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' /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 /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' /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' /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' /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 /SPI.

The Plan Sponsor will not use or disclose individuals' /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 /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' /SPI/Disclosure by the Plan Sponsor

The Plan Sponsor will make the /SPI of the individual who is the subject of the /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' /SPI available for amendment and incorporate any amendments to individuals' /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' /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' /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' /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 /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 Employees, classes of Employees, or workforce members under the control of the Plan Sponsor who may be given access to individuals' /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 Employees, classes of Employees, or other workforce members of the Plan Sponsor who receive individuals' /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' /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' /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 Associates 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 Associates 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 Associates 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, Preferred Administrators complied with the HIPAA final rule ("Omnibus Rule").

NOTES

10/2014