



UMC HEALTH SYSTEM

University Medical Center Employee Health Plan Document and Dental Reimbursement Plan Effective Date June 2, 2020

A Message to University Medical Center Employees:

This benefit booklet is your guide to using the health benefits available to you under the self-funded health benefit program established by the University Medical Center. Please refer to the benefit booklet when you need health care or when you have a question about your health benefits.

The Plan is designed to meet your family's health care needs by providing access to the TeamChoice network of Hospitals, Primary Care Physicians, and Specialty Care Physicians while keeping your cost for the coverage affordable. For a list of In-Network providers refer to your provider directory or the online directory located at www.team-choice.com.

IT IS YOUR RESPONSIBILITY TO UNDERSTAND YOUR COVERAGE. Choices that you make, or that are made on your behalf on account of a referral by your physician, which result in additional charges or medically unnecessary care, that is not payable by the Plan are YOUR responsibility.

**Administered by
UMC Health Plan Operations
309 N. Slide Road
Lubbock, Texas 79416
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**INFORMATION IMPORTANT TO UNDERSTANDING THE BENEFITS
IN THE GROUP PLAN DOCUMENT**

The UMC Health Plan is a Self-Funded Nonfederal Governmental Group Health Plan sponsored by the Lubbock County Hospital District, d/b/a University Medical Center (“the Employer”).

The Employer has complete authority to control, operate, and manage the UMC Health Plan. The Department of UMC Health Plan Operations is authorized to provide day-to-day management of the Plan. The Employer has provided full discretion to UMC Health Plan Operations to determine eligibility status, interpret Plan benefits and rules, and determine whether a claim should be paid or denied according to the provisions of the Plan set forth in this *Plan Document*. The Employer reserves the right to amend, reduce, or eliminate any part of the Plan at any time.

The UMC Health Plan has established a network of contracted health care providers. Participants will be provided a list of “In-Network Providers” from whom Participants may receive Covered Health Care Services. Participants may, however, choose to receive emergency services from any Out-of-Network licensed provider at the same amounts as shown in the Schedule of Benefits for In-Network providers. See Section 4 for additional information related to Emergency Services.

“In-Network Provider” means a physician, hospital, facility, home health agency or other health care provider that is located within the Service Area and is contracted with TeamChoice to provide services and treatment under this Health Plan. TeamChoice is responsible for recruiting, credentialing, and communicating with In-Network Providers. In-Network Providers participating in the TeamChoice Network agree to accept the allowable charge fees set by the Health Plan and agree to file claims for Health Plan participants.

“Out-of-Network Provider” means a physician, hospital, facility, home health agency or other health care provider that is NOT contracted with TeamChoice to provide services and treatment under this Health Plan.

See Section 8 of this Health Plan document for additional details about network providers.

Your Benefits Under the Patient Protection and Affordable Care Act

UMC has amended this Plan Document in good faith to comply with the requirements of a recent federal law entitled the Patient Protection and Affordable Care Act (“PPACA”). However, the regulations and other guidance under PPACA are interim final regulations, or in some cases, not yet promulgated. UMC reserves the right to amend this Plan Document, retroactively if deemed necessary, to comply with PPACA and the regulations and other guidance promulgated thereunder.


Your Benefits Under the COVID-19-Related Laws

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UMC has amended this Plan Document in good faith to comply with the requirements of recent laws such as the Families First Coronavirus Act (“FFCRA”) and the Coronavirus Aid, Relief, and Economic Security Act (“CARES Act”). However, many of the regulations and other guidance under such laws are interim final regulations, or in some cases, not yet promulgated. UMC reserves the right to amend this Plan Document, retroactively if deemed necessary, to comply with COVID19-related laws and the regulations and other guidance promulgated thereunder.

UMC EMPLOYEE HEALTH PLAN

SECTION 1
GENERAL PLAN INFORMATION

| | |
|---|--|
| <p><u>Plan Administrator:</u></p> <p>For health claims, dental claims, plan appeals, and Participant service.</p> <p>Mailing address: UMC Health Plan Operations 309 N. Slide Road Lubbock, Texas 79416</p> <p>(806) 775-8793 Appeals Fax: (806) 761-0897</p> | <p><u>RX Providers:</u></p> <p>UMC Pharmacy Monday through Friday 7:00 a.m. – 6:00 pm. Saturday 10:00 a.m. - 2:00 p.m. Phone: (806) 775-8696</p> <p>Medimpact RX Customer Service (844) 282-5344</p> |
| <p><u>TeamChoice Network:</u></p>  <p>Online provider directory www.team-choice.com</p> <p>or UMC Health Plan Operations at (806) 775-8793</p> | <p><u>Pre-authorization:</u></p> <p>For all in-patient services, surgical procedures, sleep studies, and Behavioral Health.</p> <p>Call Spectrum Review Services 1-800-258-5055 M-F 7:00 a.m. – 6:00 p.m. CST</p> <p><u>Privacy Officer:</u></p> <p>Lana Daniel Privacy Officer UMC Employee Health Plan c/o Compliance Office P.O. Box 5980 Lubbock, Texas 79408 (806)761-0992</p> |
| <p><u>UMC Human Resources Department:</u></p> <p>Employee Benefits, enrollment forms, changes in eligibility, address change, health appeal forms, dental claim forms, and COBRA.</p> <p>Located in the basement of the Medical Office Plaza (MOP 1). (806) 775-9222</p> | <p><u>COBRA, Active Board Member, & Retiree Premiums:</u></p> <p>Premiums must be paid on or before the 1st day of each month by check, money order, or bank draft to:</p> <p>UMC Health Plan Operations 309 N. Slide Road Lubbock, TX 79416</p> |

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Employee Health Insurance*

**Premium Rates
(Effective January 1, 2020)**

| <u>Coverage Category</u> | <u>Premium Rates</u> | <u>Premium Rates***</u> |
|-----------------------------------|------------------------|----------------------------|
| | Base Per Pay Period | Discount Per Pay Period |
| Employee Only – Full Time | \$ 73.00 | \$ 48.00 |
| Employee Only – Part Time | \$ 160.00 | \$ 135.00 |
| Employee & Child(ren) – Full Time | \$ 223.00 | \$ 198.00 |
| Employee & Child(ren) – Part Time | \$ 302.00 | \$ 277.00 |
| Employee & Spouse – Full Time | \$ 296.00 | \$ 271.00 |
| Employee & Spouse – Part Time | \$ 394.00 | \$ 369.00 |
| Family – Full Time | \$ 364.00 | \$ 339.00 |
| Family – Part Time | \$ 446.00 | \$ 421.00 |

| <u>COBRA Coverage Category**</u> | <u>Monthly COBRA Premium Rates</u> | <u>Monthly COBRA Premium Rates***</u> |
|--|--|---|
| | Base | Discount |
| Employee or Spouse Only | \$ 575.00 per month | \$ 521.00 per month |
| Employee & Child(ren) or Spouse & Child(ren) | \$ 1460.00 per month | \$ 1406.00 per month |
| Employee & Spouse | \$ 2281.00 per month | \$ 2227.00 per month |
| Family | \$ 2150.00 per month | \$ 2096.00 per month |

| <u>Retiree & Active UMC Board Member Coverage Category **</u> | <u>Monthly Retiree & Active Board Member Premium Rates</u> | <u>Monthly Retiree & Active Board Member Premium Rates***</u> |
|---|--|---|
| | Base | Discount |
| Retiree Only | \$ 350.00 per month | \$ 296.00 per month |
| Retiree & Child(ren) | \$ 656.00 per month | \$ 602.00 per month |
| Retiree & Spouse | \$ 853.00 per month | \$ 799.00 per month |
| Family | \$ 974.00 per month | \$ 920.00 per month |

* Failure to pay premiums may result in a lapse of coverage.

** Premium Payment for Retiree(s), Active Board Member(s) and COBRA covered health plan Participants: Premiums must be paid on or before the 1st day of each month by check, money order, or bank draft to:

UMC Health Plan Operations, 309 N. Slide Road, Lubbock, TX 79416.

***To be eligible for a premium discount, employees must comply with the requirements outlined on page 14.

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2020 SCHEDULE OF BENEFITS

The following is a summary of the copayment amounts, which Participants must pay when receiving the services listed below. Please refer to the LIMITATIONS AND EXCLUSIONS section for a detailed explanation of benefit coverage.

*Out of network services are allowed only for prescription drug coverage and emergency services. The Participant may be responsible for any balances billed by the Out-of-Network Provider for emergency services that are in excess of the Plan's responsibility. The Participant is responsible to contact UMC Health Plan Operations (806-775-8793) if the Participant resides outside of the usual TeamChoice service area in order to obtain In-Network benefits through the approved out-of-area provider network.

| Covered Health Services | In-Network Benefits | Out-of-Network Benefits* |
|--|--|------------------------------|
| Annual Deductible Individual | \$300 (excludes office visits, prescription benefits, and preventive services) | No coverage except emergency |
| Out-of-Pocket Maximum Individual Family | \$8,150 \$16,300 Includes Prescription Drugs | N/A |
| Outpatient Services | | |
| <i>Office Visits</i> including medications (except certain injectable medications) and materials administered in the Physician's office, and surgical procedures performed in the physician's office and/or outpatient setting or through telemedicine other than through MyTeamCare Now. | | Not Covered |
| <ul style="list-style-type: none"> ● Primary Care Physician ● Specialist Physician | \$30 per visit \$60 per visit | |
| <ul style="list-style-type: none"> ● Express Care Clinic Visit <ul style="list-style-type: none"> ○ United Supermarket Express Care – 82nd and Boston ○ United Supermarket Express Care – 50th and Avenue Q ○ Urgent Care Center at UMC – Medical Office Plaza 2 ● Express Care Clinic at the South Plains Mall – 6002 Slide Road, Space P12 | \$10 per visit, deductible waived | N/A |
| <ul style="list-style-type: none"> ● Telemedicine Services through MyTeamCare Now | \$20 per visit, deductible waived | Not Covered |
| Laboratory Services | No Copay | No coverage except emergency |
| Diagnostic Radiology Services (except for the following procedures): | No Copay | |

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| Covered Health Services | In-Network Benefits | Out-of-Network Benefits* |
|--|--|------------------------------|
| <ul style="list-style-type: none"> Arteriograms, CT Scan, Magnetic Resonance Imaging (MRI); EEG; & Myelogram; Needle Biopsies, VCUg (voiding cysto-urethrogram) | \$200 per day | |
| <ul style="list-style-type: none"> Radionuclide Stress Test | \$200 per visit | |
| <ul style="list-style-type: none"> PET Scans | 20% Coinsurance | |
| <ul style="list-style-type: none"> Ultrasound (maximum of 3 during pregnancy absent documented medical necessity) | No Copay | |
| Surgical Procedures performed in the Physician's office | Applicable office co-pay | No coverage except emergency |
| Pre- and Post-Natal Obstetrical Care | \$30 (one time only) | No coverage except emergency |
| Rehabilitation, Speech, Occupational and Physical Therapy | \$15 per visit | Not Covered |
| Outpatient Surgery | \$400 per admission | Not Covered |
| Injectable Medications | 20% Coinsurance in the office, outpatient or home health setting. | Not Covered |
| Physician Home Visits | \$30 per visit | |
| Allergy Services | | |
| <ul style="list-style-type: none"> Office Visits including Testing | \$30 per visit to PCP \$60 per visit to Specialist | |
| <ul style="list-style-type: none"> Serum | 50% of charges | |
| <ul style="list-style-type: none"> Injection Administration | \$0 | |
| Mental Health Services | \$30 per visit to PCP. \$60 per visit to Specialist. Limited to 20 outpatient visits per Plan Year | |
| Serious Mental Illness Health Services | \$60 per visit to Specialist. Limited to 60 Outpatient visits per Plan Year | Not Covered |
| Chemical Dependency Services | \$60 per office visit to Specialist. Limited to 60 Outpatient visits per Plan Year <i>Limited to 3 series of treatments per lifetime.</i> | |
| Day Treatment Facility for chemical and substance abuse treatment | 20% Coinsurance <i>Limited to 30 days per Treatment and 3 series of treatments per Lifetime</i> | |
| Pain Management Services | \$30 per visit to PCP \$60 per visit to Specialist | |

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| Covered Health Services | In-Network Benefits | Out-of-Network Benefits* |
|--|---|------------------------------|
| | \$400 for all outpatient surgical procedures <i>except</i> for the following: <ul style="list-style-type: none"> • Percutaneous Decompression Nucleoplasty (PDNP) - 50% of all charges • Intradiscal Electrothermal Annuloplasty (IDET) - Not Covered | |
| Preventive Health Care Services, <i>DEDUCTIBLE WAIVED</i>. See Section 4 for a complete list of preventative health care services and for additional information and limitations. | | |
| Routine Physical Exams | No Copay | Not Covered |
| Well-Baby and Well-Child Care | No Copay | |
| Routine Immunizations <ul style="list-style-type: none"> • For Children under 18 years of age • For other Participants | No Copay | |
| Well-Woman Examinations | No Copay | |
| <u>Screening</u> Mammograms | No Copay, (limited to one within each Plan year) | |
| <u>Screening</u> Colonoscopy (asymptomatic) | No Copay, (limited to one within a five-year period under age 50) | |
| Bone Mass Measurement | No Copay | |
| Examinations for Detection of Prostate Cancer | No Copay | |
| Routine Sight, Speech and Hearing Screenings for Children | No Copay | |
| Family Planning and Infertility Services | | |
| Family Planning Counseling | No Coinsurance, Deductible Waived | Not Covered |
| Depo-Provera™ Injections | No Coinsurance, Deductible Waived | |
| Contraceptive Implants | No Coinsurance, Deductible Waived | |
| Infertility Testing (<i>see exclusions</i>) | 50% applies to all office visits and diagnostic services | |
| Inpatient Services | | |
| Inpatient Admissions including: <ul style="list-style-type: none"> • Hospital | \$500 Copay Per Day Per Admission, \$2500 max out-of-pocket, after deductible (inpatient physician services are covered at 100%, after deductible) | No coverage except emergency |
| <ul style="list-style-type: none"> • Newborn Care (inpatient) | No Copay, after deductible | |
| <ul style="list-style-type: none"> • Rehabilitation Facility | \$500 Copay Per Day Per Admission (waived if transferred from inpatient), | |

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| Covered Health Services | In-Network Benefits | Out-of-Network Benefits* |
|--|--|---------------------------------|
| | \$2500 max out-of-pocket, after deductible | |
| <ul style="list-style-type: none"> Skilled Nursing Facility and Long-term Care Facility <i>Limited to 100 days per Plan Year combined.</i> | \$500 Copay Per Day Per Admission (waived if transferred from inpatient), \$2500 max out-of-pocket, after deductible | |
| <ul style="list-style-type: none"> Chemical Dependency Residential Treatment Center <i>Limited to 3 series of treatments per lifetime.</i> | 20% Coinsurance if residential treatment (limited to 30 days per treatment) | |
| <ul style="list-style-type: none"> Psychiatric Hospital <i>Mental Health – 15 Inpatient days per Contract Year. Serious Mental Illness – 45 Inpatient days per Contract Year.</i> | \$500 Copay Per Day Per Admission, \$2500 max out-of-pocket, after deductible | |
| Observation Unit Admission | \$150 per admission | No coverage except emergency |
| Other Health Care Services | | |
| Home Health Services | 20% Coinsurance Per Day | Not Covered |
| Custodial Care | Not Covered | Not Covered |
| Chiropractic Services | Not Covered | Not Covered |
| Prosthetics/Orthotics (Medically necessary for condition commencing after effective date of coverage) | 20% Coinsurance | Not Covered |
| Durable Medical Equipment (DME) & Medical Supplies | 25% per piece or equipment or supply. | |
| Insulin and Diabetic Medications (<i>up to a 34-day supply</i>): Deductible Waived <ul style="list-style-type: none"> Generic (up to a 34-day supply) Brand Name Formulary Brand Name Non-Formulary Formulary Excluded Drugs | UMC OUTPATIENT PHARMACY and MEDIMPACT (Retail Pharmacy) \$35 Copay per prescription Greater of \$55 copay or 20% per prescription Greater of \$75 copay or 20% per prescription Not Covered | Not Covered |
| Diabetic Supplies | 20% per item, deductible waived. Supplies are limited to a 30-day fill for each prescription | |
| Diabetic Self-Management Education | \$30 per visit to PCP \$60 per visit to Specialist No Copay to In plan Diabetic Center | |
| Hearing Aids | Coverage limited to a maximum of \$500 per ear once every 36 months, remaining amount Participant responsibility | |
| Speech & Hearing/Audiology Diagnostic Testing | \$30 copay | Not Covered |

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| Covered Health Services | In-Network Benefits | Out-of-Network Benefits* |
|---|---|---|
| Organ Transplant Services | Included in the office visit, outpatient surgery -OR- Inpatient hospital copay | No coverage except emergency |
| Prescription Drug Coverage, including Immuno-suppressive Medications (up to a 34 day supply): Deductible Waived | UMC OUTPATIENT PHARMACY and MEDIMPACT (Retail Pharmacy) | Not Covered |
| • Generic | \$35 Copay per prescription | |
| • Brand Name Formulary | Greater of \$55 copay or 20% per prescription | |
| • Brand Name Non-Formulary | Greater of \$75 copay or 20% per prescription | |
| • Formulary Excluded Drugs | Not Covered | |
| • Generic Mail Order | 3-month supply, \$80 Copay | |
| Chemotherapy , Radiation Therapy Services and Infusion Services | 10% Coinsurance with a \$2,500 out of pocket max per year in the office, outpatient or home health setting. Cimzia, Cosentyx, Enbrel, Humira, Stelara, Xolair, Simponi, Tremfya, Orencia, Taltz, Abilify Maintena, Aimovig Autoinjector, Ajovy, Dupixent, Emgality, Praluent Pen, Prolia, Repatha Sureclick, and Fabrazyme will only be covered if administered at the UMC Infusion Center (coinsurance will be waived) | No coverage except emergency |
| Dialysis Services (Outpatient) <u>Participating Providers:</u> Fresenius locations in the State of Texas | No Coinsurance | Not Covered |
| Hospice Services | No Copay for home hospice services. Other services are included in the office visit, outpatient surgery or inpatient hospital copay. | Not Covered |
| Gastric Bypass | 30% Coinsurance with any and all expenses not applied against the annual out of pocket maximum; Coverage limited to only once in the lifetime of the Participant; the usual inpatient hospital co-pay and out of pocket maximum does not apply | Not Covered |
| Emergency Services | | |
| Emergency Room | \$300 per Hospital emergency room visit. Emergency room Copay is waived if admitted to Hospital. Participant may be responsible for additional charges if visit is deemed to be non-emergent. | \$300 per Hospital emergency room visit. Emergency room Copay is waived if admitted to Hospital. If provider is not part of the approved provider network the Participant may be responsible for additional charges if visit is deemed to be non-emergent. |
| Minor Emergency or Urgent Care Center | \$30 per visit | Not Covered |
| Ambulance – ground or air | \$200 per ambulance trip (ambulance services subject to Plan review for medical necessity) | No coverage except emergency; If emergent, then, \$200 per ambulance trip |

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| Covered Health Services | In-Network Benefits | Out-of-Network Benefits* |
|-------------------------|---------------------|---|
| | | (ambulance services subject to Plan review for medical necessity) |

* The Participant is responsible to contact UMC Health Plan Operations (806-775-8793) if the Participant resides outside of the usual TeamChoice service area in order to obtain In-Network benefits through the out of area wrap network. See Section 8 for additional details and requirements.

FOR PRE-AUTHORIZATION CALL: 1-800-258-5055

See Section 10 regarding Pre-authorization requirements. The Participant is responsible for obtaining Pre-Authorization for certain types of medical services. If the Participant does not comply with these provisions, benefits under this Plan Document may be reduced or denied. Pre-Authorization is NOT a guarantee of payment. Benefits are subject to the Participant's eligibility at the time charges are actually incurred, and to all other terms, conditions, and exclusions of the Plan.

BENEFIT VERIFICATION & ELIGIBILITY: (806) 775-8793

**MAIL ALL CLAIMS TO:
UMC HEALTH PLAN OPERATIONS
309 N. Slide Road
Lubbock, TX 79416
(806) 775-8793**

Premium Discount

Employees who attest to not using nicotine products will be eligible for a premium discount. This means those employees will pay the Discount Premium Rates listed on page 8.

A nicotine product is any type of product that contains or is made or derived from nicotine and intended for human consumption. This includes products that are chewed, smoked, absorbed, dissolved, inhaled, snorted, sniffed, or ingested.

Current employees are eligible for premium discount if they sign up for Quit for Life® and have completed three (3) calls with Quit for Life® by the date set by UMC Human Resources. Contact UMC Human Resources at 775-9222 or 775-9212 for the applicable date. UMC will pay for 2 Quit for Life® sessions for the employee.¹ Current employees are also eligible for the premium discount if: (1) they provide proof of enrollment in a nicotine cessation program other than Quit for Life® and proof of having completed three (3) calls with the nicotine cessation program by the required date and (2) have their physician complete the Nicotine Physician Form.

Employees who have benefit status changes/special enrollment events are eligible for premium discount if they sign up for Quit for Life® and have completed three (3) calls within 90 days AND UMC has not already paid for 2 Quit for Life® sessions for the employee. Employees with benefit status changes/special enrollment events are also eligible for the premium discount if they provide proof of enrollment in a nicotine cessation program other than Quit for Life® and have completed three (3) calls within 90 days and have their physician complete the Nicotine Physician Form. A change in nicotine status only is **not** a benefit status change/special enrollment event for purposes of this Premium Discount.

If it is unreasonably difficult due to a medical condition for an employee to stop using nicotine (or if it is medically inadvisable for an employee to attempt to stop using nicotine), the UMC Health Plan will work with an employee to obtain a premium discount. Such medical conditions require physician documentation before the employee can obtain the premium discount. Contact UMC Health Plan Operations at 775-8793 for the Nicotine Physician Form or for additional information.

The Nicotine Attestation Form must be submitted by November 30. The Nicotine Physician Form, if applicable, must be submitted to UMC Health Plan Operations during open enrollment or within 31 days for employees who have benefit status changes. Employees who have a health factor arise during the year that makes it unreasonably difficult or medically inadvisable to stop using Nicotine Products can submit the Nicotine Physician Form to UMC Health Plan Operations. The premium discount will then be applied at the start of the next month, or as soon as administratively possible.

An Employee's falsification regarding nicotine status may subject the Employee to repayment of any discount of premiums received or other termination or rescission action as outlined in Section 2(D) of the Plan.

¹ UMC pays for 2 Quit for Life® sessions for the employee during the employee's lifetime (not per plan year).

DEFINITIONS

The following terms shall have the meanings ascribed to them hereafter for purposes of this Plan Document, whether capitalized or not, unless the context clearly requires otherwise:

Adverse Benefit Determination means rescission, denial, reduction, or termination of, or a failure to provide payment (in whole or in part) for a benefit including determinations of a Participant's eligibility under the Plan; determinations that a benefit is not a covered benefit; the imposition of a source-of-injury exclusion, network exclusion, or other limitation on otherwise covered benefits; or a determination that a benefit is experimental, investigational, or not medically necessary or appropriate.

Chemical Dependency means the abuse of, the psychological or physical dependence on, or addiction to alcohol or a Controlled Substance.

Claim means the request for reimbursement from the Plan for a covered expense.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, which is the law that, among other things, requires employers to offer continuation coverage to Participants and Dependents who would otherwise lose Group Health Plan coverage because of certain events such as termination of employment.

Coinsurance means the percentage of the cost of the healthcare services received that the Participant must pay.

Complainant means a Participant, a Physician, a provider, or other person designated to act on behalf of the Participant who files a Complaint.

Complaint means any dissatisfaction expressed by a Complainant orally or in writing to UMC Health Plan, including but not limited to dissatisfaction with plan administration; procedures related to appeal of an Adverse Determination; the denial, reduction, or termination of a service not related to Medical Necessity; the way a service is provided; or disenrollment decisions. A Complaint is not a misunderstanding or a problem of misinformation that is resolved promptly by clearing up the misunderstanding or supplying the appropriate information to the satisfaction of the Participant. A Complaint filed concerning dissatisfaction or disagreement with an Adverse Determination constitutes an appeal of that Adverse Determination.

Controlled Substance means a toxic inhalant or a substance designated as a controlled substance in Chapter 481, Texas Health and Safety Code.

Coordination of Benefits (COB) means the payment arrangement when a Participant is covered by two or more health plans. Coordination of benefits divides the responsibility of payment among the health plans so that the coverage combined will pay up to 100% of hospital and professional services within the limits of all contracts.

Copayment or Copay means the amount required to be paid to a Plan Provider or other authorized provider by a Participant in connection with the provision of Covered Health Services to such Participant. The Copayment amounts are indicated in the Schedule of Copayments.

Covered Health Services means those medical and health care services and items specified and defined in Section 4, Covered Health Services of this Plan Document, as being covered services. Covered Health Services must be Medically Necessary and performed, prescribed, directed, or authorized in accordance with this Plan Document.

Crisis Intervention means a short-term process which provides intensive supervision and highly structured activities to Participants who are demonstrating an acute psychiatric crisis of severe proportions which substantially impairs the Participant's thoughts, perception of reality, judgment or grossly impairs behavior.

Custodial Care means care that is not primarily for therapeutic value in the treatment of an illness or injury and is:

- Provided primarily for the maintenance of the Participant; and
- Essentially designed to assist a Participant in the activities of daily living.

Deductible means an amount which a Participant must pay before the Plan begins reimbursing for eligible expenses.

Dependent means a member of an employee's family who meets the eligibility requirements specified in Section 2 of this Plan Document and who has become enrolled in this plan.

Disclosure refers to materials the UMC Health Plan must distribute or make available to plan Participants and/or Dependents. Disclosure requirements include making certain documents available for inspection by Participants and providing copies on request of:

The UMC Health Plan document
Summary of material modifications to the Health Plan

Emergency Care means health care services provided in a Hospital emergency facility or comparable facility to evaluate and stabilize medical conditions of a recent onset and severity, including but not limited to severe pain, that would lead a prudent lay person possessing an average knowledge of medicine to believe that the condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in:

- Placing the patient's health in serious jeopardy;
- Serious impairment to bodily functions;
- Serious dysfunction of any bodily organ or part;
- Serious disfigurement, or
- In the case of a pregnant woman, serious jeopardy to the health of the fetus.

HIPAA means the Health Insurance Portability and Accountability Act of 1996 (HIPAA) that protects workers who switch from one job to another or who leave a job without taking another by limiting the use of pre-existing limitation exclusions, waiting periods and health status exclusions.

Home Health Agency means a public agency or private organization, or a subdivision of such an agency or organization that is:

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Primarily engaged in provided skilled nursing services and other therapeutic services;

Has policies established by a group of professional personnel associated with the agency or organization, including one or more legally qualified Physicians and one or more Registered Professional Nurses (R.N.), to govern the services referred to in item (1) which it provides, and provides for supervision of such services by a legally qualified Physician or Registered Nurse.

Maintains clinical records on all patients, and

In the case of an agency or organization in any State in which State or applicable local law provides for licensing of agencies or organizations of this nature,

is licensed pursuant to such law, or

is approved, by the agency or organization in any State or locality responsible for licensing agencies or organization of this nature, as meeting the standards established for such licensing.

In no event, however, shall the term "Home Health Agency" include any agency or organization or subdivision thereof, which is engaged primarily in the care and treatment of mental disease.

Hospital means an acute care institution licensed by the State of Texas as a Hospital, which is primarily engaged, on an inpatient basis, in providing medical care and treatment of sick and injured persons through medical, diagnostic, and major surgical facilities under supervision of a staff of Physicians and with 24 hour a day nursing and Physician service; provided however, it does not include a nursing home or any institution or part thereof which is used principally as a custodial facility.

Investigational and/or Experimental means a procedure, device, drug, or service, which meets one or more of the following criteria:

The Participant or authorized representative is required to sign an informed consent document which indicates that the procedure, device, drug, or service is to be used in a manner which is Investigational and/or Experimental;

The procedure, device, drug, or service is being used under a research protocol or in a clinical trial to determine its toxicity, safety, and/or efficacy for the Participant's indication;

The applicable provider's Institutional Review Board (IRB) has acknowledged that the use of the procedure, device, drug, or service is Investigational and/or Experimental; or

In the case of a device, a drug or other supply which is subject to FDA approval:

It does not have current FDA approval; or

It has FDA approval under the treatment investigation new drug regulation or a similar regulation;

It has FDA approval, but is being used for an indication or in a fashion that does not constitute accepted off-label use.

UMC's Utilization Review Services has determined that the procedure, device, drug or service is Investigational and/or Experimental based upon:

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Lack of sufficient evidence of safety and efficacy in the English language medical literature; or

Conclusions and recommendations of government entities such as the Agency for Health Care Policy and Research, the National Institutes for Health, the Centers for Disease Control, the FDA, etc.; or

The consensus of expert medical opinion in the United States; or

The procedure, device, drug or service is provided incident to a procedure, drug, device or service, which is Investigational and/or Experimental, based upon any of the above criteria, except that the Plan will cover routine patient costs if a Participant is in an approved clinical trial. An approved clinical trial is a Phase I-IV clinical trial for the prevention, detection or treatment of cancer or other life-threatening condition or disease, and is either (i) a federally funded or approved study or investigation, (ii) a study or investigation conducted under an investigational new drug application reviewed by the Food and Drug Administration, or (iii) a study or investigation that is a drug trial exempt from having such an investigational new drug application. Routine Patient Costs include all items and services consistent with the coverage provided in the Plan that are typically covered for a Participant who is not enrolled in a clinical trial. However, routine patient costs do not include (i) the investigational item, device or service itself, (ii) items and services that are provided solely to satisfy data collection and analysis needs, and that are not used in the direct clinical management of the patient, or (iii) a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

Life Threatening means a disease or condition for which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Material Modification means a change in information required to be in a Plan Document (SPD) or a change in the terms of the plan considered important to Participants.

Medical Child Support Order means a domestic relations judgment, decree, or order issued by a court that requires a parent to provide family coverage to a child. It can also enforce certain state medical child support laws.

Medical Director means a Physician designated by UMC Health Plan to monitor appropriate provision of Medically Necessary Covered Health Services to Participants in accordance with their applicable Evidences of Coverage.

Medical Necessity means that the service must meet *all* of the following conditions:

The service is required for diagnosing, treating or preventing an illness or injury, or a medical condition such as pregnancy;

If Participant is ill or injured, it is a service Participant needs in order to improve Participant's condition or to keep Participant's condition from getting worse;

It is generally accepted as safe and effective under standard medical practice in Participant's community; and

The service is provided in the most cost-efficient way, while still giving Participant an appropriate level of care.

NOT EVERY SERVICE THAT FITS THIS DEFINITION IS COVERED UNDER THE PLAN. JUST BECAUSE A PHYSICIAN OR OTHER HEALTH CARE PROVIDER HAS PERFORMED, PRESCRIBED OR RECOMMENDED A SERVICE DOES NOT MEAN IT IS A MEDICAL NECESSITY AND/OR MEDICALLY NECESSARY OR THAT IT IS COVERED UNDER PARTICIPANT'S PLAN.

Medicare means Title XVIII of the Social Security Act and all amendments thereto.

Morbid Obesity means the Participant has a BMI of 40 or more, or a BMI of 35 or more with at least 1 comorbidity;

Nursing Facility means an institution, which is licensed as such by the State of Texas to provide skilled nursing services in accordance with applicable Texas law.

Open Enrollment Period means a 31-day period established during which eligible Participants may enroll in the Group Health Plan.

Out of Pocket Maximum means the total amount Participant must pay each Plan Year before UMC Health Plan pays benefits at 100% up to the Usual, Reasonable and Customary Charge. Co-Insurance amounts, and inpatient and outpatient hospital copays count toward the Out-of-Pocket Maximum.

Participant means an employee of UMC Health System or such employee's eligible Dependent who enrolls in the UMC Health Plan.

Participating Chemical Dependency Treatment Center means a facility which has directly or indirectly contracted with the TeamChoice Provider Network, and which provides a program for the treatment of Chemical Dependency pursuant to a written treatment plan approved and monitored by a Physician and which facility is also:

- Affiliated with a Hospital under a contractual agreement with an established system for patient referral; or
- Accredited as such a facility by The Joint Commission; or
- Licensed as a Chemical Dependency treatment program by the Texas Commission on Alcohol and Drug Abuse; or
- Licensed, certified, or approved as a Chemical Dependency treatment program or center by any other state agency having legal authority to so license, certify, or approve.

Physician means any Physician who is duly licensed and qualified to practice within the scope of a medical practice license issued under the laws of the State of Texas or in which state treatment is received.

Plan Administrator means the Employer through UMC Health Plan Operations, and the Employer has the fiduciary responsibility for the operation of the Plan.

Plan Document means this booklet.

Plan Provider means those Physicians, Hospitals, Chemical Dependency Treatment Centers, Skilled Nursing Facilities, Home Health Agencies, health professionals, health institutions, and

other entities and persons who have directly or indirectly contracted to provide Covered Health Services.

Plan Sponsor means University Medical Center.

Plan Year means the 12-month period beginning January 1 and ending December 31.

Pre-authorization means the Participant's duty to obtain authorization from the Plan for routine hospital admissions (inpatient or outpatient) and certain procedures. Pre-authorization involves an appropriateness review against criteria and assignment of length of stay. Failure to obtain pre-authorization may result in the Plan not covering the services obtained.

Primary Care Physician (PCP) means a Physician Plan Provider who is primarily responsible for providing, arranging and coordinating all aspects of a Participant's health care.

Qualified Beneficiary for COBRA purposes means a Participant or a Participant's spouse or Dependent child who, on the day before the qualifying event, is covered by the UMC Health Plan. A qualified beneficiary also includes a child born or placed for adoption with a covered Participant during the continuation coverage period.

Qualifying Events means certain types of events that would cause, except for COBRA continuation coverage, an individual to lose group health coverage. The qualifying events are:

- A Participant's termination of employment for any reason except gross misconduct;
- A Participant's reduction in hours to fewer than the number required for plan participation;
- A Participant's divorce or legal separation from spouse;
- A Participant's death;
- A Participant's entitlement to Medicare;
- A child's loss of Dependent status as defined under the plan, or
- A retiree's (or a retiree's spouse's or child's) substantial loss of coverage within one year (before or after) the employer is subject to a Title XI bankruptcy proceeding.

Serious Mental Illness means the following psychiatric illnesses as defined by the American Psychiatric Association in the Diagnostic and Statistical Manual (DSM):

- Schizophrenia;
- Paranoid and other psychotic disorders;
- Bipolar disorders (hypomanic, manic, depressive and mixed);
- Major depressive disorders (single episode or recurrent);
- Schizo-affective disorders (bipolar or depressive);
- Pervasive developmental disorders;
- Obsessive-compulsive disorders; and
- Depression in childhood and adolescence.

Service Area means the geographical area serviced by the TeamChoice Network.

Special Enrollment Event means a special enrollment for certain individuals to enroll in the Plan without having to wait until the plan's next regular enrollment season (i.e. Open Enrollment). A special enrollment event occurs if an individual with other health insurance loses

coverage, an employee or dependent child loses eligibility for coverage under a State Medicaid or CHIP program, an employee or dependent child becomes eligible for State premium assistance under Medicaid or CHIP, or if an individual becomes a new dependent through marriage, birth, adoption or placement for adoption.

Telemedicine means the use of interactive audio, video, or other electronic media to deliver health care. The term includes the use of electronic media for diagnosis, consultation, treatment, transfer of medical data, and medical education. The term does not include services performed using a facsimile machine. Health services will not be excluded based solely on the fact that they were provided through telemedicine and not provided through a face-to-face consultation.

Usual, Customary and Reasonable (UCR) Amount is the amount the Plan Administrator has determined to be the allowable prevailing charge for a particular professional service in the geographical area in which it is performed.

SECTION 2

ELIGIBILITY, ENROLLMENT, EFFECTIVE DATES, AND TERMINATION OF COVERAGE

A. ELIGIBILITY

1. Employee Eligibility

- a. To be eligible to enroll an employee must:
- Be a bona fide employee who is entitled to participate in the health care benefit program funded by UMC Health Plan; and
 - Satisfy any probationary or waiting period requirements established by UMC Health Plan; and
 - Be a full-time employee,² or
 - Be an employee who is scheduled to work 20 or more but less than 30 hours per week

b. Initial Election

An employee must enroll for coverage within 31 days of the starting date of employment or becoming eligible based on benefited status change. If the employee does not enroll, the employee may enroll only during the Open Enrollment period or upon a Special Enrollment Event.

For variable hour/on-call employees, UMC will use a 12 month measurement period and corresponding 12 month stability period. If the variable hour/on-call employee is determined eligible to enroll in the Plan, the initial election must not extend beyond the last day of the first calendar month beginning on or after the first anniversary of the employee's start date.

c. Annual Election

UMC has designated the month of November as annual Open Enrollment Period during which Employees may enroll for coverage or withdraw from the Plan. Coverage elected during the annual open enrollment period will become effective January 1 of the coming year. If the Employee does not complete and return a new election form during the Open Enrollment Period each year, the employee will be treated as having elected to continue the benefit coverage then in effect for the following year. The coverage elected by an Employee may not be changed, except during an annual open enrollment period, unless a Special Enrollment Event occurs (see below).

2. UMC Board Member Eligibility

² For purposes of the UMC Health Plan only, an employee is a full-time employee if the employee averages at least 30 hours of service per week or 130 hours of service in a calendar month. The full-time status will be decided based on UMC's measurement period, and the employee will remain eligible for the duration of the stability period, subject to all other plan term and conditions, including election, premium payments, etc.

Active members of the Lubbock County Board of Managers are eligible to elect the health insurance benefit and dental benefit for themselves and eligible family members and dependents. All references in this document to “Covered Employees” shall apply to Covered Board Members except as otherwise stated. At the end of the Board Member’s term of service, the Board Member will no longer be eligible for coverage under the UMC Health Plan.

3. Dental Reimbursement Eligibility

The employee must enroll into the health insurance plan to receive the dental reimbursement benefit.

4. Family Member or Dependent Eligibility

To be eligible to enroll as a Dependent, the Covered Employee must be enrolled in the Health Plan, the Family Member or dependent must meet all dependent eligibility criteria established by the Employer in this Health Plan Document, and the Family Member or dependent must meet one of the following categories:

- a. Be the Covered Employee’s lawful spouse.
 - The Covered Employee may be required to submit a certified copy of the marriage license or declaration of informal marriage with the dependent’s enrollment form before coverage will be extended.
- b. Be a child of the Covered Employee under age 26, (including step-child, legally adopted child, child placed with the employee for legal adoption, an eligible foster child placed with the employee by agency or court as well as natural child). The Covered Employee may be required to submit documentation proving dependency for the child before coverage will be extended.
- c. Be a child of the Covered Employee’s child (“grandchild”), if the grandchild is unmarried and under age twenty-five (25), and if the grandchild is a dependent of the Covered Employee for federal income tax purposes at the time of the grandchild’s enrollment. The covered employee may be required to submit documentation proving dependency for the grandchild.
- d. Be a child of the Covered Employee over age 26 who because of mental retardation or physical handicap existing before age 26 is and continues to be both (1) incapable of self-sustaining employment by reason of mental retardation or physical handicap, and (2) chiefly dependent upon the Covered Employee for economic support and maintenance, provided a statement of dependent disability or other proof of such incapacity and dependency is furnished to the Plan Administrator by the Covered Employee within thirty-one (31) days of the child’s attainment of the applicable limiting age and subsequently as may be required by the Plan Administrator, but not more frequently than once per year. The Claims Administrator will make the eligibility determination. In addition, such unmarried child must be a Family Member enrolled under the Plan prior to

attaining the applicable limiting age.

- e. Have a court order for coverage to be provided for a spouse or minor child under the Covered Employee's plan. A request for enrollment shall be made within thirty-one (31) days after issuance of the court order.

5. Effects of Medicare Eligibility

Medicare eligibility does not alter eligibility under this Plan Document. Medicare eligibility does affect the way benefits are coordinated. Refer to *Section 11, Coordination of Benefits* for information on primary and secondary coverage.

B. ENROLLMENT

No person meeting eligibility requirements will be refused enrollment or re-enrollment because of current health status, age, or requirements for health services, or the existence of a pre-existing physical or mental condition, including pregnancy on the effective date of coverage. No Participant's coverage shall be terminated due to a Participant's health status or health care needs.

1. Open Enrollment

An Open Enrollment Period shall be held at least annually, at which time eligible employees and/or Dependents may enroll in the UMC Health Plan.

An employee working on a full-time basis at the time of Open Enrollment who does not enroll in the UMC Health Plan during the Open Enrollment period, will not be eligible to enroll in the Plan until the next scheduled Open Enrollment Period, even if his/her employment status changes to part-time during the Plan Year.

An employee working on a benefits-eligible part-time basis or a new variable hour /on-call employee at the time of Open Enrollment who does not enroll or isn't eligible to enroll in the UMC Health Plan during the Open Enrollment period, but who has a benefit status change to a full-time employee during the Plan Year, will be eligible to enroll in the Plan as of the date he/she becomes a full-time employee due to the benefit status change. An ongoing employee's change in employment status during the employee's stability period will not affect the employee's status as a full-time employee or non-full-time employee for the remainder of that stability period.

2. Newly Eligible Employee

Each new employee of UMC Health Plan who becomes eligible for coverage at other than the Open Enrollment Period shall be permitted to enroll himself or herself and eligible Dependents within 31 days of becoming eligible. Newly eligible persons who do not enroll within 31 days of eligibility may only be enrolled during a subsequent Open Enrollment Period.

3. Newly Eligible Dependents

Any person attaining eligibility to become a Dependent may be enrolled by the employee by completing and submitting to UMC Human Resources a signed enrollment form within 31 days of attaining eligibility. No proof of Insurability shall be required. If a newly eligible Dependent is not added within the first 31 days of eligibility, that Dependent cannot be added to coverage until the next Open Enrollment Period.

4. Special Enrollment Events

The following circumstances make an Employee or Dependent newly eligible and able to enroll within thirty-one days of the event:

- a. Marriage, Birth, or Adoption. An eligible Covered Employee who did not enroll when initially eligible may:
 - (i) In the event of marriage, enroll himself or herself and the spouse by completing and submitting to the Plan appropriate enrollment forms within thirty-one (31) days of the date of marriage; or
 - (ii) In the event of the birth of a child, or the adoption of a child, or becoming a party in a suit for adoption of a child, enroll himself or herself, and (a) the spouse, and/or (b) such newborn or newly adopted child, by completing and submitting to the Plan appropriate enrollment forms within thirty-one (31) days of the date of birth, adoption, or becoming a party in a suit for the adoption of a child.
- b. Loss of Other Coverage. An eligible Covered Employee and/or any eligible Dependent who did not enroll when initially eligible may be enrolled if each of the following conditions is met:
 - (i) The individual or Dependent was covered under another Health Benefit Plan, self-funded employer Health Benefit Plan, or other health insurance coverage at the time he was initially eligible to enroll;
 - (ii) The individual eligible as a Covered Employee declined enrollment, in writing, for himself or herself and/or his Dependents at the time of initial eligibility, stating that coverage under another Health Benefit Plan, self-funded employer Health Benefit Plan, or other health insurance coverage was the reason for declining enrollment; and
 - (iii) The individual or Dependent has lost coverage under another Health Benefit Plan, self-funded Health Benefit Plan, or other health insurance coverage as a result of (a) termination of employment, (b) reduction in the number of hours of employment, (c) termination of the other Health Benefit Plan's coverage, self-funded employer Health Benefit Plan's coverage, or other health insurance coverage, (d) termination of contribution payments made by the Employer, (e) death of a spouse, divorce, or legal

separation, or (f) expiration of continuation of coverage period for the Health Benefit Plan, self-funded employer Health Benefit Plan, or other health insurance coverage under Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, or the continuation provisions of the Texas Insurance Code. Such individual eligible as a Covered Employee, and/or eligible Dependent may be enrolled by completing and submitting to the Plan appropriate enrollment forms within thirty-one (31) days after the date coverage ends under the prior Health Benefit Plan, self-funded employer Health Benefit Plan, or other health insurance coverage.

NOTE: To enroll for coverage due to loss of other coverage, enrollment forms must be submitted within thirty-one (31) days of losing coverage under the other plan and appropriate premium payments must be made. Proof of loss of coverage must be provided.

- c. Medicaid/CHIP. An Employee or Dependent is newly eligible and able to enroll within sixty days of the following:
- (i) The Employee or Dependent Child loses eligibility for coverage under Medicaid or a State Children's Health Insurance Program ("CHIP"); or
 - (ii) The Employee or Dependent Child becomes eligible for premium assistance from Medicaid or CHIP, if available in Texas, which allows the individual to enroll in the UMC Health Plan.

5. Notice of Ineligibility

It shall be the Participant's responsibility to notify UMC Human Resources of any event or changes that will affect the Participant's or Dependent's eligibility for services or benefits under this Plan Document. The Participant must give notice within 31 days of the event.

6. Failure to Enroll

Eligible individuals who do not apply within the required periods may be enrolled only during a subsequent Open Enrollment period.

C. EFFECTIVE DATE OF COVERAGE

Subject to Plan Administrator's receipt of a completed enrollment form, coverage under this Plan Document shall become effective on the earliest of the following dates:

1. Open Enrollment

Coverage shall be effective as of January 1st following the open enrollment period.

2. Newly Eligible Employees & Dependents As a Result of Hire or Benefit Status Change

Newly hired Employees or Employees with a benefit status change who become eligible for coverage other than at the Open Enrollment Period shall be permitted to enroll themselves and eligible Dependents within thirty-one (31) days after becoming eligible and meeting any other guidelines set by the employer. The following calendar month is the mandatory waiting period. The effective date of coverage is the first day of the month following the waiting period, subject to any other time frames required by PPACA for effective dates of coverage.

3. Special Enrollment Events

Coverage for Participants who enroll pursuant to a special enrollment event will be effective as follows:

- a. Marriage. Coverage for Covered Employee and the spouse will be effective on the first day of the month after completed enrollment forms are received by UMC Health Plan, provided forms are received within thirty-one (31) days of the date of marriage.
- b. Birth, Adoption, or Placement for Adoption. Coverage for an eligible newborn or newly adopted child will be effective on the date of birth, adoption, or placement for adoption, provided appropriate enrollment forms are received by UMC Health Plan within thirty-one (31) days of the birth, adoption, or placement for adoption.
- c. Loss of Other Coverage. An Employee and any Dependent eligible due to loss of other coverage have thirty-one (31) days from the date of the loss of coverage to make benefit elections. Coverage will be effective on the first day of the month after the completed enrollment forms are received by UMC Health Plan.
- d. Loss of Eligibility under Medicaid or SCHIP. An Employee and any Dependent Child eligible due to loss of eligibility for coverage under Medicaid or a State Children's Health Insurance Program ("SCHIP") have sixty (60) days from the date of termination of such coverage to make benefit elections. Coverage will be effective on the date of Employee's or Dependent's loss of eligibility for coverage under Medicaid or SCHIP.
- e. Eligibility for Premium Assistance under Medicaid or SCHIP. An Employee and any Dependent Child who becomes eligible for premium assistance from Medicaid or SCHIP, if available in Texas, which allows enrollment in the UMC Health Plan has sixty (60) days from the date of being determined eligible for such assistance to make benefit elections. Coverage will be effective on the date for which premium assistance is payable.

D. TERMINATION AND RESCISSION

Termination means a cancellation or discontinuance of coverage with a **prospective** effect. Rescission means a cancellation or discontinuance of coverage with a **retroactive** effect. The UMC Health Plan may only rescind coverage for fraud or intentional misrepresentation of a material fact. In addition, should the UMC Health Plan find fraud or intentional misrepresentation of a material fact, the UMC Health Plan may

elect in its sole discretion to terminate a Participant's benefits rather than rescind a Participant's benefits.

1. Termination of Covered Employee's Coverage

A Covered Employee's benefits and coverage under the Health Plan will terminate on the earliest of the following dates:

- The date the Employer terminates the Health Plan;
- The date the Health Plan is amended to terminate the benefits of a class of employees of which the Covered Employee is a member;
- With respect to any benefits for which the Covered Employee ceases to be a member of the class or classes of employees eligible for such benefits, the date of cessation of membership;
- 30 days after the date ending the period for which the Covered Employee's last contribution is made, if the Covered Employee fails to make any required contribution towards the cost of benefits when due;³
- The end of the month in which the Covered Employee ceases to be regularly scheduled to work at least 20 hours per week, subject to any contrary guidance under the employer shared responsibility requirements; or
- The end of the month in which the Covered Employee's active employment with University Medical Center is terminated.

2. Termination of Covered Dependent's Coverage

The benefits and coverage under the Health Plan with respect to Dependents will terminate on the earliest of the following dates:

- The date the Employer terminates the Health Plan;
- The date the Health Plan is amended to terminate the benefits of a class of dependents of which the Dependent is a member;
- With respect to any benefits for which the Dependent ceases to be a member of the class or classes of dependents eligible for such benefits, the date of cessation of membership;
- 30 days after the date ending the period for which the Dependent's last contribution is made, if the Covered Employee or Dependent fails to make any required contribution towards the cost of benefits when due;

³ The Plan will provide the employee with a 30 day grace period to make payment. If the payment is not paid within the grace period, the Plan will not provide coverage for the period for which the premium is not timely paid and may terminate coverage. If the employee makes a partial payment that is "not significantly less" than the total amount due (the lesser of 10% of what is due or \$50), the Plan will notify the employee in writing of the underpayment and give the employee a reasonable amount of time to pay the remaining balance.

- The end of the month in which the Dependent's Covered Employee ceases to be regularly scheduled to work at least 20 hours per week, subject to any contrary guidance under the employer shared responsibility requirements; or
- The end of the month in which the Dependent's Covered Employee's active employment with University Medical Center is terminated.
- The date a Dependent ceases to be eligible as a Dependent. Benefits for medical care expenses may be continued for a Dependent who is mentally or physically incapable of earning a living and who is dependent upon the support and maintenance of the covered employee. The covered employee must provide evidence of the Dependent's incapacitation within 31 days after the Dependent is no longer eligible. Any benefits continued for such a Dependent will terminate under any of the conditions described above, or in any event, when the Dependent ceases to be incapacitated, or at the end of the 31 day period after any request for proof of continued incapacity if the proof is not furnished.
- The end of the month in which the Dependent's Covered Employee dies.

3. Automatic Termination

Except as otherwise provided in this Plan Document, the coverage of any Participant who ceases to be eligible shall automatically terminate on the date on which eligibility ceases, and such termination of coverage shall also apply to each Dependent of such Participant whose coverage so terminates.

4. Termination for Cause

A Participant's benefits and coverage under the Health Plan may be terminated by the Health Plan for cause. Reasons for termination may include, but is not limited to:

- The Covered Employee or Participant provides false or misleading information or conceals information about the status of individuals for whom the covered employee elects coverage in order to obtain coverage under the Health Plan. Coverage may be cancelled after not less than fifteen (15) days written notice to the Covered Employee or Participant.
- The Covered Employee or Participant knowingly submits, or cause another person or entity to submit, false claims for payment under the Health Plan. Coverage may be cancelled after not less than fifteen (15) days written notice to the Covered Employee or Participant.
- The Covered Employee or Participant provides false or misleading information or conceals information for the purpose of misleading the Health Plan concerning any fact pertaining to a claim. Coverage may be cancelled after not less than fifteen (15) days written notice to the Covered Employee or Participant.

- The Covered Employee or Participant allows another person to use a Participant's Health Plan information to obtain services under the Health Plan. Coverage may be cancelled after not less than fifteen (15) days written notice to the Covered Employee or Participant.
- The Covered Employee or Participant fails to pay copayments or other amounts due under the Plan. Coverage may be cancelled after not less than thirty (30) days written notice, except no written notice will be required for failure to make contribution payments.
- The Covered Employee or Participant commits fraud in the use of services or facilities. Coverage may be cancelled after not less than fifteen (15) days written notice to the Covered Employee or Participant.
- The Covered Employee or Dependent exhibits abusive behavior or misconduct detrimental to safe program operations and the delivery of services on or on the premises of the Plan or a Plan Provider setting. Coverage may be cancelled immediately.
- Failure of the Participant and a Plan Physician to establish a satisfactory patient-physician relationship if it is shown that the Plan has, in good faith, provided the Participant with the opportunity to select an alternative Plan Physician, the Participant is notified in writing at least thirty (30) days in advance that the Plan considers the Patient-Physician relationship to be unsatisfactory and specifies the changes that are necessary in order to avoid termination and the Participant has failed to make such changes. Coverage may be cancelled at the end of the thirty (30) days.

5. Rescission of Coverage

A Participant's benefits and coverage under the Health Plan may be rescinded. Rescission shall be retroactive to the initial date of the fraud or initial misrepresentation of a material fact, whichever is earlier. Reasons for rescission are:

- The Covered Employee or Participant provides false or misleading information or conceals information about the status of individuals for whom the covered employee elects coverage in order to obtain coverage under the Health Plan. Coverage may be cancelled after not less than thirty (30) days written notice to the Covered Employee or Participant.
- The Covered Employee or Participant knowingly submits, or cause another person or entity to submit, false claims for payment under the Health Plan. Coverage may be cancelled after not less than thirty (30) days written notice to the Covered Employee or Participant.
- The Covered Employee or Participant provides false or misleading information or conceals information for the purpose of misleading the Health Plan concerning any fact pertaining to a claim. Coverage may be cancelled after not less than thirty (30) days written notice to the Covered Employee or Participant.

- The Covered Employee or Participant allows another person to use a Participant's Health Plan information to obtain services under the Health Plan. Coverage may be cancelled after not less than thirty (30) days written notice to the Covered Employee or Participant.
- The Covered Employee or Participant commits fraud in the use of services or facilities. Coverage may be cancelled after not less than thirty (30) days written notice to the Covered Employee or Participant.

6. Continuation of Coverage

Upon termination or rescission of coverage, a Participant may be eligible to continue coverage. See Section 7 of this Health Plan about the requirements for continued coverage.

SECTION 3

RETIREE HEALTH PLAN BENEFITS

A. PHASE-OUT OF RETIREE HEALTH PLAN.

UMC retirees and eligible dependents may continue health plan coverage, subject to certain stipulations and guidelines.

However, the UMC Health Plan will phase out the Retiree Health Plan, beginning January 1, 2010 through December 31, 2012. The Section entitled "Eligibility" below describes the period during which retirees and dependents may participate. Retirees and dependents should plan for alternative health care coverage after the Retiree Health Plan is no longer available.

B. RETIREE HEALTH PLAN BENEFITS

Covered benefits are the same as those offered to active employees. The provisions of the UMC Health Plan document govern the Retiree Health Plan except as otherwise stated in this section. All references to "Covered Employee" in this document shall apply to the Covered Retirees except as otherwise specifically stated.

C. ELIGIBILITY

1. An eligible retiree is an employee:
 - a. whose age and years of service total 80 or more at the time of retirement; and,
 - b. who is enrolled in the UMC Health Plan on the day prior to retirement; and,
 - c. who is employed by UMC at the time of retirement.
2. An eligible retiree is a member of the Board of Managers:
 - a. who completes at least four (4) years of service; and
 - b. is enrolled in the UMC Health Plan on the last day of service as a Board Member.
3. An eligible dependent is:
 - a. a dependent defined under the Health Plan; and,
 - b. enrolled in the UMC Health Plan on the day prior to the employee's retirement.
4. Phase-Out
 - a. Existing Retirees and Dependents.

As of January 1, 2010, all current Participants in the Retiree Health Plan may continue participation in the Plan for three years or until age 65,

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whichever period is greater. Participation is subject to termination or rescission under conditions described in Section 2 and Section 3(G) below.

b. Newly Eligible Retirees and Dependents

As of January 1, 2010, if a Covered Employee met or will meet on or before December 31, 2012 all eligibility requirements to retire, the Covered Employee and eligible Dependents may participate in the Plan for three years or until age 65, whichever period is greater, based on the Covered Employee's eligibility. Participation is subject to termination or rescission under conditions described in Section 2 and Section 3(G) below.

c. Cessation of Enrollment

Effective January 1, 2013, no retirees or dependents will be eligible for or enrolled in the Retiree Health Plan other than those in 4(a) and 4(b).

D. MEDICARE ELIGIBILITY

When the Retiree Health Plan Participant reaches age 65 or otherwise receives Medicare benefits, the Retiree Health Plan will become a secondary Payor to Medicare, subject to the time limitations listed in Sections C,4(a) and C, 4(b).

E. PREMIUM RATES AND PAYMENT

1. Premiums must be paid on or before the 1st day of each month by check, money order, or bank draft to the address noted in Section 1 of this Health Plan Document.
2. Failure to pay premiums may result in a lapse of coverage.

F. ENROLLMENT

1. An eligible retiree must complete the Retiree Health Plan election form, available from UMC Health Plan Operations, and remit the appropriate premium payment to UMC Health Plan Operations within thirty (30) days following the effective date of retirement.
2. Dependents may be added or dropped from the Plan after initial enrollment in accordance with the Plan guidelines concerning qualifying events.

G. TERMINATION AND RESCISSION OF RETIREE HEALTH BENEFITS

1. In addition to termination provisions in Section 2 of this Plan Document, retiree health benefits will automatically terminate for the retiree and/or covered dependents if:
 - a. UMC ceases to sponsor an employee health benefit plan;
 - b. UMC ceases to sponsor a retiree health plan;

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- c. The retiree or retiree's dependent fails to remit the monthly premium payment by the last day of each month;
 - d. The retiree returns to active employee status with UMC and becomes covered under the UMC Health Plan as an employee;
 - e. The retiree dies;
 - f. There is fraud or misrepresentation by the retiree/dependent(s), coverage may be cancelled after not less than fifteen (15) days written notice;
 - g. There is fraud in the use of services or facilities, coverage may be cancelled after not less than fifteen (15) days written notice;
 - h. The retiree/dependent(s) fail to meet eligibility requirements; coverage may be canceled immediately;
 - i. The retiree/dependent(s) engage in abusive behavior or misconduct detrimental to safe program operations and the delivery of services in or on the premises of the Plan or a Plan Provider setting; or,
 - j. There is a failure of the retiree/dependent(s) and a Plan Physician to establish a satisfactory patient-physician relationship if it is shown that the Plan has, in good faith, provided the retiree/dependent(s) with the opportunity to select an alternative Plan Physician, the retiree/dependent is notified in writing at least thirty (30) days in advance that the Plan considers the Patient Physician relationship to be unsatisfactory and specifies the changes that are necessary in order to avoid termination and the retiree/dependent has failed to make such changes, coverage may be cancelled at the end of the thirty (30) days.
2. In addition to rescission provisions in Section 2 of this Plan Document, retiree health benefits may be rescinded at the sole discretion of the UMC Health Plan for the retiree and/or covered dependents for fraud or intentional misrepresentation of material fact. The UMC Health Plan will provide the Retirees and covered dependents with 30 days notice of its intent to rescind coverage.
 3. Retiree health benefits will automatically become secondary if the retiree and/or covered dependents become covered under another health plan.
 4. Retirees and dependents who are no longer eligible for the Retiree Health Plan may be eligible for COBRA continuation coverage under the COBRA guidelines.

SECTION 4

COVERED HEALTH SERVICES, LIMITATIONS AND EXCLUSIONS

Benefits are provided for the services listed in this section. The Covered Health Services listed below are subject to Copayments, Deductibles and Coinsurance which are specified in the Schedule of Benefits in the front of this booklet. The payment for specific services is also specified in the Schedule of Benefits. Special copayments for certain Covered Health Services are listed below.

A. INTEGRATION OF BENEFITS

The Health Plan includes integration of benefits for Plan maximums between in-Network and out-of-network benefits. This means that annual maximums and maximums which apply per day or visit will be cross applied, regardless of whether the provider is in-network or out-of-network. Coverage maximums will also be cross-applied between all coverage types.

B. COVERED HEALTH SERVICES

To be a Covered Health Service, the service must be Medically Necessary and performed, prescribed, directed, or authorized in accordance with this Health Plan. Some Covered Health Services require advance authorization from the Health Plan.

1. If an In-Network Plan Provider cannot provide Medically Necessary services, the UMC Health Plan must give advance approval for a referral to an out-of-network provider. Section 8 of this Health Plan document describes benefit limitations regarding out-of-network providers and the process for advance approval. If the Health Plan gives advance approval for the referral, the Health Plan will cover the health services according to the In-Network benefit schedule. If the Health Plan does not give advance approval, the Health Plan will not cover the health services.

2. If a Participant resides outside of the TeamChoice network service area, the Participant must notify the Health Plan in order for Covered Health Services to be paid according to the In-Network benefit schedule. Section 8 of this Health Plan document describes out-of-area services.

See Section 10 for a list of Covered Health Services which must be approved in advance by the Health Plan in order for benefits to be paid.

Allergy Services

Medically Necessary allergy testing conducted to evaluate and determine the cause of allergy and the appropriate allergy treatment including the administration of an injectable substance are Covered Health Services.

Ambulance Services

Medically Necessary ambulance service to the nearest medical facility for Emergency Care Services is a Covered Health Service. Medically Necessary non-emergency ambulance service when **authorized in advance by the Health Plan** is a Covered Health Service.

Chemical Dependency Services

Chemical Dependency is the abuse of psychological or physical dependence on, or addiction to, alcohol or a Controlled Substance, a Toxic Inhalant or a substance designated as a controlled substance in Chapter 481, Texas Health and Safety Code. **Toxic Inhalant** means a volatile chemical under Chapter 484, Texas Health and Safety Code, or abusable glue or aerosol paints under Section 485.001, Texas Health and Safety Code. Medically Necessary inpatient and outpatient services for the treatment of Chemical Dependency are provided on the same basis and subject to the same limitations, exclusions and Copayments as treatment for physical illness.

Treatment in an In-network approved Chemical Dependency Treatment Center **must be authorized in advance** by the Health Plan. Treatment for Chemical Dependency is limited to a lifetime maximum of three separate series of treatments for each Participant. A series of treatments is a planned, structured and organized program to promote chemical free status when provided by Health Plan approved facilities and providers and is complete when the Participant is discharged on medical advice from inpatient detoxification, inpatient rehabilitation/treatment, partial hospitalization or intensive outpatient, or a series of these levels of treatments without a lapse in treatment or when a Participant fails to materially comply with the treatment program for a period of thirty 30 days.

A Day Treatment Facility means a facility that provides treatment for not more than 8 hours in any 24-hour period after which the Participant is allowed to leave.

Diabetic Services

Covered Health Services include Medically Necessary services and supplies provided for the treatment of insulin dependent or non-insulin dependent diabetes, elevated blood glucose levels induced by pregnancy or other medical conditions associated with elevated blood glucose levels.

The following *diabetic equipment* is considered Covered Health Services based on Medical Necessity when prescribed by the Physician and purchased through an authorized Provider:

- Blood glucose monitors, including monitors designed to be used by blind individuals;
- Injection aids, including devices used to assist with insulin injection and needleless systems;
- Insulin pumps, both external and implantable and associated appurtenances which include:
 - insulin infusion devices
 - batteries
 - skin preparation items
 - adhesive supplies
 - infusion sets
 - insulin cartridges

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- durable and disposable devices to assist in the injection of insulin
- other required disposable supplies
- Repairs and necessary maintenance of insulin pumps and rental fees for pumps during the repair and necessary maintenance of insulin pumps, and
- Podiatric appliances for the prevention of complications associated with diabetes.

The following *diabetic supplies and medications* are considered Covered Health Services based on Medical Necessity when prescribed by the Physician:

- Test strips specified for use with corresponding glucose monitor;
- Lancets and lancet devices;
- Visual reading strips and urine testing strips and tablets which test for glucose, ketones and protein;
- Insulin and insulin analogs preparations;
- Insulin syringes;
- Biohazard disposal containers;
- Prescription medications which bear the legend “Caution: Federal Law prohibits dispensing without a prescription” and medications available without a prescription for controlling blood sugar levels; and
- Glucagon emergency kits.

As new or improved insulin, prescription drugs, treatment, monitoring equipment or supplies become available and are approved by the United States Food and Drug Administration, such equipment or supplies shall be covered if determined to be Medically Necessary and appropriate by a treating Provider through a written order.

All supplies, including brand name medications and equipment for the control of diabetes shall be dispensed as written, unless the Provider who issues the written order for supplies or equipment approves a substitution.

Diabetes self-management training is covered when provided by a Plan Provider or approved Provider who is licensed, registered or certified in this state to provide appropriate health services. Self-management training will include nutritional counseling, education as to use of equipment and supplies, follow up education dependent on condition changes and needs of Participant, periodic or episodic continuing education training when prescribed by an appropriate health care practitioner.

An annual eye examination by an eye specialist is a Covered Health Service for a Participant diagnosed with diabetes.

Dietary Counseling Services

Dietary counseling and nutritional education for patients with morbid obesity and metabolic diseases, and for adult patients with high cholesterol and other known risk factors for cardiovascular and diet-related chronic disease are Covered Health Services when determined to be Medically Necessary by the treating Physician. Morbid obesity means the disorder

defined by a current weight which is 100 pounds or 100% over the ideal weight for any given age, sex, height and body frame that is statistically associated with the standard life expectancy.

Durable Medical Equipment

Durable Medical Equipment (DME) is that medical equipment which, in the absence of illness or injury, is of no medical or other value to the Participant; which is able to withstand repeated use by more than one person; and which is not disposable. Examples of such equipment include crutches, hospital beds, and wheelchairs. Medically Necessary durable medical equipment is a Covered Health Service if it meets the following conditions:

- DME must be ordered or prescribed by the Provider.
- DME must be Medically Necessary as determined by the Medical Director.
- DME may be purchased or rented; whichever is most cost effective, as determined by the Medical Director.
- Coverage is provided for the initial equipment only.
- Only the standard equipment is covered. Special features which are not part of the basic equipment are not covered, such as electric beds, electric wheelchairs.
- DME over \$1,000 in charges must be **authorized in advance by the Health Plan**.

Medically Necessary monitoring devices, such as apnea monitors and uterine monitors, for use in the home will be covered when prescribed and directed by the Provider and **authorized in advance by the Health Plan**.

Replacement of DME can be made after 5 years if the item is worn down from normal wear and tear and can no longer be fixed or with medical necessity due to a physiological change to the patient. Replacement equipment requires a new order or prescription.

Maintenance and repairs resulting from misuse and abuse, replacements and duplicates of Durable Medical Equipment are the responsibility of the Participant.

Supplies which can be purchased over the counter without a Physician order are excluded. Please refer to Limitations and Exclusions.

Emergency Care Services

Emergency care means health care services provided in a hospital emergency facility or comparable facility to evaluate and stabilize medical conditions of a recent onset and severity, including but not limited to severe pain, that would lead a prudent lay person possessing an average knowledge of medicine to believe that the condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in:

- Placing the patient's health in serious jeopardy;
- Serious impairment to bodily functions;
- Serious dysfunction of any bodily organ or part;
- Serious disfigurement, or
- In the case of a pregnant woman, serious jeopardy to the health of the fetus.

Any medical screening or other evaluation required by state or federal law, which is necessary to determine whether an emergency medical condition exists, should be provided to Participant in the hospital emergency facility or comparable facility. Services, other than the medical screening and stabilization, for any situation that does not meet the definition of Emergency Care above will not be covered and will result in Participant being financially responsible for those services. The Health Plan **must authorize** services originating in a hospital emergency facility or comparable facility following stabilization of an emergency condition. Upon request from the treating provider for approval or denial of post stabilization care, the Health Plan will respond within a reasonable time period. Emergency Care services will be administered as stated above, regardless of whether services are received in the Service Area or outside the Service Area.

The emergency room Copayment will be waived if Participant is admitted to the hospital.

Emergency Care services rendered by out-of-network Providers will be covered subject to the same amounts for such services in the In-Network based upon the signs and symptoms presented at the time of treatment as documented by the attending health care personnel, whether the Emergency Care services were received within the Service Area or outside the Service Area. However, the out-of-network Provider may bill the Participant for additional money once the Plan has paid the appropriate amount required by law. This means that once the Plan has paid its applicable part of the out-of-network Provider's bill and the Participant has paid the applicable co-payment, the Participant could still owe the out-of-network Provider more money if the Provider bills the Participant.

Out-of-area coverage is provided for care which cannot be medically postponed until the Participant is able to return to the Service Area. (Exceptions to the Out-of-area coverage are available for those Participants who are designated participants residing out-of-area and have notified the Health Plan of their status. These Participants will be required to access applicable Out-of-area network providers in order to obtain services payable at In-Network rates.) Elective, routine or specialized care that is not of an emergent nature will not be covered outside the Service Area.

Any continuing or follow-up treatment outside of the service area must be **authorized in advance by the Health Plan** and is limited to care required before the Participant can, without medically adverse consequences, return to the TeamChoice Service Area.

Family Planning Services

1. Diagnostic counseling, consultations and planning services for problems of fertility and infertility are Covered Services.
2. Subject to limitations and exclusions, Medically Necessary testing for problems of infertility is a Covered Health Service. Diagnostic procedures include sperm count, endometrial biopsy, and hysterosalpingography and diagnostic laparoscopy.
3. Voluntary sterilization is a Covered Health Service when authorized by the Plan.
4. Medically Necessary pregnancy terminations (abortions) are a Covered Health Service. Voluntary and elective abortions are not a covered benefit.

5. Depo-Provera™ Injections are a Covered Health Service.
6. Contraceptive implants are a Covered Health Service.
7. Oral contraceptives along with other contraceptive devices (other than implants) are covered benefits under the pharmacy benefits.
8. Insertion or removal of an intrauterine device (IUD) is a Covered Health Service.

Gastric Bypass

This benefit is only available to Participants who have been covered by the UMC Health Plan for three (3) continuous years prior to the gastric bypass surgery. There cannot be any break in coverage to be eligible. Additional eligibility requirements include:

- Participant must have a BMI of 40 or more, or a BMI of 35 or more with at least 1 comorbidity;
- Participant must adhere to pre-surgery guidelines and requirements established by the surgeon and/or other medical staff as appropriate; and
- Participant must have a screening at least 30 days prior and 6 months post surgery that measures at a minimum lipid profile, cholesterol, glucose, tri-glycerides, and hemoglobin.

All services are required to be performed at UMC. Benefits pertaining to pre and/or post surgery, and all services performed in the course of this service are subject to a 30% coinsurance rate. Expenses are not applied against the annual out of pocket maximum. Plan benefits are limited to In-Network only, and there is no coverage for out-of-network services. Coverage for Gastric Bypass Surgery is allowed only once in the lifetime of the Participant. Body contouring surgery to remove sagging or extra skin required as a result of the gastric bypass surgery will be covered. ***The Health Plan must authorize all services in advance.***

Post Surgery Coverage for Prior or Non-Covered Gastric Bypass Surgery

Post-Operative Benefits for complications, labs, and follow-up visits are covered for Participants who had gastric bypass surgery prior to obtaining coverage under the UMC Health Plan or did not qualify for gastric bypass surgery under the UMC Health Plan. All services are required to be performed at UMC. These benefits are subject to a 30% coinsurance rate. Expenses are not applied against the annual out of pocket maximum. Plan benefits are limited to In-Network only, and there is no coverage for out-of-network services. Body contouring surgery to remove sagging or extra skin is not covered unless deemed medically necessary. ***The Health Plan must authorize all services in advance.***

Genetic Testing

BRCA1 and BRCA2 genetic testing is a Covered Health Service for the following individuals:

1. Clinically-affected individuals (invasive breast cancer or ovarian cancer at any age) meeting at least one of the following criteria:
 - a. one or more first- degree (mother, father, sister, daughter) or second-degree (aunt, uncle, grandmother, niece, granddaughter) relatives with invasive breast cancer diagnosed before age 50; or
 - b. one or more first or second-degree relatives with ovarian cancer; or
 - c. one or more first or second-degree relatives with male breast cancer.

2. Individuals with a personal history of at least one of the following (no family history required):
 - a. invasive breast cancer before age 50;
 - b. ovarian cancer at any age;
 - c. both invasive breast cancer and ovarian cancer at any age; or
 - d. male breast cancer at any age.
3. Individuals with a family member (related by blood) with a known BRCA1 or BRCA2 mutation.
4. Individuals of Ashkenazi (Eastern European) Jewish ancestry with invasive cancer at any age or meeting any of the above-listed (1 through 3) criteria.

Gynecological Services

An OB/GYN Specialist or Primary Care Physician may provide the following health care services:

- One well-woman exam per Plan Year;
- Care related to pregnancy;
- Care for all active gynecological conditions, and
- Diagnosis, treatment, and referral for any disease or condition within the scope of the professional practice of the OB/GYN, including treatment of medical conditions concerning the breasts.

Home Health Care Services

Home health care consists of services that are Medically Necessary for the care and treatment of a covered illness or injury furnished to a Participant at his or her place of residence. Skilled health care services in the home are covered when provided by an In-Network provider or approved Home Health Agency. ***The Health Plan must authorize all services in advance.***

Hospice Care Services

Hospice care is a coordinated program designed to meet the special physical, psychological, spiritual, and social needs of a terminally ill Participant by providing palliative and supportive medical, nursing and other services through at-home or inpatient care. These services must be provided by a hospice organization licensed in accordance with the laws of the state in which the hospice organization is located. Hospice care services are covered in full upon certification by the treating Provider that the Participant has a life expectancy of six months or less. ***The Health Plan must authorize all services in advance.***

Hospital Services

The Health Plan must approve all Hospital admissions in advance except Emergency Care admissions. The following inpatient services are Covered Health Services for the medical and surgical treatment of illness and injury when Medically Necessary:

- Room and board;
- General nursing care;
- Special diets when Medically Necessary;
- Use of operating room and related facilities;
- Use of intensive care unit and services;
- X-ray services, laboratory, and other diagnostic tests;
- Drugs, medications, and biologicals;
- Anesthesia and oxygen services;
- Special duty nursing when Medically Necessary;
- Radiation therapy;
- Chemotherapy
- Inhalation therapy
- Administration of whole blood and blood plasma, storage expenses, including the storage of blood for an elective surgery;
- Rehabilitative services in physical, speech and occupational therapy, and Physician services.

Inpatient services required to diagnose and treat breast cancer are covered for a minimum 48-hour inpatient stay following a mastectomy and a 24-hour inpatient stay following a lymph node dissection. The inpatient stay may be less than the minimum hours of inpatient care, if the Participant and the Participant's treating Physician determine that a shorter period of inpatient care is appropriate.

Immuno-Suppressive Medications

Covered Health Services include Medically Necessary immuno-suppressive drugs. Participants must pay a copayment for each prescription for immune-suppressive drugs:

| | |
|--|---|
| UMC OUTPATIENT PHARMACY and MEDIMPACT (up to a 34-Day Supply): | |
| Generic (or Brand Name without generic equivalent) | \$35 Copay |
| Brand Name | Greater of \$55 Copay or 20% per prescription |
| Generic Mail Order or in-house equivalent | 3 month supply, \$80 Copay |

Laboratory Services, Diagnostic and Therapeutic Radiology Services

Laboratory services, diagnostic and therapeutic radiology services including mammograms are covered when Medically Necessary. Services must be prescribed or ordered by the Plan Provider or other authorized Provider.

Bone mass measurement for the detection of low bone mass and to determine the Participant's risk of osteoporosis and fractures associated with osteoporosis is a Covered Health Service.

Except for Emergency Care as provided in the Health Plan Document, outpatient PET Scans, arteriograms, EEGs, myelograms, needle biopsies, VCUGs (voiding cysto-urethrogram), MRIs, and CT Scans must be **authorized in advance by the Health Plan**.

Long-Term Acute Care Facility

Medically Necessary long-term acute care facility services are a Covered Health Service for a maximum of 100 days per Participant per Plan Year (combined with Skilled Nursing Facility days), provided that such services are of a temporary nature and lead to rehabilitation and increased ability to function. Long-term acute care facility services must be **authorized by the Health Plan in advance** and be provided at an authorized Long-Term Acute Care Facility. Custodial or domiciliary care is not a Covered Health Service.

Participants remaining in a Long-Term Acute Care Facility after discharge or after the maximum benefit period is reached shall be responsible for all subsequent costs incurred. Private duty nursing services, private room accommodations, personal or comfort items and other articles not specifically necessary for treatment of illness or injury are excluded. Please refer to Limitations and Exclusions.

Maternity Care Services

Coverage is provided for maternity care, including Physician services for pre- and post-natal care; use of Hospital delivery rooms and related facilities; use of newborn nursery and related facilities; and any special procedures as may be Medically Necessary. Inpatient care is provided for the mother and her newborn child in a health care facility for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by cesarean section unless the mother requests and the attending Physician agrees to discharge prior to the expiration of the minimum length of stay. Please refer to Maternity Services in the Schedule of Benefits.

A child born outside the Service Area due to an emergency, or born in an out-of-network facility to a mother who has coverage under this Plan Document may be required to be transferred to an In-Network facility and if applicable, to an In-Network Plan Provider when such transfer is medically appropriate as determined by the newborn's treating Physician, in order to receive the highest level of benefits.

Maternity care coverage is not provided for a Dependent Child (see Limitations and Exclusions).

Mental Health Services

Covered Health Services include short-term evaluation and for crisis intervention, a short-term process which provides intensive supervision and highly structured activities to Participants who are demonstrating an acute psychiatric crisis of severe proportions which substantially impairs the Participant's thoughts, perception of reality, judgment or grossly impairs behavior. Benefits are provided up to a maximum of 20 visits per Participant per Plan Year.

Limited inpatient coverage is provided for acute psychiatric conditions other than the Serious Mental Illness diagnoses described below, when authorized by the Provider and **authorized by the Health Plan**. Acute psychiatric conditions are those situations where substantial impairment exists in the thought process, perception of reality, emotional process or judgment as manifested

by recent disturbed behavior. This benefit is limited to 15 inpatient treatment days per Plan Year, which may be provided in any combination of treatment days as follows:

- One day in an **approved** inpatient psychiatric Hospital equals one inpatient treatment day;
- One day in an **approved** Psychiatric Day Treatment Facility equals one-half (1/2) inpatient treatment day; or
- One day in an **approved** Crisis Stabilization Unit or Adolescent Residential Treatment Center for Children and Adolescents equals one-half (1/2) inpatient treatment day.

Residential Treatment Center for Children and Adolescents means a child-care institution that provides residential care and treatment for emotionally disturbed children and adolescents.

Crisis Stabilization Unit means a 24-hour residential program that is usually short-term in nature and provides intensive supervision and highly structured activities to persons who are demonstrating an acute psychiatric crisis of moderate to severe proportions.

Some exclusions apply to Mental Health Services. Refer to the Exclusions section.

Mental Illness -- Serious

Covered Health Services include outpatient treatment of Serious Mental Illness up to a maximum of 60 outpatient visits per Participant per Plan Year for treatment, including group and individual outpatient treatment.

Coverage is provided for the Medically Necessary inpatient care, diagnosis and treatment of Serious Mental Illness when authorized by the Provider and **authorized by the Health Plan**. This benefit is limited to 45 inpatient treatment days per Participant per Plan Year.

Serious Mental Illness means the following psychiatric illnesses as defined by the American Psychiatric Association in the Diagnostic and Statistical Manual (DSM):

- Schizophrenia;
- Paranoid and other psychotic disorders;
- Bipolar disorders (hypomanic, manic, depressive and mixed);
- Major depressive disorders (single episode or recurrent);
- Schizo-affective disorders (bipolar or depressive);
- Pervasive developmental disorders;
- Obsessive-compulsive disorders, and
- Depression in childhood and adolescence.

Outpatient visits for the purpose of medication management of Serious Mental Illness are treated as any other outpatient visit for a physical illness and are not included in the maximum visits.

Except for Emergency Care as provided in the Health Plan Document, the benefits provided for Mental Health Services are available only when pre-authorized by the Provider and the Health Plan. A Plan Provider or approved Provider must provide all services.

Observation Unit Admission

Admissions to the Observation Unit of a hospital or other approved facility are a Covered Health Service if the admission for observation is ordered by the Participant's treating Provider and **is limited to less than 24 hours**.

Oral Surgery Services

General dental services are not Covered Health Services. However, limited dental services for the restoration and correction of damage caused by external violent accidental injury to natural teeth, and certain oral surgeries due to medical causes are Covered Health Services. A Participant must contact the Health Plan prior to seeking emergency services for an accidental dental injury if reasonably possible. In the event pre-authorization is not obtained prior to seeking emergency dental care, the Participant must notify the Health Plan within 48 hours of emergency treatment. Covered Health Services include dental treatment related to accidental injury within six months after the date of accident. NOTE: Injuries caused by chewing or biting are not Covered Health Services. See Limitations and Exclusions.

Oral and maxillofacial surgery is a Covered Health Service for non-dental surgical procedures and hospitalization for congenital defects, such as cleft lip and cleft palate, and for medical or surgical procedures occurring within or adjacent to the oral cavity or sinuses including, but not limited to, treatment of fractures and excision of tumors and cysts. All other procedures involving the teeth or intra-oral areas surrounding the teeth are not Covered Health Services, including shortening of the mandible or maxillae for cosmetic purposes, correction of malocclusion and any non-surgical dental care involved in the treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. **The Health Plan must authorize all services in advance.**

Outpatient facility services, including anesthesia, is a Covered Health Service for a Participant who is unable to undergo dental treatment in an office setting or under local anesthesia due to a documented physical, mental, or medical reason as determined by the Participant's Provider or the dentist providing the dental care. These services must be pre-authorized by the Health Plan and must be provided in the In-Network or approved facility such as an outpatient surgical facility or outpatient department of a hospital.

Organ Transplant Services

The Medically Necessary services, including those services necessary to procure the organ, for the following organ transplant procedures are covered as any other illness when prescribed, directed and arranged by the Participant's attending physician **and authorized in advance** by contacting the Health Plan:

- Kidney transplant
- Corneal transplant
- Liver transplant
- Bone marrow transplant
- Heart transplant
- Lung transplant

- Heart-Lung transplant
- Pancreas transplant

Covered Health Services include organ acquisition fees and Medically Necessary surgical expenses of a person who is acting as a donor for a Participant. All transplant procedures must take place in a transplant facility approved by the Health Plan. Medically Necessary immunosuppressive medications following an organ transplant are covered.

Pain Management Services

Medically Necessary Pain Management treatment and related services are Covered Health Services when the services meet all of these conditions:

- The treating Physician or specialist orders such pain management services;
- Services can be expected to meet or exceed treatment goals established for the Participant by the Participant's Physician;
- Services are scientifically proven and evidence-based to improve the Participant's medical condition; and
- ***The Health Plan authorizes the services in advance.***

Office visit copayments apply. Most outpatient procedures require the Outpatient Surgery Copayment. Percutaneous Decompression Nucleoplasty (PDNP) requires a Copayment of 50%. Refer to Limitations and Exclusions for non-covered services.

Physician Services

The following services of a Physician who is a Plan Provider or otherwise authorized by the Health Plan will be Covered Health Services. Please refer to Physician Services in the Schedule of Benefits.

- Diagnosis and treatment of illness or injury;
- Administration of drugs, chemotherapy, medications, injectables, biologicals, fluids, and radioactive material;
- Routine health assessments for adults once per year or as directed by your Physician;
- Immunizations for all Participants according to generally accepted medical practice standards, including immunizations for travel outside the United States. Childhood immunizations from birth through the date the child is six years of age are not subject to a Copayment. A Copayment may be charged for other services provided at the same time as the immunization;
- Well-child care;
- Annual eye, ear and speech screenings by the Provider for Participants through age 18, and biennial eye, ear and speech screenings by the Provider for Participants age 19 and older to determine vision and hearing loss and speech impairment (eye examinations do not include examinations for the purpose of prescribing eye glasses or contact lenses);

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- Physician home visits when the nature of the illness or injury so dictates;
- Physical examination for the detection of prostate cancer including PSA testing; and
- Initial evaluation and diagnoses of attention deficit disorder (ADD). ADD is a persistent pattern of inattention that is more frequent and severe than is typically observed in individuals at a comparable level of development. There must be clear evidence of interference with developmentally appropriate social, academic, or occupational functioning manifesting itself predominately in at least two settings, (e.g., at home and at school or work).

Preventative Health Services

In general, certain preventative health services will be provided from In-Network providers without any cost-sharing requirements (such as a copayment, coinsurance, or deductible). The UMC Health Plan will provide the below preventative health services free of charge and without any deductible to Participants as required by PPACA⁴. However, under some circumstances, the Plan may bill the Participant for certain preventative services.

For instance, a Participant’s physician may provide a preventative service, such as a cholesterol screening test, as part of an office visit. The Plan may require a Participant to pay some costs of the office visit (for example, an office co-pay) if the preventative service is not the primary purpose of the visit, or if a Participant’s physician bills for the preventative service separately from the office visit. Be aware that these preventative services are NOT covered through an out-of-network provider.

| Preventative Services | Frequency/Limitations |
|--|---|
| Screening for abdominal aortic aneurysm | One-time screening by ultrasound in men age 65 to 75 who have ever smoked |
| Screening and counseling to reduce alcohol misuse | Screening and behavioral counseling in primary care settings for adults, including pregnant women |
| Assessment of alcohol and drug use in adolescents | Assessment for adolescents |
| Screening for Anemia for pregnant women | Screening on a routine basis for pregnant women |
| Counseling for the use of aspirin | Men: Use of aspirin for men aged 45 to 79 years when the potential benefit of a reduction in heart attacks outweighs the potential harm of an increase in gastrointestinal hemorrhage Women: Use of aspirin for women aged 55 to 79 years when the potential benefit of a reduction in ischemic strokes outweighs the potential harm of an increase in gastrointestinal hemorrhage |
| Screening for autism in children | Screening for children at 18 and 24 months |
| Screening for bacteriuria | Screening for asymptomatic bacteriuria by urine culture for pregnant women at 12 to 16 weeks’ gestation or at the first prenatal visit, if later |
| Behavioral assessments for children | Behavioral assessments for children of all ages |

⁴ Preventative services under PPACA are those having a rating of A or B in the current recommendations of the United States Preventative Services Task Force; Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; and with respect to infants, children, women, and adolescents, evidence-informed preventative care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services administration, subject to the applicable effective dates by which plans are required to adopt those guidelines.

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| Preventative Services | Frequency/Limitations |
|--|--|
| Bilirubin concentration screening | For newborns |
| Screening for high blood pressure | Screening for adults aged 18 and older |
| Screening for blood pressure for children | Ages: 0-11 months, 1 to 4 years, 5 to 10 years, 11-14 years, 15-17 years |
| Blood screening | For newborns |
| Counseling related to BRCA screening | Women whose family history is associated with an increased risk for deleterious mutations in BRCA1 or BRCA2 genes may be referred for genetic counseling and evaluation for BRCA testing |
| Screening for breast cancer (mammography) | Screening mammography for women with or without clinical breast examination (CBE), every 1-2 years for women aged 40 and older |
| Chemoprevention of breast cancer | Discussion of potential benefits and harms of chemoprevention with women at high risk for breast cancer or at low risk for adverse effects of chemoprevention |
| Breast cancer preventive medications | Recommends that clinicians engage in shared, informed decision making with women who are at increased risk for breast cancer about medications to reduce their risk. For women who are at increased risk for adverse medication effects, clinicians should offer to prescribe risk-reducing medications, such as tamoxifen or raloxifene |
| Counseling to support breast feeding | Interventions during pregnancy and after birth to promote and support breast feeding |
| Screening for cervical cancer (Pap test) | Annual screening for cervical cancer |
| Screening for Cervical Dysplasia | Screening for sexually active females |
| Screening for chlamydial infection | Screening for all sexually active women aged 24 and younger, for older women who are at increased risk and pregnant women |
| Screening for cholesterol abnormalities: Men 35 and older | Screening for men aged 35 and older for lipid disorders |
| Screening for cholesterol abnormalities: Men younger than 35 | Screening for men aged 20-35 for lipid disorders if they are at increased risk for coronary heart disease |
| Screening for cholesterol abnormalities: Women 45 and older | Screening for women aged 45 and older for lipid disorders if they are at increased risk for coronary heart disease |
| Screening for cholesterol abnormalities: Women younger than 45 | Screening for women aged 20-45 for lipid disorders if they are at increased risk for coronary heart disease |
| Screening for colorectal cancer | Screening using fecal occult blood testing, sigmoidoscopy, or colonoscopy, in adults, beginning at age 50 and continuing until age 75. Under age 50 limited to one within a five-year period |
| Contraceptive methods and counseling | All Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity |
| Chemoprevention of dental caries | Oral fluoride supplementation by primary care physician for preschool children older than 6 months of age whose primary water source is deficient in fluoride |

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| Preventative Services | Frequency/Limitations |
|---|--|
| Screening for depression : adults | Screening of adults when systems are in place to ensure accurate diagnosis, effective treatment, and follow-up |
| Screening for depression : adolescents | Screening of adolescents (12-18 years of age) when systems are in place to ensure accurate diagnosis, psychotherapy (cognitive-behavioral or interpersonal), and follow-up |
| Developmental screening for children | Developmental screening for children under age 3, and surveillance throughout childhood |
| Screening for diabetes | Screening for type 2 diabetes in asymptomatic adults with sustained blood pressure (treated or untreated) greater than 135/80 mm Hg |
| Counseling for a healthy diet | Intensive behavioral dietary counseling for adult patients with high cholesterol 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 |
| Healthy diet and physical activity counseling | Recommends offering or referring adults who are overweight or obese and have additional cardiovascular disease (CVD) risk factors to intensive behavioral counseling interventions to promote a healthful diet and physical activity for CVD prevention |
| Dyslipidemia screening | Screening for children at higher risk of lipid disorders at the following ages: 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years |
| Fall prevention in older adults | Exercise or physical therapy to prevent falls in community-dwelling adults age 65 years and older who are at increased risk of falls |
| Fall prevention in older adults: vitamin D | Vitamin D supplementation to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls |
| Supplementation with folic acid | For all women planning or capable of pregnancy: daily supplement containing 0.4 to 0.8 mg (400 to 800 mg) of folic acid |
| Fluoride varnish | For all infants and children as soon as teeth are present |
| Screening for gestational diabetes | In pregnant women between 24 and 28 weeks of gestation and at the first prenatal visit for pregnant women identified to be at high risk for diabetes |
| Screening for gonorrhea : women | Screening of all sexually active women, including those who are pregnant, if they are at increased risk for infection (that is, if they are young or have other individual or population risk factors) |
| Prophylactic medication for gonorrhea : newborns | Prophylactic ocular topical medication for all newborns |
| Screening for hearing loss | Screening for hearing loss for newborn infants, children, and adults |
| Height, weight and body mass index measurements for children | Height, weight and body mass index measurements for children |
| Screening for hematocrit or hemoglobin in children | Screening for children |
| Screening for hemoglobinopathies | Screening for sickle cell disease in newborns |
| Screening for hepatitis B | Screening for pregnant women at their first prenatal visit |

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| Preventative Services | Frequency/Limitations |
|---|---|
| Screening for hepatitis B | Screening for hepatitis B virus infection in persons at high risk for infection |
| Screening for hepatitis C virus infection: adults | Screening for hepatitis C virus (HCV) infection in persons at high risk for infection. A one-time screening for HCV infection to adults born between 1945 and 1965 |
| Screening for HIV | Screening for all adolescents, adults, and sexually active women at increased risk for HIV infection |
| HIV screening: pregnant women | Screening for all pregnant women for HIV, including those who present in labor who are untested and whose HIV status is unknown |
| Human Papillomavirus (HPV) DNA test | High risk HPV DNA testing every three years for women with normal cytology results who are 30 or older |
| Screening for congenital hypothyroidism | Screening for newborn |
| Screening and counseling for interpersonal and domestic violence | Annual screening and counseling for interpersonal and domestic violence |
| Screening for iron deficiency anemia | Screening for pregnant women |
| Iron supplementation in children | Routine iron supplementation for asymptomatic children aged 6 to 12 months who are at increased risk for iron deficiency anemia |
| Screening for lead exposure in children | Screening for children at risk of exposure |
| Lung Cancer screening | Annual screening for lung cancer with low-dose computed tomography in adults ages 55 to 80 years who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years. Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery |
| Maternal depression screening | For mothers of infants at 1,2,4, and 6 months visits |
| Medical history for children | Medical history for all children throughout development |
| Screening and counseling for obesity : adults | Screening of all adult patients and intensive counseling and behavioral interventions to promote sustained weight loss for obese adults |
| Screening and counseling for obesity : children | Screening of children aged 6 years and older and intensive behavioral interventions to promote improvement in weight status |
| Oral health risk assessment for children | Assessment for young children |
| Screening for osteoporosis : women | Screening for osteoporosis in women age 60 years and older and in younger women whose fracture risk is equal to or greater than that of a 65 year old white woman who has no additional risk factors |
| Ovarian cancer screening | Ovarian cancer screening for at risk women. Includes CA125 and transvaginal ultrasound screening |

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| Preventative Services | Frequency/Limitations |
|---|--|
| Screening for PKU | Screening for newborns |
| Preeclampsia prevention: aspirin | Recommends the use of low-dose aspirin (81 mg/d) as preventive medication after 12 weeks of gestation in women who are at high risk for preeclampsia |
| Screening for prostate cancer | Prostate cancer screening for men aged 40 or over who are symptomatic or in a high risk category and for all men aged 50 or older |
| Screening for RH incompatibility : first pregnancy visit | Rh (D) blood typing and antibody testing for all pregnant women during their first visit for pregnancy-related care |
| Screening for Rh incompatibility : 24 – 28 weeks gestation | Rh (D) antibody testing for all unsensitized Rh (D) – negative women at 24-28 weeks’ gestation, unless biological father is known to be Rh (D)- negative |
| Skin cancer behavioral counseling | Counseling children, adolescents, and young adults ages 10 to 24 years who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer |
| Counseling for STIs | High-intensity behavioral counseling to prevent sexually transmitted infections (STIs) for all sexually active adolescents and for adults at increased risk for STIs |
| Screening for STI’s | Screening for sexually transmitted infections (STI’s) for all sexually active patients between the ages of 11 and 21 years |
| Screening for syphilis : non-pregnant persons | Screening of persons at increased risk |
| Screening for syphilis : pregnant women | Screening of all pregnant women |
| Counseling for tobacco use | Counseling for adults about tobacco use and provide tobacco cessation interventions for those who use tobacco products |
| Counseling for tobacco use : pregnant women | Counseling for pregnant women about tobacco use and provide augmented, pregnancy-tailored counseling for those who smoke |
| Testing for tuberculosis in children and adults | Tuberculin testing for children at higher risk of tuberculosis |
| Urinary tract or other infection screening | Screening for pregnant women |
| Screening for visual acuity in children | Screening to detect amblyopia, strabismus, and defects in visual acuity in children younger than age 5 years |
| Well-woman visits | Well-woman preventive care visit annually for adult women to obtain the recommended preventive services that are age and developmentally appropriate, including preconception and prenatal care. This well-woman visit should, where appropriate, include other preventive services listed in this set of guidelines |
| Immunizations | Immunization vaccines for children and adults---doses, recommended ages, and recommended populations vary |

Prosthetics Devices and Orthotic Devices

Only basic or standard prosthetics and orthotic equipment or devices are Covered Health Services, unless added functions or features are Medically Necessary and **authorized in advance by the Health Plan**.

- Prosthetic devices, which aid bodily functioning or replace a limb or body part after accidental or surgical loss and orthotic appliances to correct a defect of body function, are covered items. Benefits are provided only for the initial standard prosthetic or orthotic appliance and any Medically Necessary special features prescribed by the Provider and **authorized in advance by the Health Plan**. Replacement or adjustment if necessitated by skeletal growth is a Covered Health Service. Repair, replacement and/or duplicates, except for replacement due to skeletal growth, are not covered regardless of whether the device was purchased prior to or during coverage under this Plan Document.
- Orthotic means serving to protect or restore function; pertaining to the use or application of orthosis, an orthopedic appliance or apparatus used to support, align, prevent, or correct deformities or as to improve the function of movable parts of the body. Medically Necessary corrective appliances and artificial aids (orthotic devices) to correct a defect in body form and/or function are covered items when authorized by the Provider and **authorized in advance by the Health Plan**. Benefits are provided for the initial implantable lenses or prescription lenses (eye glass lenses or contact lenses) following an operation for cataracts or other diseases of the eye or to replace an organic lens missing because of congenital absence or when customarily used during convalescence from authorized eye surgery. In each case, it must be Medically Necessary and authorized by the Provider and **authorized in advance by the Health Plan**. Contact lenses are covered for the treatment of keratoconus. Please refer to Limitations and Exclusions.

Reconstructive Surgery Services

Services are limited to the Medically Necessary surgery by a Plan Provider Physician. **The following services must be authorized in advance by the Health Plan:**

- Surgery to correct a functional defect which results from a congenital and/or acquired disease or anomaly; or
- Surgery to correct a seriously disfiguring condition resulting from accidental injury; or
- Surgery, which is incidental to the treatment of disease, including breast reconstruction necessitated by a mastectomy. Reconstruction of the unaffected breast will be covered when necessary to achieve symmetry. Prostheses and treatment of physical complications of the mastectomy, including lymphedema will be covered if medically necessary. Initial breast reconstruction resulting from a mastectomy that occurred prior to the effective date of coverage is a covered benefit; or
- Surgery for a child who is younger than 18 years of age for craniofacial abnormalities to improve the function of, or to attempt to create a normal appearance of, an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infection or disease.

The Schedule of Benefits describes specific Copayments for Physician office visits, Hospital admissions and outpatient procedures.

Reduction Mammoplasty

This benefit is only available to Participants who have been covered by the UMC Health Plan for three (3) continuous years prior to the reduction mammoplasty. There cannot be any break in coverage to be eligible. Reduction mammoplasty for symptomatic breast hypertrophy is considered medically necessary when ALL of the following medical criteria are met:

- Neck, shoulder, or arm pain;
- Pendulous breast (pictures must be provided showing hypertrophy and grooving);
- Anticipated amount of tissue to be removed 300 to 500 grams (each breast); and
- Intertigo (rash, not attributed to season).

All services are required to be performed at UMC. Plan benefits are limited to In-Network only, and there is no coverage for out-of-network services. Coverage for reduction mammoplasty is allowed only once in the lifetime of the Participant. ***The Health Plan must authorize all services in advance.***

Rehabilitation Services

Medically Necessary physical, occupational and cardio-pulmonary services will be considered Covered Health Services when referred by the Participant's Provider.

Skilled Nursing Facility Services

Medically Necessary skilled nursing services are a Covered Health Service for a maximum of 100 days per Participant per Plan Year (combined with Long-Term Care Facility days), provided that such skilled nursing services are of a temporary nature and lead to rehabilitation and increased ability to function. Skilled nursing services must be ***authorized by the Health Plan in advance*** and be provided at an authorized Skilled Nursing Facility. Custodial or domiciliary care is not a Covered Health Service.

Participants remaining in a Skilled Nursing Facility after discharge or after the maximum benefit period is reached shall be responsible for all subsequent costs incurred. Private duty nursing services, private room accommodations, personal or comfort items and other articles not specifically necessary for treatment of illness or injury are excluded. Please refer to Limitations and Exclusions.

Speech and Hearing Services

Medically Necessary testing and treatment for loss or impairment of speech and hearing are Covered Health Services.

Coverage for hearing aids is limited to a maximum of \$500 per ear once every 36 months. Repair or replacement due to normal wear and tear and loss or damage is not covered.

Surgical Procedures

Covered Health Services include Medically Necessary surgical procedures when ***authorized in advance by the Health Plan.***

Temporomandibular Joint Syndrome Services

Covered Health Services include only the diagnosis and Medically Necessary surgical treatment of disorders of and conditions affecting the temporomandibular joint, which includes the jaw and the craniomandibular joint, as a result of:

- An accident;
- A trauma;
- A congenital defect;
- A developmental defect; or
- A pathology.

Oral appliances and devices used to treat temporomandibular pain disorders or dysfunction of the joint and related structures, such as the jaw, jaw muscles and nerves are not covered benefits. See Limitations and Exclusions.

D. LIMITATIONS AND EXCLUSIONS

Services which otherwise might be Covered Health Services may be limited or modified under certain conditions as follows:

Out-of-Network and Out-of-Area Services

Other than for emergency services and prescription drug coverage, the UMC Health Plan does not provide any out-of-network benefits. This means that if a Participant receives services from an out-of-network provider, other than for emergency services or prescription drug coverage, the Participant is responsible for the full cost of those services as billed by the provider.

The Health Plan will apply In-Network benefits to Covered Services provided to enrolled Out-of-Area Participants. See Section 8 of this Health Plan Document for additional out-of-network and out-of-area requirements.

Limitations Due to Certain Conditions

If Covered Health Services are delayed or rendered impractical because of circumstances not within the Health Plan's control, the Health Plan will make a good faith effort to arrange for an alternative method of providing coverage. Such circumstances include but are not limited to a major disaster, epidemic, and the complete or partial destruction of facilities, riot, civil insurrection, disability of a significant number of Plan Providers and their personnel, or similar causes. In such event, the Health Plan and authorized Plan Providers shall render Covered Health Services insofar as practical and according to their best judgment. However, UMC Health Plan and Plan Providers shall incur no liability or obligation for delay or failure to provide or arrange for services if such failure or delay is caused by any such event.

Care That is not Medically Necessary

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Covered Health Services include only those services which are determined to be Medically Necessary by the Participant's authorized Provider or Medical Director. Services which are deemed to not be Medically Necessary include, but are not limited to:

- Services that in the judgment of the Participant's Provider or Health Plan Medical Director are not Medically Necessary.
- Physical examinations, health reports, and treatments required for employment, flight clearance, camp, insurance, school, sports or legal proceedings.
- Personal, comfort, or convenience items.
- Any procedure or treatment designed to alter physical characteristics of the Participant to those of the opposite sex and any other treatment or studies related to sex transformations.

Services That Are Not Authorized

Certain Covered Health Services require the Participant to obtain advance approval and authorization from the Health Plan. If the Participant does not obtain the required approval, the services or items will not be covered. This does not include Emergency Care.

Certain Types of Care in Specific Settings

The following are not Covered Health Services:

- Custodial, respite or domiciliary care.
- Any services or supplies furnished by a provider, which is primarily a place of rest, a place for the aged, a nursing home or any similar institution.
- Services provided in the Participant's home to assist with daily living activities, such as cooking, cleaning, bathing, dressing, etc.
- Outpatient services received in federal facilities or any items or services provided in any institution operated by any state government or agency when a Participant has no legal obligation to pay for such items or services.

Inpatient Hospital care costs incurred on behalf of U.S. Armed Forces retirees and Dependents unless the services are pre-authorized by the Health Plan.

Treatments and Services Specifically Excluded

The following services **ARE NOT COVERED HEALTH SERVICES** under the Health Plan

1. Elective abortions.
2. Services to reverse sterilizations.
3. Cosmetic surgery, defined as any plastic or reconstructive surgery done primarily to improve the appearance of any portion of the body and for which there is no Medical

Necessity and from which no improvement in physiological function could be reasonably expected. Examples of excluded cosmetic surgery are as follows: surgery for sagging or extra skin; any augmentation or reduction procedures; rhinoplasty and associated surgery and any procedures utilizing an implant except for breast reconstruction following a mastectomy.

4. Services related to in-vitro fertilization, gamete intrafallopian transfer (GIFT) and zygote intrafallopian transfer (ZIFT), surrogate parenting fees. Maternity charges incurred by a Participant acting as a surrogate mother are not covered charges. For the purpose of this plan, the child of a surrogate mother will not be considered a dependent of the surrogate mother or her spouse if the mother has entered into a contract or other understanding pursuant to which she relinquishes the child following its birth.
5. Fertility Drugs
6. Dental care, such as:
 - Treatment on or to the teeth;
 - Extraction of teeth;
 - Treatment of gingival tissues (other than for tumors);
 - Dental surgery;
 - Treatment for overbite or underbite and any malocclusion associated thereto, including those deemed congenital or developmental anomalies;
 - General correction of malocclusion;
 - Dental examinations;
 - Orthodontics;
 - Services related to osseointegrated implants;
 - Any other dental product or service unless specifically described in the Schedule of Benefits; or
 - Injuries caused by chewing or biting.
7. Reduction mammoplasty, unless Participant meets the criteria outlined in *Section 4, Covered Health Services, Reduction Mammoplasty* and is authorized by the Health Plan.
8. Contact or corrective lenses and eyeglass frames unless specifically provided in the Schedule of Benefits of this Plan Document.
9. Repair or replacement of hearing aids due to normal wear and tear and loss or damage.
10. Prescription drugs and other medications, except as provided while confined as an inpatient, medications used for the treatment of diabetes, immuno-suppressive medications as a result of an organ transplant, and certain injectable medications; except as provided under the Prescription Drug Coverage (see section 6). Discharge or take home drugs are excluded.
11. Prescription drugs or other treatments for obesity, except for dietary counseling, nutritional education services for morbid obesity, and gastric bypass surgery for morbid obesity.

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12. Services and appliances for the correction of vision deficiencies. Examples of these excluded services and appliances include: orthoptics, vision training, vision therapy or radial keratotomy (RK), automated lamellar keratoplasty (ALK or LK), astigmatic keratotomy (AK), and photorefractive keratectomy (PRK-laser).
13. Any medical, surgical, or other health care procedures determined to be experimental.
14. Any organ transplant not specifically listed in the Schedule of Benefits, all artificial organs, and services when the Participant acts as a donor, unless the recipient is a Participant of the Group Health Plan.
15. Ambulance services which are not of an emergency nature or which are not Medically Necessary.
16. Care for conditions that federal, state or local law requires to be treated in a public facility.
17. Genetic testing, except Medically Necessary peri-natal genetic testing and BRCA1 and BRCA2 testing.
18. Private duty nursing.
19. Enteral feeding formulas, other nutritional or electrolyte supplements unless the items are available by prescription only.
20. Additional expenses incurred as a result of the Participant's failure to follow a Plan Provider's medical orders.
21. Vocational rehabilitation services.
22. Care, treatment, services or items that may be purchased without a Physician's recommendation or written prescription.
23. Acupuncture, naturopathy, hypnotherapy and Christian Science Practitioner services.
24. Diagnosis and treatment of weak, strained, or flat feet and the cutting or removal of corns, calluses and toenails. This will not apply to the removal of nail roots.
25. Biofeedback services.
26. Cranio-facial surgery, i.e., correction of maxillary vertical excess with malocclusion except for the surgical treatment of TMJ disorders and conditions affecting the temporomandibular joint.
27. Massage therapy unless associated with a physical therapy modality provided by a licensed physical therapist.
28. Maternity care for a Dependent Child or Grandchild.
29. Intradiscal Electrothermal Annuloplasty (IDET) procedures for pain management.

30. "Illegal Occupation": The Plan is not liable for any loss to which a contributing cause was the Participant's **commission** of or attempt to commit a **felony** or to which a contributing cause was the Participant's being engaged in an illegal occupation.
31. If a service is not a Covered Health Service under the Plan, the Health Plan will not cover any services related to it. Such related services include:
- Services provided in preparation for the non-covered service;
 - Services provided in connection with providing the non-covered service; or
 - Services that are usually provided following the non-covered service, such as follow-up care or therapy after surgery.

For example, if a Participant undergoes non-covered cosmetic surgery, the Health Plan will not cover pre-operative care, post-operative care or hospitalization related to the non-covered surgery. Even if the service was covered by another health plan, it will be considered non-covered under this Plan.

Devices, Equipment and Supplies Specifically Excluded

The following items **ARE NOT COVERED HEALTH SERVICES** under the Health Plan

1. Comfort or convenience items, such as bathtub chairs, whirlpool tubs safety grab bars, stair gliders or elevators, over-the bed tables, bed boards, saunas, and exercise equipment.
2. Environmental control equipment, such as air purifiers, humidifiers, dehumidifiers, air conditioners and electrostatic machines, heat lamps.
3. Institutional equipment, such as air fluidized beds and diathermy machines.
4. Stethoscopes, sphygmomanometers, recording oximeters.
5. Corrective shoes, shoe inserts, arch supports, orthotic inserts except as provided for under Diabetic Services.
6. Hygienic or self help items or equipment.
7. Electric and custom wheelchairs, auto tilt chairs.
8. Wigs or prosthetic hair.
9. Consumable medical supplies, such as: over-the-counter bandages, dressings and other disposable supplies, skin preparations, surgical leggings, elastic stockings, Jobst and TED stockings, and form cervical collars.
10. Sports cords and exercise equipment.

**SECTION 5
DENTAL REIMBURSEMENT PLAN**

****NEW SUPPLEMENTAL DENTAL PLAN – PRINCIPAL FINANCIAL GROUP**

UMC OFFERS TWO SUPPLEMENTAL DENTAL PLANS THROUGH PRINCIPAL FINANCIAL GROUP, A PREVENTIVE PLAN AND A FULL COVERAGE PLAN. EMPLOYEES MUST CHOOSE BETWEEN THE DENTAL REIMBURSEMENT PLAN BELOW OR ONE OF THE TWO SUPPLEMENTAL DENTAL PLANS. CHANGES MAY ONLY BE MADE DURING OPEN ENROLLMENT OR WITH A QUALIFYING EVENT. EMPLOYEES MAY CONTACT UMC HEALTH PLAN OPERATIONS FOR FURTHER DETAILS.

A. GENERAL INFORMATION

This dental plan is a “direct reimbursement” plan, which means that no outside insurance company is involved. The Plan will reimburse dental charges as outlined below directly to the eligible Participant if filed directly to the Plan. Reimbursement to Participant is based on the date of payment of the dentist bill, not on the date of the performance of services. Claims must be filed within ninety (90) days of the date of service. Note that this is a reimbursement plan only. Liability for dental work remains with the Participant.

B. EFFECTIVE DATE

Plan year is effective calendar year January 1 to December 31.

C. ELIGIBILITY

Same as defined under the medical care benefit program. See Section 2. Participant must be enrolled in the Medical Plan in order to be eligible for Dental Benefits.

D. BENEFITS

The Plan will reimburse as follows:

- 100% of the first \$150.00 for covered dental expenses.
- 80% over \$150.00 up to \$500.00 for covered dental expenses.
- 50% over \$500.00 up to an annual maximum reimbursement of \$1,500 per Participant per plan year for covered dental expenses.

E. COVERAGE

Coverage under this Plan will include eligible employees, spouses and dependent children. Definitions of these groups will be the same as in the medical care benefit program.

F. COORDINATION OF BENEFITS/CO-COVERAGE

Dental benefits under this Plan are coordinated with dental benefits of other plans under the Order of Benefits Payment Rules. Coordination means that if you or a dependent are covered under other plans, total benefits paid, subject to the limitations discussed in the benefits section of the Plan, will not exceed 100% of the actual covered charges.

“Plan” means any arrangement of coverage, which provides dental benefits for individuals, on an insured or non-insured basis.

For dependent claims involving other insurance, an insurance payment statement must be included with the reimbursement claim. Reimbursement involving other insurance is made using the appropriate sharing percentage to the unpaid amount.

G. REIMBURSEMENT PROCEDURES

1. Participant or Dental Provider must complete a dental expense reimbursement form and sign the form indicating that questions were correctly answered. Dental forms are available through UMC Human Resource office. (PLEASE NOTE: There are separate forms for reimbursement to the Participant versus reimbursement to the dental provider.).

Mail completed form to:
UMC Dental Reimbursement Plan
309 N. Slide Road
Lubbock, TX 79416
(806) 775-8793 (phone)
(806) 761-0897 (fax)

Claims must be filed within ninety (90) days of the date of service. Claims received ninety (90) days after the date of service will not be reimbursed.

2. For dental providers, the reimbursement check should be received within fifteen (15) days from the date a properly completed reimbursement form has been submitted. Payments will be mailed to the dental provider at the address indicated on the claim form. Participant reimbursements are issued through payroll once a properly completed reimbursement form and proof of payment have been submitted.

H. REIMBURSED EXPENSES

All procedures (except those procedures listed as not covered) performed by or under the direction of a dentist licensed by the state in which the provider practices are covered.

I. PROCEDURES/EXPENSES NOT REIMBURSED

- Dental prescriptions for medication
- Orthodontia
 - Orthodontic care for proper alignment of teeth
- Treatment of temporomandibular joint dysfunction (TMJ)
- Cosmetic Dentistry
 - Expenses incurred for any treatment which is for cosmetic purposes or for the correction of congenital malformations except as provided in Section 4 as a Medical Benefit and Covered Health Service.
- Expenses incurred before insurance begins or after it ends.
- Occupational Injury

- Expenses incurred for or in connection with any injury arising out of or in the course of any employment for wage or profit.
- Replacement of a bridge or denture which is lost or stolen.

J. PLAN TERMINATION

Same as defined under the medical care benefit program. See Section 2.

K. EMPLOYEE TERMINATION OF PARTICIPATION

If an eligible employee is terminated or resigns, any dental covered expense incurred before his termination or resignation will be reimbursed as outlined in this Plan.

L. PROGRAM CHANGES

The Plan reserves the right to make changes in benefit levels, the annual maximum, or other provisions of the program. Employees will be notified of changes at least one month in advance of the effective date of the change.

SECTION 6

PRESCRIPTION DRUG COVERAGE

A. OUTPATIENT PRESCRIPTION DRUGS

Drugs and medicines, as provided below, which are prescribed by a Physician or other licensed Provider are covered. ***Out-of-Network, see Schedule of Benefits.**

Drugs and medicines must be approved by the Food and Drug Administration and dispensable upon prescription as provided for in the Federal Food, Drug and Cosmetic Act. Dietary formulas necessary for the treatment of phenylketonuria or other heritable diseases are included.

Insulin, insulin analogs, syringes, and prescriptive and non-prescriptive oral agents for controlling blood sugar levels are covered.

Prescription Co-pays are based on a 34-day supply of medication. Prescriptions are limited to a 90-day supply.

Each prescription or refill is subject to the Co-payment, as set forth in the Schedule of Medical Benefits, payable by the Covered Person directly to the Pharmacy.

In addition to the Limitations and Exclusions contained in the benefit booklet, the following Limitations and Exclusions will also apply to your Prescription Drug Coverage.

B. EXCLUDED PRESCRIPTION DRUGS

1. Drugs that do not by law require a prescription order from a Physician (except injectable insulin, insulin analogs, and prescriptive and non-prescriptive oral agents for controlling blood sugar levels); and drugs, for which no valid prescription order is obtained.
2. Devices or Durable Medical Equipment of any type (even though such devices may require a prescription order), such as, but not limited to, glucose monitors, therapeutic devices, artificial appliances, or similar devices (except disposable hypodermic needles and syringes for self-administered injections). For other coverage information, see Covered Services and Benefits Section 4.
3. Administration or injection of any drugs except as administered in the physician's office or hospital.
4. Vitamins except prenatal, as prescribed by a physician.
5. Any services provided or items furnished for which the Participating Pharmacy normally does not charge.
6. The cost amount of drugs which is above the usual and customary charge.
7. Drugs required by law to be labeled: "Caution - Limited by Federal Law to Investigational Use," or experimental drugs, even though a charge is made for the

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drugs.

8. Refills of any prescriptions in excess of the number of refills specified by the Physician or by law, or any drugs or medicines dispensed more than one (1) year following the prescription order date.
9. Legend Drugs which are not approved by the U.S. Food and Drug Administration (FDA) for a particular use or purpose or when used for a purpose other than the purpose for which FDA approval is given.
10. Drugs prescribed and dispensed for the treatment of obesity or for use in any program of weight reduction, weight loss, or dietary control.
11. Drugs for use or intended use that would be illegal, unethical, imprudent, abusive, not Medically Necessary, or otherwise improper.
12. Drugs obtained by unauthorized, fraudulent, abusive, or improper use of the identification card.
13. Drugs used or intended to be used in the treatment of a condition, sickness, disease, injury, or bodily malfunction which is not covered under the UMC Plan, or for which benefits have been exhausted.
14. Rogaine, minoxidil or any other drugs, medications, solutions or preparations used or intended for use in the treatment of hair loss, hair thinning or any related condition, whether to facilitate or to promote hair growth, to replace lost hair, or otherwise.
15. Any prescription antiseptic or fluoride mouthwashes, mouth rinses or topical oral solutions or preparations.
16. Any Retin A or pharmacologically similar topical drugs for Covered Persons age twenty-five (25) and older.
17. Drugs purchased from an out-of-network Pharmacy.
18. Viagra or any other drugs, medications, solutions, or preparations used or intended for use in the treatment of sexual dysfunction, impotence, or other related conditions.

All other terms, conditions, exclusions and limitations of the benefit booklet remain in full force and effect except as specifically modified by the information in this section.

SECTION 7

COBRA CONTINUATION

A. GENERAL

The UMC Health Plan shall be in compliance with any and all provisions and amendments to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) as amended, Title X of COBRA amends the Internal Revenue Code, (IRC), and the Public Health Services Act, which require employer-sponsored group health plans with certain exceptions, to provide Employees and their Covered Dependents the opportunity to continue to participate in the Employer-sponsored Health Benefit Plan after their coverage would otherwise cease. To the extent any of the above laws are changed while this Plan is in effect and the changes require changes to the provisions of this Section 7, then such changes shall be incorporated herein automatically. Furthermore, should this Plan contain any provisions inconsistent with the requirements of such laws, this Plan shall be construed in a manner consistent with such laws.

B. DEFINITIONS

For purposes of this Article, the following terms have the following definitions:

1. **“Continuation Coverage”** means continuation of Plan coverage of a Covered Person, following a Qualifying Event, as provided by COBRA.
2. A **“Qualified Beneficiary”** means those Covered Persons who are participating in the Plan on the day before a Qualifying Event occurs and who would lose coverage under the Plan as a result of a Qualifying Event (defined below) but for Continuation Coverage. Effective January 1, 1997 and after, the term "Qualified Beneficiary" will also mean a dependent child born to or placed for adoption with a covered employee during a period of COBRA continuation coverage. However, if an individual is not a Qualified Beneficiary, then a spouse or dependent child(ren) of the individual shall not be considered a Qualified Beneficiary by virtue of the relationship with the individual.
3. **“Qualifying Event”** means any one of the following occurrences which, but for Continuation Coverage, would result in loss of coverage for the Qualified Beneficiary:
 - (i). Death of a Covered Employee;
 - (ii). Termination of a Covered Employee's employment (unless terminated for gross misconduct) or reduction in Covered Employee's hours;
 - (iii). Divorce or legal separation of the Covered Employee from his spouse;
 - (iv). Entitlement of the Covered Employee to Medicare, leaving Dependents no coverage;
 - (v). Disqualification of Dependent child for coverage under the Plan;

- (vi). With respect to a retired Covered Employee, his Employer's bankruptcy proceedings.

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

These definitions shall be modified as is necessary to comply with any amendments to COBRA or its regulations.

C. TYPE OF COVERAGE

Continuation Coverage under this provision is coverage which is identical to the coverage provided under this Plan to similarly situated Covered Persons under this Plan with respect to whom a Qualifying Event has not occurred, as of the time coverage is being provided. If coverage under this Plan is modified for any group of similarly situated beneficiaries, the coverage shall also be modified in the same manner for all Qualified Beneficiaries under this Plan in connection with such group.

D. NOTICE

1. **Divorce or Legal Separation; Change in Dependent Child**
The Covered Employee or Qualified Beneficiary is responsible for notifying the Plan Administrator of divorce or legal separation of the Covered Employee from his spouse and a Covered Employee's dependent child's ceasing to be a dependent child under this Plan within sixty (60) days after the date of the Qualifying Event. Failure to give such notice in a timely fashion constitutes a waiver of Continuation Coverage for all Qualified Beneficiaries with respect to the Qualifying Event.
2. **Other Qualifying Events**
In the case of all other Qualifying Events, the Employee must notify the Plan Administrator within thirty (30) days of its occurrence.
3. **Social Security Disability**
Each Qualified Beneficiary, who is determined under Title II or XVI of the Social Security Act to have been disabled at the time of a Qualifying Event, is responsible for notifying the Plan Administrator of such determination within sixty (60) days after the date of determination, and is responsible for notifying the Plan Administrator within thirty (30) days of the date of final determination under such Title(s) that the Qualified Beneficiary is no longer disabled.
4. **Notice to Qualified Beneficiaries**
It is the Employer/Plan Administrator's responsibility to notify the COBRA Administrator within thirty (30) days after receiving notification of the occurrence of a Qualifying Event, with respect to an Employee or an Employee's Dependents.

Within fourteen (14) days after receiving notification from the Employer/Plan Administrator, the COBRA Administrator is responsible for providing written notice to each Qualified Beneficiary of his right to Continuation Coverage under this provision, or as otherwise required by Federal Law. This notice shall include the cost of Continuation Coverage, along with an election form. If the Qualifying Event is the divorce or legal separation of the Covered Employee from his spouse or a dependent child ceasing to be a dependent child under the terms of this Plan, the COBRA Administrator shall only be required to notify a Qualified Beneficiary of his right to elect Continuation Coverage if the Covered Employee or the Qualified Beneficiary notifies the Plan Administrator of such Qualifying Event within sixty (60) days after the date of such Qualifying Event. Notification of the requirements of this provision to the spouse of a Covered Employee shall be treated as notification to all other Qualified Beneficiaries residing with such spouse at the time notification is made.

5. Method of Giving Notice

Notice by mail to the Qualified Beneficiary's last known address is deemed to be sufficient as to that Qualified Beneficiary.

E. ELECTION

1. A Qualified Beneficiary who would lose coverage under this Plan as a result of a Qualifying Event has a period of sixty (60) days, from the latter of the date coverage terminates due to a Qualifying Event, or the date notice is given to the Qualified Beneficiary by the COBRA Administrator in which to elect Continuation Coverage under this Plan. No evidence of good health will be required.
2. Except as otherwise specified in an election, any election by a Qualified Beneficiary who is a Covered Employee or spouse of the Covered Employee will be deemed to include an election for Continuation Coverage under this provision on behalf of any other Qualified Beneficiary who would lose coverage by reason of a Qualifying Event. Neither the Covered Employee nor his spouse may decline Continuation Coverage on behalf of any other Qualified Beneficiary unless such Covered Employee or his spouse is the parent or legal guardian for a minor Qualified Beneficiary or unless such Covered Employee or his spouse is the legal guardian or representative or spouse of an incapacitated Qualified Beneficiary or the estate of a deceased Qualified Beneficiary.
3. If this Plan provides a choice among the types of coverage under this Plan, each Qualified Beneficiary is entitled to make a separate selection among such types of coverage.

F. DURATION OF COVERAGE

The coverage under this provision will extend for at least the period beginning on the date of a Qualifying Event and ending not earlier than the earliest of the following:

1. In the case of a terminated Covered Employee (except for gross misconduct), a Covered Employee who voluntarily quits or a Covered Employee whose hours have been reduced, the date which is eighteen (18) months after the Qualifying Event;

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2. In the case of a Qualifying Event (other than the Employer's bankruptcy) which occurs during the eighteen (18) months after the date that a Covered Employee is terminated (except for gross misconduct) or the date that a Covered Employee's hours are reduced, the date which is thirty-six (36) months after the date of such termination or reduction in hours;
3. In the case of a Qualifying Event arising out of the Employer's bankruptcy, the date of death of the Covered Employee or Qualified Beneficiary, or in the case of the surviving spouse or Dependent children of the Covered Employee, thirty-six (36) months after the date of death of the Covered Employee;
4. In the case of a Qualified Beneficiary who becomes disabled at any time during the first sixty (60) days of COBRA continuation coverage, all references to eighteen (18) months shall be deemed to refer to twenty-nine (29) months (so long as the Plan Administrator has received the notice required before the end of such 18 months);
5. For Qualified Beneficiaries other than Covered Employees, in the event a Covered Employee becomes entitled to Medicare, the date which is thirty-six (36) months after the date of such entitlement;
6. In the case of any Qualifying Event except as described in (1), (2), (3), and (4) above, the date which is thirty-six (36) months after the date of the Qualifying Event;
7. The date on which the Company ceases to provide any group health Plan to any Employee;
8. The date on which the Qualified Beneficiary fails to make timely payment of the required contribution pursuant to this provision;
9. The date the Qualified Beneficiary first becomes, after the date of election: (1) covered by any other group health plan (as an Employee or otherwise) which does not contain any exclusion or limitation with respect to any Pre-existing condition of such beneficiary other than such an exclusion or limitation which does not apply to (or is satisfied by) such beneficiary by reason of Chapter 100 of the Internal Revenue Code of 1986, Part 7 of this subtitle, or Title XXVII of the Public Health Service Act; or (2) in the case of a Qualified Beneficiary, other than a retired Employee or a Covered Dependent of such retired Employee, entitled to Benefits under Medicare;
10. In the case of a Qualified Beneficiary who is disabled at the time of the Covered Employee's termination (except for gross misconduct) or reduction in hours, the month that begins more than thirty (30) days after the date of the final Social Security determination that the Qualified Beneficiary is no longer disabled.

G. CONTRIBUTION

1. A Qualified Beneficiary shall only be entitled to Continuation Coverage under this provision provided such Qualified Beneficiary pays the applicable contribution

required by the Company in full and in advance. Such applicable contribution shall not exceed the requirements of applicable Federal Law. A Qualified Beneficiary may elect to pay such contribution in monthly installments.

2. The payment of any contribution shall be considered to be timely if made within thirty (30) days after the date due or within such longer period of time as applies to or under this Plan.
3. Notwithstanding 1 and 2 above, if an election is made after a Qualifying Event during the election period, this Plan will permit payment of the required contribution for Continuation Coverage during the period preceding the election to be made within forty-five (45) days of the date of the election.

H. USERRA (ACTIVE MILITARY DUTY) AND LEAVE OF ABSENCE

USERRA provides for the continuation of health benefit coverage for persons who are absent from work to serve in the uniformed services. If an Employee covered by the UMC Health Plan loses coverage under the plan due to being called to active military duty, continuation of coverage under COBRA may extend for up to 24 months after the absence begins, or the period of absence, whichever is shorter. However, according to SPP #HR-25 (Military Leave), UMC will grant military leave of absence to full-time and part-time with benefits employees.

If an employee is on a leave of absence (SPP #HR-21), the employee may continue the employee's group medical, dental, and supplemental insurance deductions by paying the applicable premiums. Failure to pay the premiums will result in termination of benefits.

SECTION 8

OUT-OF-NETWORK SERVICES AND OUT-OF-AREA SERVICES

The Health Plan uses a network of contracted providers to provide health care services to Participants. The network is called “TeamChoice.” If a Participant selects a provider that is not in the TeamChoice network, services are not covered unless they are emergency services.

A. DEFINITIONS

“In-Network Provider” means a physician, hospital, facility, home health agency or other health care provider that is located within the Service Area and is contracted with TeamChoice to provide services and treatment under this Health Plan. TeamChoice is responsible for recruiting, credentialing, and communicating with In-Network Providers. In-Network Providers participating in the TeamChoice Network agree to accept the allowable charge fees set by the Health Plan and agree to file claims for Health Plan participants.

“Out-of-Network Provider” means a physician, hospital, facility, home health agency or other health care provider that is NOT contracted with TeamChoice to provide services and treatment under this Health Plan.

“Service Area” means the geographic area serviced by the TeamChoice network. Participants may check the online provider directory www.team-choice.com for an updated list of In-Network Providers in the Service Area for TeamChoice.

“Out-of-Area” means health care services provided in a geographic area not serviced by the TeamChoice network. Participants may check the online provider directory www.team-choice.com for an updated list of In-Network Providers in the Service Area for TeamChoice. Out-of-Area services are available to Participants as described below.

B. SELECTION OF PROVIDER

Participants may choose any In-Network provider for Covered Services. Participants may choose any In-Network or Out-of-Network provider for Emergency Services. However, using In-Network providers gives Participants the maximum benefits available through the Health Plan. See the Schedule of Medical Benefits for applicable co-pays, coinsurance, and deductibles.

To find an In-Network Provider, Participants may check the online provider directory www.team-choice.com for an updated list of In-Network Providers for TeamChoice. Provider participation in the Network may change from time to time. It is important for Participants to verify provider participation prior to receiving services.

C. WHEN COVERED SERVICES ARE NOT AVAILABLE FROM AN IN-NETWORK PROVIDER

If a Participant requires Medically Necessary services that are not available from an In-Network Provider, the Participant must contact the Health Plan to request a review of the availability of the needed services. This is called an “out-of-network review” and must be requested prior to receiving medical services.

If the Health Plan certifies that the service is not available in the Network, the Health Plan may assist the Participant in obtaining a Provider who is willing to provide services and accept the In-Network or negotiated payment.

If the Health Plan approves service by an Out-of-Network Provider, the Health Plan will pay the Provider at the in-network or negotiated benefit level. Services approved through an out-of-network review are subject to the in-network calendar year copayment and coinsurance. Although the Health Plan may grant approval to use an Out-of-Network Provider, the Provider may not agree to accept the in-network or negotiated payment, and the Participant may be responsible for amounts charged by the provider that exceed the Plan's allowable charge or payment.

Approvals for out-of-network requests will be reviewed again and the Health Plan must give further approval for follow-up testing after active treatment is complete.

Out-of-network approval does not guarantee that services are covered. Benefits are subject to the Participant's eligibility at the time charges are actually incurred, and to all other terms, conditions, and exclusions of the Plan.

D. PARTICIPANTS WHO RESIDE OUT-OF-AREA

An Out-of-Area Participant is a Participant whose principal and primary address is located outside the geographic area serviced by the TeamChoice network. A Participant must enroll as an Out-of-Area Participant by contacting the Health Plan. The Health Plan reserves the right to require proof of residence for any Participant. The Health Plan must approve the Participant as an Out-of-Area Participant.

An Out-of-Area network is available only for **enrolled** Out-of-Area Participants. If a Participant resides outside the TeamChoice service area, the Participant may enroll and then access providers in the Health Plan-approved provider network. The Out-of-Area Participant may check the Out-of-Area network providers contacting the Health Plan at **806-775-8793**.

The Health Plan will apply In-Network benefits to Covered Services provided to enrolled Out-of-Area Participants.

Participants who reside in the Service Area may not access the Out-of-Area provider networks except for Emergency Services when the Participant is outside the Service Area temporarily.

Out-of-Area Participants must notify the Health Plan promptly when the Participant ceases to reside out-of-area.

Out-of-Area Participants are encouraged to seek care within the TeamChoice network when possible.

F. EMERGENCY SERVICES

Emergency care means health care services necessary to evaluate and stabilize medical conditions of recent onset and severity, including but not limited to severe pain, that would lead a prudent layperson possessing an average knowledge of medicine to believe that the condition, sickness, or injury is of such a nature that failure to get immediate attention could result in placing the patient's health in serious jeopardy, serious impairment to bodily functions, serious dysfunction of any bodily organ or part, serious disfigurement, or in the case of a pregnant woman, serious jeopardy to the health of the fetus.

When reasonably possible, the Participant should go to **UNIVERSITY MEDICAL CENTER** for emergency services. If the Participant is enrolled as an Out-of-Area Participant, the Participant should go to a provider in the Health Plan-approved network.

If it is not reasonably possible to go to UMC or an approved Out-of-Area provider, the Participant should go to the nearest appropriate facility. Payment for the service is described in Section 1 "Schedule of Benefits" and Section 4 under "Covered Health Services – Emergency Care Services."

SECTION 9

PLAN ADMINISTRATION

Plan Administrator means the Employer (University Medical Center) through UMC Health Plan Operations, and the Employer has the fiduciary responsibility for the operation of the Health Plan.

A. RECORDS

The Plan Administrator will maintain records of the Participants that will include:

1. Name, age and amount of coverage for each Participant;
2. Effective date of coverage for each Participant;
3. Effective date of increase, decrease or termination in coverage; and
4. Other such information as may be required to administer the Plan.

B. ACTIONS OF PLAN ADMINISTRATOR

The Plan Administrator may act for and on behalf of the Employer and all subsidiaries and affiliates, if any, in all matters pertaining to this Plan. Every agreement made with the Plan Administrator will be binding on the Employer and the subsidiaries and affiliates, if any. Every notice given to the Plan Administrator will be deemed to have been given to the Plan Administrator, the Employer and the subsidiaries and affiliates, if any.

The Plan Administrator shall have the following powers and duties:

1. To require any person to furnish such information as is reasonably necessary or appropriate for administration of the Plan as a condition to receiving Benefits under the Plan;
2. To make such rules and regulations and prescribe the use of such forms as the Plan Administrator shall deem necessary for the efficient administration of the Plan;
3. To decide on questions concerning the Plan eligibility of Employees to participate, all in accordance with the Plan;
4. To determine whether medical expenses are Reasonable and Customary and to determine whether fees and charges are eligible charges under the Plan;
5. To determine the amount of Benefits payable to or on behalf of a Participant, in accordance with the Plan, and to provide a full and fair review to any Participant whose claim for Benefits has been denied in whole or in part;
6. To designate other persons to carry out any duty or power which would otherwise be a fiduciary responsibility of the Plan Administrator, under the terms of the Plan;

7. To employ the services of a third party administrator as Plan Supervisor in connection with the administration of claims or other operations of the Plan; and,
8. To amend the Plan with the approval of the Board of Managers.

The Plan Administrator has full discretionary authority in all matters related to the discharge of its responsibilities, including, without limitation, its construction of the terms of the Plan and its determination of eligibility for Coverage and Benefits.

C. RELATIONSHIP OF PARTIES

The relationship between the Health Plan and Providers is that of an independent contractor relationship. Providers are not agents or employees of the Health Plan or the Employer. The Health Plan shall not be liable for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by a Participant while receiving care from any Provider.

D. PATIENT/PROVIDER RELATIONSHIP

Providers maintain a Provider-Patient relationship with Participants and are solely responsible to Participants for all health services. If a Provider cannot establish a satisfactory Provider-Patient relationship, the Provider may request that the Participant choose another Provider, and the termination of the Patient/Provider relationship may extend to other Providers in that medical group.

E. REFUSAL TO ACCEPT TREATMENT

Certain Participants may, for personal reasons, refuse to accept procedures or treatment by a Provider. Providers may regard such refusal to accept their recommendations as incompatible with continuance of the Provider-Patient relationship and as obstructing the provision of proper medical care. Providers shall use their best efforts to render all necessary and appropriate Professional Services in a manner compatible with a Participant's wishes, insofar as this can be done consistent with the Provider's judgment as to the requirements of proper medical practice. If a Participant refuses to follow a recommended treatment or procedure, and the Provider believes that no professionally acceptable alternative exists, such Participant shall be so advised. In such case, neither the Health Plan nor any Provider shall have any further responsibility to provide care for the condition under treatment. The continued refusal by the Participant to follow the recommended treatment or procedure(s) may result in termination of the Participant's coverage, subject to the Plan's complaint procedure, and subject to procedures set forth under Termination in this Health Plan document.

F. COMPLAINT PROCEDURE

Any problem or claim between a Participant and the Health Plan or between a Participant and a Provider must be dealt with through the Health Plan's complaint procedure. Complaints may concern non-medical or medical aspects of care as well as the terms of this benefit booklet, including its breach or termination. Complaint and appeal procedures are described in Section 12 of this Health Plan Document.

G. IDENTIFICATION CARD

Cards issued by the Health Plan to Participants pursuant to this Health Plan are for identification only. The identification card confers no right to services or other benefits. To be entitled to any services or benefits, the holder of the identification card must, in fact, be a Participant on whose behalf all applicable contribution payments under the Plan have actually been paid. A person who receives services or benefits to which the person is not entitled to under the provisions of the Health Plan is liable for the actual cost of such services or benefits.

H. CLAIMS SUBMISSION AND PAYMENT

It is not expected that a Participant will make payment, other than required Co-payments, coinsurance, and deductibles for any benefits provided under the Health Plan. However, if the Participant pays the Provider amounts payable by the Health Plan, the Participant may make a claim for reimbursement from the Health Plan. A claim shall be allowed only if the claim is submitted to the Health Plan within ninety (90) days from the date of service, unless it is shown that it was not reasonably possible to submit within the time limit, and that the claim was submitted as soon as was reasonably possible. However, benefits shall not be allowed if the claim is submitted more than one (1) year from the date of service.

Forms for the submission of claims and reimbursement are available from the Health Plan.

Within fifteen (15) days of receipt of a written claim, the Health Plan shall acknowledge receipt of claim and begin any necessary investigation of the claim. It may be necessary for the Health Plan to request additional information from the Participant. Claims shall be acted upon within fifteen (15) business days of receipt of a completed claim unless the Participant is notified that additional time is needed and why. The Health Plan will act on a completed claim no later than forty-five (45) days after the additional time notification is given to the Participant.

Any claim denial will be made in writing and will contain the reasons for the denial. A Participant may obtain a review of the denial by following the procedures set out in Section 12 of this Health Plan document.

Payments made for claims must be returned to the UMC Health Plan if it is found that such payments were made in error. The UMC Health Plan may deduct the amount of overpayments from any subsequent benefits payable to or on behalf of the Participant or to other present or future amounts payable or may recover the overpayment by any other method that UMC Health Plan may determine.

I. TERMINATION OF PLAN PHYSICIAN OR PLAN PROVIDER

From time to time, a Plan Physician or Provider may terminate participation under the Health Plan. Participants may use the on-line directory to select an In-Network provider.

If a Plan Provider has terminated, a Participant may request to continue treatment with the Provider if the Participant has special circumstances. This may not be approved if the Plan Provider was terminated for reason of medical competence or professional behavior, Special circumstances means a condition that the treating Plan Provider

reasonably believes that discontinuing care by the treating Plan Provider could cause harm to the Participant. Special circumstances may include a person with a disability, acute condition, Life Threatening illness, or is past the 24th week of pregnancy. The period of continued treatment may not exceed 90 days from the date of termination, or beyond nine months in the case of a Participant who at the time of the termination has been diagnosed with a terminal illness. Coverage will be extended for a Participant who at the time of termination is past the 24th week of pregnancy, through delivery of the child, immediate postpartum care, and the follow-up checkup within the first six weeks of delivery.

The Provider must agree to accept the contracted payment rates, which were in effect prior to termination, for the ongoing treatment of a Participant who is receiving Medically Necessary treatment in accordance with medical dictates of medical prudence. The Participant will be responsible for the applicable copayment.

J. AUTHORIZATION TO EXAMINE HEALTH RECORDS

The Participant consents to and authorizes a Physician, Hospital, Skilled Nursing Facility, Chemical Dependency Treatment Center or other Plan Provider of care to permit the examination and copying of any portion of the Participant's medical records, as permitted by law, when requested by the Health Plan. Information from medical records of Participants and information received from Providers or facilities incident to the Provider-Patient relationship or facility-patient relationship shall be kept confidential and except for use reasonably necessary in connection with government requirements established by law, may not be disclosed without the further consent of the Participant.

K. INCONTESTABILITY

All statements made by a Participant are considered representations and not warranties. A statement may not be used to void, cancel or non-renew a Participant's coverage or reduce benefits unless it is in a written enrollment application signed by the Participant and a signed copy of the enrollment application has been furnished to the Participant. Coverage may be contested because of fraud or intentional misrepresentation of material fact on the enrollment application.

Section 10

UTILIZATION REVIEW (U.R.) PROGRAM

A. PRE-AUTHORIZATION/UTILIZATION REVIEW PROGRAM

Pre-authorization establishes in advance the Medical Necessity of certain care and services covered under this Plan. It ensures that the pre-authorized care and services described below will not be denied on the basis of Medical Necessity.

Pre-authorization does not guarantee payment of benefits. Coverage is always subject to other requirements of the Plan, such as Pre-existing Conditions, limitations and exclusions, payment of contributions, and eligibility at the time care and services are provided.

UMC Health Plan has contracted with a medical review specialist, **Spectrum Review Services, Inc.** (Spectrum), to review the Medical Necessity of certain medical services, care, or treatments, including Participant's Hospital admission and the length of the Participant's Hospital stay. Spectrum along with UMC Case Management will work with the Participant's Provider to review Participant's stay and continue to make recommendations on Medical Necessity and appropriateness so that Participant can be discharged as soon as it is medically safe and acceptable.

The Participant is responsible for obtaining pre-authorization for services. To satisfy pre-authorization requirements, the Participant, Provider of services, or a family member calls Spectrum Review Services at 1-800-258-5055 between the hours of 7 a.m. to 6 p.m. Monday through Friday. Calls made after working hours or on weekends will be recorded and returned the next working day. A benefits management nurse will follow up with the Participant's Provider.

Note: Pre-authorization is not required for those Participants having Medicare or other primary coverage, unless the service, procedure, or admission is not covered by the primary coverage. In this case, the service, procedure, or admission will be subject to the pre-authorization process.

B. SERVICES REQUIRING PRE-AUTHORIZATION

At least two (2) business days before the service, the Participant must contact Spectrum and provide all information requested by Spectrum. The Participant's Provider may contact Spectrum on Participant's behalf. The following services require pre-authorization:

- **All inpatient Hospital admissions**
- The following surgeries must be authorized:
 - Adenoidectomy
 - Anal Surgery (Fissures, Hemorrhoids)
 - Appendectomy
 - Arthrodesis (Finger/Hammer Toe, Trigger Finger)
 - Bartholin cyst (I&D)
 - Biopsies (Except skin)

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- Breast Surgery
- Bronchoscopy (Diagnostic & Therapeutic)
- Bunionectomy
- Cardiac Catheterization
- Carpal Tunnel Release
- Cataract and/or Lens Implantation
- Cholecystectomy
- Circumcision (other than newborn)
- Dilation & Curettage (D&C)
- Endarterectomy
- Endoscopies:
 - (ERCP) Bile Duct & Pancreas
 - Laparoscopy (Peritoneal Cavity) Diagnostic & Therapeutic
 - Arthroscopy (Joint) Diagnostic & Therapeutic
 - Hysteroscopy (Uterus)
 - Cusdoscopy (Vaginal pelvis)
- EGD (Esophagogastroduodenoscopy)
- Excisions:
 - Cryosurgery: Curettage & Electrosurgery/Fulguration/Uterine Cervix
 - Ganglion cyst – Wrist
 - Morton Neuroma – Foot
 - Tendon Sheath or Capsule – Hand
- Gastric Bypass Surgery
- Hernia Repair (Inguinal, Umbilical and/or Ventral)
- Hysterectomy
- Laminectomy
- Myringotomy/Tympanotomy
- Oral surgery
- ORIF (Open reduction internal fixation)
- Pain management services
- Proctosigmoidoscopy (Biopsy & Polypectomy & Colonoscopy)
- Reconstructive Surgery
- Reduction Mammoplasty
- Sinus Surgery
- Temporal Mandibular Joint Surgical Reconstruction (TMJ)
- Tonsillectomy
- Tubal Ligation
- Vein Ligation & Stripping
- Skilled Nursing Facility and Long Term Acute Care admissions
- Home Infusion Therapy
- Home Health Services
- DME in excess of \$1,000
- Prosthetic and Orthotic Services
- Outpatient MRI/CT/PET Scans
- Inpatient treatment of Chemical Dependency
- Inpatient treatment of Mental Health Care
- Hospice

- Speech and Hearing Services
- Transfer to another facility or to or from a specialty unit within the facility
- Transplants
- Non-emergency ambulance transport

C. SECOND SURGICAL OPINION

The UMC Health Plan may require the Participant to seek a second surgical opinion.

D. IN-NETWORK, AND OUT-OF-NETWORK PROVIDERS

See Section 2 and Section 8 for an explanation of payment for services provided by providers who are in-network and approved by the Health Plan and for those who are out-of-network.

E. AUTHORIZING MATERNITY CARE AND HOSPITALIZATION

All Participants should notify Spectrum within 48 hours (or 96 hours in the case of a cesarean section) from the Participant's admission for delivery. Neither UMC Health Plan nor the medical review specialist may, under federal law, require Participant or Participant's provider to obtain pre-authorization for prescribing a hospital length of stay in connection with childbirth for the mother of a newborn child not in excess of 48 hours following a vaginal delivery or 96 hours following a cesarean section.

F. AUTHORIZING A HOSPITAL ADMISSION AFTER EMERGENCY SERVICES

If confinement in a Hospital is the result of an emergency, pre-authorization is not necessary; however, Spectrum must be notified of the emergency admission as soon as reasonably possible, but no more than forty-eight (48) hours after the admission. If the Participant is unable to make the call, another party may make the call on the Participant's behalf. However, it is the Participant's responsibility to ensure the notification requirements are met. Weekend and holiday admissions must also be reported during these time frames.

G. FAILURE TO OBTAIN PRE-AUTHORIZATION

If pre-authorization, as described above, is not obtained:

- The Health Plan will review the Medical Necessity of the treatment prior to the final benefit determination.
- If the Health Plan determines the treatment or service is not Medically Necessary, benefits will be reduced or denied.
- In connection with an inpatient hospital admission, the Participant may be responsible for any balances above and beyond the out-of-network benefit level.
- If an inpatient hospital admission or extension for any treatment or service is not preauthorized and it is determined that the admission or extension was not Medically Necessary, benefits will be reduced or denied.

SECTION 11

COORDINATION OF BENEFITS, ON-THE-JOB INJURY/ILLNESS, and SUBROGATION

The purpose of the UMC Health Plan is to help Participants pay their medical bills. If coverage is provided under any other Health Care Plan, benefits provided under the UMC Health Plan and the other Health Care Plan(s) might exceed actual medical expenses incurred. If this is the case, the combined benefits payable under the UMC Health Plan and other Health Care Plan(s) will not exceed “allowable expenses.” These coordination of benefits provisions apply whether or not a claim is filed under the other Health Care Plan(s). This provision does not apply to individual coverage.

THE PARTICIPANT HAS AN AFFIRMATIVE DUTY TO NOTIFY THE UMC HEALTH PLAN OF COVERAGE PROVIDED UNDER ANY OTHER HEALTH CARE PLAN. The Participant must ensure that accurate information is maintained and kept updated regarding coverage under any other Health Care Plan.

A. DEFINITIONS

For purposes of this section only, the following words and phrases shall have the following meanings:

“Allowable Expenses” means any necessary, reasonable and customary item of expense at least a portion of which is covered under at least one of the Health Care Plans covering the person for whom claim is made. When a Health Care Plan (including the UMC Health Plan) provides benefits in the form of services, the reasonable cash value of each service rendered shall be deemed to be both an Allowable Expense and a benefit paid.

“Health Care Plan” means any of the following (including the UMC Health Plan) that provide benefits or services for, or by reason of, medical care or treatment:

Coverage under government programs, including Medicare, required or provided by any statute unless Coordination of Benefits with any such program is forbidden by law;

Group coverage or any other arrangement of coverage for individuals in a group whether on an insured or uninsured basis, including any prepayment coverage and group practice or individual practice coverage; provided that the term Health Care Plan shall be construed separately with respect to:

- Each policy, contract or other arrangement for benefits or services; and
- That portion of any such policy, contract or other arrangement which reserves the right to take the benefits of other Health Care Plans into consideration in determining its benefits and that portion which does not; and
- Group, group-type and individual automobile, “no-fault” and traditional automobile “fault” type of contract.

B. COORDINATION OF BENEFITS

If a Participant is eligible to receive benefits under another Health Care Plan that duplicates benefits provided under this Plan Document, the Plan Administrator will

coordinate benefits with the other Health Care Plan(s) according to the Coordination of Benefits rules outlined below. The Plan Administrator may seek reimbursement from any Health Care Plan(s) for the cost of services provided. To determine how the plans coordinate benefits, one plan is considered “primary” and the other is considered “secondary.” The primary plan pays benefits first, up to that plan’s limits. The secondary plan will not pay benefits until the primary plan pays or denies a claim. However, the Plan Administrator will not seek reimbursement that exceeds this Plan’s financial responsibility. It is the Participant’s responsibility to ensure that all procedures are properly authorized in advance by the Plan Administrator and to provide the Plan Administrator with information that will assist in determining Coordination of Benefit obligations. The rules establishing the order of benefit determination between this Plan Document and any other Health Care Plan covering the Participant on whose behalf a claim is made are as follows:

1. Whenever a Health Care Plan does not contain a Coordination of Benefits provision, that Health Care Plan must be primary; the primary Health Care Plan pays benefits before the secondary Health Care Plan pays; and
2. If, according to the rules set forth in this section, the benefits of another Health Care Plan that contains a provision coordinating its benefits with this Plan would be determined before the benefits of this Plan have been determined, the benefits of such other Health Care Plan will be considered before the determination of benefits under this Plan.

C. RULES OF COORDINATION

Rules establishing the order of benefit determination as to a Participant's claim for the purposes of this section are as follows:

1. Non-Dependent/Dependent

The benefits of the Health Care Plan which covers the Participant as an employee are determined before those of the Health Care Plan which covers the Participant as a Dependent except, if the Participant is also a Medicare beneficiary and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:

- (i) Secondary to the Health Care Plan covering the Participant as a Dependent; and
- (ii) Primary to the Health Care Plan covering the Participant as other than a Dependent (e.g., a retired employee), then the benefits of the Health Care Plan covering the Participant as a Dependent are determined before those of the Health Care Plan covering that Participant as other than a Dependent.

2. Dependent Child/Parents Not Separated or Divorced

Except as stated below, when this Health Care Plan and another Health Care Plan cover the same child as a Dependent of different persons, called parents:

- (i) The benefits of the Health Care Plan of the parent whose birthday falls earlier in a year are determined before those of the Health Care Plan of the parent whose birthday falls later in that year; but
- (ii) If both parents have the same birthday, the benefits of the Health Care Plan, which covered one parent longer, are determined before those of the Health Care Plan that covered the other parent for a shorter period of time.

However, if the other Health Care Plan does not have the rule described immediately above, but instead has a rule based on gender of the parent, and if, as a result, the Health Care Plans do not agree on the order of benefits, the rule in the other Health Care Plan will determine the order of benefits.

3. Dependent Child/Separated or Divorced

If two or more Health Care Plans cover a Participant as a Dependent child of divorced or separated parents, benefits for the child are determined in this order:

- (i) First, the Health Care Plan of the parent with custody of the child;
- (ii) Then, the Health Care Plan of the spouse of the parent with custody; and
- (iii) Finally, the Health Care Plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expense of the child and the entity obligated to pay or provide the benefits of the Health Care Plan of that parent has actual knowledge of those terms, the benefits of that Health Care Plan are determined first. The Health Care Plan of the other parent shall be the Secondary Health Care Plan. This paragraph does not apply with respect to any claim paid or provided before the entity has that actual knowledge.

4. Joint Custody

If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the Health Care Plans covering the child shall follow the order of benefit determination rules outlined above in the Dependent Child/Parents Not Separated or Divorced provision.

5. Active/Inactive Employee

The benefits of a Health Care Plan which covers a Participant as an Employee who is neither laid off nor retired, are determined before those of a Health Care Plan which covers that Participant as a laid off or retired Employee or as that Employee's Dependent. If the other Health Care Plan does not have this rule, and if, as a result, the Health Care Plans do not agree on the order of benefits, this rule is ignored.

6. Continuation Coverage

If a Participant whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another Health Care Plan, the following shall be the order of benefit determination:

- (i) First, the benefits of a Health Care Plan covering the Participant as an employee (or as that employee's Dependent); and
- (ii) Second, the benefits under the continuation coverage.

If the other Health Care Plan does not have the rule described above, and if, as a result, the Health Care Plans do not agree on the order of benefits, this rule is ignored.

7. Longer/Shorter Length of Coverage

If none of the above rules determine the order of benefits, the benefits of the Health Care Plan that covered an employee or Participant longer are determined before those of the Health Care Plan that covered that Participant for the shorter term.

D. RULES OF COORDINATING BENEFITS WITH MEDICARE

Rules establishing the order of benefit determination for Participants age 65 or older or Participants with end-stage renal disease are as follows:

1. For the employee and the employee's spouse, the benefits of this Plan Document shall be determined before the benefits of Medicare if the Participant is actively employed;
2. Medicare is the primary payer for a qualified retired employee, surviving spouse, or dependent of a retired employee or surviving spouse who is:
 - Age 65 or older;
 - Under age 65 with Social Security disability; or
 - Under age 65 with end-stage renal disease after the first 30 months of Medicare eligibility.
3. If the Participant does not elect Medicare Part A, B, or D, benefits will be reduced as though Medicare is the primary payor. The UMC Health Plan will calculate benefits assuming the Participant has Medicare A, B, and D.
4. When Medicare benefits are primary, claims must be filed with Medicare first for determination of benefits. The Participant is responsible for sending the Medicare explanation of benefits form to the Plan Administrator for determination of benefits under this Plan Document.
5. **End-Stage Renal Disease**
 - a. The UMC Health Plan is the primary payer for an active employee or employee's dependent spouse or child with end-stage renal disease during the first thirty (30) months of Medicare eligibility solely by reason of end-stage renal disease (Medicare is primary after the first 30 months).

- b. The UMC Health Plan is the primary payer for a retiree, surviving spouse, or retiree's or surviving spouse's dependent spouse or child under age 65 with end-stage renal disease during the first 30 months of Medicare eligibility (Medicare is primary after the first 30 months).
- c. Once eligible, if the Participant does not elect Medicare Part A, B, or D, benefits will be reduced as though Medicare is the primary payor. The UMC Health Plan will calculate benefits assuming the Participant has Medicare A, B, and D.
- d. When Medicare benefits are primary, claims must be filed with Medicare first for determination of benefits. The Participant is responsible for sending the Medicare explanation of benefits form to the Plan Administrator for determination of benefits under this Plan Document.

E. MILITARY PROVIDERS

Services and benefits for military service connected disabilities for which a Participant is legally entitled and for which facilities are reasonably available, shall in all cases be primary before the benefits of this Plan Document.

F. RELEASE OF INFORMATION

For purposes of this Plan Document, the Plan Administrator may, subject to applicable confidentiality requirements set forth in this Plan Document, release to or obtain from any insurance company or other organization necessary information to implement these Coordination of Benefit provisions. Any Participant claiming benefits under this Plan Document must furnish to the Plan Administrator all information deemed necessary by it to implement these Coordination of Benefits provisions.

G. RECOVERY OF PAYMENTS

Whenever payments have been made by the Plan Administrator on behalf of UMC Health Plan, pursuant to Allowable Expenses in accordance, with the Coordination of Benefits provisions of this section, then the Plan Administrator shall have the right to recover such excess payment(s). On behalf of UMC Health Plan, the Plan Administrator shall determine such excess payment recovery from among one or more of the following:

- (i) Any person or persons to or for or with respect to whom such payments were made, and
- (ii) Any insurance company or companies (or any other organization or organizations) to which such payments were made.

H. ON-THE-JOB INJURY/ILLNESS

This Plan Document does not provide benefits for on-the-job injuries or illness sustained by a Participant or such Participant's Dependents, whether such injuries or illness are covered by a Worker's Compensation System, other insurance, or are the responsibility of another employer. If payments are made by the Plan Administrator, on behalf of UMC

Health Plan, for services determined to be covered by a Worker's Compensation System or other insurance, or are determined to be as a result of an on-the-job injury/illness, then the Plan Administrator, on behalf of UMC Health Plan, shall have the right to recover payments for services so provided. It is understood that coverage under this Plan Document is not in lieu of, and shall not affect, any requirements for coverage under an applicable Worker's Compensation System(s).

I. SUBROGATION

In the event any hospital, medical, and related service or benefit is provided for, or any payment is made or credit is extended to a Participant for injuries or illnesses resulting from an act or omission of another party, the Plan will be subrogated and will succeed to the right of the Participant to recovery against any person, organization, or other carrier. The acceptance of such benefits hereunder will constitute such subrogation. As a condition to receiving medical benefits under the Plan, Participant agrees to fully cooperate with the Plan Administrator in all matters involving this Plan Document, including, (but not limited to) transfer to the Health Plan Participant's rights to recover damages in full for such benefits when the injury or illness occurs through the act or omission of another person, execution, or cause to be executed, and delivery of any and all consents, releases, assignments, and other documents, including a Subrogation Reimbursement Agreement, as may be required by the Plan, and execution, or cause to be executed, and delivery of any and all documents on behalf of minor dependents covered by the Plan.

The UMC Health Plan's rights become effective as to all third parties their insurers and their attorneys upon the giving of written notice to such third parties, their insurers or attorneys. It is agreed that, by receipt of such benefits from the Group Health Plan, such Participant shall be legally considered to have assigned all first and prior rights of recovery to UMC Health Plan and to have agreed to cooperate and help obtain such recovery by settlement or judgment. UMC Health Plan shall have the right to intervene in any action brought by the Participant against any third party alleged to be responsible for the Participant's illness or injury, in order to protect and prosecute UMC Health Plan's rights to recovery. Participant agrees not to take any action prejudicing the rights and interest of the Health Plan hereunder.

If a Participant receives any recovery, by way of judgment, settlement, or otherwise, from another person or business entity, the Participant agrees to reimburse the Plan in full, in first priority, for any medical expenses paid by it (i.e., the Plan shall be first reimbursed fully to the extent of any and all benefits paid by it from any monies received, with the balance, if any, retained by the Participant).

The obligation to reimburse the Plan, in full, in first priority, exists regardless of whether the settlement or judgment specifically designates the recovery, or a portion thereof, as including medical expenses. The Plan's right of full recovery, either by way of subrogation or right of reimbursement, may be from funds the Participant or legal representative of the Participant receives or is entitled to receive from any third party or the insured's own uninsured/underinsured or medical payment motorist insurance. Participant's legal representative includes, without limitation, Participant's attorney. The Plan may enforce reimbursement or subrogation rights by requiring the Participant or legal representative of the Participant to assert a claim to any of the foregoing coverage to which he may be entitled.

The Plan will not contribute to any attorney fees or costs associated with the Participant's recovery efforts.

Each Participant agrees to fully cooperate with the Plan Administrator, including, (but not limited to) execution and delivery of any and all consents, releases, assignments and other documents as may be required by the Plan Administrator in order to obtain or assure reimbursement under Medicare, for on-the-job injury/illness, and for subrogated rights provided by this Plan Document. Further, any Participant who fails to so cooperate (including, but not limited to, a Participant's failure to properly enroll under Part A of the Medicare program to the extent eligible) will be liable for the amounts that UMC Health Plan would have received had the Participant appropriately cooperated.

All references to the UMC Health Plan in this section shall include University Medical Center.

J. PROVISION OF HEALTH CARE

None of the above rules as to Coordination of Benefits or subrogation will serve as a barrier to the Participant first receiving direct health care that is covered under this Plan Document.

SECTION 12

COMPLAINT AND APPEAL PROCEDURE

If a Participant is dissatisfied with a decision that the Plan has made or with the operation of the Plan, there are procedures for Participants to follow.

The process depends on the type of complaint that a Participant has. The two categories of complaints are:

- Quality of care or operational issues; and
- Adverse benefit determinations.

Complaints about quality of care or operational issues are called grievances. Complaints about adverse benefit determinations are called appeals.

A. GRIEVANCES

Quality of care or operational issues arise if a Participant is dissatisfied with the service received from the Plan or wants to complain about a participating provider. To make a complaint about a quality of care or operational issue (called a grievance), the Participant should call or write to UMC Health Plan Operations within 30 days of the incident. The Participant should include a detailed description of the matter and include copies of any relevant records or documents. UMC Health Plan Operations will review the information and provide the Participant with a written decision within 30 days of the receipt of the grievance, unless additional information is needed, but cannot be obtained within this period.

B. APPEALS

Adverse benefit determinations means rescission, denial, reduction, or termination of, or a failure to provide payment (in whole or in part) for a benefit including determinations of a Participant's eligibility under the Plan; determinations that a benefit is not a covered benefit; the imposition of a; source-of-injury exclusion; network exclusion; or other limitation on otherwise covered benefits; or a determination that a benefit is experimental, investigational, or not medically necessary or appropriate. Adverse benefit determinations can be made for one or more of the following reasons:

- The individual is not eligible to participate in the Plan; or
- UMC Health Plan determines that a benefit or service is not covered by the Plan because:
 - It is not included in the list of covered benefits;
 - It is specifically excluded;
 - A Plan limitation has been reached; or
 - It is not medically necessary.

UMC Health Plan will send the Participant a written notice of an adverse benefit determination. The notice will give the reason for the decision and explain what steps the Participant must take if the Participant wishes to appeal.

The Plan provides for two levels of appeal, plus an option to seek external review of the final adverse benefit determination. The Participant MUST complete the two levels of internal appeal and an external appeal before bringing a lawsuit against the Plan.

C. NOTICE OF GRIEVANCE OR APPEAL

The Participant must notify the Health Plan in writing of a complaint or appeal by contacting the Health Plan at:

UMC Health Plan Operations
309 N. Slide Road
Lubbock, TX 79416
Customer Care Professional: PHONE # 806-775-8793

D. HOW TO APPEAL A DENIED CLAIM

If a Participant wishes to appeal a denied pre-service request for Benefits, post-service claim or a rescission of coverage as described below, the Participant or the Participant's authorized representative must submit the appeal in writing within 180 days of receiving the adverse benefit determination. Participants do not need to submit Urgent Care appeals in writing. This communication should include:

- the patient's name and identification number as shown on the ID card;
- the provider's name;
- the date(s) of medical service(s);
- the reason the claim should be paid and include facts based only on whether or not Benefits are available under the Plan in which the Participant is enrolled, and the proposed treatment or procedure; and
- any clinical documentation or other written information to support the request for claim payment.

Please note that the decision is based only on whether or not Benefits are available under the Plan in which a Participant is enrolled, and the proposed treatment or procedure. The decision for a Participant to receive services is between a Participant and a Participant's Physician.

For requests for Urgent Care Benefits that have been denied, a Participant can call UMC Health Plan Operations at the toll-free number on the Participant's ID card to request an appeal.

Types of Claims

The timing of the claims appeal process is based on the type of claim a Participant is appealing. If a Participant wishes to appeal a claim, it helps to understand whether it is a:

- request for Urgent Care Benefits;
- pre-service request for Benefits;
- post-service claim; or
- concurrent claim.

There are four types of claims:

- Request for Benefits for Urgent Care - a request for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the Participant or the Participant's ability to regain maximum function, or in the opinion of a physician with knowledge of the Participant's medical condition would subject the Participant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. If a physician with knowledge of the Participant's medical condition determines that a claim involves urgent care, the claim will be treated as an urgent care claim.
- Pre-Service request for Benefits - a request for Benefits which the Plan must approve or in which a Participant must notify the Plan before non-Urgent Care is provided; and
- Post-Service - a claim for reimbursement of the cost of non-Urgent Care that has already been provided.
- Concurrent Care – a request to extend an on-going course of treatment previously approved for a specific period of time or number of treatments beyond that which was previously approved. (The way this request is processed depends on whether the treatment extension is an Urgent Care request or involves a non-urgent circumstance.)

APPOINTMENT OF AUTHORIZED REPRESENTATIVE

Participant may appoint an Authorized Representative to act on the Participant's behalf for appeal of an adverse benefit determination. *An assignment of benefits by a Participant to a provider is NOT an appointment of that provider as an Authorized Representative.* To appoint such a representative, the Participant must complete a form, which can be obtained from the Plan Administrator. If a Participant designates an Authorized Representative, all future communications from the Plan will be with the representative, rather than the Participant, unless the Participant directs the Plan Administrator, in writing, to the contrary.

Review of an Appeal

UMC Health Plan will conduct a full and fair review of a Participant's appeal. The appeal may be reviewed by:

- an appropriate individual(s) who did not make the initial benefit determination; and
- a health care professional with appropriate expertise who was not consulted during the initial benefit determination process.

Once the review is complete, if UMC Health Plan upholds the denial, the Participant will receive a written explanation of the reasons and facts relating to the denial.

FILING A SECOND APPEAL

The Plan offers two levels of appeal. If a Participant is not satisfied with the first level appeal decision, the Participant has the right to request a second level appeal within 60 days after receipt of the first level appeal determination.

The appeal must be in writing and must include at least the same information as previously provided during the Participant's first level appeal. This appeal will go to the UMC Health Plan Operations medical review committee.

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UMC Health Plan will conduct a full and fair review of a Participant's appeal. The appeal may be reviewed by:

- an appropriate individual(s) who did not make the initial benefit determination or make the decision to uphold the adverse benefit determination during the first appeal; and
- a health care professional with appropriate expertise who was not consulted during the initial benefit determination nor the first level appeal process.

Note: Upon written request (or orally for urgent care claims) and free of charge, any Participant may examine documents relevant to their claim and/or appeals and submit opinions and comments. UMC Health Plan will review all claims in accordance with the rules established by the U.S. Department of Labor.

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Timing of Appeals Determinations

Separate schedules apply to the timing of claims appeals, depending on the type of claim.

The tables below describe the time frames which a Participant and the UMC Health Plan are required to follow.

| Request for Urgent Care Benefits* | |
|--|---|
| Type of Request for Benefits or Appeal | Timing |
| If Participant's request for Benefits is incomplete, UMC Health Plan must notify Participant within: | 24 hours |
| Participant must then provide a completed request for Benefits to UMC Health Plan within: | 48 hours after receiving notice of the additional information required |
| UMC Health Plan must notify Participant of the benefit determination within: | 72 hours after receiving the additional information |
| If UMC Health Plan denies Participant's request for Benefits, Participant must appeal a claims denial no later than: | 180 days after receiving the claim denial |
| UMC Health Plan must notify Participant of the appeal decision within: | 72 hours after receiving the appeal |

*Participants do not need to submit Urgent Care appeals in writing. Participant should call UMC Health Plan as soon as possible to appeal a Request for Urgent Care Benefits.

| Pre-Service Request for Benefits | |
|--|--|
| Type of Request for Benefits or Appeal | Timing |
| If Participant's request for Benefits is filed improperly, UMC Health Plan must notify Participant within: | 5 days |
| If Participant's request for Benefits is incomplete, UMC Health Plan must notify Participant within: | 15 days |
| Participant must then provide the complete request for Benefits information to UMC Health Plan within: | 45 days |
| UMC Health Plan must notify Participant of the benefit determination: | |
| <ul style="list-style-type: none"> ■ If the initial request for Benefits is complete, within: | 15 days after receiving the complete request for Benefits |

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| Pre-Service Request for Benefits | |
|--|--|
| Type of Request for Benefits or Appeal | Timing |
| <ul style="list-style-type: none"> ■ If the initial request for Benefits is incomplete, within: | 15 days after receiving the additional information to complete the request for Benefits |
| Participant must appeal an adverse Benefit determination no later than: | 180 days after receiving the adverse benefit determination |
| UMC Health Plan must notify Participant of the first level appeal decision within: | 15 days after receiving the first level appeal |
| Participant must appeal the first level appeal (file a second level appeal) within: | 60 days after receiving an adverse benefit determination on the first level appeal |
| UMC Health Plan must notify Participant of the second level appeal decision within: | 15 days after receiving the second level appeal** |

**UMC Health Plan may require a one-time extension of no more than 15 days only if more time is needed due to circumstances beyond their control.

| Post-Service Claims | |
|---|---|
| Type of Claim or Appeal | Timing |
| If Participant's claim is incomplete, UMC Health Plan must notify Participant within: | 30 days after receipt of Participant's claim |
| Participant must then provide completed claim information to UMC Health Plan within: | 45 days after notice of the incomplete information |
| UMC Health Plan must notify Participant of the benefit determination: | |
| <ul style="list-style-type: none"> ■ if the initial claim is complete, within: | 30 days after receipt of the complete claim |
| <ul style="list-style-type: none"> ■ If the initial claim is incomplete, within: | 30 days after receiving the completed claim |
| Participant must appeal an adverse benefit determination no later than: | 180 days after receiving the adverse benefit determination |

UMC EMPLOYEE HEALTH PLAN

| Post-Service Claims | |
|---|--|
| Type of Claim or Appeal | Timing |
| UMC Health Plan must notify Participant of the first level appeal decision within: | 30 days after receiving the first level appeal |
| If Participants wish to appeal, Participant must appeal the first level appeal (file a second level appeal) within: | 60 days after receiving an adverse decision on the first level appeal |
| UMC Health Plan must notify Participant of the second level appeal decision within: | 30 days after receiving the second level appeal** |

^{2**}UMC Health Plan may require a one-time extension of no more than 15 days only if more time is needed due to circumstances beyond their control.

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and a Participant's request to extend the treatment is a request for Urgent Care Benefits as defined above, UMC Health Plan will make a determination on the request for the extended treatment within 24 hours after receipt of the request.

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and Participant requests to extend treatment in a non-urgent circumstance, the request will be considered a new request and decided according to post-service or pre-service timeframes, whichever applies.

E. EXTERNAL REVIEW PROGRAM

If, after exhausting both internal appeals, a Participant is not satisfied with the final determination, the Participant may participate in the external review program. This program only applies if the adverse benefit determination is based on:

- clinical reasons;
- exclusions for Experimental or Investigational Services or Unproven Services; or
- as otherwise required by applicable law.

The Plan shall provide for an external review process through three independent review organizations ("IRO"). The cost of the IRO to conduct the external review will be paid by the Plan.

All requests for an independent review must be made within four (4) months after the date Participant receives the final, second level internal appeal denial. Participant may make the request for an independent review by contacting UMC Health Plan Operations or by sending a written request to UMC Health Plan Operations.

Within five (5) business days following the date of receipt of the external review request, the Plan will complete a preliminary review to determine if the Participant is or was covered under the Plan at the time the service was provided; that the denial is not due to failed eligibility requirements for the plan; that the internal appeals process was exhausted; and that all required forms were submitted. The Plan will issue a notification to the Participant in writing within one (1) business day after completion of the preliminary review. If the request is complete but not eligible for external review, the notification will include the reasons for its ineligibility. If the request is not complete, the notification will describe the information or materials needed to make the request complete and the Participant will have the later of forty-eight (48) hours following the date of receipt of the notification or the end of the original four (4) month deadline described above to submit the information.

Following the Plan's preliminary review, if the request is eligible for external review, the Plan will randomly assign an IRO as soon as administratively feasible to make a determination on the request for external review. Within five (5) business days following assignment of the IRO, the Plan will forward all information and materials relevant to the final internal adverse benefit determination.

The assigned IRO will notify the Participant in writing of the request's eligibility and acceptance for external review. The notice will include a statement regarding the Participant's right to submit any additional information, within five (5) business days from the date of receipt of the notice, for the IRO to consider as part of the external review process. Any such additional information the IRO receives will be forwarded and shared with the Plan within one business day. The Plan, based upon any new information received, may reconsider its final internal adverse benefit determination. Reconsideration by the Plan will not delay the external review process. The external review may be terminated as a result of reconsideration only if the Plan decides, upon completion of its reconsideration, to reverse its adverse benefit determination and provide coverage or payment. Within one business day after making such a decision, the Plan must provide written notice of its decision to the Participant and the IRO. The assigned IRO will terminate the external review upon receipt of such notice from the Plan.

Within forty-five (45) days after receipt of the external review request from the Plan, the IRO must provide written notice to the Participant and the Plan. The notice will contain the information deemed necessary by PPACA.

Upon receipt of a notice of a final external review decision reversing the adverse benefit determination, the Plan will immediately provide coverage or payment for the claim.

Expedited External Review

A Participant may file a request for an expedited external review in the following three situations:

- If the adverse benefit determination involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize the life or health of the Participant or would jeopardize the Participant's ability to regain maximum function and the Participant has filed a request for an expedited internal appeal; or
- If the final internal adverse benefit determination involves a medical condition where the timeframe for the completion of a standard external review would seriously jeopardize the life or health of the Participant or would jeopardize the Participant's ability to regain maximum function; or

- If the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which the Participant received emergency services, but has not been discharged from a facility.

Immediately following the date the Plan receives the external review request, the Plan will complete a preliminary review and notify the Participant in writing immediately after completion of the preliminary review either the request is eligible for the external review process.

Following the Plan's preliminary review, if the request is eligible for external review, the Plan will assign an IRO to make a determination on the request for external review. The Plan will promptly forward to the IRO, by any available method (i.e. telephone, fax, etc.) all information and materials relevant to the final internal adverse benefit determination.

The IRO must provide notice to the Participant and the Plan, either in writing or orally, as soon as the Participant's medical condition or circumstance requires, but no later than seventy-two (72) hours after receipt of the expedited external review request from the Plan. If the notice was not provided initially in writing, within 48 hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to the Participant and the Plan.

Exhaustion of Procedures

Exhaustion (i.e. completing) the internal appeals is required prior to external review unless the Plan waives the exhaustion requirement; the Plan fails to comply with the requirements of the internal appeals process except those failures that are based on *de minimis* violations that do not cause, and are not likely to cause, prejudice or harm to the Participant; or the Participant simultaneously requests an expedited internal appeal and an expedited external review.

Any requests for appeals that do not comply with the above-stated procedures will not be considered for review.

SECTION 13

**STANDARDS FOR PRIVACY AND SECURITY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION
("PRIVACY AND SECURITY RULE")**

The Privacy and Security Rule is a part of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). The Privacy and Security Rule sets forth standards with respect to the rights of individuals who are the subject of information created or received by health care plans; procedures for the exercise of those rights; the security of electronically transmitted health information; and the authorized and required uses and disclosures of individually identifiable health information which is considered protected health information. The use of these standards will provide enhanced protections for protected health information while also providing for increased access to an individual's protected health information.

University Medical Center Employee Health Plan (the "Plan") falls under the Privacy and Security Rule. The Plan is sponsored by University Medical Center ("Plan Sponsor") for use by its workforce and their dependents.

A. PROTECTED HEALTH INFORMATION

Protected Health Information ("PHI") is defined as information that:

- Relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present or future payment for the provision of health care to an individual;
- Is created or received by a health care provider, health plan, employer, or health care clearinghouse; and
- Identifies the individual or with respect to which there is a reasonable basis to believe that the information can be used to identify the patient.

Therefore, PHI consists of all clinical, financial and demographic data that is individually identifiable. PHI will cover all verbal, paper and electronic forms of communication.

B. NOTICE OF PRIVACY PRACTICES

The Plan Sponsor will issue a Notice of Privacy Practices which describes how protected health information may be used and disclosed. It will also describe how a Participant may access his or her information. The Notice of Privacy Practices will be distributed at the time of enrollment for new participants. The Plan Sponsor will provide information about how to obtain a copy of the Notice within 60 days after a material revision to the Notice and no less frequently than every three years.

C. CERTIFICATION BY PLAN SPONSOR

The Plan Sponsor certifies that this Plan Document incorporates all provisions as required by §164.504(f)(2)(ii).

D. ENROLLMENT/DISENROLLMENT INFORMATION

The Plan may disclose to the Plan Sponsor information regarding whether an individual is enrolled in or has disenrolled from the Plan.

E. PROVISION OF PHI TO PLAN SPONSOR

The Plan Sponsor shall have access to PHI from the Plan only as permitted under this Plan document, or as otherwise required or permitted by the Privacy Rule.

F. USE OF PHI BY PLAN SPONSOR

Unless otherwise permitted by law, the Plan may disclose PHI to the Plan Sponsor provided the Plan Sponsor uses or discloses such PHI only for Plan administration purposes. "Plan administration purposes" means administrative functions performed by the Plan Sponsor on behalf of the Plan, such as quality assurance, claims processing, auditing, and monitoring. Plan administration functions do not include functions performed by the Plan Sponsor in connection with any other benefit or benefit plan of the Plan Sponsor. Additionally, Plan administration functions do not include any employment-related functions.

The Plan Sponsor agrees that with respect to any PHI disclosed to it by the Plan for administrative purposes, Plan Sponsor shall:

1. Not use or further disclose the PHI other than as permitted or required by the Plan or as required by law;
2. Ensure that any agent, including a subcontractor, to whom it provides PHI received from the Plan agrees to the same restrictions and conditions that apply to the Plan Sponsor with respect to PHI;
3. Not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;
4. Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;
5. Provide Participants with the right to access PHI in accordance with 45 CFR §164.524;
6. Make available to Participants PHI for amendment and incorporate any amendments to PHI in accordance with 45 CFR §164.526;
7. Make available the information required to provide an accounting of disclosures in accordance with 45 CFR §164.528;
8. Make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Rule; and
9. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or

destruction is not feasible, limit further uses and disclosures to those that make the return or destruction of the information infeasible.

10. Not sale any PHI unless appropriate, prior written authorization has been obtained.
11. Not collect genetic information (including family medical history) from an individual prior to or in connection with their enrollment in the plan or at any time for underwriting purposes.
12. Not engage in any inappropriate fundraising or marketing activities involving PHI.

G. ADEQUATE SEPARATION BETWEEN THE PLAN AND THE PLAN SPONSOR

Any officer or employee of the Plan Sponsor who serves as a fiduciary with respect to the Plan, and any officer or employee of the Plan Sponsor (including, but not limited to, benefits, audit, legal, accounting, case management, and systems personnel) who, from time to time in the ordinary course of business of the Plan Sponsor, perform plan administration functions related to the Plan, may be given access to PHI received from the Plan, subject to the following restrictions:

1. These persons may only have access to, and use and disclose, PHI for Plan administration functions that are performed by the Plan Sponsor for or on behalf of the Plan; and
2. These persons shall be subject to disciplinary action and sanctions in accordance with the policies of the Plan Sponsor, up to and including termination of employment, for any use or disclosure of PHI in breach of, or in violation of, or in noncompliance with, the provisions of this Article or the law. The Plan Sponsor shall arrange to maintain records of such violations, as well as disciplinary and corrective measures taken with respect to each incident.

H. SUMMARY HEALTH INFORMATION

The Plan may disclose Summary Health Information to the Plan Sponsor, provided 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.

“Summary Health Information” means: information that (a) summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a plan sponsor had provided health benefits under a Health Plan; and (b) from which the information described at 42 CFR §164.514(b)(2)(i) has been deleted, except that the geographic information described in 42 CFR §164.514(b)(2)(i)(B) need only be aggregated to the level of a five-digit zip code.

I. SECURITY OF ELECTRONIC PROTECTED HEALTH INFORMATION

The Plan agrees to implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic protected health information that it creates, receives, maintains or transmits on

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behalf of the Plan in accordance with 45 CFR 164 (the HIPAA Security Rule).

The Plan Sponsor agrees to be bound by the following requirements:

1. The Plan Sponsor shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of ePHI that it creates, receives, maintains, or transmits on behalf of the Plan in accordance with 45 C.F.R. Parts 160, 162, and 164.
2. The Plan Sponsor will make certain that the HIPAA privacy requirements, applicable to its employees and other workforce members under the control of the Plan Sponsor who are not allowed access to ePHI as part of their role in performing Plan administrative functions, are also supported by reasonable and appropriate security measures.
3. The Plan Sponsor will make certain that any third party administrators or other entities providing services to the Plan (called business associates) and their subcontractors agree to implement reasonable and appropriate security measures to safeguard the ePHI in their possession or control.
4. The Plan Sponsor will report any incident involving the security of ePHI to the Plan's Security Official as soon as reasonably possible.
5. The Plan Sponsor will implement a policy regarding disclosures of breach of ePHI.

SECTION 14

MISCELLANEOUS PROVISIONS

A. Entire Plan Document

This booklet and the enrollment form(s) constitute the entire agreement between UMC Health Plan and the Participant as of the effective date of the Participant's coverage. This Plan Document supersedes all other agreements.

B. Severability

If any provision of this Health Plan shall be held invalid or unenforceable, such invalidity or unenforceability shall not affect any other provision, and this Health Plan shall be construed and enforced as if such provision has not be included.

C. Right to Receive and Release Information

For the purpose of determining the applicability of and implementing the terms of these benefits, the Health Plan may, without the consent of or notice to any person, release or obtain any information necessary to determine acceptability of any applicant or Participant in and/or benefits from the Plan. In so acting, the Health Plan shall be free from any liability that may arise with regard to such action. Any Participant claiming benefits under this Health Plan shall furnish the Health Plan with such information as may be necessary to implement this provision.

D. Legal Action

No action at law or in equity shall be brought to recover under this Health Plan Document prior to the expiration of sixty 60 days after notice of claim has been presented in writing to UMC Health Plan Operations, nor shall such action be brought at all unless brought within one year from the expiration of the time within which notice of claim is required by this Plan Document. Venue shall be in Lubbock, Lubbock County, Texas for all purposes.

E. Notice

Any notice required by or given involving this Plan may be given by personal delivery, by telephone facsimile transmission, by overnight delivery service, or by United States mail, first class, postage prepaid, addressed as follows:

**UMC Health Plan Operations
309 N. Slide Road
Lubbock, TX 79416**

and if to a Participant, at the last address specified in the records of the Health Plan.

F. Gender

The use of any gender in this Plan Document shall be deemed to include and reference the other genders, and likewise, use of the singular tense shall be deemed to include the plural and vice versa.

G. Amendment and Termination

UMC Health Plan may amend or terminate this Plan at any time by action of the UMC Board of Managers. No amendment shall deprive any Participant of any benefit to which he or she is entitled under this Plan with respect to contributions previously made

H. Clerical Error

Clerical error, whether made by UMC Health Plan or any administrative service, in keeping records pertaining to the coverage of Participants under this Plan will not invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated.

I. Headings and Captions

The headings and captions used in this Plan document are provided for purposes of reference and convenience only, and shall not be used in continuing or interpreting this Plan.

J. Effect of Plan on Employment

The Plan shall not be deemed to constitute a contract of employment between the Employer and any Participant or to be consideration or an inducement for the employment of any Participant or employee. Nothing contained in this Plan shall be deemed to give any Participant or employee the right to be retained in the services of the Employer or to interfere with the right of the Employer to discharge any Participant or employee at any time regardless of the effect which such discharge will have upon him or her as a Participant of this Plan.

K. No Waiver or Estoppel

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

L. ERISA Does Not Apply

The Lubbock County Hospital District, d/b/a University Medical Center (“UMC” and “the Employer”) is a political subdivision of the State of Texas. The Employer has established this self-funded health plan for its eligible employees and their eligible dependents. The Health Plan is not subject to the Employee Retirement Income Security Act of 1974 (ERISA) because it is a governmental plan.

M. No Waiver of Sovereign Immunity

The Lubbock County Hospital District, d/b/a University Medical Center (“UMC” and “the Employer” is a political subdivision of the State of Texas. Nothing within the UMC Health Plan shall be construed as a waiver of the Employer’s sovereign immunity.

N. No Third Party Beneficiaries

This UMC Health Plan is for the benefit of the Employer’s eligible employees and eligible dependents. The Employer does not intend for the UMC Health Plan to benefit any third party.

O. Not Assignable

The terms of the UMC Health Plan shall be binding upon and shall inure to the benefit of the Employer and Participants and their respective heirs (as applicable), legal representatives, and successors. Participants may not assign this Health Plan nor any rights, interests, or obligations hereunder.

P. Single Entity

The Lubbock County Hospital District, d/b/a UMC Health System and d/b/a University Medical Center and the UMC Health Plan are not separate legal entities.

Q. Limitation of Liability

The Employer shall have no liability under the UMC Health Plan except for the benefits provided by the Plan. Neither the Employer nor its contractors, their agents, or their employees will be liable for or on account of any fault, act, omission, negligence, misfeasance, malfeasance, or malpractice on the part of any healthcare facility or other institution, any agent, or employee thereof, or on the part of any physician, health care professional, pharmacist, or other person participating in or having to do with the care or treatment of the Participant.

SECTION 15

NOTICES

A. NEWBORNS' ACT DISCLOSURE

42 USC §300gg-4; 45 CFR Parts 144, 146, and 148

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 section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

B. WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 / ANNUAL NOTICE

42 USC §300gg-4, et. seq.

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call your Plan Administrator at 806-775-8793 for more information.

C. WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 / ENROLLMENT NOTICE

42 USC §300gg-4, et. seq.

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- ◆ all stages of reconstruction of the breast on which the mastectomy was performed;
- ◆ surgery and reconstruction of the other breast to produce a symmetrical appearance;
- ◆ prostheses; and
- ◆ treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. The deductibles and coinsurance are described in Section 1 of this Health Plan document.

If you would like more information on WHCRA benefits, call your Plan Administrator at 806-775-8793.

D. NOTICE TO ENROLLEES IN A SELF-FUNDED NONFEDERAL GOVERNMENTAL GROUP HEALTH PLAN

45 CFR 146.180(f)(2) and (g)(3)

Group health plans sponsored by State and local governmental employers must generally comply with Federal law requirements in title XXVII of the Public Health Service Act. However, these employers are permitted to elect to exempt a plan from the requirements listed below for any part of the plan that is "self-funded" by the employer, rather than provided through a health insurance policy.

University Medical Center has elected to exempt the UMC Health Plan from the following requirements:

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

The exemption from these Federal requirements will be in effect for the 2020 Health Plan year beginning January 1, 2020 and ending December 31, 2020. The election may be renewed for subsequent plan years.

University Medical Center voluntarily provides the following protections under the UMC Health Plan:

1. Protection against limiting hospital stays in connection with the birth of a child to less than 48 hours for a vaginal delivery, and 96 hours for a cesarean section.
2. Certain requirements to provide benefits for breast reconstruction after a mastectomy.
3. Continued coverage for up to one year for a dependent child who is covered as a dependent under the plan solely based on student status, who takes a medically necessary leave of absence from a postsecondary educational institution.

If you would like more information, call your Plan Administrator at 806-775-8793.

E. PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

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If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS-NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2020. Contact your State for more information on eligibility.

| | |
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| ALABAMA – Medicaid | COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+) |
| Website: http://myalhipp.com/ Phone: 1-855-692-5447 | Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 |
| ALASKA – Medicaid | FLORIDA – Medicaid |
| The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx | Website: http://flmedicaidprecovery.com/hipp/ Phone: 1-877-357-3268 |
| ARKANSAS – Medicaid | GEORGIA – Medicaid |
| Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447) | Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131 |
| CALIFORNIA – Medicaid | INDIANA – Medicaid |
| Website: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_co nt.aspx Phone: 1-800-541-5555 | Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864 |

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| <p align="center">IOWA – Medicaid and CHIP (Hawki)</p> <p>Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563</p> | <p align="center">NEBRASKA – Medicaid</p> <p>Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178</p> |
| <p align="center">KANSAS – Medicaid</p> <p>Website: http://www.kdheks.gov/hcf/default.htm Phone: 1-800-792-4884</p> | <p align="center">NEVADA – Medicaid</p> <p>Medicaid Website: http://dhcfnv.gov Medicaid Phone: 1-800-992-0900</p> |
| <p align="center">KENTUCKY – Medicaid</p> <p>Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIP.PPROGRAM@ky.gov</p> <p>KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718</p> <p>Kentucky Medicaid Website: https://chfs.ky.gov</p> | <p align="center">NEW HAMPSHIRE – Medicaid</p> <p>Website: https://www.dhhs.nh.gov/oi/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218</p> |
| <p align="center">LOUISIANA – Medicaid</p> <p>Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)</p> | <p align="center">NEW JERSEY – Medicaid and CHIP</p> <p>Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710</p> |
| <p align="center">MAINE – Medicaid</p> <p>Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711</p> | <p align="center">NEW YORK – Medicaid</p> <p>Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831</p> |
| <p align="center">MASSACHUSETTS – Medicaid and CHIP</p> <p>Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840</p> | <p align="center">NORTH CAROLINA – Medicaid</p> <p>Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100</p> |
| <p align="center">MINNESOTA – Medicaid</p> <p>Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/medical-assistance.jsp [Under ELIGIBILITY tab, see “what if I have other health insurance?”] Phone: 1-800-657-3739</p> | <p align="center">NORTH DAKOTA – Medicaid</p> <p>Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825</p> |
| <p align="center">MISSOURI – Medicaid</p> <p>Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005</p> | <p align="center">OKLAHOMA – Medicaid and CHIP</p> <p>Website: http://www.insureoklahoma.org Phone: 1-888-365-3742</p> |
| <p align="center">MONTANA – Medicaid</p> <p>Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084</p> | <p align="center">OREGON – Medicaid</p> <p>Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075</p> |

UMC EMPLOYEE HEALTH PLAN

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| PENNSYLVANIA – Medicaid | RHODE ISLAND – Medicaid and CHIP |
| Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462 | Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line) |
| SOUTH CAROLINA – Medicaid | VIRGINIA – Medicaid and CHIP |
| Website: https://www.scdhhs.gov Phone: 1-888-549-0820 | Website: https://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282 |
| SOUTH DAKOTA - Medicaid | WASHINGTON – Medicaid |
| Website: http://dss.sd.gov Phone: 1-888-828-0059 | Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022 |
| TEXAS – Medicaid | WEST VIRGINIA – Medicaid |
| Website: http://gethipptexas.com/ Phone: 1-800-440-0493 | Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447) |
| UTAH – Medicaid and CHIP | WISCONSIN – Medicaid and CHIP |
| Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669 | Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002 |
| VERMONT– Medicaid | WYOMING – Medicaid |
| Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427 | Website: https://wvequalitycare.acs-inc.com/ Phone: 307-777-7531 |

To see if any more States have added a premium assistance program since January 31, 2020, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

F. IMPORTANT NOTICE FROM UNIVERSITY MEDICAL CENTER ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with UMC Health Plan and about your options under Medicare’s prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare’s prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug

coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. University Medical Center has determined that the prescription drug coverage offered by the UMC Health Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

Active Employees

If you decide to join a Medicare drug plan, your current UMC Health Plan coverage will be affected. There will be no reduction in your monthly UMC Health Plan premium. Medicare Part D will become the secondary payor of prescription drugs.

Retirees

If you are a retired employee, surviving spouse, or dependents of a retired employee or surviving spouse who is:

- Age 65 or older;
- Under age 65 with Social Security disability; or
- Under age 65 with end-stage renal disease after the first 30 months of Medicare eligibility;

you may enroll in Medicare Part D. Medicare Part D will become the primary payor for prescription drugs.

If you do not enroll in Medicare Part A, B, or D, benefits will be reduced as through Medicare is the primary payor. The UMC Health Plan will calculate benefits assuming the Retiree has Medicare Part A, B, and D.

If you do decide to join a Medicare drug plan and drop your current UMC Retiree Health Plan coverage, be aware that you and your dependents will not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with UMC Health Plan and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be

at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage...

Contact UMC Health Plan Operations.

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through UMC Health Plan changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

Visit www.medicare.gov

Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help

Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

G. NOTICE REGARDING WELLNESS PROGRAM

UMC Wellness Program, supported by HealthSource Solutions and WellRight, is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health assessment or "HA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to enter biometric results if you have a screening done in 2020. Biometric data includes total cholesterol, HDL cholesterol, LDL cholesterol,

triglycerides, blood glucose, blood pressure and height/weight. You are not required to complete the HA or to participate in the blood test or other medical examinations.

Employees who choose to participate in the wellness program, including completing the health assessment, entering biometric screening results and other health-related activities (portal challenges, company sponsored events) will be eligible for prize drawings throughout the year. Although you are not required to participate in any wellness program or activity, only employees who do so will be eligible for the prize drawing.

If you are unable to participate in any of the health-related activities, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting Annie Ketcher at 763-287-0746 or annieketcher@healthsource-solutions.com.

The information from your HA and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and UMC Health System may use aggregate information to design a program based on identified health risks in the workplace, HealthSource Solutions and WellRight will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. The only individual(s) who will receive your personally identifiable health information is (are) HealthSource Solutions and WellRight in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Adrienne Cozart at 806-775-8514.