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UNIVERSITY MEDICAL CENTER
OF EL PASO

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

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

1. Limitations on Pre-Existing Condition exclusions periods (146.111).
2. Special enrollment periods for individuals (and Dependents) losing other coverage (146.117).
3. Prohibitions against discriminating against individual participants and beneficiaries based on health status (146.121).
4. Standards relating to benefits for mothers and newborns (section 2704 of PHS Act).
5. Parity in the application of certain limits to mental health benefits (section 2705 of PHS Act).
6. Required coverage for reconstructive surgery following mastectomies (section 2706 of PHS Act).

However, the law also permits the Plan Sponsor of a non-Federal governmental plan the right to exempt the plan in whole or in part from the requirements (1) through (6) described above. Therefore, University Medical Center of El Paso has elected to exercise its option as a non-Federal governmental plan to be exempt from certain provisions of the "Health Insurance Portability and Accountability Act" (HIPAA), the "Newborns' and Mothers' Health Protection Act" (NMHPA), and the "Mental Health Parity Act" (MHPA).

University Medical Center of El Paso has elected to accept requirements 2 through 4 and 6, and to be exempt from requirements 1, Pre-Existing Condition, and 5, the Mental Health Parity Act (MHPA):

- 1) Limitations on Pre-Existing Condition exclusions periods (146.111).
- 2) Parity in the application of certain limits to mental health benefits (section 2705 of PHS Act).

Notwithstanding an election to be exempt from the requirement (1) and (2) above, University Medical Center of El Paso, as a non-Federal governmental plan, must provide for certification and disclosure of creditable coverage under the plan with respect to participants and their dependents in accordance with 146.115.

This exemption from these federal requirements will be in effect for one year for the Plan year beginning October 1, 2009, and it may be renewed for subsequent years.

COBRA NOTIFICATION PROCEDURES

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

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

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

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

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

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

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

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

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

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

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

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

IMPORTANT INFORMATION

WHO TO CONTACT FOR ADDITIONAL INFORMATION

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

THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

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

DEFINITIONS

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

NOTICE OR RIGHT TO RECEIVE A CERTIFICATE OF CREDITABLE COVERAGE

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

INTRODUCTION

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

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

We expect and encourage you to review this booklet which describes the benefits provided by this Plan. Associates are encouraged to participate in the Health Risk Assessment Program which is provided through the University Medical Center of El Paso Wellness Program and to be active participants of healthy lifestyles and preventive health practices.

SCHEDULE OF BENEFITS

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

- (1) University Medical Center of El Paso and Texas Tech Physicians
- (2) Preferred Administrators Network in El Paso and other providers contracted by Preferred Administrators Network on behalf of this Plan
- (3) Texas True Choice in the State of Texas and its affiliated Network Beech Street outside of Texas.

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

- (1) The Covered Associate or Covered Dependent resides or is enrolled in school full time outside El Paso County and the provider is located in the City or County where the Associate or Covered Dependent resides or attends school, or
- (2) The Covered Associate or Covered Dependent is traveling on vacation and requires urgent or emergency medical care while outside of El Paso County, or
- (3) The medical service required has been confirmed by the Medical Utilization Review program as not being provided / performed by a provider in El Paso County.

Benefits for medical services provided outside El Paso County (and the immediate surrounding areas where active Associates reside) will be based on the "WRAP NETWORK FOR OUT-OF-AREA / NON-CONTRACTED PROVIDERS" Schedule of Benefits unless the criteria listed above applies or the provider has entered a contract with Preferred Administrators for the provision of medical services to the Associates covered by this Plan. In the event a Covered Associate elects to receive medical services from a non-contracted provider when one has been identified by the Medical Utilization Review Program, (as provided in number 3 above) then benefits will be provided based on the

Wrap Network for Out-of-Area Providers and not the PPO Benefit as described in the Schedule of Benefits. Out-of-area services provided by Providers contracted with the Texas True Choice and its affiliated networks will be covered according to the "WRAP NETWORK FOR OUT-OF-AREA / NON-CONTRACTED PROVIDERS" Schedule of Benefits.

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

MEDICAL UTILIZATION REVIEW AND MANAGEMENT

THIS PLAN REQUIRES PRIOR AUTHORIZATION FOR ALL SCHEDULED INPATIENT ADMISSIONS AND SPECIFIED OUTPATIENT PROCEDURES AND DIAGNOSTIC TESTS. ENSURING THAT THE TREATING PHYSICIAN / FACILITY COMPLETES THE PRIOR AUTHORIZATION PROCESS IS THE RESPONSIBILITY OF THE COVERED ASSOCIATE. Medical Utilization review services for this Plan also include:

- a) Concurrent review for inpatient admissions;
- b) Discharge planning;
- c) Review of Home Health Care Services;
- d) Review of Hospice Services;
- e) Review of Durable Medical Equipment purchases;
- f) Medical Case Management

Prior Authorization for inpatient / outpatient procedures can be completed by faxing the Health Services Department of Preferred Administrators at (915) 298-7866. For additional questions or assistance contact the Health Service Department at (915) 532-3778. OBTAINING PRIOR AUTHORIZATION IS NOT A GUARANTEE OF ELIGIBILITY FOR BENEFITS OR PAYMENT. All benefit determinations are made after receipt of a claim.

Failure to obtain prior authorization for a scheduled inpatient admission and outpatient procedure within the University Medical Center of El Paso, Texas Tech Physicians or Preferred Administrator Preferred Provider Network will result in a benefit reduction of 50% of the eligible benefit.

Failure to obtain prior authorization for a scheduled inpatient admission and outpatient procedure within the Wrap Network for Out of Area Providers or a non-contracted provider will result in a denial of the eligible benefit.

Failure to comply with the Utilization Review determinations will result in the denial of benefits for the services received.

Medical Case Management services are provided by the Plan at no charge to the Covered Participant and when determined to be necessary and appropriate require participation by the Covered Associate.

PRIOR AUTHORIZATION FOR INPATIENT ADMISSIONS:

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

All emergency admissions (those through an Emergency Room or a direct admit from a physician's office) require notification within twenty four (24) hours or the next business day following the emergency admission. Prior Authorization or inpatient notification must be faxed to the Health

Services Department at Preferred Administrators at (915) 298-5278. Failure to notify Health Services of an emergency admission will result in denial of a claim. When emergency admissions occur and the patient will be confined beyond twenty four (24) hours, transfer to University Medical Center of El Paso will be offered when the patient's condition can appropriately be treated at University Medical Center of El Paso and the patient is medically stable and able to be transported to University Medical Center of El Paso.

Prior authorization can be completed by the physician's office / admitting facility by contacting the Health Service Department of Preferred Administrators by facsimile at (915) 298-7866.

The information required will include:

- a) Name of Covered Associate;
- b) Member ID of Covered Associate;
- c) Name of patient;
- d) Relationship of patient to Covered Associate;
- e) Patient date of birth, and home address;
- f) Social Security number of patient;
- g) Admitting physician name, address, phone number;
- h) Admitting hospital name and address;
- i) Admitting diagnosis including ICD codes;
- j) Proposed treatment plan including CPT codes;
- k) Proposed date for Admission.

Following the review of the above information (and any additional medical information requested from the admitting physician) the Covered Associate, Admitting Physician and proposed facility will be notified of the determination by the Health Services Department.

CONCURRENT REVIEW AND DISCHARGE PLANNING

All inpatient admissions will be monitored for compliance with the certified length of stay. Admissions which are continued beyond the length of stay expected will be reviewed to determine the medically necessity for the continued stay and identify the expected discharge date of the patient.

When a patient can appropriately be transferred to an alternative care setting or discharged from an acute care setting to an alternative such as home health care, the Discharge Planning process will consider such alternatives. Discharge planning may coordinate with Medical Case Management when patients may be discharged with a requirement for sub-acute care.

PRIOR AUTHORIZATION FOR CHILDBIRTH

Covered Associates are expected to notify Health Services of a diagnosis of pregnancy as soon as the initial diagnosis is made by the physician. Information requested by Health Services upon the initial notice will include identification of the expected delivery date and the anticipated facility. Covered Associates are responsible for contacting Health Services when the patient is admitted to the hospital for childbirth.

PRIOR AUTHORIZATION FOR OUTPATIENT PROCEDURES / DIAGNOSTIC TESTS / OTHER

Prior authorization review is required for:

- 1) Outpatient dialysis, chemo-therapy, radiation therapy and infusion;
- 2) Oral or Injectable drug administration in an outpatient setting, including physician's office, that has a charge for the drug in excess of \$500;
- 3) Outpatient surgery;
- 4) Home Health Services;
- 5) OB/GYN Ultrasounds (requests greater than two);
- 6) PET scans;
- 7) Sleep Studies;
- 8) Non emergency medical transportation;
- 9) Diagnostic tests related to potential organ transplantation and evaluations for transplant procedures;
- 10) Outpatient Occupational, Physical, or Speech Therapy;
- 11) Orthotics for adult / children(\$200.00 per line item allowable amount);
- 12) Durable Medical Equipment (\$300.00 per line item allowable amount).

PRIOR AUTHORIZATION FOR BEHAVIORAL HEALTH ADMISSIONS AND OUTPATIENT THERAPY

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

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

MEDICAL CASE MANAGEMENT

The Health Service Department, including registered nurses and Medical Directors provide medical case management to Covered Associates at no cost when situations emerge which involve potentially high cost medical services, complex medical care needs, catastrophic medical illness or injury, or out of area medical services. Medical Case Management is provided to assist the Covered Associate and family members and to consult with the treating physicians and facility representatives regarding medical service needs and potential alternative treatment plans. The focus of Medical Case Management is to assist the Covered Associate by monitoring the situation, identifying available clinical resources, making suggestions regarding treatment plan options, helping the Associate understand a disease process, a treatment plan or medical terminology, and may include the following:

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

Participation in Medical Case Management is required when it is determined to be an appropriate resource. Accepting Medical Case Management recommendations is voluntary and there will be no reduction of benefits if the Associate chooses not to accept recommendations presented by the Medical Case Manager.

BENEFIT PERCENTAGE, DEDUCTIBLES AND LIMITATIONS

Benefit Description	UMC, University Medical Center of El Paso	Texas Tech Provider	Preferred Administrators Network / PPO Benefit	Wrap Network for Out-of-Area Providers / Non-Contracted Providers
BENEFIT PERCENTAGE or COINSURANCE PERCENTAGE (payable by the Plan)				
Inpatient Hospital Admissions (per admission)	\$150 co-pay and 100% coverage once deductible is met	N/A	\$600 co-pay and 80% coverage once deductible is met	\$2000 co-pay and 60% coverage once deductible is met
Other Outpatient Surgery including Birthing Centers (unless specified otherwise)	\$60 co-pay and 100% coverage once deductible is met	N/A	\$200 co-pay and 80% coverage once deductible is met	\$1000 co-pay and 60% coverage once deductible is met
<p>Failure to obtain Prior Authorization or the failure to comply with the determination of the Medical Review process may result in the denial of a claim for benefits. See the preceding provision for Medical Management and Prior Authorization requirements.</p> <p>The Benefit Percentage will be applied to the contracted allowable amounts for the participating contracted providers and Preferred Provider Network participating providers, and to Allowable Amounts for charges by non-contracted providers.</p> <p>PPO benefits will also be applied when using Out-of Area Providers for:</p> <ul style="list-style-type: none"> • Treatment for a sudden acute medical illness or injury that presents an urgent or emergency situation provided by non-network / non-contracted providers; • Treatment by out-of-area / non-contracted emergency room physicians who staff an emergency room of an out-of-area / non-contracted hospital. <p>• SPECIAL NOTICE: Additional charges (Balance Billing) may be incurred when receiving services from Non-Contracted Providers.</p>				
DEDUCTIBLE PER FISCAL YEAR				
Per Covered Participant	\$100		\$500	
Maximum Family Deductible Limit	\$300		\$1,500	
<p>After the deductible is met, the Plan pays the Benefit Percentage (co-insurance percentage) of Covered Expenses incurred in the balance of the Fiscal Year for each individual up to the Out-of-Pocket maximum.</p>				
LIFETIME MAXIMUM BENEFIT (Per Covered Participant)	\$1,000,000 combined medical and prescription drugs			

Benefit Description	UMC, University Medical Center of El Paso	Texas Tech Provider	Preferred Administrators Network / PPO Benefit	Wrap Network for Out-of-Area Providers / Non-Contracted Providers
OUT-OF-POCKET MAXIMUM PER FISCAL YEAR				
Per Covered Participant	N/A		\$3000	Unlimited
Family Out-of-Pocket	N/A		\$9000	Unlimited
<p>The Out-of-Pocket maximum does not include any applicable deductibles, co-pays, non-compliance penalties, and amounts in excess of allowable amounts or any non-Covered Expenses. After the Out-of-Pocket maximum has been reached, the Plan pays 100% of Covered Expenses incurred for the individual in the balance of the Fiscal Year (excluding deductibles, co-pays, non-compliance penalties, and non-Covered Expenses).</p> <p>When the Out-of-Pocket limit is reached, the reimbursement percentage rate is increased to 100% for the balance of the Fiscal Year for covered medical charges as limited by any maximum benefit amounts. The reimbursement percentage rate does not increase to 100% for the treatment of Mental and Substance Abuses or for Substance Abuse treatment.</p> <p>The Out-of-Pocket Maximum does not apply to treatment of Mental and Substance Abuse treatment, Prescription Drug deductibles and co-pays, Durable Medical Equipment, Orthotic Devices, Emergency Room Co-pays, and Bereavement Benefits. Out-of-Area services will not apply.</p>				

ALPHABETICAL SCHEDULE OF PLAN BENEFITS

Benefit Description	UMC, University Medical Center of El Paso	Texas Tech Provider	Preferred Administrators Network / PPO Benefit	Wrap Network for Out-of-Area Providers / Non-Contracted Providers
ALLERGY TESTING AND INJECTIONS				
Allergy Testing and Injections	100% after deductible	100% after deductible	80% after deductible	60% after deductible
Allergy Serum Vials Dispensed in a Physician's Office	100% after deductible	100% after deductible	80% after deductible	60% after deductible
Allergy Serum Vials Dispensed by a Pharmacist	Covered as a Prescription Drug			
AMBULANCE (AIR AND GROUND)				
Ambulance	N/A	N/A	80%	80%
Emergency air and ground ambulance transportation covered to the nearest appropriate facility. Non emergency ground ambulance transportation that is medically necessary for local area transfer between inpatient facilities (acute, subacute or hospice) when appropriate. Non emergency air or ground transportation for any other reason requires Prior Authorization review. Benefit amounts based on the Reasonable & Customary rate or the provider's contracted rate if applicable.				
DIAGNOSTIC X-RAY, PATHOLOGY AND LABORATORY SERVICES				
Radiology, Pathology, and Laboratory Benefits	inpatient or outpatient 100% after deductible	inpatient or outpatient 100% after deductible	inpatient or outpatient 80% after deductible	inpatient or outpatient 60% after deductible
DURABLE MEDICAL EQUIPMENT				
Hospital Inpatient / Outpatient or Other Medical / DME Provider	100% after deductible	100% after deductible	80% after deductible	60% after deductible
EMERGENCY ROOM				
Per Visit for sudden acute medical illness or injury	100% after co-pay of \$50	N/A	80% after co-pay of \$50	80% after co-pay of \$50
University Medical Center of El Paso Urgent Care Center and Pediatric Urgent Care or University Medical Center of El Paso CAREs for Kids	100% after co-pay of \$50	N/A	N/A	N/A
Charges for Observation up to 23 hours NOTE: Observation charges greater than 23 hours will be paid based on the allowable amount of an inpatient day	100% after co-pay of \$50	N/A	80% after co-pay of \$50	80% after co-pay of \$50
Emergency Room Co-pay waived if admitted. Co-pay will not apply to the Out-of-Pocket Maximum.				

Benefit Description	UMC, University Medical Center of El Paso	Texas Tech Provider	Preferred Administrators Network / PPO Benefit	Wrap Network for Out-of-Area Providers / Non-Contracted Providers
HOME HEALTH CARE				
Benefit	N/A	N/A	80% after deductible	60% after deductible
Maximum Benefits	N/A	N/A	120 visits per Fiscal Year (Includes Skilled Nursing)	60 visits per Fiscal Year (Includes Skilled Nursing)
HOSPICE CARE				
Benefit	100%	100%	80%	60% after deductible
Maximum visits per Fiscal Year	180			
HOSPITAL SERVICES				
Hospital Charges – Inpatient Admissions (Medical and Surgical)	\$150 co-pay 100% inpatient after deductible	N/A	\$600 co-pay 80% after deductible	\$2000 co-pay 60% after deductible
Hospital Charges – Outpatient Services (Medical and Surgical)	\$60 co-pay 100% after deductible	N/A	\$200 co-pay 80% after deductible	\$1000 co-pay 60% after deductible
HOSPITAL ROOM AND BOARD CHARGES				
Room and Board Charges (Including Medically Necessary Private Room Isolation)	N/A		80% after deductible	60% after deductible
Intensive Care Unit (Allowable Room Rate)	N/A		80% after deductible	60% after deductible
Private Room Charges for Hospitals with Private Rooms Only	N/A		80% after deductible	60% after deductible

Benefit Description	UMC, University Medical Center of El Paso	Texas Tech Provider	Preferred Administrators Network / PPO Benefit	Wrap Network for Out-of-Area Providers / Non-Contracted Providers
BEHAVIORAL HEALTH				
MENTAL AND SUBSTANCE ABUSE —				
Prior Authorization is required for professional services by the Employee Assistance Program (EAP) beyond the 8 counseling sessions it provides, and for therapy / counseling by providers outside the EAP Program.				
Outpatient Office Visit	N/A	\$30 co-pay	\$30 co-pay	60% after deductible
Intensive Outpatient Visit	N/A	N/A	\$30 co-pay	60% after deductible
Psychiatric Day Treatment	N/A	N/A	\$30 co-pay	60% after deductible
Partial Hospitalization	N/A	N/A	80% after deductible	60% after deductible
Inpatient Behavioral Admission	N/A	N/A	\$600 co-pay 80% after deductible	\$2000 co-pay 60% after deductible
Inpatient Substance Abuse Admission	N/A	N/A	\$600 co-pay 80% after deductible	\$2000 co-pay 60% after deductible
CO-PAY PROVIDES FOR THE OFFICE VISIT/CONSULTATION ONLY. All other Covered Expenses provided during an office visit are covered at the 100%, 80% or 60% Benefit Percentage according to the network contracted status of the service provider.				
Covered Expenses During Office Visit (Lab, X-Ray)	100% after deductible	100% after deductible	80% after deductible	60% after deductible
Maximum Benefit per Fiscal Year (Outpatient and Psychiatric Day Treatment)	30 visits a year*			
Maximum Fiscal Year Benefit	None			\$10,000*
Lifetime Maximum Benefit	\$25,000*			
*Mental and Nervous and Substance Abuse charges (inpatient and outpatient) combined.				
Prior Authorization for professional services is required through the Health Service Department of Preferred Administrators. If Prior Authorization is not obtained benefits will be denied.				
NUTRITIONAL COUNSELING by a Registered Dietitian or Nutritionist				
Benefit – For children and adults (Limited to 12 sessions)	100%	\$20 co-pay	Not Covered	
OCCUPATIONAL THERAPY — Non-Workers' Compensation				
Outpatient	100% after deductible	100% after deductible	80% after deductible	60% after deductible
Maximum Benefit per Fiscal Year	\$5,000			

Benefit Description	UMC, University Medical Center of El Paso	Texas Tech Provider	Preferred Administrators Network / PPO Benefit	Wrap Network for Out-of-Area Providers / Non-Contracted Providers
OFFICE VISITS				
Physician, Nurse Practitioner, or Certified Nurse Midwife	\$10 co-pay	\$20 co-pay	\$30 co-pay	60% after deductible
Covered Expenses During Office Visit (Lab, X-Ray)	100% after deductible	100% after deductible	80% after deductible	60% after deductible
Co-pay provides for the office visit/consultation only. All other Covered Expenses provided during an office visit are covered at a 100%, 80% or 60% Benefit Percentage according to the network / Out-of-Area / contracted status of the service provider.				
ORGAN TRANSPLANTS				
Organ Transplant services are provided through the transplant network or contracted transplant facility approved by the Plan Administrator and stop loss carrier.				
ORTHOTICS				
Benefits	100% after deductible	100% after deductible	80% after deductible	None
One device/pair of orthopedic shoes, orthotics, and other supportive devices for the feet for adults. Limited to one orthotic device/pair per fiscal year. Orthotic devices for dependent children will be covered as needed for medical necessity.				
PHYSICAL THERAPY				
Outpatient therapy performed by a licensed therapist or Physician	100% after deductible	100% after deductible	80% after deductible	60% after deductible
Maximum Benefit per Fiscal Year	\$8,000			
PREGNANCY EXPENSES				
Covered Associates and Spouses	Same as any other Illness			
Covered Dependent Daughters	Same as any other Illness (Covered only at University Medical Center of El Paso and Texas Tech if denied services from another source). Delivery only covered at University Medical Center and Maternity Care only covered with Texas Tech providers if denied services from another source.			
PRESCRIPTION DRUGS				
Co-Payments	University Medical Center of El Paso Pharmacies \$10 Generic \$20 Brand \$30 Non-Formulary		All Network Pharmacies \$20 Generic \$40 Brand \$60 Non-Formulary	
Prescription Drug Deductible	Separate \$50 Fiscal Year Deductible per member. Prescription Drug Deductible does not apply to Medical Plan Deductible or the Out-of-Pocket Maximum.			
Maintenance Medication	University Medical Center of El Paso Pharmacies Only A 90 day supply (after prescription deductible) \$10 Generic \$20 Brand \$30 Non-Formulary			
<i>continued on next page</i>				

Benefit Description	UMC, University Medical Center of El Paso	Texas Tech Provider	Preferred Administrators Network / PPO Benefit	Wrap Network for Out-of-Area Providers / Non-Contracted Providers
PRESCRIPTION DRUGS – <i>continued</i>				
Prescriptions over \$500 *Authorization Required	Co-pay applies.		All Network Pharmacies 60% after prescription drug deductible.	
<p>Examples of Covered Drugs</p> <ul style="list-style-type: none"> • Adderall, Dexedrine, and Dextrostat • Drugs requiring a prescription under the applicable state law • Federal legend prescription drugs • Injectable insulin, insulin syringes, chemstrips, and blood lancets • Injectables (other than insulin) • I.V. medications prescribed by a licensed physician and dispensed by a licensed pharmacist • Non-insulin needles/syringes • Oral and injectable contraceptives • Prescription pre-natal vitamins <p>Examples of Excluded Drugs</p> <ul style="list-style-type: none"> • Accutane, Retin A after age 25 • Anabolic steroids • Anorectics (any drug used for the purpose of weight loss) • Anorexiant (except for Adderall, Dexedrine, and Dextrostat) • Cosmetics • Fertility medications • Fluoride supplements • Growth hormones • Investigational or experimental drugs including compounded medications for non-FDA approved use • Out dated drugs or medicines (dispensed more than a year after the date of the Prescription) • Medical devices and other supplies (example Diabetes blood level monitor is covered under the Plan) • Non-legend drugs other than insulin • No charge prescription under Workers' Compensation, or other governmental program • Rogaine • Viagra and similar drugs • Vitamins other than prescription pre-natal vitamins 				
REHABILITATION (PHYSICAL) FACILITIES				
In/Outpatient Services	100% after deductible		80% after deductible	60% after deductible
Covered Expenses During Rehab Stay (Lab, X-Ray)	100% after deductible	100% after deductible	80% after deductible	60% after deductible
SKILLED NURSING FACILITIES				
Benefit	N/A	N/A	80% after deductible	60% after deductible
Maximum Days per Fiscal Year	60			
Confinement must begin within 7 days of the Hospital stay for the same or related conditions unless the admission is certified by medical review as an alternative to an admission to an acute care facility.				
SPEECH THERAPY				
Benefit	100% after deductible	100% after deductible	80% after deductible	60% after deductible
Maximum Benefit per Fiscal Year	\$5,000 — Subject to certain other limitations			

Benefit Description	UMC, University Medical Center of El Paso	Texas Tech Provider	Preferred Administrators Network / PPO Benefit	Wrap Network for Out-of-Area Providers / Non-Contracted Providers
SPINAL ADJUSTMENT/CHIROPRACTIC ADJUSTMENT				
Office Visit	N/A	\$20 co-pay	\$30 co-pay	60% after deductible
Covered Expenses During Office Visit (Lab, X-Ray)	N/A deductible	100% after deductible	80% after deductible	60% after deductible
Maximum Benefit per Fiscal Year	\$1,000			
Co-pay provides for the office visit/consultation only. All other Covered Expenses provided during an office visit are covered at a 100%, 80% or 60% Benefit Percentage according to the network / Out-of-Area / contracted status of the service provider.				
SURGICAL EXPENSES				
Anesthesiology	inpatient or outpatient 100% after deductible	inpatient or outpatient 100% after deductible	inpatient or outpatient 80% after deductible	inpatient or outpatient 60% after deductible
Primary Surgeon	inpatient or outpatient 100% after deductible	inpatient or outpatient 100% after deductible	inpatient or outpatient 80% after deductible	inpatient or outpatient 60% after deductible
Pathology and Radiology	inpatient or outpatient 100% after deductible	inpatient or outpatient 100% after deductible	inpatient or outpatient 80% after deductible	inpatient or outpatient 60% after deductible
URGENT CARE/WALK-IN CLINICS				
Urgent Care Services – after hours and weekend medical services for non emergency illnesses and minor injuries.	\$10 co-pay	\$20 co-pay	\$30 co-pay	60% after deductible
WELLNESS BENEFITS				
Office Visits for Annual Physical Exams (PCP). One per Fiscal Year.	\$10 co-pay	\$20 co-pay	\$30 co-pay	Not Covered
Office Visits for annual Well Women's (OB/GYN). One per Fiscal Year.	\$10 co-pay	\$20 co-pay	\$30 co-pay	Not Covered
Covered Diagnostic Tests including lab, cardiology, and radiology ordered as part of Wellness Exam/Annual Physical Exam.	100% after deductible	100% after deductible	80% after deductible	Not Covered
Mammogram and Prostate Examination. (see Medical Benefit section for guidelines)	100% after deductible	100% after deductible	80% after deductible	Not Covered
Flu Shots	See Covered Medical Expenses in Article III on Page 40	Not Covered		

Benefit Description	UMC, University Medical Center of El Paso	Texas Tech Provider	Preferred Administrators Network / PPO Benefit	Wrap Network for Out-of-Area Providers / Non-Contracted Providers
HPV – Age 9 up to 21.	\$10 co-pay for office visit and 100% coverage for immunizations		Not Covered	
Meningococcal Vaccine.	\$10 co-pay for office visit and 100% coverage	\$20 co-pay for office visit and 100% coverage	\$30 co-pay for office visit and 80% coverage	Not Covered
Zostavax – Age 60 and over.	\$10 co-pay for office visit and 100% coverage for immunizations		Not Covered	
Well Baby and Well Child Preventative Care and annual physical exams and routine immunizations for covered participants under 18 years of age.	\$10 co-pay for office visit and 100% coverage for immunizations	\$20 co-pay for office visit and 100% coverage for immunizations	\$30 co-pay for office visit and 80% coverage for immunizations	Not Covered
<p>All Immunizations required by the Centers for Disease Control and Prevention (CDC) are covered. Routine Immunizations include: Diphtheria, Hepatitis B, Rotavirus, Haemophilus Influenzae Type B (Hib), Pneumococcal, Pediarix, Measles, Mumps, Rubella (MMR), Pertussis, Polio, Tetanus, and Varicella. Tetanus – After age 11 and boosters no more than every 10 years or unless medically necessary.</p>				

ARTICLE I

DEFINITIONS

- 1.01 **Adverse Benefit Determination** A denial of a request for service or a failure to provide or make payment in whole or in part for a benefit. An Adverse Benefit Determination based in whole or in part on a medical judgment also includes:
- (a) any reduction or termination of a benefit or an administrative denial of a service due to reasons other than Medical Necessity or medical appropriateness;
 - (b) a denial to cover services because they are determined to be experimental or investigational;
 - (c) a denial to cover services because they are determined to be not Medically Necessary or inappropriate;
 - (d) a denial to cover services because they are Cosmetic.
- 1.02 **Accidental Injury** means accidental bodily Injury caused by unexpected external means, resulting, directly and independently of all other causes, in necessary care rendered by a Physician.
- 1.03 **Actively at Work** means the active expenditure of time and energy in the service of the Employer, except that an Associate are deemed Actively at Work on each day of a regular paid vacation or on a regular non-working day, provided he was Actively at Work on the last preceding regular working day.
- 1.04 **Affiliates** means El Paso First Health Plans, Inc., University Medical Center of El Paso, and any other qualifying or eligible employer authorized to adopt the Plan by the Employer and who has adopted the Plan by its duly authorized board.
- 1.05 **Ambulatory Surgical Facility** means any public or private specialized facility (state licensed and approved whenever required by law) with an organized medical staff of Physicians, that:
- (a) has permanent facilities equipped and operated primarily for the purpose of performing surgical procedures on an outpatient basis; and
 - (b) has continuous Physician services and registered professional nursing service whenever a patient is in the facility; and
 - (c) does not provide accommodations for patients to stay overnight.
- 1.06 **Ancillary Services** means services rendered in connection with inpatient or outpatient care in a Hospital or in connection with a Medical Emergency including the following: ambulance, anesthesiology, assistant surgeon, pathology, and radiology. This term also includes services of the attending Physician or primary surgeon in the event of a Medical Emergency.
- 1.07 **Appeal** An Appeal is a request by a Covered Participant for re-consideration of an Adverse Benefit Determination of a health service request or benefit that the Covered Participant believes they are entitled to receive.
- 1.08 **Associate** means a person who is directly employed on a full-time basis (who is regularly scheduled to work a minimum of 36 hours per week), or on a part-time basis (who is regularly scheduled to work a minimum of 20 hours per week), and who is performing his customary duties at the Employer's facility or other location designated by the Employer. Associate does not include:
- (a) any individual who is classified as an independent contractor for purposes of federal income tax reporting and withholding;

- (b) any individual who performs services as a leased employee within the meaning of Code Section 414(n), or who otherwise performs services through an agreement with a leasing organization or outsourcing provider;
 - (c) relief personnel;
 - (d) temporary employees; or
 - (e) PRNs.
- 1.09 Balance Billing** occurs when physicians or other medical providers and hospitals or facilities who are not contracted within the preferred provider benefit plan bill you for the difference between the amount the health plan pays them and the amount the provider or facility has billed.
- 1.10 Benefit Percentage** means the portion of eligible expenses payable by the Plan in accordance with the coverage provisions as stated in the Plan.
- 1.11 Benefit Management Advisors** The team established by the Plan Sponsor to oversee the operations of the Plan including the development of recommendations regarding coverage and plan provisions, establishing the budget for the Plan, and making final determinations regarding complaints and appeals. The advisory team is comprised of the positions of Chief Financial Officer, Chief Executive Officer El Paso First Health Plans, Corporate Controller, and Director Human Resources. The team is staffed by the Benefits section of the Human Resources Department.
- 1.12 Birthing Center** means a freestanding facility that:
- (a) is licensed to provide a setting for prenatal care, delivery and immediate postpartum care; and
 - (b) has an organized staff of Physicians; and
 - (c) has permanent facilities that are equipped and operated primarily for Dependent Childbirth; and
 - (d) has a contract with at least one nearby Hospital for immediate acceptance of patients who require Hospital care; and
 - (e) does not provide accommodations for patients to stay overnight; and
 - (f) provides continuous services of Physicians, registered nurses, or certified nurse midwife practitioners when a patient is in the facility.
- 1.13 Change in Family Status** means
- (a) the marriage or divorce of the Covered Participant;
 - (b) the death of the Covered Participant's Spouse or Dependent;
 - (c) the birth, adoption, or placement for adoption of a child of the Covered Participant;
 - (d) a Dependent ceases to satisfy the requirements of Dependent coverage due to attainment of age, or any similar circumstance as provided in a Benefit Program;
 - (e) the termination of employment (or commencement of employment) of his Spouse;
 - (f) the strike or lockout of the Covered Participant, or his Spouse or Dependent;
 - (g) the switching from part-time to full-time employment status or from full-time to part-time status by the Covered Participant or his Spouse;
 - (h) the taking of an unpaid leave of absence by the Covered Participant or his Spouse;
 - (i) a significant change in the health coverage of the Covered Participant or Spouse attributable to the Spouse's employment; or
 - (j) any other event determined by the Plan Administrator to be a Change in Family Status consistent with Code Section 125.

1.14 Change in Status or Coverage means

- (a) the marriage or divorce of the Covered Participant;
- (b) the death of his Spouse or Dependent;
- (c) the birth, adoption, or placement for adoption of a Dependent Child;
- (d) a Dependent ceases to satisfy the requirements of Dependent coverage due to attainment of age, or any similar circumstance as provided in a Benefit Program;
- (e) the termination of employment (or commencement of employment) of the Covered Participant's Spouse;
- (f) the strike or lockout of the Covered Participant, or the Spouse or Dependent Child;
- (g) the change in residence or worksite of the Covered Participant, or the Spouse or Dependent;
- (h) the switching from part-time to full-time employment status or from full-time to part-time status by the Covered Participant or his Spouse;
- (i) the taking of an unpaid leave of absence by the Covered Participant or his Spouse;
- (j) a significant change in the health coverage of the Covered Participant or his Spouse attributable to the Spouse's employment;
- (k) the change in employment status of the Covered Participant, Spouse or Dependent Child that affects eligibility for a Benefit Program or a plan of the employer of his Spouse or Dependent Child;
- (l) the addition of a Benefit Program, or of an option for coverage under a Benefit Program providing accident or health benefits;
- (m) the significant improvement of coverage under a Benefit Program or Benefit Program option providing accident or health benefits;
- (n) a coverage change made under the plan of the employer of a Covered Participant's Spouse or Dependent, including an election change made during the open enrollment of a Covered Participant's Spouse;
- (o) the change in a Covered Participant's, or a Covered Participant's Spouse's or Dependent's, entitlement for Medicare or Medicaid;
- (p) an HMO or other arrangement in the individual market that does not provide benefits to individuals who no longer reside, live, or work in a service area (whether or not within the choice of the individual); or
- (q) an HMO or other arrangement in the group market that does not provide benefits to individuals who no longer reside, live or work in a service area (whether or not within the choice of the individual), and no other benefit package is available to the individual; or
- (r) an HMO ceasing operations; or
- (s) an individual incurring a claim that would meet or exceed a lifetime limit on all benefits (the special enrollment right begins when a claim that would exceed a lifetime limit on all benefits is incurred and continues until at least 30 days after the earliest date that a claim is denied due to the operation of the lifetime limit); or
- (t) a plan no longer offering any benefits to a class of similarly situated individuals; or
- (u) cessation of employer contributions for the other health coverage; or
- (v) the exhausting of COBRA continuation coverage; or
- (w) any other event determined by the Plan Administrator to be a Change in Status or Coverage consistent with Code Section 125.

- 1.15 **COBRA** means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.
- 1.16 **Complaint** Any expression of dissatisfaction expressed by a Covered Participant regarding a Benefit Plan issue. A Complaint is informational in nature and cannot be Appealed.
- 1.17 **Coordination of Benefits (COB)** means the technique used to determine the amount of benefits paid on a claim when the Covered Participant has more than one source of medical benefit coverage.
- 1.18 **Cosmetic Procedures** means procedures performed solely to improve appearance rather than for the improvement or restoration of bodily function.
- 1.19 **Coverage Date** means the date an Associate or Dependent has met all of the eligibility requirements for coverage.
- 1.20 **Covered Expenses** means eligible charges for medical benefits that constitute contracted charges or Allowable Amounts for medical care and services, which are Medically Necessary and are ordered by or provided by a legally qualified Provider. Covered Expenses must have been incurred while eligible for benefits under this Plan, but do not include any expenses contained in the list of Exclusions.
- 1.21 **Covered Participant** means any Associate and/or Dependent covered under this Plan.
- 1.22 **Creditable Coverage** means prior continuous health coverage and includes prior coverage under:
- (a) another group health plan;
 - (b) group or individual health insurance coverage issued by a state regulated insurer or an HMO;
 - (c) COBRA;
 - (d) Medicaid;
 - (e) Medicare;
 - (f) State Children's Health Insurance Program (SCHIP);
 - (g) the Active Military Health Program;
 - (h) Tricare/CHAMPUS;
 - (i) American Indian Health Care Programs;
 - (j) a State health benefits risk pool;
 - (k) the Federal Employees Health Plan;
 - (l) the Peace Corp Health Program; or
 - (m) a public health plan, including plans established or maintained by a state, the United States government, a foreign country, or any political subdivision of a state, the United States government, or a foreign country that provides health coverage to individuals who are enrolled in the plan (for example, coverage through the United States Veterans Administration and coverage from a state or federal penitentiary).
- 1.23 **Custodial Care** means care (including room and board needed to provide that care that is given principally for personal hygiene or for assistance in daily activities and can (according to generally accepted medical standards) be performed by individuals who have no medical training. Examples of custodial care include help in walking and getting out of bed; assistance in bathing, dressing, and feeding; or supervision over medication, which could normally be self-administered.

- 1.24 Deductible** means the amount of covered medical expenses which must be paid by a Covered Participant each Fiscal Year before benefits are payable under this Plan. A separate deductible applies to a covered Associate and each of the Associate's Dependents, subject to the family deductible limit. As applied to dental benefits under this Plan, this term means the amount of covered dental expenses which must be paid by a Covered Participant each Fiscal Year before benefits are payable under this Plan. A separate deductible applies to a covered Associate and each of the Associate's Dependents, subject to the family deductible limit.
- 1.25 Dentist** means a currently licensed dentist practicing within the scope of the license or any other Physician furnishing dental services, which the Physician is licensed, to perform.
- 1.26 Dependent** means a Covered Participant's Spouse (unless divorced or legally separated), Dependent Child, and/or grandchild who is eligible to receive benefits hereunder in accordance with the Benefits Enrollment/Change agreement or on-line enrollment.
- A Dependent, for medical coverage only, includes a Covered Participant's grandchild if at the time of enrollment of the grandchild, the Dependent Child and the grandchild is a legal Dependent of the Associate for federal income tax purposes. The covered grandchild will not lose eligibility status if at a later date the Dependent Child and/or the covered grandchild can no longer be claimed as a Dependent for federal income tax purposes. A grandchild will be eligible as a Dependent provided the grandchild is:
- (a) under the age of 25, or over the age of 25 if Totally Disabled upon reaching the age of 25, proof of Total Disability provided to the Plan Administrator within 31 days of age 25 and may be required from time to time but not more frequently than annually, Total Disability is continuous, and the grandchild is continuously covered by the Plan;
 - (b) unmarried and never married; and
 - (c) principally dependent on the Covered Participant for maintenance and support.
- 1.27 Dependent Child or Dependent Children** means, for coverage under the medical plan only, the Associate's natural children, legally adopted children (including children placed for adoption for whom legal adoption proceedings have been started), step-children, children the Covered Participant has obtained legal guardianship for; and children required to be covered under a Qualified Medical Child Support Order (QMCSO). A Dependent Child does not include foster children. A Dependent Child must also meet the following requirements:
- (a) under the age of 25, or over the age of 25 if Totally Disabled upon reaching the age of 25, proof of Total Disability is provided to the Plan Administrator within 31 days of age 25 and may be required from time to time but not more frequently than annually, Total Disability is continuous, and the Dependent Child is continuously covered by the Plan;
 - (b) unmarried and never married; and
 - (c) principally dependent on the Covered Participant for maintenance and support.
- 1.28 Durable Medical Equipment** means equipment prescribed by the attending Physician which: is Medically Necessary; is not primarily or customarily used for non-medical purposes; is designed for prolonged use; and serves a specific therapeutic purpose in the treatment of an Accidental Injury or Illness. Durable Medical Equipment includes surgical equipment and accessories needed to operate the equipment.
- 1.29 Effective Date** means October 1, 2002 and the dates of subsequent amendments and restatements. The current restatement effective date is October 1, 2009.

- 1.30 Eligible Expense** Coverage is provided only for medical services and supplies that are both necessary and reasonable. Necessary means that it is broadly accepted professionally as essential to the treatment of the Illness or Injury. The reasonable charge for the service or supply is the lesser of (a) the contracted rate with the provider; (b) the allowable amount or supply for a non contracted provider or; (c) the actual charge made by the provider. In the event an actual charge is less than a contracted charge, the lesser amount will be considered the eligible amount unless prohibited by the terms of the specific contract.
- 1.31 Employer** means University Medical Center of El Paso and/or its Affiliates, as the circumstances relating to a particular Associate or situation dictate.
- 1.32 Experimental or Investigational** A treatment, test, procedure, medicine, supply or device which:
- (a) is not approved by the Centers for Medicare and Medicaid (CMS), or
 - (b) is not approved for marketing by the U.S. Food and Drug Administration for the condition being treated, or
 - (c) is not endorsed or approved by the American Medical Association or has been deemed as not therapeutic by the AMA, or
 - (d) is not approved or endorsed by the National Institutes of Health or any of its affiliated institutes.
- Experimental or Investigational shall also mean:
- (a) Reliable evidence shows that to determine its maximum tolerated dose, toxicity, safety and / or efficacy (or efficacy as compared with the standard means of treatment or diagnosis) it is undergoing phase I, II, or III Clinical Trials or is under study, or
 - (b) Reliable evidence shows that further clinical trials or studies are needed, according to the experts consensus of opinion, or
 - (c) Reliable evidence means only published reports and articles in the authoritative medial and scientific literature or the written protocol or written informed consent used by the treating facility (or by another facility studying substantially the same treatment, procedure, device, drug or medicine).
- 1.33 FMLA** means the Family and Medical Leave Act of 1993, as amended.
- 1.34 Family Deductible Limit** means that once the combined individual deductibles of all Covered Participants in the same family reach the combined deductible limit, no further individual deductibles apply during the remainder of the Fiscal Year.
- 1.35 Health Care Spending Account** means the Health Care Spending Account under the University Medical Center of El Paso Section 125 Cafeteria Plan, or any subsequent cafeteria plan maintained by the Employer.
- 1.36 Health Risk Assessment (HRA)** means the University Medical Center of El Paso annual program which evaluates an Associate's overall health condition through a series of questionnaires, lab work, fitness testing, etc.
- 1.37 HIPAA** means the Health Insurance Portability and Accountability Act of 1996, as amended.
- 1.38 Home Health Care Agency** means an agency or organization that:
- (a) is licensed and primarily engaged in providing skilled nursing care and other therapeutic services; and
 - (b) has policies established by a professional group associated with the agency or organization that includes at least one Physician and one registered nurse (R.N.) who provide full-time supervision of such services; and
 - (c) maintains complete medical records on each individual and has a full-time administrator.

- 1.39 **Hospice Care** means a coordinated treatment plan of home and inpatient care, which treats the terminally ill patient and family as a unit. This treatment plan provides care to meet the special needs of the family unit during the final stages of a terminal illness and during bereavement. A team made up of trained medical personnel and counselors provides care. The team acts under an independent hospice administrator to help the family unit cope with physical, psychological, spiritual, social and economic stresses.
- 1.40 **Hospice Care Program** means a formal program directed by a Physician to help care for a person with a life expectancy of six months or less. It must meet the standards set by the National Hospice Organization. If such Program is required by a state to be licensed, certified, or registered, it must also meet that requirement to be considered a Hospice Care Program.
- 1.41 **Hospital** means an institution that:
- (a) is licensed to provide and is engaged primarily in providing on an inpatient basis, for compensation from its patients, diagnostic and therapeutic facilities for the surgical, medical diagnosis, treatment and care of ill and injured persons;
 - (b) operates 24 hours a day every day under continuous supervision of a staff of doctors (MD, DO);
 - (c) continuously provides on the premises of the facility 24 hours a day skilled nursing services by licensed nurses under the direction of a full-time registered nurse (R.N.);
 - (d) provides, or has a written agreement with another Hospital in the area for the provision of, generally accepted diagnostic or therapeutic services that may be required during a confinement; and
 - (e) is not, other than incidentally, a place for rest, a place for the aged, a nursing home, and a place for alcoholics, a residential treatment center, or a convalescent Hospital.
- 1.42 **Hospital Expenses** means charges by a Hospital for room and board and/or for care in an intensive care unit, provided that its charges for such care are furnished at the direction of a Physician. Hospital expenses for private room accommodations, which are in excess of the average charge for semi-private accommodations in the facility, shall not be considered under this Plan for any purpose (except as specified in the Schedule of Benefits).
- 1.43 **Injury** A condition caused by accidental means that result in damage to the Covered Person's body from an external force.
- 1.44 **Illness** means a bodily disorder, disease, physical or mental sickness, functional nervous disorder, pregnancy or complication of pregnancy. The term Illness when used in connection with a newborn Dependent Child includes, but is not limited to, congenital defects and birth abnormalities, including premature birth.
- 1.45 **In-Network** means University Medical Center of El Paso, Texas Tech providers, and the medical providers contracted by Preferred Administrators Network/PPO.
- 1.46 **Immediate Family** means an individual who is related to a Covered Participant, either by blood or created by law, including a Spouse, parent, Dependent Child, brother, or sister.
- 1.47 **Inpatient Behavioral Services** means an acute inpatient program designed to provide medically necessary, intensive assessment, psychiatric treatment and support to individuals with a severe and/or persistent mental illness and/or co-occurring disorder experiencing an acute exacerbation of a psychiatric condition. The acute inpatient setting is equipped to serve patients at high risk of harm to self or others and in need of a safe, secure, locked setting. The purpose of the services provided within an acute inpatient setting is to stabilize the patient's acute psychiatric condition. Medical necessity drives the number of days a patient is able to stay at this level of care.

- 1.48 **Inpatient Substance Abuse Services** means an acute program for patients with alcohol and other addictive disorders that provides inpatient detoxification and/or recovery. Patients work with a team of professionals including physicians, nurses, and therapists to address triggers to alcohol or drug use and relapse and are taught coping skill. Treatment is structured, short-term and intensive. The length of stay is based on clinical need.
- 1.49 **Intensive Care Unit** means an accommodation in a Hospital which is reserved for critically and seriously ill patients requiring constant audiovisual observation as prescribed by the attending Physician, and which provides room and board, nursing care by registered nurses whose duties are confined to care of patients in the intensive care unit, and special equipment or supplies immediately available on a standby basis segregated from the rest of the Hospital's facilities.
- 1.50 **Intensive Outpatient Program** means an intermediate level of mental health care where individuals are seen in a group setting 2 to 5 times a week for 2 to 3 hours at a time (depending on the structure of the individual program). The clinical work is primarily done in a group setting, with individual sessions scheduled as needed outside of group hours. Medical necessity drives the number of days a patient is able to stay at this level of care.
- 1.51 **Late Entrant** means an individual who enrolls other than during the initial enrollment period or a special enrollment period as provided under Article III.
- 1.52 **Lifetime** means while a person is covered under this Plan. Lifetime does not mean during the lifetime of the Covered Participant.
- 1.53 **Maximum Benefit per Plan Year** means the maximum benefit payable for certain expenses during the Plan Year, which commences October 1 of each year.
- 1.54 **Medical Emergency** means an sudden acute medical illness or Injury which occurs suddenly and unexpectedly, requiring immediate medical care and use of the most accessible Hospital equipped to furnish care to prevent the death or serious impairment of the Covered Participant. Such conditions include but are not limited to suspected heart attack, loss of consciousness, actual or suspected poisoning, acute appendicitis, heat exhaustion, convulsions, emergency medical care rendered in the case of Accidental Injury cases and other acute conditions. For purposes of benefits payable under this Plan, the Claim Administrator will determine the existence of a Medical Emergency.
- 1.55 **Medically Necessary** means Covered Medical Services further defined as follows:
- (1) Non-behavioral health related Health Care Services that are:
 - a. reasonable and necessary to prevent illnesses or medical conditions, or provide early screening, interventions, and/or treatments for conditions that cause suffering or pain, cause physical deformity or limitations in function, threaten to cause or worsen a handicap, cause illness or infirmity of a Member, or endanger life;
 - b. provided at appropriate facilities and at the appropriate levels of care for the treatment of a Member's health conditions;
 - c. consistent with health care practice guidelines and standards that are endorsed by professionally recognized health care organizations or governmental agencies;
 - d. consistent with the diagnoses of the conditions;
 - e. no more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency;
 - f. are not experimental or investigative; and
 - g. are not primarily for the convenience of the Member or Provider; and

- (2) Behavioral Health Services that are:
- a. are reasonable and necessary for the diagnosis or treatment of a mental health or chemical dependency disorder, or to improve, maintain, or prevent deterioration of functioning resulting from such a disorder;
 - b. are in accordance with professionally accepted clinical guidelines and standards of practice in behavioral health care;
 - c. are furnished in the most appropriate and least restrictive setting in which services can be safely provided;
 - d. are the most appropriate level or supply of service that can safely be provided;
 - e. could not be omitted without adversely affecting the Member's mental and/or physical health or the quality of care rendered;
 - f. are not experimental or investigative; and
 - g. are not primarily for the convenience of the Member or Provider.
- 1.56 **Medicare** means the program of medical care benefits provided under Title XVIII of the Social Security Act of 1965 as amended.
- 1.57 **Mental Disorder** means any disease or condition that is classified as a mental disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services, Texas True Choice or its affiliated network Beech Street.
- 1.58 **Non-Preferred Provider** means a legally licensed, health care Provider, who has not entered into a contract with El Paso First Health Plans.
- 1.59 **Organ Transplant Services** means the services of a contracted network or contracted facility for the transplantation of human organs as described under Medical Benefits.
- 1.60 **Orthotic Device** means an apparatus used to support, align, prevent, or correct deformities, or to improve the function of movable parts of the body.
- 1.61 **Out-of-Area** means outside of El Paso County and the immediate surrounding areas (including Dona Ana County in southern New Mexico) where active Associates reside and may receive routine or other medical services.
- 1.62 **Out-of-Pocket or Maximum Out-of-Pocket** means the amounts for which the Covered Participant is financially responsible for eligible services in one Fiscal Year. The Out-of-Pocket amount does not include deductibles, co-pays, any non-compliance penalty amounts, any charges for any services not defined as a Covered Charge, charges that exceed maximum amounts specified in the Schedule of Benefits, charges that are in excess of the allowable amount for any service, and charges incurred for the treatment of Mental or for Substance Abuse treatment.
- 1.63 **Outpatient Behavioral Health Services** means office visits to a licensed behavioral health practitioner that occur in a community location on a regular basis. Treatment at this level can include psychotherapy and/or medication management. These services can be delivered in an individual, family or group setting.
- 1.64 **Pharmacy** means a licensed establishment where prescription drugs are filled and dispensed by a pharmacist licensed under the laws of the state where the pharmacist practices.
- 1.65 **Physician** means a duly licensed doctor of medicine (M.D.), a doctor of osteopathy (D.O.), a licensed podiatrist (D.P.M.), a doctor of optometry (O.D.) or other similarly licensed healthcare professional who is acting within the scope of the license.

- 1.66 **Plan** means the University Medical Center of El Paso and its Affiliates Associate Benefit Fund, as it may be amended from time to time.
- 1.67 **Plan Administrator** means the Plan Sponsor.
- 1.68 **Plan Sponsor** means the University Medical Center of El Paso.
- 1.69 **Plan Year** means the 12-month period starting on October 1 and ending September 30.
- 1.70 **Pre-existing Condition** means a condition (whether physical or mental and regardless of the cause of the condition) for which medical advice, diagnosis, care or treatment was recommended or received within the 12-month period prior to an individual's enrollment date. Genetic information will not be treated as a condition in the absence of a diagnosis of a specific condition. Pregnancy will not be treated as a Pre-Existing Condition.
- 1.71 **Preferred Provider** means University Medical Center of El Paso, Texas Tech Providers, and Providers contracted by El Paso First Health Plans, d.b.a. Preferred Administrators, and provider contracted by Texas True Choice and its affiliate networks Beech Street.
- 1.72 **Protected Health Information** means health information maintained in any medium and collected from an individual that is created or received by a health care provider, health plan, employer, or health care clearinghouse and that relates to past, present, or future physical or mental health or condition of the individual; to the provision of health care to an individual; or to the past, present, or future payment for the provision of health care to an individual and that identifies an individual or with respect to which there is a reasonable basis to believe the information could be used to identify an individual.
- 1.73 **Provider** means a Birthing Center, Certified Nurse Midwife, Home Health Care Agency, Hospice, Hospital, Licensed Dietician, Pharmacy, Physician, Psychiatric Day Treatment Facility, Psychologist, Rehabilitation Facility, or Skilled Nursing Facility, and any other licensed practitioner who is required to be recognized for health insurance by law or regulation and is acting within the scope of the license, as the context may indicate.
- 1.74 **Psychiatric Day Treatment Facility** means an institution that:
- (a) is a mental health facility which provides treatment for individuals suffering from acute mental, nervous or emotional disorders, in a structured psychiatric program utilizing individualized treatment plans with specific attainable goals and objectives appropriate both to the patient and the treatment modality of the program, and is clinically supervised by a doctor of medicine who is certified in psychiatry by the American Board of Psychiatry and Neurology; and
 - (b) is accredited by the Program for Psychiatric Facilities or its successor, or the Joint Commission on Accreditation of Hospitals; and
 - (c) treats its patients for not more than 8 hours in any 24-hour period.
- 1.75 **Qualified Dependent** means a Dependent who loses coverage under a Welfare Program due to a Qualifying Event.
- 1.76 **Qualifying Event** means any of the following events that, but for COBRA continuation coverage, would result in a Covered Participant's or eligible Dependent's loss of coverage:
- (a) death of a Covered Participant;
 - (b) termination of employment of a Covered Participant;
 - (c) reduction in hours of a Covered Participant;
 - (d) divorce or legal separation of the Covered Participant;
 - (e) the Covered Participant's entitlement to Medicare benefits; or
 - (f) Dependent Child ceasing to qualify as a Dependent under a Welfare Program.

- 1.77 **Qualified Medical Dependent Child Support (QMCSO)** means a Qualified Medical Dependent Child Support Order in accordance with the Omnibus Budget Reconciliation Act of 1993 (OBRA), as amended.
- 1.78 **Rehabilitation (Physical) Facility** means a facility that provides services of non-acute rehabilitation. All services are provided under the direction of a physiatrist, a medical doctor with a specialty in rehabilitation and physical medicine. Registered nurses staff the facility around the clock and it does not provide services of a custodial nature. The facility must be Medicare certified, licensed by the State Department of Health as a special Hospital and accredited by the Joint Commission on Accreditation of Healthcare Organizations. The Commission on Accreditation of Rehabilitation Facilities also accredits it.
- 1.79 **Skilled Nursing Facility** (this term also applies to a facility which refers to itself as an extended care facility or convalescent facility) means a facility that meets all of the following:
- (a) is licensed to provide professional nursing services on an inpatient basis to patients convalescing from Injury or Illness to help restore patients to self-care in essential daily living activities;
 - (b) provides continuous nursing services by licensed nurses for 24 hours of every day, under the direction of a full-time registered nurse (R.N.);
 - (c) provides services for compensation and under the full-time supervision of a Physician;
 - (d) a complete medical record on each patient;
 - (e) maintains has an effective utilization review plan; and
 - (f) is not, other than incidentally, a clinic, a place for rest, a place devoted to care of the aged, a place for treatment of mental disorders or mental retardation, or a place for custodial care.
- 1.80 **Spouse** means the person recognized under Texas law as the covered Associate's husband or wife unless divorced or legally separated under the laws of the State. Documentation proving a legal marital relationship may be required. This Plan will recognize Common Law Marriage in Texas if the Associate provides documentation required by the State to substantiate Common Law Marriage including: (1) an agreement to be married; (2) holding yourself out to a third party as being married and (3) living together. Requires Common Law Marriage Certificate from the County Clerk's Office.
- 1.81 **Subrogation** means the benefits provided by the Plan are secondary when a Covered Participant is entitled to receive money from any other source, including but not limited to any party's liability insurance or uninsured/underinsured motorist proceeds.
- 1.82 **Substance Abuse** means the condition caused by physical and/or emotional dependence on drugs, narcotics, alcohol, or other addictive substances resulting in a chronic disorder, which affects physical health, and/or personal or social functioning. This does not include dependence on tobacco or ordinary caffeine-containing beverages.
- 1.83 **Schedule of Medical Benefits** means the listing of Medical Benefits and description of the benefit levels provided in the Introduction.
- 1.84 **Temporomandibular Joint Dysfunction (TMJ)** means jaw joint disorders including conditions of structures linking the jaw bone and skull and the complex muscles, nerves and other tissues related to the temporomandibular joint.
- 1.85 **Third Party (Claim) Administrator** means Preferred Administrators to whom the Plan Administrator has delegated the duty to process and/or review claims for benefits under the Plan.

- 1.86 **Thomason Hospital or R. E. Thomason General Hospital** means University Medical Center of El Paso.
- 1.87 **Totally Disabled** means the complete inability of an Associate to substantially perform the important daily duties of the Associate's own occupation, for which the Associate is reasonably suited by education, training or experience. A Dependent who is Totally means that the Dependent is prevented solely because of a non-occupational Injury or non-occupational Illness from engaging in all of the normal activities of a person of like age and sex and in good health. A Dependent Child or grandchild will be considered Totally Disabled if they are incapable of self-support because of developmental disability or physical handicap. The Third Party Administrator may require proof of continuing Total Disability from time to time.
- 1.88 **USERRA** means the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended.

ARTICLE II ELIGIBILITY AND PARTICIPATION REQUIREMENTS

2.01 Eligibility

- (a) Associate Eligibility. All full-time regular Associates (normally working a minimum of 36 hours per week) and part-time regular Associates (normally working a minimum of 20 hours per week) are eligible to participate in the Plan on the first of the month following 30 days of regular full-time or part-time employment. An Associate who is not Actively at Work for any reason other than medical disability on his Coverage Date will become covered once he is Actively at Work.

Coverage under the Plan requires participation under the University Medical Center of El Paso Flexible Benefits Plan. The benefits elected must be for a 12-month period as described under the Flexible Benefits Plan unless the Covered Participant experiences a Change in Family Status or a Change in Status or Coverage.

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

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

- (b) Dependent Eligibility.
- (i) Dependents are eligible to participate at the same time as the Associate, or on the first day of the month after they become Dependents, if later. Newborn and adopted Dependent Children participate in the Plan immediately upon birth or adoption, provided that the Associate enrolls the child within 30 days of birth or adoption.
 - (ii) Dependent coverage may continue under this Plan following an Associates election of Medicare as primary. The Dependent will be treated in the same manner as if the Associate had remained on the Plan, as long as the Associate continues to meet the eligibility requirements and completes all necessary agreements on a timely basis.
 - (iii) A Dependent may be added to the Plan pursuant to a Qualified Medical Dependent Child Support Order (QMCSO) issued by a court of competent jurisdiction or administrative body that requires the Plan to provide medical coverage to the Dependent Child of an Associate. A stepchild not living with the Associate is not considered a Dependent Child for purposes of the QMCSO rules. The Plan Administrator will establish reasonable procedures for determining whether a court order or administrative decree requiring medical coverage for a Dependent Child meets the requirements for a QMCSO. The Plan Administrator shall have the authority to enroll both the Associate and Dependent Child, if the Associate is not a current participant at the time the QMCSO is received. The cost of coverage or any additional cost of such coverage, if any, is borne by the Associate.
 - (iv) Documentation may be required to confirm that a Dependent meets the Plan's Dependent eligibility requirements.

2.02 Failure to Elect

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

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

2.03 Enrollment

- (a) Effective Date. Each Associate on the Effective Date shall be eligible to participate in this Plan as of such date. Any new Associate shall participate effective as of the date coinciding with his eligibility for the Benefit Programs and be permitted to enroll in the Plan within the first 30 days of employment. Any reclassified Associate will be permitted to enroll in the Plan or change his enrollment in the Plan within 30 days of the status reclassification.
- (b) Late Enrollment. If enrollment is not requested within 30 consecutive days after satisfying the waiting period and becoming eligible to enroll in the Plan, then the Associate may only request enrollment for himself and/or his eligible Dependent(s) as a Late Enrollee.
- (c) Loss of Other Coverage – Special Enrollment. An Associate or Late Enrollee is eligible during a special enrollment period for an employee who either initially declined coverage for himself and/or his eligible dependent(s) because of existing other health coverage, or who previously declined coverage for himself and/or his eligible dependent(s) at a subsequent opportunity to enroll under a special enrollment period or as a late entrant because of existing other health coverage (such notice provided to the Plan Administrator in writing), if the employee requests enrollment for himself and/or such dependents not later than 30 days after loss of the other health coverage provided that the other coverage was terminated due to:
 - (i) loss of eligibility as a result of legal separation, divorce, cessation of dependent status (such as attaining the limiting age for a dependent child), death, termination of employment, or reduction in hours; or
 - (ii) an HMO or other arrangement in the individual market that does not provide benefits to individuals who no longer reside, live, or work in a service area (whether or not within the choice of the individual); or
 - (iii) an HMO or other arrangement in the group market that does not provide benefits to individuals who no longer reside, live or work in a service area (whether or not within the choice of the individual), and no other benefit package is available to the individual; or
 - (iv) an HMO ceasing operations; or
 - (v) an individual incurring a claim that would meet or exceed a lifetime limit on all benefits (the special enrollment right begins when a claim that would exceed a lifetime limit on all benefits is incurred and continues until at least **30** days after the earliest date that a claim is denied due to the operation of the lifetime limit); or
 - (vi) a plan no longer offering any benefits to a class of similarly situated individuals; or
 - (vii) cessation of employer contributions for the other health coverage; or
 - (viii) the exhausting of COBRA continuation coverage.

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

- (d) New Dependent – Special Enrollment. If an Associate has a new Dependent due to marriage, birth, adoption, or Placement for Adoption, the Associate may enroll himself, his Spouse, and his new Dependent in the Plan. The Associate must submit a written request for enrollment within 30 days after the marriage, birth, adoption, or Placement for Adoption. Coverage for the Dependent Child will be effective to the date of marriage, birth, adoption or Placement for Adoption.
- (e) Change in Family Status Change. The Associate must request enrollment for himself and/or such Dependent(s) within a 30-day period, which begins on the date of the Change in Status event. Coverage will be effective on the first of the month following notification.
- (f) Court Ordered Coverage. Coverage for a Dependent Child pursuant to a QMCSO will be effective as of the date of the decree provided the Associate requests enrollment for the Dependent Child within 30 days of the QMCSO.
- (g) Significant Change in Cost. Enrollment may commence as of the first day of the next payroll period if the Associate has experienced a significant change (increase in cost or significant curtailment of coverage) provided that the Associate requests enrollment for himself and/or such Dependent(s) within a 30-day period which begins on the date that the significant increase in cost or significant curtailment of coverage occurs.
- (h) Significant Change in Coverage. Enrollment may commence as of the first day of the next payroll period following notification due to a significant change in health coverage attributable to a Spouse's employment provided that the request for enrollment is necessary or appropriate due to the significant change. The Associate must request enrollment for himself and/or his Dependent(s) within a 30-day period beginning on the date that the significant change in health coverage occurs.

2.04 Coverage During A Leave Of Absence

- (a) Total Disability Leave of Absence. If a Covered Person is Totally Disabled on the date their Leave of Absence commences under the Plan, coverage for the Injury or Illness which caused the Total Disability may be continued at the Associate rate, up to the earliest of the following dates:
 - (i) the date that the Total Disability ends; 6 months; or
 - (ii) the date the Covered Person becomes covered, with respect to such disability, under any other group benefit program.In lieu of this coverage, the Associate may elect COBRA at the COBRA premium rates.
- (b) Personal Leave Of Absence. If an Associate receives authorization for an educational or personal Leave of Absence coverage while on a:
 - (i) paid leave will continue at the Associate rate through the end of the paid leave. Coverage for periods thereafter will be through COBRA.
 - (ii) unpaid leave will continue through the end of the month at the regular Associate contribution rate (paid through either payroll deduction or on an after-tax basis). Coverage for periods thereafter will be through COBRA.
 - (iii) temporary layoff will continue for up to a 3-month period at the regular Associate contribution rate (paid through either payroll deduction or on an after-tax basis). In lieu of this coverage, the Associate may elect COBRA at the COBRA premium rates.

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

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

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

- (d) Military Leave. Pursuant to the provisions of the Uniformed Services Employment and Reemployment Rights Act of 1994, an Associate on military leave will be considered to be on a leave of absence and will be entitled during the leave to the health and welfare benefits that would be made available to other similarly situated Associates if they were on a leave of absence. This entitlement ends if the Associate provides written notice of intent not to return to work following the completion of the military leave. The Associate shall have the right to continue his coverage, including any Dependent coverage, for the lesser of the length of the leave or 18 months (24 months for elections made on or after December 10, 2004). If the military leave is for a period of 31 days or more, the Participant can be required to pay 102 percent of the total premium (determined in the same manner as a COBRA continuation coverage premium).

If coverage is not continued during the entire period of the military leave because the Participant declines to pay the premium or the leave extends beyond 18 months (24 months for elections made on or after December 10, 2004), the coverage must be reinstated upon reemployment within the time specified by law with no Pre-Existing Condition exclusions (other than for service-related illnesses or injuries) or waiting periods (other than those applicable to all eligible Associates.)

2.05 Continuation of Coverage Under COBRA

Continuation of health coverage under COBRA (Consolidated Omnibus Budget Reconciliation Act) shall not duplicate health coverage continued under any state or Federal law.

A. DEFINITIONS

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

1. **“Entitlement to Medicare”** or **“Entitled to Medicare”** means the covered employee has enrolled in either Medicare Part A or Part B.
2. **“Qualified Beneficiary”** means:
 - a. a covered employee, for termination or reduced hours;
 - b. a spouse or a dependent child who were covered dependents under the Plan on the day before the covered employee’s Qualifying Event occurred;
 - c. a child who is born to a covered employee, or placed with a covered employee for adoption, during a period of COBRA continuation coverage.

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

“Qualifying Event” for a covered dependent means a loss of coverage due to:

- a. a covered employee’s termination of employment (for any reason other than gross misconduct) or reduction in hours of employment;
- b. a covered employee’s death;
- c. a spouse’s divorce or legal separation from a covered employee;
- d. a covered employee’s entitlement to Medicare;
- e. a dependent child’s loss of dependent status under the Plan.

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

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

B. CONTINUATION OF HEALTH COVERAGE NOTICE AND ELECTION PROCEDURES

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

GENERAL NOTICE (INITIAL COBRA NOTICE):

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

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

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

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

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

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

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

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

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

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

PLAN ADMINISTRATOR'S NOTICE OBLIGATION – ELECTION NOTICE:

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

ELECTION PROCEDURES:

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

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

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

Upon election to continue health coverage, a Qualified Beneficiary must, within **45** days of the date of such election, pay all required contributions to date to the Plan Administrator. All future contribution payments by a Qualified Beneficiary must be made to the Plan Administrator and are due the first of each month with a **30**-day grace period. If the initial contribution payment is not made within **45** days of the date of the election, COBRA coverage will not take effect. If future contribution payments are not made within the allotted **30**-day grace period, COBRA coverage will be terminated retroactively back to the end of the month in which the last full contribution payment was made.

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

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

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

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

**PLAN ADMINISTRATOR'S NOTICE OBLIGATION –
EARLY TERMINATION NOTICE:**

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

TRADE ACT OF 2002:

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

C. PREMIUMS FOR COBRA COVERAGE

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

A Qualified Beneficiary will be notified by the Plan Administrator of the amount of the required contribution payment and the contribution payment options available.

The cost of COBRA coverage may be subject to future increases during the period it remains in effect.

D. TERMINATION OF COVERAGE

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

1. if an employee is terminated or has his/her hours reduced:
 - a. **18** months from the date of the Qualifying Event; or
 - b. **29** months from the date of the Qualifying Event if the Qualified Beneficiary is determined under Title II or Title XVI of the Social Security Act to be disabled on such date or at any time during the first **60** days of COBRA continuation coverage and provides notice as required by the Plan (including COBRA continuation coverage of non-disabled family members of the Qualified Beneficiary entitled to the disability extension).
2. the day, after the **18** month continuation period, which begins more than **30** days from the date of a final determination under Title II or Title XVI of the Social Security Act that a Qualified Beneficiary, entitled to **29** months, is determined to be no longer disabled (including COBRA continuation coverage of non-disabled family members of the Qualified Beneficiary entitled to the disability extension who is no longer disabled).
3. for a covered dependent, **36** months from the date of the Qualifying Event if the Qualifying Event is:
 - a. the covered employee's death;
 - b. the covered employee's entitlement to Medicare;
 - c. a spouse's divorce or legal separation from a covered employee; or
 - d. a dependent child's loss of dependent status under the Plan.
4. if any of the Qualifying Events listed in 3. occurs during the **18**-month period (or **29**-month period if there is a disability extension) after the date of the initial Qualifying Event listed in 1., coverage terminates **36** months after the date of the initial Qualifying Event listed in 1.
5. the date on which the Employer ceases to provide any group health plan coverage to any employee.
6. the date of the Qualifying Event if the Qualified Beneficiary fails to make the initial contribution payment within **45** days of the date of the election.
7. the last day of the month in which the last contribution payment was made if the Qualified Beneficiary fails to make future contribution payments within the allotted **30**-day grace period as described in this section.
8. the date on which a Qualified Beneficiary first becomes (after the date of the election) covered under any other group health plan (as an employee or otherwise) which does not contain any exclusion or limitation with respect to any pre-existing condition of such Qualified Beneficiary.

9. the first day of the month in which a Qualified Beneficiary becomes entitled to Medicare.
10. the date this Plan terminates.

2.06 Termination Of Coverage

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

2.07 Rehired Or Transferred Associates

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

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

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

2.08 Premium Contributions

Premiums shall be determined on an annual basis and shall be communicated prior to the annual election period under the University Medical Center of El Paso General Hospital And Its Affiliates Flexible Benefits Plan. Premium amounts may, at the discretion of the Employer, be offset by a set amount to be determined on an annual basis for the completion of a HRA.

ARTICLE III MEDICAL BENEFITS

3.01 Benefits Provided

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

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

3.02 Deductibles and Co-Pays

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

3.03 Covered Medical Expenses

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

- 1) **Allergy Testing, Allergy Injections And Allergy Serums.** Allergy testing, allergy injections, and allergy serums dispensed and/or administered at a Physician's office, and the syringes necessary to administer them.
- 2) **Ambulance Services.** Air ambulance (if Medically Necessary) or ground ambulance for transportation to or from the nearest appropriate Hospital by a licensed ambulance service.
- 3) **Ambulatory Surgical Facility.** Treatment, services and supplies furnished by an ambulatory surgical facility.
- 4) **Anesthetics.** Anesthetics and their professional administration and services of an anesthesiologist.
- 5) **Birth Control (Family Planning/Contraceptive Counseling).** Charges for:
 - Office visit for contraceptive purposes.
 - Depo-Provera injections dispensed and/or administered at a Physician's office if Medically Necessary or for contraceptive purposes.
 - Lunelle injections dispensed and/or administered at a Physician's office for contraceptive purposes.
 - Services and supplies related to insertion and removal of Norplant and other birth control devices are covered the same as any other Illness.
 - Depo-Provera and Lunelle injections dispensed by a pharmacist, are covered under the Schedule of Benefits (Prescription Drug Benefits).
- 6) **Birthing Center.** Care, treatment and services furnished by a birthing center (please rely on the advice of your Physician when considering a birthing center).
- 7) **Blood And Blood Derivatives.** Blood transfusion services, including the cost of whole blood or blood plasma not donated or replaced.
- 8) **Chemotherapy/Radiation Therapy.** Chemotherapy, radiation therapy, and treatment with radioactive substances; materials and services of a technician.

- 9) **Colorectal Cancer Screening (CRC).** Persons at risk for CRC (family history of CRC, previous adenomatous polyps, inflammatory bowel disease, previous resection of CRC, genetic syndromes) may use more intensive screening efforts which includes AMA recommended screening for colorectal cancer including:
 - a. an annual fecal occult blood testing;
 - b. flexible sigmoidoscopy every 3 to 5 years from age 50 for persons at average risk;
 - c. colonoscopy;
 - d. double-contrast barium enema procedures which screen the entire colon.
- 10) **Contact Lenses Or Eyeglasses.** Initial purchase of contact lenses or eyeglasses but not both if required following cataract surgery.
- 11) **Cosmetic Procedures/Reconstructive Surgery.** Cosmetic procedures/ reconstructive surgery for:
 - repair due to Accidental Injury;
 - reconstruction incidental to or following surgery due to an Injury or Illness;
 - correction of a congenital defect that results in a functional defect of a Covered Dependent Child; or
 - reconstruction of the breast on which a Medically Necessary mastectomy has been performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; prostheses and treatment of physical complications for all stages of the mastectomy, including lymphedemas.
- 12) **Diabetic Education.** Participation in the University Medical Center of El Paso Diabetic Management Program will be provided at 100% subject to the fiscal year deductible. Benefits for Diabetic Education are provided only at University Medical Center of El Paso.
- 13) **Diagnostic X-Ray And Laboratory Services.** Diagnostic X-ray and laboratory examinations; services of a radiologist or pathologist.
- 14) **Durable Medical Equipment.** Rental, initial purchase, or replacement of Durable Medical Equipment. Purchase is covered only if long-term use is planned and the equipment cannot be rented or it is less costly to purchase than to rent. Repair or replacement will be covered when required due to growth or development of a Dependent Child, Medical Necessity because of a change in the Covered Participant's physical condition, or deterioration from normal wear and tear if prescribed by the attending Physician. Replacement is covered if it is likely to cost less to buy a replacement than repair or rent like equipment. Covered items include, but are not limited to, crutches and braces, a durable brace specially made for and fitted to the Covered Participant, and rental of wheelchairs and Hospital beds. Charges for more than one item of equipment for the same or similar purpose are not covered.
- 15) **Flu Immunizations (Adult).** Annual Flu shots / immunizations will be provided by University Medical Center of El Paso as follows:
 - a) For Associates:
 - i) Flu shots will be provided by Occupational Health at no cost to the Associate.
 - ii) Flu shots will be provided by University Medical Center of El Paso Care Clinics subject to payment of the \$10 co-pay.
 - iii) Flu shots provided by any other provider are not covered by the Plan and payment is the Associate's responsibility.

- b) For Dependent Spouses and Children Covered by this Plan:
- i) Flu shots will be considered as eligible expenses for covered dependents when provided by University Medical Center of El Paso Care Clinics subject to payment of the \$10 co-pay.
 - ii) Flu shots provided by any other provider are not covered by the Plan and payment is the Associate's responsibility.
- 16) **Home Health Care And Skilled Nursing.** For covered participants who meet the criteria for "Homebound Status": 1. Patients leave home infrequently for only short durations of time for reasons other than to seek medical care that they cannot receive at home. 2. When homebound patients leave home, it must take great and taxing effort and/or require maximum assistance. Patients may, however, leave home to attend adult day care programs that meet certain requirements and religious services and remain homebound.
- Charges by a Home Health Care Agency on its own behalf for Covered Expenses and supplies furnished in the patient's home in accordance with a home health care plan made by the attending Physician. Part-time or intermittent nursing care by a registered nurse (R.N.) or a licensed practical nurse (L.P.N.) or licensed vocational nurse (L.V.N.) and home health aide services provided in conjunction with nursing services are covered under the Plan if the attending Physician certifies that treatment of the condition would require confinement as a Hospital inpatient in the absence of home health care. Home health care expenses shall **not** include charges for: services or supplies not included in the home health care plan; services of a person who ordinarily resides in the patient's home or is a member of the patient's family, or Dependents of the patient; transportation services; custodial care.
- 17) **Hospice Care.** Services and supplies furnished in a licensed inpatient hospice facility or in the patient's home by a licensed hospice care program when the attending Physician certifies that life expectancy is 6 months or less. Hospice care expenses include charges for bereavement counseling of the Covered Participant's immediate family prior to, and within 3 months after, the Covered Participant's death and charges for respite care provided to give temporary relief to the family or other caregivers in emergencies and/or from the daily demands of caring for a terminally ill person.
- 18) **Hospital Care (Inpatient).** The following services and supplies while an inpatient at a Hospital:
- daily room charge in a Hospital, but not to exceed the daily rate equal to the average Hospital semi-private room charge (charges when a Hospital private room accommodation has been used will be reimbursed at the average semi-private room rate in the facility);
 - charges for confinement in an intensive care unit;
 - meals, special diets, nursing care;
 - maternity and routine nursing care while mother is Hospital confined. A Hospital length of stay for the mother or newborn Dependent Child will be at least 48 hours following a vaginal delivery, or 96 hours following a cesarean section. The 48-hour period [or 96-hour period if applicable] begins at the time a delivery occurs in the Hospital [or in the case of multiple births, at the time of the last delivery] or, if the delivery occurs outside the Hospital, at the time a mother and/or newborn are admitted. The mothers' or newborn's attending provider, after consulting with the mother, may discharge the mother or her newborn earlier than 48 hours [or 96 hours, if applicable] after delivery;

- operating, delivery, recovery and other treatment rooms;
 - prescribed drugs and medications;
 - dressings and casts;
 - use of Hospital equipment, laboratory and radiology services;
 - treatment by a Physician or surgeon.
- 19) **Hospital Care (Outpatient)**. Treatment, services and supplies furnished by a Hospital on an outpatient basis to a Covered Participant not admitted as a registered bed patient.
 - 20) **Immunizations**. Expenses related to Immunizations as required by law or as prescribed by a Physician subject to coverage limits specified in the Summary Of Benefits.
 - 21) **Injectable And Intravenous Prescription Medications**. Covered Expenses as set forth in the Summary of Benefits under Prescription Drugs.
 - 22) **Insulin And Diabetic Supplies**. Refer to Prescription Drug Benefits in the Summary of Plan Benefits for coverage of injectable insulin, insulin syringes, chemstrips and blood lancets. Insulin pumps and blood glucose monitors are covered through the Plan if not used as convenience items.
 - 23) **Medical And Surgical Supplies**. Casts, splints, trusses, surgical dressings, and other devices used in the reduction of fractures and dislocations.
 - 24) **Mental And Nervous Disorders**. Services provided for treatment of Mental And Nervous Disorders and services provided by a Physician, including Group Therapy and collateral visits with members of the Patient's immediate family.
 - 25) **Newborn Care**. Routine care of a hospital-confined newborn child, provided that coverage for the newborn child is requested, if necessary, according to the eligibility requirements of the Plan. The Plan will cover up to 5 days of hospitalization or until the mother's discharge, whichever occurs first, on the same basis as an Illness of such newborn child, including routine nursery care, physician charges, necessary laboratory tests, and circumcision. Such charges will be considered separate from the mother's charges.
 - 26) **Nursing Services**. Services of a registered nurse (R.N.), licensed vocational nurse (L.V.N.), or licensed practical nurse (L.P.N.), other than a person related by blood or marriage. The Plan provides benefits for skilled nursing care furnished by a registered nurse or a licensed practical or vocational nurse if the services of a registered nurse are not available. In-Hospital private duty nursing services are not covered. Charges for skilled nursing services provided in the home are covered under the Home Health Care provision.
 - 27) **Nutritional Counseling**. Expenses related to Nutritional Counseling for dependent children and adults, which are Medically Necessary according to evaluation by a Registered Dietician when provided at University Medical Center of El Paso or Texas Tech Physicians, limited to twelve sessions per fiscal year.
 - 28) **Occupational Therapy**. Charges for services requiring the technical medical proficiency and skills of a registered or licensed occupational therapist and rendered in accordance with a Physician's specific instructions as to type and duration to restore or improve lost or impaired function. Services for outpatient occupational therapy are covered only when the Covered Participant is able to actively participate in such therapy, and there is documented continuous physical improvement. No coverage will be made for Workers' Compensation related Illness or Injuries.

- 29) **Organ Transplants.** Covered Expenses incurred for human-to-human organ or tissue transplants are covered subject to the following:
- eligible organ transplant procedures which are medically necessary and appropriate for the condition being treated and which have been confirmed by medical management / utilization review and a complete second opinion by a board certified physician and an organ transplant review committee are:
 - heart transplants
 - heart and lung transplants
 - kidney transplants
 - liver transplants
 - bone marrow transplants
 - stem cell transplants
 - tissue transplant procedures, joint replacements and other specified procedures which are medically necessary and appropriate for the condition being treated and which have been confirmed by medical management / utilization review and a complete second opinion by board certified physicians are:
 - cornea transplant
 - artery or vein transplants
 - joint replacements
 - heart valve replacements
 - implantable prosthetic lenses in connection with cataracts
 - prosthetic bypass or replacement vessels
 - Additional consideration for organ transplant include:
 - Benefits are available for human organ, tissue, and bone marrow transplantation, subject to determination made on an individual case by case basis in order to establish Medical Necessity.
 - Organ Transplant Services are provided only through the Preferred Administrators Network, Interlink Transplant Network or other facility contracts as approved by the Plan Administrator and the stop loss company.
 - Benefits will be provided only when the Hospital and Physician customarily charge a transplant recipient for such care and services.
 - Donor expenses (professional fees and facility charges) will be considered eligible expenses when a Covered Participant is the recipient of the organ donation as follows:
 - 1) if the donor is covered by another benefit / insurance plan that plan will be considered primary for the expenses associated with the organ harvesting procedure and this Plan will be secondary;
 - 2) if the donor is not covered by another benefit / insurance plan this Plan will be primary.
 - Donor expenses (professional fees and facility expenses) will be considered eligible expenses when a Covered Participant is the donor of the organ for a person who is not covered by this Plan as follows:
 - 1) if the recipient's benefit / insurance plan provides coverage for organ donation, that plan will be considered primary and this plan will be secondary;
 - 2) if the recipient's benefit / insurance plan does not provide for organ donation this Plan will provide a benefit allowance for the donation procedure expenses.

- When the donor recipient are both Covered Participants, benefits will be paid under recipient.
 - Benefits for organ procurement expenses will be considered eligible expenses.
 - Benefits paid for organ donor expenses and procurement will be applied to the benefit maximums of the Covered Participant.
 - No benefits are provided for organ transplant procedures unless the facility and network contract is approved by Preferred Administrators.
- 30) **Orthotic Devices.** Orthotic Devices used to support, align, prevent or correct deformities, or to improve the function of movable parts of the body. Repair or replacement of covered Orthotic Devices will be covered when required due to growth or development of a Dependent Child, medical necessity because of a change in the covered participant's physical condition, or deterioration from normal wear and tear for dependent children up to age 18, if recommended by the attending physician. Orthotic devices for dependent children are based on medical necessity.
- Supportive foot devices for adults (such as arch supports) and orthopedic shoes are covered when prescribed by an In-Network Physician.
- 31) **Oxygen.** Oxygen or other gases and rental of equipment for its administration including IPPB (Intermittent Positive Pressure Breathing equipment).
- 32) **Physical Therapy.** Services of a licensed physical therapist or Physician for non-Workers' Compensation Illnesses or Injuries, but limited to services requiring the technical medical proficiency and skills of a recognized physical therapist and rendered in accordance with a Physician's specific instructions as to type and duration.
- 33) **Physician Care.** Professional services of a Physician for surgical and medical care, including but not limited to, surgery, anesthesia, inpatient medical visits, consultations, office visits, and office treatment.
- 34) **Preadmission or Preoperative Testing.** Tests or exams relating to surgery for a Covered Participant who is scheduled for surgery.
- 35) **Prescription Drugs.** Drugs requiring a prescription under the applicable state law. Examples of covered Prescription Drugs include:
- Adderall
 - Contraceptives (oral and injectable)
 - Dexedrine
 - Dextrostat
 - Federal legend prescription drugs
 - Injectable insulin, insulin syringes, chemstrips, and blood lancets
 - Injectables (other than insulin)
 - I.V. medications prescribed by a licensed physician and dispensed by a licensed pharmacist
 - Non-insulin needles/syringes
 - Pre-natal prescription vitamins
- 36) **Pregnancy Care.** Care and treatment for pregnancy and complications of pregnancy are covered on the same basis as for any other Illness for a covered Associate, Spouse or dependent daughter.

- 37) **Prosthetic Devices.** Prosthetic devices such as artificial limbs or eyes. After a mastectomy, an external breast prosthesis is covered. Prosthetic device repair or replacement will be covered when required due to growth or development of a Dependent Child, Medical Necessity because of a change in the Covered Participant's physical condition. After a mastectomy, external breast prosthesis is covered, and also the first bra made solely for use with the external breast prosthesis.
- 38) **Psychiatric Day Treatment Facilities.** Covered Expenses incurred for treatment in a psychiatric day treatment facility for a mental or nervous disorder if the attending Physician certifies that such treatment is in lieu of Hospitalization, will be subject to the same benefits and limitations as applicable to treatment provided on an inpatient basis for mental or nervous disorders, as specified in the Schedule of Benefits. Any benefits so provided are considered as inpatient care and treatment in a Hospital.
- 39) **Rehabilitation Facilities.** Services and supplies including room and board furnished by a rehabilitation facility. The Covered Participant must be under the continuous care of a Physician and the attending Physician must certify that the individual requires nursing care 24 hours a day. A registered nurse or a licensed vocational or practical nurse must render nursing care. The confinement cannot be primarily for domiciliary, custodial, personal type care, care due to senility, alcoholism, drug abuse, blindness, deafness, mental deficiency, tuberculosis, or mental and nervous disorders. Charges for vocational therapy or custodial care are not covered.
- 40) **Routine Care.** Services as specified in the Summary of Benefits as well as gamma globulin injections.
- 41) **Skilled Nursing Facilities.** Services and supplies (including room and board furnished by a skilled nursing facility).
- 42) **Speech Therapy.** Charges for services of a licensed speech therapist (or, in states not requiring a license, one who holds a Certificate of Clinical Competence from the American Speech and Hearing Association) when rendered in accordance with a Physician's specific instructions as to type and duration but only when necessary:
- to restore loss of functional speech or swallowing after a loss or impairment of a demonstrated, previous ability to speak or swallow;
 - to develop or improve speech after surgery to correct a defect that both existed at birth and impaired or would have impaired the ability to speak;
 - for a speech impediment due to cerebral palsy;
 - to treat dysphasia following surgery;
 - Treatment of fluency (stuttering) disorders;
 - Voice disorders secondary to vocal abuse/misuse.
 - Dysphagia following surgery
- Speech and Language impairments in children three to eight years as determined via standardized or non-standardized testing. Sessions for the above noted are to be forty five – sixty minutes in duration two – three times a week.
- 43) **Spinal Adjustments.** Skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body performed by a Physician to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.
- 44) **Sterilization Procedures.** Voluntary sterilization procedures are covered on the same basis as for any other illness.

- 45) **Substance Abuse.** Services provided for treatment of substance abuse conditions.
- 46) **Temporomandibular Joint Dysfunction (TMJ).** Only open-cutting operations for treatment of TMJ are covered.
- 47) **Treatment In Mouth Or Oral Cavity.** Coverage is limited to:
- surgical treatment of fractures and dislocations of the jaw or for treatment of an Accidental Injury to sound, natural teeth, including replacement of such teeth, within six months after the date of the Accidental Injury (except when delay of treatment is Medically Necessary);
 - surgery needed to correct an Accidental Injury to the jaws, cheeks, lips, tongue, floor and roof of the mouth;
 - removal of non-odontogenic lesions, tumors or cysts;
 - incision and drainage of non-odontogenic cellulitis;
 - surgical treatment of accessory sinuses, salivary glands, ducts and tongue;
 - treatment to correct a non-odontogenic congenital defect that results in a functional defect of a Covered Dependent Child.
- 48) **Vaccinations.** Expenses for medically necessary vaccinations are covered the same as any other illness. Vaccinations for over-seas travel are not covered. See item number 14 for Special Instructions for Flu Shots.
- 49) **Wellness Benefit.** Preventive Benefits as specified in the Schedule of Benefits.

3.04 **Expense Limitations**

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

ARTICLE IV EXCLUSIONS

4.01 Claims Submitted After One Year

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

4.02 Miscellaneous Restrictions on Benefits

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

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

4.03 Benefit Exclusions

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

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

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

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

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

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

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

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

Home Health Care. Home health care expenses exclude charges for: services or supplies not included in the home health care plan; services of a person who ordinarily resides in the patient's home or is a member of the patient's family, or Dependents of the patient; transportation services; and custodial care.

Hospitalization and/or Surgery. Charges are not covered for:

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

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

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

Massage. Charges for massage or for any rolfing services and/or supplies.

Morbid Obesity and Obesity. Charges in connection with treatments, surgical procedures or programs for obesity, morbid obesity, dietary control or weight reduction, whether Medically Necessary or not, and for any complications arising out of non-covered services.

Not-Medically Necessary. Charges for treatment and care which are not generally accepted in the United States as being necessary and appropriate for the treatment of the patient's illness or injury.

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

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

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

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

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

Prescription Drugs.

- Accutane after age 25
- Anabolic steroids
- Anorectics (any drug used for the purpose of weight loss)
- Anorexiant (except for Adderall, Dexedrine, and Dextrostat)
- Cosmetics
- Drugs or medicines dispensed more than one year after the date of the Prescription order
- Fertility medications
- Fluoride supplements
- Growth hormones
- Investigational or experimental drugs including compounded medications for non-FDA approved use
- Medical devices and other supplies (example Diabetes blood level monitor is covered under the Plan)
- No charge prescriptions available under Workers' Compensation, or other city, state or federal governmental program
- Non-legend drugs other than insulin
- Retin A after age 25
- Rogaine
- Viagra and similar drugs
- Vitamins (prescription or otherwise) except for prescription pre-natal vitamins

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

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

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

Self Inflicted Injuries. Charges for:

- intentionally self-inflicted Injury, unless such Injury results from medical condition (physical or mental health condition) or domestic violence
- Injury resulting from or sustained due to being engaged in an illegal occupation, commission of an assault or felonious act, unless such Injury results from a medical condition (physical or mental health condition) or domestic violence.

Sexual Health and Family Planning. Charges for:

- infertility treatment, services and fertilization attempts, including but not limited to: artificial insemination, Pergonal therapy for infertility, in-vitro fertilization, micro-surgery for infertility treatment, and HCG injections
- expenses related to adoption
- surrogate mother and all related newborn Dependent Child expenses
- elective abortions, unless the life of the mother is endangered or the pregnancy is the result of a criminal act
- sexual transformation, including sex transformation surgery and all expenses in connection with such surgery
- treatment of sexual dysfunctions not related to organic disease
- reversal or attempted reversal of sterilization

Therapy. For physical or psychological therapy where the method of treatment is art, play, music, drama, reading, massage, home economics or recreational activities. No coverage for therapy to correct pre-speech deficiencies or to improve speech skills that have not yet fully developed.

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

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

Under the Influence of Alcohol. For charges incurred as a result of being under the influence of alcohol in excess of the Texas legal blood alcohol limit or under the influence of intoxicants, or narcotics or prescription drugs that were not taken according to the prescription instructions or were not prescribed for the covered person.

Vax-D Therapy. For Vax-D therapy

Vision and Hearing. Charges for:

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

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

Workers Compensation. No benefits will be provided for Accidental Injury or Illness arising out of or in the course of any employment for wage or profit or which Workers' Compensation or Occupational Disease Policy, or any expenses payable cover under compromise settlement agreements under a Workers' Compensation claim.

ARTICLE V

CLAIMS PROCEDURES

5.01 Claims Procedure

Claims shall be submitted directly to the Third Party Administrator. *Instructions for submitting claims are described on the Associates Identification Card.*

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

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

5.02 Notice of a Complaint or Appeal

Covered Participants may contact Preferred Administrators Member Services department to advise them of a Complaint. Notice of a Complaint may be made by telephone (915) 532-3778, by fax (915) 532-2286 or sent in writing to Member Services, Preferred Administrators Health Plans, P.O. Box 971100, El Paso, TX 79997-1100.

Covered Participants may contact Preferred Administrators Compliance Department to advise them of an Appeal of an Adverse Benefit Determination. Notice of an Appeal must be made in writing and sent to Compliance Department, Preferred Administrators, P.O. Box 971100, El Paso, TX 79997-1100.

Written Appeals must include the following information:

- a) Associate name;
- b) Claimant name;
- c) Provider name;
- d) Dates of Service for which services were requested and denied or Dates of Service for which services were obtained and benefits were denied;
- e) Clear description of the reason(s) for the Appeal and explanation of the remedy being sought, and an explanation of why the Plan should "reverse" the Adverse Benefit Determination;
- f) Copy of documentation to support the Appeal and request to reverse the Adverse Benefit Determination;
- g) Covered Associates mailing address.

First Level Appeal

The Compliance Department will acknowledge receipt of an Appeal of an Adverse Benefit Determination within five (5) business days of receipt of the Appeal.

Within thirty (30) business days after receipt of all information required to evaluate the Appeal, the Compliance Department for the Plan will verbally notify the Covered Participants of the Plan's decision regarding the Appeal, and the right to Appeal for a second level review. The verbal notification will be followed by a written notice of the determination of the Appeal including clear and detailed reasons for the determination.

Second Level Appeal

If a Covered Participant is not satisfied with the determination of the first level Appeal, the Covered Participant may request a second level Appeal review. Written notice of a request for a second level Appeal must be sent in writing to the Compliance Department for the Plan within thirty (30) days of the date the first level Appeal determination was made. The Compliance Department will acknowledge receipt of a request for a second level Appeal review within five (5) business days of receipt of the Appeal.

A request for a second level Appeal review must include a written explanation of why the Covered Participant believes the determination made at the first level Appeal is flawed and should be over ruled.

Within thirty (30) business days of receipt of the request for a Second Level Appeal review, the Compliance Department will present the Appeal and the issues to the Benefit Management Advisors. The Benefit Management Advisors will make a final benefit determination regarding the Appeal. The determination by the Benefits Management Advisors will be final.

5.03 Covered Participant's Responsibilities

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

5.04 Unclaimed Benefits

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

5.05 Limitation of Rights

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

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

ARTICLE VI PRE-EXISTING CONDITIONS

6.01 Expenses for Treatment of Pre-Existing Conditions

Expenses for treatment of a Pre-Existing Condition will not be covered for 12 months following an individual's enrollment date (18 months for late entrants.) Once this exclusion period has been satisfied, normal benefits will be payable.

All Covered Participants enrolled on the Effective Date of this Plan, and who have been continuously covered, will not be subject to the additional six month Pre-Existing Condition exclusion.

The Pre-Existing Condition exclusion period will not apply to pregnancy (regardless of whether the woman had previous coverage or to a newborn or adopted Dependent Child under age 18 (or Dependent Child placed for adoption under age 18) provided the Dependent Child became covered under the Plan or other creditable coverage within 31 days of birth or adoption (or adoptive placement) and provided they have not incurred a subsequent break in coverage of 63 consecutive days or more.

6.02 HIPAA Certification

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

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

6.03 Application Against Pre-Existing Condition Time Frames

Associates who have been continuously covered for medical benefits for more than 12 months prior to employment shall receive full credit toward the Pre-Existing Limitation upon proof of such prior coverage with less than a 63-day lapse in coverage.

Associates, who cannot or are unable to obtain a certificate, may demonstrate prior health care coverage by:

- (a) attesting to the period of creditable coverage;
- (b) presenting corroborating evidence of creditable coverage for the period (such as pay stubs that reflect a deduction for health insurance, explanation of benefits forms (EOBs), or verification for health insurance by a doctor or former health care benefits provider that the individual had prior health coverage); and
- (c) cooperating in the verification process.

An Associate may also demonstrate proof of Dependent creditable coverage without a certificate by:

- (a) attesting to such dependency and the period of such status as a dependent; and
- (b) cooperating in the verification of dependent status.

ARTICLE VII MISCELLANEOUS

7.01 Plan Interpretation

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

7.02 Exclusive Benefit

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

7.03 Non-Alienation of Benefits

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

7.04 Limitation of Rights

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

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

7.05 Governing Laws

The Plan is governed by the Code. In no event shall the Employer guarantee the favorable tax treatment sought by this Plan. To the extent not preempted by federal law, the provisions of this Plan are construed, enforced and administered according to the laws of Texas.

7.06 Severability

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

7.07 Captions

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

7.08 Construction

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

7.09 Expenses

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

7.10 Claim Determination Period

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

7.11 Right To Receive And Release Necessary Information

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

7.12 Facility Of Payment

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

7.13 Right To Recovery

If the Plan has made an erroneous or excess payment to any Covered Participant, the Plan Administrator is entitled to recover such excess from the Covered Participant to whom such payments were made. The recovery of such overpayment may be made by offsetting the amount of any other benefit or amount payable by the amount of the overpayment under the Plan.

ARTICLE VIII

SUBROGATION, REIMBURSEMENT, AND THIRD PARTY RECOVERY PROVISION

8.01 Right of Subrogation

Except as otherwise specifically provided in a Welfare Program, the subrogation provisions of this Section shall apply. By filing a claim for payment of benefits under the Plan or by receiving benefits for which payment is made by the Plan, a Covered Participant thereby assigns, transfers, and subrogates to the Plan, the Company and/or the Employer all rights, claims and interest to the extent of the amount of benefits paid or owed by the Plan on the claim which the Covered Participant has against any third party who may be liable for the amount of such benefits, and thereby authorizes the Plan, Company, and/or Employer to sue, compromise or settle with any such third party in the Covered Participants name or otherwise.

If a Covered Participant makes a claim for benefits for which a third party may be responsible, the Plan may either:

- (a) pay all benefits covered under the Plan and obtain reimbursement for such benefits upon settlement with or judgment against the responsible third party; or
- (b) delay payment and require the third party to pay such benefits upon such settlement or judgment. As a condition of receipt of benefits paid by the Plan, the Covered Participant must cooperate with the Plan, the Company and/or the Employer for the purpose of exercising such rights, claims or interest to recover the amount paid. In addition, a Covered Participant may be required to execute a subrogation/reimbursement agreement prior to the payment of any benefits; provided however, that payment by the Plan of any benefits prior to, or without, obtaining a signed subrogation/reimbursement agreement shall not operate as a waiver of this subrogation/reimbursement right.

Should a Covered Participant make or file a claim, demand, lawsuit or other proceeding against a third party who may be liable for the amount of benefits covered or paid by the Plan, the Covered Participant shall, as part of such claim, demand, lawsuit or other proceeding, and on behalf of the Plan, also seek payment or reimbursement for the amount of such benefits covered or paid by the Plan. A Covered Participant must notify the Plan Administrator prior to making or filing any such claim, demand, lawsuit or other proceeding. The Plan Administrator or the Company may, at that time or at any time, (a) instruct the Covered Participant not to seek, or to discontinue seeking, payment or reimbursement on behalf of the Plan, and (b) pursue such payment or reimbursement independently in the same or in a separate lawsuit or other proceeding or may abandon such payment or reimbursement altogether, in its sole discretion. Any compromise or settlement entered into by a Covered Participant purporting to reduce or limit the amount of the payment designated as reimbursement for medical or any other expenses covered under the Plan to an amount which is less than the benefits paid or covered by the Plan shall not be effective unless the Plan Administrator or the Company consents thereto in writing.

8.02 Coordination of Benefits with Other Plans

If a Covered Participant has coverage under this Plan as well as coverage from another Source, benefits that are available under this Plan shall be coordinated with the benefits available under the plan containing the Covered Participant's other source of benefits.

This Plan will determine the difference in the payable benefit amounts according to the Schedule of Benefits, including applicable deductibles, co-pays, and co-insurance amounts, and shall determine if any amounts in addition to the amount paid by the other source are payable, up to benefit amount that would be payable under this Plan.

In determining if additional amounts may be payable by this Plan, this Plan will determine the amount that would have been payable in the absence of other sources of coverage, subtract the covered balance remaining from the Covered Participant, and then determine if any additional benefits may be payable.

- (a) Ordering of Benefits. When coverage is provided by two or more sources, the plan that is primary is established in the following order:
- (i) the plan that has no Coordination of Benefits (“COB”) provision will be considered primary to a plan that has COB provisions;
 - (ii) the plan covering the person as an employee will be primary to the plan covering the person as a dependent;
 - (iii) the plan covering the Associate as a dependent will be primary for an Associate covered by (A) Medicare, (B) Medicare supplemental coverage, and (C) as a dependent of an actively employed Spouse;
 - (iv) for a dependent covered under a plan of both of his non-divorced parents, the plan covering the parent whose birthday falls first in the year will be primary to the plan covering the parent whose birthday falls later in the year. If both parents have the same birthday, the plan covering the parent for the longest period of time will be primary.
 - (v) for a dependent whose parents are divorced or separated, and the dependent is covered by plans of both parents, the plan covering the parent who is responsible for the dependent’s health care under the terms of the court decree will be the primary payor. In the absence of such a court decree, payment will be made in the order as follows:
 - (A) the plan of the parent with custody;
 - (B) the plan of the stepparent with custody;
 - (C) the plan of the parent without custody.
 - (vi) vehicle insurance, including but not limited to uninsured/underinsured, medical payment coverage, no-fault, and similar policies or coverage, as well as casualty and liability insurance coverage’s are primary.

If rules (i) to (vi) do not apply, the plan covering the person the longest period of time shall be primary to the plan covering the person for a shorter period.

- (b) Reduction of Benefits Payable by the Plan. Whenever this Plan is considered secondary to another plan, benefits paid by the primary plan will be considered when determining if benefits may be payable by this Plan. This Plan’s liability for benefits as a secondary payer shall be limited to the amount it would have considered based payable according to the Allowable Amount under the Plan and the Plan’s provisions for benefits, including applicable deductibles, co-pays and co-insurance requirements less the amounts paid by the primary plan.
- (c) Recovery of Duplicate Payments. If duplicate payments have been made by the Plan, the Plan Administrator may take whatever action deemed necessary to recover the amount including reduction of future payments for subrogation claims.

8.03 Coordination with Medicare

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

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

ARTICLE IX AMENDMENT AND TERMINATION

9.01 Amendment

The Employer reserves the right to amend the Plan at any time. Each amendment to the Plan will be made only pursuant to action by the Human Resources Department. Upon such action, the Plan will be deemed amended as of the date specified as the effective date by such action or in the instrument of amendment. The effective date of any amendment may be before, on or after the date of such action.

9.02 Termination

The Employer expects to continue the Plan indefinitely, but continuance is not assumed as a contractual obligation and each Employer reserves the right at any time by action of its Board of Directors or other governing body to terminate the Plan, in whole or in part, at any time. If the Plan is terminated, no Salary Reduction shall be made.

9.03 Effect on Other Benefits

The right to amend or terminate the Plan includes the right to change, limit, curtail, or eliminate coverage or benefits for any treatment, procedure, or service (including with respect to Covered Participants who are receiving benefits or Covered Participants who are Former Associates or retirees), regardless of whether the coverage or benefits relate to an Injury, defect, illness, or disease that was contracted or that occurred before the effective date of amendment or termination.

ARTICLE X MISCELLANEOUS STATUTORY REQUIREMENTS

10.01 Newborns' and Mothers' Health Protection Act of 1996

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

10.02 Women's Health and Cancer Rights Act of 1998

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

10.03 HIPAA Certification

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

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

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

10.04 Qualified Medical Dependent Child Support Orders (QMCSO)

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

10.05 Plan Administrator's Duty to Issue Certificates of Creditable Coverage

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

ARTICLE XI

HIPAA PRIVACY RULE

Effective April 14, 2003, the University Medical Center of El Paso And Its Affiliates Associate Health Benefit Fund Plan (hereinafter referred to as the "Plan") conforms with the requirements of § 164.504(f) of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations, 45 C.F.R. parts 160 through 164 (the regulations are referred to herein as the "HIPAA Privacy Rule" and § 164.504(f) is referred to as "the '504' provisions") by establishing the extent to which the Plan Sponsor will receive, use, and/or disclose Protected Health Information (hereinafter referred to as "PHI").

11.01 Plan's Designation of Person/Entity to Act on Its Behalf

The Plan has determined that it is a group health plan within the meaning of the HIPAA Privacy Rule, and the Plan designates University Medical Center of El Paso to take all actions required to be taken by the Plan in connection with the HIPAA Privacy Rule (e.g., entering into business associate contracts; accepting certification from the Plan Sponsor).

11.02 The Plan's Disclosure of PHI to the Plan Sponsor/ Required Certification of Compliance by Plan Sponsor

Except as provided below with respect to the Plan's disclosure of summary health information, the Plan will (a) disclose PHI to the Plan Sponsor, or (b) provide for or permit the disclosure of PHI to the Plan Sponsor by a health insurance issuer or HMO with respect to the Plan, **only if** the Plan has received a certification (signed on behalf of the Plan Sponsor) that:

- (a) the Plan Document has been amended to establish the permitted and required uses and disclosures of such information by the Plan Sponsor, consistent with the "504" provisions;
- (b) the Plan Document has been amended to incorporate the Plan provisions set forth in this section; and
- (c) the Plan Sponsor agrees to comply with the Plan provisions as modified by this section.

11.03 Permitted Disclosure of Individuals' PHI to the Plan Sponsor

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

All disclosures of the PHI of the Plan's individuals by the Plan's business associate, health insurance issuer, or HMO to the Plan Sponsor will comply with the restrictions and requirements set forth in this section and in the "504" provisions.

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

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

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

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

The Plan Sponsor will report to the Plan any use or disclosure of PHI that is inconsistent with the uses or disclosures provided for in the Plan Documents (as amended) and in the "504" provisions, of which the Plan Sponsor becomes aware.

11.04 Disclosure of Individuals' PHI/Disclosure by the Plan Sponsor

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

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

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

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

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

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

11.05 Disclosures of Summary Health Information and Enrollment and Disenrollment Information to the Plan Sponsor

The Plan, or a health insurance issuer or HMO with respect to the Plan, may disclose summary health information to the Plan Sponsor without the need to amend the Plan documents as provided for in the "504" provisions, if the Plan Sponsor requests the summary health information for the purpose of:

- (a) obtaining premium bids from health plans for providing health insurance coverage under the Plan; or
- (b) modifying, amending, or terminating the Plan.

The Plan, or a health insurance issuer or HMO with respect to the Plan, may disclose enrollment and disenrollment information to the Plan Sponsor without the need to amend the Plan Documents as provided for in the "504" provisions.

11.06 Required Separation between the Plan and the Plan Sponsor

In accordance with the "504" provisions, following is a description of the employees, classes of employees, or workforce members under the control of the Plan Sponsor who may be given access to individuals' PHI received from the Plan or from a health insurance issuer or HMO servicing the Plan.

1. Analysts/Administrators;
2. Human Resources Personnel;
3. Information Technology Personnel;
4. Clerical Personnel;
5. Supervisors/Managers;
6. Compliance Personnel Quality Assurance Unit.

The above list reflects the employees, classes of employees, or other workforce members of the Plan Sponsor who receive individuals' PHI relating to payment under, health care operations of, or other matters pertaining to plan administration functions that the Plan Sponsor provides for the Plan. These individuals will have access to individuals' PHI solely to perform these identified functions, and they will be subject to disciplinary action and/or sanctions (including termination of employment or affiliation with the Plan Sponsor) for any use or disclosure of individuals' PHI in violation of, or noncompliance with, the provisions of this section.

The Plan Sponsor will promptly report any such breach, violation, or non-compliance to the Plan and will cooperate with the Plan to correct the violation or noncompliance, to impose appropriate disciplinary action and/or sanctions, and to mitigate any deleterious effect of the violation or noncompliance.

ARTICLE XII

HIPAA SECURITY STANDARDS

This section is intended to bring the University Medical Center of El Paso and Its Affiliates Associates Benefit Fund (hereinafter "Plan") into compliance with the requirements of 45 C.F.R. § 164.314(b) (1) and (2) of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations, 45 C.F.R. parts 160, 162, and 164 (the regulations are referred to herein as the "HIPAA Security Standards") by establishing the Plan Sponsor's obligations with respect to the security of Electronic Protected Health Information. The obligations set forth below are effective on April 20, 2005.

12.1 DEFINITIONS

1. **"Electronic Protected Health Information"** has the meaning set forth in 45 C.F.R. § 160.103, as amended from time to time, and generally means protected health information that is transmitted or maintained in any electronic media.
2. **"Plan"** means the University Medical Center of El Paso and Its Affiliates Associates Benefit Fund.
3. **"Plan Document"** means the group health plan's governing documents and instruments (i.e., the documents under which the group health plan was established and is maintained), including but not limited to the Plan Document of the University Medical Center of El Paso and Its Affiliates Associates Benefit Fund.
4. **"Plan Sponsor"** means the entity as defined at section 3(16)(B) of ERISA, 29 U.S.C. § 1002(16)(B). The Plan Sponsor is University Medical Center of El Paso.
5. **"Security Incidents"** has the meaning set forth in 45 C.F.R. § 164.304, as amended from time to time, and generally means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operations in an information system.

12.2 PLAN SPONSOR OBLIGATIONS

Where Electronic Protected Health Information will be created, received, maintained, or transmitted to or by the Plan Sponsor on behalf of the Plan, the Plan Sponsor shall reasonably safeguard the Electronic Protected Health Information as follows:

1. Plan Sponsor shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information that Plan Sponsor creates, receives, maintains, or transmits on behalf of the Plan;
2. Plan Sponsor shall ensure that the adequate separation that is required by 45 C.F.R. § 164.504(f)(2)(iii) of the HIPAA Privacy Rule is supported by reasonable and appropriate security measures;
3. Plan Sponsor shall ensure that any agent, including a subcontractor, to whom it provides Electronic Protected Health Information agrees to implement reasonable and appropriate security measures to protect such Information; and

4. Plan Sponsor shall report to the Plan any Security Incidents of which it becomes aware as described below:
 - (a) Plan Sponsor shall report to the Plan within a reasonable time after Plan Sponsor becomes aware, any Security Incident that results in unauthorized access, use, disclosure, modification, or destruction of the Plan's Electronic Protected Health
 - (b) Plan Sponsor shall report to the Plan any other Security Incident on an aggregate basis every year, or more frequently upon the Plan's request. NOTE: The Plan Sponsor shall have a reasonable period of time after learning of a security incident to report any successful attempt to the Plan, but can aggregate the data relating to unsuccessful attempts and report that information to the Plan on a less frequent basis.

ARTICLE XIII GENERAL INFORMATION

TYPE OF PLAN:

This benefit plan is partially self funded with medical stop loss coverage and provides Covered Participants with reimbursement for certain hospital, surgical, and professional medical expenses and prescription drugs.

PLAN NAME:

University Medical Center of El Paso and its Affiliates Associates Benefit Fund

EMPLOYER TAX IDENTIFICATION NUMBER:

74-6000756

EFFECTIVE DATE:

The restated Effective Date of the Plan as set forth in this Plan Document is October 1, 2009.

END OF PLAN YEAR:

September 30

PLAN SPONSOR:

University Medical Center of El Paso

PLAN ADMINISTRATOR/AGENT FOR SERVICE OF LEGAL PROCESS:

University Medical Center of El Paso
Attn: Legal Department
4815 Alameda Avenue
El Paso, Texas 79905

BENEFIT MANAGEMENT ADVISORS:

University Medical Center of El Paso
Attn: Human Resources Director
4815 Alameda
El Paso, Texas 79905

PRIVACY OFFICERS:

University Medical Center of El Paso
Attn: Compliance Department
4815 Alameda
El Paso, Texas 79905

THIRD PARTY ADMINISTRATOR:

El Paso First Health Plans, Inc. D/B/A Preferred Administrators
P.O. Box 971100
El Paso, Texas 79997-1100
(915) 532-3778 or (877) 532-3778 (Outside Area)
Fax: (915) 532-2877

Preferred Administrators provides claims administration for the Plan only and is not an insurer.

FUNDING THE PLAN AND PAYMENT OF BENEFITS:

The Plan is funded through contributions by the Employer and/or the Plan's Participants.

**ARTICLE XIV
ADOPTION OF THE PLAN**

IN WITNESS WHEREOF, University Medical Center of El Paso
has executed this Plan document this 1st day of October, 2009.

University Medical Center of El Paso

By: James N. Valenti
Title: JAMES N. VALENTI
President & CEO