IMPORTANT NOTICE TO UNIVERSITY MEDICAL CENTER OF EL PASO (UMC) MEMBERS

This member handbook explains many features of the UMC PPO handbook. It describes your benefits in general terms and is not intended to give all the details of every benefit, limitation or exclusion. The information contained in this handbook is accurate at the time of printing.

The Member Handbook is the official legal publication that defines eligibility, enrollment, benefits and the administrative rules. A copy is available for your review at www.preferredadmin.net

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

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

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


- New office co-pays for Texas Tech $30.00, PPO $40.00, and Out-of-Network 50% after deductible.
- New behavioral office co-pay for Texas Tech $35.00.
- New inpatient co-pays for PPO $1,000 and Out-of-Network $2,500.
- New deductibles per covered participant. UMC/El Paso Children’s Hospital (EPCH)/Texas Tech $125, PPO $1,250, and Out-of-Network $3,000.
- New family deductibles for a UMC/EPCH/Texas Tech $375, PPO $3,750, and Out-of-Network $9,000.
- New co-insurance. PPO 70/30 and Out-of-Network 50/50.
- Medical Maximum Out-of-Pocket per covered participant $6,000/$12,000 per family.
- Pharmacy Maximum Out-of-Pocket per covered participant $6,000/$12,000 per family.
- The pharmacy Out-of-Pocket is determined separately from the medical Maximum Out-of-Pocket.
- Maximum Out-of-Pocket now includes co-pays, deductibles, and co-insurance.
- Maximum 30 visits to be combined with professional visits for physical therapy, occupational therapy, and speech therapy.
- Maximum of 10 Chiropractic visits per Fiscal Year.

Our Wrap Network (MultiPlan)

MultiPlan is the Provider network available for members residing out of El Paso. The best way to verify if a Provider participates with MultiPlan is by calling the number on the back of your ID card. A facility-based physician or facility-based health care practitioner, such as an anesthesiologist or radiologist, may not be included in the network. Non-participating facility-based physicians and non-participating facility-based health practitioners may balance bill the enrollee for amounts not paid by the enrollee’s benefit plan. For more information, please refer to the 1-800 number located on your ID card. While MultiPlan proactively works to verify their data, they rely on Providers to update them on whether they are accepting new patients. If you learn that any data in these results is inaccurate, please call the number on the back of your ID card for Provider referrals.

How to find a Provider with Privileges at UMC

The Provider Directory now includes a listing of Providers that have privileges at UMC. These Providers are credentialed to render professional services at University Medical Center of El Paso (UMC). However, this list is subject to change. Please verify if the Provider still has UMC Privileges by logging on to http://www.umcelpaso.org/ and select the Find a Doctor option on the left side menu where you can locate a Medical/Professional Staff Member by name or specialty and by city or zipcode.

FSA

WHAT IS FSA?

A Flexible Spending Account:

- Covers out-of-pocket anticipated medical costs:
  - Office co-pays, prescriptions co-pays, eligible over-the-counter medication or equipment, eye glasses, contacts, etc.
- May elect for dependent care
- The dollars put into an FSA are pre-tax dollars
Coverage Type:

• Medical Reimbursement Account ($2,500)
• Dependent Care Reimbursement Account
  ($5,000 or up to $2,500 if married filing separately)
• FSA Debit Mastercard:
  — The FSA Debit MasterCard is a special purpose financial debit card linked to your
    Health Care Flexible Spending Account (FSA). Note, this card cannot be used for your
    Dependent Child/Adult Day Care.
  — Use your FSA Debit MasterCard to quickly and conveniently draw funds from your
    FSA to pay for eligible expenses such as: pharmacy prescription co-payments, doctor
    office visit co-payments and eligible over-the-counter health care items.

WHAT IS THE MAXIMUM AMOUNT TO USE FOR FSA?
Since October 1, 2013, the maximum amount is $2,500.

HOW AND WHERE CAN I USE MY FSA CARD?
If you already have a card, for the new benefit year, the amount you select will be deposited on the
same card, you will not receive another card.

YOU CAN TRACK YOUR FSA BALANCE ON-LINE.
To create an account please log on to www.preferredadmin.net. To reset your FSA password,
please contact:

  Veronica Maldonado: 915-298-7198 extension 1073
  Alice Rodriguez: 915-298-7198 extension 1051

Available Monday to Friday from 8 am to 5 pm (except for holidays).
IMPORTANT CONTACT INFORMATION

Please call member service for information about specific questions regarding your benefits or health care claims. Our representatives are familiar with your specific coverage and are available to answer your questions. When contacting our TPA Member Service Department, you will be asked to verify your identity and give information from our identification card.

Benefits Administrator
University Medical Center of El Paso
4815 Alameda Avenue
El Paso, TX 79905
Phone: 915-521-7950

The TPA Claims Administrator (Third Party Claims Administrator)
Preferred Administrators
P.O. Box 971100
El Paso, TX 79997
Phone: 915-532-3778 or 877-532-3778
Fax: 915-532-2877

Mailing Address for Claims:
P.O. Box 971370
El Paso, TX 79997
Electronic Claims: EPF10

Preferred Administrators Customer Service
1145 Westmoreland Drive
El Paso, TX 799925
7 a.m.–5:00 p.m. (MT) M-F
Phone: 915-532-3778

Preferred Administrators Complaints and Appeals Unit
1145 Westmoreland Drive
El Paso, TX 799925
Phone: 915-532-3378
Fax: 915-298-7872

WEBSITE

Members can access benefit and provider information at www.preferredadmin.net. To view your information in a secure environment using member self-service with a user ID and password. With your password you can:

• Verify benefits
• Check medical claim status (excludes prescription drug claims)
• Look up prior authorization status
• Claims History
• Provider Lookup
• Order replacement of ID Cards
MEMBER RIGHTS AND RESPONSIBILITIES

As a Preferred Administrator member, you have certain rights and responsibilities, as outlined below.

YOU HAVE THE RIGHT TO:

- Receive medical treatment that is available when you need it and is handled in a way that respects your privacy and dignity.
- Get the information you need about your health care plan, including information about services that are covered, and services that are not covered.
- Have access to a current list of providers in the Preferred Administrators Network and have access to information about a particular provider’s education, training and practice.
- Have your medical information kept confidential by Preferred Administrators, Members, and your health care provider.
- Learn about any care you receive. You should be asked for your consent for all care, unless there is an emergency and your life and health are in serious danger.
- Be heard. Our complaint-handling process is designed to hear and act on your complaint or concern about Preferred Administrators and/or the quality of care you receive.
- Preferred Administrators understands your concerns. We have a 24/7 Customer Support Hotline 915-504-5764 that you can call on any services related issues including scheduling of appointments, concerns, and complaints.

YOU HAVE THE RESPONSIBILITY TO:

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

Preferred Provider Organizations (PPO) and Preferred Providers

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

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

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

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

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

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

Wrap Network Criteria for Out-of-Area

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

(1) The Member resides outside El Paso County and the provider is located in the City or County where the member resides or attends school, or

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

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

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

— Prior authorization must be obtained. Failure to obtain an authorization will result in a loss of coverage for the service or procedure.

— You will be required to meet a higher deductible and co-insurance.

— You may be required to pay the difference between the amounts the health care provider charges and the sum the PPO plan claims to be “reasonable charge” for the given medical service.
SCHEDULE OF BENEFITS
FOR WRAP NETWORK PROVIDERS

1. **Wrap Network Providers for Covered Members**, residing outside of the State/Area to include:
   - Benefits for medical services provided for members residing outside of El Paso County will be based on the “PPO Network” Schedule of Benefits, when the Member receives services from a contracted provider within our Wrap Network (Multiplan/Private Healthcare System (PHCS)).
   - Members will be responsible to update their Out of State/Out of area address with Preferred Administrators and verify if the provider is a contracted provider with (Multiplan/PHCS) at 1-800-922-4362 and or you can verify on line at Multiplan.com. This will determine how the associate’s benefits will be applied.
   
   Prior-Auth will be requested for services listed on page 3. Prior Authorization is not a guarantee of payment. All benefit determinations are subject to eligibility enrollment, and the terms of coverage defined in this Plan.

2. **Wrap Network Providers for Out-of-Area.** Members traveling or on vacation, requiring an emergency medical care.
   - PPO Benefits will be applied when using Out-of-Area Provider when the treatment is for a sudden acute medical illness or injury that presents an urgent or emergency situation. If the provider is a contracted provider, the Benefit Percentage will be applied to the contracted allowable amounts for the contracted allowable amounts. If the provider is not a contracted provider with our Wrap Network, the PPO Benefit will be applied but additional charges (Balance Billing) may be incurred when receiving services from a Non Contracted Provider.
   - PPO Benefits will be applied when using Out-of-Area Provider when the treatment is for an emergency room physician who staffs an emergency room for Out-of-Area/Non Contracted Providers. If the provider is not a contracted provider with our Wrap Network, the PPO Benefit will be applied but additional charges (Balance Billing) may be incurred when receiving services from a Non Contracted Provider.
   
   All Emergency Admissions must be authorized within 24 hours of admission. Prior Authorization is not a guarantee of payment. All benefit determinations are subject to eligibility enrollment, and the terms of coverage defined in this Plan.

3. **Wrap Network Providers** for medical services not being provided/performed by a provider in El Paso County and confirmed by the Medical Utilization Review Program
   - When services are not available within El Paso County but the services are available with one of our Wrap Network Providers (Multiplan/PHCS), the benefits will be applied at PPO Benefits. **If the member electively chooses a provider that is not contracted with our Wrap Network, the benefit will be Out of Network Benefits at 50% when services are not offered in El Paso County and confirmed by our Medical Utilization Review Program.**
   - Prior authorization must be obtained for any services requiring a prior-authorization as stated on page 3. Failure to obtain prior authorization will result in a loss of coverage for the service or procedure. Prior Authorization is not a guarantee of payment. All benefit determinations are subject to eligibility, enrollment, and the terms of coverage defined in this Plan.

**FINDING PROVIDERS:**

1. For El Paso Area Network Providers: [www.preferredadmin.net](http://www.preferredadmin.net) or call **915-532-3778**
2. For providers outside (State/Area): [www.multiplan.com](http://www.multiplan.com) or call **1-800-678-7427** or to locate a PHCS provider, please contact **800-922-4362**
3. If you have any questions, you can reach our Customer Service Department at **915-532-3778** or 1-877-532-3778 if outside of the calling area. The Customer Service Department is available **Monday through Friday from 7 a.m. to 5 p.m., Mountain Time.**
UTILIZATION MANAGEMENT AND PRIOR AUTHORIZATION

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

PRIOR AUTHORIZATION:
The Plan requires that a Provider obtains a prior authorization for the following Covered Services or procedures:

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

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

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

Radiology/Diagnostic Imaging
• PET Scans
• Obstetrical Ultrasounds (Member is allowed four ultrasounds without obtaining pre-authorization)

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

Outpatient Procedures
• Ambulatory Surgical Center
• Endoscopy Center
• Cardiac Catheter Center
• Wound Clinic
• Outpatient Hospital
Pharmacy Medical

- Growth Hormones
- Synagis
- Oral Injectable or IV Drug Administration over $500
  
  **NOTE:** This includes oral, injectable, or IV provided in a Physician’s office
- Specialty Medicines
  
  **NOTE:** Please go to www.preferredadmin.net for complete list of specialty medicines

Durable Medical Equipment (DME) ($500 and over)

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

Other Services

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

<table>
<thead>
<tr>
<th>Medical Plan Benefits</th>
<th>UMC, EPCH</th>
<th>Texas Tech</th>
<th>Preferred Provider Organization/PPO Wrap Network</th>
<th>Non-Contracted Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Benefit Plan Limits per Fiscal Year October 1, 2014 – September 30, 2015</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Deductible Per Fiscal Year</strong></td>
<td>Individual $125.00&lt;br&gt;Maximum Family $375.00</td>
<td>Individual $1,250&lt;br&gt;Maximum Family $3,750</td>
<td>Individual $3,000&lt;br&gt;Maximum Family $9,000</td>
<td></td>
</tr>
<tr>
<td><strong>MEDICAL OUT-OF-POCKET MAXIMUM PER FISCAL YEAR</strong></td>
<td>All members cost share from UMC, EPCH, or Texas Tech, the Plan will pay 100% of covered expenses incurred for the current Fiscal Year.</td>
<td>Unlimited</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per Covered Participant</td>
<td>$6,000</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family Out-of-Pocket</td>
<td>$12,000</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The Out-of-Pocket maximum includes any applicable deductibles, co-insurance, and co-pays from any in-network provider. The annual Out-of-Pocket maximum applies to all in-network services. Once the Out-of-Pocket maximum has been reached, the Plan will pay 100% of eligible in-network expenses for the remainder of the Fiscal Year. The Out-of-Pocket maximum does not include non-compliance penalties and amounts in excess of allowable amounts or any non-covered expenses.

| **ANNUAL LIMIT**<br>(Per Covered Participant) | | | |
| **Co-Insurance** | No Annual Limit | No Annual Limit |
| | N/A | 70% after deductible | 50% after deductible |

**Covered Services**—All Covered Services are subject to deductible (Fiscal Year) unless specified otherwise in this Schedule of Benefits.

<table>
<thead>
<tr>
<th>Covered Services</th>
<th>UMC, EPCH</th>
<th>Texas Tech</th>
<th>Preferred Provider Organization/PPO Wrap Network</th>
<th>Non-Contracted Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergy Testing, Treatment and Serum</td>
<td>100% after deductible</td>
<td>100% after deductible</td>
<td>70% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Ambulance (patient must be transported)</td>
<td>N/A</td>
<td>70%</td>
<td>70%</td>
<td></td>
</tr>
<tr>
<td>Ambulatory Surgical Facility Services</td>
<td>$100 co-pay and covered at 100% after deductible</td>
<td>N/A</td>
<td>$300 co-pay and covered 70% after deductible</td>
<td>$1000 co-pay and covered 50% after deductible</td>
</tr>
<tr>
<td>Chemotherapy Hematology/Oncology</td>
<td>100% after deductible</td>
<td>100% after deductible</td>
<td>70% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Chiropractic Services and Manipulation (Max 10 visits per Fiscal Year)</td>
<td>N/A</td>
<td>70% after deductible</td>
<td>50% after deductible</td>
<td></td>
</tr>
<tr>
<td>Cosmetic Services Only (Medically Necessary Reconstructive Surgery)</td>
<td>N/A</td>
<td>70% after deductible</td>
<td>50% after deductible</td>
<td></td>
</tr>
<tr>
<td>Diabetic Education</td>
<td>100%</td>
<td></td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Diagnostic X-Ray, Pathology and Lab Services</td>
<td>100% after deductible</td>
<td>100% after deductible</td>
<td>70% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>N/A</td>
<td>70% after deductible</td>
<td>50% after deductible</td>
<td></td>
</tr>
</tbody>
</table>
## Emergency Care Benefits

<table>
<thead>
<tr>
<th>Facility</th>
<th>Professional</th>
<th>Facility</th>
<th>Professional</th>
<th>Facility</th>
<th>Professional</th>
</tr>
</thead>
<tbody>
<tr>
<td>100% of Contracted Amount after co-pay of $50</td>
<td>100% of Contracted Amount</td>
<td>100% of Contracted Amount after co-pay of $50</td>
<td>100% of Usual and Customary Charges</td>
<td>100% of Usual and Customary Charges after co-pay of $50</td>
<td>100% of Usual and Customary Charges</td>
</tr>
</tbody>
</table>

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

| Home Health Care (Max Benefit 120 visits per Fiscal year to include Skilled Nursing of 60 visits) | 70% after deductible | 50% after deductible |
| Hospice Care Outpatient | N/A | 70% after deductible | 50% after deductible |
| Hospice Inpatient | N/A | $1,000 co-pay after deductible | $2,500 co-pay after deductible |
| Nutritional Counseling | 100% | N/A | N/A |

**Occupational Therapy (OT) (Max 30 visits per Fiscal Year. All combined with OT, PT, and ST to include professional and facility outpatient services.)**

| 100% after deductible | 70% after deductible | 50% after deductible |

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

| Organ Transplant services are provided through the transplant network or contracted transplant facility approved by the Plan Administrator and stop loss carrier. |
| Orthotics | N/A | 70% after deductible | 50% after deductible |
| Physician Office Visits—To include first evaluations of OT, PT, and ST | $15 co-pay | $30 co-pay | $40 co-pay |

**Physical Therapy (PT) (Max 30 visits per Fiscal Year. All combined with OT, PT, and ST to include professional and facility outpatient services.)**

| 100% after deductible | 70% after deductible | 50% after deductible |

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

Global Maternity for all covered females. The initial office visits to confirm pregnancy is covered under an office visit (non-routine) benefit. All remaining pre- and post-natal office visits billed as part of delivery expenses.

Wellness Benefits

<table>
<thead>
<tr>
<th>Benefit Description</th>
<th>Coverage</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine Annual GYN Exam to include Pap Smear (One per Fiscal Year)</td>
<td>100%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Routine Mammograms (for women 40 yrs and older)</td>
<td>100%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Routine Sigmoidoscopy &amp; Colonoscopy (50 yrs and older)</td>
<td>100%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Routine Well-Child Care</td>
<td>100%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Routine Immunizations for children and adult (All Immunizations required by the Centers of Disease Control and Prevention (CDC) are covered.)</td>
<td>100%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Routine Well-Child Care and Routine Adult Physical Exams</td>
<td>100%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>The frequency of visits for children from 0-1 year are according to American Academy of Pediatrics as follows: 3-5 days, 1 month, 2 months, 4 months, 6 months and 9 months. The frequency of visits for children 1-17 years is once per Fiscal Year.</td>
<td>100%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Routine Vision Exams (Children five years and under are covered at 100% and all children five years and older are covered as medical and applicable deductibles or co-insurance will apply.)</td>
<td>100%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Routine Hearing Exams (Children five years and under are covered at 100% and all children five years and older are covered as medical and applicable deductibles or co-insurance will apply.)</td>
<td>100%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Prostate Screening Antigen Testing</td>
<td>100%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>All Covered Preventive Screenings under the United States Preventive Services Task Force (USPSTF) A &amp; B Recommendations and Women’s Preventive Care are covered at 100% with an in-network provider.</td>
<td>100%</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

Hospital Services (Facility)

<table>
<thead>
<tr>
<th>Service Description</th>
<th>UMC, EPCH</th>
<th>Texas Tech</th>
<th>Preferred Provider Organization/PPO Wrap Network</th>
<th>Non-Contracted Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Hospice Care</td>
<td>N/A</td>
<td>$1,000 co-pay 70% after deductible</td>
<td>$2,500 co-pay 50% after deductible</td>
<td></td>
</tr>
<tr>
<td>Inpatient Hospital</td>
<td>$250 co-pay and 100% coverage once deductible is met</td>
<td>N/A</td>
<td>$1,000 co-pay and 70% coverage once deductible is met</td>
<td>$2,500 co-pay and 50% coverage once deductible is met</td>
</tr>
<tr>
<td>Observation Less than 24 hours in the hospital</td>
<td>$50 co-pay and 100% coverage</td>
<td>N/A</td>
<td>$50 co-pay and 100% coverage</td>
<td>$50 co-pay and 100% coverage of usual and customary</td>
</tr>
<tr>
<td>Outpatient Surgery</td>
<td>$100 co-pay and 100% coverage once deductible is met</td>
<td>N/A</td>
<td>$300 co-pay and 70% coverage once deductible is met</td>
<td>$1,000 co-pay and 50% coverage once deductible is met</td>
</tr>
<tr>
<td>Rehabilitation (Max 30 visits per Fiscal Year. All combined with OT, PT, and ST to include professional and facility outpatient services).</td>
<td>100% once deductible is met</td>
<td>70% coverage once deductible is met</td>
<td>50% after deductible</td>
<td></td>
</tr>
</tbody>
</table>
Speech Therapy (ST)  
(Max 30 visits per Fiscal Year. All combined with OT, PT, and ST to include professional and facility outpatient services.)  

<table>
<thead>
<tr>
<th>Medical Plan Benefits</th>
<th>UMC, EPCH</th>
<th>Texas Tech</th>
<th>Preferred Provider Organization/PPO Wrap Network</th>
<th>Non-Contracted Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Speech Therapy (ST)</td>
<td>100% after deductible</td>
<td>70% after deductible</td>
<td>50% after deductible</td>
<td></td>
</tr>
</tbody>
</table>

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

### Mental Health/Substance Abuse (30 visits per Fiscal Year) are combined with Inpatient/Outpatient Treatment

<table>
<thead>
<tr>
<th>Service</th>
<th>Outpatient Office Visit</th>
<th>Inpatient Hospital</th>
<th>Inpatient Substance Abuse</th>
<th>Intensive Outpatient Visit</th>
<th>Partial Hospitalization/ Psychiatric Day Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N/A</td>
<td>$35 co-pay</td>
<td>$1,000 co-pay 70% after deductible</td>
<td>$40 co-pay</td>
<td>$40 co-pay 70% after deductible</td>
</tr>
<tr>
<td></td>
<td>$35 co-pay</td>
<td>$40 co-pay</td>
<td>$2,500 co-pay 50% after deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$40 co-pay</td>
<td>$50 co-pay</td>
<td>$2,500 co-pay 50% after deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$40 co-pay</td>
<td>$50 co-pay</td>
<td>$2,500 co-pay 50% after deductible</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The Employee Assistance Program (EAP) offers 8 free counseling sessions for therapy and counseling by providers within the EAP Program. If you require more than 8 professional services a Prior Authorization will be required. You can call the EAP program at 915-351-4680 to make your appointment.

### Urgent Care

<table>
<thead>
<tr>
<th>Service</th>
<th>N/A</th>
<th>N/A</th>
<th>$40 co-pay</th>
<th>50% after deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent Care Services—after hours and weekend medical services for non-emergency illnesses and minor injuries.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Covered Expenses During an Urgent Office Visit (For example Labs, X-Ray, Injections, etc.)</td>
<td>N/A</td>
<td>N/A</td>
<td>$70 co-pay 50% after deductible</td>
<td></td>
</tr>
</tbody>
</table>

### Schedule of Pharmacy Benefits

<table>
<thead>
<tr>
<th>Pharmacy Benefit</th>
<th>UMC Pharmacies</th>
<th>Retail Participating Pharmacy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic</td>
<td>$5 co-payment</td>
<td>$25 co-payment</td>
</tr>
<tr>
<td>Preferred Brand Name</td>
<td>$25 co-payment</td>
<td>$45 co-payment</td>
</tr>
<tr>
<td>Non-Preferred Brand Name Drug</td>
<td>$50 co-payment</td>
<td>$70 co-payment</td>
</tr>
<tr>
<td>Preferred Brand or Non Preferred Drug Purchased When Generic Available</td>
<td>Covered Person pays the difference between the Brand and Generic price plus the co-payment</td>
<td>Covered Person pays the difference between the Brand and Generic price plus the co-payment</td>
</tr>
<tr>
<td>Specialty Drug Medications Mail Order available for Specialty Drug Medications only.</td>
<td>$50 co-payment and will be dispensed at 30 day supply. Please go to <a href="http://www.preferred">www.preferred</a> admin.net for a complete list of specialty medications.</td>
<td>N/A</td>
</tr>
<tr>
<td>Prescriptions over $500 Authorization Required</td>
<td>Co-pay applies</td>
<td>50% after prescription drug deductible</td>
</tr>
</tbody>
</table>
### SCHEDULE OF PHARMACY BENEFITS – continued

<table>
<thead>
<tr>
<th>PHARMACY Benefit Description</th>
<th>UMC Pharmacies</th>
<th>In-Network Pharmacies</th>
<th>Non-Contracted Pharmacies</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHARMACY OUT-OF-POCKET MAXIMUM PER FISCAL YEAR</td>
<td>All members cost share from UMC Pharmacies and all in-network pharmacies will be applied towards the Pharmacy Out-of-Pocket maximum.</td>
<td></td>
<td>Unlimited</td>
</tr>
</tbody>
</table>

Per Covered Participant $6,000
Family Out-of-Pocket $12,000

The Pharmacy Out-of-Pocket maximum includes any applicable co-pays and deductibles from any in-network Pharmacy provider. The Out-of-Pocket maximum applies to all in-network Pharmacy providers. Once the Out-of-Pocket maximum has been reached, the Plan will pay 100% of eligible in-network expenses for the remainder of the current Fiscal Year. The Out-of-Pocket maximum does not include non-compliance penalties and amounts in excess of allowable amounts or any non-covered expenses.

The level of benefits are available for prescription drugs and your choice determines the co-payment you pay each time you have drugs dispensed by a participating network pharmacy.

- Generic drugs are in the first tier and offer the best value. When your doctor writes your prescription, ask about using a generic drug. Generics are safe, effective, and affordable alternatives to brand name drugs, and are available in many instances.
- Preferred brands are in the second tier. If a generic alternative is not available, talk to your doctor about prescribing a brand-name drug from the preferred drug list.
- Non-preferred brands are in the third tier and will cost you the highest co-payment.

Pharmacy benefits are administered by Optum Rx. Please call 1-800-788-7871 for further information or visit [https://www.optumrx.com/RxSolWeb/mvc/home.do](https://www.optumrx.com/RxSolWeb/mvc/home.do) — once there, register to view the Prescription Drug List.

### TIPS TO MAKE YOUR PLAN WORK FOR YOU

- **Stay In-Network**: Please make sure you contact Preferred Administrators to confirm that your Provider is in network (local or wrap) to lower out-of-pocket costs for you.
- **Use the Emergency Room for Emergencies Only**: You can save out-of-pocket expenses by scheduling a visit to your Primary doctor for colds, minor sprains and non-threatening conditions.
- **Use Generic Drugs**: They are more affordable and offer the lowest co-pay. These medications are pharmaceutically and therapeutically equivalent to brand-name drugs.
- **Adopt Healthy Habits**: Try to eat right, exercise and get regular health screenings. Take advantage of your EAP benefits and discounts.
- **Get Online**: Preferred Administrators has a member portal at [www.preferredadmin.net](http://www.preferredadmin.net) where you can obtain our Provider Directory, Summary of Benefits and Coverage, important updates, links to the Pharmacy formulary and to the Wrap Network.
COVERED MEDICAL BENEFITS

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.

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.

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

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

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

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

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

5) **Approved Clinical Trial.** An “approved clinical trial” is defined as a Phase I, II, III or IV clinical trial for the prevention, detection or treatment of cancer or other life-threatening condition or disease including federally funded trials, trials conducted under an investigational new drug application reviewed by the FDA or drug trials exempt from having an investigational new drug application. A life-threatening condition is any disease or condition from which the likelihood of death is probable unless the course of the disease is interrupted. The following must be met:
   - The clinical trial must be Pre-Authorized.
   - The trial for which routine patient costs must be covered but must be approved or sponsored by number of federal agencies, including the National Institutes of Health, the Centers of Medicare and Medicaid Services and the Food and Drug Administration, This is not an inclusive list.
   - The members may qualify for clinical trials if they meet the protocols of the trial and a participating provider deems them eligible and refers them to the trial as appropriate for the purposes of the trial, consistent with the member's benefit plan documents. Members also can provide medical and scientific information to establish that their participation in the trial is appropriate.
   - All medical necessary health care provided to the individual for purposes of the trial, consistent with this plan medical coverage (patient costs), Such services include those rendered by a physician, diagnostic, or laboratory tests, and other services provided during the course of treatment for a condition or one of its complications that are consistent with the usual and customary standard of care. Applicable co-pays, deductibles, co-insurance, and maximum out of pockets will apply as stated the benefit's coverage.

Preferred Administrators

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• Routine patient costs do not include the actual device, equipment or drug that is being studies as part of the clinical trial. Also excluded are: items or services not used in the direct clinical management of the patient, such as those solely to satisfy data collection and analysis needs, or items and services clearly inconsistent with accepted standards of care for the particular diagnosis.

6) **Birth Control (Family Planning/Contraceptive Counseling).** Charges for:
   - Office visit for contraceptive purposes.
   - Depo-Provera injections dispensed and/or administered at a Physician’s office if Medically Necessary or for contraceptive purposes.
   - Lunelle injections dispensed and/or administered at a Physician’s office for contraceptive purposes.
   - Services and supplies related to insertion and removal of Norplant and other birth control devices are covered the same as any other illness.
   - Depo-Provera and Lunelle injections dispensed by a pharmacist, are covered under the Schedule of Benefits (Prescription Drug Benefits).

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

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

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

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

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

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

11) **Colorectal Cancer Screening (CRC).** Persons at risk for CRC (family history of CRC, previous 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.

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

13) **Cosmetic Procedures/Reconstructive Surgery.** “Cosmetic Surgery” shall mean any surgery, service, drug or supply designed to improve the appearance of an individual by changing, improving and/or alteration of a physical characteristic. Reconstructive surgery is performed incidental to an injury, sickness, or congenital anomaly when the primary purpose is to improve functioning of the involved part of the body. The fact that physical appearance may change or improve as a result of reconstructive surgery does not classify such surgery as cosmetic when a functional impairment exists, and the surgery restores or improves function. For reconstructive surgery to be considered medically necessary there must be a reasonable expectation that the procedure will improve the functional impairment.
14) **Diabetic Education.** Participation in the University Medical Center of El Paso Diabetic Management Program will be provided at 100% or with a PPO Provider.

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

16) **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.

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

18) **Global Maternity.** Maternity Care for all confirmed pregnancies effective October 1, 2012 consists of antepartum care, delivery and postpartum care, including the following:
   - Hospital admission
   - Patient history
   - Labor management
   - Postpartum office visit, vaginal or cesarean section delivery
   - Vaginal or cesarean section delivery, after previous cesarean delivery
   - Hospital discharge
   - And all applicable postoperative care.

Services that are not included in the global basis include:
   - Antepartum consultation paid to the same provider, for dates of service either within the from-through period of the global billing within 270 days prior to the global OB delivery date
   - Hospital visits that are related to the OB delivery
   - Postpartum consultations that are related to the delivery paid to the same provider within the 45 day follow-up period of the global OB delivery date
   - Laboratories
   - Ultrasounds (a prior authorization is required after the 4th ultrasound with the exception of confirmed High Risk Pregnancies after the Provider’s submission of Prior-Auth Form High Risk Pregnancy)

Global claims are subject to the 1 year timely filing, based on the delivery date. Ultrasounds are not part of global billing.

19) **Hearing Exam Covered Expenses for Children and Adults** include charges for an audiometric hearing exam if the exam is performed by:
   - The Primary Care Provider who can also refer for more specialized care to a certified physician in the following categories:
   - A physician certified as an otolaryngologist or otologist; or
   - An audiologist who:
     - Is legally qualified in audiology; or
     - Holds a certificate of Clinical Competence in Audiology from the American Speech and Hearing Association in the absence of any applicable licensing requirements; and
   - Performs the exam at the written direction of a legally qualified otolaryngologist or otologist.
Routine hearing exams are covered at 100% for children five years and under. For children five years and older, the hearing exams are covered as medical and applicable co-pay, deductible, or co-insurance percentage shown in your Schedule of Benefits.

20) **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 home-bound 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:
- Registered Nurses or Licensed Practical Nurses;
- Certified home health aides under the direct supervision of a Registered Nurse;
- Registered therapist performing physical, occupational or Speech Therapy;
- Physician calls in the office, home, clinic or Outpatient department;
- Services, drugs and medical supplies which are Medically Necessary for the treatment of the Plan Participant that would have been provided in the Hospital, but not including Custodial Care; and
- Rental of Durable Medical Equipment or the purchase of this equipment if economically justified, whichever is less.

21) **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.

22) **Hospital Care (Inpatient).** The following services and supplies while an inpatient is at a Hospital:
- daily room charge in a Hospital, but not to exceed the daily rate equal to the average Hospital semi-private room charge (charges when a Hospital private room accommodation has been used will be reimbursed at the average semi-private room rate in the facility);
- charges for confinement in an intensive care unit;
- meals, special diets, nursing care;
- maternity and routine nursing care while mother is Hospital confined. A Hospital length of stay for the mother or newborn Dependent Child will be at least 48 hours following a vaginal delivery, or 96 hours following a cesarean section. The 48-hour period [or 96-hour period if applicable] begins at the time a delivery occurs in the Hospital [or in the case of multiple births, at the time of the last delivery] or, if the delivery occurs outside the Hospital, at the time a mother and/or newborn are admitted. The mother's or newborn's attending provider, after consulting with the mother, may discharge the mother or her newborn earlier than 48 hours [or 96 hours, if applicable] after delivery;
- operating, delivery, recovery and other treatment rooms;
- prescribed drugs and medications;
- dressings and casts;
- use of Hospital equipment, laboratory and radiology services;
- treatment by a Physician or surgeon.
23) **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.

24) **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*.

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

26) **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.

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

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

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

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

29) **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.

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

31) **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.
32) **Nutritional Counseling.** Expenses related to Nutritional Counseling which are Medically Necessary according to evaluation by a Registered Dietician when provided at University Medical Center of El Paso, Texas Tech Physicians or PPO Providers, limited to twelve sessions per fiscal year.

33) **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. Visit limits specified in the *Summary of Benefits.*

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

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

- eligible organ transplant procedures which are medically necessary and appropriate for the condition being treated and which have been confirmed by medical management / utilization review and a complete second opinion by a board certified physician and an organ transplant review committee are:
  - heart transplants
  - heart and lung transplants
  - kidney transplants
  - liver transplants
  - bone marrow transplants/stem cell transplants

  — If the transplant procedure is a hematopoietic stem cell transplant, coverage will be provided for the cost of the acquisition of stem cells. This may be either peripherally or via bone marrow aspiration as clinically indicated, and is applicable to both the patient as the source (autologous) and related or unrelated donor as the source (allogeneic). Coverage will also be provided for search charges to identify an unrelated match, treatment and storage costs of the stem cells, up to the time of reinfusion. (The harvesting of the stem cells need not be performed within the transplant benefit period.) “Benefit Period” means the period that begins on the date of the initial evaluation and ends on member’s last day of termination date. (If the transplant is a bone marrow transplant, the date the marrow is reinfused is considered the date of the transplant.)

- tissue transplant procedures, joint replacements and other specified procedures which are medically necessary and appropriate for the condition being treated and which have been confirmed by medical management / utilization review and a complete second opinion by board certified physicians are:
  - cornea transplant
  - artery or vein transplants
  - joint replacements
  - heart valve replacements
  - implantable prosthetic lenses in connection with cataracts
  - prosthetic bypass or replacement vessels
  - Additional consideration for organ transplant include:

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

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

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

INTERLINK Exclusive Provider Organization (EPO) Network Benefits

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

Emergency Transplant Care at NON-INTERLINK Transplant COE Providers

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

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

3) A detailed contract proposal for the Emergency Transplant.

**Medical Hardships Proposed Transplant Care: NON-EPO Transplant Exceptions**

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

1) A letter from the Surgical Director to the plan detailing the medical conditions supporting the Medical Hardship;

2) A completed Medical Hardship Form: Key Outcome Indicators Worksheet;

3) A completed Medical Hardship Form: Transplant Billing Report Table for the prior three years of transplant billing history; and


**COVERAGE FOR ORGAN AND/OR TISSUE TRANSPLANTS**

**Pre-Authorization Requirement for Organ Transplant**

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

No benefits are provided for organ transplant procedures unless the facility and network contract is approved by Preferred Administrators.

As soon as reasonably possible, but in no event more than ten (10) days after a Covered Person’s attending physician has indicated that the Covered Person is a potential candidate for a transplant, the Covered Person or Covered Person’s physician should contact the Plan Administrator for referral to the network’s medical review specialist for evaluation and pre-authorization. A comprehensive treatment plan must be developed for this plan’s medical review, and must include such information as diagnosis, the nature of the transplant, the setting of the procedure, (i.e., name and address of the hospital), any secondary medical complications, a five year prognosis, two (2) qualified opinions confirming the need for the procedure, as well as a description and the estimated cost of the proposed treatment. (One or both confirming second opinions may be waived by the plan’s medical review specialist.) Additional attending physician’s statements may also be required. A non-network hospital may provide a comprehensive treatment plan independent of the EPO, but this will be subject to a Medical Hardship review and may result in no benefit coverage for the transplant at that center. All potential transplant cases will be assessed for their appropriateness for Large Case Management.
Organ Transplant Network
As a result of the pre-authorization review, the Covered Person will be asked if they wish for assistance gathering information about participating transplant programs. The term “participating transplant program” means a licensed healthcare facility and transplant program that has met INTERLINK’s Quality Assurance Program standards for participation, and been declared a Transplant COE program by INTERLINK Health Services’ Quality Assurance Committee. The transplant network’s goal is to perform necessary transplants in the most appropriate setting for the procedure using some of the nation’s most experienced and qualified transplant teams.

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

35) 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.

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

37) Pervasive Developmental Disorders. A group of conditions originating in childhood in several areas, including physical, behavioral, cognitive, and social, and language developmental.

The following services are eligible for development disorders.

- Evaluation services;
- Speech therapy;
- Occupational therapy;
- Physical therapy;
- Applied behavior analysis and behavior training management are not covered under this plan.

38) 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. Visit limits specified in the Summary of Benefits.

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

39) 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.

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

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

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

44) **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.

45) **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.

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

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

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

- Injury or trauma
- Stroke
- 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 dysphagia following surgery;
- treatment of fluency (stuttering) disorders;
- voice disorders secondary to vocal abuse/misuse;
- dysphagia following surgery.
- Treatment of congenital anomaly which includes but are not limited to down syndrome, cleft palate, and tongue tie. Speech therapy for developmental disorders (including autism spectrum, and Asperger's are covered. For pervasive developmental disorder benefits, refer to page 18.

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

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

50) **Spinal Adjustments.** Skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body performed by a Physician or Chiropractor to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

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

52) **Substance Abuse.** Services provided for treatment of substance abuse conditions.
53) **Temporomandibular Joint Dysfunction (TMJ).** Only open-curing operations for treatment of TMJ surgical are covered. Open surgical procedures including, but not limited to meniscus or disc repositioning or TMJ surgery may also be considered medically necessary in cases where there is conclusive evidence that severe pain or functional disability is produced by an intra-capsular condition, confirmed by magnetic resonance imaging (MRI), computed tomography or other imaging, which has not responded to nonsurgical management, and surgery is considered to be the only remaining option. The following services are eligible for TMJ prior to surgery. This may be covered when all other treatment has failed.

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

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

54) **Treatment In Mouth or Oral Cavity.** Coverage is limited to:

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

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

56) **Wellness Benefit.** Preventive Benefits as specified in the Schedule of Benefits.
EXCLUDED SERVICES AND PROCEDURES

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.

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.

EXCLUSIONS

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

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

3) **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.

4) **Cosmetic Surgery/Procedures.** Charges for Cosmetic Surgery with the following exceptions:
   a) Treatment provided for the correction of defects incurred in an accidental injury sustained by the participant; or
   b) Treatment provided for reconstructive surgery following cancer surgery; or
   c) Surgery performed on a newborn child for the treatment or correction of a congenital defect; or
   d) Surgery performed on a covered dependent child (other than a newborn child) under the age of 19 for the treatment or correction of congenital defect other than conditions of the breast; or
   e) Reconstruction of the breast on which a mastectomy has been performed; surgery and reconstruction of the other breast to achieve a symmetrical appearance; and prosthesis and treatment of physical complications, including lymphedemas, at all stages of the mastectomy; or
   f) Reconstructive surgery performed on a covered dependent child under the age of 19 due to craniofacial abnormalities to improve the function of, or attempt to create a normal appearance of an abnormal structure caused by a congenital defect, developmental deformities, trauma, tumors, infections, or disease.
5) **Counseling.** Charges for marital counseling and other counseling services are not covered. Counseling charges are covered for Nutritional Counseling and for bereavement counseling under the Hospice Care provisions. (The Employee Assistance Program (EAP) offers 8 free counseling sessions for therapy and counseling to include marriage counseling by providers within the EAP Program. Associates can call the EAP program at 915-351-4680 to make an appointment).

6) **Dental Services.** Any treatment, services or supplies related to the care, filling, removal or replacement of teeth and the treatment of injuries and diseases of the teeth, gums, and other structures supporting the teeth. This includes but is not limited to:
   - services of dentists, oral surgeons, dental hygienists, and orthodontists including apicoectomy (dental root resection), root canal treatment, soft tissue impactions, removal of bony impacted teeth, treatment of periodontal disease, alveolectomy, augmentation and vestibuloplasty and fluoride and other substances to protect, clean or alter the appearance of teeth;
   - dental implants, false teeth, prosthetic restoration of dental implants, plates, dentures, braces, mouth guards, and other devices to protect, replace or reposition teeth; and
   - non-surgical treatments to alter bite or the alignment or operation of the jaw, including treatment of malocclusion or devices to alter bite or alignment;
   - removal of bony impacted wisdom teeth.
   - General anesthesia and monitored anesthesia are not covered under this plan for neither adult or children, unless meeting medical necessity of treatment in mouth or oral cavity or meeting Temporomandibular Joint Dysfunction (TMJ) Benefits. See page 21.
   - Orthodontic and Orthognathic Surgery are not covered under this medical plan.

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

8) **Educational Services.** Any charge for any services or supplies related to education, training services or testing, including:
   - Special education;
   - Remedial education, job training and job hardening programs;
   - Treatment of learning disabilities, minimal brain dysfunction, behavioral disorders, (including pervasive developmental disorders) training.
   - Educational testing and training related to behavioral (conduct) problems, learning disabilities and delays in developing skills.
   - Applied behavior analysis.
   - Behavior training and behavior management.

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

10) **Excess.** That are not payable under the Plan due to application of any Plan maximum or limit or because the charges are in excess of the Usual and Customary amount, or are for services not deemed to be Reasonable or Medically Necessary, based upon the Plan Administrator’s determination as set forth by and within the terms of this document.
11) **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).

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

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

14) **Foot Care.** Charges for surgical treatment of bunions, corns, calluses, and routine trimming of toenails.

15) **Hearing.** Charges for are not covered for:

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

16) **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.

17) **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.
18) **Injury Caused by Engaging in Illegal Act.** For injury caused by or contributed to by engaging in an illegal act or occupation, by committing or attempting to commit any crime, criminal act, or other criminal behavior. It is necessary for a person to be charged or convicted in order for this exclusion to apply.

19) **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).

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

21) **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.

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

23) **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.

24) **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.

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

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

26) **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.

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

28) **Other than Attending Physician.** Any charge for care, supplies, treatment, and/or services other than those certified by a Physician who is attending the Participant as being required for the treatment of Injury or Disease, and performed by an appropriate Provider.

29) **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.
30) **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.

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

The following provider services are not covered.

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

32) **Personal Comfort and Convenience Items.** Any service or supply primarily for your convenience and personal comfort or that of a third party, including: Telephone, television, internet, barber or beauty service or other guest services; housekeeping, cooking, cleaning, shopping, monitoring, security or other home services; and travel, transportation, or living expenses, rest cures, recreational or diversional therapy.

33) **Prescription Drugs.** This list is not inclusive of all covered/not covered drugs. For an inclusive list review the Prescription Solutions drug formulary at [www.preferredadmin.net](http://www.preferredadmin.net).

- Anabolic steroids
- Anorectics (any drug used for the purpose of weight loss)
- Anorexiants (except for Adderall, Dexedrine, and Dextrostat)
- Cosmetics
- Drugs or medicines dispensed more than one year after the date of the Prescription order
- Fertility medications
- Fluoride supplements
- Investigational or experimental drugs including compounded medications for non-FDA approved use
- Medical devices and other supplies (example Diabetes blood level monitor is covered under the Plan)
- No charge prescriptions available under Workers’ Compensation, or other city, state or federal governmental program
- Non-legend drugs other than insulin
- Retin A after age 26
- Rogaine
- Viagra and similar drugs
- Vitamins (prescription or otherwise) except for prescription pre-natal vitamins

34) **Prosthetic Devices.** Charges over $500.00 for a 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.

35) **Radioactive Materials.** For charges in connection with treatment for exposure to radioactive materials.
36) **Self Inflicted Injuries.** Charges for:
   - intentionally self-inflicted Injury, unless such Injury results from medical condition (physical or mental health condition) or domestic violence.
   - injury resulting from or sustained due to being engaged in an illegal occupation, commission of an assault or felonious act. This exclusion does not apply (a) if the injury resulted from being the victim of an act of domestic violence, or (b) resulted from a medical condition (including both physical and mental health conditions).

37) **Sexual Health and Family Planning.** Charges for:
   - Treatment of infertility with the confirmed diagnosis of infertility or purpose of treatment is for discovery of infertility, are not covered benefits if the services and fertilization attempts, including but not limited to: artificial insemination, Pergonal therapy for infertility, in-vitro fertilization, microsurgery for infertility treatment, and HCG injections
   - expenses related to adoption are not a covered benefit
   - 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

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

39) **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.

40) **TMJ (Temporomandibular Joint Dysfunction).** Charges for treatment, other than by an open-cutting operation, of temporomandibular joint dysfunction. Charges for orthodontic treatment or services are not covered. Orthognathic surgery is not covered under this plan.

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

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

43) **Vax-D Therapy.** Vax-D therapy is not covered. The VAX-D Therapeutic Table is designed to relieve pressure on structures that may be causing low back pain. It relieves the pain associated with herniated discs, degenerative disc disease, posterior facet syndrome and radicular pain. It achieves these effects through decompression of intervertebral discs, that is, unloading, due to distraction and positioning.
44) **Vision.** Vision-related services and supplies, except as described in the *What the Plan Covers* section. The plan does not cover:

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

45) **Vitamins.** Charges for nutritional supplements and prescription vitamins (except for pre-natal vitamins requiring a prescription under the Prescription Drug Program).
HOW THE PLAN WORKS

CHOICE OF DOCTORS
This plan does not require you to choose a Primary Care Physician nor is there a required referral process for specialist services. The network is made up physicians, hospitals, and other health care providers who have contracted with Preferred Administrators. In order to receive maximum benefits, you must use a network physician.

While you are not required to select a primary care provider, you are encouraged to seek routine care from the same primary provider whenever possible for the purpose of establishing a medical home. A primary care provider can be a general practitioner, a doctor who practices family medicine, internal medicine, an OB/GYN or Pediatrician.

Member sometimes have a need to see a specialist for a medical condition. Simply choose a specialist that participates in the network and schedule an appointment. If a network specialist determines that you should be admitted to the hospital or need services that require prior authorization they will handle these plan requires for you. However, it is a good idea to contact us to confirm benefits for hospital admission or their services that require prior authorization. If you sign any agreements with your provider, this is between you and the provider. Please, read all your documentation.

FISCAL YEAR BENEFITS
The Plan Fiscal Year beings October 1st and ends on September 30th. Benefits reset each year. This means that if your doctor recommends that you have a certain service on an annual basis, that service will be covered once anytime within the Fiscal Year as long as the service is considered medically necessary, subject to any applicable plan limits.

PLAN DEDUCTIBLE
A deductible is the amount you pay each year before the plan pays for services that require co-insurance. It does not apply to services with co-pay or max out pocket. After the deductible has been met, the plan pays a certain percentage of eligible expense and you are responsible for that balance.

OUT-OF-POCKET MAXIMUMS
The Out-of-Pocket maximum includes any applicable co-insurances, deductibles, and co-pays. It does not include 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. 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.

BENEFITS: IN-NETWORK OR OUT-OF-NETWORK
In-network benefits are those provided by a network provider. You will pay a co-pay or percentage of the cost when you receive care. You can receive care from doctors and hospitals not participating in the network and benefits will be provided; however, your responsibility will be higher. If you utilization an out-of-network provider the cost to you will be substantial. You will receive the lower level of benefits and will be required to pay the difference between the maximum allowable charge and the actual charge.
MAXIMUM ALLOWABLE CHARGE DEFINED
In the simplest terms, the maximum allowable charge is the maximum amount that we will pay to a particular provider for a particular service. Providers who have contracted with us to provide network services have agreed to accept that amount as payment in full, writing off the rest of the charge after any applicable deductible, coinsurance, or copayment is paid by the member.

COMPLAINTS AND APPEALS PROCEDURES
If you experience a problem relating to the plan policies or the service provided, there are established internal and external procedures to help you resolve your complaint. These procedures do not apply to any complaint or grievance alleging possible professional liability, commonly known as malpractice, or for any grievance concerning benefits provided by any other plan. If you are in disagreement with a decision or the way a claim has been paid or processed, you or your authorized representative should call our Preferred Administrators Customer Service Department to request assistance on how to submit a verbal or written complaint. When your request for review or member grievance is received, you will get an acknowledgment letter within five (5) business days to receipt of the verbal or written complaint. The Complaints and Appeals Unit will mail the Member and acknowledgment letter. The complaint resolution will be completed no later than thirty (30) calendar days following the receipt of the written complaint. All documentation related to complaints will be logged and readily available for review. Specific questions regarding initial levels of appeal should be directed to the Complaints and Appeals Unit in writing. The complaint must be mailed or faxed to:

Preferred Administrators
Complaints and Appeals Unit
1145 Westmoreland Drive
El Paso, TX 79925
915-532-3778
FAX 915-298-7872

The following information will be required:
1) Member’s name and address
2) Member’s phone number
3) Provider’s name
4) Health Plan identification number
5) Date of Service
6) Details of the exact nature of the complaint
7) Documentation to support the complaint

COORDINATION OF BENEFITS WITH OTHER INSURANCE PLANS
If you are covered under two different insurance plans, benefits will be coordinated for reimbursement. At no time should reimbursement be more than 100 percent of actual expenses. If you are covered as the subscriber or employee by more than one group health program, primary and secondary liability between the plans will be determined based on the order of benefit determination rules included the Plan Document. Different coordination of benefits rules apply based on the type(s) of policies.

CLAIMS SUBROGATION
Preferred Administrators has the right to subrogate claims. This means that Preferred Administrators can recover (1) any payments made as result of injury or illness caused by the action or fault for another person or (2) a lawsuit settlement from payments made by a third party or insurer of a third-party. This would include automobile or homeowners’ insurance, whether yours or another’s.
CONTINUATION COVERAGE
RIGHTS UNDER COBRA

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

This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

The right to COBRA continuation coverage was created by a federal law, Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and to other members of your family who are covered under the Plan when you would otherwise lose your group health coverage. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. This notice gives only a summary of your COBRA continuation coverage rights. For more information about your rights and obligations under the Plan and under federal law, you should either review the Plan’s Summary Plan Description or get a copy of the Plan Document from the Plan Administrator.

WHAT IS COBRA CONTINUATION COVERAGE?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a “qualifying event.” Specific qualifying events are listed later in the notice. COBRA continuation coverage must be offered to each person who is “qualified beneficiary.” A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because either one of the following qualifying events happens:

1) Your hours of employment are reduced, or
2) Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because any of the following qualifying events happens:

1) Your spouse dies;
2) Your spouse’s hours of employment are reduced;
3) Your spouse’s employment ends for any reason other than his or her gross misconduct;
4) Your spouse becomes enrolled in Medicare (Part A, Part B, or both); or
5) You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they will lose coverage under the Plan because any of the following qualifying events happens:

1) The parent-employee dies;
2) The parent-employee’s hours of employment are reduced;
3) The parent-employee’s employment ends for any reason other than his or her gross misconduct;
4) The parent-employee becomes enrolled in Medicare (Part A, Part B, or both);
5) The parents become divorced or legally separated; or
6) The child stops being eligible for coverage under the plan as a “dependent child.”
HOW LONG WILL CONTINUATION COVERAGE LAST?
In the case of a loss of coverage due to end of employment or reduction in hours of employment, coverage generally may be continued only for up to a total of 18 months. In the case of losses of coverage due to an employee's death, divorce, the employee's becoming entitled to Medicare benefits or a dependent child ceasing to be a dependent under the terms of the plan, coverage may be continued for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. This notice shows the maximum period of continuation coverage available to the qualified beneficiaries.

Continuation coverage will be terminated before the end of the maximum period if:

- any required premium is not paid in full on time,
- a qualified beneficiary becomes covered, after electing continuation coverage, under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary (Note: there are limitations on plans' imposing a preexisting condition exclusion and such exclusions will become prohibited beginning in 2014 under the Affordable Care Act),
- a qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both)
- the employer ceases to provide any group health plan for its employees.

Continuation coverage may also be terminated for any reason the Plan would terminate coverage of participant or beneficiary not receiving continuation coverage (such as fraud). You are expected to notify the Plan Administrator of the events described in items 2 through 3.

WHEN IS COBRA COVERAGE AVAILABLE?
The plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or enrollment of the employee in Medicare (Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

**IMPORTANT NOTE** There may be other coverage options for you and your family. When key parts of the health care law take effect, you’ll be able to buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse’s plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

YOU MUST GIVE NOTICE OF SOME QUALIFYING EVENTS
For the other qualifying events (divorce of the employee and spouse or a dependent child’s losing eligibility for coverage as dependent child), you must notify the Plan Administrator. The Plan requires you to notify the Plan Administrator within 60 days after the qualifying event occurs. You must submit a written notice to:

University Medical Center of El Paso
Human Resources–Benefits
4824 Alberta Ave
El Paso, TX 79905
915-521-7580
HOW IS COBRA COVERAGE PROVIDED?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation, COBRA continuation coverage will begin either (1) on the date of the qualifying event or (2) on the date that Plan coverage would otherwise have been lost, depending on the nature of the Plan. Covered employees may elect COBRA continuation coverage on behalf of their spouse, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee’s becoming entitled to Medicare benefits (under Part A, Part B, or both) your divorce, or dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts up to 36 months.

When the qualifying event is the end of employment or reduction of the employee’s hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18 month period of COBRA continuation coverage can be extended.

DISABILITY EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If you or anyone in your family covered the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. A copy of the Social Security Administration Award Letter must be sent to:

Preferred Administrators
1145 Westmoreland Drive
El Paso, TX 79925

SECOND QUALIFYING EVENT EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If your family experiences another qualifying event while receiving COBRA continuation coverage, the spouse and dependent children in your family can get additional months of COBRA continuation coverage, up to a maximum of 36 months. This extension is available to the spouse and dependent children receiving continuation coverage if the former employee dies, (becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced. The extension is also available to a dependent child when that child stops being eligible under the Plan as a dependent child. In all of these cases, you must make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event. A written notice must be sent to:

Preferred Administrators
1145 Westmoreland Drive
El Paso, TX 79925
915-532-3778 or 877-532-3778 (Outside Area)
Fax: 915-298-7863
IF YOU HAVE QUESTIONS

If you have questions about your Plan or your COBRA continuation coverage, you should address them to the contact listed below or you may contact the nearest Regional or District Office of the U.S. Department of Labor’s Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA’s website at www.dol.gov/ebsa.

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

In order to protect your family’s rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

PLAN CONTACT INFORMATION

Preferred Administrators
1145 Westmoreland Drive
El Paso, TX 79925
915-532-3778 or 877-532-3778 (Outside Area)
Fax: 915-298-7863

PAPERWORK REDUCTION ACT STATEMENT

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

The public reporting burden for this collection of information is estimated to average approximately four minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Office of the Chief Information Officer, Attention: Departmental Clearance Officer, 200 Constitution Avenue, N.W., Room N-1301, Washington, DC 20210 or email DOL_PRA_PUBLIC@dol.gov and reference the OMB Control Number 1210-0123.
Si usted requiere este manual en Español, por favor comuníquese con Preferred Administrators al 915-532-3778 o gratis al 1-877-532-3778 si llama fuera de El Paso de 7 am a 5 pm de Lunes a Viernes.