

# Preferred ADMINISTRATORS

EI PASO CHILDREN'S HOSPITAL AND ITS AFFILIATES  
Associate Health Benefit Fund Plan

Si usted requiere este manual en Español por favor comuníquese con Preferred Administrators. Estamos disponibles de 7 de la mañana a 5 de la tarde de Lunes a Viernes. Nuestro teléfono es 915-532-3778, or gratis 1-877-532-3778 si llama de un área fuera de El Paso.

Effective February 5, 2012



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**EL PASO CHILDREN'S HOSPITAL  
EMPLOYEE HEALTH BENEFIT PLAN**

**PLAN PARTICIPANT RIGHTS AND RESPONSIBILITIES**

As an El Paso Children's Hospital Employee Health Benefit Plan Participant 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 contracted Preferred Administrators Network and have access to information about a particular provider's education, training and practice.
- Have your medical information kept confidential by the contracted Preferred Administrators employees and your health care provider.
- Learn about any care you receive. You should be asked for your consent for all care, unless there is an emergency and your life and health are in serious danger.
- Be heard. Our complaint-handling process is designed to hear and act on your complaint or concern about the contracted Preferred Administrators and/or the quality of service you receive.
- Preferred Administrators, the contracted claim administrator for our Plan 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 the El Paso Children's Hospital Employee Health Benefit Plan and the administrative services provided by 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 El Paso Children's Hospital Employee Health Benefit Plan ID Card with the Preferred Administrators information before you receive care.
- Establish 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.
- Notify your employer El Paso Children's Hospital Human Resources Department at **915-521-7067** about any changes in family size, address, phone number or membership status.



## **NOTICE TO PARTICIPANTS**

# **NOTICE TO PARTICIPANTS OF THE EL PASO CHILDREN'S HOSPITAL EMPLOYEE HEALTH BENEFIT PLAN**

Under a Federal law known as Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, as amended, group health plans must generally comply with the requirements listed below:

1. Special enrollment periods for individuals (and Dependents) losing other coverage (146.117).
2. Prohibitions against discriminating against individual participants and beneficiaries based on health status (146.121).
3. Standards relating to benefits for mothers and newborns (section 2704 of PHS Act).
4. Parity in the application of certain limits to mental health benefits (section 2705 of PHS Act).
5. Required coverage for reconstructive surgery following mastectomies (section 2706 of PHS Act).

### **COBRA NOTIFICATION PROCEDURES**

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

**Notice of Divorce or Legal Separation** – Notice of the occurrence of a Qualifying Event that is a divorce or legal separation of a covered Employee 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 either the covered Employee, a Qualified Beneficiary with respect to the Qualifying Event, or any representative acting on behalf of the covered Employee 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 or the Plan Sponsor's General COBRA Notice.

If an Employee 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 Employee 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 Employee 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:

**El Paso Children's Hospital**  
**Human Resources Department**  
4845 Alameda Avenue  
El Paso, TX 79905  
**(915) 521-7067**

### **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.

**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 El Paso Children's Hospital (the "Company" or the "Plan Sponsor") as of February 5, 2012.

**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.

**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.

**El Paso Children's Hospital**

By:   
Name: Lawrence G. Duncan  
Title: CEO

Date: 1-19-12

## ARTICLE II

# INTRODUCTION AND PURPOSE; GENERAL PLAN INFORMATION

### 2.01 Introduction and Purpose

The purpose of the Plan is to provide eligible and enrolled Employees 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 Employees with coverage options that provide benefits based on point of service decisions made by the Employee. When Employees 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 Employee. Because of the cost of medical care, Covered Employees 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 Employees when they select El Paso Children's Hospital or 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. Employees are mandated to participate in the Health Risk Assessment Program which is provided through El Paso Children's Hospital Wellness Program and to be active participants of healthy lifestyles and preventive health practices.

### 2.02 General Plan Information

<b>NAME OF PLAN:</b>	El Paso Children's Hospital Employee Health Benefit Plan Employee
<b>PLAN SPONSOR:</b>	El Paso Children's Hospital 4845 Alameda Avenue El Paso, TX 79905
<b>PLAN ADMINISTRATOR: (Named Fiduciary)</b>	El Paso Children's Hospital 4845 Alameda Avenue El Paso, TX 79905
<b>PLAN SPONSOR ID NO. (EIN):</b>	26-3075429
<b>SOURCE OF FUNDING:</b>	Partially Self-Funded with Medical Stop Loss
<b>APPLICABLE LAW:</b>	ERISA
<b>PLAN YEAR:</b>	October 1 through September 30
<b>PLAN NUMBER:</b>	501
<b>PLAN TYPE:</b>	Medical Prescription Drug
<b>THIRD PARTY ADMINISTRATOR:</b>	Preferred Administrators P.O. Box 971100 El Paso, TX 79997 Phone: (915) 532-3778 or (877) 532-3778 Fax: (915) 532-2877
<b>PARTICIPATING EMPLOYER(S):</b>	None

**AGENT FOR SERVICE OF PROCESS:** Kemp Smith  
221 N. Kansas, Suite 1700  
El Paso, TX 79901

**Legal Entity; Service of Process**

The Plan is a legal entity. Legal notice may be filed with, and legal process served upon, the Plan's agent, Kemp Smith and Associates.

**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 Employee. Nothing in this Plan Document shall be deemed to give any Employee the right to be retained in the service of the Company or to interfere with the right of the Company to discharge any Employee at any time; provided, however, that the foregoing shall not be deemed to modify the provisions of any collective bargaining agreements which may be entered into by the Company with the bargaining representatives of any Employees.

**Applicable Law**

The Plan is governed by the Employee Retirement Income and Security Act (ERISA) as amended. In no event shall the Employer guarantee the favorable tax treatment sought by this Plan.

**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). This is a new Plan. The effective date for this Plan is after the effective date of the PPACA. 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  
El Paso, TX 79925

For individual market policies and nonfederal 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](http://www.dol.gov/ebsa/healthreform) or the U.S. Department of Health and Human Services at [www.healthreform.gov](http://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](http://www.preferredadmin.net).

This Plan provides options for Employees to receive medical services from providers who have contracted with the provider networks contracted by the Plan. This Plan rewards Employees with increased benefit coverage amounts based on the providers selected as described in the Schedule of Benefits. The greatest benefit amounts are provided when Employees use El Paso Children's Hospital and 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) El Paso Children's Hospital and University Medical Center of El Paso and Texas Tech Physicians
- (2) Preferred Administrators Network in El Paso and other providers contracted by Preferred Administrators Network on behalf of this Plan

### **3.02 Wrap Network for Out-of-Area**

Benefits for services received out-of-area (outside El Paso County and the immediate surrounding areas where active Employees reside) will be provided as PPO benefits when one or more of the following criteria apply:

- (1) The Covered Employee 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 Employee or Covered Dependent resides or attends school, or
- (2) The Wrap Network for Out-of-Area/Non-Contracted Providers Covered Employee or Covered Dependent is traveling on vacation and requires urgent or emergency medical care while outside of El Paso County, or
- (3) The medical service required has been confirmed by the Medical Utilization Review program as not being provided / performed by a provider in El Paso County.

#### **Finding Providers:**

- (1) For El Paso Area Network Providers: [www.preferredadmin.net](http://www.preferredadmin.net) or call **915-532-3778**
- (2) For Texas True Choice Providers: [www.texastruechoice.com](http://www.texastruechoice.com) or call **1-800-683-4856**
- (3) For Beech Street Providers: [www.beechstreet.com](http://www.beechstreet.com) or call **1-800-432-1776**

Benefits will be paid at 60/40 in the event a Covered Employee elects to receive medical services from an Out-of-Area/Non-Contracted Provider without meeting the criteria as provided in number 1, 2, and 3 of the Schedule of Benefits. Please note the following for these services.

- Prior authorization must be obtained. Failure to obtain an authorization will result in a denial of benefits and you will be required to pay the entire bill .
- You will be required to satisfy a higher deductible and co-insurance.
- You may be required to pay the difference between the amounts the health care provider charges and the sum the PPO plan determines to be "reasonable charge" for the given medical service.

Benefits for medical services provided outside El Paso County (and the immediate surrounding areas where active Employees reside) will be based on the "PPO WRAP NETWORK" Schedule of Benefits unless the criteria listed above applies or the provider has entered a contract with Preferred

Administrators for the provision of medical services to the Employees covered by this Plan. Out-of-Area services provided by Providers contracted with the Texas True Choice and its affiliated networks will be covered according to the "PPO WRAP NETWORK" Schedule of Benefits.

Preferred Administrators Network physicians who provide services at El Paso Children's Hospital or University Medical Center of El Paso will have professional services paid at contracted rate. Member's responsibility will be at El Paso Children's Hospital or University Medical Center of El Paso/ Texas Tech benefit coverage level.

### **3.03 Utilization Review:**

**The Plan requires prior authorization through Preferred Administrators 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 denial of eligible benefit.**

#### **PRIOR AUTHORIZATION FOR OUTPATIENT PROCEDURES / DIAGNOSTIC TESTS / OTHER**

Prior authorization review is required for:

- 1) Behavioral Health (Initial evaluation does not require pre-authorization)
- 2) Chiropractic Services (Initial evaluation does not require pre-authorization)
- 3) Diagnostic Tests Related to Potential Organ Transplantation
- 4) Dialysis Services
- 5) Durable Medical Equipment (\$500.00 per line item). DME max allowable up to 12 months not to exceed purchase price.
- 6) Elective Admissions
- 7) Growth Hormones
- 8) Home Health Services (Initial evaluation does not require pre-authorization)
- 9) Inpatient Admissions
- 10) Laser Surgeries
- 11) Intense Allergy Desensitization
- 12) Non-Emergent Admission
- 13) Non-Emergency Medical Transportation
- 14) Obstetrical Ultrasounds (member is allowed four ultrasounds without obtaining pre-authorization)
- 15) Occupational Therapy (Initial evaluation does not require pre-authorization)
- 16) Oral, Injectable or IV Drug Administration over \$500. (This includes oral, injectable or IV provided in a physician's office)
- 17) Oral Surgery
- 18) Orthotics and Prosthetics (Adult and Children)
- 19) Outpatient Chemo-Therapy and Infusion
- 20) Out-of-Network/Non-Participating Facility, Provider or Vendor
- 21) Outpatient Procedures
- 22) Outpatient Surgery
- 23) PET Scans
- 24) Physical Therapy (Initial evaluation does not require pre-authorization)
- 25) Podiatry Services (Excluding debridement of nails, avulsion of nail plate, excision of nail and wedge excision of skin of nail)
- 26) Radiation Therapy
- 27) Sleep Studies
- 28) Specialty Medicine – (All specialty medicines require pre-authorization)  
Please go to [www.preferredadmin.net](http://www.preferredadmin.net) for a complete list of specialty medicines.
- 29) Speech Therapy (Initial evaluation does not require pre-authorization)
- 30) Synagis
- 31) Transplants
- 32) 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 Employee'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.

**NOTE:** Preauthorization is not a guarantee of eligibility for benefits or payment. Please refer to the covered benefits section.

## **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.

## **MATERNITY:**

Covered Employees are asked to contact the Preferred Administrators OB Unit at **915-532-3778** ext. 1500 to report a diagnosis of pregnancy as soon as the initial diagnosis is made by the physician. The OB Case Manager will ask for basic information such as the expected delivery date and the facility where the Employee anticipates delivery.

## **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 El Paso Children's Hospital Plan Participant you qualify for certain Case Management benefits determined to be necessary and appropriate at no charge to the Employee. Case Management services are provided through Preferred Administrators and will require full participation by the Employee.

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

- personal support to the Employee 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 Employee chooses not to accept recommendations presented by the Case Manager.

3.04 **Benefit Percentage, Deductibles and Limitations**

**BENEFIT PERCENTAGE, DEDUCTIBLES AND LIMITATIONS**

Benefit Description	EPCH & UMC, El Paso Children's Hospital & University Medical Center of El Paso	Preferred Texas Tech Provider	Wrap Network Network / PPO Benefit	Administrators Non-Contracted Providers
<b>BENEFIT PERCENTAGE or COINSURANCE PERCENTAGE (payable by the Plan)</b>				
Inpatient Hospital Admissions (per admission)	\$150 co-pay and 100% coverage once deductible is met	N/A	\$600 co-pay and 75% coverage once deductible is met	\$2000 co-pay and 60% coverage once deductible is met
Other Outpatient Surgery including Birthing Centers (unless specified otherwise)	\$60 co-pay and 100% coverage once deductible is met	N/A	\$200 co-pay and 75% coverage once deductible is met	\$1000 co-pay and 60% coverage once deductible is met
<p>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.</p> <p>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.</p> <p>PPO benefits will also be applied when using Out-of-Area Providers for:</p> <ul style="list-style-type: none"> <li>• Treatment for a sudden acute medical illness or injury that presents an urgent or emergency situation provided by Non-Network / Non-Contracted Providers;</li> <li>• Treatment by Out-of-Area / Non-Contracted emergency room physicians who staff an emergency room of an Out-of-Area / Non-Contracted hospital.</li> </ul> <p>• <b>SPECIAL NOTICE: Additional charges (Balance Billing) may be incurred when receiving services from Non-Contracted Providers.</b></p>				
<b>DEDUCTIBLE PER FISCAL YEAR</b> Per Covered Participant	\$100		\$1,000	\$1,500
Maximum Family Deductible Limit	\$300		\$3,000	\$4,500
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.				
<b>ANNUAL LIMIT</b> (Per Covered Participant)	combined medical and prescription drugs \$1,250,000			

Benefit Description	EPCH & UMC, El Paso Children's Hospital & University Medical Center of El Paso	Preferred Texas Tech Provider	Wrap Network Network / PPO Benefit	Administrators Non-Contracted Providers
<b>OUT-OF-POCKET MAXIMUM PER FISCAL YEAR</b> Per Covered Participant		N/A	\$4,000	Unlimited
Family Out-of-Pocket		N/A	\$12,000	Unlimited
<p>The Out-of-Pocket maximum does not include any applicable deductibles, co-pays, non-compliance penalties, and amounts in excess of allowable amounts or any non-Covered Expenses. After the Out-of-Pocket maximum has been reached, the Plan pays 100% of Covered Expenses incurred for the individual in the balance of the Fiscal Year (excluding deductibles, co-pays, non-compliance penalties, and Non-Covered Expenses).</p> <p>When the Out-of-Pocket limit is reached, the reimbursement percentage rate is increased to 100% for the balance of the Fiscal Year for covered medical charges as limited by any maximum benefit amounts.</p> <p>The Out-of-Pocket Maximum does not apply to , Prescription Drug deductibles and co-pays, Durable Medical Equipment, Orthotic Devices, Emergency Room Co-pays, and Bereavement Benefits. Out-of-Area services will not apply.</p>				

### 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 review. 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 Reasonable and/or Medically Necessary and/or Appropriate. 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 inappropriate or ineligible or 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 Calendar Year Maximum Benefit

The following calendar year maximums apply to each Employee:

CALENDAR YEAR MAXIMUM BENEFITS FOR:	
All Essential Health Benefits	[no less than \$1,250,000 for plan years beginning on or after 09/23/11, but before 09/23/12]

### 3.07 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	EPCH & UMC, El Paso Children's Hospital & University Medical Center of El Paso	Preferred Texas Tech Provider	Wrap Network Network / PPO Benefit	Administrators Non-Contracted Providers
<b>ALLERGY TESTING AND INJECTIONS</b>				
Allergy Testing and Injections	100% after deductible	100% after deductible	75% after deductible	60% after deductible
Allergy Serum Vials Dispensed in a Physician's Office	100% after deductible	100% after deductible	75% after deductible	60% after deductible
Allergy Serum Vials Dispensed by a Pharmacist	Covered as a Prescription Drug			
<b>AMBULANCE (AIR AND GROUND)</b>				
Ambulance	N/A	N/A	75%	75%
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.				
<b>DIAGNOSTIC X-RAY, PATHOLOGY AND LABORATORY SERVICES</b>				
Radiology, Pathology, and Laboratory Benefits	inpatient or outpatient 100% after deductible	inpatient or outpatient 100% after deductible	inpatient or outpatient 75% after deductible	inpatient or outpatient 60% after deductible
<b>DURABLE MEDICAL EQUIPMENT</b>				
Hospital Inpatient / Outpatient or Other Medical / DME Provider	N/A	100% after deductible	75% after deductible	60% after deductible
<b>EMERGENCY ROOM</b>				
Per Visit for sudden acute Medical illness or injury	100% after \$50 co-pay	N/A	100% of Usual and Customary \$50 co-pay	100% of Usual and Customary \$50 co-pay
Charges for Observation Up to 23 hours	100% after \$50 co-pay	N/A	100% of Usual and Customary \$50 co-pay	100% of Usual and Customary \$50 co-pay
Emergency Room Co-pay waived if admitted. Co-pay will not apply to the Out-of-Pocket Maximum.				
<b>NOTE:</b> If you receive service at a PPO 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.				

Benefit Description	EPCH & UMC, <i>El Paso Children's Hospital &amp; University Medical Center of El Paso</i>	Preferred Texas Tech Provider	Wrap Network Network / PPO Benefit	Administrators Non-Contracted Providers
<b>HOME HEALTH CARE</b>				
Benefit	N/A	N/A	75% after deductible	60% after deductible
Maximum Benefits	N/A	N/A	120 visits per Fiscal Year (Includes Skilled Nursing)	60 visits per Fiscal Year (Includes Skilled Nursing)
<b>HOSPICE CARE</b>				
Benefit	100%	100%	75%	60% after Deductible
Maximum visits per Fiscal Year	180			
<b>HOSPITAL SERVICES</b>				
Hospital Charges – Inpatient Admissions (Medical and Surgical)	\$150 co-pay 100% inpatient after deductible	N/A	\$600 co-pay 75% after deductible	\$2000 co-pay 60% after deductible
Hospital Charges – Outpatient Services (Medical and Surgical)	\$60 co-pay 100% after deductible	N/A	\$200 co-pay 75% after deductible	\$1000 co-pay 60% after deductible
<b>HOSPITAL ROOM AND BOARD CHARGES</b>				
Room and Board Charges (Including Medically Necessary Private Room Isolation)	N/A		75% after deductible	60% after deductible
Intensive Care (Allowable Room Rate)	N/A		75% after deductible	60% after deductible
Private Room Charges for Hospitals with Private Rooms Only	N/A		75% after deductible	60% after deductible

Benefit Description	EPCH & UMC, El Paso Children's Hospital & University Medical Center of El Paso	Preferred Texas Tech Provider	Wrap Network Network / PPO Benefit	Administrators Non-Contracted Providers
<b>BEHAVIORAL HEALTH MENTAL AND SUBSTANCE ABUSE</b>				
<b>Crisis Hotline – 866-804-8873</b> Preferred Administrators provides a crisis hotline that offers immediate support for employees who are experiencing emotional and behavioral distress.				
Outpatient Office Visit	N/A	\$20 co-pay	\$30 co-pay deductible	60% after
Intensive Outpatient Visit	N/A	N/A	\$30 co-pay deductible	60% after
Psychiatric Day Treatment	N/A	N/A	\$30 co-pay deductible	60% after
Partial Hospitalization	N/A	N/A	75% after deductible	60% after deductible
Inpatient Behavioral Admission	N/A	N/A	\$600 co-pay 75% after deductible	\$2000 co-pay 60% after deductible
Inpatient Substance Abuse Admission	N/A	N/A	\$600 co-pay 75% after deductible	\$2000 co-pay 60% 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%, 75% or 60% 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	75% after deductible	60% after deductible
<b>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.</b>				
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.				
<b>NUTRITIONAL COUNSELING by A Registered Dietitian or Nutritionist</b>				
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, page 21.			Not Covered	
<b>OCCUPATIONAL THERAPY — Non-Workers' Compensation</b>				
Outpatient	100% after deductible	100% after deductible	75% after deductible	60% after deductible
Maximum Benefit per Fiscal Year	\$5,000			

Benefit Description	EPCH & UMC, El Paso Children's Hospital & University Medical Center of El Paso	Preferred Texas Tech Provider	Wrap Network Network / PPO Benefit	Administrators Non-Contracted Providers
<b>OFFICE VISITS</b>				
Physician, Nurse Practitioner, or Certified Nurse Midwife	\$10 co-pay	\$20 co-pay	\$30 co-pay	60% after deductible
Covered Expenses During Office Visit (Lab, X-Ray)	100% after deductible	100% after deductible	75% after deductible	60% 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%, 75% or 60% Benefit Percentage according to the network / Out-of-Area / contracted status of the service provider.				
<b>ORGAN TRANSPLANTS</b>				
Organ Transplant services are provided through the transplant network or contracted transplant facility approved by the Plan Administrator and stop loss carrier.				
<b>ORTHOTICS</b>				
Benefits	100% after deductible	100% after deductible	75% after deductible	None
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.				
<b>PHYSICAL THERAPY</b>				
Outpatient therapy performed by a licensed therapist or Physician	100% after deductible	100% after deductible	75% after deductible	60% after deductible
Maximum Benefit per Fiscal Year	\$8,000			
<b>PREGNANCY EXPENSES</b>				
Covered Employees and Spouses	Same as any other Illness			
Covered Dependent Daughters	Same as any other Illness (Inpatient/Non-Emergent will require Prior Authorization if dependent resides in or outside of El Paso County. Services will be covered at PPO Benefit if Prior Authorization is obtained. Services will be denied if no authorization is obtained).			
<b>PRESCRIPTION DRUGS</b>				
Co-Payments	<b>University Medical Center of El Paso Pharmacies</b> \$5 Generic \$25 Brand \$50 Non-Formulary		<b>All Network Pharmacies</b> \$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	<b>University Medical Center of El Paso Pharmacies Only</b> A 90 day supply (after prescription deductible) \$5 Generic \$25 Brand \$50 Non-Formulary			
<i>continued on next page</i>				



Benefit Description	EPCH & UMC, El Paso Children's Hospital & University Medical Center of El Paso	Preferred Texas Tech Provider	Wrap Network Network / PPO Benefit	Administrators Non-Contracted Providers
<b>PRESCRIPTION DRUGS – continued</b>				
Specialty Drug Medication	<b>University Medical Center of El Paso Pharmacies Only or mail order</b> \$50 Co-pay and will be dispensed at 30 day supply. Please go to <a href="http://www.preferredadmin.net">www.preferredadmin.net</a> for a complete list of specialty medicines.			
Prescriptions over \$500 *Authorization Required	Co-pay applies.	All Network Pharmacies 60% after prescription drug deductible.		
<p><b>Examples of Covered Drugs</b></p> <ul style="list-style-type: none"> <li>• Adderall, Dexedrine, and Dextrostat</li> <li>• Drugs requiring a prescription under the applicable state law</li> <li>• Federal legend prescription drugs</li> <li>• Injectable insulin, insulin syringes, chemstrips, and blood lancets</li> <li>• Injectables (other than insulin)</li> <li>• I.V. medications prescribed by a licensed physician and dispensed by a licensed pharmacist</li> <li>• Non-insulin needles/syringes</li> <li>• Oral and injectable contraceptives</li> <li>• Prescription pre-natal vitamins</li> </ul> <p><b>Examples of Excluded Drugs</b></p> <ul style="list-style-type: none"> <li>• Anabolic steroids</li> <li>• Anorectics (any drug used for the purpose of weight loss)</li> <li>• Anorexiant (except for Adderall, Dexedrine, and Dextrostat )</li> <li>• Cosmetics</li> <li>• Fertility medications</li> <li>• Fluoride supplements</li> <li>• Investigational or experimental drugs including compounded medications for non-FDA approved use</li> <li>• Out dated drugs or medicines (dispensed more than a year after the date of the Prescription)</li> <li>• Medical devices and other supplies (example Diabetes blood level monitor is covered under \ the Plan)</li> <li>• Non-legend drugs other than insulin</li> <li>• No charge prescription under Workers' Compensation, or other governmental program</li> <li>• Rogaine</li> <li>• Viagra and similar drugs</li> <li>• Vitamins other than prescription pre-natal vitamins</li> </ul>				
<b>REHABILITATION (PHYSICAL) FACILITIES</b>				
In/Outpatient Services	100% after deductible		75% after deductible	60% after deductible
Covered Expenses During Rehab Stay (Lab, X-Ray)	100% after deductible	100% after deductible	75% after deductible	60% after deductible
<b>SKILLED NURSING FACILITIES</b>				
Benefit	N/A	N/A	75% after deductible	60% 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.				

Benefit Description	EPCH & UMC, El Paso Children's Hospital & University Medical Center of El Paso	Preferred Texas Tech Provider	Wrap Network Network / PPO Benefit	Administrators Non-Contracted Providers
<b>SPEECH THERAPY</b>				
Benefit	100% after deductible	100% after deductible	75% after deductible	60% after deductible
Maximum Benefit per Fiscal Year	\$5,000 – Subject to certain other limitations			
<b>SPINAL ADJUSTMENT/CHIROPRACTIC ADJUSTMENT</b>				
Office Visit	N/A	\$20 co-pay	\$30 co-pay deductible	60% after
Covered Expenses During Office Visit (Lab, X-Ray)	N/A	100% after deductible	75% after deductible	60% after deductible
Maximum Benefit per Fiscal Year	\$2,500			
Co-pay provides for the office visit/consultation only. All other Covered Expenses provided during an office visit are covered at a 100%, 75% or 60% Benefit Percentage according to the network / Out-of-Area / contracted status of the service provider.				
<b>SURGICAL EXPENSES</b>				
Anesthesiology	inpatient or outpatient 100% after deductible	inpatient or outpatient 100% after deductible	inpatient or outpatient 75% after deductible	inpatient or outpatient 60% after deductible
Primary Surgeon	inpatient or outpatient 100% after deductible	inpatient or outpatient 100% after deductible	inpatient or outpatient 75% after deductible	inpatient or outpatient 60% after deductible
Pathology and Radiology	inpatient or outpatient 100% after deductible	inpatient or outpatient 100% after deductible	inpatient or outpatient 75% after deductible	inpatient or outpatient 60% after deductible
<b>URGENT CARE/WALK-IN CLINICS</b>				
Urgent Care Services – after hours and weekend medical services for non emergency illnesses and minor injuries.	\$10 co-pay	\$20 co-pay	\$30 co-pay	60% after deductible
<b>WELLNESS BENEFITS</b>				
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
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 List, page 21. <b>NOTE:</b> These services come with specific Guidelines (e.g., frequency). <i>continued on next page</i>				Not Covered

Benefit Description	EPCH & UMC, El Paso Children's Hospital & University Medical Center of El Paso	Preferred Texas Tech Provider	Wrap Network Network / PPO Benefit	Administrators Non-Contracted Providers
<b>WELLNESS BENEFITS – continued</b>				
Mammogram – Covered at 100% for women ages 40 and older. One per Fiscal Year.	100%	100%	75% after deductible	Not Covered
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
<b>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.</b>				
Well Baby and Well Child Preventative Care and annual physical exams and routine immunizations for covered participants under 18 years of age.	100%	100%	100%	Not Covered
All Immunizations required by the Centers for Disease Control and Prevention (CDC) are covered.				
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

<b>Abdominal aortic aneurysm screening: men</b> – Recommends one-time screening for abdominal aortic aneurysm by ultrasonography in men aged 65 to 75 who have ever smoked.
<b>Alcohol misuse counseling</b> – Recommends screening and behavioral counseling interventions to reduce alcohol misuse by adults, including pregnant women, in primary care settings.
<b>Anemia screening: pregnant women</b> – Recommends routine screening for iron deficiency anemia in asymptomatic pregnant women.
<b>Aspirin to prevent CVD: men</b> – 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.
<b>Aspirin to prevent CVD: women</b> – 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.
<b>Bacteriuria screening: pregnant women</b> – 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.
<b>Blood pressure screening</b> – Recommends screening for high blood pressure in adults aged 18 and older.
<b>BRCA screening, counseling</b> – Recommends that women whose family history is employed with an increased risk for deleterious mutations in BRCA1 or BRCA2 genes be referred for genetic counseling and evaluation for BRCA testing.
<b>Breast cancer preventive medication</b> – 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.
<b>Breast cancer screening</b> – Recommends screening mammography for women, with or without clinical breast examination, every 1-2 years for women aged 40 and older.
<b>Breastfeeding counseling</b> – Recommends interventions during pregnancy and after birth to promote and support breastfeeding.
<b>Cervical cancer screening</b> – Strongly recommends screening for cervical cancer in women who have been sexually active and have a cervix.
<b>Chlamydia infection screening: non-pregnant women</b> – 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.
<b>Chlamydia infection screening: pregnant women</b> – 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.
<b>Cholesterol abnormalities screening: men 35 and older</b> – The USPSTF strongly recommends screening men aged 35 and older for lipid disorders.
<b>Cholesterol abnormalities screening: men younger than 35</b> – Recommends screening men aged 20 to 35 for lipid disorders if they are at increased risk for coronary heart disease.
<b>Cholesterol abnormalities screening: women 45 and older</b> – Strongly recommends screening women aged 45 and older for lipid disorders if they are at increased risk for coronary heart disease.
<b>Cholesterol abnormalities screening: women younger than 45</b> – Recommends screening women aged 20 to 45 for lipid disorders if they are at increased risk for coronary heart disease.
<b>Colorectal cancer screening</b> – 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.

<b>Dental cares chemoprevention: preschool children</b> – 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.
<b>Depression screening: adolescents</b> – 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.
<b>Depression screening: adults</b> – Recommends screening adults for depression when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment, and follow-up.
<b>Diabetes screening</b> – Recommends screening for type 2 diabetes in asymptomatic adults with sustained blood pressure (either treated or untreated) greater than 135/80 mm Hg.
<b>Folic acid supplementation</b> – 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.
<b>Gonorrhea prophylactic medication: newborns</b> – Strongly recommends prophylactic ocular topical medication for all newborns against gonococcal ophthalmia neonatorum.
<b>Gonorrhea screening: women</b> – 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).
<b>Healthy diet counseling</b> – 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.
<b>Hearing loss screening: newborns</b> – Recommends screening for hearing loss in all newborn infants.
<b>Hemoglobinopathies screening: newborns</b> – Recommends screening for sickle cell disease in newborns.
<b>Hepatitis B screening: pregnant women</b> – The USPSTF strongly recommends screening for hepatitis B virus infection in pregnant women at their first prenatal visit.
<b>HIV screening</b> – Strongly recommends that clinicians screen for human immunodeficiency virus (HIV) all adolescents and adults at increased risk for HIV infection.
<b>Hypothyroidism screening: newborns</b> – Recommends screening for congenital hypothyroidism in newborns.
<b>Iron Supplementation in children</b> – Recommends routine iron supplementation for asymptomatic children aged 6 to 12 months who are at increased risk for iron deficiency anemia.
<b>Obesity screening and counseling: adults</b> – Recommends that clinicians screen all adult patients for obesity and offer intensive counseling and behavioral interventions to promote sustained weight loss for obese adults.
<b>Obesity screening and counseling: children</b> – 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.
<b>Osteoporosis screening: women</b> – 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.
<b>PKU screening: newborns</b> – Recommends screening for phenylketonuria (PKU) in newborns.
<b>Rh incompatibility screening: first pregnancy visit</b> – Strongly recommends Rd (D) blood typing and antibody testing for all pregnant women during their first visit for pregnancy-related care.
<b>Rh incompatibility screening: 24-28 weeks gestation</b> – 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.

## 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 Employee 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 Preferred Administrators to act within the described timeframes
  - (2) The denial in whole or in part of payment for service
  - (3) Dispute of a claim denial for a non-covered benefit
  - (4) Reimbursement dispute
  - (5) Claims Coding dispute
- 4.05 **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 experimental or investigational or 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.*
- 4.06 **Adverse Determination** – the formal process by which Provider, a Member or their legal representative requests a review of any of the below Preferred Administrator's actions requiring medical interpretation:
- (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
- 4.07 **Affiliates** means El Paso Children's Hospital , 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.
- 4.08 **AHA** shall mean the American Hospital Association.
- 4.09 **Allowable Expense** All medically necessary, customary, and reasonable health care services that are to be provided pursuant to this Benefit Plan "Covered Services".

- 4.10 **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.
- 4.11 **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.
- 4.12 **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.
- 4.13 **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.
- 4.14 **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.
- 4.15 **Benefit Percentage** means the portion of eligible expenses payable by the Plan in accordance with the coverage provisions as stated in the Plan.
- 4.16 **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 Chief Nursing Officer, Chief Financial Officer and the Human Resources Manager.
- 4.17 **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.
- 4.18 **Centers of Excellence** means transplant centers with proven credentials and outcome statistics.



**4.19 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.

**4.20 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) an individual incurring a claim that would meet or exceed a lifetime limit on all benefits (the special enrollment right begins when a claim that would exceed a lifetime limit on all benefits is incurred and continues until at least 31 days after the earliest date that a claim is denied due to the operation of the lifetime limit); or
- (t) a plan no longer offering any benefits to a class of similarly situated individuals; or
- (u) cessation of employer contributions for the other health coverage; or
- (v) the exhausting of COBRA continuation coverage; or
- (w) any other event determined by the Plan Administrator to be a Change in Status or Coverage consistent with Code Section 125.

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

**4.22** 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.

**4.23** 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.

**4.24** 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 or medical appropriateness 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.

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

**4.26** Complaint Any dissatisfaction, expressed by a complainant, orally or in writing to Preferred Administrators with any aspect of Preferred Administrators 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.

- 4.27 **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.
- 4.28 **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.
- 4.29 **Coverage Date** means the date an Employee or Dependent has met all of the eligibility requirements for coverage.
- 4.30 **Covered Expenses** means a Usual and Customary fee for a Reasonable, Medically Necessary and Medically Appropriate 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.
- 4.31 **Covered Participant** means any Employee and/or Dependent covered under this Plan.
- 4.32 **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).
- 4.33 **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.

- 4.34** **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 Employee and each of the Employee'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 Employee and each of the Employee's Dependents, subject to the family deductible limit.
- 4.35** **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.
- 4.36** **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 Employee. 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 Employee 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 Employee's Dependent Child or Children, for coverage under the medical plan only, the Employee'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) Age 26 does not apply if the adult child is eligible for other employer sponsored health plan coverage until 2014.
- 4.37** **Domestic Partner** is a person of the same or opposite sex (gender) who has the same principal place of residence as the employee and both the employee and domestic partner meet the following requirements:
- (a) Both are at least 18 years of age; and
  - (b) Have lived with each other continuously for at least one (1) year and will continue to live together throughout the entire period of benefit coverage; and
  - (c) Have a serious, committed, and exclusive relationship with each other and intend for the relationship to be permanent; and

- (d) Neither is legally married to any other individuals and if previously married, a legal divorce or annulment has been obtained or the former spouse is deceased and neither is considered the domestic partner of anyone else; and
- (e) Are not related to each other in any way that would bar marriage under state law if able to satisfy the other applicable marriage requirements; and
- (f) Are both mentally competent to enter into a contract according to state law; and
- (g) Are not in the relationship solely for the purpose of obtaining benefits; and
- (h) Are jointly financially responsible for "basic" living expenses defined as the cost of food, shelter, and other expenses of a domestic partner because of the domestic partnership.

**4.38 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.

**4.39 Effective Date** means February 5, 2012 and the dates of subsequent amendments and restatements.

**4.40 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.

**4.41 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.

**4.42 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.

**4.43** **Employee** 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/her customary duties at the Employer's facility or other location designated by the Employer. Employee 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.

**4.44** **Employer** means El Paso Children's Hospital

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

**4.46** **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 rerehabilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

**4.47** **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.

- 4.48** **FMLA** means the Family and Medical Leave Act of 1993, as amended.
- 4.49** **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.
- 4.50** **GINA** shall mean the Genetic Information Nondiscrimination Act of 2008 (Public Law No. 110-233), which prohibits group health plans, issuers of individual health care policies, and employers from discriminating on the basis of genetic information.
- 4.51** **Health Care Spending Account** means the Health Care Spending Account under the El Paso Children's Hospital Section 125 Cafeteria Plan, or any subsequent cafeteria plan maintained by the Employer.
- 4.52** **Health Risk Assessment (HRA)** means the El Paso Children's Hospital annual program which evaluates an Employee's overall health condition through a series of questionnaires, lab work, fitness testing, etc.
- 4.53** **HIPAA** means the Health Insurance Portability and Accountability Act of 1996, as amended.
- 4.54** **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 employed 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.
- 4.55** **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.

- 4.56 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.
- 4.57 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.
- 4.58 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).
- 4.59 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.
- 4.60 Injury** A condition caused by accidental means that result in damage to the Covered Person's body from an external force.
- 4.61 Illness** means a bodily disorder, disease, physical or mental sickness, functional nervous disorder, pregnancy or complication of pregnancy. The term Illness when used in connection with a newborn Dependent Child includes, but is not limited to, congenital defects and birth abnormalities, including premature birth.
- 4.62 In-Network** means El Paso Children's Hospital, University Medical Center of El Paso, Texas Tech providers, and the medical providers contracted by Preferred Administrators Network/ PPO and Wrap Network.
- 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 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.



- 4.65 **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.
- 4.66 **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.
- 4.67 **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.
- 4.68 **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.
- 4.69 **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.
- 4.70 **Late Entrant** means an individual who enrolls other than during the initial enrollment period or a special enrollment period as provided under Article III.
- 4.71 **Lifetime** means while a person is covered under this Plan. Lifetime does not mean during the lifetime of the Covered Participant.
- 4.72 **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, Medically Appropriate 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.
- 4.73 **Maximum Benefit per Plan Year** means the maximum benefit payable for certain expenses during the Plan Year, which commences October 1 of each year.

- 4.74 **Medical Emergency** means a sudden 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.
- 4.75 **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 Sickness or Injury. Such services, to be considered Medically Necessary, must be clinically appropriate in terms of type, frequency, extent, site and duration for the diagnosis or treatment of the Covered Participant's Sickness 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 alternative interventions, including no intervention and are at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Covered Participant's Sickness 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.

- 4.76 **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.

- 4.77 **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.
- 4.78 **Medicare** means the program of medical care benefits provided under Title XVIII of the Social Security Act of 1965, as amended.
- 4.79 **Non-Preferred Provider** means a legally licensed health care Provider who has not entered into a contract with Preferred Administrators.
- 4.80 **Organ Transplant Services** means the services of a contracted network or contracted facility for the transplantation of human organs as described under Medical Benefits.
- 4.81 **Orthotic Device** means an apparatus used to support, align, prevent, or correct deformities, or to improve the function of movable parts of the body.
- 4.82 **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.
- 4.83 **Out-of-Area** means outside of El Paso County and the immediate surrounding areas (including Doña Ana County in southern New Mexico) where active Employees reside and may receive routine or other medical services.
- 4.84 **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 does not include deductibles, co-pays, 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.
- 4.85 **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.
- 4.86 **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.
- 4.87 **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.

- 4.88** **Plan** means the El Paso Children’s Hospital Employee Health Benefit Plan Employee as it may be amended from time to time.
- 4.89** **Plan Administrator** means the Plan Sponsor.
- 4.90** **Plan Sponsor** means El Paso Children’s Hospital.
- 4.91** **Plan Year** means the 12-month period starting on October 1 and ending September 30. For the inception and effective date of the Plan, the first Plan Year shall be the 8 month period of February 1, 2012 to September 30, 2012.
- 4.92** **Preferred Provider** means El Paso Children’s Hospital, University Medical Center of El Paso, Texas Tech Providers, and Providers contracted by El Paso First Health Plans, d.b.a. Preferred Administrators.
- 4.93** **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](http://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.
- 4.94** **Prior to Effective Date or After Termination Date** are dates occurring before a Participant gains eligibility from the Plan, or dates occurring after a Participant loses eligibility from the Plan, as well as charges incurred prior to the effective date of coverage under the Plan or after coverage is terminated, unless Extension of Benefits applies.
- 4.95** **Protected Health 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.
- 4.96** **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.
- 4.97** **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.

- 4.98 Qualified Dependent** means a Dependent who loses coverage under a Welfare Program due to a Qualifying Event.
- 4.99 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.
- 4.100 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.
- 4.101 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.
- 4.102 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.

- 4.103 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.
- 4.104 Specialty Medications** mean high-cost oral or injectable medications used to treat complex acute and / or 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.
- 4.105 Spouse** means the person recognized under Texas law as the covered Employee'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 Employee 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 party as being married and (3) living together. Requires Common Law Marriage Certificate from the County Clerk's Office.
- 4.106 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.
- 4.107 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.
- 4.108 Schedule of Medical Benefits** means the listing of Medical Benefits and description of the benefit levels provided in the Introduction.
- 4.109 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.
- 4.110 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.
- 4.112 Totally Disabled** means the complete inability of an Employee to substantially perform the important daily duties of the Employee's own occupation, for which the Employee 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.
- 4.113 USERRA** means the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended.
- 4.114 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.
- 4.115 Wrap Network** A group of doctors, hospitals and other health care providers contracted by Texas True Choice and Beechstreet 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) Employee Eligibility.

All full-time regular Employees (normally scheduled to work a minimum of 36 hours per week) and part-time regular Employees (normally scheduled to work a minimum of 20 hours per week) are eligible to participate in the Plan on the first of the month following 30 days of regular full-time or part-time employment. An Employee who is not Actively at Work for any reason other than medical disability will become eligible for coverage upon his/her return to work.

Employees who were specifically hired to work for EPCH prior to the opening date, February 5, 2012 and signed an EPCH offer/commitment letters shall continue benefit coverage with no break in coverage and service and are eligible for deductible credits.

Coverage under the Plan El Paso Children's Hospital 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.

Eligible expenses for registered same-sex domestic partners and their children may be covered under the flexible spending health care and dependent day care accounts if they meet the definition of dependents under IRS Section 152.

If an individual becomes an Employee 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 Employees 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 Employee covered as a participant may not also be covered as a Dependent under this Plan. If an Employee's Spouse is covered under this Plan as the Employee's Dependent, the Spouse cannot also be covered as an Employee. If both parents are Employees, 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 Employee, 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 Employee enrolls the child within 30 days of birth or adoption.
- (ii) Dependent coverage may continue under this Plan following an Employee's election of Medicare as primary. The Dependent will be treated in the same manner as if the Employee had remained on the Plan, as long as the Employee 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 Employee. A stepchild not living with the Employee 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 Employee and Dependent Child, if the Employee 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 Employee.

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

(c) Domestic Partner Eligibility.

The Domestic Partner of an Eligible Employee is eligible to participate in the Plan if he/she meets the definition of Domestic Partner and produces documentation\* of at least two of the following as evidence of our joint responsibilities and commitment to the Domestic Partnership (one of the two items must be from List A).

LIST A	LIST B
Joint Obligation on a loan (including an affidavit by a creditor on a personal loan)	Designated as the beneficiary under the others life insurance policy, retirement benefits account or will or executor of each other's will
Joint ownership of shared residence	Joint bank account
Joint responsibility for a child (eg. guardianship )	Joint credit card accounts
Joint ownership or holding of investments	Status as authorized signer on the partners bank account, credit card or debit or charge card
Joint ownership or lease of a motor vehicle	Other proof of financial interdependence
Both listed as tenants on the lease of a residence	
Mutually granted authority to make health care decisions (healthcare power of attorney)	
Mutually granted durable power of attorney	

\* All documents must be pre-dated by at least one year

1. Any dependent child(ren) of the covered employee's Domestic Partner will not be eligible for any coverage unless the child(ren) are also an eligible dependent child(ren) of the employee;
2. No employee who is eligible for the El Paso Children's Hospital Health Benefit Plan can be covered as a Domestic Partner of another employee who is also eligible for benefits;
3. Domestic Partner benefits may have federal and possibly state tax consequences;
4. If the Domestic Partnership no longer meets all of the criteria attested to in this Affidavit, a Notice of Termination of Domestic Partnership must be filed within thirty-one (31) days of such change, with the Human Resources department.

**5.02 Failure to Elect**

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,, he shall be deemed to have elected Employee Only Medical Coverage.

Effective for Plan Years on and after October 1, 2012 , 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 Employees will default to Employee Only Medical Coverage.

### 5.03 **Enrollment**

- (a) **Effective Date.** Each Employee on the Effective Date shall be eligible to participate in this Plan as of such date. Any new Employee shall participate effective as of the date coinciding with his eligibility for the Benefit Programs and be permitted to enroll in the Plan during the first 30 days of employment. Any reclassified Employee 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.
- (b) **Late Enrollment.** If enrollment is not requested within 30 consecutive days after satisfying the waiting period and becoming eligible to enroll in the Plan, then the Employee may only request enrollment for himself and/or his eligible Dependent(s) as a Late Enrollee.
- (c) **Loss of Other Coverage – Special Enrollment.** An Employee or Late Enrollee is eligible during a special enrollment period for an employee 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 employee 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 an individual incurring a claim that would meet or exceed a lifetime limit on all benefits (the special enrollment right begins when a claim that would exceed a lifetime limit on all benefits is incurred and continues until at least 30 days after the earliest date that a claim is denied due to the operation of the lifetime); 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 employee 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 Employee has a new Dependent due to marriage, birth, adoption, or Placement for Adoption, the Employee may enroll himself, his Spouse, and his new Dependent in the Plan. The Employee 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 Employee 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 Employee 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 Employee has experienced a significant change (increase in cost or significant curtailment of coverage) provided that the Employee 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 Employee 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, the Employee may elect COBRA at the COBRA premium rates.
- (b) Personal Leave Of Absence. If an Employee receives authorization for an educational or personal Leave of Absence coverage while:
  - (i) paid leave will continue at the Employee 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 Employee 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 Employee contribution rate (paid through either payroll deduction or on an after-tax basis). In lieu of this coverage, the Employee 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 30 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 Employee 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 Employees if they were on a leave of absence. This entitlement ends if the Employee provides written notice of intent not to return to work following the completion of the military leave. The Employee 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.

##### **A. DEFINITIONS**

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

1. **"Entitlement to Medicare" or "Entitled to Medicare"** means the covered employee has enrolled in either Medicare Part A or Part B.
2. **"Qualified Beneficiary"** means:
  - a. a covered employee, 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 employee's Qualifying Event occurred;
  - c. a child who is born to a covered employee, or placed with a covered employee for adoption, during a period of COBRA continuation coverage.
3. **"Qualifying Event"** for a covered employee 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 employee's termination of employment (for any reason other than gross misconduct) or reduction in hours of employment;
- b. a covered employee's death;
- c. a spouse's divorce or legal separation from a covered employee;
- d. a covered employee'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 employee 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 employee by delivery of the Summary Plan Description.

The Plan may notify a covered employee and the covered employee’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 employee’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 employee 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 employee’s death;
  - b. the covered employee’s termination (other than for gross misconduct) or reduction in hours;
  - c. for a covered dependent, the covered employee’s entitlement to Medicare.
2. the employee 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 employee;
    - 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 employee 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 employee'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 employee 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.

**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 employee 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 employee's death;
  - b. the covered employee's entitlement to Medicare;
  - c. a spouse's divorce or legal separation from a covered employee; 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 employee.
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. the date on which a Qualified Beneficiary first becomes (after the date of the election) covered under any other group health plan (as an employee or otherwise) which does not contain any exclusion or limitation.
9. the first day of the month in which a Qualified Beneficiary becomes entitled to Medicare.
10. the date this Plan terminates.

#### 5.06 Termination Of Coverage

- (a) An Employee'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 Employee ceases to meet the Plan's eligibility requirements;
  - (v) date all coverage or certain benefits are terminated for Employees 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 Employee becomes covered under another Group Health Plan as a Dependent; or
  - (viii) date the Employee'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 Employee terminates employment;
  - (iii) date an Employee 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 Employee; or
  - (viii) date the Employee's or Dependent's coverage terminates for any reason.

**5.07 Rehired Or Transferred Employees**

Rehired Employees. An Employee's or Dependent's coverage under the Plan that ends by reason of the Employee's termination of employment will become reinstated on the date the Employee resumes employment if such date is within the same Fiscal Year and is within 30 days immediately following the date of termination.

If an Employee is rehired after 30 days or in the following Fiscal Year, the employee will be treated as a new Employee (except in the case where COBRA has been elected and continued with no lapse in coverage).

**5.08 Participant Contributions**

Contribution requirements shall be determined on an annual basis and shall be communicated prior to the annual election period for the El Paso Children's Hospital Employee Health 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 and Appropriate;
- (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) **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).
- 6) **Birthing Center.** Care, treatment and services furnished by a birthing center (please rely on the advice of your Physician when considering a birthing center).
- 7) **Blood And Blood Derivatives.** Blood transfusion services, including the cost of whole blood or blood plasma not donated or replaced.
- 8) **Chemotherapy/Radiation Therapy.** Chemotherapy, radiation therapy, and treatment with radioactive substances; materials and services of a technician.

- 9) **Colorectal Cancer Screening (CRC).** Persons at risk for CRC (family history of CRC, previous adenomatous 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.
- 10) **Contact Lenses Or Eyeglasses.** Initial purchase of contact lenses or eyeglasses but not both if required following cataract surgery.
- 11) **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.
- 12) **Diabetic Education.** Participation in the University Medical Center of El Paso Diabetic Management Program will be provided at 100% or with a PPO Provider.
- 13) **Diagnostic X-Ray And Laboratory Services.** Diagnostic X-ray and laboratory examinations; services of a radiologist or pathologist.
- 14) **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.
- 15) **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 than to seek medical care that they cannot receive at home;
  2. When homebound patients leave home, it must take great and taxing effort and/or require maximum assistance. Patients may, however, leave home to attend adult day care programs that meet certain requirements and religious services and remain homebound.

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

supplies not included in the home health care plan; services of a person who ordinarily resides in the patient's home or is a member of the patient's family, or Dependents of the patient; transportation services; custodial care.

- 16) **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.
- 17) **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.
- 18) **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.
- 19) **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.
- 20) **Injectable And Intravenous Prescription Medications.** Covered Expenses as set forth in the Summary of Benefits under Prescription Drugs.
- 21) **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.
- 22) **Medical And Surgical Supplies.** Casts, splints, trusses, surgical dressings, and other devices used in the reduction of fractures and dislocations.
- 23) **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.

- 24) **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.
- 25) **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.
- 26) **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.
- 27) **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.
- 28) **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 hematopoietic 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 Employees last day of termination date. (If the transplant is a bone marrow transplant, the date the marrow is re-infused 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 the Plan Administrator
- 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 employeeed 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](http://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](http://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 the Plan Administrator.

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, per lifetime.

- 29) **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.
- 30) **Oxygen.** Oxygen or other gases and rental of equipment for its administration including IPPB (Intermittent Positive Pressure Breathing) equipment.
- 31) **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.
- 32) **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.



- 33) **Preadmission or Preoperative Testing.** Tests or exams relating to surgery for a Covered Participant who is scheduled for surgery.
- 34) **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
- 35) **Pregnancy Care.** Care and treatment for pregnancy and complications of pregnancy are covered on the same basis as for any other illness for a covered Employee, Spouse or dependent daughter.
- 36) **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.
- 37) **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.
- 38) **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.
- 39) **Routine Care.** Services as specified in the Summary of Benefits as well as gamma globulin injections.
- 40) **Skilled Nursing Facilities.** Services and supplies including room and board furnished by a skilled nursing facility.
- 41) **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.

- 42) **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.

Speech and Language impairments in children three to eight years as determined via standardized or non-standardized testing. Sessions for the above noted are to be forty five-sixty minutes in duration two-three times a week.

- 43) **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.
- 44) **Sterilization Procedures.** Voluntary sterilization procedures are covered on the same basis as for any other illness.
- 45) **Substance Abuse.** Services provided for treatment of substance abuse conditions.
- 46) **Temporomandibular Joint Dysfunction (TMJ).** Only open-cutting operations for treatment of TMJ are covered.
- 47) **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;
  - 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.
- 48) **Vaccinations.** Expenses for medically necessary vaccinations are covered the same as any other illness. Vaccinations for over-seas travel are not covered.
- 49) **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 services or treatment that are the result of complications that occur from services or treatments that are excluded from coverage by this Plan. This exclusion includes charges for complications resulting from any excluded services or procedures, including, but not limited to, any reversal procedure unless otherwise covered.

**Cosmetic Procedures.** Charges for cosmetic procedures or reconstructive surgery are not covered unless specifically covered under the terms of the Plan.

**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.

**Durable Medical Equipment.** Charges for purchase, or replacement of more than one item of Durable Medical Equipment or surgical equipment if it is for the same or similar purpose.

**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.

**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; transportation services; and custodial care.

**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 employee diagnostic testing), whether or not employee 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 rolling services and/or supplies.

**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 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 employee 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.

**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](http://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 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.

**Routine Care.** Charges for routine or preventive care, immunizations, or vaccinations except as otherwise specified in the Schedule of Benefits or for gamma globulin injections.

**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 or purpose of treatment is for discovery of infertility, is not a covered infertility treatment, 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
- 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. No coverage for therapy to correct pre-speech deficiencies or to improve speech skills that have not yet fully developed.

**TMJ.** Charges for treatment, other than by an open-cutting operation, of temporomandibular joint dysfunction.

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

**Vax-D Therapy.** For Vax-D therapy.

**Vision and Hearing.** Charges for:

- eye exercises
- visual training (orthoptics)
- routine examinations for the purpose of determining level of hearing or visual acuity
- hearing aids, eyeglasses or contact lenses (except the initial pair of contact lenses or eyeglasses required following cataract surgery)
- radial keratotomy surgery, orthokeratology, and any eye surgeries in lieu of corrective lenses
- surgical implants including the Cochlear ear

**Vitamins.** Charges for nutritional supplements and prescription vitamins (except for prenatal vitamins requiring a prescription under the Prescription Drug Program).

## ARTICLE VIII CLAIMS PROCEDURES

### 8.01 Claims Procedure

Claims shall be submitted directly to the contracted Third Party Administrator, Preferred Administrators. *Instructions for submitting claims are described on the Employees Identification Card.*

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

Upon receipt of an incomplete claim, the Claim Administrator will advise the Covered Employee of the need for additional information or that a request for additional information has been made to the provider, within thirty (30) days. The Claim Administrator will wait for the requested information to complete the claim. If the requested information is not submitted by the Employee or the provider, the Claim Administrator will deny the claim and advise the Employee. If the Employee or the provider submits the requested information the Claim Administrator 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 Employee.

### 8.02 Covered Participant's Responsibilities

- (a) **Update Records.** Each Covered Participant must provide the Plan Administrator with the Covered Participant'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. The Plan Administrator shall have no obligation or duty to locate a Covered Participant. If a Covered Participant becomes entitled to a payment under this Plan and payment is delayed or cannot be made because:
  - (i) the current address according to Employer records is incorrect;
  - (ii) the Covered Participant fails to respond to the notice sent to the current address according to Employer records;
  - (iii) of conflicting claims to the payments;
  - (iv) of any other reason; or
  - (v) the amount of payment, if and when made, will be determined under the provisions of this Plan without payment of any interest or earnings.
- (b) **One Year Filing Limit.** Completed claim forms and original bills for Covered Expenses must be submitted within one year after the date of service. No payment will be made for claims submitted after one year except due to the legal incapacity of the Covered Participant.
- (c) **Appeals Deadline.** A first level appeal for an Adverse Benefit Determination must be received by the Plan Administrator no later than one year after the date the Injury or Illness occurred or commenced but in no event later than six months following the denial of the claim.

### 8.03 Unclaimed Benefits

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 the amount is incurred or the check is issued, the amount will be forfeited and will cease to be a liability of the Plan provided the Plan Administrator has exercised reasonable efforts to make such payments.



#### **8.04 Limitation of Rights**

The establishment, amendment, or existence of the Plan, will not:

- (a) give any person any legal or equitable right against the Employer, except as expressly provided herein or required by law; or
- (b) create a contract of employment with any Employee, obligate the Employer to continue the service of any Employee, or affect or modify the terms of an Employee's employment in any way.

#### **8.05 Payment of Benefits**

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

##### **A. Assignments**

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

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

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

##### **B. Recovery of Payments**

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

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

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

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

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

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

## **ARTICLE IX**

# **STANDARD COMPLAINT APPEALS PROCESS**

### **9.01 Notice of a Complaint or Appeal**

All Administrative Appeals will be handled by the Compliance Department.

Preferred Administrators has a process in place for all (PA) complaints and appeals. The Compliance Department in collaboration with the Member Services Department, the Provider Relations Department and the Health Services Department coordinate 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.

Preferred Administrators has designated Member Service Representatives as PA Member Advocates to assist Members with the complaints and appeals process. Upon receipt of an oral complaint the PA Member Service Representative will accept and acknowledge the complaint and request that the Member submit the complaint in writing. The following data will be obtained and logged from the complainant in the Information Systems Department (ISD):

- Date complaint was received
- Employee's name, address
- Claimant's or Member's name
- Claimant's phone number
- Provider's name
- HP identification number
- Date of service
- Details of the exact nature of the complaint recorded
- Documentation to support the complaint

Covered Participants may contact Preferred Administrators Customer Service Department to advise them of a complaint and provide them with the required information at:

**Preferred Administrators  
Complaints & Appeals Unit**  
1145 Westmoreland  
El Paso, Texas 79925  
(915) 532-3778  
Fax (915) 298-7872

Within five (5) days of receipt of the oral complaint, the PA Member Service Representative will mail the Member an acknowledgment letter. A copy of the acknowledgment letter mailed to the Member will be forwarded to the Complaints and Appeals Unit. Complaints will be accepted from the Member or the Member's legal Representative.

Upon receipt of the complaint, the Complaints and Appeals Unit will be responsible for involving appropriate departments and contacting appropriate resources in an effort to resolve the Member's complaint.

Within five (5) business days after El Paso First's Complaints and Appeals Unit receives a written complaint, the Complaints and Appeals Specialist will send the Member written acknowledgment that the complaint has been received.

The written acknowledgement will refer the Member to a description of the complaint procedures and timeframes. El Paso First's Complaints and Appeals Specialist will investigate the complaint and dictate a response. The Complaints and Appeals Specialist will prepare the written decision which will be mailed no later than thirty (30) calendar days following the receipt of the Member's written complaint.

The resolution letter to the Member includes information regarding the Administrative Appeals Process. If a Member or their legal representative expresses orally or in writing any dissatisfaction with a resolution of an Action, El Paso first will consider that dissatisfaction as a request to appeal the Action. The Member may request an appeal, the appeal process will allow the Member to appear in person before an internal El Paso First complaint appeal panel at the site at which the Member normally receives health care services or at a site determined by the Member. The El Paso First internal Complaints Appeal Panel (CAP) will be composed of an equal number of staff Members, physicians or other Providers, and enrollees.

Within 5 days of receiving a request for an appeal El Paso First will send an acknowledgment letter to the Member. The acknowledgement letter will also include the description of the appeals process and timeframes for this process. The appeals process will be completed within 30 days of receiving the request for appeal.

If the Member has exhausted the internal CAP process, the Member may request a review by an external Independent Review Organization (IRO). If the complaint or appeal is regarding an adverse determination relating to the denial, delay, reduction, termination or suspension of covered services, the Member will be informed by the Health Services Department of their right to access and external IRO at any time in lieu of El Paso First's internal appeal process.

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

Covered Participants may contact Preferred Administrators Customer Service Department to request an appeal; the appeal must be made in writing and sent to:

**Compliance Department**  
**Preferred Administrators**  
Complaint and Appeals Unit  
1145 Westmoreland  
El Paso, Texas 79925  
(915) 532-3778  
Fax (915) 298-7872

## 9.02 **Adverse Determination Appeal**

An Employee or Employee's representative (the Employees provider of care can also be the Employee's representative) has the right to appeal a complaint filed concerning dissatisfaction or disagreement with an adverse determination. The Employee, or Employee's representative, has the right to appeal a decision made by Preferred Administrators when a determination is made that the services requested are not medically necessary appropriate, or are experimental or investigational in nature.

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

Appeals may be made orally or in writing. Instructions for filing the appeal are included in the adverse determination notification. The adverse determination notification is sent out within three (3) working days of receipt of an authorization request, provided that all the information needed to make a determination is included.

The adverse determination will include the procedures for appealing an adverse determination and a reasonable list of documents that will be needed to ensure a timely appeal response. The adverse determination letter will include the member's right to seek review of the denial by an Independent Review Organization (IRO) and the process for doing so.

Preferred Administrators requires the following information for the appeal:

- A cover letter – Letter must include the Employee's name, Employee's Plan assigned;
- I.D. number, Preferred Administrator's reference number (from the Notice of Determination), date of service;
- A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim;
- A copy of the medical record if not previously submitted; and
- Any new or additional information.

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

Oral appeals can be made by contacting a Preferred Administrators Representative at **915-532-3778** or toll free at **1-877-532-3778**. A one-page appeal form will be mailed within twenty-four (24) hours of receipt.

Written appeals can be submitted by fax to 915-298-7866 Attn: Health Services Appeals Unit, or mailed to:

**Preferred Administrators**  
**Attn: Health Services Department – Appeals Unit**  
1145 Westmoreland Dr.  
El Paso, TX 79925

All appeals are date stamped and logged in the Adverse Determination Appeal's 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.

A resolution to the appeal will be made 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 Employee or the person acting on the Employee's behalf, and the Employee's physician or other health care provider. The appeal resolution letter will include:

- A clear and concise statement of the clinical basis for the denial;
- The specialty of the physician or other health care provider who made the decision;
- The rights for the appealing party to seek an independent review organization (IRO) and the procedure for filing; and
- A copy of the resolution letter will be mailed to both the Provider and the Employee.

#### **WHAT IS AN IRO?**

IROs are 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.

#### **CRITERIA FOR REQUESTING AN IRO**

The following criteria must be met to request an IRO:

- The claimant is or was covered by the El Paso Children's Hospital Employee Benefit Plan at the time the health care service was requested; or in the case of a retrospective review, was covered by the Plan at the time the health care was provided.
- The Adverse Determination does not relate to the claimant's failure to meet the requirements for eligibility under the terms of the Plan.
- The claimant has exhausted this Plan's internal appeals process as described herein
- The claimant has provided all the information and forms required to process an external review.

The IRO does not apply to a denial, reduction, termination or a failure to provide payment for a benefit based on a determination that an Employee or beneficiary fails to meet the requirements for eligibility under the terms of the Plan.. Benefits not covered and payable under the provisions of the Plan will not be considered for review by an IRO.

#### **SPECIALTY REVIEW FOR AN ADVERSE DETERMINATION**

The Plan Administrator 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. A request for a Specialty Review must be made within ten (10) days of adverse determination. It must be made in writing and state a good cause for having a particular type of specialty provider review the case.

#### **EXPEDITED APPEAL FOR AN ADVERSE DETERMINATION**

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

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

#### **TIMEFRAME FOR RESOLUTION OF THE 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. Initial notice of the decision may be delivered orally, followed by written notice of the determination within (3) three days.

A resolution to a standard appeal will be made as soon as practicable, but not later than thirty (30) working days from the date the appeal was received.

#### **PROCESS FOR REQUESTING AN IRO**

If the decision is made to uphold the adverse determination, the member or their representative has the right under Texas law to have this decision reviewed by an IRO. There is no cost to the member for filing an IRO. However, the above criteria for requesting an IRO must be met.

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.

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

**Preferred Administrators Health Plans, Inc.**  
**Attention: Health Services Department – Appeals Unit**  
1145 Westmoreland  
El Paso, TX 79925

The Plan Administrator will conduct a preliminary review to determine whether the request meets the reviewability requirements for external review to set forth in Criteria for Requesting IRO.

Upon a determination that a request is eligible for external review, the Plan Administrator will assign an IRO and notify the Employee of the assigned IRO.

The Plan Administrator will provide or transmit all necessary documents and information considered in making the adverse determination or final internal determination to the assigned IRO by fax. The Plan Administrator 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.

The IRO will review the documentation and information submitted. The IRO will provide a final external review decision as expeditiously as the claimant's medical condition or circumstances require.

#### **IMPORTANT TIMEFRAMES TO REMEMBER**

- A determination for a requested service will be made within three (3) working days of receipt of all the information necessary to make a determination.
- If request for additional information is made, the Employee or Employee's representative has ten (10) days to submit the additional information for the requested services.
- If services are considered not medically necessary or appropriate, investigative or experimental in nature, the Employee may appeal the decision within thirty (30) days of receipt of the Notice of Adverse Determination.
- A letter of acknowledgement will be issued within five (5) days of receipt of the appeal.
- 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.
- The Employee or their representative may request an external appeal within four (4) months of receipt of resolution letter excluding holidays and weekends.
- Upon receipt of request for external review, The Plan Administrator has five (5) days to review the documentation submitted.
- The Plan Administrator will submit documentation to the IRO as soon as possible, taking into account the medical exigencies, but not later than three (3) working days after receipt of the request for external review.
- The IRO has twenty (20) days to make a decision for non-life threatening cases and eight (8) days to make a decision for life threatening cases. The IRO will notify the Employee of its decision.

#### **DETERMINATION OF APPEAL**

If the final determination of the appeal is adverse to the Employee and is upheld, the Plan Administrator will recover such costs.

If the determination of the appeal is reversed, the Plan Administrator 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.

A copy of the resolution letter will be mailed to both the provider and the plan participant.

## **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 Employee, obligate the Employer or one of its Affiliates to continue the service of any Employee, or affect or modify the terms of an Employee's employment in any way.

### **10.05 Governing Laws**

The Plan is governed by ERISA. In no event shall the Employer guarantee the favorable tax treatment sought by this Plan.

### **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 Employer will be reimbursed by the Plan, unless the Employer in its discretion elects 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 February 1, 2012 and ending September 30, 2012 shall be the initial Plan Year. Thereafter the Claim Determination period and Plan Year shall commence each October 1. 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 dependants, 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) employed 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 Right of Reimbursement**

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) employed 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 employed 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 Right to Receive and Release Necessary Information**

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

**12.08 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 Employee 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 Employee 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.



## **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. The 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 Employees 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**

# **MISCELLANEOUS STATUTORY REQUIREMENTS**

### **14.01 Newborns' and Mothers' Health Protection Act of 1996**

To the extent the Plan provides benefits for hospital lengths of stay in connection with childbirth, the Welfare Program will cover the minimum length of stay required for deliveries (i.e., a 48-hour hospital stay after a vaginal delivery or a 96-hour stay following a delivery by Cesarean section.) The mother's or newborn's attending physician, after consulting with the mother, may discharge the mother or her newborn earlier than the minimum length of stay otherwise required by law. Such coverage is subject to any applicable deductible or coinsurance amounts.

### **14.02 Women's Health and Cancer Rights Act of 1998**

To the extent the Plan provides benefits for mastectomies, it will provide, for an individual who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy, coverage for reconstruction on the breast on which the mastectomy was performed, surgery and reconstruction on the other breast to give a symmetrical appearance, and prosthesis and coverage for physical complications of all stages of the mastectomy, including lymphedemas, as recommended by the attending physician of any patient receiving Plan benefits in connection with a mastectomy in consultation with the patient. Such coverage is subject to any applicable deductibles, benefit percentages, co-payments or coinsurance amounts.

### **14.03 HIPAA Certification**

Pursuant to the provisions of the Health Insurance and Portability and Accountability Act of 1998 (HIPAA), limits have been placed on pre-existing condition exclusion periods. Under HIPAA, an Employee's period of coverage under a Welfare Program will offset the exclusion period of a new health care plan as long as the break in health care coverage is not over 60 days. If an Employee loses coverage under a Welfare Program, a certificate will be issued that provides written confirmation of his prior health care coverage. This certificate will be used to determine pre-existing condition exclusion periods under another employer's health care plan. The certification will identify the persons coverage under the Welfare Program, the period of coverage and the waiting periods. Certification is provided when: the Employee terminates employment, the Employee or his Dependent loses coverage, the Employee or his Dependent's COBRA coverage ends, the Employee requests certification up to 24 months after he terminates employment, and the Employee or his Dependent becomes eligible for coverage under another plan.

Covered Participants, who cannot obtain a certificate, may demonstrate prior health care coverage by:

- (a) attesting to the period of creditable coverage;
- (b) attesting to a Dependent's dependency and the period of dependency status;
- (c) presenting corroborating evidence of creditable coverage for the period such as pay stubs that reflect a deduction for health insurance, Explanation of Benefits forms (EOBs), or verification for health insurance by a doctor or former health care benefits provider that the individual had prior health coverage; and
- (d) cooperating in verifying the information provided.

**14.04 Qualified Medical Dependent Child Support Orders (QMCSO)**

The Plan will comply with any Qualified Medical Child Support Order (QMCSO) issued by a court of competent jurisdiction or administrative body that requires the Plan to provide medical coverage to a Dependent Child of an Employee. 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 Qualified Medical Child Support Order. The Plan Administrator shall have the authority to enroll the Employee and child if the Employee is not a current participant at the time the Qualified Medical Child Support Order is received. The cost of coverage or any additional cost of such coverage, if any, must be paid by the Employee.

**14.05 Plan Administrator's Duty to Issue Certificates of Creditable Coverage**

The Plan Administrator shall issue certificates of creditable coverage to a Covered Person:

- (a) whose coverage terminates;
- (b) when the individual's coverage ceases due to the operation of a lifetime limit on all benefits (coverage is considered to cease on the earliest date that a claim is denied due to the operation to the lifetime limit);
- (c) to individuals upon their written request while the individual is covered under the Plan and within 24 months of the date of coverage termination, as required by Federal law. Written procedures for requesting certificates of creditable coverage may be obtained from the Plan Administrator.

## **ARTICLE XV**

# **HIPAA PRIVACY RULE**

Effective April 14, 2003, the University Medical Center of El Paso And Its Affiliates Employee Health Benefit Fund Plan (hereinafter referred to as the "Plan") conforms with the requirements of § 164.504(f) of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations, 45 C.F.R. parts 160 through 164 (the regulations are referred to herein as the "HIPAA Privacy Rule" and § 164.504(f) is referred to as "the '504' provisions") by establishing the extent to which the Plan Sponsor will receive, use, and/or disclose Protected Health Information (hereinafter referred to as "PHI"). Effective February 18, 2010, the University Medical Center of El Paso complied with the HITECH Privacy Act provisions. Members can request a copy of the Notice of Privacy Practice or can be accessed through [www.preferredadmin.net](http://www.preferredadmin.net).

### **15.01 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 University Medical Center of El Paso to take all actions required to be taken by the Plan in connection with the HIPAA Privacy Rule (e.g., entering into business employee contracts; accepting certification from the Plan Sponsor).

### **15.02 The Plan's Disclosure of PHI to the Plan Sponsor/ Required Certification of Compliance by Plan Sponsor**

Except as provided below with respect to the Plan's disclosure of summary health information, the Plan will (a) disclose PHI to the Plan Sponsor, or (b) provide for or permit the disclosure of PHI 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.

### **15.03 Permitted Disclosure of Individuals' PHI to the Plan Sponsor**

The Plan (and any business employee acting on behalf of the Plan), or any health insurance issuer or HMO servicing the Plan, will disclose individuals' PHI to the Plan Sponsor only to permit the Plan Sponsor to carry out plan administration functions. Such disclosure will be consistent with the provisions of this section.

All disclosures of the PHI of the Plan's individuals by the Plan's business employee, 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 employee acting on behalf of the Plan) may not permit the health insurance issuer or HMO, to disclose individuals' PHI to the Plan Sponsor for employment-related actions and decisions, or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

The Plan Sponsor will not use or further disclose individuals' PHI other than as described in the Plan Document and permitted by the "504" provisions.

The Plan Sponsor will ensure that any agent(s), including a subcontractor, to whom it provides individuals' PHI received from the Plan (or from the Plan's health insurance issuer or HMO), agrees to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI.

The Plan Sponsor will not use or disclose individuals' PHI for employment-related actions and decisions, or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

The Plan Sponsor will report to the Plan any use or disclosure of PHI 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.

**15.04 Disclosure of Individuals' PHI/Disclosure by the Plan Sponsor**

The Plan Sponsor will make the PHI of the individual who is the subject of the PHI available to such individual in accordance with 45 C.F.R. § 164.524.

The Plan Sponsor will make individuals' PHI available for amendment and incorporate any amendments to individuals' PHI in accordance with 45 C.F.R. § 164.526.

The Plan Sponsor will make and maintain an accounting so that it can make available those disclosures of individuals' PHI that it must account for in accordance with 45 C.F.R. § 164.528.

The Plan Sponsor will make its internal practices, books and records relating to the use and disclosure of individuals' PHI received from the Plan available to the U.S. Department of Health and Human Services for purposes of determining compliance by the Plan with the HIPAA Privacy Rule.

The Plan Sponsor will, if feasible, return or destroy all individuals' PHI received from the Plan (or a health insurance issuer or HMO with respect to the Plan) that the Plan Sponsor still maintains in any form after such information is no longer needed for the purpose for which the use or disclosure was made. Additionally, the Plan Sponsor will not retain copies of such PHI 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.

The Plan Sponsor will ensure that the required adequate separation, described elsewhere in this section, is established and maintained.

**15.05 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.

#### **15.06 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' PHI 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' PHI relating to payment under, health care operations of, or other matters pertaining to plan administration functions that the Plan Sponsor provides for the Plan. These individuals will have access to individuals' PHI solely to perform these identified functions, and they will be subject to disciplinary action and/or sanctions (including termination of employment or affiliation with the Plan Sponsor) for any use or disclosure of individuals' PHI in violation of, or noncompliance 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 noncompliance, to impose appropriate disciplinary action and/or sanctions, and to mitigate any deleterious effect of the violation or noncompliance.

## **ARTICLE XVI**

# **HIPAA SECURITY STANDARDS**

This section is intended to bring the University Medical Center of El Paso and Its Affiliates Employees 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.

### **16.01 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 El Paso Children's Hospital Employee Health Benefit Plan Employee.
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 El Paso Children's Hospital Employee Health Benefit Plan Employee.
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 El Paso Children's Hospital.
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.

### **16.02 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 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 Protected Health Information 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 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.



